Greetings to all from my enclave in sunny Florida! Your Winter Bulletin is being assembled while the frigid weather is affecting most of you. Here it is in the 80s. Come on down and tour South Florida!

The 2014 NCE in San Diego was another outstanding experience. Double and triple-scheduled activities had something for everyone. Our Senior Section Education Program was particularly relevant and informative. The attendance was terrific, albeit I would have liked to have seen more of you guys. (MORE ABOUT THAT LATER IN MY MESSAGE). The program included presentations from the three winning Pediatric History Center Poster Contest and the presentation of the Section Annual Advocacy Award to Suzanne Boulter, MD. More information about that will be found elsewhere in this Bulletin. Your Executive Committee also met during the NCE and continued to pursue activities which will maximize the value of section membership for our growing numbers.

I must share with you an epiphany I experienced.

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rienced during the NCE. Having an extra few minutes and eager to visit the History of Pediatrics Poster Presentation in the Exhibit Hall because we had partnered with the AAP History Center in planning the session, I took a quiet seat in the near-empty Convention Center Entrance Lobby. As the Exhibit Hall opening hour drew near, a growing number of attendees arrived. Young, some very young, excited, enthusiastic attendees, embracing their new and old friends, sharing their career and family development updates. As the chatter and palpable vibrancy rose to a crescendo, this octogenarian was overwhelmed. What a bright future lies ahead for young pediatricians and the AAP. While the Old Guard grouses about MOC and leaving practice and the ravages of aging, here are the NEW pediatricians ready for new and better care models and life opportunities. Go for it!

Several members of the Executive Committee are completing their term this next year and the Nominating Committee will be seeking volunteers to place their names in nomination. If you feel willing and able to join the section leadership, and especially if you’re experienced in planning CME activities, please contact our staff at jburke@aap.org or tcoletta@aap.org.

Although the Executive Committee has been gratified with recent AAP policies, which are favorable to us senior pediatricians, we are still disappointed that more attention is not being paid to maintaining the loyalty and devotion of older pediatricians to the AAP. For example, at each NCE, local pediatricians who would like to attend only our educational program and business meeting are deterred from doing so by the cost of registration. Certainly, there must be an answer to this continuing frustration.
We are also attempting to increase the attendance of older pediatricians at the NCE and CME programs by removing the financial barriers for those who merely want to “audit” the programs without CME credit. (i.e.: Those of us who either do not want or need CME credit but merely want to keep learning and meeting their colleagues.) Specifically, SOSM will be proposing a resolution at the annual Leadership Forum in March, 2015 to waive registration fees for members 80 years and older for NCE and CME presentations. We will keep you informed of our progress in this regard.

If you have any suggestions on how we can better address your needs and interests, please contact me at artmaron@aol.com.

**Winter 2014-15 Editor's Notes:**

*Lucy Crain, MD, FAAP, Editor*

As another year bites the dust and we embark on the unwritten slate of 2015 making resolutions we won't remember, going to the gym with enthusiasm for at least 2 weeks, going on the proverbial diet and then…However, I hope many of our readers will resolve to submit articles for the Senior Bulletin this next year. This winter edition includes many personal reflections including grief and loss, as well as events worth celebrating. All are reminders of taking time to celebrate when we can, to be thankful for and to cherish family and friends and the time and experiences we have had and look forward to having. As always, the *Bulletin* features a variety of topics, ranging from cruise experiences to media frenzy to Guatemala service missions to different types of Senior Moments.

The Section Education Program at NCE was excellent and exceptionally well attended. Those who attended the 2014 Section Education Program in San Diego agreed that Dr. Shira had selected outstanding and relevant topics and speakers. Attendance was excellent and feedback outstanding. Here are the links to the power point presentations, along with appreciation to our speakers for sending their slides and to Dr. Shira for a terrific education program. Dermatology of the Aging Skin – William R. Crain, MD, FAAD [http://www.aap.org/en-us/Documents/sosm_crain_NCE.pdf](http://www.aap.org/en-us/Documents/sosm_crain_NCE.pdf) Optimal Heart Health - J. Kern Buckner, MD [http://www.aap.org/en-us/Documents/sosm_buckner_NCE.pdf](http://www.aap.org/en-us/Documents/sosm_buckner_NCE.pdf)

Read, enjoy, and submit an article of your own to a future issue of the *Senior Bulletin*. You'll find the schedule for Bulletin submissions in this and every issue.

Congratulations to Dr. George Cohen for receiving a Local Heroes Award from the Council on Community Pediatrics at this year's NCE. George is a former member of the Executive Committee of SOSM and one of our long time heroes. Congratulations also to Dr. Suzanne Boulter, a hero of dental health, teens, and children in general, who received the Senior Advocacy Award. She describes some of her work in this issue. And hearty congratulations to the many other members of the SOSM who received awards at this year's NCE.

With best wishes for a happy, healthy new year!

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*Dr. Bernard Dreyer won the 2014 election for the next AAP President- Elect. Dr. Dreyer is Chair of Pediatrics at Bellevue Medical Center in New York and is a strong advocate for children and families. He also is a member of the Section on Senior Members, so we offer special congratulations and look forward to working with him in his new role with the Academy.*
“Many are eligible but few are chosen”. With deep gratitude and significant surprise the Senior Section Child Advocacy Award was presented to me in San Diego on October 12, 2014. Reflecting on advocacy and our role as pediatricians raises many questions. What exactly is advocacy? One definition is “eliciting public support for, or recommendation of, a specific cause or policy.” As pediatricians we are in a unique position to advocate for our patients and the definition might be expanded to include details of advocacy key to our work such as:

- A – advise (parents, patients, colleagues)
- D – define (set goals)
- V – vote (for child friendly initiatives)
- O – orate (testify often!)
- C – children’s issues
- A – adolescent’s issues
- C – collaborate (convene others)
- Y - yes (the answer to every request!)

I’ve been asked to summarize my advocacy efforts over my years as a pediatrician. Reflecting back on my career there were three distinct advocacy chapters which I’ve called *The Three T’s – Teens, Tots and Teeth.*

**Teen** activities included:
- Developed teen clinics for underserved and to promote teaching
- Volunteered as school and camp physician
- Convened eating disorders advocacy workgroup
- Long term participant in youth suicide prevention efforts
- PFLAG advisor
- Member of AAP Committee on Adolescence
- Authored first AAP policy statement on Sexual Assault in the Adolescent
- Principal investigator in teen substance abuse prevention research at my practice site
- Member of legislative task forces on suicide prevention, cervical cancer prevention, dental access, and fetal alcohol syndrome prevention appointed by three different governors

**Tot** advocacy was next including:
- Expanded *Reach Out and Read* in New Hampshire
- Developed *Growing Up Healthy*, a free guidebook for parents of all newborns in New Hampshire
- Access to health insurance (chair of CHIP in New Hampshire)
- Child abuse prevention activities through NH Children’s Trust Fund
- Testifying to the NH Legislature on child health bills – gun safety, immunizations, water fluoride, PCP oral screening and others

*Continued on Page 5*
**Senior Advocacy Award 2014 Continued from Page 4**

_Teeth_ advocacy has been my area of significant advocacy over the past 15 years and includes the following:

State –
- NH Oral Health state plan development and implementation
- Collaboration with dental colleagues for state wide projects and grant selection activities

National –
- Chair of AAP Oral Health Initiative and member of Section on Oral Health Exec Committee
- Trained oral health champions in each AAP chapter
- Webinar presenter for AAP, PEW and MCHB
- Developed Caries Risk Assessment Tool
- Trained residents and practitioners about oral health
- Publications in 8 different journals on oral health topics
- “Toothbrush Travels” - presentations on oral health in 12 states
- eQIPP oral health editor
- Bright Futures oral health contributor
- Funded first CATCH endowment for oral health projects

In summary, many pediatricians are deserving of this child advocacy award because as pediatricians we all continually advocate for our constituents – those infants, children and teens who are unable to speak up or vote for themselves. We are their voice and we take our mission seriously. In my opinion here is no question that advocacy greatly enriches the advocate's professional satisfaction in the career path that we have chosen as pediatricians. Hopefully pediatricians of the future will continue to feel the calling to step out of their traditional work environments and speak up for kids.

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**UNLESS THEY ARE TALKING ABOUT PEDIATRICS!**

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.
Ahead of Their Time: The Story of Alice Berry Graham and Katharine Berry Richardson
the Founders of Children’s Mercy Hospital in Kansas City, Missouri

Jane Knapp, MD

Alice Berry Graham was born in 1850 in Warren PA. Her sister Katharine was born in 1858. Their mother died when Katharine was three and they were raised by their father Stephen. Stephen Berry held strong opinions and deeply-felt community values. He taught his daughters that, “the truly charitable woman is big enough to help children other than her own,” and “that principles were more important than public opinion”.

Stephen believed in education for women and sent his daughters to high school. They went on to college and Alice worked as a teacher to put Katharine through medical school. When she graduated, Katharine returned the favor and paid for Alice's tuition to dental school.

The sisters moved to Kansas City in the early 1890’s. They found that the medical community excluded women. Undaunted, Alice set up her dental chair in their home and Katharine made housecalls.

Then one day Alice found an abandoned, crippled and ill child on the street. She brought her home and the sisters rented a hospital bed to nurse her back to health. Herein, they discovered their calling to care for poor and sick children and in 1897 they founded The Free Bed Association for Crippled, Deformed and Ruptured Children. The name was changed to Mercy Hospital in 1904 and then to Children's Mercy Hospital in 1916.

Early on the sisters established a nursing school. The nurses wore blue gingham dresses, starched white aprons and a hat designed by Florence Nightingale. Alice and Katharine were devoted to their nurses and saw them as equal partners in the health care of children.

They wrote a nursing pledge expressing this sentiment. To me, the parts in bold demonstrate how much ahead of their time they were.

I pledge myself to be loyal to all that is best in the profession of which I am a member. I pledge myself to strive to cooperate intelligently, conscientiously, and faithfully with the physician or surgeon in an effort to lessen disease and suffering, not by blind unreasoning obedience to orders, but through my realization of the dignity and responsibility of the nursing profession.

I will endeavor to do so, think and study and live that I may always act toward the sick with the sympathy of a sister and I will be especially mindful of the helplessness and need, by difference of race or creed or social position and I will hold before myself an ideal, not measured by money or personal favor or advancement, but that will always inspire me to give to my work the best of which I am capable.

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In 1911, Alice began writing the Mercy Messenger which was a 6x9 inch postcard mailed for a penny. The Messenger relentlessly asked for donations, raised awareness of the social plight of children, especially those with handicaps, and advocated for health care for those in most need. In one entry Katharine wrote, “…and it is a beastly shame to let any child remain an invalid while we brag of being the richest nation on earth and find the dollars to surround ourselves with every possible luxury money will buy.”

One of the ways they raised money was through clubs. There were hundreds of clubs devoted to various causes. For example, the Lucerne Club aided the Eye and Dental Clinics. Thousands of children were blind in the early 1900’s from ophthalmia neonatorum. In the Messenger in 1914 Katharine wrote, “(the blindness) is not due to the carelessness of the nurse. It is not due to a cold. It is gonorrhea and the lack of a 1% silver nitrate solution”.

They also communicated their needs using a blackboard on the front lawn of the hospital. They asked for food, clothing or even a new hospital saying, “We haven't half room enough to take care of our little patients. Won't you help us to build a new hospital?”

Alice died from cancer in 1913. Katharine wrote of her that, “Some unthinking persons may not believe in the immortality of the soul, but no one, having known Dr. Graham can doubt the immortality of a life.” Katharine, while she became the better known and more influential of the sisters with the passage of time, always insisted that Alice was the true founder of the hospital. She was emphatic that the cornerstone of the 1916 hospital bear Alice's name alone.

Widowed and without her sister Katharine had to carry on alone. In the early days of the hospital, Alice had been the gentle diplomat who raised money and ran the business. Katharine, very different from her sister, and described as a brusque, fiery personality, provided the medical care. Katharine was an accomplished surgeon especially known for her work in cleft lip/cleft palate repair. She left hundreds of pictures of her patients in scrapbooks and as lantern slides that demonstrate the breadth of her talent.

In the 1920’s Katharine began to work for equitable healthcare for African-American children saying, “I have not served children unless I have served them all.” Jim Crowe laws were in effect in Kansas City and she met a lot of opposition to her plans to fund beds for African-American children. She persevered however, opening a pediatric ward at the Wheatley Provident Hospital which was built as a Negro Hospital.

She also began training African-American physicians and nurses in pediatrics. The first three pediatricians graduated from a two year program on December 19, 1924. To our knowledge these are three of the earliest African-American pediatricians in the United States.

On June 3, 1933, Katharine Berry Richardson died. Both she and her sister had no children of their own but, they remained true to their fathers teachings throughout their lives. Her funeral was held underneath her favorite maple tree outside the nurse's residence. One thousand people attended and mourned the leader who was described as the most influential woman in Kansas City. She was buried next to Alice.

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On June 12, 1933 the hospital board and trustees made a resolution which in part said, “As long as Kansas City lives – as long as Mercy Hospital endures, so long will the name of Katharine Richardson be cherished in the hearts of those who came to know her work and worth. As members of the Central Board and Board of Trustees, and as her loyal friends, we pledge to our dead leader that we will keep the faith”.

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**Lasting Innovations from the University of Wisconsin**

*Ellen R. Wald, MD*

The Department of Pediatrics of the University of Wisconsin School of Medicine and Public Health, created in 1957 with 4 faculty members, is proud to celebrate three innovations which have had long-lasting effects on the well-being of children throughout the world.

**Dr. Stanley Graven**, observing Wisconsin’s low rankings in infant mortality in the 1960’s, persuaded physicians in the state’s 130 hospitals to cooperate in the development of a regional perinatal care system, including referral of premature and seriously ill infants to four regional neonatal care units. This is such a basic element in health care today that it is surprising to many that it had to be invented. Many said it could not be done, particularly in a rural state with long distances between hospitals. While technologic advances in transport vehicles became an important component of the system, in the beginning the greater obstacles were social and political, and Graven’s genius lay in his ability to develop trust and respect throughout the state. The measurable benefits in neonatal outcomes led to rapid application of the concept in other states.

**Dr. Harry Waisman**, a pioneer in the understanding of the rare disorder – phenylketonuria – demonstrated that early detection and administration of a diet restricted in phenyalanine could ameliorate and sometimes prevent the devastating brain damage associated with the disorder. He campaigned vigorously for routine newborn screening, and with the development by Robert Guthrie of a cheap, efficient screening test, state statutes were passed in the 1960’s mandating screening of all infants. Originally expected to benefit several hundred children per year, the PKU model expanded to now include over 40 conditions with more on the way, preventing death and disability in hundreds of thousands of American children, and more around the world.

**Dr. Norman Fost**, with colleague John Robertson, published the first in a series of papers in the *Journal of Pediatrics* critical of the common practice of withholding standard medical care from infants with Down syndrome and treatable conditions such as duodenal atresia. Two studies showed that 70% of U.S. pediatricians supported such decisions. The paper provided a conceptual rationale for the use of ethics committees as a mechanism for resolving disagreements between and among providers and families. Other factors contributed to the virtual disappearance of withholding effective medical care solely on the basis of Down syndrome, but ethics committees became a mechanism for resolving a wider array of clinical ethical dilemmas and are now required in all accredited U.S. hospitals.
Picking up the Pebbles: Lost in the Forest of PDA Treatment
Justin Elhoff, MD

The treatment of patent ductus arteriosus (PDA) in preterm infants has become one of the most controversial topics in pediatrics. Medical closure of PDAs had been the standard of care in the neonatal intensive care unit for 30 years, but recent studies have questioned the benefit of this practice.

The ductus arteriosus has been a perplexing structure since it was first described by Galen in the 2nd century AD. Initially believed to exist in order to provide additional “nourishing” blood to fetal lungs, it was not until after Harvey’s description of the nature of circulation that the true role of the ductus arteriosus could be elucidated. By the late-19th century persistent patency of the ductus arteriosus was a well-described congenital anomaly associated with various morbidities. Calls for treatment began in the early-20th century and the first successful PDA ligation was performed by Gross in 1938.

Through the following decades the PDA was found to be present at an increased incidence in premature infants. As survival of this population improved, the PDA was found to be strongly associated with respiratory distress. By the 1970s research confirmed the association between PDA and neonatal mortality and morbidity, and many centers initiated aggressive surgical treatment strategies. In 1976 the first landmark papers describing successful closure of the PDA in premature infants using indomethacin were published, leading to widespread adoption of medical treatment to close the PDA.

With the PDA’s nefarious reputation, the question of “if” PDAs should be closed was barely considered. Over the ensuing 20 years over 100 randomized control trials and 1400 papers were published examining “how” and “when” to best address the PDA. However by the mid-2000s review of pooled data revealed scant evidence for improved outcomes with PDA treatment. This culminated in a 2009 systematic review suggesting a strategy of delaying or avoiding altogether PDA treatment.

Decades of asking the wrong questions regarding PDA management has left current practitioners in a difficult position – extensive studies have not provided evidence that PDA treatment is beneficial, yet these studies were not designed to assess this question. This has resulted in wide variability of practice patterns with frustration and controversy regarding management of this delicate patient population. While the reflex may be strong to now ask the question “if” PDA treatment is beneficial, the more prudent approach may be to ask “who” would benefit from PDA treatment, with future research targeted towards identification of the hemodynamically significant PDA and assessment of outcomes following treatment of this group of neonates.

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

A View of the Next Few Years, You Won’t Need a Crystal Ball

Don Schiff, MD, FAAP

November 20, 2014 will long be remembered as the day the dysfunction of our national government reached an explosive level with a deleterious impact on the wellbeing of our Nation's children. On that date President Obama announced an executive order preventing the deportation of specific groups of immigrants and the provision of temporary work permits for many of the undocumented persons currently in the United States. The specifics of the executive order are open to debate and strong differences of opinion, but the souring effect this battle will bring to the legislative process is predictable so don't bother to look for that crystal ball. The Republican victories in the 2014 elections provides the opportunity to carry out a major plank in their campaign i.e. the repeal of the affordable care act (ACA).

Although it is unlikely that the Republicans can succeed in overcoming a certain Obama veto, legislation to repeal the act already passed over 50 times in the House of Representatives and will be passed again. Upon a failure to repeal, other efforts to partially damage or destroy the ACA will be passed. These will utilize defunding of specific parts of the legislation. We should also look for a congressional maneuver to work around the 60 vote requirement of the filibuster by a parliamentary gimmick called reconciliation. This enables the senate to pass legislation with budgetary implications with a simple majority of 51 votes.

The Supreme Court has placed the ACA in grave danger by accepting a case for review which, if decided against the government, could severely cripple the ACA. The issue under review deals with the intent of the bill to subsidize the near poor with federal funds, enabling them to buy private insurance in the marketplace. If this is disallowed in the 37 states in question, the states would have the option of creating their own markets which they have resisted. There is no data which suggests that more than a few of their members would be interested in following that possibility. The Academy and other child advocacy organizations will likely produce amicus briefs to influence the court to avoid a ruling which would destroy the ACA. We may not learn the court's decision until the later part of their session.

Next on the list of critical legislation this coming year will be the future of the Child Health Insurance Plan (CHIP). This is the highly successful lauded program which had bipartisan support from Senators Hatch (Utah) and Ted Kennedy (Massachusetts). It provides health insurance for over 8 million children and has been authorized to 2019. However funding for CHIP runs out in September 2015 and requires congressional action to stay alive. Some in the congress wish to place CHIP on the chopping block, while others are thinking about using it as a trading chip in an effort to revise funding and the character of the Medicaid program.

Expansion of Medicaid- which was an integral fundamental element of the ACA- was stopped in its tracks when the Supreme Court decided that expansion was optional and was to be determined by

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individual states. Many legislators have complained of the cost of Medicaid to each state in spite of the fact that expansion was to be 100% paid by the federal government for the first 3 years and 90% thereafter. A reoccurring effort to pay for Medicaid through a federal block grant with a specific designated sum for each state will undoubtedly be pushed in 2015. Proponents will emphasize the potential cost savings but will neglect to describe a probable cap on enrollees and benefits. The complexity of the issues described therein demands a greater effort on the part of all three branches of our federal government to understand and appreciate the effects of their actions on families and children.

Children require a sense of safety and stability in their lives which promotes their social development as well as their physical and mental health. We can help. Our actions will increasingly be directed at the state and community level, as federal funding will be challenged and significantly diminished. We will need to strengthen our local coalitions of child advocates bringing together foundations, grants, universities, charities and the media to continue the required level of services to children and support for families.

Monitoring of state Medicaid programs, including support of equal pay for Medicaid and Medicare, is vital to children and families and to our own membership. It’s not going to be easy, but by working together we can—and must—save the gains of the past few years.

Comments or questions are welcome by contacting Don Schiff, MD, FAAP at donroschiff@comcast.net.

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.
Report from COFGA: Government Under Construction

Lance Chilton, MD, FAAP

There were more pediatricians in Washington October 27 and 28 than there were Congressmen and women. Our legislators were home preparing for the fall elections, in which all of the House members and one-third of the Senators were up for election. By now you know the results, and I hope you were pleased by them.

Despite that, hard-working Congressional staff members were in their offices on Monday the 27th, receiving our visits while we talked about the AAP's top two priorities for legislation, renewing the “Medicaid bump,” in which primary care practitioners receive a payment for Medicaid services at the same rate as Medicare payments, and renewal of CHIP, the Children's Health Insurance Program, which is the only child-specific health insurance program in this country.

Sometimes it seems as if we have to run faster just to stand still. That's the case in these uncertain political times, when CHIP, adequate Medicaid reimbursement, home visiting programs, and the important federal nutrition programs for children, WIC and SNAP, all need to be reauthorized over the next year.

In my visits to Capitol Hill, I heard that everyone wants CHIP to succeed, so that one will probably be passed soon. The “Medicaid bump” is harder to be sure about. We pediatricians always speak out for kids and can make the point that insurance is great, but access to care is also necessary. If a practice can't afford to take Medicaid, it won't provide access, and children will still be wanting for a medical home. One speaker at the Subcommittee on Access session, Sen. Charles Grassley (R.-IA)'s aide Rodney Whitlock, indicated he felt that we should talk about our own needs as struggling practitioners – some agreed and some disagreed with that assessment.

Another speaker at the Access Subcommittee, Anne Filipic, is head of the organization Enroll America. As the name suggests, Enroll works hard to be sure that as many Americans as possible sign up for Medicaid, CHIP, or insurance products through the new marketplaces (“don't say “exchanges,” Enroll cautions, “they have a negative connotation – say marketplaces.”) They estimate that 16 million Americans signed up for one of these programs during last year's enrollment period, and expects another 8 million to sign up this winter (a shortened enrollment period, November 15-February 15). Enroll America volunteers and staffers are available to help with sign-up (and Enroll's statistics indicate that the more contact a potential new insuree has with a volunteer, the more likely he or she is to sign up. Senior members could easily volunteer to help with this – I suggested as much, and would be glad to hear from those of you willing to help with the effort, if not this year, then at least next year. On a personal basis, I, without any preparation, helped my brother sign up for coverage through Oregon's Marketplace – a case of the poor-of-sight helping the blind. But with a little training on how to do it, I might have been really useful. It's also important that those who signed up last year – those 16 million – continue their enrollment.
My own feeling is that there is much to be worried about and much to hope for both in the elections and the coming years. Many of us want to be involved in moving the needle in the right direction, and many of us have a role in getting there. Contact with our legislators this winter, making the best case we can for both CHIP reauthorization and funding, and for continuation of the increase in Medicaid payment, will serve both children and fellow pediatricians well.

In the meanwhile, I’m always glad to hear from any and all of you, and to take your messages and thoughts to the Committee on Federal Government Affairs and to its Subcommittee on Access. It is an honor to represent you there.

**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.


**THANK YOU BRON ANDERS!**

The Executive Committee of the AAP Senior Section extends a warm and generous THANK YOU to Bronwen Anders, MD, FAAP for serving on the Senior Section Executive Committee.

Bron helped to make several senior section programs better successes because of her contributions. Her lifelong dedication to children around the world helped us to remember to reach out to the International Child Health Section and get senior volunteers connected to those programs.

Thank you Dr. Anders!

**SOSM specific events began with our semi-annual Executive Committee meeting chaired by Arthur Maron MD FAAP. During the meeting, Dr. Maron presented a Certificate of Appreciation to retiring Executive Committee member, Bron Anders, MD FAAP.**
Senior Moments 2:
Guatemala, Nov. 30, 2014
Richard Wicklund, MD, FAAP

In March and again in June my wife, Kelly, and I celebrated our 50th wedding anniversary by travelling to Guatemala for medical missions with the Cascade Medical Team out of Oregon. The missions are also organized by HELPS International of Dallas. The teams of about 80 volunteers include medical doctors, surgeons, anesthesiologists, nurses, interpreters, a “culinary crew”, and even a stove team. We were based in a nice facility called Intervida/Santa Lucia near So Lo La, in the rural mountains. For a week we provided medical and surgical care for the indigenous people who are largely of Mayan descent.

The March team had two pediatricians; Dr. Rosalind Robertson from Ohio and myself. This was her fifth visit to Guatemala, her third mission with CMT. She is planning to return in February 2015. Our Spanish interpreters were from colleges in Guatemala City and Quetzaltenango. We also had interpreters from the community for K’ečçi’ and Kakchiquel, two of the 21 Mayan dialects in Guatemala. We examined about 250 patients that week. We sent one child to a national hospital in Quetzaltenango, where the emergency room was well staffed by physicians, residents, and medical students. There are huge disparities in economics and health care in Guatemala but obvious progress is being made to bridge these gaps. Dr. Robertson has seen the progress in basic wellness and nutrition over her several visits. Dental cavities in primary teeth remain a huge and yet unsolved situation in this community. Dr. Tom Macready, the dentist from Eugene, had been on nine previous missions. He pulled 525 teeth and treated many infections. He said that if we hadn't been there nothing would ever have been done for some of these chronic infections. “Lives were saved”. Surgical nurse Jane Flanagan from Eugene was on her 11th CMT trip. She exclaimed, “Oh, what good we do!” The teams do about 95 surgeries per year; hernias, gall bladders, gynecologic, cataracts, plastic procedures. The comadronas (midwives) program teaches modern clean childbirth and infant resuscitation. The stove team puts fuel efficient stoves in homes, replacing the traditional central open fires that have caused so many accidental burns and chronic lung problems.

The June team was blessed with nine medical students from the Philadelphia College of Osteopathic Medicine. Shazia Sohrawardy said that after the continual stress of pre-med and medical school she was “so happy to actually help people”. Mike Chin felt that this mission was very much connected

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to the local people, and gave them hope. Simple pediatric exams could give social and emotional support to children and reassurance to parents and children that they would be OK. He said that the experience had opened his eyes to see “the art of medicine” in practice. He felt privileged to be part of 90 people all working together to provide medical care and be helpful.

That week in June we did 262 general exams, 137 pediatric exams, 244 eye exams, 45 general surgeries, 20 gynecologic surgeries, 24 eye surgeries. 130 stoves and 65 water filters were placed. 2650 meals were served…. to us. Kelly helped in surgery scheduling, a difficult job with long hours.

Opportunities for volunteer service are plentiful on the internet. CMT is accepting applications for 2016. And, Oh, after six days of work, we had three days of touristy rest in the lovely historic city of Antigua. Great food, art galleries, and shopping.

Dr. Wicklund lives in Lakeville, MN. He retired in 2004, but still practices pediatrics in urgent care clinics 3 or 4 evenings per month. He also is a member of the SOSM Executive Committee.

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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.


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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, ext. 4759.
Growing up in a small, economically stable (at that time), town in Western New York State during the 40’s and 50’s, I came to believe that values such as honesty, integrity, fair play, and common sense, were universally found throughout the US. These values supported the widely held feelings of trust in institutions and optimism regarding the future of the country and for people living in the United States.

Now, as a 70+ year-old academic physician, I am deeply troubled about the state of these values in our country. The fact that in the national election this November only 36% of qualified voters (the lowest percentage since 1942) bothered to cast a ballot reflects a mood of pessimism and a lack of trust that their votes can improve either their own lot or the direction of the country. One survey after another, during the past decade has demonstrated discontent in the direction that the US is going and a general lack of confidence about the future.

Some of the general deterioration in our lack of trust in institutions, including the federal government, dates from the 60’s and the unpopular Vietnam War. The racial and economic inequities of those actually fighting the war and losing their lives in a country where many, if not the majority, of it people either did not welcome the presence of US troops and/or US influence or saw the was as an opportunity for personal profit.

Perhaps it is a bit naïve, but an assessment of life in the US today clearly suggests that unmitigated greed now motivates the majority of all too many business and even interpersonal interactions. President Obama is vilified because he wants to decrease class and racial disparities. Yet these disparities have increased during the past two decades and continue to feed hate, envy, and violence. The disparities have been fostered by both personal and corporate greed and a government apparatus dominated by the forces of big money.

Personal greed is starkly illustrated by the movie “The Wolf of Wall Street” (based on a real person). The large oil companies that make obscene profits, often destroy the environment, yet continue to take taxpayer dollars, illustrate corporate greed. Greedy corporations complain that the US corporate tax rate is higher than that in many other nations and move their manufacturing off shore to avoid US taxes, but continue to make the majority of their profits in the US. They threaten to move their headquarters to other countries but successfully lobby congress for greedy tax loopholes. Today, we are all assaulted by a never- ending volley of scams via out smart phones, computers, televisions, radios, magazines, etc.

It boggles the mind that US citizens do not understand that it is not valid or logical to blame the president for not personally solving all of our national economic problems (disregarding the enormous economic improvements in our national economy during his first 6 years in office). Congress refuses to act on (and even blocks a vote on) a multitude of legislative proposals that might allow the more robust resolution of our economic ills, especially for those in the middle class. The country badly needs a depression era type of infrastructure program to create the millions of jobs that would provide real middle class salaries and support a multitude of opportunities to train young adults for well paying, middle class jobs.

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Part of the blame for this lack of common sense appreciation of current political realities, lies in the fact that every issue and minor news event is sensationalized by our 24-hour media barrage, often without concern for the truth or accuracy of the reporting. The handling of the news is rarely unbiased or thought provoking. The excuse is: “That is what the public wants.” However, in reality, much of the behavior of mass media is really motivated by blatant greed for money from advertisers that fosters entertaining aimed at the lowest intellectual level.

To be sure government cannot solve all our problems but it can and does solve some of them by such proven, popular and generally well-run programs like social security, Medicare, food stamps, and long-term unemployment compensation. Instead of reforming our tax code to make it simpler and more fair, or avoiding massively expensive, ego driven, unwinnable wars in foreign lands (where the majority of people do not want us to be in the first place), or pass legislation to rebuild our national infrastructure, there is a push to benefit the greedy corporations and wealthy individuals. This is done at the expense of reduced funding to the above noted important and successful government programs that benefit the majority of US citizens, especially the middle class.

When I shared these thoughts with some of my intelligent and sophisticated relatives and friends, they suggested that the passage of time had clouded my memory and idealized my perceptions of my childhood. They further insisted that the world was, is, and shall continue to be, not as I remember it or wish it would be. Please tell me it isn’t so!

BAD Parrot

A young man named John received a parrot as a gift. The parrot had a bad attitude and an even worse vocabulary. Every word out of the bird’s mouth was rude, obnoxious and laced with profanity.

John tried and tried to change the bird’s attitude by consistently saying only polite words, playing soft music and anything else he could think of to ‘clean up’ the bird’s vocabulary.

Finally, John was fed up and he yelled at the parrot. The parrot yelled back. John shook the parrot and the parrot got angrier and even more rude. John, in desperation, threw up his hands, grabbed the bird and put him in the freezer.

For a few minutes the parrot squawked and kicked and screamed. Then suddenly there was total quiet. Not a peep was heard for over a minute.

Fearing that he’d hurt the parrot, John quickly opened the freezer. The parrot calmly stepped out onto John’s outstretched arm and said; “I believe I may have offended you with my rude language and actions. I’m sincerely remorseful for my inappropriate transgressions and I fully intend to do everything I can to correct my rude and unforgivable behavior.”

John was stunned at the change in the bird’s attitude.

As he was about to ask the parrot what had made such a dramatic change in his behavior, the bird spoke-up, very softly;

“May I ask what the turkey did?”
When comedians Larry David and Jerry Seinfeld created the brilliant hit comedy series “Seinfeld”, an early episode of the series has Jerry and George Costanza ‘take a meeting’ with the TV network executives to pitch their idea for a new show. They say ‘It’s about nothing.’ The executives clearly don’t seem to get it. “What, no plot; no story what kind of show is that?” That idea of ‘nothing’ turned into the ‘uber’ popular series ‘Seinfeld’ with all of the twists and turns in the everyday lives of Jerry, George, Elaine, Kramer and Newman created by the writers. Fiction it may have been, but it was in fact about relationships, emotions, opinions, events and all the usual stuff of everyday life.

As we approach another holiday season starting with Thanksgiving we need to appreciate the everyday events, the ‘nothings’ that make up what is most important in life. While maybe not Seinfeld interesting, but awakening for another day, even if finding restful sleep is a challenge, is still a big deal for many seniors. Mostly retired at this stage of my life. I still enjoy being active in child advocacy, the Vintage Docs (Seniors Committee of Chapter 1), and San Mateo CASA (Court Appointed Special Advocates) and still work in the Pediatric Clinic at San Mateo Medical Center. I term out this year from San Mateo First Five Commission after 9 enjoyable and enlightening years.

So, here is my personal recall of events this past year that for me were more meaningful then a trip abroad or a cruise. Maybe next year, but I don’t like airport travel as I never get through the scanner with my hip replacements setting it off. By the way I really don’t like happy birthday cards about getting old. It’s not that funny.

August was our 50th anniversary month. We celebrated with just our kids and grandkids in Pacific Grove, and it was wonderful. We plan to find any excuse to celebrate this year. Just as notable, was the SF Giants winning their 3rd World Series, in 5 years. I took Joe, my 14-year-old grandson to the 5th game of the Series where Madison Bumgarner (MadBum) pitched a classic.

Shopping for a new car this year, I opted for an Acura SUV with back-up camera and an extra-large screen on the dash and Bluetooth, just the basics for safety but all the new monitoring systems do seem attractive. Maybe next time.

Speaking of driving I recommend exploring the Central California Coast on trips to the southland. In particular Paso Robles for food and wine, Cambria on the coast, San Luis Obispo and the Santa Ynez Mountains are well worth a visit. On our way to our Marriott timeshare in Newport we broke up the long drive with an overnight stay near Solvang (like Carmel with a Danish). Also if you want to get your 60’s rock and roll mojo on I suggest listening to the Mamas and the Papas’ or the Jefferson Airplane with the sound up a bit while driving, but preserve your hearing.

No happy family gathering occurs without some unexpected event. This time it was a trip to an urgent care center where my 7 year old grandson Sammy received a shot of Solumedrol for a very swollen hand caused by a bee sting. As the pediatrician grandpa, I just watched as the doctor said, “Wow, that is an impressively swollen hand” Sam was better the next day and I felt better too.

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Finally getting down to the good stuff, we had a grand party continuing anniversary and assorted birthday celebrations in our villa with 20 adults and kids. This required much good eating, drinking, dancing, and poker playing all resulting in a knock on the door by resort security asking us to cool it. I think our grandkids enjoyed being at a party where their grandparents were busted for too much whoopee. Next time we will hold the party outdoors. This experience is for the family archives.

My daughter became a certified health coach this year…More about that in another issue.

While in Newport we met with our friends now living in San Diego. My friend has Parkinson’s and recently underwent DBS surgery where an electrode is placed deep in the brain to allow electrical stimulation of dopamine producing cells. He is much improved, requires less dosage of his meds and has fewer side effects. He thinks he has gained back 6 years in disease progression. It definitely improves his everyday life.

*That about sums up what I want to say on the subject of giving thanks for the everyday things in life, which become more meaningful as I get older. I have a Chinese fortune cookie saying on my desk that says “Don't worry about the stock market, invest in family”.*

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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.
Housecalls: Are They Returning?

Robert Abrams, MD

House calls were one of the primary ways of practicing medicine four to five decades when many of us senior members started practicing pediatrics.

Today physicians have abandoned making house calls primarily because it is much more cost effective to see a patient in their office. When I retired after 45 years in a pediatric practice that had grown to 19 practitioners, another physician and I were the only doctors still making house calls.

From the perspective of the ultimate costs of paying for health care House Calls could make a significant dent in the expensive way we diagnose and treat sick patient. Currently the US spends 17.9 percent of its GDP, which translates to $8,915 or 2.8 trillion dollars per year on health care.

If the patient cannot be seen in a doctors office or it is after hours or a weekend then the patients is often shunted to an urgent care center or an emergency room. Often ambulance transportation is required. One often does not realize that a trip in an ambulance can cost 100s to thousands of dollars.

Once in the emergency room there is a mandatory fee for the use of the facility-Then the ill patient will be seen by a physician or a physician's assistant because she/he is unaware of the patient’s past history feels obligated to order many often time inappropriate expensive tests.

Remaining in the comfort of ones home eliminates the need to be seen in a doctor's office. For handicapped patients, 20% to 30% of patients in a recent survey have to go to offices that cannot accommodate their needs.

A relative unique need for a home visit happened to me two years ago when the mother of a child I have been taken care of called me asking me to see her ill mother at home. Her mother was suffering from agoraphobia and her anxiety and panic about leaving the house prevented her from seeing a physician and receiving needed medical attention. She was constantly short of breath but had not seen a physician for many years because of her agoraphobia. When I did see her mother after office hours she indeed was in need of supplemental oxygen. Her pulse oximeter reading was in the high 80's. I was able to arrange for a Home Care Respiratory Service to supply her with oxygen. The family lives near my home and I periodically saw her for the next year. An internist friend of mine had a portable EKG and did visit her once to insure that she did not require any further medication. Several months later I received a call from the daughter who said that her mother had died peacefully in her sleep, fortunately before the ambulance came. The daughter added that if the ambulance had arrived when she was alive she would have died from fright.

When I first started practicing pediatrics in the early 60's making house calls to ill patients was the standard of care. In the 60’s emergency rooms were for true emergencies such as trauma and heart attacks. In the city where I practiced, Holyoke Massachusetts, all the physicians including urologist, family physicians psychiatrist, etc., were connected to a common answering service and took rotating turns making home visits to see patients who called the answering service seeking a physician. Occasionally I would see an elderly patient and since most patients managed to get better

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despite what we do I don’t recall any bad outcomes. In fact an 80-year-old woman asked me to be her physician. I explained that I was a pediatrician and took care of patients until they graduated from high school.

In 1957, when I was in my fourth year at Boston University School of Medicine a block of time in our fourth year was devoted to making home visits in the South End, Roxbury and Dorchester sections. Each morning we would review the visits we made with two medical school professors and they would critique us. Occasionally I would make the home visits with a team of a student nurse as well as a divinity student.

There is a small resurgence of Home Visit groups in several cities such as Charlotte North Carolina area Doctors Making House Calls. In New York City there is a group “Doctors on Call” where 6 physicians connected with Beth Israel Hospital in Manhattan and Maimonides Medical Center in Brooklyn work with 17 Physician Assistants and 20 Nurse Practitioners to cover all the New York City boroughs.

- I stopped my full-time practice 4 years ago after an Aortic valve replacement and a pacemaker but I still am a school physician and make weekly rounds with 3rd year Tuft students at Baystate Medical Center in Springfield Ma.

Reference:
Lagu T, sbcglobal.net SN et al Ann. Internal Med;2013;158(6)1- 17

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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
Cruise Anyone?

David Watson, MD

Cruising offers excellent value - for accommodation, meals, entertainment and travel. For our 40th anniversary we treated our family to a Caribbean cruise, and it was a great get together!

Our first cruise on Star Princess was offered through AAP in conjunction with the 1993 National Conference. Few of us took advantage of this offer, and I don’t think AAP did this again. The cruise industry has changed greatly since the days of the "Love Boat" TV show which did so much to make cruising popular. Sadly, last November we saw Pacific Princess, the original Love Boat, in the port of Kusadasi, Turkey on its way to be scrapped. In the 90s, cruise ships featured lots of food, black tie formal nights, and many ports could only be visited by tender. Evening dining was at set times at an assigned table. Midnight buffets were lavish and popular. Nearly all cruise lines were independent. The industry has grown and consolidated. Carnival Corporation comprises 11 brands including Costa, Holland America, Cunard and Princess, all with individual characteristics and appeal. Royal Caribbean has 5 lines including Celebrity and Azamara. Norwegian Cruise Lines just acquired Oceania Cruises and Regent Seven Seas. The ships are getting larger - the Love Boat had ~600 passengers, and our Star Princess ~1800. Many ships now carry ~3000 passengers and Royal Caribbean's Oasis class ships carry >5000. With larger fleets and ships, cruise capacity has greatly increased. This provides much revenue for cruise destinations, which have multiplied around the world. More and bigger piers and terminals have been built, and fewer destinations are only accessible by tender. As well as lectures, movies and stage and lounge performances, entertainment now may include miniature golf, rock climbing walls and zip lines; besides pools and casinos, ships usually have art galleries, spas, exercise areas, specially staffed facilities for teenagers and younger children, and boutique shopping. Dress is less formal, seating often "freestyle", and food quality is emphasized more than quantity.

There are many cruises to choose from. Itineraries vary from 3 day trips to Round the World cruises. Cruises at holiday times and during school breaks may cost more. Transoceanic cruises tend to be good value. Disney Cruises appeal to families, many lines cater to all ages, some are more adult oriented. Passengers with disabilities are welcome. Cruise lines most familiar to us cater to North Americans - the majority of passengers are from the US or Canada, with quite a few Britons, some Antipodeans, and a few (mostly north) Europeans and Latin Americans. With so much capacity, cruise lines compete for passengers - needing to fill each ship. Much of their revenue is from extras - beverages, excursions, the casino, photo shop, art gallery sales etc. Cruises may be booked directly with the cruise line, from a travel agent or from an online travel company. There are brochure fare prices, but 2 for 1 and/ or early booking rates are always offered. Cruise lines compete by offering cabin upgrades, free air, free internet, free beverage packages, free pre-paid gratuities etc. Some last minute deals may be offered, but booking early gets choice accommodation at a good price. More cruise lines now include or offer arranged air travel, usually from major US and Canadian airports. This can save money and be convenient. When the cruise line arranges your flights, it's their responsibility to get you on the ship if your flight is late or cancelled. They pick the airline but you can collect air miles. Otherwise it's wise to arrive a day ahead. Pay for cruise insurance - it's worth it. Norovirus and other outbreaks are rare, but frequent hand washing is wise, and consider adding remedies such as Imodium, Neosporin and Ibuprofen, plus sun block and insect repellent if appropriate, to your regular medications. You can book excursions or other services before sailing, but most options are available on board. At some destinations you may decide to be on your own, but be sure to re-board on time.

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Cruise Anyone? Continued from Page 22

-I am a 1952 University of Toronto graduate. I practiced and taught pediatric cardiology at the University Medical Center in Jackson, MS from 1959 to 1993 when I retired and later moved to Sandestin, FL. We spend our summers at our cottage north of Toronto. We enjoy photography and travel, often visiting our 4 children and 9 grandchildren, who live across the country, from Brooklyn to San Diego.

THE LOST ART OF CONVERSATION

Jeanette Martin, MD, FAAP

Since fully retiring four years ago, I venture out from home only for necessary chores or social duties. When I do go out, I frequently return home disgruntled, sad, disappointed, and occasionally mad.

Today was a good example. After going into town to pick up special dog food from my vet, I decided to eat a late lunch/early supper at one of my favorite cafes, a popular place which is usually very busy.

Seated in a corner near a front window and adjacent to a table where a mother and daughter sat, I listened to their lively conversation and watched as the mother helped the girl with a puzzle provided by the establishment. I asked the girl if she went to school: first grade. We exchanged a few more pleasantries before food arrived.

Another family came in and sat close by: a grandmother, mother, a young girl (she looked about the same age as the first child) and three teenage boys. The young girl was scowling as they came in, never took off her heavy coat, and only became content when her mother got out a mobile device for her to play games on. The oldest looking boy also got out a mobile device, as did the grandmother. They tweeted, twittered, Googled or whatever they were doing but rarely spoke to each other. Only after their food came did an occasional word pass among them.

I have seen this on too many occasions, sometimes when a whole group gathered for a meal will sit and concentrate on their mobile devices.

I’ve thought “Could this be one of the factors in the breakdown of the American family?” The getting together of a family at meals to socialize, discuss family happenings, etc., being supplanted by the invasion of global “Social Media”.

A good friend reports that spontaneous conversations while waiting, for example, in doctor’s or dentist’s offices or car repair shops have been virtually eliminated when she’s the only one not zoned in on a mobile device.

Luckily for me today I had the first mother-daughter leave me with a little ray of sunshine to bring home.

Dr. Martin retired from pediatric practice in 2009 but worked part-time until late 2010 before really retiring to her cabin near Bristol, Virginia. This is her first submission to the Senior Bulletin, and we hope she will send more!
MOVIE REVIEWS . . .
Lucy Crain, MD, FAAP

THE JUDGE
Released October 2014, this complex legal drama is generally fast paced, but has many diversions into family drama, return to home town, endearing adult brother with disabilities, and high school sweetheart re-connection which helps explain the length of the film. (Does 141 minutes sound shorter than 2 hours 21 minutes?) R rated for language, the setting in small town Indiana couldn't be more beautifully filmed. The story begins with courtroom scenes of Judge Palmer (acted by Robert Duvall pronouncing sentence in his no-nonsense manner) and almost concomitantly, scenes of his successful west coast attorney son played by Robert Downey Jr (perhaps his best dramatic role ever) then flying back to his mother's funeral in his hometown, from which he had moved immediately after law school. Family drama ensues as Downey's character-long estranged from his father-reconnects with his two brothers, his high school sweetheart, and others. The lawyer son returns to his law practice, only to be summoned back to Indiana to defend his father, the judge, who is charged with the murder of a young man whom he had sentenced to prison for killing a young woman. Billy Bob Thornton plays the prosecuting attorney with his usual slick depiction of competence and vindictiveness. The plot is further complicated by Judge Palmer's increasing evidence of dementia and the conflicts between and among family members. You have to see it to learn if the son saved his father from prison and to know whether the father-son hatred was ever resolved. It's well worth the time to do so.

ROSEWATER
Touted as Jon Stewart's directorial debut, this movie is a serious departure for the well known U.S. comedian and news satirist. The film script is based on the book (Then They Came for Me: A Family Story of Love, Captivity, and Survival) written by Mazier Bahari, an Iranian born Canadian citizen who is a London based journalist for the BBC and Newsweek about his 2009 arrest while covering election related riots in Tehran. The movie opens with brief documentary footage of the manufacture of rosewater and its uses (one of which is a perfume spray). With a stellar international cast including Gael Garcia Bernal playing Bahari, Kim Bodmi as Janadi (Rosewater), and the Iranian actress Shohreh Aghdashloo (an Oscar nominee for her role in the 2002 film “House of Sand and Fog” with Ben Kingsley) and others, this film covers torture from a different perspective.

Bahari was assumed by Ahmadinejad's government to be a spy because of a satirical interview in Tehran by Jason Jones, cast member of Jon Stewart's “Daily Show”, and his coverage on BBC of Mir Housseim Moussari's challenge to the incumbent in the 2009 election. Stewart's decision to make a movie may be based on his sense of guilt for assigning Jones to his interview, never appreciating the gravity of implication of guilt by association and lack of any semblance of appreciation of humor or comedy by the Iranian government. Bahari endured 118 days in solitary confinement, beatings, and various acts of torture. He was denied books, media, access to internet, news, and family, leading him to state “There are all forms of torture.” Finally, led by his strong willed mother (played by Aghdashloo) and others, outcries from international social media sources convinced the government to release him. Bahari could easily have been killed, and by accepting his role in Bahari's capture, false charges, and imprisonment, Jon Stewart has served his sense of moral responsibility and directorial debut well in directing and producing a serious and provocative film worthy of recognition. (R rating for language. One hour 43 minutes. Released November 2014.)

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THE IMITATION GAME
Directed by Marten Tyldum with Screenplay by Graham Moore, this film depicts the laborious decoding and solution of Nazi Germany’s Enigma code during WWII by a group of British cryptographers and mathematicians. Starring Benedict Cumberbatch as Cambridge mathematics professor Alan Turing and Keira Knightley as the only female cryptographer of the team, the plot is of historic interest. Churchill attributed breaking the Enigma code as crucial in saving millions of lives and leading to the Allied victory. Much of the 113 minutes of the movie is spent focusing on the whirring of the decoder machine (“Christopher”), disjointed flashbacks to Turing’s youth, the outing of his homosexuality and the punitive treatment of this by the British military. Rated PG 13.

THE THEORY OF EVERYTHING
Starring Eddie Redmayne and Felicity Jones as astrophysicist Stephen Hawking and his first wife Jane Wilde, who met at Cambridge as graduate students. The script is based on Jane Hawking’s book, Travelling to Infinity: My Life with Stephen, and is very much a love story which is tragically complicated by Hawking’s diagnosis with ALS at age 21, shortly after they had become engaged to marry. Jane’s strength and perseverance provide balance and support for Stephen’s impressive intellect and need to pursue scientific discovery long beyond his initial prognosis of two years. The intimate glimpses into the family life of this remarkable scientist and his wife and three children make this a film well worth its 123 minutes. PG-13.

NIGHTCRAWLER
Also recently seen.. Good acting by Rene Russo and Jake Gyllenhaal playing a thoroughly despicable sociopath in a genuinely creepy movie about the worst of late night news coverage. R rated for everything. 117 minutes
You've got FAAN Mail! As Section members have hopefully observed over the past few months, you have started receiving regular communications from the AAP's Washington office. That is because, consistent with Section members’ growing interest in and enthusiasm for advocacy, every member of the Section has been enrolled in the Academy’s Federal Advocacy Action Network (FAAN): you are all now officially AAP Key Contacts.

What is FAAN mail?
The FAAN mail you receive can be informational, or request an action. Receiving FAAN mail means that you are the first line of communication from the AAP’s Washington office on matters pertaining to child health at the federal level.

One type of FAAN mail you receive is the weekly Friday legislative update, where brief summaries of the week's happenings in Washington are mixed in with “what we're reading,” snapshots of pediatricians participating in advocacy events and even a “rhyming recap” written by the humble author of this newsletter article who also serves as AAP’s unofficial poet-in-residence.

What does this mean for Section members?
Section members, as Key Contacts, will be the first to know about upcoming advocacy trainings, first to receive requests to weigh in with Congress on time-sensitive bills advancing through Congress, and first to read key press statements issued by the AAP on topics like immigration reform, Medicaid payment equity and e-cigarette liquid nicotine poisoning. Section members will now be in-the-know on all things federal advocacy.

What can I do to become a #1 FAAN?
The Section is a powerful and needed voice for senior members of the Academy in topics of federal advocacy. Here are a few ways you can make your voice heard as a federal advocate:

- **Advocacy Spotlight:** We are turning to the Section for nominations of fellow Section members or pediatricians you know through other connections for our “Advocate of the Week” spotlight series in the federal update, where we interview a pediatrician who has made an impact through federal advocacy. If you know of a pediatrician who goes above and beyond speaking up for children at the federal level, please email your nomination to kids1st@aap.org with the subject line “Advocate of the Week Nomination” and AAP Washington office staff will follow up.

- **Attend an advocacy training:** Whether you are refreshing your advocacy skills or attempting to learn for the first time, we would love to see more Section members in Washington at the AAP’s Legislative Conference, April 12-14, or at any other advocacy trainings offered throughout the year. Visit http://federaladvocacy.aap.org/trainings to learn more.

- **Write an op-ed or letter-to-the-editor:** If there is a federal policy topic you are especially passionate about, consider writing to your local newspaper with your perspective. For help submitting and writing an op-ed, please email me at jposlosky@aap.org.

On behalf of the AAP Washington office, thank you for all you do to advocate for children. I look forward to working with you to amplify children’s needs in the halls of Congress.
Symbiotic Generosity:
Gifting Options That Benefit Both Donor And Recipient

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

There are a number of reasons to give to charitable causes. From a purely financial standpoint, gifts to a charity during lifetime or at death will reduce the size of the gross estate, which may reduce or even eliminate the amount of estate taxes due at death. An additional benefit of lifetime gifts is that a current income tax deduction is available, within certain percentage limitations.

If the estate owner, based on their current financial situation, is not willing or able to contribute an entire financial asset during their lifetime, he or she may consider a split interest, deferred gift. The ownership interests in an asset can be split or divided into two parts, a stream of income payable for one or more lifetimes, or a term of years (the income interest) and the principal remaining after the income term (the remainder interest). When the estate owner retains the right to the income but transfers his or her rights in the remainder to a trust, it is called a charitable remainder trust.

To qualify for an income tax deduction the trust must be a unitrust, an annuity trust, a pooled income fund, or a charitable gift annuity.

- Charitable remainder unitrust: In this type of trust, the donor retains the right to a fixed percentage of the fair market value of the trust assets, with the trust assets being re-valued annually. If the value of the assets increases, so does the annual payout, and vice versa.

- Charitable remainder annuity trust: This trust is similar to the unitrust but instead pays a fixed dollar amount each year.

- Pooled income fund: Assets are transferred to a common investment fund maintained by the charity. Each donor receives annually a share of the income from the fund, in proportion to the contribution made. These annual payments continue for the donor and spouse lifetimes. At death, the corpus of the donor's gift, together with any capital gains, passes to the charity. Payments will increase or decrease with the investment performance of the fund.

- Charitable gift annuity: The donor transfers the asset directly to the charity, in exchange for the charity's agreement to pay a fixed lifetime annuity.

The amount of the income tax deduction is dependent upon the percentage of the income interest and the period over which it will be paid (usually the life of the donor and his or her spouse). This calculation is determined from the mortality tables published by the government.

On the other end of the charitable gifting spectrum are those individuals who want the charity to receive only the income, and not the asset itself. A charitable income or lead trust is the reverse of the charitable remainder trust. The income interest is assigned to the charity, usually for a period of years, and then the remainder generally passes to the donor's heirs. The amount of the estate tax deduction and the amount left for the heirs will depend upon the number of years income is to be paid to the charity, the size of the annual payments, and the investment results achieved by the trustee.

There are many factors to consider prior to implementing any type of charitable trust strategy. To determine if it makes sense for your particular situation, be sure to consult with your tax and estate planning advisors.
So today (May 12th) was the day of reckoning, at least that is the way it felt.

A month ago I received a letter from Intermountain Health Care (IHC) asking me to take a forty-five minute cognitive test since I would turn 72 by the end of the year. This was a new requirement IHC had decided on for those of us wanting hospital privileges and participation in provider panels.

At first I was both astounded and miffed. It felt like ageism, perhaps an effort to pare down the number of senior physicians participating in IHC hospitals and insurance. I questioned a friend of mine who had been an ACLU lawyer. Her response was lawyerly and equivocal.

I debated bagging the whole thing; not taking the test and taking the professional consequences. But finally acquiesced and set an appointment for May 12th.

I had a month to fret. Friends suggested checking out Lumosity. I practiced subtracting from one hundred by sevens. I even figured out a plan to assess whether the person administering the test had a sense of humor.

If she asked me who the president of the United States was I would say, “Millard Fillmore.” If she did not laugh I would be in trouble.

I never got a chance. The test was an hour worth of a variety of challenges: a couple of paragraphs I was supposed to recall (they were presented at the beginning of the test and then queried unexpectedly at the end), a sequence of six numbers I was supposed to recall and then repeat in reverse order, complicated math problems (I discovered after the test was over that Siri knew the answer but I did not), recognizing aberrant patterns in a sequence, and a couple more conundrums. By the time I finished I was resigned to failure. My right hand (used for responding on a mouse) was shaking.

Knowing I had to do the test was stressful. I had had a month to wonder what it would be like and what if I failed? Taking the test was both stressful and infuriating.

The test was administered at the Administration office at LDS Hospital. Arriving on time, well rested I just wanted to get the damn thing over. Not knowing the implications of failure intensified my anxiety. I have not felt cognitively impaired in the least. I seem to think clearly, at least in a medical setting. I know when I do not know the answer to a medical problem and how to find it out or to whom I need to refer a patient.

Furthermore, I have a plethora of jokes in my head, easily told without hesitation.

Who, then, is the judge of my cognitive acuity? Would I need to see a neuro-psychologist if I was found impaired: this is the plan IHC has set up. Would I begin to question my abilities? Would this suggest that I might retire before I intended to?

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Cognitive Blog  Continued from Page 28

I felt like the victim of a presumptuous medical system. It was totally unclear what the relevance of the test was to my medical decision making.

Clearly this dilemma was not one Millard Fillmore had encountered.

I am a pediatrician in solo practice in SLC, Utah. I graduated from CWRU School of Medicine in 1970, did a mixed internship at Mt.Zion Hospital (SF), entered the Indian Health Service (Wind River Reservation in Wyoming), completed by pediatric residency at the University of Utah, and have been here ever since. I worked in a local HMO for five years, joined the faculty at the University of Utah for five years, and opened my practice in 1985.

Most of my medical learning has been experiential (29 years of practice) and I consider my general pediatric practice intuitional rather than relying on new technology, lab work etc. One of the most interesting aspects of my practice is helping patients deal with uncertainty, a concept that is occasionally difficult for them to handle.

My primary peripheral medical interest is medical humanities and I have published articles in The New England Journal of Medicine, Annals of Internal Medicine and on physician authors.
Son-in-Law Occupations

Joseph A.C. Girone, MD, FAAP

Any parent, with marriage-eligible daughters, has pondered about their potential son-in-law's occupation. Let's consider some of the possible fantasy jobs.

The ideal son-in-law should be a plumber with heat and AC expertise who lives nearby. Wouldn't a parent sleep better knowing that blocked toilet or lack of AC will be taken care of the next day at no charge? Two hobbies for his time off should be hair cutting and gourmet cooking.

Another “valuable” occupation is electrician. How many times has the circuit breaker malfunctioned or have you had a ceiling fan installed? Need an electrical outlet, ceiling lights or a lighting fixture? Done. A bonus would be having an intense interest and expertise in computer hardware and software.

A guy who owns a hardware store deserves serious consideration. Our “Ace” and “True Value” stores can provide almost all of your non-food needs. Imagine an endless discount on any of your hardware purchases. Over time, this would even surpass a chef or diner owner.

A carpenter is frequently needed for home improvements and additions. Watching your accountant son-in-law use a saw and hammer isn’t pretty. Let’s turn that basement into a family room. A room addition, moldings or decorative trim are always welcome.

In the unfortunate situation where one of these contenders can't happen, high on your list would be an automobile technician or a house painter.

Engineers, teachers, bankers, physicians are noble professions. It feels good to have a son-in-law in any of these occupations, but I feel good when I hit a nice golf shot. Give me a plumber, on that wedding day.

I've been in the Senior section for many years and have been fortunate to have several pieces in the Bulletin. In Winter 2014 I had “The Great Joetini”. Spring of 2013 I had a book review of Proof of Heaven. My favorite was in the Bulletin 17:3,2008- “The High Tea Gene”.

I live in Franconia, PA and I do part time Developmental Pediatrics consults at Reading Pediatrics in Wyomissing, PA.

Have an Issue?
Join the Section on Senior Members Listserv by contacting tcoletta@aap.org

For more information or to join the section... visit our website at: www.aap.org/seniors
To the Editor:

Your puzzle on page 3 of the Senior Bulletin for the Fall of 2014 was challenging enough as it requested us to recognize the twisted hidden palindromes that they all shared. However your comment was incorrect. You asked that we look carefully to figure out what these seven words “all have in common.” I agree that they all have in common the response to the shift of their initial letter to the end, which alters them into palindromes. However, this does not make it wrong to point out that they also have in common two double letters, that they all are English words, that they all start with capital letters, that they all are printed on the page 3, that they are part of the same puzzle – one could go on, but there is no need. So, please continue feeding us with these indigestibles, have us render them digestible, and bear in mind that what we all have in common is our profession, pediatrics.

Regards,

Michael Katz, MD

* * *

Dr. Katz,
Thanks for your comments. I appreciate both yours and the original comments from our unidentified colleague, who chose to omit his name as author. I think that his comments were not “incorrect”, but a different perspective on an entertaining exercise. Please send more submissions. We can always use them in the Bulletin.

LSC

Lucy Crain, MD, MPH, FAAP
Editor, AAP SOSM Senior Bulletin
Clinical Professor of Pediatrics Emerita, UCSF
Adjunct Clinical Professor of Pediatrics, Stanford University
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!

Jamie Poslosky, Director of Advocacy Communications, AAP
MYSTERY PHOTO: Can you identify these stragglers on Segways while the rest of us were attending scientific programs at the NCE?
The annual AAP NCE provides a wonderful opportunity for AAP Section on Senior Members (SOSM) to meet old friends, learn, and frolic in a wonderful location. 2014 was no different. We are pleased to share with you some of what happened at SOSM specific events. We also invite you to CLICK HERE to learn more about specific AAP NCE education and event highlights detailed in AAP News Today meeting highlights. (Editor's Note) Select and click on the blue hyperlink for the meeting day that you'd like to view.)

SOSM specific events began with our semi-annual Executive Committee meeting chaired by Arthur Maron MD FAAP. During the meeting, Dr. Maron presented a Certificate of Appreciation to retiring Executive Committee member, Bron Anders MD FAAP.

In other business before the Executive committee, Dr. Lance Chilton gave a report on the AAP Council on Federal Government Affairs. It was proposed for consideration that SOSM plan a potential webinar on child advocacy opportunities for AAP SOSM members. SOSM Executive Committee also discussed the dramatic increase in SOSM membership related to changes in AAP Membership categories, updates to the SOSM Strategic Plan, 2015 NCE Programming and SOSM webinars. It was a productive, but too short according to some, meeting.

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Sunday October 12, 2014 was the AAP NCE highlight for SOSM as we held our annual AAP NCE CME in a packed room moderated by SOSM Program Chair – Jim Shira MD

AAP SOSM members and other fellows and guests filled the meeting room.
The 2014 AAP NCE highlighted a unique collaboration between AAP SOSM and the AAP Pediatric History Center – a Pediatric History Poster Session in the Exhibit Hall. Dr. Shira included brief presentatons from the 3 Top History Poster presentations during the session. While all of the posters were excellent, the following posters were recognized as the “Top Three”:

**Pediatric Emergency Medicine: The First 40 Years**  
Jane F Knapp, MD, FAAP

**Picking up the Pebbles: Lost in the Forest of PDA Treatment**  
Justin Elhoff, MD, FAAP

**Lasting Innovations from the University of Wisconsin Department of Pediatrics**  
Ellen R. Wald, MD, FAAP

(Editor’s Note - SOSM has requested and plans to post the PowerPoint presentations of all of the participants as we receive them.)

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All of the Pediatric History Posters were displayed in the Exhibit Hall. A collage of several of the posters follows to provide readers with a sense of the exhibit.
For more details on the AAP Pediatric History Center, and the History Poster project visit the AAP Pediatric History Center. While there, listen to some of the Pediatric Oral Histories. Simply CLICK ON Collections.
As always, AAP NCE provides a wonderful opportunity for SOSM members to enjoy each others company, visit the AAP Exhibit Hall and get “free stuff that one can use”, e.g. sun-protective hats as recommended by Dr. William Crain during his presentation, meet with former residency colleagues, and explore the host city in unique ways.

Mark your calendar now for us to be together at the 2015 AAP NCE in Washington DC October 24-27, 2015.

Finally, remember, you still have an opportunity to review/visit/enjoy AAP NCE San Diego by reading AAP NEWS TODAY for each day of meeting. CLICK HERE
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.

2015 Senior Bulletin Schedule
Editor – Lucy Crain, MD, MPH, FAAP
lucycrain@sbcglobal.net

Spring Bulletin
March 2 call for articles sent
March 16 articles due to Tracey
March 23 first draft
March 30 second draft
April 3 final copy to printer
April 10 post office dropw
April 17 mailboxes

Summer Bulletin
May 11 call for articles sent
May 26 articles due to Tracey
June 5 first draft
June 12 second draft
July 6 online

Fall Bulletin
July 21 call for articles sent
August 11 articles due to Tracey
August 25 first draft
September 2 second draft
September 8 final copy to printer
September 14 post office drop
September 25 mailboxes

Winter Bulletin - Electronic
November 20 call for articles sent
December 2 articles due to Tracey
December 17 first draft
December 30 second draft
January 11, 2016 online