This Spring Edition of our Senior Bulletin is proof that the epic winter which affected many of us is now past history. The section Executive Committee is scheduled to meet in late April in Toronto and we are assembling a varied agenda for discussion. It has been exciting and gratifying to note the active input of our membership in response to our internet communications. It is reassuring to find that there are so many of you out there with valuable opinions and suggestions. Please keep the feedback going because that is how we can be most responsive to your questions and concerns.

I am pleased to share with you news of an innovative collaboration between the Section on Senior Members (SOSM) and the AAP Pediatric History Center. We are planning an exhibit area during the October 2014 National Conference and Exhibition in San Diego. We are seeking abstracts and poster presentations submitted by our members which deal with various aspects of pediatric history. It would be of great interest to our younger members to reflect on the practice of pediatrics, the modalities of therapy in the past, and the great moments of pediatrics which are etched in our memories. I’ll

Continued on Page 2
bet each of us has a photograph, a piece of memorabilia, a fond memory, or an anecdote to share with our membership and preserve for the future in our AAP archives. We intend to display selected abstracts/posters at the 2014 NCE and the top demonstrations will be invited to a brief podium presentation. Details on how to submit your abstract are found elsewhere in this Bulletin.

I represented the section at the AAP Annual Leadership Forum and had an opportunity to interact with many other section, committee and chapter leaders. Our section has been traditionally successful in bringing the needs of our members to the forefront. We continue discussions on advocating for policies that will foster continued loyalty of senior members to the AAP, enhance our ability to attend Academy events and continue to share in programs that support child health.

I hope you have already participated in our early-March Webinar dealing with Controversies in Health Care. Our webinars are becoming more and more popular; if you want to access an archived copy of a previous webinar, you are invited to our new-and-improve web page.

I would appreciate any suggestions you have to assist us in bringing more value of AAP membership to you.

Maximize your membership experience with discounts on personal and practice products and services... insurance, credit cards, car rentals, office supplies, websites and much more. www.aap.org/discountprograms.
Senior Section Welcomes a New Member to the Executive Committee
Richard “Dick” Wicklund, MD, FAAP

I would like to briefly introduce myself as a member of the SOSM executive committee. I am currently a retired general pediatrician living in Lakeville, Minnesota. I was in a private practice for 11 years in Eugene, Oregon, and then 22 years at HealthPartners, an HMO, in Apple Valley, Minnesota. I then worked in pediatric urgent care clinics for about 9 years, until April 2013. I have plans to join a medical mission to Guatemala in March and in June of this year. My wife, Kelly, and I plan to celebrate our 50th wedding anniversary this summer. We have three sons and seven grandchildren. Running, swimming, bicycling, skiing and trying to play golf occupy much of my time, and the joy of riding a motorcycle. My medical interests include prevention of illness. I look forward to being a part of the executive committee of the AAP’s Section on Senior Members.

2014 NCE Senior Program
Sunday, October 12, 2014

Health Issues for Pediatricians: “Physician Heal Thyself”

The attendee will come away from this conference with:
1. an understanding of the most recent data concerning the aging of the human cardiovascular system, the role of blood pressure control, nutrition (lipids, supplements, etc.), exercise, medications, preventive measures;
2. an updated knowledge of the various forms of dementia and current advances in therapy and of exercises and other treatments to maintain mental agility through the senior years;
3. an awareness of and ability to recognize problematic skin lesions of aging and a reinforced knowledge of proven steps to maintain a healthy integument through the senior years.

8:00 AM Welcome – Jim Shira
8:05 AM Promoting and Maintaining Cardiovascular Fitness
8:55 AM Defenses Against Dementia: Maintaining Mental Agility
9:45 AM Break
10:00 AM Caring for Aging Skin
10:50 AM Podium Presentations for Three Best Pediatric History Abstracts
11:20 AM Section business meeting and presentation of Section Award
11:50 AM Section lunch and socialization
12:30 PM Adjourn
Dr. Lighter currently serves as Professor and core faculty for the Physicians’ Executive MBA program at the University of Tennessee and as Director of The Institute for Healthcare Quality Research and Education where he works with organizations to improve quality management using techniques like Lean Six Sigma, the Baldrige Award management framework, and advanced information technologies. From 2009–10, he served as Vice President for Quality at WellCare Health Plans. Between 2001–9 and again from 2010-12, Dr. Lighter served as the Chief Quality Officer for the Shriners Hospitals for Children, a 22 hospital system, where he worked in the areas of medical staff performance and compensation, leadership training, and medical affairs strategic planning. In 2012, Dr. Lighter was appointed as a Judge for the Malcolm Baldrige Performance Excellence Program.

Dr. Lighter’s nearly 40 years in the health care industry includes academic and private practice in pediatrics, managed care leadership roles, Medicaid and Medicare quality management programs, and medical missionary work.

In addition to these medical leadership positions, Dr. Lighter has authored over 75 articles and chapters, as well as three widely used text books on health care quality improvement, the most recent published in 2013. Over the course of his career, Dr. Lighter has led the formation of two IPAs and three HMOs, and development of a university PHO. He has also served as a consultant to the Board of the American Academy of Pediatrics on medical informatics and has received the Academy’s highest informatics award.

Disaster Ready Resources and Checklist

The Pediatric Preparedness Resource Kit (http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Pediatric-Preparedness-Resource-Kit.aspx) promotes collaborative discussions and decision-making among pediatric and public health leaders about pediatric preparedness planning. Specifically, the kit aims to increase state- and community-level preparedness efforts regarding how best to address children’s needs. The strategies shared in this resource are designed to stimulate action and inspire you to take steps to form key partnerships and improve day-to-day emergency readiness for children in your area.

The Preparedness Checklist for Pediatric Practices (http://www.aap.org/disasters/checklist) offers steps that pediatricians or their practice staff can take to improve office preparedness. This checklist will allow for advanced preparedness planning that can mitigate risk, ensure financial stability, strengthen the medical home, and help promote the health of children in the community. The checklist also offers strategies on keeping vaccines safe during an emergency as well as steps to promote professional self-care.

We would like to disseminate these resources to anyone who is attending spring conferences or meetings where this resource would be useful. If you would like free copies of either resource, please let me know. Members can e-mail DisasterReady@aap.org to request copies. We are trying to disseminate the print copies so that they can be put to good use.
Pediatricians Who Served in the Military
Should be Aware of Potential VA Benefits

Jeffrey L. Brown, MD, FAAP
jlbrown100@gmail.com

Many older physicians completed their medical training during the Vietnam era and a significant percentage of them served in the military. Some were enlistees, draftees, or career military. But, most were enrolled in the Berry Plan which allowed deferment of service until completion of medical school and specialty training.

Those physicians who found themselves in combat areas often refer to their experience as if it occurred in the recent past - almost as a contemporary event. But even for those who did not serve in combat areas, most will agree that it impacted their lives because of changes in career decisions, determining the time for getting married, or affecting their choice of permanent residence. Because time spent in the military seems so long ago, many physicians forget that they may be eligible for veterans’ benefits from the Veterans Administration and that they might be able to obtain a variety of benefits from vendors and local governments. These include decreases in property taxes, free recreational licenses, discounted travel, and discounts on insurance and purchases.

Benefits that can be obtained from the Veterans Administration are generally the most important and fall into two broad categories: Those that require income verification (the veteran must have financial resources that fall below an established means test) and those that don’t. Service-related disabilities fall into this second category. As an added bonus, medical services and financial benefits for service-related disability are usually independent of other compensation and are usually tax-free.

Unfortunately, most physicians do not ask their patients if they have served in the military, and a great many eligible veterans with service-related conditions are either misdiagnosed or not diagnosed at all. Sometimes the cause of the disability is obvious, as might occur if hearing was damaged by an explosion while on active duty. Less obvious might be those times when a veteran has delayed signs or symptoms resulting from a toxic exposure.

The rules for proving causality have changed significantly. When soldiers served in Vietnam, they were told that Agent Orange was a nontoxic substance. It was later learned that the dioxin inadvertently present as a byproduct of manufacture in this defoliant caused toxicity that is now measured in parts per billion. In order to claim service-related disability, veterans had to prove (1) that they had significant exposure to Agent Orange and (2) that their illness was causally related to the exposure. This is no longer the case: Any veteran who served in Vietnam during the war years can now claim service-related disability if subsequently diagnosed with an illness shown to have increased risk after Agent Orange exposure. These conditions include Type 2 diabetes, ischemic heart disease, many cancers - including those of the prostate and respiratory system, Parkinson’s disease, Hodgkin’s disease, multiple myeloma, and others. The length of time served in Vietnam is not deemed pertinent to making the claim. And because there is no financial means test, consultations, medication, surgery, appliances, nursing care, and hospice care may all be provided without charge by the Veterans Administration. If the degree of disability is rated high enough, all medical care may be covered for this and any other medical conditions.

Continued on Page 6
Those physician-veterans who developed symptoms of Chronic Multisystem Disease (previously known as Gulf War Syndrome) should also file for benefits. It is quite possible that their symptoms of chronic fatigue, myalgia, headaches, GI complaints, and memory loss were never diagnosed as being service-related. Physicians who are veterans should review all of their current medical and psychological symptoms to determine whether any may be related to past deployments. It is interesting that soldiers who served in high stress areas may develop psychological symptoms around the time of retirement that are consistent with Late Onset PTSD. Its relationship to prior service may not be obvious because of the time lag and symptoms are frequently blamed on retirement itself. Also, patients may describe their illness as somatic rather than psychological complaints.

The best references can be found on the va.gov website which describes the types of benefits available and known disabilities associated with specific deployments. There is even a webpage dedicated to Late Onset Stress Disorder. (A patient might have symptoms of post-traumatic stress without disordering their lives.) There are also some well-designed commercial websites that can provide much of the same information in different format. It is worth visiting www.military.com.

Physicians who believe they may qualify for veterans’ benefits should not try to file an application without help. Applications can be filed on line but the process is tedious, difficult to understand, and using proper terminology will improve the chances of having your application approved in a timelier manner. Make an appointment with a representative from your state’s Office of Veterans Affairs or a more specialized group like Vietnam Veterans of America. These people are dedicated to helping you understand the process and your potential for success. No one who is eligible for benefits from the Veterans Administration should be hesitant to file for them. It is part of your reward for having carved out a piece of your life to serve your country and sometimes risking your life in the process.

About the Author: Decorated combat infantry battalion surgeon, Vietnam 1966-67 ,Clinical Professor of Pediatrics, New York Medical College, Assoc. Clin. Professor of Pediatrics in Psychiatry, Weill Cornell Medical College, Clinical Pediatric Practice 1972-2012, past member of COMLRM and SOTC

**Editor’s note:** Dr. Brown addresses an important topic which impacted many SOSM members personally. The realities of medical officer supply and demand during the height of the Vietnam conflict led to use of the term: “Doctor’s Draft” in reference to the Berry Plan deferments during this era, and it’s likely that most physician veterans who were not career military never even consider their own eligibility for benefits.
Travels to India
Trisha Roth, MD, FAAP
TrishaRoth@aol.com

I just returned from a 12 day trip to northern India as a civilian on a tour with my sister and 17 new family/friends co travelers. All with different experiences.

We crossed paths with Road Scholars
(formerly Elder Hostel)
And a health professionals that did Creativity and Madness!
I was originally going with my temple for mindfulness however that didn't fill!

My brother died suddenly a few years ago @ 68. I so wanted to guarantee time with my sister.

We started and ended in the most polluted city in the world Dehli.
Just passed Beijing where I visited with my son on his international business school graduate program
Which had been the most polluted city in the World!
I brought my inhalers.

Needless to say. For me Varanasi
The home of the Ganges pyres
Celebrating death in a magnificent Ways, one of the worlds oldest living cities.

The extreme wealth and poverty
Wanting to take every child home with me.

Being grateful to have been healthy enough to go, travel and return
With a minimum of Dehli Belly.
Azithromycin has replaced Cipro.
Fortunately I managed with out
Those drugs or anti diarrhea.
As a true pediatrician I handled it with diet alone.

Visiting Gahndi’s life during Martin Luther King’s birthday!

We didn't go to their Silicon Valley.
Their 6% growth is to be admired!

Their forts, their temple, their castles.
Their cast system,
The exclusion of women
The growth of their middle class

Vegetarian life styles
Animals in the street

Continued on Page 8
Travels to India  Continued from Page 7

Udaipour Jaipour Agra
Each with their own specialties

My worst food experience was on the plane home mistaking a very hot green pepper for a green string bean.
Remedies
Milk
Yogurt
Sprite
Benadryl

My sister's son was killed in a car crash 15 years ago at 34.

I am so grateful for my 34 year old son. My former spouse's step son was killed in Iraq.

As we all know, life is fragile.
I have 7 grandchildren,
Work on substance abuse
And do locums.

Thank you for the senior bulletin
For giving me perspective.

My apologies for my tangential nonlinear writing. Having 24 years in recovery from 28 years as a bulimic
It's a common pattern.

Namaste
Shalom
Behind The Curtain-
Supporting Paying for Children's Healthcare

Don Schiff, MD, FAAP

Comments on this article are welcome at DONROSCHIFF@comcast.net

The battle over the Affordable Care Act “Obama Care” goes on and on and will probably intensify over the remaining months leading up to the midterm election in November 2014. True stories of difficulties in utilizing the governmental sites have been joined by distorted and created versions of experiences by those attempting to enroll in the new health care plans. An unprecedented effort to destroy the ACA continues.

As the current deadline of March 31, 2014 to sign up for ACA this year approaches we receive reports that 4.2 million individuals are in new plans. This number falls considerably short of the original anticipated 7 million later reduced to 6 million. The administration will be pleased if this year’s final figure exceeds 5 million. Advocates of using the ACA to expand coverage and reduce the nations level of uninsured will readily accept the 5 million figure as an adequate if somewhat disappointing number. Their next task will be to promote a public awareness of the ACA advantages, details of the available plans and to counter the negative publicity from those determined to destroy the plan.

The individual mandate to have health insurance does not change. The requirement to buy insurance or pay a fine will remain in place. The fines which initially are small rapidly advance in cost and are designed to make the insurance option a desirable choice.

Health care finance for children is never simple and as we look at the next 18 months there are two potential losses of funding resources which deserve our immediate attention. Funding for the CHIP (Child Health Insurance Program) is due for renewal next year (2015). This program devised by senators HATCH (Utah) and Kennedy (Massachusetts) currently provides care for approximately 9 million American children.

The loss of this program due to a lapse in funding is truly unthinkable and must not be allowed to happen. Retiring Senator Rockefeller of West Virginia has taken a lead position in the effort to renew funding for CHIP. The number of dollars required is small and the benefit is enormous. The academy has anticipated significant resistance to CHIP renewal and is marshaling a coalition to win this battle.

The SGR (Sustainable Growth Rate) is a window into a continuing controversy over funding for Medicare. The multiple year battle over proper payment schedules for Medicare become very important to pediatricians who care for Medicaid patients as Medicaid payments are based on Medicare rates. Those pediatricians in practice found the increase in payment from poor incredibly low Medicaid payments to still low but clearly improved Medicare payment schedules to be a welcome positive change. This year as in every year the congress is facing a costly decision i.e. forcing a reduction in Medicare fees of up to 20% or finding a permanent change in the SGR formula which would take this recurring issue off of the congressional list of painful decisions. Painful because the sum required to resolve the rate controversy and properly increase rates 1-2% annually would be 130 Billion dollars. Republicans have stated that they will accept long term SGR funding if Democrats will remove the individual mandate from the ACA. It appears at this time that

Continued on Page 10
the Democrats will continue to refuse that trade and the SGR will be approved for a period of 3-6 months without any significant change. The importance to pediatricians is that since the increase from Medicaid to Medicare payment levels has occurred, any decline in Medicare payments would be to lower Medicaid payments. This logical pediatric upgrade has been put into effect for fee for service care in 49 states and Washington DC. However managed care organizations have been lagging behind as only 50% have advanced the payment schedule as the law requires.

AAP History Center’s
ORAL HISTORY PROJECT

Interviews with selected pediatricians and other leaders in the advancement of children’s health care are conducted and preserved as part of the center’s oral history project. Recordings and transcripts of interviews provide narrative accounts of important developments in the care of children and augment the center's written, recorded, and photographic records of pediatric history. Learn more at: http://www2.aap.org/pediatrichistorycenter/PHCRsearch.htm.

IF YOU’RE NOT A MEMBER
OF THE SENIOR SECTION . . . JOIN!

If you are an Emeritus or Retired member of the AAP, you can now join the Senior Section for free! It is included in your benefits as a member of either of these membership categories.

Please visit the AAP Web page at https://fs25.formsite.com/aapmembership/SOSM/secure_index.html and complete the short form.

If you have any questions, please contact our staff at jburke@aap.org.
ALL POLITICS (AND ADVOCACY) IS LOCAL
Lance Chilton, MD, FAAP, Section COFGA Liaison

I’m taking a break from writing about federal legislation and federal child advocacy for two reasons:

1) COFGA has not met since fall (next meeting is at the end of April), and
2) not much has happened in Washington since I last wrote – no movement on gun safety and precious little on immigration, for example.

A budget was passed, and a farm bill got passed as well, with shameful cuts to WIC, but less severe than some in Congress wanted. I definitely don’t mean to say that our Washington office isn’t working as hard as humanly possible to advocate for our patients, but even they have been limited by nearby brick walls.

So this little piece will be more about local and state advocacy, which I am pleased to teach at the University of New Mexico to pediatric residents. An awful lot of extreme importance to our patients goes on within a few miles of our homes, so we don’t always have to get on a plane to encounter one of those aforementioned brick walls. And the walls may not be quite as hard nearby.

About two years ago, the staff for the Municipal Water Utility in my town decided to stop adding fluoride to our water. This was done very quietly. Some of our water has 0.7 ppm of fluoride, some, especially in the poorer parts of town, has 0.4–0.5 ppm. The results are predictable. More caries, particularly in populations who regularly have difficulty finding dental care. Four hours before a hearing to decide whether fluoride should be added back to our water, we got notice that testimony would be taken. We mobilized, and gave testimony that aligned well with dental providers’ thoughts; the final results aren’t in, but I imagine that we will all have 0.7 ppm fluoride in the near future.

New Mexico hasn’t done very well on recent ratings of child well-being. We employ dark humor here: we’re at the top of every bad list and at the bottom of every good one (except for beauty and excellence as a place to visit, but those lists are harder to find). One area where we do much better now than previously – we’re 17th in the nation, which is something to write home about in NM – is in vaccine coverage. That’s partly due to our being a Universal Coverage Vaccines for Children state, where the vaccines for all children are obtained through the state, simplifying matters for both them and for providers. We were recently in danger of losing that status, so again we mobilized on this rather technical issue, supporting legislation in the just-ended State Legislature that would compel private payers to contribute to the cost of vaccines given to children they insure. This has required watching the legislative website and reacting quickly and definitively to save the program.

Our pediatric (and family medicine) residents can do some of this work, but their schedules often make it difficult to respond to suddenly discovered needs for testimony. The same is true of practicing pediatricians. Ideal, we feel, is a tripartite alliance: our residents, practicing members of the New Mexico AAP chapter, and (and here’s where you, my fellow SOSM members come in) retired physicians. We still bear the mantle of respect and responsibility that comes with our profession, and many of us have flexible schedules and can respond quickly. In my case it has meant bicycling downtown to speak before the Water Board or driving 60 miles north to the state Capitol. In both cases, we were treated well and listened to carefully – an ego boost if that’s even desired. But more importantly, we’re doing something for children.
Missing but not forgotten

Mark Rosenberg, MD, FAAP

Here is an essay that I wrote recently for a writing class that I am taking. The spaces are intended as you will gather from reading it. Best MR

There are times when I am speaking and a thought escapes me. I know it is there, somewhere. The mystery is where the thought is. Like a set of misplaced keys, I know exactly when I left the thought. It was

Perhaps there is a section of the brain for missing thoughts. If there isn’t there should be. We can call it the missing thought lobe of the frontal cortex. As I get older I think the missing thought lobe is enlarging. At least it seems to be. That is where all those thoughts reside, resting for the moment when

My first memory lapse that I can pull up from my brain’s data base occurred when I was speaking in front of a large audience. I remember looking out into the crowd and the panic that set in as I tried to recall the anecdote that I had chosen, deviating from my prepared script. From then on I tried to have notes that I might fall back on. That is not always possible and sometimes I have had to use my memory bank. Usually that works but sometimes those synapses that once were connected to each other have an open

We understand so much of what our minds are capable of. Yet there are frequent lapses that occur with age that are poorly understood. Hopefully the neuroscientists are soon able to find that magical remedy, a wonder drug to provide the cement that fills the gap between thoughts and concepts. After all, it was right where I
Most of our generation were HOME SCHOoled in many ways
Submitted by Stan and Judy Singer

1. My mother taught me TO APPRECIATE A JOB WELL DONE.
   “If you're going to kill each other, do it outside. I just finished cleaning.”

2. My mother taught me RELIGION.
   “You better pray that will come out of the carpet.”

3. My father taught me about TIME TRAVEL.
   “If you don't straighten up, I'm going to knock you into the middle of next week!”

4. My father taught me LOGIC.
   “Because I said so, that's why.”

5. My mother taught me MORE LOGIC.
   “If you fall out of that swing and break your neck, you're not going to the store with me.”

6. My mother taught me FORESIGHT.
   “Make sure you wear clean underwear, in case you're in an accident.”

7. My father taught me IRONY.
   “Keep crying, and I'll give you something to cry about.”

8. My mother taught me about the science of OSMOSIS.
   “Shut your mouth and eat your supper.”

9. My mother taught me about CONTORTIONISM.
   “Will you look at that dirt on the back of your neck!”

Continued on Page 14
10. My mother taught me about **STAMINA**.
   “You’ll sit there until all that spinach is gone.”

11. My mother taught me about **WEATHER**.
   “This room of yours looks as if a tornado went through it.”

12. My mother taught me about **HYPOCRISY**.
   “If I told you once, I’ve told you a million times. Don’t exaggerate!”

13. My father taught me the **CIRCLE OF LIFE**.
   “I brought you into this world, and I can take you out...”

14. My mother taught me about **BEHAVIOR MODIFICATION**.
   “Stop acting like your father!”

15. My mother taught me about **ENVY**.
   “There are millions of less fortunate children in this world who don’t have wonderful parents like you do.”

16. My mother taught me about **ANTICIPATION**.
   “Just wait until we get home.”

17. My mother taught me about **RECEIVING**.
   “You are going to get it from your father when you get home!”

18. My mother taught me **MEDICAL SCIENCE**.
   “If you don’t stop crossing your eyes, they are going to get stuck that way.”

19. My mother taught me **ESP**.
   “Put your sweater on; don’t you think I know when you are cold?”
20. **My father taught me HUMOR.**
   “When that lawn mower cuts off your toes, don’t come running to me.”

21. **My mother taught me HOW TO BECOME AN ADULT.**
   “If you don’t eat your vegetables, you’ll never grow up.”

22. **My mother taught me GENETICS.**
   “You’re just like your father.”

23. **My mother taught me about my ROOTS.**
   “Shut that door behind you. Do you think you were born in a barn?”

24. **My mother taught me WISDOM.**
   “When you get to be my age, you’ll understand.”

25. **My father taught me about JUSTICE.**
   “One day you’ll have kids, and I hope they turn out just like you!”

---

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

The pre-retirement check list provides an overview of various considerations associated with retirement. Written by members from SOSM and SOAPM and located on the Senior Section Web Page: check it out at [www.aap.org/seniors](http://www.aap.org/seniors), and look for “Pre-Retirement Check List” under the ‘Education and Career Resources’ section.
How To Tell That You Are Getting Old

Lawrence D. Frenkel, MD

Certainly we know that people age at different rates and we admire those who apparently remain active, functional, apparently healthy, and alert into their 80’s and even 90’s. I wish that I were one of those blessed individuals; however, as I pass my 70th birthday, I conclude that it is time to re-orient my thinking about the future. You may wonder what factors enter into this decision. Perhaps some of the following parameters may be helpful in this evaluation of your own status.

The most important is your perception of your current place in the world and how people view you. A strong indicator of your age is when your adult children tell you that you are a dinosaur and you decide that the next ice age may be more of an imminent danger to you than global warming. Also telling is when your colleagues no longer perceive your advice as a manifestation of valuable experience but rather as the ramblings of a soon to be senile person. Another indication for those of you who give formal lectures, occurs when half of the expected attendees never show up and the rest act bored to death, hide in the back of the room playing computer games, and at the end of the lecture, no one asks a question.

A second important parameter is financial. It starts when your insurance agent calls to tell you that you have outlived your term life insurance policy. It continues when you realize that your monthly Social Security check has become a crucial part of your budget and you wake up at night in a cold sweat contemplating the awful thought that you and your family will outlive your retirement funds.

The status of your current life can also be reflected by the chilling realization that the vast majority of your phone calls on your home telephone are mostly robotic requests for money or yet another scam. And there is no doubt about your status as technologically handicapped when the smart phone that your grandchildren have given to you for your birthday and that they have so easily mastered proves to be smarter than you are.

Finally, your medical status is a wake-up call that you are getting too old, if you have more personal physicians than you can count on the fingers of one hand, or when your weight and systolic blood pressure are both over 200. Similarly, when your physician warns you that your state of current health mandates a long-term diet restricted to bread and water. These health issues become more distressing when all of your joints either ache or need to be replaced, and further, when, not only your wife and children, but your good friends suggest that you get a hearing aid. Another indication occurs when over-the-counter eye glasses are no longer strong enough to allow you to read the most recent version of your will. Finally, there is no doubt about your advancing age, when you cannot always remember your children’s names and perhaps as distressing, why you just went to the refrigerator.

When the above circumstances become a fact of your life, you know that you have become too old to plan your third career and/or around-the-world excursions. There is nothing else to do but live each day as if it was your last and retain as much of your sense of humor as possible. Perhaps it is time to alternate 3-hour naps with 3-hour sessions reading the New York Times, Wall Street Journal or favorite magazine from cover to cover each day.
MOBILE REVIEWs...
Lucy Crain, MD, MPH, FAAP

BLUE JASMINE
Woody Allen’s latest cinematic effort is another amalgam of relationships and interactions among interesting people with intriguing psychopathology. The film begins in the Hamptons and New York environs, superficially delving into relationships and describing the luxurious lifestyle to which Jasmine is accustomed. Glimpses are had of romantic affairs and nefarious financial dealings with which her handsome husband is involved, leading to his arrest for investment fraud. This provides the background for a complex plot which transitions to the San Francisco Bay Area, where now a nearly destitute Jasmine has escaped after her investment banker’s empire crumbled (due not in small part to Jasmine). Although the scenery across the Bay is lovely, much of the action is in the small Mission District apartment of Jasmine’s sister, Ginger. The sister’s role is played by Sally Hawkins and the differences between the sisters is magnified by Ginger’s taste in men, with Bobby Cannevale playing her boyfriend, Chili. It’s puzzling that the majority of Jasmine’s sister’s friends are played by actors with New York and New Jersey accents. The only supposed Bay Area native is played by a too good to be true, very wealthy and politically ambitious man who drops Jasmine like a hot potato when he discovers her true past. The precipitous end of this fairy tale romance plunges Jasmine into an overt schizophrenic break and a despairing end to this intriguing film. Cate Blanchett’s depiction of Jasmine merits Oscar consideration and the supporting characters are strong as well. While Allen treats the subject of mental illness with trademark superficiality, the film is one of his best. It is worth seeing for the questions it instills when we wonder about the backgrounds of well-spoken persons, who are talking to themselves and living on the streets of San Francisco and other cities around the world.

PHILOMENA
This story of a spunky Irish woman who’s spent 50 years trying to locate her son is based on the true story related in the 2009 book, The Lost Child of Philomena Lee by Martin Sixsmith. Philomena was one of many pregnant teenagers abandoned by their own parents and exiled to years of enslavement working in the laundry and other undesirable jobs working in a Catholic nunnery. Dame Judi Dench plays Philomena with understanding, determination and a mix of sadness and humor in another Oscar-worthy performance. Steve Coogan is well cast as the journalist who discovers the story, tracks down Philomena and finally traces her son, who had been sold to an American couple for a thousand pounds at age 3. Various glimpses of the life of her son, who had worked for the Reagan Administration add to the depth of this gripping story and the heartbreak, as well as her abiding faith so well acted by Ms. Dench contribute to this remarkable film, made more compelling by its factual basis.

INSIDE LLEWYN DAVIS
Set in New York City in the early 1960s, this Coen brothers film stars Oscar Isaac as a folk singer. He sings well, plays the guitar well, but never quite makes it to the stardom enjoyed by his contemporaries like Bob Dylan. The film starts and ends with a haunting ballad, “Hang Me, Oh Hang Me”, and the movie continues on its journey through some great folk music, traveling to auditions without a winter coat to his name in the freezing New York winter. The Coen brothers specialize in studies of atypical characters and Llewyn’s irascible, ungrateful behavior toward his sister and numerous friends who provide him shelter cause the viewer to think he deserved nothing better than mediocrity…It’s a downer of a movie, but the music and the acting are good. You might want to wait for the video of this one!
Grandpa Trauma

Michael O’Halloran, MD, FAAP

My grandson, Max, was lost. And lost on my watch.

Max was 7 years old. His dad, his older brother Henry, Max, and I were camping in the northern Minnesota Boundary Waters Canoe Wilderness Area. I was approaching 70 years old and in pretty good shape but still, I was surprised and flattered to have been invited to be the other adult on this trip.

We were on a very large island about a day’s paddle from a road and our car. It was a beautiful spot by the water with wonderful hiking, good fishing, great for just sitting around on a nice day.

Many times that day we had explored a path into the dense woods of the island behind our site. Then Max and I decided to explore further but Henry was going to wait at the camp for his father who was due to be back soon from fishing for our supper. Max, with my permission, planned to go up the path a bit while I got ready and chatted for a few minutes with Henry. I soon followed … but I couldn't find Max on the trail!

I yelled. No answer. I suppressed an awful feeling in my chest. In a bit further. No answer. Henry and I went even further, yelling. No answer. I walked Henry back to the camp where he could wait for his father and be there in case Max showed up.

Still no Max. Henry was very upset with worry about his brother. I went deeper into the forest. Yelling. No answer. I knew about a fairly precipitous drop further in; not exactly a cliff, but steep. I checked that out. No Max. His father returned. We split up with me going further into the woods and he roughly followed the shore. Although we were on an island, it was very big. A person could stay lost on it for a long time. I remembered bad stories about people being lost in the Minnesota Northwoods. I was scared. Max’s father was scared. Henry was crying.

But just as I was coming back from making a big but unsuccessful search loop through the woods, I heard them. Max has been found! I was so relieved that I ran up and grabbed Max. A memorable hug. Later that night, Max said, “Grandpa, I was really scared.” That comment tore me up.

Although barely 7 years old, he had devised a reasonable strategy. It was to get close to the water and follow the shore so that, being on an island, he'd eventually get back to our landing. Unfortunately, he was going the wrong way and it would have taken a very long time on such a big island. His dad got to him before he had gone too far.

How to describe how I felt? Like a miserable failure. He was my responsibility and it happened on my watch. Max’s father never expressed disappointment or blame; Max either, as far as I know. But I knew. Had I kept him on a shorter leash, it wouldn't have happened.

So what to learn from this traumatic day? For me it was that I should have known the whereabouts of my charges at every minute. I could have reviewed what to do if lost. I could have set rules about how far to go from camp when alone. I could have … could have … could have… but I didn’t.
**Editor's Notes:**

**MANDATORY RETIREMENT AGE QUESTIONS**

Several recent letters to the editor regarding mandatory retirement practices by pediatric practice groups led me to ask Ken Slaw, PhD, Director of the AAP Department of Membership for additional information on this important topic. Ages 65 and 75 don't seem as “old” as when we began to practice pediatrics, so this topic certainly is deserving of more scrutiny. Dr. Slaw referred the issue to the AAP Committee on Medical Liability and Risk Management (COMLRM) for consideration and the Committee agreed to consider publishing an educational article on the topic in the near future.

Meanwhile, Ms. Roberta Bosak, Director, AAP Department of Human Resources and Administration kindly offered the following general overview of the topic to Dr. Slaw for educational purposes only. DISCLAIMER: You may find this information useful in answering your questions, however, it should be noted this is a quick review of the topic and should not be taken as the advice of legal counsel. If you have specific concerns you should seek your own legal counsel.

Based upon my limited understanding and research, mandatory retirement is generally unlawful in the United States, except in certain industries and occupations that are regulated by law, and are often part of the government (such as military service and federal police agencies, such as the Federal Bureau of Investigation). State and federal age discrimination laws generally prohibit an employer from imposing a mandatory retirement age; however, these laws only apply to individuals classified as employees, and do NOT apply to non-employees such as independent contractors, or bona fide partners and shareholders in a closely held professional corporation.

**Federal Law**

The Age Discrimination in Employment Act (ADEA) applies to employers with twenty or more employees and prohibits employers from discriminating “against any individual with respect to his compensation, terms, conditions, or privileges of employment,” because of such individual's age. The ADEA makes two exceptions. One allows a mandatory retirement age for certain executives and high-level policymakers when particular criteria are met. Since this provision is an exemption from the ADEA's requirements, it is narrowly interpreted and the burden is on the employee to prove that all of the elements of the exemption have been met. The exemption applies to any employee who is:

1. At least 65 years of age;
2. Employed in a bona fide executive or high policymaking position for the two-year period immediately before retirement; and
3. Entitled to an immediate, nonforfeitable annual retirement benefit from an employer pension, profit-sharing, savings, or deferred compensation plan, or any combination of those plans, which equals in the aggregate at least $44,000 per year.

Continued on Page 20
According to Equal Employment Opportunity Commission (EEOC) regulations, the exemption for executives does not apply to middle management employees, no matter how great their retirement income. It applies only to top-level employees who exercise substantial executive authority over a significant number of employees and a large volume of business. Similarly, the phrase “high policymaking position” is limited to certain top level employees who have little or no line authority but whose position and responsibility are such that they play a significant role in the development and implementation of corporate policy.

The second ADEA exemption allows you to require employees to retire at a certain age if you can show that age is a bona fide occupational qualification (BFOQ) “reasonably necessary to the normal operation of the particular business.” Like the exemption for certain highly compensated executives, the age BFOQ is limited in scope and application and must be narrowly applied.

The EEOC regulations implementing the ADEA indicate that any employer using the BFOQ exemption must prove that:

1. the age limit is reasonably necessary to the essence of the business; and either
2. all or substantially all individuals excluded from the particular job are in fact disqualified; or
3. some of the excluded individuals possess a disqualifying trait that cannot be ascertained except by reference to age.

Mandatory retirement at a specified age rarely has been upheld under the BFOQ exemption, though the courts have recognized the BFOQ defense when safety issues are involved. However, the employee has the burden of proving that age materially affects an employee’s job performance. In addition, the employee must show that substantially all older employees are similarly affected or that there is no way, other than basing the decision on age, to determine the capabilities of individual older employees. Additionally, the EEOC has set forth a six-factor test to determine whether a shareholder-director is an employee (and thus protected by the statute) or an employer (and thus not protected by the statute): I. Whether the organization can hire or fire the individual or set the rules and regulations of the individual’s work. II. Whether and, if so, to what extent the organization supervises the individual’s work. III. Whether the individual reports to someone higher in the organization. IV. Whether and, if so, to what extent the individual is able to influence the organization. V. Whether the parties intended that the individual be an employee, as expressed in written agreements or contracts. VI. Whether the individual shares in the profits, losses, and liabilities of the organization. [EEOC Compliance Manual §605:0009.] The United States Supreme Court endorsed the EEOC’s six-part test in Clackamas Gastroenterology Associates v. Wells, emphasizing that the employer is the group of persons who own and manage the enterprise and that the mere fact that a person has a particular title is not dispositive. The court commented that where shareholders control the operation of the business, share the profits and are personally liable for malpractice claims, those factors weigh in favor of determining that the shareholder is not an employee protected by the discrimination laws. An additional rationale for finding that partners and professional corporation shareholders are not employees subject to the discrimination laws is that by virtue of their status as owners they have other protection under the law.

Continued on Page 21
Other Certain Professions

- Pilots: the mandatory retirement age of airline pilots is 65. The Fair Treatment for Experienced Pilots Act (Public Law 110-135) went into effect on December 13, 2007.[16]
- Air traffic controllers: Mandatory retirement age of 56, with exceptions up to age 61
- Federal law enforcement officers, national park rangers and firefighters: Mandatory retirement age of 57, or later if less than 20 years of service[17]
- Florida Supreme Court justices: The Florida Constitution establishes mandatory retirement at age 70.
- New Jersey Supreme Court also established mandatory retirement at age 70.
- Maryland Constitution establishes mandatory retirement age of 70 for Circuit and Appellate Court judges.
- New Hampshire Constitution - Article 78 sets the retirement of ALL Judges and sheriffs at age 70.

AAP Travel Office

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

We also offer reservations through Concur 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.

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
LETTER TO THE EDITOR

Am I the only senior finding the term “evidence based” to be irritating? We all came up through the science of premed and med school, only to find 25 years later that there was no evidence that could be found for what we did, and told we should embrace, nay, insist on only evidence based practices. Perhaps there’s new evidence. Perhaps the evidence changes over the years. Whence cometh the hubris that we can now do better stuff because it’s “evidence based”?

Evidence and Evidence-Based Medicine: What’s it all About?

Carol D. Berkowitz, MD, FAAP

As someone who deals with the field of child abuse, I am constantly confronted by the question from my legal colleagues: “What is the evidence that this child died as a result of his injuries?” What the district attorney means by evidence and what the medical community means by evidence are different. In its broadest sense, the definition of evidence is everything used to determine or demonstrate the truth of an assertion. In the legal arena, there is a distinction between circumstantial evidence and direct evidence, or evidence that suggests truth as opposed to evidence that directly proves truth. As a child abuse pediatrician, I am asked to state the level of medical certainty of my opinion. How does legal evidence, medical certainty and evidence-based medicine interface? How much evidence-based medicine is there that relates to child abuse?

The concept of evidence-based medicine first appeared in JAMA in 1992 in an article entitled “Evidence-based medicine. A new approach to teaching the practice of medicine” from a group called Evidence-Based Medicine Working Group. The notion was that decisions about the care of patients should be based on the best possible evidence. The greater the level of evidence, the stronger the recommendation. The best evidence comes from randomized controlled trials but evidence comes from other sources as well. The Cochrane Review gathers all the data available about the effects of intervention on prevention, treatment and rehabilitation in healthcare settings. Some have countered this evidence-based approach to state that it is not applicable to all situations. For instance, there have been no randomized controlled trials related to the use of parachutes to prevent death and major trauma when jumping out of an airplane! (Gordon, Smith, Pell. BMJ 2003;327:1459-1461). Likewise we have seen controversy as well as an outcry from the medical community when the US Task Force on Preventive Services has come out and stated there is no evidence that screening for certain conditions, eg, interpersonal violence, has any effect on ameliorating the condition. Often the conclusion is that screening without intervention or access to resources is not useful and makes no demonstrable difference.

So, as my colleague, Leona Ewing asks, was the medicine that we practiced prior to 1992 not evidence based? Was everything anecdotal and was there no literature to support our decisions? Is this relatively new term, evidence-based medicine, old wine in new bottles? A bit, but not entirely. The computer age has allowed us to gather massive amounts of data that can best help to inform us of what proves to be most beneficial in large populations of patients. Not all of these recommendations emanate from randomized controlled trials. Some simply reflect an electronic approach to data gathering and analysis. But sometimes what works for one population (that

Continued on Page 23
studied) may not be applicable for a given patient. And we have seen that many studies excluded certain populations such as children, women and minorities. For instance, children are often excluded from drug trials and we as pediatricians are left with using a medication off-label. Much of the evidence as relates to child abuse relies on observational studies or simulation models. No one would ever consider shaking a baby to determine if that infant would sustain brain damage or retinal hemorrhages as a result of that action. Remember that the focus of evidence-based medicine is on seeing whether an intervention is beneficial, not whether a proposed mechanism of action explains the findings. And the absence of evidence is not evidence of absence!

The medical community for the most part has always used the best information to benefit our patients. Journals have been around for many years as have professional societies and scientific meetings. We shouldn’t feel offended by the “new” term evidence-based medicine. It is like the ACGME’s move to delineating competences. It doesn’t mean that those of us who trained prior to 2000 were incompetent or not assessed for our professional skills. And evidence-based medicine doesn’t stand alone as an absolute. We must always use our clinical experience and judgment as we care for our patients.

---

**Repairing Hearts & Getting Older**

A mechanic was removing a cylinder head from the motor of a Harley motorcycle when he spotted a well-known heart surgeon in his shop.

The surgeon was there, waiting for the service manager to come and take a look at his bike.

The mechanic shouted across the garage, “Hey, Doc, can I ask you a question?”

The surgeon a bit surprised, walked over to the mechanic working on the motorcycle. The mechanic straightened up, wiped his hands on a rag and asked, “So Doc, look at this engine. I open its heart, take the valves out, fix ‘em, put ‘em back in, and when I finish, it works just like new. So how come I get such a small salary and you get the really big bucks, when you and I are doing basically the same work?”

The surgeon paused, smiled and leaned over, and whispered to the mechanic... “Try doing it with the engine running.”

---

**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
The Birth of a Book
Robert E. Hannemann, MD, FAAP
Past President, AAP
Associate Medical Editor, Emeritus
Caring for Your Baby and Young Child: Birth to Age Five

I think the idea of the American Academy of Pediatrics to publish an authoritative book on child care had its birth in 1982, when the Task Force on the Promotion of Pediatrics was formed. It consisted of Chairman, Doctor Murray Pendleton, and members, Doctors Don Cook, Bob Grayson, Doris Howell, Dick O’Neill, and myself. Doctors Art Maron, Alan Coleman, Bob Williams, and Don Schiff were later added.

The task assigned to this group was to find ways and means of promoting the pediatrician as the physician for all children from birth through young adulthood and to increase the utilization of their services. Various ideas and techniques were explored and implemented, including radio and television public service announcements and magazine articles and inserts to accomplish this task.

Eventually it was recognized that further expertise was needed, and a public relations (PR) firm was hired to coordinate this program. This firm developed the “New Age” slogan, capitalizing on a double meaning of “New Age,” indicating a dawning of an expanded era for pediatrics and pediatricians that embraced the adolescent and young adult age category. Although controversial, this slogan survived and the task force became known as the “New Age” group.

In 1983, Doctor Pendleton stepped down as Chairman, and I was assigned that responsibility. I then had the privilege of working with the recently hired director of the Communications Department, Ms. Susan Casey. Under her guidance, the projects of the PR firm were rapidly brought in-house. Among these were newspaper and magazine inserts, media placements, and newsletters, all aimed at increasing public awareness of the pediatrician and the value of his/her services to children from birth to 21 years of age.

By 1984 it became apparent to the AAP Board that public communication was going to require a continued commitment of resources, so the Task Force became the Provisional Committee on Communications (PCOC). Concomitantly many new ideas on giving pediatricians a competitive edge began to surface. Among these was authoring a comprehensive, authoritative book on child care. This concept was gaining more and more interest, and crystallized early in 1985 when the Academy began discussions with Doctor Art Ulene and his “Feeling Fine” Programs.

These deliberations initially centered around a newsletter and television production, but the idea of a book soon became a center of interest. Within eight months, an editorial board was selected, and I had the privilege of being one of those chosen. This group had its first meeting at the LaGuardia Marriott in November of 1985. In addition to myself, those physicians present were Executive Editor, Doctor Art Ulene; Managing Editor, Doctor Steve Shelov; and Doctors Catherine DeAngelis Bob Haggerty, Andrew Mezey, Jack Shonkoff, and Jim Strain. This was an extremely productive meeting. All of the existing major child care books were reviewed and their good and bad points discussed. It was decided to divide the Academy’s effort into three publications according to age. Optimistically, it was predicted that the first book (0 to 5-year-olds) would be released in 1988 with a second (6 to 12-year-olds) to be published in 1989, and the final (the teen years) to hit the market in 1990.
It was also decided to employ parent focus groups early to gain public input and to employ as wide a group of AAP “experts” as possible to write the material. In addition to these major decisions, many minor ones were discussed, including gender pronouns to be used and indexing to be employed. As we later found, this was only the beginning of a large number of problems that would have to be faced before this enormous task would be accomplished.

We eagerly went to work on the content of the book, entering every topic we could think of on age-specific worksheets. These were then alphabetized and prioritized as to whether they “absolutely” had to be included or not. In early 1986 the focus groups began meeting and their views were funneled to Feeling Fine Programs. Writing was begun and finished material was being circulated through the Academy’s various sections and committees and the Board itself. Invaluable service was performed by Doctor Leonard Rome who was the designated Board reviewer. Doctor Morris Green was also added to the Editorial Board, and his writing and editing expertise were valuable.

As the writing progressed, major problems sometimes seemed to be solved more easily than the minor ones. Efforts to be accurate led to many frustrating and amusing episodes. One of the most memorable had to do with correct spelling of Denis Browne of the bar and splint fame. I finally xeroxed a page of my old medical dictionary to convince the editorial group of the correct spelling.

In early 1987 Doctor Steve Shelov’s title was changed to Editor-in-Chief, and the editing work took on a new dimension. It became obvious that a final rewriting and review mechanism was necessary and I was then asked to assume more responsibility for these efforts. This involved many long (sometimes more than two hours) telephone conversations and the development of an editing sheet. All of this eventually led to my being named Associate Medical Editor in 1988 and the development of a final three member editing team that involved myself, Doctor Steve Shelov, Doctor Bob Mendelson (Chairman of PCOC) and his wife Lottie. This resulted in completion of most of the manuscript by the end of the year, and work was begun on illustrations and final format.

By mid-1989 it was thought that things were winding down when a major change in format was made. Originally, the developmental chapters were preceded by “A Day in the Life” scenarios/vignettes illustrative of the age being discussed. However, it was felt that these were unrealistic and probably could never be written to accurately depict what was happening in the real world and they were deleted from the book. This necessitated changes in the remaining copy and further delays in the progress toward the final galley proofs which was finally attained in October 1990, after which final review of the illustrations was carried out. This required a meticulous check for the appropriateness of the illustrations and also for accuracy of the labeling.

Just when everything seemed to be set for printing and distribution at the AAP Spring meeting in mid-March, disturbing changes began to surface. AAP committees were making major alterations and recommendations for immunizations and feeding practices. These had to be accommodated up to the last minute. The most amusing of these involved a special note that had to be added on the page preceding the Table of Contents to cover the Nutrition Committee’s decision to delay introduction of whole milk for the infant feeding schedule until one year of age.
The final review of this was made standing in the snow outside Academy headquarters as I was leaving to catch a plane. Lisa Reisberg (Director, Division of Public Education of the AAP Department of Communications) was there to pencil in the final wording as the snowflakes were falling on the page.

And so in mid-March 1991, six years after the start of the project, the book was finished. I saw it for the first time in the booth at the Academy display at the San Diego Convention Center and held my copy in my hand shortly thereafter. It was truly like handling one’s own baby, a baby born out of a great deal of individual effort, but also the combined work of over 70 Academy contributors and scores of Academy members and staff workers – truly a team effort.

And it is not really over. Part of the agreement with the publishers is that the book will be updated every five years. That updating has already been done five times and has involved hundreds of word changes and updated recommendations and decisions. In addition, the Academy has the option of requesting that extremely significant updates or changes, such as those in immunization schedules, be included in the next printing. The “baby” is now 23 years old and was given a new “outfit” in the form of a trade paperback edition in 1993. Selected editions have been translated into ten different languages (Hispanic, Greek, Hebrew, Chinese, Japanese, Korean, Arabic, Portuguese, Russian, and Turkish) and, overall, the book has sold more than four million copies. And the historical development of this amazing creation is still not over. It continues to be the flagship of the AAP’s child care information fleet of printed information for parents and their advisors, the Pediatricians of the world. This could not have been done over the past 23 years without the dedicated efforts of AAP staff such as Maureen DeRosa and Mark Grimes, who have been involved with this project from the beginning, and the numerous reviewers, contributors, and specialty assistants named and acknowledged in each addition.

---

GETTING OLDER? ME TOO!

A distraught senior citizen phoned her doctor’s office.

“Is it true,” she wanted to know,
“that the medication you prescribed has to be taken for the rest of my life?”

“Yes, I’m afraid so,” the doctor told her.

There was a moment of silence before the senior lady replied,
“I’m wondering, then, just how serious is my condition because this prescription is marked ‘NO REFILLS’.”
Retirement Readiness: What Adjustments Should You Make?

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

Physicians contemplating retirement within a few years need to understand the future risks of the financial situation they may be facing. People are living longer, which means you may have to provide for a bigger cushion in retirement than you initially intended. In addition, uncertainty over the future of Social Security benefits as Baby Boomers continue to retire adds to the concerns. As a result, you could face a personal shortfall, especially if you incur unforeseen expenses from a medical condition or some other situation.

So what could/should you do? Even if retirement is imminent, you may be able to make up lost ground quickly or take other steps to protect yourself. Here are several ideas to consider:

• Maximize retirement savings vehicles: Just a few years of making contributions at or near the maximum level can significantly bolster your account. If you have any qualified retirement plans that you are not fully funding, determine if your cash flow will allow you to do so.

• Work on the budget: If a financial planning retirement needs analysis determines that you may have a potential shortfall, you might want to dial down your expectations. Make realistic estimates about the income you expect to have coming in and the expenses going out. Although you will likely be paying less for housing (see below) and other items such as life insurance, especially if your children are already adults, consider the impact of potential increases in some expenses such as travel expenditures.

• Move to a smaller home or condo: For most people, housing is the largest overall cost, representing on average more than one-third of overall spending. If your kids no longer live with you, but you’re still living in the large home where you raised them, it may be time to downsize. In addition, you might want to move to a state with a different climate, taking state income taxes into account. Of course, various other factors such as proximity to family and personal preferences will come into play.

• Refinance your current home: If you decide not to downsize, you should consider refinancing an existing mortgage if you are paying a rate higher than those currently available. At the beginning of 2013, mortgage rates had reached historic lows. Even though rates have increased slightly since then, you may save tens of thousands of dollars over time by refinancing. Keep in mind that your interest payments will generally continue to be tax-deductible.

• Do not stop working altogether: Just because you have reached retirement age does not mean you have to stop working completely. If needed, you could pursue part-time employment. For some individuals, working full-time a little longer is also a viable option.

Every physician’s situation is unique, but the most important thing to do is assess your financial planning objectives, which of course includes a review of your investment portfolio. Planning involves assumptions about the future; assumptions that may not pan out. Although you cannot avoid making assumptions, you can evaluate whether they are realistic and consider how your lifestyle might change if future economic and financial conditions are much different than projected. And while you also cannot fully control the factors involved in portfolio endurance during retirement, having more wealth can improve the odds of having a less stressful financial life. A more substantial nest egg might enable you to take fewer risks, enjoy a higher sustainable spending rate, or extend the productive life of your portfolio.
CALL FOR ABSTRACTS

for the

American Academy of Pediatrics

SECTION ON SENIOR MEMBERS

IN COLLABORATION WITH

THE AAP PEDIATRIC HISTORY CENTER

for the

AAP National Conference and Exhibition

October 11-14, 2014
San Diego, CA

Submission deadline:
Friday, April 11, 2014
(Abstracts must be received by this date)

The AAP Section on Senior Members
and the AAP Pediatric History Center is providing a forum for pediatric history.

The Senior Section, in conjunction with the AAP Pediatric History Center is accepting abstracts that reflect any historical aspect of the field of pediatrics. It may be a historical aspect of health or disease, medical management, disease history, history of a pediatric institution, history of an AAP chapter, section, biographical materials, or other. Selected abstracts will be invited to show a poster at the 2014 NCE and the top abstracts will be invited to make a short podium presentation during the Senior Section educational program. The poster area will be in the convention center in close proximity to the exhibit hall.

The call is through the AAP’s NCE abstract call and can be found at https://aap.confex.com/aap/2014/cfp.cgi. Scroll down to Section on Senior Members/Pediatric History Center to begin. For now, you need to submit an abstract of your history project and that deadline is Friday, April 11. Please select CASE STUDY and not RESEARCH. After filling in the authors’ page, the next page is to upload your abstract, which should be no more than 450 words. For a case report, the required headings are “case report” and “discussion.” Just title the first paragraph Case Report and the last paragraph Discussion. Please do not enter your name or your affiliation in the abstract text. You can upload a file or copy and paste!

If selected, you’ll have plenty of time to actually create your poster for the NCE.

Feel free to pass along this information. If you have questions or comments, please contact Veronica Booth, the AAP’s new Archivist, in the AAP History Center at vbooth@aap.org.
Learn about the new American College of Cardiology/American Heart Association’s Lipid and JNC VIII’s Hypertension Treatment Guidelines. What are the diagnostic and treatment dilemmas with diet and drugs for men and women. Is there a relationship to Erectile Dysfunction? Does “Low-T” as the commercials tell us really exist? Join J. Thomas Cross, Jr., MD, MPH, FAAP, FACP, former associate professor in the Department of Internal Medicine and Pediatrics at Louisiana State University Health Sciences Center, a past president of the AAP’s Section on Med-Peds, past president of the National Internal Medicine-Pediatrics Program Directors’ Association, and a former member of the Clinical Efficacy Subcommittee of the American College of Physicians for this lively discussion.

This is a free member benefit brought to you by the AAP Section on Senior Members and the AAP Section on Med-Peds!

IT’S NOT TOO LATE TO SEE THIS WEBINAR! YOU CAN WATCH THIS WEBINAR (AT NO COST) AT: http://youtu.be/A2AXZLJyiNA

2014 Senior Bulletin Schedule
We welcome contributions to the Bulletin on any topic of interest to the senior community. Articles for consideration and letters to the editor should be sent to the Editor at lucycrain@sbcglobal.net with copies to the Academy headquarters tcoletta@aap.org.

2014 Summer Bulletin
May 29 articles due to Lucy Crain, MD, MPH, FAAP • July 3 mailboxes

2014 Fall Bulletin
August 14 articles due to Lucy Crain, MD, MPH, FAAP • September 19 mailboxes
COMMON QUESTIONS ABOUT CHANGES
FOR SENIOR MEMBER CATEGORIES IN THE AAP

1) What are the criteria for the new senior category?
• Good standing members who have reached the age of 70 OR
• Members age 65 or older and no longer derives income from professional employment

With passage of the 2013 bylaws referendum, all national AAP members will be eligible for the Senior Member category when they meet the eligibility criteria described above. CURRENT Emeritus and Retired will be automatically rolled into the new Senior Member category, whether they meet the criteria or not. This will be accomplished through the FY2014-2015 membership renewal process. Newly eligible members will have to request Senior Member category as there is no automatic roll to this category.

2) What are the dues and benefits for Senior Member?
Dues are $200.
Privileges include:
• FAAP Designation (for previous FAAP members only)
• Inclusion in and access to Member Directory
• Inclusion in the Find a Pediatrician search tool, upon request
• Can Serve on National Committees
• Can vote in AAP elections (FAAP members only)
Benefits include:
• AAP News (online and print)
• Automatic membership in the Senior Section at no additional cost
• Discounted pricing on AAP publications, subscriptions, meetings
• Discounted travel through CONCUR, the AAP Travel Office’s on-line travel booking agent
• Member discount programs
• eBreaking News and On-Call alerts
• Key Contact Network
• Access to members-only content on all Academy Web sites
• PediaLink
• Pediatrics (online, print by request)
• Red Book Online (print by request)
• Section/Council membership

3. Do members 80+ pay dues to the AAP or the Senior Section?
No, members who are age 80+ do not have to pay dues to AAP or Senior Section.

4) Is senior member category automatic or do you have to request it?
Not automatic; eligible members must request to switch to the Senior Member category. Senior Members will automatically receive the national dues waiver the membership renewal year they become 80 years old.

Continued on Page 31
5) **Can members 55 and older still join the Section on Senior Members?**
Yes.

6) **If a Senior Section member achieves the new age criterion for AAP senior membership, can he/she stop paying section dues but maintain section membership?**
Yes, but only if they change member category.

7) **Is the Senior Member category a mix of board-certified and non-board certified members?**
Yes, all national members are eligible for the Senior Member category. Those who were previously FAAP will retain their FAAP designation.

8) **What is the difference between Senior Member and Senior Section Member?**
Senior member is the new national membership category. Senior Section member is any member of the AAP who belongs to the Senior Section.

---

**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.

---

**An older gentleman was on the operating table awaiting surgery and he insisted that his son, a renowned surgeon, perform the operation. As he was about to get the anesthesia, he asked to speak to his son.**

“**Yes, Dad, what is it?**”

“**Don’t be nervous, son; do your best, and just remember, if it doesn’t go well, if something happens to me, your mother is going to come and live with you and your wife...**”
Aging:
Eventually you will reach a point when you stop lying about your age and start bragging about it. This is so true. I love to hear them say “you don't look that old.”
***
The older we get, the fewer things seem worth waiting in line for.
***
Some people try to turn back their odometers. Not me! I want people to know why I look this way. I’ve traveled a long way and some of the roads weren't paved.
***
When you are dissatisfied and would like to go back to youth, think of Algebra.
***
You know you are getting old when everything either dries up or leaks.
***
One of the many things no one tells you about aging is that it is such a nice change from being young.
***
Ah, being young is beautiful, but being old is comfortable.
***
First you forget names, then you forget faces. Then you forget to pull up your zipper....it’s worse when you forget to pull it down.
***
Two guys, one old, one young, are pushing their carts around Wal-Mart when they collide. The old guy says to the young guy, “Sorry about that. I’m looking for my wife, and I guess I wasn't paying attention to where I was going.”
The young guy says, “That's OK, it's a coincidence. I’m looking for my wife, too... I can't find her and I’m getting a little desperate.”
The old guy says, “Well, maybe I can help you find her...what does she look like?”
The young guy says, “Well, she is 27 yrs. old, tall, with red hair, blue eyes, is buxom... wearing no bra, long legs, and is wearing short shorts. What does your wife look like?’
To which the old guy says, “Doesn't matter, --- let's look for yours.”
(Great One!)
***
(And this final one especially for me,) “Lord, keep Your arm around my shoulder and Your hand over my mouth!”
***
Now, if you feel this doesn't apply to you . . . stick around awhile . . . it will!