Senior Bulletin

AAP Section on Senior Members

Editor: Lucy S. Crain, MD, MPH, FAAP
Associate Editors: Carol Berkowitz, MD, FAAP
Michael O'Halloran, MD, FAAP
James Reynolds, MD, FAAP
Donald Schiff, MD, FAAP

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Message from the Chairperson

Arthur Maron, MD, MPA, FAAP
Chairperson, Section on Senior Members
artmaron@aol.com

We hope this Fall Issue of our Senior Bulletin captures your interest and continues to meet your expectations. Our diligent devoted editor, Lucy Crain, has made every effort to make the articles relevant, educational and entertaining. As you may have noticed, our leadership has decided to have two print issues (Spring and Fall) per year and two issues (Winter and Summer) sent electronically. As we consider the relative merits of each delivery modality, your input is encouraged and important. Please let us know what you think of the print versus the cyber version.

As I prepare this message in mid-August, we are all being overwhelmed by media coverage of three major issues: disturbances in police handling of law and order; the proposed nuclear treaty with Iran; and the tumultuous presidential race into 2016.

It is apparent that a miniscule number of poorly-trained and/or poorly-motivated

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What's Inside?

Section on Senior Members Executive Committee

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Membership • Stanford Singer, MD, FAAP

Web Master • Jerold Aronson, MD, FAAP

Newsletter Editor
Lucy S. Crain, MD, MPH, FAAP
lucycrain@sbcglobal.net

Staff
Jackie Burke
Section Manager
jburke@aap.org

Tracey Coletta
Section Coordinator
tcoletta@aap.org

Mark A. Krajecki
Journal Production Specialist
mkrajecki@aap.org

Message from the Chairperson

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police officers are tarnishing the image of the vast number of dedicated and professional police officers. It was particularly distressing to me to recall the civil unrest and rioting in New Jersey in 1967 while watching the repeat scenes in Baltimore nearly 50 years later. Even as the AAP addresses the effect of poverty on child health, we need to consider the danger poverty brings to our very future as a healthy society.

The fate of the nuclear deal with Iran may be settled by the time you read this, but the implications for world peace will still be a source of debate. Every one of us is concerned about the world in which our progeny will live, and it is easy to become depressed.

As of today, the most unlikely match-up of Donald Trump and Bernard Sanders for the 2016 presidential election is upon us. The sick circus of presidential politics is the "perfect storm" which has resulted from the outrageous influence of special-interest groups, the injection of huge amounts of money into campaigns, the inability or unwillingness of Congress to legislate, the unspeakable depths of negative campaign advertising, and the pandering of candidates to their supporters rather than honestly defending their positions. The success of a non-politician may be a wake-up call for all of us.

I apologize for these rants, but hopefully I have stimulated some of our readers to respond and lend their opinions and insights to the discussion. Let's hear from you.

Section on Senior Members NCE Program

SOSM Education Program Chairman Dr. James Shira

Senior Matters: a discussion of important senior member interests

Sunday, October 25

8:00 AM – 12:30 PM

Renaissance, Ballroom West Salon A

Description: Issues of importance to senior-aged physicians are ever changing. This program provides a forum for senior AAP members to discuss issues of importance.

1. Learn about ways to optimally cover yourself with medicare and supplemental insurance.
2. Learn of ways to volunteer in food banks and other programs to help feed hungry families.
   A CASE STUDY FROM SACRAMENTO, CA WILL BE PRESENTED.
3. Learn about the process and issues to be considered when considering retirement from practice.

Agenda:

8:00 Welcome – *Jim Shira*

8:05 AM	Beyond Medicare: What coverage do you need? *Ariel Gonzalez, Esq., AARP*
8:55 AM	Hungry Children in the United States: How can senior pediatricians make an impact? *Andrew Racine, MD, PhD, FAAP, Chair, AAP Work Group on Poverty and Child Health*
9:45 AM	Break
10:00 AM	Markers for Retirement *Jerald Zarin, MD, MBA, FAAP*
10:50 AM	BREAK
11:00 AM	Section business meeting and presentation of Section Award
11:30 AM	Section lunch and socialization
12:30 PM	Adjourn

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.

SOSM International Volunteer Webinar

Jerold M. Aronson, MD, FAAP

On May 20, 2015, over 200 AAP Fellows attended the 4th SOSM educational webinar on International Volunteers in Child Health. The webinar, produced in collaboration with the AAP Section on International Child Health (SOIC) featured Chris O'Callahan MD. Dr. O'Callahan, a member of SOICH, has extensive personal and continuing experience in international child health primarily in Central America as well as in other locations throughout the world. Dr. O'Callahan clearly presented the risks and benefits of volunteering as a pediatrician providing direct care or education in exotic locations and issued a call to action to those in attendance. We urge you to view his recorded presentation on our SOSM website https://www.youtube.com/watch?v=HUlaEbNyr7Q&feature=youtu.be ON DEMAND and to make good use of the many AAP resources available on the AAP International Health website http://www2.aap.org/sections/ich/.

Almost 25% of attendees completed a SOSM Webinar Survey: Dr. O'Callahan's presentation was well received and received high marks for quality and content. Pediatricians from all time zones in the US participated with the largest percentage of attendees representing the Eastern Time zone. While most attendees were aged 60-70 years of age, 35% of attendees were > 70 years of age. 75% of attendees participated from their home office. Of note, 37% described themselves as AAP Fellows but neither members of SOSM or COICH. This may provide an interesting opportunity for Section recruitment options. For example, since Attendees represented approximately 50% of the pre-webinar registrations, it may be beneficial to include SOSM enrollment as an option during the SOSM webinar registration process, if not already enrolled. Continuing support for SOSM webinars during the mid-week noon hour was documented. Members perceived the webinars as a good and valuable member benefit. The following topics were suggested for future SOSM webinars:

- More on International Child Opportunities
- Information on Domestic pediatric volunteer opportunities
- Challenges/opportunities for pediatricians interested in re-entry into pediatrics, and/or PT jobs.
- Volunteer options for those currently employed rather than retired.
- Practical pharmacology of interest and importance to Seniors.

Click here https://www.aap.org/en-us/Documents/sosm_2015_survey_results.pdf to view the complete results of the SOSM Webinar Survey.

SOSM leadership is interested in your opinions, recommendations, and suggestions. All comments welcome to SOSM Webmaster and SOSM Webinar Manager jmaronson@aap.net.

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.

Winter Bulletin - Electronic

December 2 articles due to Lucy Crain, MD, MPH, FAAP

January 11, 2016 online

Willed Body Programs

Wm. R. Brown, Jr., MD, MPH, FAAP
Assistant Clinical Professor
Department of Pediatrics
John A. Burns School of Medicine
University of Hawai'i at Mānoa

Renewed involvement in academic pediatric medicine has opened new horizons regarding 21st century health care. Power Point, telemedicine, drop boxes and EMR are slowly becoming familiar.

Through the department of anatomy here, I have learned of and registered for the Willed Body Program to serve as a "Silent Teacher" for future students. Fifty-three years ago, the first day of anatomy at Kansas University Medical Center, we were read a letter from the individual whose body was used by the prosector on instructional closed-circuit television. She was the wife of the orthopedics department chairman who wrote how much medicine had family meant to her family and of her desire to assist in the education of future physicians in this manner. My Daddy at age 95 elected to do the same thing.

The program here in Hawai'i is very well executed. Comprehensive literature and application is readily available. I've researched enough to know that many academic institutions have similar programs. I write to encourage section members to investigate the possibility of making such a thoughtful donation locally and to encourage colleagues, family and friends to do so.

There is an annual service for the families and friends of the past year's donors, which is truly wonderful. First and second year students speak personally by name in appreciation for their "silent teachers" at this gathering. A hula is performed by students, their lei placed with the cremains of their "teachers." Any family choosing to have the ashes after the service may do so. The others are taken in double-hulled outrigger canoes out to sea by other students, the ashes distributed at sea with tropical flowers and lei. The DVD of this event is quite moving.

At a time when end-of-life planning and preparation is appropriate, individuals are counseled regarding long-term care insurance, legal and medical power of attorney, terminal care directives, and financial planning. Additional thought could well be spent regarding organ donation terminally as well as willing one's body for medical education.

As seniors in our field which relates primarily to the opposite end of life's spectrum, consideration of future generations of physicians and specialists by contributing in this significant manner is to be encouraged. Myself just having celebrated my Diamond Jubilee Birthday, I look forward to the next twenty-five years as one of professional service and volunteering; "silent teaching" will have to wait a while.

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

A Low Profile Marvel

Joseph A.C. Girone, MD, FAAP

It was invented in 1927 by John W. Hammes, an architect working in Racine, Wisconsin. He applied for a patent in 1933 that was issued in 1935. This controversial invention is one of the most underrated and widely used innovations. The ban of this novelty in New York City was rescinded in 1997. Mr. Hammes' **InSinkErator** Company put his disposer on the market in 1940. People throughout the world use this magnificent contraption daily yet hardly a mention at cocktail parties. Garbage disposers work well and are relatively inexpensive so no complaints from old-timers when replacement is necessary.

Perhaps it is too painful to think about the time it didn't exist. As a senior, I remember that time and I will remind you. Your appreciation of this wonderful device is about to shoot up. I must warn you. This may bring back some unpleasant memories.

Garbage is not the subject of authors, reporters, poets or playwrights. Its journey usually starts in the kitchen and then moves on. The unpleasantness starts with a unique eyesore, quickly accompanied by a foul odor. The displeasing experience changes from day to day, depending on the make-up of the discarded food. The result is one never being able to adapt to handling this mess.

Without a disposer, the garbage begins its travels to its final resting place in some type of non-porous container close to the kitchen sink. It remains there until the container is overflowing or the smell is intolerable. Some poor soul then transfers the refuse to the household garbage can. This article is placed outdoors, usually far enough from an outside door to escape the odor. Most importantly, the garbage can must have an airtight lid that is always securely in place. This keeps the unpleasantness in the can and also reduces visits by hungry, unwanted guests who live outdoors in the neighborhood. The content of the garbage pail provides a scientific educational opportunity. You may recall seeing small, pale white objects wiggling on the mess in the can. They turned out to be maggots and you were stunned by the fact that they will become houseflies. This was an introduction to the wonder of complete metamorphosis.

Living in a city with close-by neighbors made the garbage disposal more memorable for me. The family garbage can would be emptied on the day when the garbage collection truck came by. Usually, this happened once a week. It involved all of the homes on a city block placing their garbage can by the curb. Pedestrians were not happy strolling on that block. Now we get to the piece de resistance of garbage disposal and the reason we should honor Mr. Hammes. The truck, dedicated to garbage, could appear after 12 noon on a summer day. The 90+ degree temperature intensified the odor. The ghastly smell persisted throughout the entire time the open truck was on the street. The CIA has considered recreating this garbage collection environment to be part of their intensive interrogation program. No human olfactory sense could tolerate the fierce disgusting odor for long. After they were emptied, all of the cans remained on the sidewalk without lids. This unbearable situation persisted for some time before all of the cans were retrieved by every household.

Next, we had close family involvement. Each family determined who and how the empty can was handled. This is a time when you did not want to be an only child. Many parents wanted the can hosed down, the lid put on and the can replaced. What a blessing when the hose down chore was shared and not your turn.

So, the next time you scrape your plate into the sink with a garbage disposal, take a moment to thank Mr. Hammes that you don't have to wash out the garbage can.

LETTERS TO THE EDITOR:

THE WRITTEN WORD

Mark Scott Smith, MD, FAAP

I retired from the University of Washington as an emeritus professor of pediatrics in 2006. After a year of full retirement on the Oregon coast, I missed practicing medicine and found a position once a week as a pediatrician for the local county health department. About a third of my patients were Mexican immigrants and I was able to practice my intermediate Spanish as well. It was a delightful experience until the grant ran out three years later.

Thinking I was finally completely retired, I was surprised when the county hospital opened a clinic in my little town of Manzanita and asked me to be their pediatric consultant twice a month. After two years, I finally retired from pediatrics completely to concentrate on research and writing.

After UW retirement, I developed a passion for creative writing with a particular interest in human consciousness during wartime (see my blog enemyinmirror.com).

In 2012, after several years of research and visiting historical sites in Japan and Oregon, I self-published a novel entitled Enemy in the Mirror-Love and Fury in the Pacific War based on actual events during WWII.

I am currently working on a history-inspired novel about the Battle for the Atlantic in 1942. My two protagonists are a Mexican-American B-25 pilot and a German U-boat commander.

Thanks so much for your interest.

The mimeograph machine, with its hand-turned drum, was secreted away, amidst the cobwebs, in a two century-old storage room that would later become my adolescent bedroom. As a 8-year-old reporter, I compiled canine news from our North Sylvan Road neighborhood and submitted my hand-written Dog Tales column to the editor who happened to be my 14-year-old sister. She would then type it onto a stencil through which ink would be forced onto blank sheets of paper rolling through the printing press as we cranked its handle. I can still smell the volatile aroma of printer's ink and feel the oily black coat that inevitably covered my fingertips after turning out a new edition of our newsletter.

I don't recall the details of cursive lessons in elementary school, but I always felt my handwriting was less than ideal. Somehow the girls' writing always seemed more elegant than the boys', particularly my own which was (and remains) a bit on the edge between cursive and printing. When I look at the signatures on the Declaration of Independence, I feel quite heathen. But cursive was required throughout most of my school years, and I somehow got by.

In high school, however, typewritten reports were expected. Unfortunately for me and most other boys in the 50s, type writing classes were mainly for girls who would, of course, become secretaries in later life when we boys, in positions of power, would dictate to them. So I began a lifetime of hunting

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and pecking at the keyboard. Occasionally, my mother, bless her heart, would type out a high school report for me at the last moment.

On my own in college, all of my reports and essays were rolled out with two fingers pounding away, often well into the night. Tap, tap, tap, space, clunk, swing, chime, period. After a while, I'm proud to say, I became both swift and adept at hunt and peck. All through medical school, internship, residency and Army service I plunked away. My final product was often typed on coarse yellow paper for some reason I've forgotten. Perhaps it was so much cheaper, or maybe I just felt my humble efforts didn't deserve elegant, shiny, white paper.

When I finally got a real job in academic medicine, it came with transcriptionists for clinic reports and a part-time secretary in my cubbyhole office in the hospital basement. I would dictate and they would type. When no one was around to help, clickety-clack, tap tap, I turned out the work on my own. Then came the electric typewriter which made the process much more fun. But it was the arrival of the computerized keyboard that really astonished me. Select, cut, paste, bold, italicize, underline, highlight. Soon, when my part-time secretary wasn't around, I found myself hunting and pecking again just to enjoy the electronic experience. I won't go into my discovery of PowerPoint presentations here, but suffice it to say, many of my lectures were a bit over-suffused with color.

Then, in the final few years of my academic career, my lack of basic typing skills caught up with me again. Electronic medical records were introduced at the same time that the cost of transcribing dictation was deemed excessive. I was back at the keyboard. Even after retirement, my part-time employment in a community clinics required the same skill.

On top of all this - enter the world of handheld devices. WTF? I watch the kids flying over the tiny keyboards with fingers of both hands flashing. Immediate access, always available, always connected. Just what I was eager to leave behind when I turned in my on call beeper after 40 years of pediatric practice. Unlike the young, I am reduced to one thumb, occasionally two, because I need my shaky fingers to stabilize the device. Do I feel like grandpa? Give me a break. I won't go into the clunkiness of opening multiple pages or cruising the internet on my iPhone. Call me a dinosaur and let me get back to my desktop where at least I can see what's going on.
What about a dictation program like Dragon Naturally Speaking? Got that, use it often. But there are still errors in almost every other sentence. Don't correct them manually; use a microphone, they say. Then the program will learn and make fewer mistakes. Well, after Dragon misunderstands several spoken commands to correct an entry, it's hard to resist a quick stroke of the fingertips. It's faster than hunt and peck, I'll grant you. But when I watch those who learned how to type in childhood breeze across the keys, I feel disadvantaged. Is my brain too hard-wired to learn new pathways, or should I give that Mavis Bacon typing course one more try?

Response: *Thank you for your article. However, I must disagree with your premise about typing classes in the 1950s: "Typewriting classes were mainly for girls who would, of course, become secretaries in later life when we boys, in positions of power, would dictate to them." This editor was one of those "girls", but I went on to become a professor of pediatrics at UCSF and Stanford University (not to mention typing many term papers and reports for myself and my children) and, like many of my female peers achieved a reasonable degree of professional status. Mine has been in the predominantly male field of medicine,*

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others in business and law and politics. I will agree that my 1954 typing class, taken in summer school after junior high, was one of the most useful adjuncts to my education.

Lucy Crain, Editor

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!

Internet Sites Promoting High Rate of Unvaccinated Children

Galo E. Grijalva, MD, FAAP

My name is Galo E. Grijalva, MD, FAAP. I am a member of the Academy and of the Senior Pediatrician Section. I am semi-retired but still practicing pediatrics in various Locum Tenens positions. I am a former Assistantt Professor at the University of West Virginia, University of Kentucky, and an Emeritus Senior Staff at Miami Children's Hospital in Miami and Baptist Children's Hospital in Miami FL. I am sending the note to you with my experience.

-I just completed a second Locum assignment in the Eureka-Arcata area (far northern California) in the last six months. The majestic landscape with the giant trees and the majestic coastline with beautiful cliffs, rocks and an impressive ocean with giant waves breaking simultaneously one behind the other and the other, that they seem to be in a boiling mass of foam with a continuous roar of their crashing into the rocks or upon the previous waves that after reaching the coast they go back towards the ocean, crashing again with the incoming waves. Words fall short to express the beauty, the power, the sound, that makes you feel so humble in front of this display of Mother Nature.

Whether this eternal beauty has frozen the time and inspired its people to remain so close to Mother Nature, rejecting what the civilization of the XXI century in the medical world, or the evil minds of extremists based on the hippy philosophy of the 60's, who have created internet sites, that taking advantage of the Second Amendment, blast the Government, blast the Establishment, blast the Medical World, and consequently the vaccination of children.

Very unfortunately in my two tours in the area, I saw about 40 cases of whooping cough. The vast majority were in unvaccinated children, but a few in vaccinated children, since most likely the "herd immunity" was broken. Previous to this experience, the last case of Pertussis I saw was in West Virginia in the mid-sixties. I am sure many of the vaccine-preventable diseases are also increasing, such as varicella and many others that will make the headlines in the no so far future.

The California Legislature just passed a Law making it compulsory that children will not be able to attend school unless fully immunized. Unfortunately these people are so brain washed by their internet sites that are absolutely convinced that vaccines are full of poisons that enter their children's bodies, and most likely they will opt to home school their children, thus avoiding the law. Yes, that is how bad the situation is.

The information about vaccines provided by the American Academy of Pediatrics and the CDC are simply useless for them. I know is a matter of education, but does anyone have any idea how to do it?

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

A CONVERSATION WITH MY GRANDSON ABOUT VACCINES

John T. McCarthy, MD, FAAP

Dr. McCarthy is a non-hammock retired, triple-boarded physician who spent half his professional career as a pediatrician and half as a child and adolescent psychiatrist. As a result of 911, he worked his last 10 years as an associate clinical professor at the Child Study Center NYU School of Medicine where he ran the school rotation for the child fellows and directed the cosultation-liaison program. Dr McCarthy has been an active member of AACAP's Schools Comnittee since 2002. With his wife Jane, a retired Internist, he enjoys spending time with their 9 grandchildren (10th due in September 2015) and writing.

On a recent summer day while eating a bowl of cheerios with my 11 year old grandson, I asked him if he knew what Polio was. With a puzzled grin, he replied, "a polo shirt?" This was my foot in the door history lesson of the day. My highly intelligent grandson didn't know that when I was a kid growing up in The Bronx during the 1940's and 1950's, Polio was a summer plague every parent feared would strike their children and cripple them for life. But then Dr. Jonas Salk and his research team, undeterred, developed the first effective vaccine against a disease that had killed or paralyzed 58,000 (mostly children) annually in the US at its peak, and distributed in 1957 and reduced the number of cases to 5,000 per year. It was, however, too late to help Ralphie, my 3rd grade classmate who contracted Polio and ended up in braces for the rest of his life. Soon, Dr. Albert Sabin created a more effective oral vaccine. By 1961, only 161 cases were reported in the United States.

In June, 1969, I began a pediatric internship at The Children's Hospital in Denver where while on rounds, we passed a rather large room filled with youngsters in Iron Lungs, a stark reminder of just how devastating this disease could be. By the time I had completed my pediatric training, even Iron Lungs had vanished. But there would be other fish to fry.

My conversation with my grandson stimulated another vaccine related memory during my pediatric residency in 1975 (I had been waylaid by the US Navy who drafted me 4 years earlier during the Vietnam conflict to serve as a submarine doc), when I took care of an 11 year old boy who had developed acute transverse myelitis secondary to chickenpox (varicella). My forward thinking attending pediatrician, Dr. Jules Amer suggested we write a case report and make a plea for the development of a varicella vaccine. We submitted our paper to Pediatrics and included a comprehensive review of the literature and discussion in which we advocated for a new vaccine. At the time, we learned that of the approximately 4 million who contracted chickenpox annually in the US, 10, 000 needed hospitalization, and 150 died. The older the person when infected with the varicella virus, the worse the outcome. Shockingly, the editorial board loved our article (1) but insisted we drop the varicella sales pitch. Somewhat disappointed, we complied with the hope that someone in the future (ala Jonas Salk and Albert Sabin) would concur with us and develop an effective vaccine. In 1995, the first such vaccine arrived on the scene and licensed for use in the United States. By the end of our conversation, my duly impressed grandson said, "Wow, Papa John, that's awesome! I'm sure glad I got those vaccines and not polio or chickenpox."

Reference:

1. McCarthy J.T. and Amer J. Post-varicella transverse myelitis: a case presentation and review of the literature. *Pediatrics* 1978:62, 202-204.

Memory; The Explanation

So Very True

Brains of older people are slow because they know so much. People do not decline mentally with age, it just takes them longer to recall facts because they have more information in their brains, scientists believe. Much like a computer struggles as the hard drive gets full, so, too, do humans take longer to access information when their brains are full.

Researchers say this slowing down process is not the same as cognitive decline. The human brain works slower in old age, said Dr. Michael Ramscar, but only because we have stored more information over time. The brains of older people do not get weak. On the contrary, they simply know more.
Also, older people often go to another room to get something and when they get there, they stand there wondering what they came for. It is NOT a memory problem, it is nature's way of making older people do more exercise.

SO THERE…..

Now when I reach for a word or a name, I won't excuse myself by saying
"I'm having a senior moment". Now, I'll say,
"My start up disk is full!"

I have more friends I should send this to, but right now I can't remember their names.
So, please forward this to your friends; they may be my friends, too.

Are you Ready for This???

The local news station was interviewing an 80-year-old lady because she had just gotten married for the fourth time. The interviewer asked her questions about her life, about what it felt like to be marrying again at 80, and then about her new husband's occupation.

"He's a funeral director," she answered.

"Interesting," the newsman thought.

He then asked her if she wouldn't mind telling him a little about her first three husbands and what they did for a living. She paused for a few moments, needing time to reflect on all those years. After a short time, a smile came to her face and she answered proudly, explaining that she had first married a banker when she was in her 20's, then a circus ringmaster when in her 40's, and a preacher when in her 60's, and now - in her 80's - a funeral director.

The interviewer looked at her, quite astonished, and asked why she had married four men with such diverse careers.

(Wait for it)

She smiled and explained, "I married one for the money, two for the show, three to get ready, and four to go."

My Pediatric Residency 1958-60

Philip Brunell, MD, FAAP

In the spring of 1958, I received a letter from Dr. Donal Dunphy, the director of the house staff program at Buffalo Children's Hospital offering a position as assistant resident. Although I was making the almost unheard of salary of $275 a month at the E.J. Meyer Memorial Hospital, the county hospital, where I was a rotating intern I wrote back accepting the position that paid $125 a month. The alternatives were to accept a salary of $25 a month at another top notch program and bear the expense of moving. At the time, we were expecting our first child and were living quite happily in a County housing project. We had a garden apartment along with a number of other medical and dental students and house officers. The wives had established their own community within the community. The decision to go to Buffalo Children's turned out to be one of the best I had ever made.

So, off we went. I had been in the first class to use Children's for my junior pediatric rotation, just two years earlier. A number of my classmates were to join me at the Children's. The hospital had the top floor dedicated to patients with infectious diseases, which became unbearably hot even in Buffalo, and made it necessary for us to carefully calculate the fluid requirements for our patients. There were two "private floors" where practitioners admitted their own patients. We had an out-patient department in an older building and an adjoining lying in facility with a newborn nursery. There was no neonatal intensive care unit at the time.

Our chairperson was Mitchell Rubin who was one of the most impressive physicians and teachers I have ever met. An accomplished nephrologist, he continued to be active in his subspecialty during his chairmanship. His able associate Phil Calcagno, was later to become the Chair of Pediatrics at Georgetown. Phil has a great sense of humor and seemed to take great joy in tormenting Charlie Lowe, also one of teachers, who had described Lowe's syndrome before coming to Buffalo. Some years later when I was interviewing for an attending position at Long Island Jewish Hospital, a case was presented to me on rounds. After hearing the patient's history and performing a relevant physical examination, I confidently declared that the child had Lowe's syndrome, which impressed them no end. Dr. Charles Upton Lowe was referred to as "uptown" Charlie as opposed to the other Charlie Lowe who was a classmate. IHe remained a good friend and always looked after those of us who had been residents at the Children's. He was to become the founding editor of Pediatric Research and Scientific Director of the National Institute of Child Health and Human Development.

Each day we met for noon intake rounds conducted by Dr. Rubin or by Dr. Lowe. We received a list of all the admissions of the previous day and Dr. Rubin would call on the senior residents to describe those listed who seemed to be of interest. Drs. Rubin or Lowe's comments were priceless and we all could share in discussion of all the admissions of interest. We did not look forward to Dr. Lowe's rounds. He was an excellent teacher but merciless in his grilling of the residents. He was particularly scathing when steroids were used needlessly. He once came in with a toilet seat and gave the "Up John" award to a resident who he felt was using steroids indiscriminately.

Each morning before ward rounds we would go to Dr. Erwin Niter's bacteriology laboratory to discuss the previous day's admissions. He would hand one of us an agar plate of interest, ask for the patient's history and expect us to identify to isolates on the plate we were holding. He was a distinguished bacteriologist who had escaped from Nazi Germany. In those days, we would be expected to plate the

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isolates from each patient we admitted after hours. This experience proved to be invaluable when I was in practice as we had our own small bacteriology laboratory.

After bacteriology rounds, we would go back to our wards for patient rounds which were attended by both a full time member of the faculty and a community pediatrician. This provided a perfect blend of the practical and the academic. It was never boring. The community pediatricians were very generous with their time and punctilious about attendance. We also got to spend time in some of their offices. Dr. David Weintraub graciously cared for my own children. I remember him coming to our home to examine my son who had a high fever and full fontanels. He confidently assured us not to worry.

One of the unsung stars of the faculty was Erica Bruck. She also was a refugee from Europe. She had encyclopedic knowledge and knew every patient in the hospital. Years after residency, I had returned to look up information on one of the patients I had cared for. She not only remembered the details of the patient but she even remembered his admitting physician. She was always available if you had a problem and she never failed to offer great suggestions. Diminutive in stature but a giant intellectually.

One of my personal heroes was Dr. Karzon. He was a virologist and our infectious diseases consultant. He had me immunize the house staff against diphtheria, which in those days involved a Schick test to determine susceptibility and then a Maloney tests to determine reactivity to diphtheria vaccine. During my rotation on the infectious disease service in my senior year of residency we planned to study polio admissions. We still had some cases but always had the reminder of that dread disease by our experience in the chronic disease hospital a few doors down from the main children's hospital where some children lived in "iron lungs". That year, instead of peaking slightly before the enterovirus season, it came before. So, I got to study an epidemic of enterovirus meningitis with Dr. Karzon providing the laboratory component as well as guidance. I had not decided on a career in infectious diseases at that point but this experience most certainly shaped my future plans. Dave went off to chair to department of pediatrics at Vanderbilt.

I was quite interested in cardiology as I had a Master's in physiology before entering medical school. Ed Lambert, who had trained with Helen Taussig, was the chief. I got to spend a month with him and Peter Vlad. Peter was absolutely brilliant. If you found an abnormality in the cath lab he could rattle off the likelihood of associated abnormalities. Peter had escaped from Hungary during the 1956 uprising. He went on to co-author "Heath Disease in Infants and Children"

It was difficult for me settle on a subspecialty as I loved everything I did. I looked forward to going into pediatric practice. For this reason, I took an elective in allergy, which I spent in Carl Arbesman's office. Dr. Arbesman was an internist. I learned about doing clinical trials in an office settling. He was the allergist's allergist. He tested for 120 substances. He maintained a close relationship with Dr. Witebsky the chair of Microbiology at the medical school and an internationally known immunologist and another gift from Nazi Germany.

One of the greatest role models for us was Don Dunphy. He had come out of the Yale program and gone into pediatric practice with a fellow resident, Dick Olmstead. They left practice, Don coming to

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Buffalo and Dick going to St. Christopher's Children's Hospital in Philadelphia. A few years later Don left to become chair at Iowa and Dick to the chair at Oregon. Don was the consummate pediatrician. He was an astute clinician with outgoing personality and endless energy and a very practical approach to patients. In addition to a very busy out-patient clinic and emergency room, the specialty clinics provided a chance to see "office pediatric stuff". In orthopedics we learned about common problems that one never saw on an inpatient service. The same was true of dermatology clinic and ENT. In neurology clinic we learned about the office management of seizures and of learning and behavior problems. We got to spend one-hour per week with Sherman Little, a pediatric psychiatrist, one of the highlights of this extraordinary program. Don also arranged for me to supplement my income by $25 a month by being on call for the poison control center 24/7 along with another resident.

Kornel Terplan, another escapee from Nazi Europe, was chair of pathology at the medical school and an authority on childhood tuberculosis. In those days, our autopsy rate was always over 90 %. One would never want to miss Dr. Terplan's autopsies. We were always cognizant of his respect for the dead. He was a marvelous teacher and clinician in the autopsy room. I remember his making the diagnosis of cystic fibrosis post mortem that had been missed during life.

In the absence of a neonatal intensive care unit, we had lots of spare time on our newborn rotation. I had taken an interest in bronchiolitis and asked to have the autopsy records pulled for me to review. I was surprised at how few children died from this condition. This was confirmed by a search of textbooks looking for the pathologic descriptions of those who did not survive. It seems that one textbook copied the illustrations from the others.

Patients with malignancies were cared for at the Roswell Park Memorial Hospital. The chief was Don Pinkel one of the pioneers in the treatment of childhood malignancies who devoted his entire career to curing childhood leukemia. Don was the consummate clinical investigator measuring liver size with a steel tape measure. Most impressive, however, was how he cared for his patients. In those days, there were no IV teams. I remember his going to a child's home over Christmas vacation to administer treatment at his home so he could spend this holiday with his family. Don was to be one of the founders of St. Jude's Hospital. He later went on to become the chair of Pediatrics at Marquette.

Hematology remained at the Children's under the direction of Clare Shumway. Clare was a soft-spoken rather laid back clinician who just oozed with compassion for his patients. I lost track of him for a few years until I attended a benefit for the move "Patch Adams" which was about a doctor who dressed a clown to better relate to his patients. Robin Williams, who was the doctor in the movie, asked Clare who was in the audience to stand so he could be acknowledged as instigator of the clown caper.

One of the most memorable experiences of residency is going to a community well child clinic and sitting on one side of a two -way mirror with Dr. Rubin critiquing the examination and explaining what we should be noticing about the interaction of the mother and her child. We also were evaluating the examiner on the other side of the mirror. In addition to building an outstanding faculty that spawned several departmental chairman and a clinical service that delivered superb care, he never forgot about his house staff. He would see that we could attend religious services and could attend national meetings. He would invite us to his home. The spirit amongst the house staff was superb. No one left

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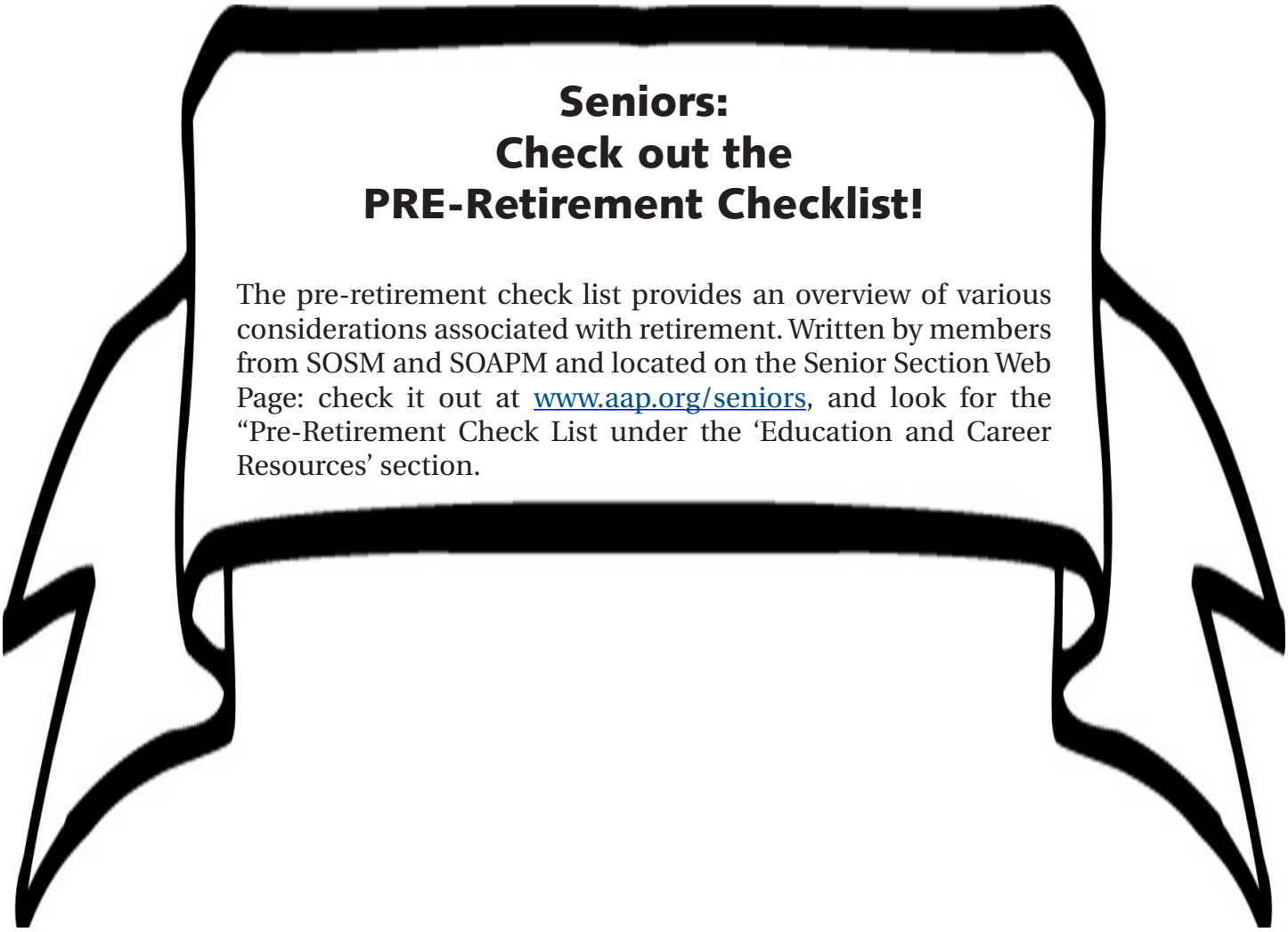
the program. Most of us had Berry Plan deferments, which enabled us to complete our residency with the proviso that we would serve in the armed forces after its completion. I remember sitting together as assignments were received. Our chief resident, was assigned to Okinawa. He was on the phone trying to get another assignment and all we could hear was yes sir, yes sir. It turned out that was a choice assignment

No one ever locked our on call rooms. I remember getting up one morning to find Dr. Robert Guthrie of the Guthrie test for phenylketonuria sleeping in the room I shared. He had a late night in the lab and just needed a place to sleep. We were on call every second or third night so we really appreciated getting to spend a little more time with our families on Sunday afternoons as they were invited to have a free luncheon. In the evening when we were on call, we gathered in the cafeteria for free snacks and conversation. No one felt poor. We all were rich. This was our residency.



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, and look for the "Pre-Retirement Check List under the 'Education and Career Resources' section.

Universal Newborn Hearing Screening

Leslie Ellwood, MD, FAAP

Leslie Ellwood MD FAAP has been a Virginia EHDI Advisory Committee member since 1999, is currently the Advisory Committee Chair, and is the Virginia EHDI Champion.

Universal Newborn hearing screening (UNHS), which lead to the establishment of state Early Hearing Detection and Intervention programs in the late 1990s still faces many challenges in implementation. Most states adopted EHDI programs under the guidance of the Joint Commission on Infant Hearing (JCIH), the Centers for Disease Control and Prevention (CDC) and the National Center for Hearing Assessment and Management (NCHAM). The American Academy of Pediatrics directed its efforts to establish EHDI as a challenge for the Pediatric Medical Home. The Academy has designated a pediatrician in each state as an EHDI Champion, and a national EHDI program manager in the AAP Division of Special Needs Children supports the Champions.

In March 2015, the National EHDI 14th annual meeting was attended by nearly 1000 health professionals in Kentucky, including the state AAP Champions.

AAP Champions interact with the state EHDI program managers to provide input from the AAP, inform the AAP chapters and members about the roles of primary care pediatricians and the Pediatric Medical Home in EHDI, and collaborate with state agencies and parent groups in implementing the program. The core of the program is reported as the 1-3-6 requirement: All infants screened by 1 month of age; all infants who fail initial OAE or ABR screens have a diagnostic audiometric test (ABR) by 3 months. If the infant is diagnosed with hearing loss, the infant is fitted for hearing aids and is enrolled in an Early Intervention educational program by 6 months.

Although the programs successfully established initial EHDI screening for over 99% of newborns in the USA, the other aspects of the programs continue to have challenges. The concept of screening, verify diagnosis, fit with hearing aids, enroll in Early Intervention (Part C), reevaluate children at risk for late onset hearing loss, and refer to ENT for possible cochlear implant by 12 months would appear to be simple and straight-forward. But, it is not.

16 years after EHDI was established, issues confronting my state (Virginia) and others include:
- Limiting the time between failed initial hospital screen and a “rescreen”
- Missed screening, particularly for infants who were in neonatal intensive care units
- Reasons for Loss to follow-up for the diagnostic audiometric testing at 3 months
- Scarcity of audiologists clinically trained and equipped to perform infant ABRs.
- Promoting the infant’s medical home to make the recommended specialty and community referrals.
- Limited number of Early Intervention teachers trained in the management of deaf children

Due to the infrequent occurrence of a congenitally deaf child in the average pediatric medical home, there is often lack of knowledge about the published protocols by the primary care pediatrician or family practice, so most state programs try to provide “on-line “ just-in-time resources for use by the medical home.

Many Senior Section members have prior experience in implementing screening programs at the state level, such as blood spot metabolic screening, developmental screening , and hearing/ vision /tuberculosis screening, as prerequisites to school attendance. Insight on barriers and successes in initiating such programs would be of interest.

Different Kinds of Summer Camps

Kathleen Braico, MD, FAAP

Do you remember summer camp? Perhaps you were a camper who caught your first fish there, or a counselor who learned how effective distraction worked when a child was homesick. Or perhaps you were a parent sending her pre-teen off for his first experience at camp, who returned having learned the valuable the skills of making new friends and coping with unfamiliar adults in a new environment. These experiences really enable kids to grow and mature in ways not possible had they stayed home and attended a day camp for that week.

Now imagine wanting that experience for your child with hemophilia, cancer, mitochondrial disease or another serious disease. Most "ordinary" camps are not equipped for these children. But these kids need the exposure to nature, the opportunity to make new friends, or to learn to cope in a new environment without their parents even more than their healthy counterparts do.

Fortunately, there are many "medically specific" camps in the US. Camps that are run by hospitals and by support groups such as the Lung Association give kids the chance to go to camp with the medical support they need. The Serious Fun Children's Network supports a sisterhood of camps all over the world that provides camp experience for children with a wide variety of diagnoses. Many of you may have volunteered at these camps and been amazed to see how different your patients are in a safe but challenging environment, far from the clinic or hospital and without the support of hovering parents. How different is "camp medicine" from what you practice in your hospital or clinic? How much does the medical component—infusions, medication, treatments, monitoring—interfere or compliment the camp experience? How do you treat a camper that you do not know when the parents are not there to give a history? What information do you need on the child's application to guide you? What equipment and supplies should such a camp have to deal with potential life threatening emergencies? How much training do you need for a counselor staff of mostly college students so that they can recognize and deal with acute medical issues that they have never heard of before? How many nurses, respiratory therapists and doctors will your camp need?

Then there are the disease specific concerns: Can you get your pool to 88 degrees for the camper with SSD? How will staff warm up that camper after he gets out of the pool? What are the G forces that a hemophilia camper will experience on your ropes course and will he need prophylactic infusion before participating? Which diabetic campers will you need to do blood sugars on during the middle of the night? Can a camper with asthma roast marshmallows over the campfire? How do you prevent your pool from becoming contaminated with cryptosporidium? Which barn animals are safe to have if you have campers who are immunosuppressed?

As with anything in medicine, we can learn so much from each other. Having worked 23 years for a SCFN camp, Double H, I have found that my greatest source of support is other physicians in our camp sisterhood. I am sure that all of us who have worked or volunteered at medically specific camps could learn so much from each other. Let us urge the AAP to support medically specific camp medicine lectures at the national conference, sponsor special camp medicine conferences and perhaps even a section on medically specific camp medicine! Let's give these kids the summer of their lives with a program that is fun and medically safe. As Paul Newman said, "let them raise a little hell!" After all, isn't the goal of everything we do in the clinic and the hospital aimed toward just letting them be kids?

Skepticism in Science

Eugene Wynsen MD, FAAP

Science is basically a skeptical approach to obtaining knowledge. I am reminded of a time in the past, when I was a young Pediatrician, that an article came out recommending Mg Sulfate enemas to treat RDS in the premature. Many Pediatricians fell for this, including yours truly. When I realized this was not acceptable, it taught me a lesson. Do not jump on the consensus bandwagon too quickly. You may get jolted and thrown off. One needs to be skeptical and evaluate things more carefully. The skeptical approach is the essence of science.

Richard Feynman, who was a well-known and highly-regarded physicist, said that if the imperial facts don't fit the theory, then the theory is wrong. It's as simple as that. Yet we cling to theories long after they are not supported by the facts. Currently there is said to be a "consensus" that CO^2 is the major cause of global warming, now known as Climate Change as there has been no significant warming for 18-25 years. There are a number of imperial facts that do not fit. There is supposed to be warming, but there is none recently in spite of CO^2 levels increasing. There is supposed to be a hot spot in the troposphere, but there is none. The Antarctic ice is at record levels, though it is supposed to decrease. Severe weather events are supposed to increase, but there is no evidence that there is any measurable increase. The Ocean is supposed to increase in level more than in the past, but the rate of increase is the same for the past century. The planet is predicted to have less growth, but satellites show there has been increased greening of the earth. CO^2 is being blamed as a cause of asthma in children. How many of you believe that? People are going to die from the heat, but all studies I have seen show that many more die in the cold weather. Apocalyptic scenarios are predicted almost daily. Diseases will increase they say, but the diseases they refer to are diarrhea and malaria, for example, but these are not caused by heat, but rather by poor conditions and hygiene. Malaria was rampant in Alaska, Finland and the USA in the past. The idea that 2 degrees C. rise in the global temperature is a critical one is held in spite of the fact that data that we have indicates the temperature of the globe has varied as much as 12 degrees C. in the past. And no attention is paid to the fact that the two degree's number is made up. The whole world goes by this in spite of the fact there is no scientific basis for it. The fact that it was warmer in the medieval period and also the Roman Holocene is ignored. CO^2 is said to be a pollutant. We exhale CO^2 at about 40,000 parts per million. CO^2 is the basic brick of life. If the atmosphere level fell to less than about 150 ppm, we would all perish. Complex climate models based on the theory have been woefully wrong. The global temperatures have been "adjusted" over 17 times by such means such as "homogenization" and secret algorithms, and a large majority of the time it results in an increased rise in temperature. The odds against random error corrections a large majority of the time to be in the same direction is enormous. The solution being promulgated is to spend 89 trillion dollars to "stabilize" the climate. That is an oxymoron as the climate has never been stable. There is much more.

Yet in spite of all these facts that do not "fit" the theory, the "consensus" continues to be that the theory is right, therefore on that assumption the empirical data must be wrong. If the facts do not fit do we ignore them? Or perhaps adjust the data? Do good researchers adjust their data to fit their theory? When is a theory no longer a valid theory? Should we still be on this bandwagon?

No Medicine is Good Medicine

Robert E. Yim, MD, FAAP

Dear Dr. Crain,

I want to first thank you for having published two of my short stories. The stories appeared in a book I published in 2012 entitled "Sleeping with Mae West and Other Stories," a memoir. The title is not an intro to something risque. It actually refers to the Navy life jacket I wore constantly because of morbid fear of the water while on a ship in the Pacific.

To my surprise "Mae West. . ." continues to sell, not due to literary excellence, but because mothers in my practice read it and buy it for their kids who were my patients many from birth and can now read.

I was so thrilled to see it appear in the Senior newsletter, not for any monetary reward but in the hope some old colleagues I may have trained with will read it and contact me.

I am attaching another writing in the Pediatric genre. This was published in the Maryland State Medical Journal. I am really enjoying the Senior bulletin. Keep up the good work

Robert E. Yim, MD

The hardest thing for a young doctor is to do nothing. After years of academic study followed by years of hands-on training, the new physician is infused with a magical aura of the power to heal. Seeing a sick patient, he is irresistibly impelled to HEAL. To sit and do nothing is incompatible with all he has been taught. When our treatment of a patient fails, there is often a feeling of resentment, as though we had deliberately withheld our magic. It is only after many years at the bedside, does the physician learn that often Tincture of Time and Mother Nature is best.

Sitting before my desk, Cindy, age twelve, looked sick. Her face was drawn and thinner than usual. Dark shadows accentuated her eyes made larger with dilated pupils. Very pale and picking nervously at chewed nails, she was a picture of total sadness.

Cindy had been my patient since birth. In fact, I learned of her when she was still in utero, when her mom and dad came to my office seeking a Pediatrician. What a handsome couple, I thought. Mom was a delicate blue-eyed blonde. Dad was an athletic young man. Looked like a classic marriage of football hero and cheerleader, I thought, with a tinge of envy.

I examined Cindy on the day of her delivery with a third year medical student who was in my class "Physical Examination of the Newborn". Cindy, rudely removed from her comfortable environment of nine months, was seven pounds of anger and resentment. Her lobster-red face scrunched in protest as her arms flailed and chubby legs kicked. I watched the young medical student gingerly handle Cindy. His hesitancy and overly careful handling only served to infect the baby with his nervousness and she howled her protest even louder. Another obvious bachelor, I thought. I was eventually able to present Cindy to her parents and grandparents, assuring them, "she has all her parts and they're all working."

Cindy's childhood was uneventful aside from one episode of dehydration requiring a stay in the hospital for fluids. She became a delightful, bright, vivacious school child. As a second grader, she

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proudly brought me a picture she had done for class. The assignment: draw a picture representing a song. She presented me a colorful picture of an airplane festooned with fruit. Grapes hung from the tail, bananas from the wings and a pineapple from an engine. "Why, thank you Cindy. This is really very nice," I remarked, "But I can't figure out what song goes with it." She smiled a missing tooth smile and declared, "Above Thy Fruited Plane!"

When Cindy began middle school, her parent's marriage was beginning to unravel. Father, the handsome "jock" became involved with various women at work. Mom continued her education with night school and soon her marketability exceeded his and she secured a highly paid position. The escalating marital war was taking its toll on Cindy. There was the usual drop in grades, social withdrawal and eventually physical symptoms of abdominal pain and headaches. At Dad's insistence, she was taken to many specialists. Perhaps from guilt over his infidelities, he refused to accept Cindy's symptoms as psychological. Cindy was repeatedly examined, imaged, scoped and blood tested. She was brought to my office on the day her mother and father decided to separate. Cindy's world had come apart.

I stepped from behind my desk and stood before Cindy and looked down at the thin figure withdrawing into itself. She looked up apprehensively but defiantly. She expected the usual. Get undressed and get examined. I easily read her thoughts, "no more, please, no more." The long silence between us thickened and I finally said, "Cindy, can I just hold you for a minute?" She rose from her chair and as I caught her, racking sobs shook her thin frame. I don't know how long I held her. When the sobs subsided, she took a tissue from the desk and those familiar haunting eyes looked into mine. "Thank you", she said very softly.

Sometimes no medicine is good medicine.

What are your Thoughts on Long-Term AAP Member Recognition?

From the Senior Section Executive Committee

Your Senior Section executive committee will be working with the AAP to suggest ways that the AAP can honor 30 + year members. If you have any ideas on how best the AAP can honor long term members, please e-mail out staff at jburke@aap.org by December 1, 2015.

Thank you!

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

Intergenerational Travel

Michael O'Halloran, MD, FAAP

I was pretty sure that I'd make a good grandparent when the time came. What surprised me was how enchanted I would be by it all. Watching them move through childhood was and is a gift. I saw those whole-body smiles of a 4 month old, the high guard, lurching first steps of the one year old, the insatiable curiosity of the 3 year old, and I loved those excited greetings I got from the five year olds. What a privilege it was! Then watching the scary and exciting elementary school years with its pride of achievement. But as those years went on, my wife, Marty and I began to wonder about fostering a different relationship with our grandchildren. What we hit on has been for us a perfect next step in the grandparenting experience. We decided that we would like to try combining our love of travel with our love of our grandchildren. And that it should be just the two of us and one child at a time; no parents, no siblings, just us.

A bit of research turned up a relatively new thing in the travel industry called "Intergenerational Travel". We found that there were several travel companies who offer these trips. We eventually settled on the intergenerational programs of Road Scholar. Their trips have an education component and are affordable. The trips are limited to about ten children, each with one or two grandparents. We liked that there would be plenty of time for exclusive grandparent interaction and that the kids would have peers with whom to interact. The tours are age grouped and we decided that the best age for us would be age ten. A ten year old would be able to be apart from his parents, have some sense of adventure, be able to remember the experience, and be able to help plan the trip.

So for Henry, our first ten year old, we picked three tours from the Road Scholar that we thought would interest him but that we adults would also enjoy. We met with him to discuss the options and asked him to do a few days of research and then present us with his choice. We have followed that procedure for our other grandkids. Henry chose a wonderful whale watching program in the village of Tadoussac, Ontario on the estuary of the St Lawrence River. Together we saw Beluga, Humpback, Minke, and Fin whales. But the kids (and the adults) especially wanted to see a Blue Whale, the largest animal to ever have existed. On the last day, rainy and cold, we saw it, a blue whale and her baby. The boat erupted with yells and whoops of joy. A wonderful experience.

Next was Max. His choice was to go to Costa Rica because of a school project involving a rain forest. It was just right. Not only did we see the rainforest from the river and from the ground, but we also saw it from an exciting hanging bridge through the forest canopy. The trip also included kayaking, a walk to a volcano, a zip line ride, and a night walk to where sea turtles were laying their eggs.

Cora was our next ten year old and she chose an adventure in the Jackson Hole area where we rode horses, biked, saw a moose (on Cora's bucket list) and did some exciting white water rafting on the Snake River.

Quinn chose a trip to Amelia Island off the east coast of Florida. It also included time on the Georgia islands of Jekyll and Cumberland. We rode on a working shrimp trawler, saw wild horses, played in the ocean, boated through the Okefenokee Swamp, and had an awesome session learning about (and holding) a variety of Florida snakes.

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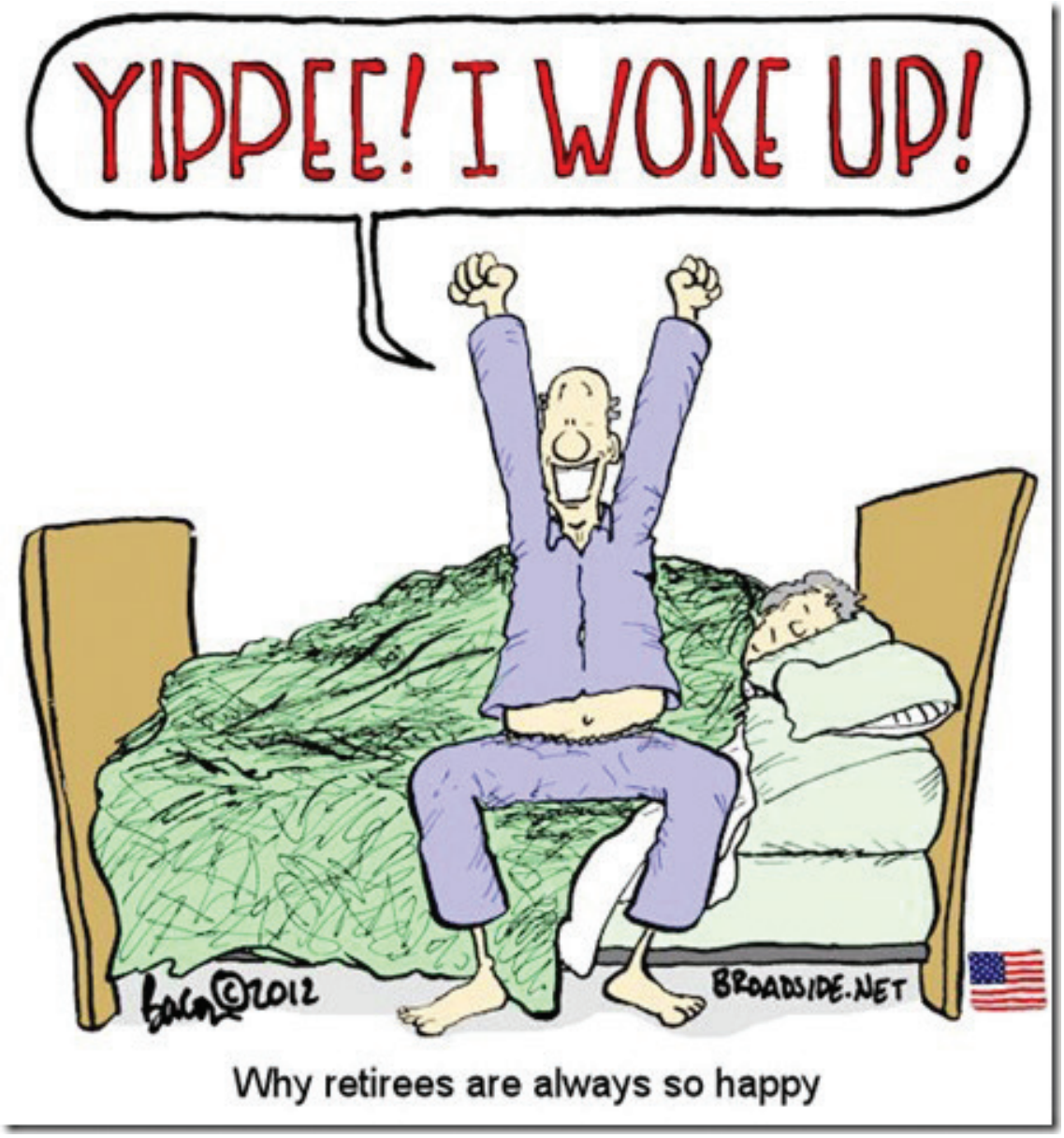
This summer we went with Will on his choice of Arizona and the Grand Canyon. We hiked to Montezuma Wells, had a swimming adventure in Oak Creek Canyon, and spent some time on the South Rim on the Grand Canyon. The highlight, though, was whitewater rafting on the Colorado River which concluded with a dramatic helicopter ride back to the rim.

With one more to go I'm already feeling a bit sad to think that the enterprise will soon be over. I enjoy these trip so much! I know that the grandkids all had a wonderful time, have abiding memories, and probably got to know us a bit better too. But I strongly suspect that we got more from these ten year olds than they got from us.



The Beauty of Aging...

Stanford Singer, MD, FAAP

"Good friends are like quilts-they age with you, yet never lose their warmth."

I am forwarding this to those on my Seniors email list because it is so well written.

I have seen too many dear friends leave this world, too soon; before they understood the great freedom that comes with aging.

Whose business is it, if I choose to read, or play on the computer, until 4 AM, or sleep until noon? I will dance with myself to those Wonderful tunes of the 50s, 60s & 70s, and if I, at the same time, wish to weep over a lost love, I will.

I will walk the beach, in a swim suit that is stretched over a bulging body, and will dive into the waves, with abandon, if I choose to, Despite the pitying glances from the jet set. They, too, will get old.

I know I am sometimes forgetful. But there again, some of life is just as well forgotten. And, eventually, I remember the important things.

Sure, over the years, my heart has been broken. How can your heart not break, when you lose a loved one, or when a child suffers, or even when somebody's beloved pet gets hit by a car? But broken hearts are what give us strength, and understanding, and compassion. A heart never broken, is pristine, and sterile, and will never know the joy of being imperfect.

I am so blessed to have lived long enough to have my hair turning gray, and to have my youthful laughs be forever etched into deep Grooves on my face. So many have never laughed, and so many have died before their hair could turn silver.

As you get older, it is easier to be positive. You care less about what other people think. I don't question myself anymore.

I've even earned the right to be wrong.

So, to answer your question, I like being old. It has set me free. I like the person I have become. I am not going to live forever. But while I am still here, I will not waste time lamenting what could have been, or worrying about what will be.

And I shall eat dessert every single day (if I feel like it).

MAY OUR FRIENDSHIP NEVER COME APART,
ESPECIALLY WHEN IT'S STRAIGHT FROM THE HEART!

Movie Reviews...

Lucy Crain, MD, MPH, FAAP

SPY:

Melissa McCarthy plays Susan Cooper, an unimpressive desk-bound CIA analyst who finds herself catapulted from this mundane existence to an unexpected field assignment shadowing an esteemed CIA field agent—a top international field operative played by Jude Law. Jason Statham co-stars as another super-agent with sinister persona. The movie displays a wealth of beautiful international venues and beautiful people—mostly intent on destroying the free world. With a stellar cast, James Bond-like credits and musical score, this is a rollickingly funny movie with many murders, explosions, excessive obscene language, and non-stop action. Written and directed by Paul Feig, the film showcases McCarthy's star qualities without sacrificing her strength as a comedienne. Her character shoots and swears with reckless abandon and manages to avert global disaster. Members of the audience were laughing so loudly throughout the film, I may need to see it again to catch more of the fast-paced clever dialog. This is a fun romp of a movie, not for children. R rating. 1 hour 57 minutes, July 2015 release.

THE WATER DIVINER:

Starring Russell Crowe in his directorial debut and supported by a strong cast, this is a beautifully filmed epic tale of a grieving Australian father in search of the fate of his three sons who enlisted in the Royal Army during WWI and fought in the Battle of Gallipoli between the Ottomans and the British. (Remember the poem "Into the Valley of Death rode the Five Hundred…"). History tends to forget the years of battle among the Ottomans, the Greeks, and the British even before Turkey was established. Millions died. Replete with violent war scenes, the improbable plot begins on a barren Australian farm, where Crowe's character-a water diviner-finds water and proudly tells his wife. She does not receive the news calmly. After her suicide, he leaves Australia on his journey to Turkey. Using his divining skills and the mysticism of imagining the long past battles, he escapes many life threatening encounters and finally finds evidence of his sons and peace. Beautiful scenes inside the blue mosque and of the Turkish and Australian countryside. R rated for violent battle scenes. 1 hour 51 minutes.

INSIDE OUT:

This new Pixel movie has something for all ages. Released summer of 2015, the movie offered an opportunity for our family to go to the local neighborhood theatre in Saint Paul for a family night out. Our resident 4 year and 9-1/2 year old juvenile reviewers both loved it. The younger grandson laughed throughout at the clever cartoon characters and the fast moving animation. His brother was amused by the story of a family who had moved from Minnesota to San Francisco because of the father's work. San Francisco took more than its share of slights starting with a pizzeria in their new neighborhood which specializes in organic broccoli pizza. The movie characters represent emotions. Anger, sadness, joy, fear, and disgust play lead roles as the star character deals with the onset of adolescence in the midst of having been uprooted from her friends and her hockey team in Minnesota. Therapists should have a great time analyzing the various emotions and reactions of the characters as they apply to a family in a real life transition situation. June 2015 release, PG, 94 minutes.

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DANNY COLLINS:

Al Pacino stars as aging rock idol, Danny Collins, who has a late onset mid-life crisis after his manager (Christopher Plummer) surprises him with a personal letter from John Lennon which had originally been sent to him in 1971and concealed until now by the manager. It's clearly a shock and prompts him to cancel his "farewell tour" and set out in search of the son he abandoned 30+ years ago. He locates the son, played by (Bobby Canavale), who has a hyperactive 7 year old daughter (Jessica Eisenberg), a pregnant wife (Jennifer Garner) and a stress-filled life as a construction worker who has recently learned that he has atypical leukemia. Danny befriends the manager of the hotel (Annette Benning) where he's staying in New Jersey, trying to retrieve the family he left and re-establish his sense of self-worth. The movie is more entertaining than the plot description may suggest and now provides worthwhile watching on DVD. R rated, 2015 release, 1 hour 50 minutes.

Plus a Book Review

ONE MURDER MORE:

Many of our Senior Members have published books or novels after retirement. Kris Calvin, the ED of District IX if the AAP, has recently published her first mystery novel and it's a good read. Set in Sacramento, CA, with which the author is quite familiar, this fast paced story of the murder of an attractive legislative aide whose fatally stabbed body is found in the restroom across the hallway from the Governor's office in the State Capitol. Moving on to more intricately involved tales of legislative lobbyists and politicians (some less trustworthy than others), mentions of the toy industry, for which the heroine-Maren Kane-is lobbyist, adds special interest for pediatrician readers....And more murders follow. A significant debut novel. I look forward to more in the series! 268 pages, published by Inkshares, San Francisco, 2015. Available at your neighborhood bookstores and on Amazon.com.

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.

Visit the Physician Reentry Web site at http://physician-reentry.org/

What Will Happen to Your IRA When You're Gone?

Joel M. Blau, CFP®

Ronald J. Paprocki, JD, CFP®, CHBC

Individual Retirement Accounts (IRAs) generally represent most physicians' largest financial asset. With this in mind, it only makes sense to ensure that retirement account beneficiary decisions are made carefully. While many institutions provide custody services for traditional IRA assets, the onus is on the IRA owner to make the ultimate beneficiary decision. Unfortunately, many physicians don't take the time to understand and personally individualize the beneficiary language within the agreement to meet their specific objectives. Understanding the impact that the beneficiary designation has on the distribution of the account after the IRA owner dies is a critical element of the planning process.

From the standpoint of those who inherit a traditional contributory IRA or IRA Rollover (as opposed to a Roth IRA), it's important to understand the unique rules associated with the process, which is different for spousal beneficiaries and non-spouse beneficiaries.

If you are the sole beneficiary of your spouse's traditional IRA, you may choose to treat that IRA as your own. This means you can contribute to the IRA if you are eligible to do so, and if you are younger than 70 1/2, you do not have to take required minimum distributions (RMDs). RMDs are generally required after reaching age 70 1/2. As an alternative, you may leave the IRA in your spouse's name with you as the beneficiary. If your deceased spouse died after age 70 1/2, you generally must base subsequent RMDs on the longer of your single life expectancy or the deceased's life expectancy. Otherwise, distributions may be based on your single life expectancy or the account must be totally liquidated in five years. Another possible option is to roll over the inherited IRA assets into your own IRA. The rollover is exempt from current tax liability if completed within 60 days.

If, on the other hand, you inherit an IRA from someone other than your spouse, you cannot treat the IRA as your own. Thus, you are not allowed to make subsequent contributions to the inherited IRA nor can you can roll over the funds to your own IRA. You must begin taking RMDs subject to the rules for IRA beneficiaries. Distributions from an inherited IRA are taxed as ordinary income. If you fail to take an RMD, you must pay a penalty equal to 50% of the required amount of the distribution.

Married IRA owners usually name their spouse as beneficiary, due to the many advantages of doing so, while either not naming or giving very little consideration to whom the contingent beneficiary should be. Those who do name a contingent beneficiary often name their children. In that case, caution does need to be exercised in the event that one of the named children dies prior to the IRA owner. Typically the deceased child's portion of the inheritance would go to the other living children, as opposed to the deceased child's family. This may indeed be your objective. However, if your intention is to have your child's portion pass through to their heirs, be sure to add the line: "to my descendants per stirpes". The Latin term "per stirpes" means "by right of the deceased". This specific legal terminology will ensure that if the beneficiary child dies, his/her descendants get the full share.

There are many IRA intricacies and nuances that should be addressed proactively to ensure you are maximizing both income tax and estate tax planning opportunities. Be sure to consult with your tax or financial advisor to ensure your IRA is structured properly now in order to avoid surprises or problems for your heirs in the future.

Response to Dr. Reynolds et al: When a Family Requests a White Doctor

Margaret Golden MD
Brooklyn, New York
mtcgolden@gmail.com

Thank you for your courageous and compassionate Ethics Rounds in the August 2015 *Pediatrics*, "When the Family Requests a White Doctor." Reading it brought a lump to my throat, and made me review how I wish I had handled similar situations in my career.

So here's what I wish I had done:

First, as the attending, I would have gone into the room with "Dr. Rowe" and somehow, basically, said to the family: I think we want the same think for your child—excellent care. That is what Dr. Rowe is trained to provide.

I then began to imagine this follow-up. When I return to the room after Dr. Rowe has presented his findings and plan to me, would I dare to open a conversation something like this:

Me: I told you I wanted your child to get excellent care. Let me ask some questions to see if we both think she got it. Could you follow Dr. Rowe's logic when he was taking the history? (*Criterion: history taking should be intelligent, informed by a well-curated fund of knowledge. How **does** that look to a lay person?*)

Dad: Yeah, I guess. But why did he ask about whether I smoke?

Me: Dr. Rowe, do you want to answer that?

Dr. Rowe: Sure. If a child is exposed to what we call "second-hand smoke", it can make the normal colds last longer or have more complications. Since you said you don't smoke, I didn't explain why I asked that.

Dad: Thanks. I used to smoke; quit about 2 years ago—you just made me feel better about going through that.

Me: I congratulate you for doing that. Now, Dr. Rowe, tell me what you saw when you examined the ears.

Dr. Rowe: The right TM was bulging, with what looked like green pus behind it. I couldn't see any landmarks, but there was a rim of erythema.

Me: Green pus, hum. Sure it wasn't a foreign body?

Dr. Rowe: I don't think so, because I could see that rim of red.

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Me: Good point. But your exam puts something else into the differential. May I take a look at your daughter's ear?

Dad: Sure.

Me: But first, on a scale of 1-10, how uncomfortable was the ear exam for her: 1, she barely noticed, or 10, she was screaming her head off?

Dad: She squirmed a bit, but she didn't even cry.

Me: So I have a hard act to follow…(my exam would probably rate a 2, maybe a 3…) (*Criterion: skillful and appropriate exam*). Yup—I see exactly what Dr. Rowe described. What diagnosis did he give you for your daughter's illness?

Dad: He told us she has a middle ear infection, and that it is usually a complication of a bad cold. He also said it can be very painful, and that's why she was crying all night. (*Criterion: reaching the most correct diagnosis, given information available at the point in time, translated into terms family can understand*)

Mom: But he didn't do anything—no tests or anything. And she's had this high fever!

(*Time to discuss "ancillary testing": only those tests—and all those tests-- indicated at this point in time*).

Me: Do you have any questions about the treatment Dr. Rowe prescribed? (*Criterion: treatment likely to be effective, minimal risks, feasible for the family*)…..

Me: Two last questions: Who is your regular pediatrician, so that we can let him or her know about this visit? And what did Dr. Rowe tell you to expect in the next few days? (Criterion: coordination of care; plan for assessing outcome.)

Dad: Dr. Rowe told us it should take 2-3 days for the fever to go away. If it doesn't, or it comes back, we should come back here, or call our pediatrician. But I think I want to come back here and ask for Dr. Rowe!

(Sounds like I believe in fairy tales—and maybe I do, because I have seen parents connect with a resident after strong initial reservations.)

Editor's Notes:

As another summer draws to its close, hopefully filled with pleasant vacation memories and times spent with family and friends, the fall 2015 Senior Bulletin brings us back to many topics, a good number not at all work related. (Check out Lance Chilton's blog as he is bicycling around Europe.) Ranging from intergenerational travel experiences to teaching and mentoring (and garbage disposals?!), this edition provides its usual variety of topics. Although we discourage lengthy remembrances from our

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valued senior members in the Bulletin, an occasional exception is made. Such is the case for including Dr. Phil Brunell's "My Pediatric Residency". Its great reading!

Also, I encourage you to read Dr. Golden's commentary on the article "When a Family Requests a White Doctor" as well as the **Ethics Rounds** article by Kimberly Reynolds et al in PEDIATRICS volume 136, number 2, August 2015, pp 381-388. The aspects of racial discrimination to which Dr. Maron alludes in his column in this issue are less prevalent than those described by Dr. Reynolds in 1870 when the AMA refused to seat two black delegates to its annual meeting. However, the definitions of diversity and discrimination continue to expand seemingly faster than understanding and tolerance. Gender bias, ageism, and religious discrimination are not always well considered in our profession or our society at large and deserve consideration and attention, especially by those of us who have experienced such prejudicial attitudes.

I look forward to hearing from you and receiving articles for consideration for future issues. (Please remember to cc Tracey Coletta tcoletta@aap.org on such submissions.)

-Lucy Crain, MD, MPH, FAAP
lucycrain@sbglobal.net

A Good Pick-up Line!

An elderly gentleman in his late eighties walks into an upscale cocktail lounge. He is wearing a smart-looking suit with a flower in its lapel, his hair is well groomed and he smells slightly of a good-quality after-shave. In fact, he presents a very well-looked-after image.

Seated at the bar is an elderly, very classy looking lady. She is in her mid-eighties.

The sharp-looking gentleman walks towards the bar and sits down next to her. He orders a drink. After taking a sip, he slowly turns to her and says: "So tell me, do I come here often?"

Senior Section Members Comment about Life Before Vaccines on AAP.ORG

Recently, Senior Section members were asked to comment on life before vaccines. Scores of members wrote shorts stories and submitted pictures, which we posted in *Senior Bulletin*. Many of these stories have been highlighted on the AAP's Web page. See the AAP Web page at: https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/During-National-Immunization-Awareness-Month-Pediatricians-Look-Back-at-Medicine-Before-Vaccines.aspx. Thank you for your thoughtful comments!

AAP SENIOR SECTION
IS LOOKING FOR MEMBERS
TO SERVE ON LEADERSHIP TEAM

The AAP Section on Senior Members (SOSM)
has **two openings for executive committee members**
beginning **November 1, 2016**.

These leadership positions help to steer
the current and future activities of the SOSM.

If you are a member of the AAP and the SOSM
and are interested in a 3-year executive committee position,
please forward your letter of interest and a biographical sketch
to our staff at jburke@aap.org,
who will forward to the SOSM Nominations Committee.

Also, the position of **Chairperson for the SOSM**
will also be open
beginning **November 1, 2016**.

If you have served on the executive committee of the SOSM in the past
and are interested in serving as Chairperson,
please forward your letter of interest and a biographical sketch
to our staff at jburke@aap.org.

DEADLINE: December 1, 2015.

Thank you!

Senior Bulletin

AAP Section on Senior Members

Editor: Lucy S. Crain, MD, MPH, FAAP
Associate Editors: Carol Berkowitz, MD, FAAP
Michael O'Halloran, MD, FAAP
James Reynolds, MD, FAAP
Donald Schiff, MD, FAAP

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