Message from the Chairperson

Arthur Maron, MD, MPA, FAAP
Chairperson, Section on Senior Members

Welcome to this inaugural message, as I begin my tenure as Section Chair. Allow me, first, to pay tribute to Lucy Crain, my immediate predecessor, for her outstanding efforts and accomplishments in guiding the section these past four years. Lucy and our prior leaders have brought the section to the highest level of service to our members and the AAP, as we strive to improve the lives of children and their pediatricians. With the support and guidance of our Executive Committee and AAP Staff, I shall endeavor to maintain our fine reputation.

I am pleased to report that Lucy Crain has consented to step in as Editor of the Senior Bulletin. I am confident that the perennial popularity of the Bulletin will be maintained.

Those of you who were in attendance at the AAP National Conference and Exhibition in New Orleans in late October were treated to a grand educational experience, along with entertainment and recreational opportunities galore. Our section educational program, capably chaired by Jim Shira, was well attended and the enthusiasm and interest of the attendees was gratifying. The program included the presentation of our section’s Annual Child Advocacy

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Award to Dr. Gerald Gilchrist. Look for Gerry's comments and information elsewhere in this Bulletin.

The Executive Committee met during the NCE and considered a number of issues. Dr. David Krol attended as a guest representing the AAP Section Forum Management Committee (SFMC). The SFMC coordinates and manages section activities to promote interaction and networking between the many sections of the AAP. The Annual Leadership Forum (ALF) meets annually in coordination with Committee, Section, Council and Chapter leadership to integrate AAP policies and initiatives.

The Committee reviewed several membership issues, including the initiative of opening the section to affiliate members who are in professions related to child healthcare, such as pediatric dentists, nurse practitioners and physician assistant. Stan Singer, Membership Chair, who proposed the plan, will continue to develop criteria for section affiliate membership. The committee also met with several guests relative to a potential revision in AAP membership nomenclature.

Dr. Rachel Dawkins, of the Section on Young Physicians (SOYP), joined the meeting to discuss expansion of relationships between the two sections. There is interest in both groups for mutual endeavors.

Rachel Dawkins, MD, FAAP, Section on Young Physicians

Sonya Clay, Assistant Director of the AAP Department of Federal Affairs, in the Washington, DC office, presented a comprehensive report of AAP...
activities with regard to Firearms Safety and Violence Prevention. Although Lucy Crain had presented the topic of gun safety in a recent Chair’s Message, the report by Ms. Clay was a revelation to me. We are all acutely aware of a litany of horrific incidents of murder and mayhem across the country. What is incomprehensible to me is the lack of responsible legislation and action by both state and federal entities. To its credit, the AAP has taken a number of steps in promoting reason and common sense.

1. The AAP opposed HR 822, The National Right-to-Carry Reciprocity Act, which would allow the holder of a permit to carry concealed weapons in a state to go to any other state which allows concealed weapons (49 states). This, in essence, converts a state permit to a national permit.

2. Senate bill 2213, with 33 cosponsors, is Respecting States’ Rights and Concealed Carry Reciprocity Act. The equally-disturbing provisions may also be attached to other legislation as amendments. The AAP is monitoring this bill.

3. Legislation enacted in the State of Florida would make it illegal for pediatricians to discuss gun safety during office visits. This law was fought by the AAP Florida Chapter and overturned.

4. The AAP has endorsed and advocated for important legislation to counter school bullying, violence based on gender or sexual preference, but congressional leadership has yet to act.

5. There is continuing action in Congress to withhold appropriation from any agency or department which conducts activities advocating gun safety.

WHAT IS WRONG WITH THIS PICTURE?

How can any rational citizen allow this violence and mayhem to continue? We are not referring to hunters, sportsmen, or homeowners fearing assault. We are speaking about multi-clip assault weapons and thousands of rounds of ammunition in the hands of a single individual. In the era of cyber technology, which tracks people and accumulates information instantaneously, we have the capacity to address this issue. What we need is the will and the determination. Voters are more effective than super-PACs. Those of us in the Section on Senior Members with a minute or an hour or a day to devote to advocacy need to call someone, write someone or text someone to fight this national epidemic of gun violence.

I invite any response or comment. Let’s work together.
The Executive Committee tours CHNOLA.

In conjunction with our committee's meeting at the NCE in New Orleans, a tour of Children's Hospital, New Orleans (CHNOLA) on October 19, 2012 by the SOSM Executive Committee was our second in a series of visits to our nation's children's hospitals. We were hosted by Louisiana AAP Chapter President, Keith Perrin, MD, Alan Robson, MD, senior vice president and medical director, and Mr. Brian Landry, vice president of Marketing of CHNOLA for an overall introduction to this 220 bed (licensed for up to 281 inpatients) full service children's hospital, the only exclusively pediatric hospital in the state of Louisiana. (Both Tulane and Ochsner Medical Centers provide pediatric as well as adult medical services.) CHNOLA has a staff of over 400 physicians, as well as 100 residents and subspecialty fellows. Close association with the Louisiana Chapter of the AAP is emphasized and child health advocacy and services both domestic and international are evident. A number of CHNOLA services are jointly collaborative with LSU and Tulane medical centers and training programs.

Located on Henry Clay Avenue -about a 25 minute taxi ride from New Orleans city center in an area of high density population and many families, the main hospital was built in 1955 in the peak of the nation's polio epidemic, responding to the first of many major health crises in the area. CHNOLA has about 50 subspecialty services, 16 primary care sites with 170,000 annual outpatient pediatric visits. Additional specialty outpatient centers are located in Metairie, Baton Rouge, and Lafayette. There is a 36 bed NICU, an 18 bed PICU, a 20 bed CICU and a group of fulltime hospitalists. Of interest, the New Orleans and Jefferson parishes have separate ambulance services, which creates an unusual situation for transfer of patients requiring emergency services at the two story emergency department. Enabling critically ill children from across Louisiana and southern Mississippi to be flown to New Orleans for medically indicated care, an emergency transport helicopter was added to services in January 2011. In its first year of operation, 190 children were emergently transported by helicopter to Children's Hospital, more than by ambulance. LSU pediatric emergency medicine fellows train at CHNOLA, as do a number of other pediatric subspecialty fellows.

As Dr. Robson and Dr. Perrin described the hospital’s experience during the Katrina disaster, it became readily apparent that this is a unique institution, which has learned to successfully deal with ongoing onslaughts of predictable and unpredictable hurricanes, floods, and other natural disasters. We learned that the staff calls a “Code Gray” in advance of predicted major hurricanes in the Gulf of Mexico. The code initiates all protocols necessary to prepare for any eventuality during a major storm. After the storm, an extensive review takes place to improve procedures and protocols. With Hurricane Katrina, 100 patients remained hospitalized at CHNOLA, and were later evacuated to other hospitals in unaffected areas, and there were no deaths. Dr. Robson recalled that two newborns on ventilator support required transfer from another hospital which was without electricity. When CHNOLA lost power, two pediatrics residents paddled the babies in a canoe,
providing manual bag ventilation, to the waiting fire rescue unit staffed by Children's Hospital nurses and a neonatologist. The two infants were safely evacuated to Houston for further neonatal care.

We were impressed by the multi-ethnic, multi-lingual staff and patients we met on our tour, as well as the sheer numbers of children served here. There are three cardiac surgeons on staff with more than 250 cardiac surgeries per year and the only pediatric CICU in Louisiana. Hematology/Oncology provides an average of 20 bone marrow transplants per year, as well as ongoing chemotherapy treatments both outpatient and inpatient. Of note, both MRI and CT services are available on site. In addition to clinical service and teaching, staff actively participates in research on a variety of relevant topics, often in conjunction with colleagues at LSU or Tulane. This children's hospital, like most, is dependent largely on charitable donations, telethons, and other fundraisers. Brian Landry left our tour early, excusing himself to attend a “Boo at the Zoo” Halloween fundraiser for some 10,000 attendees. As we thanked our hosts in order to return to NCE duties, we felt privileged to have visited Children's Hospital, New Orleans, convinced that this is a truly remarkable full service hospital for children. Additional information can be found on the hospital website at CHNOLA.org.

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**Did You Know . . . ?**

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

Try it, you’ll like it!

Happy browsing.

[www.aap.org/seniors](http://www.aap.org/seniors)
I’m truly honored at being selected for this award and particularly at having been nominated by my colleagues in Minnesota. The Minnesota Chapter works tirelessly on behalf of the children and adolescents in the State of 10,000 lakes and I consider it a privilege to be able to work with them. I’m particularly indebted to Anne Edwards, whose knowledge of the legislative process has quick-started my recent efforts.

Lucy Crain asked me to comment on what motivated some of my advocacy activities. And that has caused me to reflect on the notion that advocacy comes in many forms and flavors and can result in both positive and negative outcomes. I’ll try to highlight examples from my own experiences, while being very conscious that all our colleagues are advocating for kids day in and day out in offices, clinics, hospitals and research laboratories. My earliest advocacy efforts actually predated my entry into the profession.

One thinks of advocacy as either promoting change or resisting it. Although promoting change has the more progressive connotations, in medical school in South Africa in the mid-1950s, many of my fellow students and I found ourselves resisting change. In this case, we pushed back against the increasingly rigid color lines being enforced on our universities by the Nationalist government, which had come to power in the previous decade.

I was in my fourth year of medical school, which was a six year course directly out of high school, when I was elected to the Students Representative Council, the body responsible for directing student activities and organizations around campus and the public voice of the student body both in and outside the university. Unlike in the US, medical students were undergraduates and very involved in university-wide activities including student politics and sports.

The Nationalist government was pressuring South Africa’s two racially integrated universities, including the one I attended, the University of Witwatersrand, to no longer admit students of color. We student leaders were committed to our roles as advocates for justice. However, in spite of protests, marches, and entreaties to the government, apartheid laws were expanded and applied to our universities; it took forty years for them to be repealed.

Many of my fellow student leaders who stayed in South Africa and resisted endured profound political oppression. They took risks, made sacrifices and choices that I am thankful I was never faced with. One became a justice on the post-apartheid supreme court. More soberingly, another was executed for planting a bomb in the Johannesburg Railroad Station.
Upon graduation, I reached my own personal crossroads. All post-graduate training and hospital staff appointments in South Africa were ultimately controlled by the government. As the curtain of apartheid descended upon the country, my antigovernment activities could be not only a risk to my work as a physician, but also to my life, limb, and freedom. I considered changing careers to become a lawyer and, as such, to be somewhat protected against the government. However, the country’s increasingly bleak-looking future, which to me at the time held little prospect of a peaceful outcome, combined with my lack of appetite for another three intense years of study, pushed me to reject law and to leave the country—first to the UK in 1960 and then to the US in 1962.

My interest in improving hemophilia care began when Denny Hammond, my fellowship director at Children’s Hospital of LA assigned me a case of hemophilia A in a female as my first project. It was not long after this, in 1965, that Judith Pool at Stanford identified the factor VIII-rich cryoprecipitate in human plasma. These two events spurred my career-long involvement in advocating at the local, state and federal level for access to care for patients with inherited bleeding disorders. Success in these efforts allowed us to rehabilitate patients crippled by joint deformities, to facilitate outpatient and then home-based replacement therapy and prevent many of the life and health threatening complications.

In 1981 the “golden age” of hemophilia care came crashing down with the first recognition of HIV as a blood product contaminant and its devastating effect on our patients. Because of societal attitudes, infected patients were stigmatized and even isolated and quarantined. Overcoming governmental inertia and indifference required constant lobbying on behalf of patients, both in terms of meeting their medical and social needs, but also in pushing the pharmaceutical industry to develop safer blood products, including the much earlier-than-expected recombinant factor VIII.

After moving to Mayo in 1971 and as our subspecialty was maturing, I became increasingly concerned that pediatric subspecialists had very little voice nationally. We were afterthoughts in the major specialty societies and, at the time, the AAP was perceived as only representing the interests of primary care providers. Yet I saw the AAP’s potential as a compelling voice for both medical and surgical subspecialists, and this became another cause for advocacy. Over time, as I and my many like-minded colleagues were successful in raising the profile of pediatric subspecialties, we turned our attention to the rigid—almost impenetrable—barriers between sections, committees and chapters. Our efforts culminated in the merging of some committees and sections and in the establishment of the Annual Leadership Forum.

Since retirement from Mayo, I have been active on the Public Policy Committee of the AAP Minnesota Chapter. In 2004, I was invited to attend a Forum on early childhood education of which I knew close to nothing. Art Rolnick, then the director of research for the Minneapolis Federal Reserve, was the main speaker and presented his work on the economic, social and educational benefits of preschool education. The event also introduced me to organizations and people working to improve education, including Reach Out and Read. To impact at least some of the unmet needs of disadvantaged kids, I began tutoring first graders at an inner city public school in Minneapolis. (Two years ago, I was moved up to the third grade, but don’t anticipate any further promotions!) These kids, nearly all of whom are Native-American, have provided me with astonishing insight into life on the other side of our economic divide. Up until 3 years ago, when my wife and I began taking care of our first grandchild several days a week, I was spending virtually every-
morning one-on-one tutoring.

In tandem with these direct efforts in the schools, I joined the advisory board of Reach Out and Read MN, and have had opportunities to testify before early childhood-related committees at the state legislature and to meet regularly with state lawmakers. Even in these very challenging fiscal times and polarized political climate, we have successfully turned back a number of attempts to scale back early childhood enrichment opportunities.

In my opinion we all have an obligation to our patients to work to ensure that our professional organizations and our public institutions are serving children of all ages as we strive to give our patients the best care possible.

My more recent advocacy efforts, both within and on behalf of the AAP, have been truly rewarding and will hopefully serve as an example to younger colleagues in various branches of pediatrics. This award from my peers in the AAP is truly valued and enormously appreciated.

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 participate in the healthycildren.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](http://www.aap.org), click on “MYAAP” located in the upper right hand corner or call the AAP Customer Service Center at 866-TH-E-AAP1.

BE AN AAP KEY CONTACT AND RECEIVE FEDERAL LEGISLATIVE UPDATES!

**Key Contacts** are AAP members who have expressed an interest in federal advocacy, and receive regular e-mail communications from the Department of Federal Affairs with legislative updates and specific requests for action. Armed with the most up-to-date knowledge on federal legislation affecting children and pediatricians, **Key Contacts** speak up to our nation’s leaders during critical decision points in the legislative process.

E-mail DOFA at kids1st@aap.org to become a Key Contact today!
On The Campaign Trail or How I Spent My Summer Vacation Worrying About Polls

By Mark Rosenberg, MD, FAAP

After leaving clinical practice, I decided that I would spend my summer and fall working in the Obama re-election campaign. I joined the Organizing for America summer fellowship to learn the ropes of campaigning, joining about 100 other ‘summer fellows’ in Chicago. I was the oldest in the group, being about 3 times the age of most other fellows. Learning the ins and outs of Votebuilder, the campaign tool for identifying voters was not always easy for a low tech pediatrician like me. After training completed, most of us were assigned to geographic areas within the state of Illinois. We were first tasked with making phone calls from weekly phone banks to bring in new recruits to the campaign and made weekly day trips to Iowa, canvassing voters in a battleground state crucial to the election.

As summer progressed I sought out a more active role so I moved to Iowa for the months of September and October through the election. There I was housed with a wonderful family in rural Scott County, just outside of Davenport, Iowa. Our initial assignment was to identify those undecided voters and sway them to vote for Obama as well as recruit more volunteers as we neared election day. While Obama had won Iowa in 2008, the economy despite being relatively stable in Iowa was the major issue. Many voters were disillusioned by the inaction of Congress and the building negative rhetoric of the campaign. We learned how the campaign’s goals were to get our voters to the polling place on Election Day and all efforts soon hit stride as November approached.

All of our teams were led by young people, taking orders from the full time campaign workers not much older than they were. An interesting experience, highlighted by a visit to Davenport by the President one day in October. As we worked the crowd, my team leader asked me if I wanted to go out to lunch, where a ‘special guest’ would attend. Jumping at the opportunity, we went to a small Mom and Pop restaurant in downtown Davenport and had lunch with President Obama, accompanied by a dozen Secret Service agents and twice as many press. He sat at a table and talked with a few older women, a key demographic of course. Upon leaving he saw my Chicago White Sox cap and stopped to say hello and autograph a book.

It was all downhill from then until Election Day. We worked the streets and back roads of Scott County, collecting mail-in voting requests and registering voters. When I began working in Iowa in the summer Obama’s lead was 6 and that was the final election outcome. Thousands of phone calls and hundreds of doors knocked. It was hard work, but good friendships and camaraderie among the many, many volunteers. After years of lobbying on behalf of children both in state government and Congress, the difference in elections is boots on the ground and talking to real people.
Summer in an old house by the lake in Casco Point, Minnesota is a kid’s paradise. I know. I was a kid there. While I was doing the serious 8 year old’s job of going fast and making mischief, one of my mother’s serious jobs as a 1940’s housewife and mother of 6 was capturing a bit of summer in canning jars. [I must give credit for that poetic idea to a great lyricist, Greg Brown, from his song *Canned Goods.*] Mom would put up mainly plums, pears and peaches. But oh, those peaches!

Our old basement was pretty standard for the early part of the 20th century. It had the cracking cement floors, the musty cobwebbed corners, the abandoned coal chute, the cluttered tool bench, and a laundry room roughed in with thin wooden planks on a 2x4 frame. Dominating everything, sort of like a huge, smelly Jabba the Hut, sat our ancient, temperamental, noisy oil furnace. Its main significance to us kids was that it formed the infield of our winter tricycle race track; a great past-time, by the way, as long as we left the stuff drying on the winter clothesline alone. If violation of that regulation was discovered, Mom, the ever vigilant referee would put up the “game over” flag.

In the darkest corner, smelling musty and faintly of wet cement was a small room that we called our fruit cellar. That’s where we’d keep our batches of summer-in-a-jar until that time of winter when we would run out of our supply of summer memories; maybe February.

After supper in, say, February, when it’s only 6:00 but has been dark for over an hour, and the wind is blowing the snow around outside, came the question, “What’s for dessert?” If my Dad wasn't home, the answer in 1940’s Minnesota kid’s talk was, “Cookie pudding“. Making cookie pudding means crumbling up cookies in the bottom of a dessert bowl. Then add the canned fruit. Then, most importantly, pour on the syrup from the jar; delicious, sweet, and very necessary. And mix it all together. When Dad was home, we'd have to eat the fruit, cookies, and syrup separately because the very thought of that saccharine slurry made him physically ill. Anyhow, if I were elected to retrieve a fruit jar from the cellar, I’d always opt for my favorite; the peaches.

Then life went racing along, a big jumble of memories and peach experiences, some good and some not so good. What is it, for example, about one year’s tree-ripened Colorado peaches being so disappointing after a previous year having been so wonderfully perfect? Just like life, I suppose, one year is not the same as another. Truth be told, there are problems with peaches. The skin is annoying for one thing. And, unlike an apple, a really good peach is too darn juicy to pick up and walk around with or to eat while driving. Worse, at least half of a given summer’s peaches aren't really very good. Maybe it’s just that I’m getting particular or maybe more peevish the older I get. I don’t really know. What I do know is that the search is worth it.

So, indeed, are most of the memories associated with them: Like peach slices over vanilla ice cream from my early married self; like peach daiquiris, a feature of our life on an army base in Virginia; like canned Freestone peaches right off the grocery shelf for a snack during a neuroanatomy study session, or like peach chutney after discovering curried food while trying to learn as much pediatrics as I could in an Arizona residency. Not to forget peach jam and peach preserves and peach ice cream and peach cobbler of much more recent memory.

Now, what’s this all come to? It's come to the pie! It's a very sad thing that I spent the first third of my life without my wife Marty’s peach pie. Who is the luckiest person on earth? A person whose
spouse is a pie artist! I mean really an artist. I’ve read that art usually includes several “signatures”, some of which are virtuosity, style, and imagination. Maybe that describes some art but doesn’t do those pies justice. Marty treasures an essay she found years ago about the Zen of pie making. That, I think, may describe it better.

Also, especially when it comes to pie, I believe that a creation isn’t really art unless there is someone around to appreciate it. That’s where I come in.

I’m almost 3/4 of a century old but that peach passion is still very much alive…and I’m still doing my part.

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**PARAPROSDOKIANS**

Paraprosdokians (Winston Churchill loved them) are figures of speech in which the latter part of a sentence or phrase is surprising or unexpected; frequently humorous. Enjoy!

1. Where there’s a will, I want to be in it.
2. The last thing I want to do is hurt you. But it’s still on my list.
3. Since light travels faster than sound, some people appear bright until you hear them speak.
4. If I agreed with you, we’d both be wrong.
5. We never really grow up, we only learn how to act in public.
6. War does not determine who is right - only who is left.
7. Knowledge is knowing a tomato is a fruit. Wisdom is not putting it in a fruit salad.
8. To steal ideas from one person is plagiarism. To steal from many is research.
9. I didn’t say it was your fault, I said I was blaming you.
10. In filling out an application, where it says, ‘In case of emergency, Notify:’ I put ‘DOCTOR’.
11. Women will never be equal to men until they can walk down the street with a bald head and a beer gut, and still think they are sexy.
12. You do not need a parachute to skydive. You only need a parachute to skydive twice.
13. I used to be indecisive. Now I’m not so sure.
14. To be sure of hitting the target, shoot first, and call whatever you hit the target.
15. Going to church doesn’t make you a Christian any more than standing in a garage makes you a car.
16. You’re never too old to learn something stupid.

Discovered on the internet by Arthur Maron, MD, MPA, FAAP
**Book Review**

**Proof of Heaven**  
*By Eben Alexander, M.D.*

Reporting near-death experience (NDE) reaches a new level in this book. The reader is treated to an entirely unique recount of an NDE by Eben Alexander, M.D., an academic neurosurgeon. His succinct, direct writing style is thorough and typical of a scientist, resulting in successfully achieving his goal. The author makes a complex, intricate experience of his spirit easy to read and understand.

In this 196 page paperback, Dr. Alexander goes beyond all previously described NDE’s in clearly stating with appropriate detail his NDE over one week’s time beginning November 10, 2008. In coma, he experienced heaven and the supreme being. There are several reasons that make this account the most significant and persuasive of all.

Dr. Alexander was the victim of the rare, adult onset, E. Coli meningitis. Over a period of hours, he went from an awake, uncomfortable neurosurgeon to a patient in coma. This was the start of the NDE. Most previously reported NDE’s involve cardio-respiratory arrest for a short time. The brain, or specifically the neocortex, is rarely affected. Skeptics have room for doubt that the stress on the brain results in brain activity unique to the situation with resulting fantasies. For Dr. Alexander, this was not the case. His life threatening illness attacked the neocortex with severe meningitis, “turning-off” the brain. His cardio-respiratory system was not the cause of his coma. The neocortex could not have created the NDE.

As a neuroscientist, Dr. Alexander is knowledgeable about the theories of mechanisms of “consciousness” in humans. Many attribute human consciousness to the neocortex of the brain. During his week in coma, his images are described in detail, yet his neocortex was not functioning and was surrounded by pus.

Another feature that makes Dr. Alexander’s book different from others is that he is an experienced writer and teacher. In the past, many who wished to share their NDE experiences have found difficulty with their limited writing ability and use of the language.

Spirituality did not play a meaningful role in his life prior to the NDE. He describes himself as a secular neurosurgeon dedicated to his patients and his quest for scientific knowledge. The out of body experience was not explainable by his past life ambitions or upbringing.

For several chapters, there are parallel accounts reported after the onset of coma. The most dramatic and poignant is the description of the NDE by Dr. Alexander during his one week in coma. These pages are the most impressive for the reader and the purpose for writing the book. The other story relates the information he was given after recovery from coma of his physical body and medical treatment. Appendix A gives a statement by Scott Wade, M.D., an infectious disease specialist who directed the medical care, ICU, team. This statement gives credible facts regarding the serious medical condition.

With convincing detail, the author describes a spiritual life beyond the physical life. He is sure that the human brain is a filter and limits the potential of the spirit that will live forever. Essentially, Dr.
Alexander recounts his time in heaven and being in the presence of God.

The final chapters describe his remarkable recovery from a condition that should have killed him. The closest he gets to writing as a neuroscientist is Chapter 33: The Enigma of Consciousness. Here he makes the argument that his NDE is not in conflict with science but can unify science with spirituality.

Skeptics, believers, scientists and agnostics will find thought provoking material from Dr. Alexander's story. This secular, neuroscientist who survived a rare brain infection with a high mortality had a brief encounter with heaven and God that totally changed his life. He decided to share this amazing time with us. Was Dr. Alexander a victim of a series of ill-fated events or was he chosen to deliver a message to his fellow humans?

What happens to you after physical death? If you have pondered this question, and who hasn't, this book is a must read.

*Joseph A.C. Girone, MD, FAAP*

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**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](http://aap.thatsmybrick.com) or contact Grace Geslowski at ggeslowski@aap.org or call 888/700-5378.
Book Review

The Lost Mother
Published by Viking Adult, 2005
By Mary McGarry Morris

Although published in 2005, and by no means a current hot title, this novel vividly portrays life during the Great Depression and poignantly follows a family through hardship and crisis. In addition, it will be of interest to us pediatricians, with a litany of challenges faced by young children and their families.

Henry Talcott is camping near the edge of Black Pond with his two children, Thomas and Margaret. It is summer, and the pastoral ambiance could be exciting and adventurous. Not so. Their beautiful wife and mother, Irene, has left, ostensibly to seek employment in the city. They are living in a tent because they have lost their home. Henry assures the children that mother will soon be home, and the children wait anxiously for her imminent return. In spite of Henry’s hopes and the children's fantasies, however, it soon becomes apparent that mother has, in fact, deserted them and they are on their own.

Henry is an itinerant butcher who earns a few pennies slaughtering livestock for farmers, but there is precious little work and the travel distances leave the children too frequently home alone. Thomas and Margaret are depicted with the expected sibling rivalries. The elder Thomas is “big brother”. He squabbles with Margaret and is domineering, but staunchly will defend her against any outside danger. Their personalities are, as you would expect, opposites.

The family becomes entangled with a nearby neighbor household. As the plot thickens, winter is approaching, food is scarce, and the neighbor mother becomes enamored with the children, particularly Margaret. An older, emotionally challenged and invalid son needs young companionship and playmates. The warmth of the home and the well-stocked larder draws the children in, even as Henry is proud and resistant to gratuitous aid.

The children ultimately run away in search of their mother. The story is replete with child abuse, foster care, orphanage, injustice, and more. As the Great Depression deepens, the Talcotts continue to become entangled in crisis.

Even the title evokes interpretation. To the children and Henry, Irene has been lost to them. Irene, on the other hand, is herself lost in poverty and degradation. You will learn, in reading this excellent novel, whether Irene is ever really found by her children, and whether she ever really finds herself.

Arthur Maron, MD, MPA, FAAP

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visit our website at: www.aap.org/seniors
Movie Review

SKYFALL

Can you believe that this is the 50th year of the James Bond series? “Skyfall” may be one of the best Bond movies. Starting with a wild chase through Istanbul streets, we soon see Bond (Daniel Craig) running after the fugitive atop a train, committing gratuitous acts of violence against VW Beetles (You just have to see it!), ducking tunnels and avoiding gun shots until he is inadvertently shot apparently in his heart, lungs, and other vital organs by the “friendly fire” of another agent of HM Secret service. This causes him to plummet from the train roof for about a mile off a railroad bridge.

While Craig ostensibly plays the lead role, perhaps the strongest character in the film is played by octogenarian Dame Judi Dench, as M—the director of M16 in London and 007’s commanding officer. M has just finished composing the obituary of Commander James Bond, feeling that she should also be writing her own. She feels old and personally responsible for the death of 007. Suffice it to say that M is not ready to retire, and “Skyfall” provides a role worthy of Judi Dench, one of the best actors of any age. Her new boss, Mallory (Ralph Fiennes), is ageist and initially ready to relieve her of duty. He convenes a hearing requiring her to defend her position. Terrorists invade the hearing chamber, much violence ensues before she is rescued by the not ready to be dead yet 007. The film is directed by Sam Mendes, who chose to delay the introduction of the maniacal villain and big time computer thief Silva (Javier Bardem) until well into the action. (By the way, has anyone else ever survived swallowing cyanide?)

More chases, more gunfire, lovely young women in keeping with a Bond movie plus the reappearance of his classic Aston Martin and the origins of James Bond himself are revealed at last.

A must see for any Bond fan!

Lucy Crain, MD, MPH, FAAP

For a sobering analysis of movie violence, read BOND, JAMES BOND: A Review of 46 years of violence in films at www.ARCHPEDIATRICS.COM published online 12/10/12, authors McAnally, Robertson, Strasburger, and Hancox.

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.
Movie Review

Lincoln Review

Filmed mostly in and around Richmond, Virginia last fall and depicting a brief history-changing period in the three months leading up to surrender of the Confederacy in the spring of 1865, this film focuses on a president embroiled in a great civil war largely about slavery. As he has been re-elected for a second term and the Union is assured victory in the war, the President’s attention is on accomplishing successful adoption by Congress of the 13th Amendment to the Constitution. It’s often hard to say that a 2-1/2 hour long movie is consistently riveting, but “Lincoln,” Steven Spielberg’s $50 million history lesson about the 16th President of the United States is that and more. Screenplay is by Tony Kushner (“Angels in America”) and partly based on Doris Kearns Goodwin’s book “Team of Rivals”. Outstanding performances by a stellar cast, attired in seemingly authentic uniforms and dress with only brief depiction of the carnage and tragedies of the battlefield quickly transform a potentially dreary, bitter political battle into one action scene after another. The primary focus is within chambers of the US House of Representatives of the time, with depiction of political differences no less divisive than today.

I personally questioned (as someone originally from Kentucky) why Daniel Day-Lewis was chosen to play Lincoln. I no longer question that choice. He embraced the role with convincing accent and mannerisms, and mesmerizing authority, spiced with just enough folksy humor. The struggle to pass the unpopular 13th Amendment to legally abolish slavery through debates, filibuster, and depiction of vote buying tactics may or not be historically accurate, but it makes a great movie.

Fearful that the Emancipation Proclamation, passed in his first term might not survive legal challenges, the President enlists Secretary of State William Seward (David Strathairn) hire a trio of unorthodox men (James Spader, John Hawkes and Tim Blake Nelson) to bribe and manipulate the outgoing Democrats in the House of Representatives in exchange for their support.

Drama in the Lincoln household is supported by Sally Field’s performance as Mary Todd Lincoln, with only passing reference to her profound depression after the death of her son Will in early childhood. The president’s devotion to his youngest son, Tad and his disagreement with oldest son Robert (Joseph Gordon-Levitt), who is determined to enlist in the Army against his parents’ objections.

Spielberg posts title cards in the opening scenes and it helps. The cast includes Lee Pace, Hal Holbrook, Jared Harris, Jackie Earle Haley, Gloria Reuben and S. Epatha Merkerson, as well as Tommy Lee Jones as Thaddeus Stevens as an outspoken supporter of abolition. This film is worth seeing and is a likely Oscar nominee.

The AAP Section on Senior Members (SOSM) has one opening for an executive committee member beginning October 2013. Senior leaders help 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 nominations committee, Dr. Michael O’Halloran or Dr. Carol Berkowitz at mmohalloran@CHARTER.NET or carolb@pol.net.
I. **Memory**
   1. Definition: mneme
   2. Goddess of memory: Mnemosyne
   3. Memoirs: *apomnemoneumata*
   4. Memory aid: *aide-mémoire*, anamnestic, mnemonic, mnemotechnist, Pelmonism
   5. Memory renewal or preservation by brain exercise: neuroplasticity
   6. Store of computer memory: cache, cache memory
   7. A forgotten, outmoded word, sometimes resurrected: metaforgotten
   8. Immediate things (working memory): *prefrontal cortex* (brain site of working memory)

II. **Bad, impaired memory**
   1. General:
      a. confused memory: paramnesia
      b. impaired memory: dysmnesia
      c. no memory: amnesia, lethe, lexaphasia
      d. temporary memory lapse: senior moment, SM
   2. Inability to remember:
      a. anything: CRAT
      b. drug used to forget: nepenthe
      c. names: anomia, lethonomia
      d. words: lethologica, onomatomania
      e. facts: prosopagnosis
      f. faces: prosopolethy
      g. hidden, subconscious memories: cryptomnesia, nepimnemic
      h. the three-letter acronym: CRTLA: Can't remember the three-letter acronym
      i. things happening long ago: telamnesia
      j. immediate things (working memory) *prefrontal cortex* (brain site)
      k. things in succession (interrupted memory): AAAD: age-activated attention-deficit disorder

   **Good, excellent:**
   1. For long-past events: paleomnesia
   2. For recent events: neomnesia, ecnnesia, hippocampus (brain site of recent memory)
   3. From memory: ex capite
   2. Total memory: panmnesia, mnemonist
   3. Vivid memory: eidetic, eidetic image, hypermnnesia

   **Obsessive memory:**
   1. Obsession recalling a word: loganamnosis, onomatomania

V. **Slip:**
   1. Of the tongue: lapsus linguæ, lubricum linguæ, parapraxis
   2. Of the pen, writin, typing, texting: lapsus calami

VI. **Remembering: rememble**
   1. An incompleted task: zeigarnik
   2. Handbook: enchiridion
   3. Medical past history: anamnesis
   4. Something long forgotten: revenant, Proustian experience
   5. Things that never happened, false memory: pseudomnnesia

VII. **Role:**
   1. One who loves to forget: philalethe
   2. One skilled in remembering: mnemonist, mnemotechnist
Beneficiary Designations:
Careful Not To Set Them, Then Forget Them!
Joel M. Blau, CFP®
Ronald J. Paprocki, JD, CFP®, CHBC

There is never a bad time to revisit the beneficiary designations you have made over the years. Unfortunately, once various beneficiary forms are completed, they are often forgotten until the time of death. In many cases, executors find that no beneficiaries have been named at all, creating confusion, anger, and time delays in settling an estate. In other cases, the named beneficiaries may no longer be members of the family due to divorce, or worse yet, have died.

One of the main reasons for this oversight is that many of the financial accounts requiring a beneficiary designation are established far earlier in life. There may be a life insurance policy that was purchased when you were first married, an IRA that you opened prior to marriage, etc.

Having a sound financial plan dictates that you ensure there are designated beneficiaries for all your retirement plan accounts, life insurance policies and other assets, and that these individuals are the intended recipients based on your current family structure. It is often not as cut-and-dried as it first seems. Following these guidelines should help you avoid the most common and costly mistakes:

- **Do not leave the beneficiary lines blank.** If you don't name specific beneficiaries for your accounts, or if you name your estate as the beneficiary, your heirs will likely end up in probate court. This can be both time-consuming and costly. If assets go to your estate, they are subject to the reach of creditors. A better option is to choose individual beneficiaries and list them on the forms.

- **Use trusts for beneficiaries who are minors.** In some states, minors face restrictions until they turn 18 or 21. If you designate a minor as a beneficiary, a court will appoint a guardian to manage the funds until the child reaches the age of majority. Alternatively, you might establish a trust to handle the funds and name the trust as the beneficiary. Thus, you maintain control now and provide asset protection for minors when you are gone.

- **Understand the key rules.** Beneficiary designations on retirement accounts and insurance contracts will override your will. If you want someone other than your spouse to inherit retirement account assets, your spouse must sign a written waiver. Without the waiver, a non-spouse beneficiary designation will be invalid upon your death.

- **Inform your beneficiaries.** Do not keep your beneficiary designations a secret. Also, let the people you have designated as beneficiaries know where to find important documents and contact information for your professional advisers. On the other end, make sure your advisers have the vital contact information.

- **Double-check names and numbers.** Make sure they are spelled correctly and that figures are accurate. This is particularly important when listing Social Security numbers as well as telephone numbers and addresses.

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• **Use percentages instead of dollar amounts.** For example, suppose you have an IRA worth $100,000, and you designate a nephew as beneficiary of $75,000 of that amount. If the IRA drops in value to $75,000 or below at your death, your nephew gets the entire amount—any remainder beneficiaries receive zero. Perhaps a better way to meet your objectives is to give your nephew 75% of the overall account value.

• **Name contingent beneficiaries.** If your primary beneficiary has died and you have not updated your accounts with a new primary, the assets would go to your contingent (or “secondary”) beneficiaries. If a contingent beneficiary was never named, the assets are transferred to your estate (see above). Avoid potential problems by indicating contingent beneficiaries in appropriate places.

Finally, don't stuff all the paperwork in a desk or drawer somewhere and forget about it. Make the proper beneficiary designation adjustments when warranted and review these periodically with your advisor to ensure that they remain up-to-date and make financial sense.

Mr. Blau and Mr. Paprocki welcome readers’ questions. They can be reached at 800-883-8555 or at blau@mediqus.com or paprocki@mediqus.com.

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**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

**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
EDITOR'S NOTE:

I am honored to succeed Arthur Maron as editor of our Senior Bulletin and hope to maintain the high editorial standards set by him, our contributing editors and webmaster Jerry Aronson, and our remarkable staff. Your contributions to the success of our Section Bulletin are of utmost importance and are both needed and welcome. This is the 4th annual online winter edition, enabling inclusion of more photos and other information about the NCE than in our print versions. I’d appreciate your feedback and suggestions, as well as articles for the Bulletin.

I’m writing this less than a week after the senseless massacre of 20 innocent children, as well as teachers and others at Sandy Hook Elementary School in Connecticut. Agreed that we as a nation must be better than this and must find the means of curbing violence in general, irrational use of and access to firearms, and the lack of mental health services for children and youth, we all need to speak to our local and state leaders and our congressional representatives, of course and advocate for better preventative services in our communities and nation. But, we really need to know how to speak to our children and grandchildren, so they will neither grow up crippled by fear or trying to emulate the violence constantly depicted on the media and all too often within dysfunctional, abusive families. Read the following recommendations by our SDBP colleagues, Drs. Pam High and Nate Blum, share them widely, and remember to teach your children well and let them know they are loved and cherished.

Lucy Crain, MD, MPH, FAAP

During this extremely sad, confusing and stressful time, parents and caregivers can support their children by considering these points.

• Try to limit children’s exposure to all graphic media including TV, video, radio, magazines and news.

• When children do confront this information on TV or in other media, talk with them about what they are seeing and hearing and offer opportunities for them to ask questions.

• Answer children’s questions honestly. This doesn’t mean that they need to understand the whole story. Allow the child’s questions to guide the information parents provide.

• Spend extra time with your children during stressful times.

• Pay attention to your children’s moods, behavior and sleep, as well as their play themes and drawing, to identify signs that they may be worried. If you see signs that they may be upset by events, ask them how they are feeling and respond to their distress.

• Maintain family routines such as those around mealtimes and bedtimes, because this structure usually reassures children that their own world is secure.

• Infants and toddlers will know if their parents are stressed. They will respond to their parents’ emotional tone.

• Preschoolers will also be very aware of their parents’ emotions and reactions. They will ask how events will touch them personally. They may also repeat the same question many times seeking reassurance.

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• School age children often have a strong sense of right and wrong and will try to make sense of what has happened. Participating in activities that are healing such as sending a card or making a donation can help them cope with their feelings.

• Teens are likely to seek support from peers as well as their family. Actively assisting others in need, possibly alongside peers and family, can be an effective strategy to help them feel that they have some control over the problem before them.

• Parents and caregivers who are themselves highly distressed should seek their own support, so that they can model effective coping for their children. Pam High, MD Hasbro Children’s/Rhode Island Hospital Nate Blum MD Children’s Hospital of Philadelphia.

Lucy Crain, MD, MPH, FAAP (left) thanks Michael O’Halloran, MD, FAAP (right) for his term on the Seniors Executive Committee.
Eblast that went to members 70 years old +

At the 11th hour, the US Congress extended the charitable IRA rollover as part of the "fiscal cliff" bill.

If you are age 70½, you can benefit from this special tax break on your 2012 taxes. This tax-smart gift can be done easily, and you may be able to increase your legacy now to the American Academy of Pediatrics. But, you must act before February 1, 2013.

The charitable IRA rollover legislation allows you to transfer lifetime gifts up to $100,000, using funds from your individual retirement account (IRA) without undesirable tax effects. If you are 70½ years old and you have an IRA that is not a Roth IRA, you must take yearly minimum required distributions. With a charitable IRA rollover, a donation directly from the IRA to the AAP can count as your minimum distribution, without paying taxes on the distributed amount.

Since annual minimum distributions typically have to be taken before December 31, Congress created an exception to the direct transfer rule for 2012. If you made a cash gift of any amount up to $100,000 in 2012 or make a new gift by Feb. 1, 2013, it may count retroactively towards all or a part of your 2012 required IRA minimum distribution.

To learn more, visit our website, where you can download a free brochure on this topic.

If you have any questions about making a donation, please contact, Joseph Like, by phone at 847-434-4740 or by email at jlike@aap.org.

Please note, this information is not intended as legal or tax advice. For legal or tax advice, please consult an attorney.

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.

Written by Members of SOSM and SOAPM