Message from the Chairperson

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

One of the tasks of your SOSM chairperson is the completion of the Section Annual Report, assisted by our section manager, Ms. Jackie Burke. It’s a required task, but not one which we truly look forward to each year.

I completed my sections of the report, feeling depressed to see how little we actually do as a section for the senior contingent of the AAP, other than foster maintenance of affiliation and membership with the Academy, help people prepare for retirement, and promote philanthropic gifting to AAP entities (including the waiver of first year Section membership fees with donation to Friends of Children or Tomorrow’s Children Endowment), plus the advocacy award, the section education program, and the terrific Bulletin and website. Adding questions of the AAP president elect candidates with SOSM and the Section on Young Physicians was a successful endeavor and should be repeated annually, and the shared columns in our respective Section newsletters have been well received. Perhaps our advocacy efforts in repeatedly discussing with the ABP our widely shared opposition to MOC as an implied requirement for senior pediatricians with permanent diplomat cer-

What’s Inside?

Message from the Chairperson .............. 1-4
Executive Committee/Subcommittee Chairs .... 2
2013 Senior Bulletin Schedule .................. 4
AAP Section on Senior Members ............... 5
NCE Section Lunch & Program .................. 5
Will Medicaid be Saved? ....................... 6-7
Drs. Lucy Crain and Mike O’Halloran ........... 7
Preparing for the Unexpected .................... 8-9
Pre-Retirement Checklist ....................... 9
Leadership Openings for the Section on Senior Members .. 9
The Doctor Will Tweet You Now .............. 10
NIRU PRASAD, MD, FAAP
Recipient of Claude S. Pepper Award
Michigan Blue Cross-Blue Shield .................. 11
Two More Genes .................................. 12
Travel
The “High Country” of North Carolina .......... 13
Mead Johnson Nutrition Thank You .............. 13
Seniors Launch Innovative Program to Increase Member Giving at the AAP .. 14
Have an Issue? .................................. 14
Grandparent Week .............................. 15
U.S. Supreme Court Upholds Affordable Care Act ............... 16-17
AAP NCE .................................. 17
Did You Know ... website shortcut? .............. 17
Adult Preventive Healthcare for Pediatricians ............... 18-19
AAP Senior Members Have Membership Options ............... 18
AAP Voting Members ........................... 20-26
Donate to AAP Brick Program .................. 26
AAP Travel Office .............................. 26

Continued on Page 2

Copyright© 2012 American Academy of Pediatrics Section on Senior Members
talificates should count for something. Perhaps the tours of children's hospitals by our executive committee in its new role of self-appointed children's hospital ambassadors in order to publicize the importance of these special pediatric health care entities and the foster grandparenting proposed efforts will bear fruit... Well, having listed all those things, I now feel better about our Section's accomplishments, and I hope that you do, too!

It's human nature to feel that so much more remains to be done and to feel guilty about not having done nearly enough while having the honor of serving as chairperson for this remarkable Section of the most experienced pediatricians in the American Academy of Pediatrics. I leave the position knowing that the Section's leadership is in excellent hands with Dr. Arthur Maron at the helm and a worthy executive committee and staff with knowledge and commitment to serve children and families and our colleagues, as well. I thank you all for the privilege of my tenure as chair of the committee. Now, I ask that you encourage your pediatric colleagues age 55 and older to join the Section on Senior Members. The Academy needs us!

The Academy needs contributions to its philanthropic entities: Friends of Children Fund (FCF) and the Tomorrow’s Children Endowment (TCE). It is reassuring to note in a recent study of gifting by AAP Section members, the Senior Section leads the ranking. However, only 1 in 5 (20%) of our membership have given to FCF and/or TCE. The percentages of donors for other sections range from less than 1.0% to nearly 20% (for Home Care and Section on Early Childhood Sections.) In other Sections, an average of 1 in 50 members donates to these entities, even though it’s a remarkably easy way to give a memorial or honorific tax deductible donation. I am thankful to my colleagues on
the SOSM executive committee to note that we have 100% participation in contributing to these charitable entities, which help children and families in so many ways. You can learn more about FCF and TCE by going to the AAP website. Remember that such gifts are beneficial to children and families, as well as being tax deductible.

**IF NOT NOW, THEN WHEN?**

A benefit of writing this column is that it offers a bully pulpit for personal opinion, so here goes: We are all painfully aware of the July 20 massacre by a seemingly emotionally disordered, heavily armed young man in an Aurora Colorado movie theatre. Another much publicized incident was the August 5 mass shooting in a Sikh temple near Milwaukee. As the eldest members of the AAP, we have seen history repeat itself again and again in similar tragic events, which should be preventable. We remember the headlines: Paducah, Kentucky, 101 California Street, Virginia Tech and so many more. The Brady Campaign attests that there have been at least 61 mass shootings since former Representative Gabrielle Gifford was gravely wounded and 6 others killed by a lone gunman at a Tucson shopping mall. Drive-by shootings happen every day around our country and seem to be encouraged by the media's coverage of massacres, violent movies, and video games, as well as the ready availability of drugs and gangs and guns and ammunition. Yes, it’s a complex issue.

It also distracts from the urgent need to have a civil and meaningful dialog about guns and firearm safety when pundits, politicians, and NRA spokespeople counter that this would inevitably threaten the 2nd Amendment and the right to bear arms. When asked for time to “have the discussion about guns” in the U.S. Senate on July 23, Senator Harry Reid refused a request to grant floor time for this item. Senator Charles Schumer aptly retorted, “If not now, then when?” Immediately thereafter, media pundits and House Speaker Boehner asserted, “This is not the time to have a discussion about guns!”

There’s a big difference between gun control (which this is not) and firearm safety. Pediatricians have been reprimanded about including firearm safety in their anticipatory guidance advice, so much so that many pediatricians skirt the issues, although we know that a 3 year old has the finger strength to pull a trigger on a 32 caliber automatic handgun. Where is the common sense in this? The front page heading in the August issue of AAP NEWS reads: “Judge's decision allows Florida pediatricians to discuss gun safety”. That such a law was ever enacted in Florida and that such legislation was proposed in at least 6 other states smacks of violation of pediatricians’ rights to provide quality care and adequate anticipatory guidance for their patients.

In my opinion, the American Academy of Pediatrics needs to issue a strong statement supporting renewal of the ban on assault weapons and to again issue a barrage of educational materials to children, families, and AAP membership on firearm safety. The AAP and the AMA did so about 12 years ago, in the wake of San Francisco’s 101 California Street assault weapon murders and other mass shootings across the country. This is not a violation of the 2nd Amendment. Children are getting shot everyday in cities around our country. People should have a right to safely take their children to theatres when they can't find a baby sitter. They should be able to attend their places of worship, to walk to and from school, and attend classes without fear of being shot. As pediatricians, we need to be more visible and vocal advocates of firearm safety. A crucial part of that is to demand renewal of the assault weapon ban. I have been told that the AAP leadership plans to issue

Continued on Page 4
Message from the Chairperson Continued from Page 3

a formal statement on firearm safety in the near future. I hope that it will precede the publication of this opinion statement. Meanwhile, please write or call your congressional representatives and senators now and speak up with your experienced pediatric voices to demand solutions to this ongoing epidemic of gun violence before it becomes an ingrained and endemic way of life for all American children and families. There are speaking points on the Children’s Defense Fund and Brady Campaign websites. Congress needs to hear from concerned pediatricians that our country cannot continue to tolerate the deaths of more than 2200 children per year by guns.

NCE
Remember to attend the Section Advocacy Award presentation at our section lunch, followed by a terrific SOSM Education Program at the NCE Saturday afternoon, developed by our own Dr. Jim Shira. There is much more about the program in this Bulletin. Check it out and we’ll see y’all in New Orleans!

Lucy Crain, MD
Chairperson, Section on Senior Members

2013 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 lucycrain@sbcglobal.net with copies to the Academy headquarters tcoletta@aap.org

**Winter Bulletin - Electronic**
December 2, 2012 articles due to Lucy Crain MD, MPH, FAAP
January 3, 2013 online

**Spring Bulletin**
February 1 articles due to Lucy Crain, MD, MPH, FAAP
March 1 mailboxes

**Summer Bulletin**
June 3 articles due to Lucy Crain, MD, MPH, FAAP
July 1 mailboxes

**Fall Bulletin**
August 15 articles due to Lucy Crain, MD, MPH, FAAP
September 16 mailboxes

**2014 Winter Bulletin - Electronic**
December 2 articles due to Lucy Crain, MD, MPH, FAAP
January 10, 2014 online
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

*Senior Child Advocacy Award
Sponsored by Mead Johnson Nutrition

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
Will Medicaid be Saved?

By Donald W. Schiff, MD, FAAP

Medicaid, the essential health care program for the low income population of our nation, is clearly in danger. The thesis that the successful federal-state shared program that provides health care for increasing numbers of our nation’s children as well as funding pregnancy care for 40% of the 4 million babies born each year in the U.S. has become a target in the broad effort to control health care costs is indisputable.

Governors and state legislatures have sought ever since Medicaid was created in 1965 to acquire more control over the determination of eligibility, benefits and costs. Although the majority of Medicaid recipients are children (53%), the largest cost center (over 60%) continues to be the elderly, blind and disabled.

The Administration’s passage of the Affordable Care Act (ACA) utilized Medicaid as an expansible resource to provide health insurance for up to 30 million additional Americans who are, because of insufficient income, unable to purchase private health insurance. There would be no additional cost to the states initially, as the federal government would cover 100% of costs for the first three years of the plan, thereafter cover 95%, and finally after 2019, 90% of the costs.

Additional features of the ACA included a new federal Medicaid floor of 133% of the federal poverty level as a measure of eligibility for both children and adults. A maintenance of effort by each state’s Medicaid regulations and enrollment was a basic feature of the ACA in both Medicaid and CHIP programs until 2014 to prevent states from cutting their programs.

The Supreme Court decision this year was hailed and reviled when the declaration was made that the individual mandate was constitutional under the taxing responsibility of the Congress. Somewhat less emphasis was placed upon the very controversial portion of the court decision which declared that requiring each state to expand Medicaid under the ACA or lose significant federal funds was a form of coercion and thus unconstitutional.

Some states are almost giddy about the removal of this requirement in the ACA, but other states will happily pick up the additional funding and reduce their health care costs (preventing ER high cost visits) as they improve the quality of health care for their citizens.

The Supreme Court Medicaid decision is possibly an early warning sign of the strong movement in many states, particularly, those which are severely stressed by the recession, to constrict their programs, reduce their payment schedules for providers and generally retrench.

The selection of Paul Ryan as the presumptive Vice Presidential candidate on the Republican ticket brings fresh consideration of the future of Medicaid, as Mr. Ryan has produced a budget as Chairman of the Congressional House of Representatives Budget Committee which would make a fundamental change in Medicaid from the “entitlement” program that it currently is to become a block grant recipient program. The result of this change would be to give each state an annual

Continued on Page 7
fixed grant. The formula for the determination of what this allocation would be for each state is unknown. What response there would be to increasing health costs is also unknown. Since the goal of this block grant approach is to reduce health care costs, it is critical to clarify whether this would be a decision made each year by the Congress, or if we would be reducing governmental costs by eliminating increases in health care budgets in spite of an almost certain rise in costs as aging and new technology continue to push basic costs up.

The recent administration’s decision to allow each state to determine its own minimum essential benefit list under the ACA is the latest surprise which has the potential to further denigrate the quality of health care under insurance programs for children. Although this decision will not remove EPSDT from current Medicaid programs, it provides further reason for questions regarding the breadth of care which will be covered by any children’s health insurance program, including Medicaid.

Will Medicaid be saved? Certainly I hope so. This admittedly imperfect program has brought health care to millions of children who would otherwise receive only emergency type care. The future of Medicaid will be determined by both financial and political considerations. November 5, 2012 is the day when part of this decision will be made.

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

---

**Dr. Lucy Crain and Dr. Mike O’Halloran Complete Their Terms on the Executive Committee of the Section on Senior Member**

Dr. Lucy Crain retires as Chairperson of the AAP Section on Senior Members in October 2012. Dr. Crain has served as chair for 4 years and is best known for her strengthening of child advocacy efforts between the seniors and the young physicians and residents. In addition, she is an unwavering advocate for AAP senior members with regard to lifetime certification issues as well as emeritus and retired dues structures in the AAP. She will be sorely missed but fortunately, will continue to serve the Section and the AAP as Immediate Past Chair, the Bulletin’s newsletter Editor and will begin a volunteer position with the AAP on the Committee on Development.

Dr. Mike O’Halloran has served on the Senior Section executive committee for six years. He has been a strong advocate for interviewing AAP members age 90+ and is the author of two important documents for AAP seniors: “Recording Personal Information” and the “Pre-retirement Check List”. Both documents are available on the Senior Section Web page at http://www2.aap.org/sections/seniormembers/docs/PreRet-PersInfo-9-2011.pdf and http://www2.aap.org/sections/seniormembers/docs/PRERetChkLst-9-2011.pdf. Dr. O’Halloran is actively involved in the AAP Wisconsin Chapter.

Thank you both for your contributions to the Senior Section and the AAP!
Preparing for the Unexpected

Joel M. Blau, CFP®
Ronald J. Paprocki, JD, CFP, CHBC®

With interest rates and inflation still historically low, many investors are becoming very concerned about the prospect of rising inflation. Inflation is the annual increase in the price of goods and services as measured by the federal government. When the general price level rises, each unit of currency buys fewer goods and services. From this standpoint, inflation is also a decline in the real value of money, which translates into a loss of purchasing power. Inflation occurs when too much money chases after available goods and services, pushing prices up.

The threat of high inflation is a concern for all investors, especially for those entering their retirement years. Concerned physicians are asking how they can prepare their overall investment portfolios for potentially higher inflation down the road.

As you consider strategies, keep in mind that there is a difference between expected and unexpected inflation. Asset prices, based on efficient market pricing models, already reflect the market’s expectations about future inflation, given all available information. Inflation may turn out to be worse than expected, and this risk of unexpected inflation is what some investors may want to manage. Investors can prepare for unexpected inflation by following one of two basic strategies—hedging the immediate effects of inflation or earning a total return that outpaces inflation over time.

Hedging involves choosing assets whose value tends to rise with inflation. Although holding these assets may reduce the total return of a portfolio, the positive correlation with inflation can help an investor keep up with rising consumer prices, at least over the short term. Candidates for a hedging strategy include retirees, fixed income investors, and others who would experience a diminished living standard during higher inflationary periods. These investors are willing to potentially forfeit greater long-term growth for more immediate inflation protection.

In a total return strategy, an investor attempts to outpace inflation by holding assets expected to earn higher real inflation-adjusted returns. This investor is willing to give up short-term inflation protection for an opportunity to grow real wealth. Younger investors are typically well-suited for this strategy because they are many years away from retirement and expect their earnings to advance faster than the inflation rate. As they save and invest for the future, they can accept more risk through greater exposure to higher-return assets, such as stocks. By choosing assets with higher expected long-term returns and maintaining broad diversification, investors can seek to grow real wealth and preserve the purchasing power of their dollars.

To insulate a portfolio from unexpected inflation risk, both strategies may employ some combination of stocks, short-term fixed income, Treasury Inflation-Protected Securities (TIPS), and commodities.

As you assess your exposure to a high-inflation scenario and form a strategy that reflects your finan-
cial goals and risk tolerance, consider that:

- Expected inflation is built into asset prices. Markets tend to efficiently integrate all known information into prices. Thus, current prices already reflect expectations of future inflation. Only unexpected news will affect the inflation outlook.

- Hedging unexpected inflation has a cost. Investments traditionally regarded as effective short-term inflation hedges tend to have lower historical returns than stocks—and some have much higher volatility.

- Volatility matters. Evaluating assets solely on their ability to track inflation disregards the effect of volatility on returns and risk. Some assets positively correlated with inflation have large return variances, and adding these to a stock and bond portfolio may increase overall volatility.

The media has featured divergent opinions and theories about the effects of recent government actions on inflation, but no one really knows how consumer prices will respond to the complex forces at work in the economy and markets. Investors should carefully review their financial circumstances and investment goals before making changes to their portfolio.

---

**Seniors: Check out the PRE-RETIREMENT CHECKLIST!**

The pre-retirement check list provides an overview of various considerations associated with retirement. Written by a senior-aged pediatrician and located on the Senior Section Web Page: check it out at www.aap.org/seniors, and look for “Pre-Retirement Check List” on the Home Page or under Financial Health in the Living Well Section of the website.

---

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

The AAP Section on Senior Members (SOSM) has one opening for an executive committee member beginning October 2013. The leadership position helps to steer the current and future activities of the SOSM. If you are a member of the AAP and the SOSM and are interested in a 3-year executive committee position, please contact the Section Chairperson, Lucy Crain lucycrain@sbcglobal.net.
The Doctor Will Tweet You Now

By Rachel Dawkins, MD FAAP
Chair, Section on Young Physicians

During the recent AAP Annual Leadership Forum, AAP President Dr. Bob Block sent out his first “tweet”. Up until this point, I used Twitter mainly to follow celebrities and sports figures. Unlike other social media sites such as Facebook, on Twitter you don’t actually have to know the person in order to follow them. Everyone expects that young physicians know everything there is to know about social media. But many young physicians are just learning about this social media site.

Once I started following Dr. Block, I found other pediatrician colleagues from across the country as well as chapters that were tweeting including my chapter (Louisiana). Unlike the celebrities I follow, I found that pediatricians and practices were sending valuable messages about things like importance of vaccines, healthy eating, and legislation being voted on affecting kids.

Practices can utilize Twitter in a variety of ways. Twitter is a great way to reach out to families and let them know important things about the practice such as when flu vaccines will be in and remind parents about scheduling back to school physicals. Or consider tweeting a picture or two of your office staff in action!

Individuals can use twitter to communicate with elected officials. All of our nation’s Senators and Congressmen have twitter accounts. They look to see their names mentioned on twitter as much as they look to see their name in print. After a recent visit to Capitol Hill regarding childhood literacy, I tweeted a thank you to my senator (and tagged her in the tweet). A few hours later she, as well as the US Democrats, had retweeted my message. This let me know that my message was read by someone in the Senator’s office - and made me feel like a political rock star!

Twitter is also a way to communicate with the general public. Families look to the Academy for advice about child health. Your practice can tweet messages giving advice to parents on health and safety issues. Physicians can also follow other groups with similar interests.

Twitter is a free communication tool. It takes up as much time as you are willing to devote to it. Think about using Twitter to promote your practice.

EDITOR’S NOTE
We are grateful for the above article, which originated from the Section on Young Physicians. For us seniors, some of whom are only partially literate in cyberspace, it was informative and helpful. We are all cognizant of the amazing power and value of social networking. There is a caveat, however, which should be considered from our perspective and experience. The loss of privacy and confidentiality is always a worry. I am always nervous when I communicate with a “friend”, only to learn that I am now a friend of my friend’s friend. The commercial enterprises which gather information from tweets and develop a marketing profile with which to attack me with ads are scary, as well. Tweets which appear harmless and innocent may antagonize and incite an unbalanced individual to violence. Who among us has not been “hacked” and had vital information compromised? Let’s use social networking as an amazing tool, but let’s keep a harness on it. AM
NIRU PRASAD, MD, FAAP  
Recipient of Claude S. Pepper Award  
Michigan Blue Cross-Blue Shield

Dr. Niru Prasad is a semi-retired physician. She is board certified in both Pediatrics and Emergency Medicine. She is highly active in the senior citizen community. She frequently provides lectures on different health related topics and precautions pertaining to older adults at multiple senior citizens centers and churches. Dr. Prasad devotes a considerable amount of time treating senior citizens at Urgent Care clinics as well as caring for local community members in need of medical treatment and or advice. Additionally, Dr. Prasad gives monthly health talks on the air on her local TV show. Dr. Prasad has demonstrated an attitude of caring toward older adults in numerous ways. Being a senior citizen herself, she understands the importance of being active and staying healthy. It is her vast knowledge in medicine and passion for ones well-being that makes Dr. Prasad such a valuable asset to our community.
Two More Genes

By Joseph A.C. Girone, MD, FAAP

In 2008, the science world reported the discovery of the first human gene that determines a specific behavior in women- The High Tea Gene (Senior Bulletin 17:3, 2008). Now two more genes have been identified associated with human behavior- one in women and one in men.

The “NI” gene, or Newborn Identification gene, is found on the X chromosome in women. This gene explains a phenomenon in women that has been observed for centuries. Once a newborn infant’s face is shown to a woman, she is able to identify that infant by the facial features forever. When placed in a newborn nursery with many babies, a woman can pick out an infant that she knows from all the other infants just from looking at the baby’s face. A mother can choose her infant by facial features alone no matter how many infants are present. This ability is not present in men. A man gazing upon a group of newborn infants has no chance of selecting one he had previously been shown. To a man, looking at a group of newborns is the same as viewing a glass jar filled with Japanese beetles. All are identical.

But the “NI” gene in women does more. Women presented with the newborn’s facial features are able to identify the genetic origin of each feature. For example, a woman can determine the resemblance of a newborn’s nose to that of the father or the mouth to that of the mother. Some women can go into more detail, able to point out features beyond the parents but those of grandparents. “He has grandpa’s hairline.”

The first gene identified in men that affects behavior is the “RDC” gene. This is a unique discovery on the Y chromosome and has a suppressive or inhibitory effect on the emotional reaction of a person. There are experiences that result in various levels of emotions. Women display the typical expression of emotion in humans. Men usually have a more muted response in emotional situations and this prompted the search for the controlling gene.

The “RDC” gene has been identified in men and is responsible for the difference of men and women in emotional outcome. An example of the “RDC” gene expression is found in the human experience of marriage. Before the wedding, women have a “bridal shower” where emotions run high. Women gather together where there is intense conversation, gifts are “showered” on the bride and tears may flow. The male counterpart to this is a poker game with drinks and friends. The bride devotes hours of thought and shopping for the wedding gown. She tries on many and after significant emotional ups and downs, a dress is chosen. Weeping usually plays a role in this search especially from the mother of the bride. Having the RDC gene, the groom rents a suit.

It is not known why more men in recent times are observed to cry in public. This was not an acceptable behavior prior to the 20th century. It is not clear if these crybabies lack the “RDC” gene or have somehow been able to overcome its effect. Time will tell. By the way, the gene is named for the basic nature of men- Really Don’t Care.

Copyright © 2012 Joseph A.C. Girone, MD
Travel

The “High Country” of North Carolina

By Arthur Maron, MD, MPA, AAP

It was our first foray to the “High Country” of North Carolina this past August, and we would recommend it to any senior seeking a respite from the heat and humidity found in much of the U.S. For us, residents of South Florida, it was a particularly good choice. The area embraces mountains as well as golf courses, and trout streams. We rented a small, one-bedroom condo in Boone, but there are several other communities – Blowing Rock, Banner Elk, and Linville. None of these communities were familiar to us, so it was a month for exploration and wandering up and down numerous mountain roads.

Most of the vacationers we encountered were from Florida, but many drove from eastern North Carolina as well as Georgia and the Mid-Atlantic States. We had initially planned a leisurely two-night drive from South Florida, but actually flew into Charlotte and rented a car for the month. Don't rent a car at the airport; the cost is unbelievably high. We rented our car in nearby Belmont, hopped a cab for a short ride, and saved nearly half the rental fee. A pleasant two-hour drive brought us to Boone.

The climate is amazing; generally 70s during the day and 60s at night. The panoramic mountain views are exciting as well as relaxing. There is a popular music festival on the campus of Appalachian State University, which we missed out on because August is summer break. There were some other stage presentations and open-air concerts – all pleasant, unpretentious, home-spun. The area is a wonderland for fly-fishing, mountain hiking, golfing, and boating, all of which we passed up. We enjoyed being in a vacation club with many couples in similar circumstances to us. Dining opportunities abound. The gamut runs from local, family-type luncheonettes to gourmet, high-ambience, inns and restaurants. The prices were moderate in general. Men required jackets at one spot! By the way, this is a ski center in winter, which may be an attraction to some of you. Don't miss the Blue Ridge Parkway, which traverses the area and affords many sites of aesthetic and historical significance.

Housing is available for a week to months, although motels are also available, but we preferred our kitchen, which permitted some “home-cooking”. Rural and rustic architecture abound, and antique shopping may interest you. There is the requisite outlet mall but we were underwhelmed with the bargains. I should mention the year-around indigenous residents. They are invariably friendly, helpful and appreciative of our patronage.

Unless you already reside in a summer paradise, consider the High Country for a pleasant, relaxing, good value stay. If you would like more details, contact artmaron@aol.com.

The AAP Section on Senior Members would like to thank Mead Johnson Nutrition for their support of the Child Advocacy Award.
Seniors Launch Innovative Program
to Increase Member Giving at the AAP

By Stanford Singer, MD, FAAP
Membership Chairperson
AAP Section on Senior Members

The Section on Senior Members has devised a new program that benefits new Section members as well as the philanthropic efforts of the Academy. For a contribution of $25 or more to the Friends of Children’s Fund new Section members will receive a complimentary, trial membership in the Senior Section. Those members will then be billed for the usual $25 dues after the free trial.

This innovative program has generated more than $3,000.00 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 age 55 or older. The Section presently has a membership of 632 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 (see http://www.aap.org/sections/seniormembers/seniorbulletin/seniorbulletin.htm), a very useful and up-to-date web site (see http://www.aap.org/sections/seniormembers), 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 Executive Committee of the Section has met with members of the AAP Executive Committee and had active correspondence with the ABP reflecting the concerns of the Section membership.

The Section is also undertaking a study of the issues of grandparents becoming primary care providers of their grandchildren.

If you are interested in joining the senior section or making a philanthropic donation to the AAP as a senior for a free trial membership in the Section, please contact the Senior Section at jburke@aap.org.

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
Grandparent Week

By Mark Rosenberg, MD, FAAP

Becoming a grandparent means entering a new phase in your family’s life, new relationships and new responsibilities. Just as you helped to shape your own child’s future, grandparents can add so much to the relationships they have with their grandchildren. There are new opportunities to share your own life’s story as well as see the world in a new way through the eyes of a child.

Most become grandparents the usual way by supporting your own children as they become parents of their own right; others through adoption. We became grandparents when our daughter married the father of four children, an instantaneous multiplication of our family. Our major challenge has been to become familiar with them not only in our new role, but from afar, over 700 miles away. That in itself has its own challenges.

We know that many grandparents are also caretakers of children. According to AARP, more than 5 million children live in their grandparents’ homes and 2.5 million grandparents are primary caretakers.

As a pediatrician, one of the things that has changed dramatically over the years that I have practiced is our understanding of the child’s mind. Improved knowledge of the neurosciences and our understanding of child development have changed the way we approach the early childhood period, changing early child care as well as education. We understand the importance of the social and emotional needs of infants and young children are to the future well being of a child and even the adult years.

In the first year of life, babies begin their rapid course of growth and change. A baby’s earliest interactions with parents and other caretakers determine the strength and adaptability of the developmental foundations that are forming. During this period when babies are changing from a totally dependent state to a toddler who can calm herself and regulate her own behavior they need a secure relationship with those around them. The crying child needs the reassurance that someone is there to comfort them. Attachment is that secure connection with caretakers that forms that link to a baby’s emerging sense of self.

Spending time together as a family or as an extended family strengthens the social and emotional bonds that are so important to raising healthy and well adjusted children. Whether it is time spent reading to your grandchild or taking her for a trip to the park that is time well spent.

As pediatricians we have become strong advocates for children in our practice setting, clinic, or hospital. Now we can continue to represent the interests of children as advocates for policies that support children, from economic insecurity to hunger to child safety, it is important to continue the work that we began in our careers.
U.S. Supreme Court Upholds Affordable Care Act

On Thursday, June 28, the U.S. Supreme Court announced one of its most highly anticipated decisions in decades: a 5-4 vote to uphold the constitutionality of the Affordable Care Act.

The Court considered several challenges brought by states in Florida et al v. Department of Health and Human Services, and upheld the Affordable Care Act, ruling:

• The Affordable Care Act’s individual mandate, while not valid under the Constitution’s Commerce Clause, is valid under Congress’s taxing authority; and
• The law’s Medicaid expansion to individuals earning about one-third more than the federal poverty level (FPL) is valid; however, its provisions allowing the federal government to withdraw Medicaid funding for states that fail to enact the expansion is not.

What the Court Found
At the centerpiece of the multi-state lawsuit against the Affordable Care Act’s individual mandate—which requires all legal U.S. residents to buy health insurance by Jan. 1, 2014, or pay a penalty—was the issue of states’ rights.

Chief Justice Roberts, along with Justices Kennedy, Scalia, Thomas and Alito, rejected the federal government’s theory that the mandate was constitutional under the Commerce Clause. However, a different set of five Justices—the Chief Justice along with Justices Ginsburg, Breyer, Sotomayor and Kagan—agreed that it was constitutional because the mandate imposes a “tax” on people who do not buy health insurance, and Congress can impose that tax using its power to levy taxes. Though the mandate is intended to encourage people to buy health insurance rather than to raise federal funds, the Chief Justice still classified it (and its accompanying penalty) as a tax.

The final issue before the Court was the law’s expansion of the Medicaid program (to individuals earning about $11,170 and families of four earning about $30,000). The Court found that Congress may offer states funding to expand Medicaid, and that states can agree to expand coverage in exchange for those new funds. If a state accepts the expansion funds, it must comply with the new rules and expand coverage, but—and this is the key underpinning of the decision—a state can refuse to participate in the expansion without losing other Medicaid funding. In other words, each state may choose to continue its current Medicaid program as-is.

The Affordable Care Act had assumed Congress could use its spending power to require states to expand Medicaid by threatening to withhold funds for the entire Medicaid program should a state fail to do so. The Court found this specific provision—by a vote of 7-2—“coercive,” and as a result, unconstitutional.

What the Court’s Decision Means for Children and Pediatricians
The AAP commended the Court’s decision to uphold the Affordable Care Act, and has been at the forefront of state and federal advocacy throughout the litigation process in support of the law’s continued implementation. While the ultimate fate of the law will depend on the outcome of the Nov. 6 Congressional and Presidential elections—with candidates from both political parties vow-
ing to overturn or uphold the law, respectively—the Supreme Court decision established a constitutional justification for protecting its gains for children and pediatricians.

Existing protections already in effect as part of the law’s implementation can therefore remain in place, and provisions set to take effect in the coming two years—such as an unprecedented increase in Medicaid payment rates to at least those of Medicare in 2013 and 2014 for certain primary care and immunization services—are on the path toward full implementation, unless Congress or the next administration changes the law.

As a result of the Court’s decision on the law’s Medicaid expansion in 2014, the Academy is concerned that states may choose to opt out of the expansion altogether and leave millions of vulnerable parents and childless adults without access to health insurance. The federal government currently pays between 50 and 60 percent of the cost for the Medicaid program to states, though as part of the law’s Medicaid expansion to 133 percent FPL, the government match would increase to 100 percent for three years, then fall to 90 percent after 2020. Should states covering less than 133 percent of the FPL still opt out of the expansion, however, a majority of the state’s uninsured would be in the same situation they are in now, earning too much to qualify for Medicaid but too little to afford private insurance. While the high federal match rate may encourage states to expand the program, the Court’s ruling on this issue leaves the ultimate decision on whether to forgo the expansion up to the states.

Now that the Supreme Court has upheld the Affordable Care Act, the Academy and AAP chapters will continue working with states and the administration to ensure that all of the law’s provisions are implemented, and that children will continue to receive the “ABCs:” access to health care services, age-appropriate benefits in a medical home and health care coverage to meet their unique needs.

To learn how to help AAP “Get Out the Vote” in advance of the Nov. 6 elections, visit www.aapGOTV.org.
Adult Preventive Healthcare for Pediatricians
From the MED-PEDS Section of the AAP

The Internal Medicine-Pediatrics (Med-Peds) Section of the American Academy of Pediatrics is proud to report that the PHD program (Pediatrician Health Day) will return to the exhibit hall at the National Convention and Exhibition in New Orleans, LA. The 3 day event will take place this October 2012, in the exhibit hall of the Ernest N. Morial Convention Center. This program is designed to give individual information and education to pediatricians about their own adult health care needs. We will provide information about adult immunizations, cancer screening, cardiovascular disease, menopause, vitamins, diet, exercise, stress and burnout so that pediatricians attending the conference can better understand what they can do to become healthier. Hundreds of pediatricians received information from our exhibit booth since our inaugural program in 2009. See the Adult Preventive Healthcare Checklist for Pediatricians on the next page.

Hours of PHD Program
The PHD program exhibit hall hours are for this year are:
Saturday, October 20: 12:15 PM - 4 PM
Sunday, October 21: 10 AM – 4 PM, 5:30 PM – 7 PM
Monday, October 22: 10 AM - 2 PM

AAP Senior Members Have Membership Options
The Senior Section helps mature members understand their membership options in the AAP:

Retired Fellow category requires that an AAP Fellow be at least fifty-five years old, must have been an AAP member for 5 years or more, and must no longer derive income from professional activities. Dues are $212; AAP News, Pediatrics and Red Book are provided as online subscriptions. Retired Fellows retain the privileges of voting in national elections and using the FAAP designation.

Emeritus Fellow category requires that a Fellow be at least 65 years of age and have been an AAP Fellow for 30 years or more. Dues are $75; Pediatrics and Red Book are provided as online subscriptions, AAP News is a print and online subscription. Emeritus Fellows retain the privileges of voting in national elections and using the FAAP designation. They may also opt to participate in the healthychildren.org Find a Pediatrician search tool.

To check your current AAP category, status or eligibility for Retired or Emeritus Fellow, log onto the AAP Web page at http://www.aap.org, click on “MYAAP” located in the upper right hand corner or call the AAP Customer Service Center at 866-THE-AAP1.
# 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 $1^1 - 2^{2,3}$ years</td>
<td>Average risk women ≥ age 40</td>
<td>CDC$^2$ USPSTF$^3$ ACS$^1$ACOG$^1$</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$^3$ or case by case$^4$</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$^5$</td>
<td>USPSTF$^7$ ACS$^1$ AUA$^5$</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
AAP Voting Members,

The 2012 national AAP election for President-elect, District Officers, and Bylaws Referenda is due to begin on August 31 and conclude October 1. Please look for an e-mail message from the AAP Election Coordinator in early September with a direct link to the AAP election ballot. The ballot will also be available by logging in to the AAP web site, and clicking on the ballot link. The ballot will not be open until August 31.

Please see below for information from each of the candidates for President-elect to assist you in making an informed choice. Additional information on the President-elect and district candidates and the bylaws referenda may be found on the AAP web site: http://www.aap.org/vote.

Please remember to vote in the forthcoming AAP election.

James M. Perrin, MD, FAAP

My primary care practice experience, advocacy, and policy work make me a strong presidential candidate. I want to help the Academy address salient problems like obesity, asthma, mental health conditions, and developmental disorders, given their growing prominence among children and adolescents. Together, we can help such children develop healthy trajectories.

We must make the Affordable Care Act work for children and pediatricians, including:
• IT to meet pediatric needs and improve communication among primary care pediatricians and specialists
• Support to expand transformation of practices into medical homes
• Better payment for generalists and specialists
• Medicaid expansions and insurance reform
• Quality and accountability where pediatricians direct assessment methods

I will link the Academy with parents, community agencies, and the business community to lower the risks children in poverty face, especially risks to early brain development, and lead Academy efforts to address growing diversity among pediatricians through expanded mentoring and career development programs.

Michael D. Klein, MD, FAAP

We need to focus on two areas, if we are to achieve the goals of the AAP:

Improve the image and prestige of the profession of pediatrics with the public and politicians.
Learn how to speak to those who do not listen to reason.

Improving the health and well-being of children is the best way to achieve any and all of humanity’s long-term goals.

We also know that there is a critical period: the first thousand days.

The data is in. We know that investment in early childhood development returns more on the dollar than ANY other investment.

Pediatricians and pediatric specialists have the best education, training and experience to propose, evaluate, and implement programs to develop better children.

We have discovered how to improve the world - improve the children.

We have even found interventions that will do just that.

It is our obligation to DO IT.

QUESTIONS OF 2012 AAP PRESIDENT CANDIDATES
FROM AAP SENIOR SECTION AND YOUNG PHYSICIAN SECTION

Senior Section Questions

If elected, what do you propose that the AAP should do to address the ongoing epidemic of deaths and injuries from firearms?

Michael D. Klein, MD, FAAP: The NRA may be the most powerful lobby in Washington. Actions should take place at the Chapter level first. Firearms must be restricted. To do this, we must learn to speak with people who do not listen to reason. The AAP has excellent resources of data, Victor C. Strasburger is particularly eloquent. We will not win this battle by piling up data, by comparing ourselves to Europe, by being strident. We need to step back and learn new techniques. Some good references are: Kerry Patterson, Influencer; Nancy Lee, Social Marketing; Jonathan Haidt, The Righteous Mind. This topic would be an excellent one to introduce this new field of knowledge in which the AAP must develop expertise. Five to ten committed physicians could get this started.

James M. Perrin, MD, FAAP: The continuing risk to children and youth from firearms is unconscionable! We must continue and expand our efforts to keep children and communities safe through educating parents and youth directly and by community efforts to diminish firearm access. As an example, the Florida Chapter recently succeeded in overthrowing legislation that would prevent pediatricians from counseling parents about gun safety. Other states (and Florida again) will likely face similar legislative efforts in the future to interfere with best pediatric prac-
practices. The AAP, nationally and in its Chapters, must have a coordinated strategy to address these threats to practice. It is important that we counsel families about limiting guns in homes and where they exist to keep ammunition and guns in separate locked places. We must work with community agencies to limit domestic and community violence, limit access to inappropriate gun purchase, and help young people learn best practices for managing conflict.

*What can be done to increase remuneration for pediatric services?*

James M. Perrin, MD, FAAP: We must advocate for payment to allow primary care pediatricians and subspecialists to provide the care they're trained and prepared to deliver. The Affordable Care Act (ACA) provides important support to improve payment – through its emphasis on team care and increased payment for the care of people with complex chronic health conditions. In addition, the ACA requires Medicaid payment parity with Medicare as of January 2013, which will lead to major increases in Medicaid support in many states, for both primary care and subspecialty services. Growing rates of chronic physical and mental conditions cared for in primary care settings highlight the need both for more time with patients and families and for non-physician staff to help coordinate care. Pediatric subspecialists, medical and surgical, address many complex conditions with new technologies, but payment remains too low. Building coalitions with families and the business community, who can advocate for better pediatric care and payment, is critical to improving payment. Implementation of the PPACA with Medicaid payments being increased to Medicare will help.

Michael D Klein, MD, FAAP: A. What is really needed, however, is to improve the image and prestige of the profession of pediatrics with the public and politicians. That is the only way to increase the income of those who care for children to be commensurate with their knowledge and skills, as well as with the risks they take, and the importance of what they are doing for everyone. The importance: we have discovered how to improve the world...improve the children. This is best achieved by interventions in the first thousand days where we have the best education, training and experience. I have some ideas, but many detailed programs can be developed. B. We must also break the survey stranglehold. Seventy percent of pediatricians are employed by someone other than themselves or their small group. Their income is based on the “surveys” (e.g. AAMC and MGMA). These surveys tell the world what pediatricians currently earn and what retina surgeons currently earn. It is these surveys which keep us at the low end of the wage scale. C. We must find a way to step over the surveys and be recognized for our value. Part of that value is that we are the ones who bring patients into any healthcare system: mother decides which health plan the family will join, and that decision is based on her perception of the care her children will receive.

*What can be done to allay the public fear of immunizations?*

Michael D Klein, MD, FAAP: We need to learn new techniques. We must learn to speak with people who will not listen to reason. One excellent approach was outlined by Jody Lanard at the Districts III and VIII meeting this summer. She points out that first we must learn to tell the truth, so that we can expect to be believed. We never point out that the flu vaccine is only 70% effective
in healthy adults. Next we must learn from Martin Buber to establish I-thou relationships: never talk down to them; do not mislead them, even for a good cause; acknowledge the kernels of truth in their arguments; acknowledge the kernels of hyperbole in ours. We must also add outrage and fear-management strategies to our armamentarium (http://www.psandman.com/index-OM.htm).

James M. Perrin, MD, FAAP: Immunizations are one of the great success stories of pediatrics and public health!! Along with forceful and accurate statements about the (limited) risk of immunizations, we must tell the stories of what changes immunizations have meant for the health, well-being, and decreased mortality of children (and adults). Here too, collaboration with public agencies and with parents who understand the value of immunizations can help spread the message that immunizations work and have made huge differences in the lives of children in the United States and worldwide.

How can the older and young generations of pediatricians work together to advocate for children?

James M. Perrin, MD, FAAP: Bringing the house of pediatrics together to advocate for children is one of the great values and visions of the Academy. I have served as a faculty adviser for an advocacy program in Boston, in which residents from all pediatric programs in the state come together to learn about state-based political efforts on behalf of children. Many of them continue to work with legislators and members of the MA Chapter to advocate for issues involving children (e.g., tobacco control, gun control, immunization access). In addition, through my leadership and participation in the AAP Legislative Conference, I have often visited legislators on both sides of the aisle in Washington with younger pediatricians. As we learn and teach at that conference, legislators want key facts, but they also want to hear compelling stories of patients and families that help them understand the issues and want to bring about change. Older and younger pediatricians bring different narratives that support our advocacy: younger pediatricians bring much passion about important child health topics; older pediatricians bring more experience and skills. Each can teach the other about their particular competence and strengthen advocacy efforts.

Michael D. Klein, MD, FAAP: This is one place where I think the AAP is already doing a great job by assuring the participation of medical students, residents, fellows, and young physicians in chapter and district leadership forums. The best method remains to ask them to do something and then give them credit for it. There are so many things to do: talk to state legislators, develop an AAP educational program for residency programs, study the issues raised in number 3 above and develop detailed specific actions we can take.

Young Physicians Questions

We are struggling to be relevant in the age of too much information. What one thing can the AAP do to differentiate itself to young physicians and stimulate membership?

James M. Perrin, MD, FAAP: Let me address two things – advocacy and practice management support.

Continued on Page 24
The AAP, especially through its Chapters, has had a major role in strengthening advocacy training in residency programs across the country. Many chapters sponsor resident days at the state house – introducing residents and other young physicians to the state legislative process, key legislation under consideration, and key legislators. Chapters also encourage residents and other young pediatricians to participate in chapter committees. These advocacy experiences can continue beyond residency, and the AAP provides an excellent base for young pediatricians to advocate for issues they care about – adolescent health, child abuse, environment, health care disparities, obesity. No other organization has the breadth and experience of the Academy in these areas, and this opportunity for advocacy allows all of us, young and old, to help children and families get the care they need.

With respect to practice management, the AAP offers tremendous benefits to young physicians entering practice. Many management tools and advice come from the AAP website. The Section on Administration and Practice Management provides an impressive forum through its listserv; its many sessions at the NCE provide much guidance to practicing pediatricians at many levels of experience, with an emphasis on pediatricians starting out in practice.

Advocacy and practice support are two compelling reasons for young pediatricians to belong to the AAP.

**Michael D Klein, MD, FAAP:** Communicate AAP value on a regular basis. I would stress three points:

1) AAP education is better for you and your patients than UpToDate.
2) AAP members create evidence-based policy that guide practice in a rational manner.
3) Only the AAP has both the credibility and the infrastructure to advocate for pediatricians and their patients at both the federal and state levels.

And I would add one more: the AAP (with your help) should create a campaign for the public recognition of the initials FAAP as THE quality standard for children’s health care.

**How can young physicians best contribute to the AAP? Would it be time, leadership, promotion via media, etc.**

**Michael D Klein, MD, FAAP:** Do something about which you are passionate. This is easy to get started at the chapter level. I assure you that you will be greeted with open arms by the Chapter Board. Some examples: talk to state legislators on a regular basis about children’s health care issues (specifics to be developed by young physicians with the chapter); call every pediatrician and pediatric specialist in the state who is not an FAAP. Deliver a carefully worked out script. Ask them to join. If they say no, ask them why not. Collect and collate the data, (publish it?), change your approach (and maybe even the AAP) based on the answers.

**James M. Perrin, MD, FAAP:** Young pediatricians can contribute in many ways to the AAP. Among the more fruitful opportunities is work with state chapters. These groups have developed much expertise about critical child and adolescent health issues in their states and local communities.

Continued on Page 25
State committees cover a wide variety of topics – legislation, immunization, obesity, abuse, adolescence, mental health. Pediatric Councils work with payors in states and local areas to improve financing of child health care. All of these offer great opportunities to collaborate with other pediatricians, generalists and subspecialists, in areas of importance to us all. Young physicians often chair state chapter committees and become involved with statewide efforts, including chapter leadership. More experienced pediatricians can mentor younger pediatricians, who in turn can mentor residents. Of course, there are many other ways to contribute – through national committees and sections, task forces, advocacy. All of these provide ways for active input of younger pediatricians to our efforts to improve the lives of children and pediatricians.

Many academic programs do not actively teach their residents the importance of the AAP and don’t financially support attendings’ membership. If their teachers and mentors are not members then residents do not receive the message that membership is worthwhile, and are less likely to continue once they have to pay dues. How would you work with residency programs to communicate the importance of AAP membership and increase involvement?

James M. Perrin, MD, FAAP: The growth of advocacy training in residency programs has helped build stronger relationships of academic programs with state and national AAP leaders. The AAP provides much benefit to academic pediatricians, medical and surgical, through advocacy for better payment for services. Academic programs, for example, provide much care to children insured by Medicaid. The Academy’s strong advocacy for Medicaid improvements will help many academic centers carry out their core functions more effectively. Pediatricians in academic settings often do not receive support – payment – appropriate for the care they provide. Building effective links with the Academy’s strong advocacy capabilities will allow many smaller subspecialty groups to band together to seek better payment.

Leaders of state chapters should systematically connect with academic programs in their state, providing grand rounds, information sessions for residents, fellows, and faculty, and involving academics in the state chapter activities. The national AAP leadership has taken on a similar program to meet with academic program leaders across the country and provide visibility in academic programs through grand rounds and similar efforts to spread the word about the value of the AAP. Faculty, residents and fellows should be encouraged to be active members of local chapter committees and other activities.

Michael D Klein, MD, FAAP: It’s like reducing a fracture – constant steady pressure. I would go back to number 1. above: communicate value on a regular basis. As part of this arrange for regular grand rounds by speakers with a strong passion for the AAP.

Also go back to number 2. above: marketing the initials FAAP. The academic department should be ashamed to have faculty that are not FAAP, as much as they would by having faculty who are not Board Certified. A national campaign can help. In addition the faculty practice plan should advertise with the aid of the AAP: “All our faculty who provide health care for children are Fellows of the AAP.” “Be sure that anyone providing health care to your children is a Fellow of the AAP – all
It might also be possible for the AAP to make strong contractual relationships with academic departments whereby portions of the dues (paid by the department as a “perk” of faculty membership) would be directed where the department thought it would be best, such as federal or state advocacy, or specific education or maintenance of certification.

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 Grace Geslowski at ggeslowski@aap.org or call 888/700-5378.

AAP Travel Office

The Academy Travel Office is here to serve your travel needs Monday thru Friday from 8:00am till 4:30pm CST. Receive air discounts to AAP meetings and car discounts through Avis and Hertz.

We also offer reservations through NU Travel on line, for those who prefer to book their own travel. If taking a vacation is what you are looking for then contact Elizabeth Harrison for air, cruises or land packages.

Our toll free number is 888-227-1772.