We are all welcoming the first buds of spring, which will, no doubt, be in full bloom by the time this Senior Bulletin reaches you. Ruth and I have recently returned to South Florida after a month touring Australia and New Zealand, and the Tasmanian Sea, which separates them. Our cruise was preceded by an independent visit to environs of Sydney and followed by a similar stay in Auckland. Amazing flora and fauna, an amazing population of friendly, laid-back and industrious people. Their health care seems up-to-date, their health status good, and health care costs modest. Not surprisingly, the native Australian Aborigines and native New Zealand Maori have more challenges in reaching economic and health levels. It was a revelation to find 21st century technology and all the “brand names” in this far-flung corner of the world.

I am poised to leave for the 2015 Annual Leadership Forum (ALF) this week in Schaumberg, Illinois. Pediatric leaders from Chapters, National Committees, Sections and Councils, and National
officers and staff combine to debate a hefty number of resolutions, many of them contentious and polarizing. A number of guest speakers will frame the issues and spark the discussions. Our Senior Section has offered a resolution to waive NCE and CME fees for our older members. We will argue that the depth of experience and clinical acumen to be shared by our more senior members is an asset which the AAP cannot afford to neglect or deny. Existing AAP policy waives dues for those of us who are 80 years of age, and an extension of this policy seems sound.

Plan ahead to attend this year's NCE in Washington, DC where once again we will have an exciting educational program to complement the other lectures, discussions and wonderful opportunities to meet and greet old friends and new.

Watch for the election ballots for the Senior Section. Our Nominations committee has narrowed the field from many qualified candidates and you will have the opportunity to vote for your choices to join the Executive Committee.

Best wishes to all for good health, good deeds and good times.
Spring 2015 Editor’s Note
Lucy Crain MD, MPH, FAAP

Many thanks to all of you who responded to my request for articles on Vaccinations. Most seniors have personal experience with measles, mumps, rubella, influenza, varicella and many other (now) vaccine preventable diseases. Eileen Ouellette's nightmare article reminded me of when my two little sisters and I had measles. Mama closed the bedroom drapes because the light hurt our eyes so much, and we entertained ourselves singing and pretending to be “Three Blind Mice”. We are fortunate not to really be left blind or worse from measles complications.

Seniors are old enough to have seen children die of complications of measles and other “childhood” diseases and knowledgeable enough to know that measles remains a major concern in the developing world, where it still kills 400 children a day. (WHO.int)

But, it’s not just measles for which reliable preventive vaccination is being ignored by parental and religious belief exceptions. Pertussis is mostly endemic in the adult population in the US, where it’s a bothersome 6 week bout of coughing. In infants, it can be fatal. There have been two recent pertussis epidemics in California. In 2010 and 2014, there were nearly 10,000 cases of measles each year with 8 infant deaths in 2010 and at least 3 deaths in infants last year. Still, California’s governor signed the “parental belief exemption” bill into law in 2009, increasing the already significant numbers of children who can legally attend public schools without the protection of vaccinations. Work is underway to rescind that legislation. (West Virginia and Mississippi are the only two states which do not permit religious or parental belief exemptions.) Meanwhile it’s scary to go to Disneyland or other theme parks, ride public transit, or go to public gatherings without benefit of immunity. It’s another flashback to when we grew up in the era of polio epidemics before those vaccines. Children and adults with impaired immunity are put at special risk for most vaccine preventable diseases because of the increased numbers of non-immunized people in our midst. Like many of you, I have had the sad experience of seeing children die of these diseases, many of which have never been seen by today’s parents and health professionals.

This issue also contains several reflections on how pediatric practice has changed over the years, plus valuable insights into how a good many of our members are remaining active advocates for children and families through teaching, writing, and legislative testimony. Send us your stories about your current advocacy work for consideration of publication in an upcoming issue. This is YOUR Senior Bulletin!

SAVE THE DATE!

The AAP Senior Section, in conjunction with the AAP Section on International Child Health, will be hosting a webinar for AAP Members on Wednesday, May 20 from 11 AM – Noon Central time. The title of the Webinar is International Volunteerism for Seniors 101. You will receive an invitation to participate by e-mail via To-Go Webinars.
Thoughts of a “Seasoned” Pediatrician
Ann Beach, MD, FAAP, FHM
Children’s Healthcare of Atlanta at Scottish Rite

I’ve now practiced 33 years, and have loved almost every minute of it. I’ve been a small town pediatrician, an HMO administrator, a hospital administrator involved in quality and patient safety, and for the last 15 years, a pediatric hospitalist in a big city pediatric tertiary referral hospital.

As a medical student and resident, I kept a list of all of my patients, and disciplined myself to write down one medical thing (the science of medicine) and one non-medical thing (the art of medicine) I learned from each patient. Today, I encourage all of the students and residents I teach to do the same thing.

I recently leafed through those old binders. Plenty of things have changed! But interestingly, plenty of things haven’t.

My Harriet Lane Handbook from 1979 was 296 pages long. My newest one (which of course includes a smart phone app) is 1131 pages long, with much smaller font! Back then there was only one generation of cephalosporins. Now I have to try to remember the difference between all of the cephalo du jours.

The IV loading dose of aminophylline is 7 mg/kg. Please check a level 1 hour after the loading dose. Gosh, when was the last time I did that? I used to know the doses of Slophyllin, Theodur, Quibron and metaprel by heart. I haven’t made an asthmatic vomit from SQ epi injections in a long time.

The immunization schedule was easy to memorize because it pretty much just included DPT, OPV and MMR. Parents were excited for their babies to get immunizations and never questioned the wisdom of vaccines.

Kawasaki’s was treated with high dose aspirin, but no IVIG I treated meningitis (and there was more of it before the HIB vaccine) with ampicillin and chloramphenicol. We knew Reye’s often happened after the flu, but didn’t understand the aspirin link. I knew how rectal paraldehyde for seizures could smell up the whole treatment room. All of my patients with acute myeloblastic leukemia were going to die soon. Now the 5 year survival rate is 60% or more.

CT scanners came to my medical school in 1976. They were slow, grainy, and slices were thick. But they were revolutionary. Now, CTs can be done in a matter of minutes. MRIs exist now and can do lovely 3D reconstructions.

What hasn’t changed?

The ability to take a thorough history and do a complete physical exam is the most important tool we have (More important than the CRP or the MRI machine). Also important is the understanding that we don’t really “take” a history; we begin a history. We continue to add to it as we ask more questions while we continue to care for the patient.

Examine the throat last. That way, if you elicit a gag and the baby vomits, you’re done with the exam.

Continued on Page 5
Thoughts of a “Seasoned” Pediatrician Continued from Page 4

Be prepared for the results of any lab test you order. Think about what you'll do if it is normal. Think about what you'll do if it is abnormal. If you'll do the same thing either way, you probably don't need to order the test.

Making sure parents know that you care is high on the list of important things.

The nurses usually know more than we do. Always ask the nurses their opinions. A good nurse is your right arm.

Expect to learn something new every day.

Children are way more fun to take care of than adults.

As I look back on all of this, what strikes me is that the science of medicine has changed dramatically. We are always told that over 50% of what we learn in residency is obsolete within 10 years, and I believe that is so. Very little of the tests and medications I order now could have been ordered in the 1970's. Not to mention that I now order everything on a computer..........

The speed of change seems to be accelerating.

Ahhhh. But it is the ART of medicine that is not changing. The all-important laying on of hands, listening, understanding, caring....That has not changed and isn't going to change.

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Guidelines for Senior Bulletin Articles

Lucy Crain, MD, MPH, FAAP, Editor

A Section member asked that I provide details of what is likely to be published in the Senior Bulletin. The Bulletin is published quarterly. The winter and summer editions are electronic as of 2015. Spring and fall editions remain in print. Our Bulletin is not peer reviewed, nor does it strive to compete with scientific publications. We welcome a wide variety of topics, including book reviews, but discourage lengthy life histories. Generally, shorter is better and deadlines are observed. We consider non-copyrighted “fillers” and occasional cartoons for most issues, but cannot use all we receive.

The editor may defer publication of articles in order to reserve them for a special focus issue, and has the right to refuse publication of inappropriate submissions. (Authors will be informed if this is the case.) There's an 850 word limit (with occasional exceptions). Opinions expressed are those of the author, and we reserve the right not to publish inappropriate material including obscene content and political rants. Fortunately, pediatricians are generally respectful of these considerations before submitting articles, and that is appreciated. Letters to the Editor are also sought for most issues and may relate to past articles or suggest topics of interest.

Questions about articles contemplated or in progress can be directed to me at lucycrain@sbcglobal.net or to our Bulletin staff point person Tracey Coletta at tcoletta@aap.org. We look forward to hearing from you and to reading your articles in the Senior Bulletin.
What is our Purpose?

Karl W. Hess, MD, FAAP

Well, the Academy statement is “Dedicated to the health of all children.” Are we on board or not? Or only what we can do in our offices.

It is becoming increasingly clear that poverty is the greatest threat to the health of American children. Inequality seems to be closely linked to poverty and a number of other social pathologies (see “The Spirit Level” – Richard Wilkerson, Kate Pickett http://www.ted.com/talks/richard_wilkinson). An article in a recent Lancet confirms that the same pattern holds in all of a sample of 34 countries. Also this from Pediatrics: Frank, DA, et al, “Cumulative Hardship and Wellness of Low-income….Peds 2010; 125:e1115-e1123

We may not like that, just like lots of people are denying science as it relates to vaccines or climate change, but facts don't care whether people like them or not.

After 40+ years of primary care, it is clear to me that no matter how good we are as physicians for the children in our offices, we can't prevent the damage to our patients and to society of social policies which create abundant poverty. Interestingly Abraham Jacobi (1830-1919) knew that very well. “Questions of public hygiene and medicine are both professional and social. Thus, every physician is by destiny a “political being” in the sense in which the ancients defined the term - viz. a citizen of a commonwealth, with many rights and great responsibilities. The latter grow with increased power, both physical and intellectual. The scientific attainments of the physician and his appreciation of the source of evil enable him to strike at its root by advising aid and remedy.”

And the AAP Section on Medical Students, Residents, and Fellowship Trainees knows it also. They have a FACE Poverty program http://www2.aap.org/sections/ypn/r/advocacy/FACEPoverty.html. Which puts the older generation (us) to shame.

International comparisons are also scandalous. Our infant mortality is double that of the OECD country average. Our lifespan is shorter at all income levels. See Avendano, et al, Ann Rev. Public Health 2014. 35:307-25


Isn't it time for the Senior Pediatrics Section to increase its advocacy in better health for all our children?

The AAP Section on Senior Members would like to thank Mead Johnson Nutrition for their support of the Child Advocacy Award.
Medical Practice Principles
Robert E. Yim, MD, FAAP
Emeritus

After one year of teaching fulltime at the University of Maryland School of Medicine, I realized I was not an inspiring teacher. I wearied of reciting the same material, telling the same jokes, and repeating the same clichés. After a year, I submitted my resignation to the Department Head and said what I really wanted was a private practice taking care of children. He expressed regret saying he had planned to send me to a prestigious teaching institution for more training so I could return as a super specialist and head my own division dealing with a narrow spectrum of pediatric disease. This prospect did little to increase my enthusiasm. On the contrary, it strengthened my resolve to leave the Ivory Tower for private practice.

The academic experience was, however, a valuable one. It forced me to study constantly and I like to believe I instilled into a few students valuable principles I carried into my own practice. I enjoyed most working one on one with a medical student and his patient, taking a history and watching him perform his exam and share in his thinking process as he discussed the case.

I preached two principles constantly until they became my mantra. The first: “Thoroughness,” I repeatedly intoned, “Not everyone can be brilliant, everyone can be thorough. Thoroughness beats brilliance every time.” The second: “I guarantee you success if you always remove all clothing from your lover and your patient.” The following case presentation supports my premise:

It was a raw, cold December day when a frantic mother appeared in the emergency room with a crying toddler bundled in a heavy snow suit. The child was inconsolable and in obvious pain. “He won’t stop crying, Doctor,” the mother explained to the triage physician. “I was getting ready to go to work, take him to daycare and right after I dressed him he started screaming and he hasn’t stopped.” The child confirmed the story with a shrill scream. “Any other problems, like a cold?” “He’s had the sniffles.” “O.K. Have a seat, someone will be with you right away.”

At that time of day only one intern was on duty and he was suturing a serious laceration. He looked impatiently at the nurse, “Look the kid has the sniffles, this time of year they come in with colds and ear infections all the time. Call the nose and throat resident.”

The EENT resident appeared shortly. He peered into the crying child's ear and throat, the latter easily accomplished, since the baby was howling. “Eardrums are shiny and glistening, a little red but that’s due to the crying. His throat is o.k. He wrote a note stating there was no EENT disease. The child kept crying. The mother placed him on the examining table and as he screamed, he pulled his legs up and was now quivering and perspiring. “The kid acts like he's got a terrible stomach ache,” said the nurse. “Let’s get a surgeon down here to evaluate his belly.” The second year surgical resident was the next specialist to appear. He raised the undershirt and gently palpated the baby’s abdomen between screams. He wrote in his note that the abdomen was soft with no organ enlargement and no tenderness to palpation. Bowel sounds were normal. His conclusion, “This is not a surgical abdomen.” The child kept crying. The intern was now becoming impatient and reacting to the child’s piteous cries. “Call the Pediatric Resident down here,” he yelled.

Continued on Page 8
When I arrived on the scene, I saw an anxious mother, a harassed charge nurse and an irritated intern trying to sew up a patient. At center stage was a screaming toddler. However, what disturbed me the most was a violation of one of my principles. The baby had not been completely undressed! “Mom,” I said, “Please take off all of your baby’s clothes.” She looked at me slightly perplexed but began taking off the undershirt and then the diapers.” She stopped and looked at me expectantly. “I said all,” I commanded, “the shoes too.” She looked even more puzzled but obediently began removing the white leather high tops. She pulled off the left shoe first and to everyone’s amazement, the crying stopped immediately. The baby’s body relaxed, the flushed face resumed its normal color. I stepped over and examined the foot. The diagnosis was immediately apparent. Mom in her rush to dress the baby had hurriedly put on the shoe and in so doing had bent the little toe down and flattened it between the foot and the hard leather sole. He flinched when I gently extended it. I asked the nurse to get some ice to apply to the offended little digit and ordered a bottle from the nursery. The baby began sucking contentedly as I again murmured my mantra, “Always remove all the clothes from your lover and your patient.”

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**Medical Practice Principles** Continued from Page 7

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**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 the “Pre-Retirement Check List under the ‘Education and Career Resources’ section.”
The 21st Century and Teaching the “ART” of Medical Practice

Wm. R. (“Will”) Brown, Jr., MD, MD, MPH, FAAP
Assistant Clinical Professor
Department of Pediatrics
John A. Burns School of Medicine
University of Hawai’i Manoa
Honolulu, Hawaii

Discussion poolside with other physician neighbors at our building overlooking Waikiki south to the Pacific has led to an exciting and beneficial personal professional adventure volunteer tutoring Patient Based Learning sessions with students at our university medical school. Once again, having been retired a number of years from clinical practice thirty plus years in New York City, I am in an academic setting...one quite different and innovative from that which I experienced fifty years ago in the nation's heartland. Rather than a lecture-driven professorial format, “PBL” focuses learning the first two years on student-generated case analysis and discussion of various clinical disciplines along with topical discussion and skills instruction. The role of the tutor is to guide the process, while focusing the elucidation of facts, problems presented in a given case and hypotheses stemming from the initial analysis. Emphasis is placed on discerning the pertinent positives and significant negatives in each patient case. Additional elements that are needed to be known are thereby generated as a basis for assigning learning issues to be researched by each member of the small study group and presented at the subsequent session.

In addition to this shared learning experience, what promoted me to pursue this stimulating learning activity was a growing concern that the technology, science and business of medicine was being taught today’s future physicians, with little attention or emphasis on the “art of medicine.” Our informal professional conversations supported my thinking and I was welcomed to the medical school's volunteer tutoring staff.

During my training there were six outstanding mentors whom I continue to emulate, one yet living with whom I continue to communicate. Each taught me a significant lesson about the art in addition to the science of our craft that I’ve attempted to incorporate in my professional life:

1. Children are a delight in their unconditional trust and literal view of the world in which they dwell.
2. Availability as an active listener to the families you have the honor and privilege to serve is the key to success for any practitioner.
3. Seriously consider the far reaching effects your actions will have in the life of each individual patient and family.
4. Focus on the abilities of any one patient, though intensely simultaneously involved with their other-dis-abilities.
5. Maintain awareness of your responsibility to serve as a mentor to those following in your footsteps.

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6. Continuing interest shown in your student’s career provide continuity with the foundation of their academic experience.

Now, I again have an opportunity to encourage future physicians to seek understanding of the illness manifest with any disease entity with which they are faced. A goal is to encourage awareness of the barriers - professional language, titles, personal appearance or demeanor that distance a health care professional from those we seek to serve. And as a pediatric practitioner, to instill a solid sense of child care confidence in the parents of patients.

I yet hear from families whose children are now in their thirties and forties regarding current concerns present in the family. I always attempted to know answers for circumstances frequently encountered and how to appropriately determine solutions for the remainder, more unusual challenges. The art of medicine-touch, listening, access, availability, direction and anticipatory guidance is a valuable adjunct to the technology and science which is central to the high standards of health care in our country today.

For those of us who have enjoyed our professional path involving families and child care, it behooves us to pass along the “pearls of wisdom” that we have collected along the way. One cannot keep it, unless you give it away. The art of medicine can be taught, insights shared and mentoring provided to enrich our future pediatric care providers ability to care for those whom they undertake to serve.

Aloha from the kumu and keiki of our island state~

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**DEFINITION.....And Food for Thought**

The Section on Young Physicians has suggested that senior pediatricians should be well suited for “speed mentoring”.

I’ve mentored students, residents, and fellows for 4 decades and didn’t know the meaning of the term. Jackie Burke investigated and Julie Raymond of AAP SOYP provided the following:

*Speed/Flash Mentoring is defined as a one-time meeting or discussion that enables an individual to learn and seek guidance from a more experienced person who can pass on relevant knowledge and experience. The purpose of flash mentoring is to provide a valuable learning opportunity for less experienced individuals while requiring a limited commitment of time and resources for more experienced individuals serving as mentors. While mentors and mentees can mutually decide to meet again after their flash mentoring session, the commitment is to participate only in the initial meeting.*

YOUR COMMENTS WILL BE WELCOME.

Lucy Crain
Vaccinations: Senior Pediatricians Speak Up!

Remember Rifampin prophylaxis for household contacts?

Thanks again to all of you who responded to my request for articles on Vaccinations. As I stated in the Editor's Note, it's not just measles for which reliable preventive vaccination is being ignored by parental and religious belief exceptions. Pertussis is mostly endemic in the adult population in the US, where it's a bothersome 6-week bout of coughing. In infants, it can be fatal. There have been two recent pertussis epidemics in California. In 2010 and 2014, there were nearly 10,000 cases of measles each year with 8 infant deaths in 2010 and at least 3 deaths in infants last year. Still, California's governor signed the “parental belief exemption” bill into law in 2009, increasing the already significant numbers of children who can legally attend public schools without the protection of vaccinations. Work is underway to rescind that legislation. (West Virginia and Mississippi are the only two states which do not permit religious or parental belief exemptions.) Meanwhile it's scary to go to Disneyland, ride public transit, or go to public gatherings without benefit of immunity. It's another flashback to when we grew up in the era of polio epidemics before the vaccine. Children and adults with impaired immunity are put at special risk because of the increased numbers of non-immunized people in our midst. Like many of you, I have had the sad experience of seeing children die of these diseases, many of which have never been seen by today's parents and health professionals.

One January pre-1985, when I was general attending on the pediatric ward at UCSF, I admitted 12 patients with H.flu meningitis as well as several with H.flu periorbital cellulitis, bacteremia, pneumonia, and/or epiglottitis. Thanks to that vaccine and the meningococcal and pneumococcal vaccines, today's pediatric residents may never have to deal with those diseases, and children shouldn't have to suffer their complications and sequelae. That's why it is so important for senior pediatricians to speak out on the importance of vaccination.

Lucy Crain, MD, MPH, FAAP
San Francisco, CA

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As I'm en route to a lecture I'm giving tonight re a newly approved meningitis vaccine, I was thinking of the progress made over the past 40 years. When I began my pediatrics career, my group generally had one or two patients hospitalized with meningitis at any given moment. With the work done by many of us in the clinical trials as well as those administering the vaccines, we have witnessed the virtual end of Hib and pneumococcal meningitis and will see the same for meningococcal meningitis (including group B) when the decision is made to give the vaccines on a universal basis. Perhaps this has not been greeted with the fanfare of Salk's work on polio but an incredible accomplishment nonetheless.

Mark Blatter, MD, FAAP
Pittsburgh, PA

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Surely vaccinations against infectious disease is the greatest medical advance of the 20th century. Their success is to some extent their downfall in the 21st century. Most childbearing couples now have never seen the devastating effects and death that these diseases can cause. That includes most physicians currently in practice. Recently I was disappointed to hear the national news say

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pediatricians who allow their patients to use the Dr Sears method or other variations of this are just doing so to keep their patients (meaning keep their money). I do not endorse any of these but if we turn these misinformed patients away after failing to convince them of the need to follow the recommended schedule they may fail to get any immunizations at all. The internet and the media are the most destructive elements, except the success of the vaccines themselves, in creating the falling vaccine percentages. It seems only current epidemics are helpful in reversing this trend. Excuse my pessimism.

William S Martens II  
Lancaster, PA

* * *

As a Pediatric Resident in the late 1950s, I had my fill of a nursery dedicated to infants struggling with the ravages of pertussis. I also remember iron lungs and kids with neurologic damage and death from measles. What a pleasure to practice in the mid-1900s when these diseases and others become a rarity due to the development of all the wonderful vaccines in use today and when parents gladly accepted our recommendations. Before my retirement in 2006, I struggled with the early appearance of the vaccine deniers (pertussis and measles). I’m sorry for my former colleagues who seem to face more and more of these vaccine resister problems almost daily. I’m happy I don’t have to deal with that problem, but if I were still in practice, I’d certainly spend a good deal of time trying to convince these recalcitrant parents of the importance and safety of vaccines, and if they still refused to have their children vaccinated, I would join the increasing numbers of pediatricians dismissing these families from their practices.

Stanley Karp, MD FAAP  
Cinnaminson, NJ

* * *

For 62 years I have taken care of children. I have seen kids with measles complications, including paralysis, deafness and death in the early years of my career. I don’t want to see these problems ever again. The MMR vaccine protects about 97% of those who receive it. It is incumbent on public officials to speak based on the facts when commenting on medical policy. They should use credible and scientific sources of information. Children need to be protected from measles — and from politicians who speak as scientists.

Dr. Alvin Miller, MD, FAAP  
Simi Valley, CA

* * *

I am retired after 40 years in practice. I trained at Children’s Memorial Hospital in Chicago after 2 years in the Air Force. During those years of training and for many years in the early part of my career we were constantly dealing with H Influenza meningitis. We lost a few children but were able to save many. A number of the children we saved were left with neurological defects. I cannot tell you how grateful I was when the H Influenza vaccine was developed. Our younger partners have never seen a case of H Influenza and probably never will!

Dr. Jerome T. Meservey  
Arlington Heights, Illinois

Continued on Page 13
Every year in my practice in rural upstate NY I would care for 2-3 cases of HIB meningitis, 1 or 2 HIB supraglottitis, 1 or 2 pneumococcal meningitis and 1 meningococcal meningitis. I still consider the vaccines to prevent these illnesses to be a miracle. Understanding how to care for these terrible diseases was a necessary skill for all pediatricians—doses of antibiotics, fluid management, dealing with increased intracranial pressure, and the possible complications during recovery. I was fortunate never to have lost a child with these afflictions, but one of my patients did suffer partial sensory-neural deafness in one ear. The parents were still enormously grateful. I would sleep in our small rural hospital until the child was out of danger, as there was no house staff or anyone to restart an IV if needed. I would wake every few hours to re-assess progress.

I saw one of the first cases of Reye's syndrome when varicella was still rampant and when we still suggested aspirin as our go to anti-pyretic. That child too survived due to early diagnosis.

Having been hospitalized with polio as a child, I find the present anti-vaccine movement to be an anathema.

Vaccines are a miracle.

Fred C. Hirschenfang MD, FAAP
Fort Lee, NJ

As a child growing up, my mother would not let us go to the “plunge”, the fresh water swimming pool during the summer because community fresh water pools were associated with polio epidemics. Like others growing up in the polio era, I had friends that were infected and died or who were paralyzed for life. I remember vividly when we received our “polio shot” in the 2nd grade and then the “sugar cube” in the 4th to prevent polio. Childhood diseases were just that, diseases that occurred in childhood and everyone “got” them: measles, rubella, and chickenpox. My mother had pertussis encephalitis as a child and survived after a protracted illness; fortunately pertussis, tetanus and diphtheria immunizations were available to me, and I was protected. But there were other illnesses for which I was not protected: H. influenza, hepatitis B and meningococcemia. The first of these causes meningitis frequently with 25% to 30% of patients left with neurologic sequelae. As a Pediatric Resident and Fellow in Pediatric Infectious Disease this was a common illness in our hospitalized patients. After 1985, when the first “Hib” vaccine was introduced, the disease has essentially disappeared. We need to keep all vaccine preventable illness “disappeared”.

Michael E. Speer, MD, FAAP
Houston, TX

I recall when rarely a month would pass without hours spent in the Emergency Room treating a child with Hemophilus influenza or pneumococcal meningitis. What a relief to not to spend those hours with the parents at bedside now that we have vaccines to prevent those devastating diseases.
We have gone from a time when parents trusted us as pediatricians to do our best for their child to a new era of social media in which irrational fear of science has superseded the fear of a life threatening illness. Parents have come to doubt the information and mistrust the messenger.

**Mark Rosenberg, MD, FAAP**
Northbrook, IL

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As a young, new pediatrician in Austin in the 50’s I saw at least three Polio patients in Iron Lungs in old Brackenridge Hospital patient. That was discomfiting! We were just beginning to immunize. About the same era, as an attending on the Pediatric floor in this City-County Hospital I observed several infant Pertussis patients literally coughing and whooping themselves to death. Again, we were behind assuring our kids were immunized.

**P. Clift Price. MD, FAAP**
Austin, TX

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I ran across a photo the other day which is more dramatic than anything I could say. I remember those days from my internship.

**Karl W. Hess, MD, FAAP**

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I’m sure I am not the only pediatrician old enough to remember seeing children die of diphtheria and tetanus, and critically ill with pertussis and measles. I also saw many children with residua from the last great polio outbreaks before the vaccines. I think that says it all.

**Stephen L. Friedland, MD, FAAP**
Poughkeepsie, New York

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What a dilemma! Our high school and college youth travel the great unimmunized world.

Back home (unnecessarily frightened) parents resist vaccines for insane reasons, while younger well-trained pediatricians have no experience in recognizing what was once commonplace contagion. A recipe for disaster!

**L. Robert Rubin, MD, FAAP**
Danbury, CT

Continued on Page 15
I retired from active practice in 2014. In my thirty-eight years of post-residency practice, I witnessed episodes of pertussis, measles, and of course varicella. However the most remarkable immunization-related benefits I witnessed were with respect to H.influenza diseases. As a resident (1973-76) we must have had 2-3 admissions each month with H. flu meningitis. I even recall occasional episodes of epiglottitis. Today’s residents may see invasive H. flu disease once in their three years of training. I realize that my professional antecedents had the same experience with poliomyelitis. Immunization rocks!

George H. Durham II, MD, FAAP  
Salt Lake City, Utah

In 1962 and the last semester of my senior year in med school part of my rotation on pediatrics, was working the evening clinic at Louisville General. By six o’clock the waiting room was full. It was not hard to diagnose measles as coughs filled the air, red eyes, and from many already, the familiar rash. Fevers were rampant, 105 and frightening to me as well as the anxious parent holding their sick child. I railed at my own helplessness that could do no more than treat symptoms and try to be more reassuring than I felt as this malicious disease attacked with relentless force every child it could find. Then the miracle occurred! Not far into my internship, the first measles vaccine, developed by Enders, was released. And, as the saying goes, the rest was history. By the time (after a tour of duty in the USAF) I had begun my pediatric residency, measles was mostly a thing of the past due to wide spread and widely accepted vaccinations. Of course measles is not the only deadly disease that got the knock-out punch from the use of vaccines, but for me, it will always be remembered as the most welcome. For those of us who lived those days, and saw the specter of death on far too many children, we continue to be grateful for the amazing role vaccines have had in the protection of all our children.

Olson Huff, MD FAAP  
Black Mountain, NC

In my early days of Pediatric training and practice I personally helped care for 7 or 8 children who died from complications occurring with measles. In one year in my small town solo pediatric practice I treated 13 cases of bacterial meningitis. About every year we had epidemics of Measles, Mumps and Chickenpox with cases of encephalitis, pneumonia or other complications. These occurred before currently used modern immunizations were available. Every single child deserves the protection of all of the recommended childhood immunizations.

William R. Purcell, MD, FAAP  
Laurinburg, NC

Like most of us pediatricians, I have met with many American parents who initially refused immunizations. Early in my career I spent four years in Laos, where I saw hundreds of children die from measles, diphtheria, pertussis, and tetanus. I also saw many children permanently disabled from polio. And, when we began our immunization programs in Laos, the hospital records showed a
wonderful plummeting of admissions for those diseases.

I would share my experience with the families who initially refused immunizations, and most changed their minds.

I returned to Laos in 1990, a time when immunization programs had almost disappeared. Once again, hospitals were admitting children who were desperately ill with measles, diphtheria, pertussis and tetanus. And I saw history repeat itself, positively, when the immunization programs were restored.

Karen Olness, MD, FAAP
Kenyon, MN

I remember a morning, many years ago, at the old San Mateo County Hospital when the front doors of the Pediatric Clinic clanked open and a young Hispanic mother having traveled alone on a bus and walking 4 blocks to the hospital, approached the reception desk carrying her quiet infant wrapped up in a blanket. One look, and palpation of his bulging fontanel was enough to confirm he was a very sick infant. I did an LP there in the exam room that showed very cloudy fluid and he was given a dose of IV Ampicillin but no steroids. The baby was 6 months old and completed treatment for H. Influenza meningitis. He did survive but unfortunately with severe hearing loss and developmental disability. He was born in the early 70's before the introduction of the HIB vaccine a decade later. In the 25 years since routine HIB immunization began, the incidence of serious disease in the US has gone from 20,000 to 50 cases annually. Vaccines are good for children.

Complications related to Varicella sometimes resulted in hospitalization in the days prior to the introduction of the vaccine in 1995. One day the ER called to say they had a 10 year old with extensive chicken pox lesions, fever and that the lesions were ‘black’. This was a case of ‘black’ chicken pox due to hemorrhagic complications causing skin bleeding. I recall treating a young child with chicken pox encephalitis and his sibs in our hospitals make shift isolation rooms which also served as the jail ward. It was a very challenging experience. Vaccines are good for children.

Harvey S Kaplan, MD, FAAP
San Mateo, CA

Starting our pediatric practice in the 1970’s, my husband and I joked we ran an infectious disease practice. Our days (and nights) seemed filled with patients with epiglottitis, meningitis, sepsis, periorbital cellulitis and pneumonia.

I feared that every midnight call from a parent of a child with croup might really be epiglottitis. More than once I escorted a parent and toddler from my waiting room to my car to personally drive them to the ER to perform the spinal tap for meningitis. I coached parents over the phone during weekend call to count their child’s respiratory rate to help determine whether we need fear pneumococcal pneumonia.

Perhaps the most cogent argument for immunizing children against these diseases came from our
drug rep for the HIB vaccine. I had noticed that she had a scar in her sternal notch. One day she shared with me that the reason she had become a drug rep for Hemophilus Influenza vaccine was because she had almost died of epiglottitis as a child, and the trache scar was her permanent reminder of the value of vaccines.

We saw children literally go from well to dead in hours. Never again.

Kathleen Braico, MD, FAAP
Queensbury, NY

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As a pediatrician who started my medical career in 1972, I have witnessed first-hand the impact of immunizations on the overall health of children in the United States. I watched polio eradicated from our country. I saw the dramatic decrease in cases of H. Flu meningitis which left thousands of children deaf or handicapped. I have witnessed the dramatic reduction in cases of rotavirus associated gastroenteritis. I have not seen a case of tetanus since my internship year. Unfortunately I have also seen the return of pertussis and measles due to the unfortunate actions of professionals and citizens who do not have or do not believe the scientific evidence of the effectiveness and safety of vaccines. We need to remain committed to providing parents and children with the best information and care to minimize their risk due to vaccine preventable diseases.

Edward O. Cox, MD, FAAP
Grand Rapids, MI

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I personally lived through 3 different measles outbreaks, one when I was an intern (1965-66) in Boston, 2nd when stationed at MCAS, Cherry Point, NC (1968-1969) and the third was in Rota, Spain (1970-1971). Never had a death but had several cases of pneumonia. My first patient on Pediatrics as a 3rd yr med student was a 3 m/o infant with pertussis and died 2 weeks later of hypoxic encephalopathy. Chicken pox was rampant in the 1960 and 70's and I lost 2 patients, one with ALL and the other with combined immunodeficiency disease. The latter was 14 years of age. I lost a 6 y/o twin 5 years ago to chickenpox while on immunotherapy for ALL. I have seen breakthrough varicella since the vaccine came out. After DPT was removed because of a mercury scare and replaced by DTaP I have seen about 10 cases/year of pertussis. The mercury article published in Pediatrics in either 1997 or 1998 used methyl mercury as the chemical agent in thiomersol not ethyl mercury. There is a considerable half-life difference between the two. The article has never been retracted and should be.

Ray M Johnson, MD, FAAP
Harker Heights, TX

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When I arrived on the Navajo Reservation in 1970, meningitis was rampant, usually due to Haemophilus influenza type B (we also saw the occasional pneumococcal and even tuberculous meningitis). Infants and toddlers were struck, seemingly one a week -- often having seizures and terribly sick partly due to muddy roads and long travel distances on the Rez. The trivial outcome was that I was often late for dinner -- my wife and I shared the grim joke that the final patient of the day always needed a spinal tap. The much more serious outcome was on the backs of those children -- about 20% died, and another fifth had severe sequelae like seizure disorders and mental retardation.

Continued on Page 18
H flu and pneumococcal vaccines were in part tested on the Navajo Reservation because of the high incidence of disease there and in other Native American tribes. Once the vaccines were released, they released the tribes from a terrible burden of disease. The Indian Health Service has done an excellent job getting immunizations to children, so pediatricians on the Rez now have seen meningitis no more frequently than most young pediatricians have. What a blessing!

Lance Chilton, MD, FAAP
Albuquerque, NM

**IMPACT OF VACCINATION**

Edwin N. Forman, M.D.
Professor of Pediatrics
Mount Sinai School of Medicine
New York, NY

Rosalind Ekman Ladd, PhD.
Visiting Scholar, Brown University
Professor Emerita, Wheaton College, MA
Providence, RI

The development of vaccines has been nothing short of amazing. Consider the elimination of polio and the virtual elimination of measles and whooping cough in the U.S. It has changed the trajectory of individual children’s lives as well as the everyday content of pediatric practice. Consider, too, by contrast, parents’ experience in the nineteenth century where the loss of children was common.

It is with dismay, then, that now we see some of the common childhood illnesses coming back due to an increased number of parental refusals of vaccination. There is a moral duty to protect children from the harm of being unvaccinated themselves and from living in an environment where the protection of herd immunity is not maintained. What to do? Mandating vaccination by law with no possibility of exemption seems too Draconian. However, protecting vulnerable children (too young, medically exempt from vaccination, vaccine failures, or waning immunity) by creating sufficient herd immunity is clearly justifiable. This can be accomplished only by imposing stricter requirements for personal exemptions, which should be part of AAP policy. Further, pediatricians should advocate that parents with personal exemptions keep their unvaccinated children out of settings such as daycare where vulnerable children may attend.

The Pediatric History Center would like to solicit funds, ideas and participation for our Oral History Project.

The AAP Pediatric History Center is working to preserve and document pediatrics’ rich heritage. Established through a generous grant from the late Harry A. Towsley, MD, FAAP, the center is located within the Drs. Harry and Ruth Bakwin Library at AAP headquarters. Guided by the Historical Archives Advisory Committee (HAAC), the center is engaged in three programs: collecting documents and memorabilia, maintaining the AAP archives, and producing oral histories of leaders in the advancement of children’s health care.

If interested or would like to know more, please contact Veronica Booth at vbooth@aap.org or 847-434-7093
Dear Senior Section Members:

As we have identified in our Section strategy map, connecting you to advocacy resources, information and opportunities is a growing priority and opportunity for engagement. We had a robust discussion at the NCE with the Section's Executive Committee about how to foster the Section's growing interest in federal advocacy, and as you may have noticed over the past several months, you have been receiving occasional emails from the AAP's Department of Federal Affairs on different child health topics. Since Congress was on recess much of the fall, the communications will now start to occur on a more regular schedule as indicated in more detail below.

As you start to notice these new communications, I wanted to be sure you understood what they mean, why you are receiving them and how they might help inform your interest in advocacy.

**Every member of the Senior Section is now automatically enrolled in the AAP's key contact program.**

**What does this mean for me?**

As a member of the Senior Section, you will now receive legislative updates every Friday with relevant news on child health policies, events and regulations impacting children at the federal level taking place each week. You will also receive targeted requests for grassroots action when a bill moves through Congress that could benefit from pediatrician advocacy, and be linked to resources like draft email text, issue briefs and talking points to guide our outreach. You'll be the first to receive information on federal advocacy trainings as well, and be the first line of communication for breaking news out of Washington.

**What does this mean for our Section?**

It means that your collective voices will be more powerful and more easily amplified by being automatically added into this federal advocacy network. Your membership will stay with you even if you decide to leave the Section; it is a one-time opt-in. As you review federal advocacy materials, members of the Section may read about a topic that interests them and that they would like to take action on, for example, by attending a training or writing an op-ed. The AAP DC office's Director of Advocacy Communications, Jamie Poslosky (jposlosky@aap.org), can serve as a liaison to Section members for these interests moving forward and help grow the Section's participation in advocacy opportunities.

**What if I would like to opt out of receiving these alerts?**

If you would like to opt out of receiving these communications, there will be an easy way to do so at the bottom of each alert labeled “unsubscribe,” or, you can email jposlosky@aap.org and request to be opted out. We are hopeful, though, that you will find that being a part of the network is beneficial to you and that it makes your advocacy easier and more effective.

This new benefit is a direct result of your feedback and diligence in leading federal advocacy efforts—keep up the good work and thank you for all you do!
Personal Recollections of Measles

Eileen M. Ouellette, MD, JD, FAAP

The sun was beating down on me and I was burning up. I had a splitting headache, my eyes burned and I was extremely parched. I was alone on a small mattress in a roiling sea with huge waves rolling over me while an enormous whale was trying to come on board to devour me. I was screaming. It went on and on.

In reality, I was in my bed in a darkened room. It was March 1945, I was eight years old and I had the measles. I also had a fever of 105 degrees F and above for 4 days. In addition to that hallucination, I also had the delusion that my dear mother was trying to kill me and I screamed every time she tried to enter the room. My loving father had to stay home from work for several days to care for me.

I still remember the terror I felt, even though my memories of much of that seemingly endless illness are hazy. My parents later told me that I screamed for four days, while my fever remained at or above 105 degrees F; in spite of all that my father did to try to reduce it.

I never had that high a fever again, nor have I ever again had hallucinations or delusions. Measles remains the most frightening and severe illness of my life, even more than the myocardial infarction I had as an adult.

At its peak in the United States, before measles vaccine became available in 1963, there were more than 494,000 cases in one year. Measles killed 3,000 children and resulted in 48,000 hospitalizations. In 2002, thanks to immunizations with measles vaccine we thought we had eliminated measles in the U.S. but we were wrong. In the first two months of this year, 2015, over 150 children and adults have come down with measles, including 16 children who are under 1 year of age, who are too young to be immunized.

This resurgence of measles can be directly ascribed to the reluctance of some parents to immunize their children or to adhere to the recommended immunization schedules, thus not only putting their own children at risk but also decreasing herd immunity. Most parents and even many grandparents have never experienced or seen measles. Even many young pediatricians and other physicians have not treated children or adults with measles. Many of these parents and physicians have become complacent. It is very troubling that a recent survey has revealed that most pediatricians acquiesce with parents who seek to amend the recommended vaccine immunization schedules and delay the provision of immunizations.

There is no scientific reason or benefit to altering the recommended schedules. Many parents seeking to deviate from the recommendations are college-educated adults who have had little or no exposure to science and have not learned to evaluate scientific data analytically, thus making them susceptible to the claims of anti-vaccine charlatans.

We senior pediatricians have a unique opportunity to educate our younger pediatricians and families about the seriousness of measles and to urge them to follow the recommendations of the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP). Most important, we should educate legislators about the risks of measles and seek to limit vaccine exemptions except for medi-
Personal Recollections of Measles  Continued from Page 20

cal reasons. Many states are now revisiting their vaccine exemption statutes. We should contact our chapter leadership to express our availability to assist them in their efforts to amend and improve their state laws.

Of interest is that even now, 70 years later, about once a year I have a recurrent dream of that measles hallucination on the mattress and awaken terrified.

OLD AGE: Words Related To FINANCE

Re: Wills:
A joint heir: parcener or coparcener:
A date certain when a will’s provision(s) will no longer prevail: sunset clause
Endowment: dotation
Having made a legally valid will: testate
Mentally competent to handle one's affairs: sui juris, apud se
Mentally incompetent to handle one's affairs; not of sound mind: alieni juris, non compos mentis
One who can legally use, as through inheritance, another's property: usufructuary
One jointly inheriting undivided property: coparcener
To declare orally or make an oral will: nuncupate
To disinherit: exheredate, forisfamiliate

Other:
Exchange-traded health-care investment fund: health-care REIT
Annual adjustments in Social Security and Medicare payments: COLA
A period of economic hardship: locust years
Carefulness or economy in the use of money or things: parsimony
Mentally competent to handle one's affairs: apud se, compos mentis, sui juris
One who lives frugally: frugalista
Property of an intestate reverting to the state: escheat
The giving of financial aid, support: subvention
Tax levied regardless of one's economic situation: Morton's fork
To amass, accumulate: coacervate
To dedicate or inscribe: nuncupate
To shed paternal authority: forisfamiliaate

(From “ElderSpeak: A Thesaurus or Compendium of Words Related To Old Age” by James L. Reynolds, M.D., 2014)
Reflections

Don Schiff MD, FAAP

Senior Pediatricians still remember seeing children with the “common childhood diseases” including measles, polio, varicella and diphtheria. We remain committed to protecting our patients from a recurrence of preventable diseases which have associated significant morbidity and mortality. The recent outbreak of measles and the recent revelation of the extent of partially and totally unvaccinated children which in some schools exceeds 25% in LA and Orange County California has created a public awareness and discussion of the lack of protection against disease which presents danger to those children who are either too young or have medical conditions which preclude their receiving vaccinations.

Vaccine protection against bacterial and viral disease has consistently been recognized as one of medicines greatest achievements and is certainly a major public health contribution to our nation's wellbeing.

The number of cases of measles reported this year (over 100) is tiny compared to the thousands seen annually in the pre-vaccine period reveals the growing dangers of allowing the incidence of the unprotected to grow.

There are multiple reasons which explain our current situation. The changing relationships between many pediatricians and the parents of the families that they care for is a factor for the development of a strong long lasting trust which is basic in producing quality care. This is diminished by (1) the mobility of our population, (2) changing insurance coverage, (3) growth of the size and organization of health care groups and (4) the internet with its remarkable ability to misinform.

Many pediatricians face parents who have determined that they wish to follow their own schedule to immunize their children based upon their own concepts of what is best for their individual child. Some refuse any immunizations. Many parents truly believe that their child will be harmed by “toxins” in the vaccine, that too many shots are given at one time, at too early an age, that the child will become autistic, or that the shots will cause unbearable pain. Other parents have a hostility to anything that is required or recommended by our government (school) law. Their distrust of the government raises a red flag and a strong negative reaction.

An additional group of naysayers not to be ignored consists of individuals who have developed a disbelief in science and the products of science and research. Many of these people believe that the earth is only 10-20 thousand years old, evolution is a fraud and that the moon landing never occurred.

Perhaps the fact that young parents have never seen the diseases that vaccines prevent is the strongest reason that they are resistant.

I have listed in this over long litany the many beliefs which we face in achieving the pediatric goal of complete vaccination of our childhood population. We can only overcome parental opposition if we understand it and respond appropriately.

A paper in the March 2nd issue of “Pediatrics” lead author “Kempe et all” reports a survey of a

Continued on Page 23
representative 534 primary care physicians in 2012 on how often they were asked by parents of children under 2 years to postpone 1 or more of their recommended vaccines. 93% of the doctors who responded stated that in any given month they were asked at least once to change the schedule and that more than 10% of the parents in their practice asked them to delay giving a vaccine. One third of the doctors acquiesced often or always, another third said that they allowed a change sometimes.

Paul Offit, M.D. of Children’s Hospital Philadelphia believes that we are making it too easy for parents and that we should make a more passionate plea to adhere to the approved schedule. Saad Omer, an epidemiologist at Emory University states that we don't have an evidence based method of how to communicate with parents about vaccines. Surveyed physicians have tried various strategies to convert parents. They state that they immunize their own children and grandchildren or that if we don't immunize sufficiently we will see a reoccurrence of the epidemics of the past. Many physicians believe that they should above all maintain a relationship with parents even though non-compliant. Some physician’s discharge these families from their practice. The academy advises its numbers to maintain their relationships as a way of advocating or persuading them to change.

The amount of time required to inform or counsel resistant parents is reported to be 10-14 minutes – a significant period taken away from or added to the time for a visit. Dr. Kempe suggests that “the time has come to acknowledge that “vaccine education” can be handled in a brief well child visit is untenable.” My own take on this vital complex question is that no single approach will overcome the current level of resistance a state ‘Mississippi’ can achieve a 98% vaccination rate by law but most states do not have the political will to use tight legal means and many states now allow families to avoid vaccines by merely stating their opposition without a specific reason.

The AAP is steadfast in its recommendation to utilize the Red Book schedule as its standard of care. Pediatricians will continue to utilize counseling which works when trust and parental open minds allow change to occur. Public health campaigns can counter inaccurate information and may convert some but to be realistic for some parents their resistance will remain unchanged.

Please feel free to send comments to me at: donroschiff@comcast.net

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**Did You Know...?**

A neat shortcut is available to allow you to get to our Section on Senior Members web site really fast. Try it, you’ll like it!

Happy browsing!

[www.aap.org/seniors](http://www.aap.org/seniors)
A Pediatrician's Musings about Immunizations

Michael O'Halloran, MD, FAAP

1) Here's an all too familiar question: “Should I give my baby her shots? My senator says that there is credible evidence that it would give my baby autism.” We've all had to address similar questions when in active pediatric practice. It’s shocking that a senator felt qualified to enter the discussion. And a politician's opinion about immunization research is worth what?

2) Parent: I can't permit you to give MMR to my child because it might lead to autism. Doctor: Science has stepped up and the evidence that it won't cause autism is overwhelming. Parent: You're saying that I don't have the right to make decisions about what's best for my child? That common conversation takes the discussion of what is best for children and changes it into something completely off the topic; the rights of parenthood. The issue of parent autonomy is of course valid but that is not the discussion; vaccine safety is.

3) Some of the anti-vaccine folks are counting on herd immunity to protect them and their children. They are free-loaders on the responsible decisions of others. Ironically, the more there are of these people in a population, the less protected they themselves are by herd immunity. And this weakened herd immunity provides less protection for those innocent folks whose immunizations did not “take”, for infants who are younger than the appropriate age for a vaccine, and for individuals who must not receive an immunization for certain medical reasons.

4) Reducing this herd immunity can potentially cause harm. Insofar as that is true, it seems reasonable to me that anti vaccine folks should be excluded from public places, including school (and Disneyland) so they can't cause harm to others. I know there are already pediatricians who fire such non-immunized patients based on not wanting them in their waiting rooms.

5) It has been argued that mandatory immunization laws infringe on personal freedom. But I'm pretty sure the Supreme Court has already addressed this issue and determined that such laws are acceptable. Might we not argue that personal freedom does not allow the endangering of others as happens in the threat to heard immunity?

6) A quick visit to Google anti vaccine sites will show how strongly the conspiracy theorists are represented. Their case is that vaccines are merely a way for “Big Pharma” to enhance their profits at the expense of our children's health. Conspiracy theory distracts from the real issue of whether vaccines are effective and safe. The discussion is not about the practices of Big Pharma. It's about whether vaccines work.

7) Encouragement to immunize from the press, the Public Health Department, and other outlets seem to leave out the mortality rate of the diseases from which vaccines protect us. In my training and in my practice I have personally seen a 3 year old girl die of measles complications, an 11 year old die of diphtheria myocarditis, and (although he survived) a boy with group A Strep necrotizing fasciitis and sepsis related to chickenpox.

8) There is a pediatrician and author in California who seems to be soft on the anti-vaxers with statements about how safe it is to have measles. The CDC, however, reports that before the

Continued on Page 25
measles vaccination program started in 1963, about 3 to 4 million people got measles each year in the United States. Of those people, 400 to 500 died, 48,000 were hospitalized, and 4,000 developed encephalitis from measles. The WHO states that 145,000 children die per year, worldwide.

All of the above notwithstanding, it seems that the anti-vaxers will always be with us. We just need to stay engaged, strive mightily, persevere, and stay informed with help from the CDC, http://www.cdc.gov/vaccines, the AAP, http://www2.aap.org/immunization, and your favorite immunization information website. My favorite is the Immunization Action Coalition, http://www.immunize.org.

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**Implementing Mental Health Priorities in Practice:**

**Strategies to Engage Patients and Families**


Pediatricians are, and will continue to be, an important first resource for parents who are worried about their child’s health concerns. Early intervention with families who have mental health concerns is critical.

Engaging families to uncover and clarify mental health needs requires skill and practice. *Implementing Mental Health Priorities in Practice: Strategies to Engage Patients and Families* is an innovative program designed to leverage the techniques of motivational interviewing, along with the power of video-based learning, to provide pediatricians with the practical skills needed to elicit accurate information and create behavior change in their patients.

This resource consists of 6 videos demonstrating examples of patient/family encounters. They encompass the most difficult conversation areas in the area of mental health, including the following topics: depression, disruptive behavior, inattention/impulsivity, social-emotional health, substance use, and suicide/self-harm.

For more information and materials on mental health, visit: www.aap.org/mentalhealth

*Supported by the American Academy of Pediatrics Friends of Children Fund*
I am sitting in a committee meeting at the New Mexico State Legislature at 8:04 pm, waiting to testify on a bill to maintain our state’s Vaccines for Children for All program. Washington State has done something similar, so I’ve gotten a lot of help from SOSM member Ed Marcuse and others in the state about how to go about this.

Vaccines are my business, seemingly at the moment my only business. I’ve been here for 7 1/2 hours now, listening to discussion on parole for sex offenders, on a single-payer healthcare system, on enhanced voter registration requirements, on bail bonding requirements, and on (horse) drug abuse in the horse racing industry and maybe by 10:00 tonight we’ll get to “my” bill.

We have a little difficulty explaining the bill to lawmakers who have to consider all these diverse topics. Perhaps I’m an appropriate person to do so, since it takes advantage of my wonkishness on vaccines and my knowledge of the legislative process. Besides, I have spent the last 40 years translating doctorese into patient speak, and think that’s a skill most of us pediatricians have. In short, our VFC for All program is at risk because some insurance companies have not been paying into the fund for the children they insure, and the state is not willing to keep picking up their tab. This law, Senate Bill 121, which was proposed at my request by my state senator, Bill O’Neill, would establish a mechanism to assess each insurance company for its “insured lives” and put in law a penalty if they refused to comply.

What’s my point for the Senior Section, of which I’m happy to be a member? Who better than me to be here testifying? Though there are others more knowledgeable than I about vaccines, there are few who have time to wait so long and to learn so much about so many interesting and unrelated issues. I’m semi-retired and can afford the time, and I’m doing something I think is worthwhile.

This state legislature maintains a modicum of decorum and camaraderie that doesn’t appear to be common in Washington. COFGA, which I’ll be attending on your behalf in May, will see just how far Congress has gotten on a pile of highly important- nay, vital - needed legislation. The overall budget, reauthorization of the nutrition programs SNAP and WIC, a temporary or permanent fix to the SGR, continuation of the enhanced Medicaid payment, and an increase in the federal debt limit to name just a few.

As I write, Congress has just funded the Homeland Security Department for one week. The amount of Angst that went into that minimal achievement does not bode well for all those other issues.

Maybe we can prevail upon our federal legislators to come together in the country’s interest. But don’t hold your breath. In the meanwhile, talk with your chapter’s legislative action committee telling them you’re willing to go to your state capitol on behalf of children and of pediatricians. It’s probably a lot closer to most of you than Washington is, and it probably works better for now.
Elizabeth was preparing dinner in the kitchen when she heard the loud scream “I was frozen!” It was her three year old son Brett yelling at Aaron who was his five year old brother. Elizabeth is a blond white girl from Wisconsin and her husband Sang-Woo is Korean American born in southern California. The couple met when Elizabeth was interning as a pharmacist at Harbor General Hospital where Sang-Woo worked as an ER physician.

A few days after Elizabeth came back from her cruise in Asia, she approached Sang-Woo in the hallway and asked “Didn't you say your parents were from Busan, Korea?” She was still elated from her recent trip “I just got back from Busan. It was one of the prettiest cities in the world. I will never forget those shiny white beaches with immaculately clean sand and the endless rows of colorful parasols and the modern high-risers, it was a breath taking scenery”.

“I am glad to know that you liked Busan but it wasn't like that when my parents lived there. Life was tough then, in a war stricken country. Busan being the south most end of Korean peninsula, was the refugee dump during the war and every day survival was a bloody competition, I heard” Sang-Woo said.

As their relationship got serious Sang-Woo brought Elizabeth to meet his parents. First time, his father didn’t even say ‘Hi’ to his future daughter-in-law and looked to the other side, but his mother ran out with open arms and hugged her. She was in her early sixties but very young looking with a round face and cute smile. She told Sang-Woo. “Your father can not handle the idea that his only son is marrying out of race but don’t worry! I know you and I can break him in” When they were leaving, his mother whispered to Elizabeth’s ear “Even if you get pregnant before getting married, I will understand. My husband will be seventy on his next birthday. He has been wanting for a grandchild for a long time”.

They were married in next six months and they planned to have a family right away. But Beth didn’t get pregnant for two years after marriage, despite no contraception. “Do I get to hold my grandchild before I die?” Sang-Woo’s father got more impatient after he was diagnosed having stomach cancer. Sang-Woo gave in to pressure and decided to run some infertility tests for himself and his wife. Nothing was wrong. One night Beth told Sang-Woo “Honey, let me try in-vitro. Maybe I am not as fertile as I would like to be. And I would like to present your father with a grandchild before he passes away” She started taking medicines and hormonal injections.

As a result, her doctor was able to harvest twelve eggs from Beth and nine healthy looking embryos were produced from them. Four embryos were implanted first and the rest of them were frozen to back up just in case none of the first batch took. Nine month later, a healthy little boy was born and they named him Aaron. Sang-Woo’s father survived his malignancy. At this point, Sang-Woo and Beth faced an ethical dilemma on what they should do with the rest of the embryos they had saved. They couldn’t think of discarding them. Beth was implanted with the rest of the embryos the following year. Another boy was born. Unlike Aaron who was blond with pointy nose favoring his mother side, this one was very Asian looking. He was named Brett, representing batch ‘B’. They were day and night different, not only the looks but personality too. “I have two sons, one Golden-Retriever and one Pit-Bull” Sang-Woo said. “Mom! Brett is hurting me!” Aaron was shrieking, following a loud thud on the...
hard wood floor.

“I am your HYUNG, an older brother! So, I get to choose first” The Golden-Retriever said, now sobbing.

“You are my older brother only because I was FROZEN!” The Pit-Bull shouted.

Beth dropped everything and ran downstairs. “Brett, what are you talking about?” She asked.

“I was frozen, wasn’t I?” Brett’s voice was cracking. She reached out to hug both of her sons.

Richard Dawkins said the gene preservation was the ultimate rationale for our existence. In-vitro fertilization was a scientific triumph which fulfilled this task for certain people. But how far should we be allowed to go? Sex selection, Genetic engineering, selective abortion and then what? Design baby? And how much is the right amount of information to disclose to these children? The public perception changes as the society goes through evolution, nevertheless isn’t it our responsibility as healthcare providers to give some guidelines in this matter as the population of in-vitro increases?

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**Physician Reentry into the Workforce**

Many physicians leave practice and then wish to reenter the physician workforce after an extended period of time away from clinical medicine.

When a physician wishes to return to practice, what kind of retraining is needed? How is the person’s clinical competence evaluated? What role in the workforce should the individual pursue? How should licensure and credentialing issues be addressed? The AAP, in collaboration with 20 other medical organizations, has explored these issues and created a set of resources for members.


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**AAP Offers New Affinity Program for AAP Members**

**Pediatric Purchasing Program**

The Child Health Advantage program provides access to group pricing discounts, member choice on products, services, and distribution channels with no fees or minimum purchase requirements.

Register today for savings on vaccine purchasing, medical/surgical supplies, pharmaceuticals and business services or call 1-877-220-2008.

What Is Intelligence?

Alvin S. Yusin, MD, FAAP

Former Director of the Child Development Program
Los Angeles County – USC Medical Center
Former Associate Professor of Pediatrics, Neurology, and Psychiatry
and Human Behavior, Keck School of Medicine, now retired.

Most people believe that IQ scores determine an individual's intelligence. After all IQ does mean Intelligence Quotient. However, that belief may not be based in fact. Understanding just what IQ tests assess requires an understanding of how and why they came into existence. They developed indirectly from the philosophical perspectives of JeanJacque Rousseau.

Jean Jacque Rousseau reacted negatively to the Age of Reason that was profoundly influencing French society at the beginning of the nineteenth century. It was his opinion that expression of emotion was a vital part of human existence. Emphasis on reason and logic during the eighteenth century had suppressed its expression. Suppression of emotion created societies built on cold hard logic, a condition which, according to Rousseau, placed humankind in ‘chains’, limiting their enjoyment of life and warping their natures. He urged a return to man's natural environment, away from cities, back to fields, streams, and forests where humankind began its existence. It was only in such surroundings that humankind’s comprehensive nature, both emotional and intellectual, could be fully expressed.

In 1798, near the village of Aveyron, France, a boy of about eleven years of age emerged from the forest. He was naked and dirty, and it was not clear as to how he had survived. However, he piqued the interest of the French government. He was Rousseau’s “natural savage”, pure and innocent, not yet warped by the chains of society. It was their hope that he could be incorporated into French society with minimal disruption of his “natural state”. The boy's care was relegated to a physician residing in Paris, who had worked extensively with the deaf. The physician's name was Jean Itard. He called the boy Victor, and established a system of evaluating and teaching children that became the basis of present day assessments. He first determined what knowledge and activities Paris society expected of eleven year old boys. He then developed assessment tools to determine which, if any, of these expectations Victor met. Having identified Victor's deficits, he developed programs to teach him what he did not know.

Itard had a student named Edouard Seguin. Seguin subsequently applied Itard's system to large populations of developmentally delayed children. He determined what was expected from children of different ages by French society. He developed tools to assess the children he followed to identify what deficits they had. He then created programs to teach them the information they lacked.

Itard and Seguin provided the foundation for developmental assessment. It had three components: Determine what functions were required by society of a normal population of children of a given age, develop assessment tools to determine if the population of children of that age could perform those functions, and provide programs to correct the deficiencies identified by their assessments should functional deficits be identified. There is little more to be said about such assessments until the Franco–Prussian War of 1870 at which time assessments were diverted from evaluations of societal expectations, that included primarily non–academic activities, to evaluations only of academics.

Continued on Page 30
This change came about in a most unusual manner.

During the reign of Napoleon III [1851 – 1870], there were populations of children who were not attending school. They ran the streets of Paris getting into mischief. They were referred to as street urchins. The aristocratic government of Napoleon III took no interest in these children. The emperor was overthrown after the war, and the third French republic was established. The government of the third republic was interested in these children, and wanted them to go to school. However, they had no idea as to what academic information, if any, these children had. They hired Theodore Binet, a psychologist and Alfred Simon, a pediatrician, to make that determination. Binet and Simon utilized Itard and Seguin’s approach to evaluation. However, they did not evaluate what French society expected of children of different ages, but rather what academic information these children were expected to have at a given age. They used the school curricula to fashion their assessment tools. If a child’s academic information was commensurate with what was expected of children of their chronological age they were said to be at grade level. If they had more academic information than what was expected, they were said to be above grade level, and if they had less, they were said to be below grade level. The results of these assessments were used to establish proper academic programs to maximize their academic capabilities. Binet and Simon used chronological age [CA] for the child’s actual age. However, they used the term mental age [MA], instead of academic age, to describe the child’s level of academic information. Subsequently, a German psychologist by name of Kuhlman, decided to make a ratio of the MA over the CA and multiply it by 100. He called the result a Mental Quotient.

Henry Goddard, Director of the Vineland School for the Retarded in New Jersey, brought these tests to the United States. He began to use them to assess American children, but quickly realized that the tests had been standardized using information derived from the Paris school curricula, not the curricula of American schools. The materials were turned over to Lewis Turman, a psychologist at Stanford University, who provided that standardization, creating the Stanford – Binet Intelligence Scales. Turman continued the practice of using the ratio of MA over CA, and multiplying it by 100. However, he introduced the term Intelligence Quotient [IQ] for the product obtained. It is not clear why Kuhlman and Terman created the ratios that they did, as the ratios served no useful function, given the reason why these testing materials were developed. It is even less clear as to why Terman coined the term IQ for the number obtained from this ratio. Unfortunately what has become fixed in the minds of most people is the idea that comprehensive intelligence is defined solely by academic achievement, defined as a ratio called IQ. Intelligence cannot correctly be defined in this way.

How should intelligence be defined?

A more accurate definition of intelligence is the human ability to use specific brain functions that include memory, attention, learning, and sequencing thoughts to name a few, in an organized manner in order to adapt and survive in the diverse environments into which they are born and which they encounter as their lives unfold. The school environment represents only one such environment. Within this definition, achieving well academically represents the ability to survive in an academic environment. The same brain functions used to survive in an academic environment are used to survive in physical environments, such as the jungle or the desert, in a vocational training environment such as carpentry, plumbing, and any other environment in which a child, or adult for that matter, finds him or herself.
Exaggerating the importance of the academic environment by creating an artificial IQ ratio, and including this ratio in the definition of intelligence has had serious deleterious consequences. It has carved out a segment of the population, and defined them as intellectually inferior. Any name applied to individuals, created by low IQ scores will continue to sustain the notion of an intellectually inferior segment of the population based on IQ. Intelligence Quotients are unnecessary and artificial contrivances that do not correctly define comprehensive intelligence. Clearly the entire concept of IQ should be eliminated, and so called “IQ tests” should be used as they were meant to be used, not to create quotients, but to provide appropriate educational programs that advance children academically... nothing more.

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**SPRING 2015 MOVIE REVIEWS**

*Lucy Crain, MD, MPH, FAAP*

**THE GRAND BUDAPEST HOTEL** is loosely based on a 1943 semi-autobiographical novel, *The World of Yesterday* by Stephan Zweig, and the non-stop dialogue in the movie reflects that in the book. Set in a mythical European province in a huge grand hotel in the interval between WWI and WWII, the frenetic action reminds one of the old Keystone Cops films. The story is written and directed by Wes Anderson and is riveting with most of Hollywood starring in this stylistic cinema. The makeup is so outstanding that it is almost impossible to recognize Jude Law and Tilda Swinton. Ralph Fiennes plays M. Gustave, the hotel concierge and in-house gigolo, reciting poetry and catering to the rich, elderly widows who frequent the hotel. He befriends and trains a young “lobby boy”, a refugee named Zero, who becomes his protégé and life long companion. How Zero, played in his old age by F. Murray Abraham, becomes eventual heir to the estate of M. Gustave after surviving many exciting escapades is the substance of the plot. The bulk of that estate is the hotel, which has become old and dowdy in the course of time, but still has a certain charm and remains much loved by those who remember it in its prime. 99 minutes in length, R for language and occasional violence.

**BIRDMAN** or The Unexpected Virtue of Ignorance is an amazing black comedy starring Michael Keaton in the performance of his career. Directed by Alejandro Gonzalez Innaritu and also starring Edward Norton, Emma Stone and Naomi Watts, the plot initially is confusing as it unfolds. Keaton's character in his youth had starred in comics and movies as the super-hero Birdman. Now in middle age, he wants to achieve a comeback and change of image as a Broadway producer/director with a new play based on the novel *What Do We Talk About When We Talk About Love?* The play stars Edward Norton and Naomi Watts as well as Keaton and promises to be a blockbuster...or possibly a flop. Keaton's character's anxiety attacks display his impressive acting talent, constantly interrupted by distracting flashbacks of his Birdman persona. Emma Stone, as his daughter, tries to be understanding of her father's troubled goals, only to find him increasingly disturbed and irrational. Does he really fly? Is he blatantly paranoid or just an eccentric genius? Does his play succeed? Does the vicious New York drama critic pan his efforts? Does he achieve his dreams? Birdman is a provocative and thoroughly entertaining movie with a terrific cast and a great performance by Keaton.....And the Academy Award went to the movie and director/producer Innaritu for Best Picture of the Year without a nod to Michael Keaton and his extraordinary talent. (Personally, I thought Boyhood was a better movie.) R rating for language, near nudity, violence. 1 hour 59 minutes.
A Fractured Tale
Alex Dubin, MD, FAAP

Like Jack and Jill
I took a spill.
What a clumsy fella.
Now here I lie,
Oh my,
The guy with the fractured Patella.

January marked my one-year retirement anniversary from pediatrics. We decided to celebrate the milestone by spending seven weeks in Florida - six weeks in Sarasota and one week at our timeshare condo in Orlando.

After a wonderful time in Sarasota, we eagerly headed to Orlando, where we would be joined for the weekend by our Tampa children. Then, on day two, calamity struck. We are all out at the pool enjoying the sun and the great musical sounds of a small band playing poolside. I get up, start walking toward the whirlpool and my right foot catches in a nearby, somewhat sunken flower bed. I fall head first, knee and hand to the ground. I couldn't believe what had just happened. I stumbled, not in the Columbus snow and ice, but in the beautiful Florida sunshine.

I am reminded of the old childhood query when a peer would fall and a young smart-mouthed witness would ask, “How was your trip?” What follows is the tale of my trip. It is the tale of what happens when the doctor turns patient.

My head is bruised and my knee is swelling. It does not take long to decide, after some immediate hotel staff first aid, that I need to go to the local hospital for an evaluation. Two hours later I am in the emergency room attended by nurses and an ER doc, who is very competent, respectful and kind, although he looks to be no more than 18.

X-rays are taken, followed by a CT scan of my head. The verdict is in within the hour. My CT is normal and my x-ray is not. The physician shows me the x-rays. The crack is there. I have a fractured Patella. The good news is no surgery, the bad news is the brace. I am then fitted with a monstrous ankle to thigh brace and ordered to keep the weight off and the ice on. I am also referred to one of the hospital-affiliated orthopedic surgeons for further evaluation. I go the next day. He concurs with all of the recommendations and the brace stays. The only concession, I do get to turn in my walker for a cane and he signs my release to fly home.

After more than five hours in the ER, I return to our condo tired and frustrated. I am met by Daphne, our four-year-old granddaughter. Initially, she is frightened by the sight of the brace. When she walks over to look, she summons all of her courage and with medical training, ala Disney's Doc McStuffins, Continued on Page 33
she makes her diagnosis. “Grandpa, you have Fracturitis.” I reassure her, and myself, that I will be alright.

I am a terrible patient. I can't stand the brace. It slips. It is tight. It is uncomfortable. And, it causes extreme grouchiness.

Flying home four days later was the next challenge. I was humbled by the amazing amount of help that I required and received both at the airport and enroute. One doesn't know what living with a handicap is really like until spending time in another man's shoes or brace in this particular case.

Once home, I complained about the brace daily. And, every time I went to see the Columbus orthopedic surgeon, I asked him to please change it. Three-brace tries later, there was nothing that was satisfactory. The doc assured me that from among the available choices I was already using the best style. I silently vowed that in my retirement perhaps I could design the perfect brace. My wife wondered which fashion designer I hoped to imitate.

Now nearly five weeks later, at my most recent weekly visit, I was given what I like to call “break out news.” My latest x-ray showed enough healing that I could wear a brace that just goes a few inches above and below the knee. My new brace is for going out only. I no longer have to wear it in the house. It gives me the mobility that I need to ride in the front seat and as of yesterday, even drive. What an amazing victory! What a medical feat!

I have a ways to go but every reason to be optimistic. In a few weeks, I will have the orders for PT and the opportunity to strengthen my leg. Ever after, I plan to take my trips without a fall.

So complaining aside,

With humility and pride,

Just call me a most happy fella.

A more patient, deeply grateful guy

Am I,

The doc with a healing Patella.

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If You Are Not a Member of the Senior Section...Join!

If you are a Senior Member of the AAP, you can now join the Senior Section for free!

If you would like to join, please contact the AAP Customer Service Center at 800/433-9016.
Review of ‘Believer’ by David Axelrod

Mark Rosenberg, MD, FAAP

Especially for those who actively participated in the presidential campaigns of 2008 and 2012 as I did, the political atmosphere of a state like Illinois is fascinating to observe. That is precisely what drew David Axelrod from Brooklyn, New York to attend college at the University of Chicago and remain here after he graduated. From a serendipitous start in journalism at the Hyde Park Herald to a political beat reporter at the Chicago Tribune, he quickly grew attached to Chicago politics, waiting for the chance to jump to ‘the big one,’ a Presidential campaign. While he missed an opportunity in the Al Gore election campaign of 2000 (due to his commitments to his family), he attached his career to that of a young black state senator from the south side of Chicago named Barack Obama. That began what Axelrod called ‘an improbable journey’ for both Axelrod and Obama.

The title ‘Believer’ refers to Axelrod’s insistence on working only for candidates whose political philosophy matched his own personal convictions, leading him fortuitously to reject the gubernatorial campaign of Rod Blagojevich because when asked why he wanted to run for Governor of Illinois, Rod replied, ‘You can help me figure that out.’ Whereupon, Axelrod told him ‘If you can't tell me why you are running, I can't help you explain it to others.’ Blagojevich would later be convicted and sent to Federal prison. Filled with anecdotes like how he noshed his way to a weight gain of 25 pounds during the 2008 campaign and honest self-assessments of his missteps along the way, the book is a story of how two individuals crafted a message and a relationship. Axelrod is unrelenting in his admiration of the sincerity and honesty of Barack Obama, as reflected in this quote, 'He was an incomparable client—not perfect by a long shot; but brilliant and honorable and motivated by the best intentions; a good friend and fellow idealist. I had been spoiled.'

Nearly half of the book is a description of the relationship of Axelrod and Barack Obama from his Senate campaign of 2004 through the West Wing years that Axelrod spent as advisor to the President, helping him craft his message. As expected much of that period contains the rich anecdotes of Axelrod’s contacts with the White house team, especially the frequent encounters with Rahm Emanuel, Chief of Staff, and Valerie Jarrett whose role often led to head butting between the two of them.

The language may be crude at times but David Axelrod documents the sacrifices he makes as his family with a special needs child survives the long campaign absences. One significant flaw is how generous Axelrod is with his assessment of his client, Richard M. Daley’s accomplishments as Mayor of Chicago, omitting some of the legacy of the financial obligations of the city following his term.

In an era of gridlock politics, it is refreshing to reflect on the career of a campaign maestro like David Axelrod and to see that there are some whose idealism drives their careers. Axelrod: ‘After a lifetime of rough and tumble, I still believed: in politics as a calling: in campaigns as an opportunity to forge the future we imagine; in government as an instrument for that progress.’
The complaints about modern medicine are legion: its basic cost, the technological imperative which drives high tech medicine, insurance company hassles (and their twenty per cent administrative costs), insurance companies inequities which preclude the poor from getting adequate coverage, the overweening public demand for health care, and litany of other issues.

On a simplistic level though one of the crucial issues confronting patients today is the issue of access. Patients have difficulty getting to see primary care doctors, specialists, or getting scheduled for some tests (e.g. MRI, echocardiogram, EEG). Only some of the problem is an issue of supply and demand.

Trying to make an appointment with a neurologist, for example, may be months away. Regardless of whether your symptoms are significantly disturbing and frightening and your anxiety is high because of uncertainty the medical system is unable to accommodate you.

There is, however, an interesting phenomenon that I have noticed which is a pure result of the fact that I have been in pediatric practice for thirty-nine years. It is called The Old Boy/Girl Network. The way it works is this:

A mother calls me with concerns over her twelve year old’s chronic abdominal pain and occasionally bloody diarrhea. She has tried number of remedies both dietary and medical. I see the child in my office and note that he has lost some weight and is uncomfortable. It is time, I decide, to have him see pediatric gastroenterologist.

If I give the mother the consultant’s phone number and suggest that she make an appointment for her son the likelihood is that she will get an appointment for him in two months. On the other hand if I intercede that conversation often goes a follows:

“Janet, I have a twelve year old boy with chronic abdominal pain and occasionally bloody diarrhea. His mom is very anxious and is at her wits end,” I say in a phone call.

“No problem Lou. We can get them in this week.”

Her willingness to acquiesce and expedite the visit is purely a function that I have been in practice for a long time and have known the gastroenterologist for as long. It a sad commentary on the state of American medicine.

Access is crucial for patients. To have to rely on older physicians to provide this is a unreasonable expectation. Assuming we are willing to facilitate access there are not enough of us around and this behavior is not a priority for younger physicians yet.....
Dear Diplomate,

The American Board of Pediatrics is well aware of the current debate throughout the medical community regarding the value of Maintenance of Certification (MOC). On Tuesday (Feb. 3, 2015), the American Board of Internal Medicine (ABIM) announced significant changes to its MOC requirements. While we are fellow members of the community of medical boards, ABIM and ABP serve different populations and have approached MOC differently. The ABP is looking closely at ABIM's changes and the reasons behind them.

The ABP's MOC program is based on the belief that ongoing learning, assessment and quality improvement are integral to our mission of assuring parents that an ABP diplomate (certified pediatrician) possesses the competencies to care for their children. We have been working tirelessly with many of you to make all parts of MOC relevant and useful to pediatricians. Just as we ask diplomates to assess their practices and improve, I assure you that we have been doing the same with ABP’s MOC program.

We certainly agree that all boards must constantly look for ways to improve their processes and we defer to ABIM on the best ways for its board to accomplish that goal. It may help you to know that a number of issues that ABIM is trying to address do not apply to the ABP. For instance, ABIM has a 2-year MOC cycle, whereas ABP has a 5-year cycle. The ABP has long had a practice-oriented MOC exam with a 95 percent pass rate, as opposed to ABIM's current MOC exam, which closely resembles its initial certification exam and has a 78 percent pass rate. The now suspended ABIM Part 4 requirements included a patient satisfaction (“patient voice”) requirement. The ABP has never had such a requirement. Whereas ABIM is now seeking more input from professional societies, the ABP bylaws stipulate representation of all major pediatric societies on our board of directors. In consultation with pediatric subspecialty societies, the ABP froze initial certification fees for 2015 based on our concern about educational debt faced by young pediatricians.

The ABP is making no changes to the requirements for maintaining certification at this time.

Continued on Page 37
However, we continuously assess our certification requirements, including examinations and MOC activities. Through our website, blog and social media, we will keep you abreast of any changes to current processes and policies for both initial certification and MOC. These communications provide opportunities for you to engage with us in a dialog to address our mutual commitment to the health care of children and youth.

Sincerely,

David G. Nichols, MD, MBA
President & CEO
American Board of Pediatrics

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**Book Review**

**The Map of Heaven: Eben Alexander, MD**

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

As a sequel to his bestselling first book (Proof of Heaven, 2012), the academic neurosurgeon, Dr. Eben Alexander takes the reader into the details of a heavenly existence. The 26 page Introduction is a review for those who read “Proof” and a comprehensible beginning for new Alexander readers.

With 97 references, Dr. Alexander cites the works of historic physicists and scientists, accompanied by supporting letters and stories he has personally received, to take the reader to the heavenly place. Those open to a larger world will benefit from the “gifts” of heaven: knowledge, meaning, vision, strength, belonging, joy and hope. The author devotes a chapter to each “gift”.

Dr. Alexander makes a compelling argument for science and spirituality working together for humans to understand their destiny. He stresses the failure of science, as yet, to explain human consciousness.

This book is not for the skeptics of “Proof”. It is a more detailed, reference based work for those who were convinced by the “Proof” book. Previously proving the existence of heaven, Dr. Alexander and his many experts now describe its nature. Readers, who seek a thought provoking account that may stimulate meditation about after life, will find this book worthwhile.
Home Sweet Home Has A Whole New Meaning

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

If your estate is substantial and you're concerned about the federal estate tax bill your heirs will have to pay, there's a way you might be able to use your house to remedy the situation. It may be as simple as giving away your home or as complex as knowing the mechanics of an estate planning tool called a Qualified Personal Residence Trust (QPRT).

With a QPRT, you essentially transfer ownership of your primary residence or vacation home to a trust while you retain the right to continue using the property during the trust term. After that, your children or other designated beneficiaries become the owners of the property. If you still want to use the property when the trust term ends, you can work out a rental arrangement with them.

Transferring property to a QPRT is considered a taxable gift, but you get a substantial break. The value of the house is discounted for gift tax purposes because you're allowed to continue using it for the term of the trust.

Understand, however, that interest rate fluctuations can affect Qualified Personal Residence Trusts. If interest rates are falling, a QPRT loses some of its allure as a tax shelter because the value of the gift increases as rates decline, which could trigger a gift tax liability.

A QPRT involves making a deferred gift, meaning your heirs get the property sometime in the future. As a result, you get a substantial discount on the value of the asset. The exact valuation is calculated using IRS tables, which change along with interest rates. Take for example a home valued at $1 million. At a 7% interest rate, the present value of a gift of that home in 20 years would be $258,420. At 6%, the value rises to $311,804. At a 5% rate, it jumps to $376,889. The prospect of declining rates can be an incentive to set up a trust before they drop further. Of course, if rates rise before you set up a QPRT, that would have favorable gift tax implications for you.

The main advantage of the QPRT is that it allows you to get your home out of your taxable estate at a reduced tax cost. And because setting up the trust is a private transaction, there is no public record that can be contested when you die.

Does that sound too good to be true? A QPRT can save your heirs taxes. However, the trust is irrevocable, and the tax rules are very complex. You need a firm grip on the pros and cons of QPRTs before you give away such a valuable asset -- and one that many people are emotionally attached to as well.

Here are four key considerations when establishing a QPRT:

1. **Get an expert.** Consult with an attorney and a tax advisor who specializes in estate planning - one mistake could render the trust worthless.

2. **Pick a short term.** Your goal is to continue using the home while getting it out of your taxable estate. Choose a term for the trust that you expect to outlive. If you die before the end of the term, the home goes back into your taxable estate with no tax savings.

Continued on Page 39
3. **Get a handle on your future.** If you’re planning to rent the house from your children or other beneficiaries after the trust ends, don’t make the future rental a provision of the QPRT. The IRS could invalidate the trust. Also, don’t set up a QPRT unless you have a good relationship with the beneficiaries, including in-laws. You don’t want to worry about being thrown out of your own home after the trust ends.

4. **Stay put.** It’s important to keep using the home for the duration of the trust or you risk losing the tax benefits.

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**SECTION ON SENIOR MEMBERS ANNOUNCES SECTION ELECTION RESULTS**

The Section on Senior Members (SOSM) closed their Section’s election on Monday, March 31, 2015. The following members have been elected by Senior Section Members to the SOSM executive committee:

- William R. Brown, Jr., MD, FAAP
- Philip Brunell, MD, FAAP
- Debra Sowell, MD, FAAP

Thank you to each person who voted in the election. The new terms will commence November 1, 2015 and each person will serve a three-year term.

If you have any questions about the election or future leadership openings, please e-mail our staff at jburke@aap.org.

Thank you to Vidya Sharma, MD, FAAP and Martin Greenberg, MD, FAAP for serving on the Section’s nominations committee.

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**2015 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.

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**Summer Bulletin - Electronic**

- **May 26** articles due to Lucy Crain, MD, MPH, FAAP
- **July 6** online

**Fall Bulletin**

- **August 11** articles due to Lucy Crain, MD, MPH, FAAP
- **September 25** mailboxes

**Winter Bulletin - Electronic**

- **December 2** articles due to Lucy Crain, MD, MPH, FAAP
- **January 11, 2016** online
Forget-fullness

Biology Test---Priceless!!!

Students in an advanced Biology class were taking their mid-term exam. The last question was, ‘Name seven advantages of Mother’s Milk.’ The question was worth 70 points or none at all.

One student, in particular, was hard put to think of seven advantages. However, he wrote:

1) It is perfect formula for the child.
2) It provides immunity against several diseases.
3) It is always the right temperature.
4) It is inexpensive.
5) It bonds the child to mother, and vice versa.
6) It is always available as needed.

And then the student was stuck. Finally, in desperation, just before the bell rang indicating the end of the test, he wrote:

7) It comes in two attractive containers and it’s high enough off the ground where the cat can’t get it.

He got an A.

Car Keys- PRICELESS!!

After a meeting several days ago, I couldn't find my keys. I quickly gave myself a personal “TSA Pat Down.”

They weren't in my pockets. Suddenly I realized I must have left them in the car. Frantically, I headed for the parking lot. My husband has scolded me many times for leaving my keys in the car’s ignition. He’s afraid that the car could be stolen. As I looked around the parking lot, I realized he was right. The parking lot was empty. I immediately called the police. I gave them my location, confessed that I had left my keys in the car, and that it had been stolen.

Then I made the most difficult call of all to my husband: “I left my keys in the car and it’s been stolen.”

There was a moment of silence. I thought the call had been disconnected, but then I heard his voice. “Are you kidding me?” he barked, “I dropped you off!”

Now it was my turn to be silent. Embarrassed, I said, “Well, come and get me.”

He retorted, “I will, as soon as I convince this cop that I didn’t steal your damn car!”

>Welcome to the golden years.............

— Thanks to an anonymous senior!