

# SENIOR BULLETIN

## AAP Section on Senior Members

Editor: Gilbert Fuld, MD, FAAP

Associate Editors: Peter Gorski, MD, MPA, FAAP  
and Richard D Krugman, MD, FAAP

Advocacy Editor: Donald Schiff, MD FAAP

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Variations, taking into account individual circumstances, may be appropriate.



### SOSM Chairperson's Column

*Renée R. Jenkins-Woodard, MD, FAAP*

Pediatricians around the world are in pain as we hear about the war in Gaza and the disproportionate impact it has had on women and children. I'm taking this opportunity to weigh in with my personal reflection and look to the resources available to me within the Academy. I'm looking for help to connect to the policy language that will help me be a more effective advocate on their behalf.

The Section on International Child Health gave us an informed report in 2018, with a policy statement (<https://doi.org/10.1542/peds.2018-2585>) and an accompanying technical report (<https://doi.org/10.1542/peds.2018-2586>), "The Effects of Armed Conflict on Children". The effects of armed conflict are direct, such as injury and death, and indirect, such as deprivation and toxic stress. The effects are immediate, during active armed conflict and are downstream, as children experience posttraumatic stress disorder. The United Nations Convention on the Rights of the Child (UNCRC) explicitly identifies six grave human right violations impacting children that breach international humanitarian law: (1) recruitment and use of children, (2) killing or maiming of children, (3) sexual violence against children, (4) attacks against schools or hospitals, (5) abduction of children, (6) denial of humanitarian access.

The recommendations in the AAP position statement that impact pediatricians and pediatric care by other health professionals are more likely to be relevant when facing children who have escaped direct conflict and are in countries where they're receiving asylum. The position statement speaks to the clinical practice, system issues, and public policy necessary to help mitigate the damaging effects of armed conflict on these children. Many of the clinical practice guidelines from 2018 are adhered to currently in general practice, such as assessing mental health and practicing trauma-based and culturally appropriate care. Training recommendations for pediatric health professionals planning to work with refugees in camps or conflict settings include a unique set of skills relative to the needs likely to be encountered in addition to basic international work. The emphasis in all of the recommendations is child and youth safety, humanitarian aid, and child and family reunification during displacement and resettlement.

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The system issues assessed are extensive and encompass not only the UNCRRC, but also the recommendation of the 26th International Conference of the Red Cross and Red Crescent. The position statement is extensively referenced with the source of these documents. The Section on International Health is in the process of updating the statement; however, an immediately expanded statement was released by the Board that underscored the need to protect children from harm because of religious, cultural or other beliefs and values, being used as tactics of war, and being denied basic necessities such as food, housing, and health. (AAP Board Update, November 3, 2023).

With the constant news feeds about the war in Gaza, children in the U.S. are hearing about the war. [HealthyChildren.org](https://www.healthychildren.org) has a very useful segment on “How to Talk with Your Child about the Israel-Gaza War”. Asking what a child has heard seems like a good place to start. Parents should find the discussions in this guide helpful for children managing the communication they’re encountering.

The closing messages from the AAP at the time of publishing this article are from two sources. One, a reminder that the mission of the Academy is to advocate for optimal physical, mental, and social health and well-being for ALL infants, children, adolescents, and young adults. ALL children includes those in conflict-torn areas of the world, never forgetting the children in the world who are receiving less media attention. The Board reminds us in their March 2024 statement, THEY COUNT! (AAP News, March 6, 2024).

The last message at this time is that we have to show up, stand up and speak up for children when their needs are not being considered as a priority. The Board responded with a letter speaking up for the urgency of humanitarian aid for the children affected by the crisis in Gaza to President Biden, Vice-President Kamala Harris, the administrator for the U.S. Agency for International Development, and other top U.S. officials. By the time you’re reading this article, it is my sincere hope that the meeting has taken place and we made our voices heard and responded to.

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**Jay Berkelhamer, MD, FAAP**

### Newsletter Editors

**Gilbert L. Fuld, MD, FAAP**  
[gilfuld@icloud.com](mailto:gilfuld@icloud.com)

**Peter A. Gorski, MD, MPA, FAAP**  
[pgorski@fiu.edu](mailto:pgorski@fiu.edu)

**Richard D. Krugman, MD, FAAP**  
[richard.krugman@cuanschutz.edu](mailto:richard.krugman@cuanschutz.edu)

### Staff

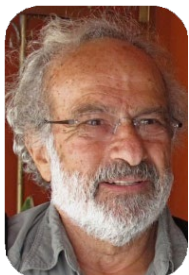
**Tori Davis • Manager, Senior Member**  
*Engagement*  
[tdavis@aap.org](mailto:tdavis@aap.org)

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## Spring 2024 Editor's Note

*Gil Fuld, MD, FAAP*

*Editor, AAP SOSM Senior Bulletin*



Welcome to the Spring issue. We're pleased to welcome several contributors who have not previously submitted work to the Bulletin. And we have the usual panoply of opinions, endeavors, and nostalgia. I hope that our writers prompt you to remember and reflect on events past and present.

For example, John McCarthy's baseball article got me musing about my own magic baseball moments. Most memorable was the 1960 World Series victory of the Pittsburgh Pirates over the Yankees - the seventh game decided by Bill Mazeroski's walk-off home run. At the time I was in my third year of medical school at the University of Pittsburgh. The Yankees were ascendent. The Pirates had recently been terrible, finishing in last or next to last place eight times in the previous decade. Pittsburgh was obsessed with the Series, and it seemed as if everybody was glued to the radio or TV for the game. There was even a rumor that a surgeon in mid-operation looked up at the OR clock, dropped his gloves, and announced "It's game time", leaving the resident to finish.

The Pirates were improbable World Series winners; the Yankees outscored them 55-27; Whitey Ford pitched two complete game shutouts. For more information, fellow baseball junkies should google "World Series: Why the 1960 Fall Classic is the Greatest of All Time" at Bleacherreport.com., and ESPN's "The Greatest Game Ever Played", full of details I never knew until now.

I didn't actually see or hear the game, as I was busy on the medicine ward at Montefiore Hospital. The evening after the game the racket of honking cars celebrating on Fifth Avenue below was inescapable. My elderly female patient, a fearful immigrant with a heavy Eastern European accent, asked me what all the noise was about. I told her and will always remember her response. "Is it good for the Jews?"

The same article reminded me that I knew where I was when Bobby Thomson hit his home run on October 3, 1951. This was big news in New York. I was at football practice (JV - I was an undersized sophomore quarterback). A close friend, a diehard Dodger fan, had somehow been able to bring a portable radio to the field. Needless to say, he was devastated.

And this led to thinking of other events that stopped me in my tracks. I still remember exactly where I was and what I was doing when I first heard about them. I'll mention three.

November 22, 1963. JFK assassination. I was a pediatric resident assigned to the private floor at New York's Babies' Hospital and in the process of working up an admission - a young girl who, although previously well, suffered a sudden neurological crisis a day after a routine immunization. (I'm no anti-vaxxer, but the chronological association has always troubled me.)

January 28, 1986. Challenger blew up. I was in a New York taxi after attending the funeral of my brother's father-in-law, a kind and gentle Manhattan veterinarian.

September 11, 2001. I was a week returned from six week road trip to the West Coast celebrating my retirement. A friend called and told me to turn on the TV.

For our next issue we'll be asking readers to submit your own magic moments (sports or otherwise) and your "stop in your tracks" dramatic memories.

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## News From the Hill: AAP Advocacy at Work

*Karen Breach - Washington, MD, FAAP, Charlotte, NC*

*SOSM Liaison to COFGA*

The Committee on Federal Government Affairs (COFGA) met in Washington, DC, February 25-27, 2024. Advocacy updates were presented on the 26th, and we visited Capitol Hill on the 27th to advocate for two issues: Caring for children in emergencies (the EMSC Program) and protecting young people online.

EMSC is the only federal program that focuses on the unique needs of children in the EMS system including standardized care in emergency departments. All states receive funding. The ask is for reauthorization for five years - Senate bill (S.3765) and House bill (H.R.6960).

Two new senate bills address online safety for children and teens: Kids Online Safety Act (S.1409) and Children and Teens' Online Protection Act (S.1418). Currently, we have only weak requirements for some online websites, apps, and social media to require parental consent for children under 13 years. We urge Congress to pass laws to better protect children and teens from the harm caused by digital platforms targeting them.

The annual AAP Advocacy Conference will be held April 14-16, 2024, in Washington, DC. This is a "must attend" at least once in the life of every AAP member. Legislative issues critical to the health of children and families will be discussed. Guest speakers as well as AAP leaders will carve out the path for advocacy. Learn about current advocacy efforts and identify key issues. Go to Capitol Hill to meet your own congressional representatives and senators. In most cases you will meet with a congressional aid to present AAP issues and why you, as a constituent, want their support. The AAP Washington office will make your Capitol Hill appointments and guide you through the process. You are in for a most rewarding experience.

The AAP is once again offering pediatric trainees the opportunity to spend a one-month advocacy rotation in Washington. This is open to medical students and residents. Interested pediatric trainees or their clerkship directors should contact the AAP for more information about the program. This is a great way to introduce our younger colleagues to the importance of professional advocacy.

The COFGA meeting is an opportunity to find out just what our leaders have been doing. It was noted that our current US Congress has passed only 34 bills, the lowest in history. The decisions of the Supreme Court have had a greater impact on policy. As the nation gears up for the 2024 elections, the AAP will launch a nonpartisan Get Out The Vote campaign.

Meanwhile, our AAP leaders continue to be impactful. AAP President Benjamin Hoffman wrote an op-ed on the need for Congress to pass a bipartisan child tax credit deal to help lift more families out of poverty. Immediate past president Sandy Chung is serving on the Bipartisan Policy Center's Youth Mental Health and Substance Use Task Force.

Several funding issues affecting children and families are looming. The WIC program could see 2 million families be turned away without additional funding. The AAP sent a letter to congressional leaders, signed by over 50 chapters, calling for continued bipartisan support and funding for WIC. AAP members are encouraged to reach out to their members of Congress.

Other priorities include support for child welfare policy, including reauthorization of Title IV-B of the Social Security Act. This is a critical child welfare policy supporting youth in foster care, foster families, and child welfare workers. Reauthorization and expansion of the bipartisan Child Abuse Prevention and Treatment Act (CAPTA) is also urged.

Medicaid unwinding is the catchphrase for the loss of coverage for 17 million Americans, including nearly 4 million children. 70% of all Medicaid terminations are for procedural reasons. Members are encouraged to share their Medicaid unwinding stories with AAP and their legislators. A media campaign will launch soon to help reconnect families to Medicaid and CHIP coverage. Advocacy resources can be found at [www.aap.org/MedicaidUnwinding](http://www.aap.org/MedicaidUnwinding).

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AAP continues to address the immigration crisis. AAP leaders went to Tucson, Arizona and the border crossing of Nogales, Sonora, Mexico. They visited a Customs and Border Protection facility and a facility for unaccompanied minors run by the Department of Health and Human Services. They also visited Casa Alitas, where hundreds of thousands of families are served each year receiving medical follow-ups and are connected to resources, and they visited a shelter on the Mexican side of the border. Although the AAP and others advocate for immigration legislation, Congress remains stalled on the matter.

On the immunization front, there is good news and bad news. The good news: A new malaria vaccine has been introduced in Cameroon and is expected to expand to 20 more African nations in early 2024. AAP is advocating for Congress to increase its contribution to Gavi, the Vaccine Alliance. The bad news: Measles is on the rise in the U.S. while more states are considering legislation to permit more vaccine exemptions. AAP chapters are mobilizing to oppose such legislation.

There was so much more advocacy work discussed at the COFGA meeting: Youth mental health, gun violence prevention, gender affirming care, reproductive health, tobacco control, pediatric drug safety, and pediatric subspecialty loan repayment program, to name just some of the hot topics. Be assured that the AAP, especially in the Washington, DC office, is advocating for children, families, and pediatricians every day.

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## SOECP Update Spring 2024

*Elizabeth Kuilanoff, MD, FAAP*

The Section on Early Career Physicians (SOECP) continues to be a great source of funding and training opportunities for physicians in their early careers. If you are mentoring or coaching a junior physician, please refer them to the SOECP website.

The **2024 SOECP Healthy Equity Grant** is sponsoring early career physicians, especially those who are underrepresented in medicine, as they conduct research, interventions, and education that address antiracism and health equity in communities and institutions. Individual projects can receive up to \$3,450 in funding, and budgets may include a maximum of \$3,000 in programmatic costs. Applications were due March 3 with winners announced early April 2023.

The **Early Career Leadership Alliance (ECLA)** has officially launched. This 2-year training program replaces the Young Physicians Leadership Alliance (YPLA). The ECLA is designed to develop leaders and build a leadership community amongst early career physicians. This learning program is intended to increase the capacity of physicians who are early in their career to support their professional growth. The 2023-2025 cohort has 22 participants and 8 faculty members: 4 senior and 4 early career. SOECP worked to leverage the success of the Young Physicians Leadership Alliance (YPLA) while redesigning the program in alignment with the AAP Equity Agenda to intentionally facilitate equity in access to AAP leadership programs. This has been important especially as those underrepresented in medicine may have less access to leadership training, and SOECP has an aim to diversify leadership in pediatrics.

The **SOECP Endowment** was established in November 2023 from the Section's reserves. An initial investment of \$250,000 was made, with an expected annual yield of at least 5%. The accrued interest will be directed towards diverse Section initiatives, such as: scholarships for attending AAP conferences, Health Equity grants aligned with strategic goals, Section awards, hardship scholarships, and advocacy initiatives. The intention is for the funding to contribute to projects that positively impact members, aligning with the Academy's commitment to equity, diversity, and inclusion, and promoting active participation from individuals historically underrepresented in medicine.

**SOECP Liaison Opportunities** are currently available. The SOECP encourages members to serve on several Section workgroups at any time. The 5 workgroups primarily focus on aspects of the SOECP strategic plan and moving key items forward to support and serve our members, such as advocacy, communications, education, EDI, and membership. The SOECP is especially interested in members who can contribute to the workgroup's diversity and foster an environment of mutual respect and acceptance. Descriptions, term limits and applications can be found on the AAP website.

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**SOECP Strategic Plan Workgroup Opportunities** are currently available. As a career-stage interest group of the AAP, the SOECP works to connect its members to varying opportunities within the Section and the Academy. Beyond the executive committee leaders, the SOECP has a network of members acting as liaisons to AAP Committees, Sections, and Councils, in addition to members on SOECP and external committees and project-focused groups. The SOECP is currently seeking members to fill several liaison roles; please view the opportunities listed below. Though membership in the SOECP is open to all AAP members, applicants must have completed training (either residency or fellowship, whichever is most recent) within the past 10 years at the time of initial appointment.

**SOECP Advocacy Conference Scholarships** are once again being offered. In conjunction with the Section on Pediatric Trainees (SOPT), the Committee on Federal Government Affairs (COFGA), and the Committee on State Government Affairs (COSGA), the SOECP offered up to 10 scholarships for early career physicians to attend the annual AAP Advocacy Conference in Washington, DC in April 2024. These scholarships aim to enhance the accessibility of this impactful conference, offering opportunities for networking, skill development, and advocacy engagement. Eligible members were encouraged to take advantage of this opportunity to participate in a dynamic event focused on advancing child health advocacy and contributing to shaping pediatric policies. The SOECP received a total of 15 applications and is currently in the process of reviewing them all for selection.

**SOECP Employment Support Program** is a partnership with the AAP Section on Administration and Practice Management (SOAPM) and is intended to provide a means of supporting ECP members who are finding it difficult to secure a position for the first time or transfer to a new position.

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## COSGA Report Committee on State Government Affairs

*Jay Berkelhamer, MD, FAAP*

Meeting December 2, 2023.

The COSGA works with AAP staff to provide consultation and technical assistance to AAP Chapters seeking to influence state government policy. I attended this meeting as SOSM liaison to help foster greater collaboration with our AAP Senior Section. The chair of COSGA, Pamela Shaw, is also a member of SOSM and expressed excitement about the potential of greater involvement of our members in advocacy activities in their respective state chapters.

Following introductions, a series of updates and reports from staff and committee members gave an overview of the many activities in various states. Topics were numerous and included firearm safety, state-level Immunization laws, Medicaid payments, and Medicaid expansion and eligibility.

Ian Van Dinther, Senior State Government Affairs Analyst, reviewed the advocacy-related offerings at the fall National Conference and encouraged attendance from SOSM members. I also encouraged COSGA members to participate in our annual NCE SOSM program.

Senior AAP members can help with their chapter's advocacy efforts by participating in various activities during State legislative sessions. Reaching out to your state senators and representatives can be readily accomplished and getting to know them personally can be extraordinarily helpful in soliciting support for state level policies to improve child health. Becoming an active member of your chapter's public policy committee is often a great first step in becoming involved in improving child health as a senior pediatrician.

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# Advocacy

*Editor's note:*

*This is an abridged and edited version of a letter, a "cri de coeur," sent to various political and medical leaders in Illinois and beyond.*

## **Rural Healthcare in America; The Third World in the Middle of the First World**

*Amar Davé, MD, FAAP, Ottawa, IL*

Readily obtainable access to healthcare is critical to good health. The availability of adequate healthcare facilities and adequate healthcare workforce are critical enablers of the healthcare service system.

I am presenting data collected online for establishing a correlation between population and the health service facilities resources in two areas in Illinois, one rural (LaSalle, Bureau, and Putnam counties) and one (Peoria County) representing a mix of urban/rural. Both serve, to a large extent, an equal number of inhabitants, showing the stark imbalance.

### **LaSalle, Bureau, and Putnam Counties**

The recent closure of three regional hospitals with 194 beds has left many people without any meaningful healthcare services over a vast area. People living in rural communities must travel 50-70 miles to deliver babies, to get emergency care, and to receive any involved medical care requiring hospital admission. As of now St. Elizabeth in Ottawa is the only hospital in the tri-county area that delivers babies and provides complex care.

- \* The total population is about 152,478.
- \* The total number of primary care physicians serving that population is about 52.
- \* There has been a loss of close to 194 beds because of the closure of three area hospitals
- \* The total number of hospital beds available including ICU beds in these three rural counties is 108, which comes to 1 bed per 1,411 persons.
- \* There are 10 OB/GYNs, but only one on call for a given time slot and while some of them reside in the tri-county area, most of them are either locum or live far away.
- \* Two midwives in the three counties are affiliated or working with St. Elizabeth delivering babies. 1,202 babies born in 2021.

### **Peoria County**

- \* The Peoria County population is 17,8383
- \* There are a total of 1,157 beds including ICU beds
- \* The number of physicians in Peoria County is 1,159 (OSF data)
- \* There are 57 OB/GYNs
- \* 13 practicing midwives.
- \* 2,149 babies born in 2021
- \* 14 pediatric psychiatrists

### **Findings and Impacts**

There is an acute shortage of health service facilities and resources in LaSalle, Bureau, and Putnam County. The cascade effects of the shortfall in health facilities in the three counties are:

Healthcare workers are overburdened and burned out because of excessive demands placed on them.

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Shortage of hospital infrastructure and human resources to accommodate and attend overflow and patients within a reasonable time of their arrival. While there is an extended waiting period for outpatients, most of the time there are no beds and patients wait for hours and at times days in the emergency room before a bed is found somewhere 90 miles to 100 miles away.

The lack of training offered to staff in many areas of patient care due to various reasons.

Our tri-county emergency room at Ottawa (serving the three counties) functions as an acute psychiatric care holding place for children with mental issues until they find an indoor mental facility usually 70-150 miles away to transfer depending upon acceptance/ insurance/ availability of beds. Due to distance and unavailability of public transportation as well as poor socio-economic status, these kids are either not followed and fall through the cracks because the local psychiatrists and the Ottawa hospital are not approved/due to certification/ legality/ availability to accept and follow these patients.

Inclement weather conditions (which are frequent during winter in this area) further stress the situation as transfer of patients may not be possible. The chances of fatal outcomes cannot be ruled out during such a challenging situation because there is a paucity of competent resources available at the local level to take care of matters. The closure of rural hospitals in LaSalle, Bureau, and Putnam County has added distances between the health service delivery system and patients leading to a very stressful situation! These distances need to be bridged ASAP.

The number of practicing physicians was reduced because the closure of the hospitals left them unemployed with no place to work or care for their patients. Many took early retirement. Replacing the physician workforce in rural America is difficult despite incentives offered by the Federal and State Governments as well as rural hospitals.

Many other healthcare professionals - nurses, lab technicians, X-ray technicians, etc. lost employment overnight and either quit working or joined other far-away workplaces.

### **Recommendations**

Major health service establishments like OSF Healthcare (*see note*) and government health departments urgently need to contemplate effective strategies for replacing the lost health service capacities (including physicians and support workers) in LaSalle, Bureau, and Putnam County.

The issue is serious and challenging as it involves multiple factors (community health and safety, government policies, procedures, and finally service providers' (agencies like OSF) interest/inclination.

I strongly feel that a civilian task force consisting of civic leaders, industrial leaders, the public, and local politicians should be established to study and assess issues/challenges of health services in LaSalle, Bureau, and Putnam County and issue recommendations on the solution.

We discussed health service delivery and its quality during various meetings I attended, but we never tried to look at the bigger picture covering the adequacy of services and the negative impact of the closure of hospitals on the community. This may be because overall community welfare, as a subject, falls under the State Government's jurisdiction. The nonchalant attitude prompted me to write this "white paper" to see if someone would sincerely, objectively and holistically look at the situation and get the community at large and the state and Federal government involved and have more help, more space, more personnel, and more expertise to serve the same size population that some urban areas have, as in this region, Peoria.

I have been actively practicing in this community for the last 42 years and these are exclusively my views, my personal observations and views.

*Editor's note: OSF HealthCare is an integrated health system owned and operated by The Sisters of the Third Order of St. Francis, headquartered in Peoria, Illinois. It's the parent of St. Elizabeth in Ottawa.*

# Reflections

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## The Pregnancy Consult-2003

*Debra Sowell, MD, FAAP Bowling, Green, KY*

When I was practicing, I introduced to our community the concept of a pregnancy consult where expecting parents could meet with me if they had specific questions or particulars our team might need to know. One that I will never forget was a 40+ year old mom who was by herself - she had five children by her first husband who had tragically died in a car accident about two years prior. Her youngest child was in high school. Unexpectedly, she met a new man in her small community who wanted to marry her and wanted to have a child since he had no children of his own. Mom had a tubal reversal and became pregnant very quickly. Four months into the pregnancy, the parents learned that the baby girl had Down Syndrome but no known cardiac, gastrointestinal, or anatomic abnormalities. Her new husband was having a difficult time dealing with the diagnosis but mom was sure that once that baby was delivered, he would be “OK” with the baby. Fast forward, dad stayed with mom until the baby was three months old, filed for divorce, asked for no visitation, but provided insurance and child support for the infant. Mom brought the baby for all well-baby visits either by herself or with one of her teenage or young adult children.

Fast forward again, it's now the baby's nine-month checkup and mom wanted to introduce me to her mother who would be bringing the baby for all subsequent visits “most likely”. Mom had been diagnosed with a very aggressive form of breast cancer and had been given just weeks to live. GG (the grandmother) was a retired first-grade teacher and was recently widowed herself. When the baby's father heard of mom's diagnosis, although he was no longer living with mom, he committed suicide. Mom did not live until the 12-month checkup but GG never missed an appointment and worked day and night with this little girl.

She was very highly functioning. She was not a translocation but phenotypically had mild features. Her grandmother dressed her in the latest styles and she had modern hairstyles and glasses. She had excellent social skills and was in a mainstream classroom well into her elementary school years. She was elected homecoming queen her senior year of high school and this was not a “pity” vote...she was truly everyone's friend. She graduated from high school with her special education degree. She works in a family business and helped GG take care of some of her other grandchildren and great-grandchildren until GG recently passed away. GG had made arrangements of course for her continued guardianship with three of her five half-siblings literally fighting for custody. She has a boyfriend and remains active in our local Buddy House for those with Down Syndrome and other mentally challenged young adults.

I never knew what I was going to hear or be asked in pregnancy consults, but I will never forget the 20 year relationship I had with this family until I retired and she transitioned to an adult primary care doctor in her community.

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## Experiences of Great Value

*David Parker, MD, FAAP, Placentia, CA*

One of the pleasures of pediatric medical practice is watching an infant grow and develop along with developing a bond of continuity with the family leading to a helpful trust relationship. These long-term bonds can be broken as families change their health plans due to a number of factors but it still can happen!

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One family asked to take a picture of their newborn son and me when I saw him at a few days of age. Then they would ask to take another picture each year at his annual check. At his 11-year-old visit the mother presented to me all those pictures. I want to say I was overwhelmed with gratitude and value these pictures immensely.

By this time the family and I had a special bond. This act of kindness by these dear parents gave me the honor to think that they felt I was helpful to them. This was a reward of great value.

Recently a college student interested in pursuing a career as a physician came to my home to meet me. I was not home but we did connect later. It turns out I had seen him as a patient for many years starting when he was several months old. Now we have met several times to answer his questions about pursuing his goal and the life of a physician.

Of course, I can only give him my perspective, which he understands. He is such a solid, gracious, and diligent student pursuing excellence. He is investigating opportunities to shadow me and other physicians. Also, he is exploring mission trips, health care professional development programs, and wants to attend medical conferences. On the side, he is a star water polo player. I appreciate that he is willing to listen to me despite his very busy schedule. This, too, is a reward of great value.

These are examples that make those years of medical school, residency, many nights on call, and working long hours worthwhile. These experiences give me immeasurable personal value.

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## Being a Physician and Seeking the Care of a Physician – A Dilemma

*Lucy Lester, MD, FAAP, Chicago, IL*

The graying of primary care physicians seems now to be a well-described phenomenon. Those of us who have worked for many years as pediatricians in academic medical centers or in private group practices have almost certainly followed the commonsense advice that we gave most of our patients - that is to see a physician on some kind of regular basis - unless of course a serious medical condition requires more frequent or specialty-based care.

During our busiest years, and before Medicare covered annual wellness exams, many of us put off any type of regular checkups and even delayed recommended screening tests. Then with retirement and no time-related excuses, the inevitable development of age-related maladies (osteoarthritis and the need for new knees or hips, hypertension, and maybe diabetes) have us making appointments with specialists and hopefully retaining a primary care physician to be our “medical home,” to coordinate our care and render opinions about what should and shouldn’t be done - what our options are.

But we may find ourselves having to find a new primary care physician, as our long-term and highly regarded PCP, the one we have had a long term relationship with, has also chosen to retire. If we are lucky, we will get a referral to a new PCP in the same area or practice where our medical records exist. (Yes, I know medical systems can often share records...) Many such programs or practices have no openings for new patients, (Yes, I know, you are not a new patient, but given the current bureaucracy, you are.) or you can see a resident in the PCP clinic. Once you do get an appointment, you may be seeing someone 20 to 30 years younger than you, who, if you were at an academic institution for any length of time, may have been one of your students or trainees, and though they may be very personable, they lack the years of experience of your old doctor.

This is not a problem unique to physicians, but what can develop is a situation that is very concerning to me personally - directing my own care. My new physician, who rarely does more than a very cursory physical exam, (these don’t generate fees...) recommends tests and procedures which then, unfortunately, beget other tests and procedures which I, at age 77 and in relatively decent health, find very problematic. I also don’t want to be counseled that I can get this test or start this medication, “if I want to.” I call this “physicians directing their own care,” and I am not happy about it. I have friends who have signed on with “executive health” practitioners, and although the care is very timely and personalized, I am not sure it is better. I wonder if others in the Senior Section have similar experiences or can relate to this problem.

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## Hubris and Humility

*Larry Eisenberg, MD, FAAP, Los Angeles, CA*

At one point during my pediatric residency, the department chief noted my troubled demeanor and asked what was wrong. I told of being overwhelmed by all that there was to know. He said not to worry, that the feeling would resolve in about 50 years. As I approach that milestone, I am still impressed by the ever-expanding body of knowledge we have acquired, but I am also acutely aware of all that we do not know, and distressed by our lack of humility while charging forward willy-nilly.

I recently took an AAP CME course on peanut allergy. The introduction noted an urgency to the issue of getting physicians and the public to introduce peanut products early to avoid allergies. Apparently, much of the community is still following our now discredited, yet fairly recent firm recommendation to avoid peanut exposure, which only served to increase the incidence of peanut allergy.

Decades ago in my pediatric GI practice, I cared for two teens with chronic ulcer disease, who bled dramatically on the not infrequent occasion that their compliance with chronic acid blockade lapsed. After a few ICU admissions and transfusions, they were on the cusp of proceeding with Bilroth surgery, at the time the most common surgical procedure in the U.S. As word of Helicobacter spread, I scoped them, found them to be infected, and successfully treated them with no further issues. Today Bilroth surgery is essentially confined to the history books. This incident always gave me great hope for the future, but a strong sense of insecurity that our current treatments would stand the test of time.

COVID is the most recent and dramatic example of our hubris. With little scientific evidence, experts and the official medical community recommended draconian measures that turned out to be of dubious benefit, with ongoing negative consequences. Worse, any debate was denounced as dangerous, and recommendations contrary to the prevailing orthodoxy, even when thoughtfully made by esteemed scientists, physicians, and Nobel laureates, were discredited by the experts and media as 'disinformation. This isn't how I was trained to approach scientific questions.

Mistakes are now being grudgingly admitted, but the emphasis seems to be on minimizing responsibility rather than on a meaningful assessment of how we went off the rails, and what we are doing to prevent similar missteps in the future. A Pub-Med search of "Covid Lessons Learned" revealed only one fairly recent observational review of policies and results from different countries, with the finding that things went best in countries with higher levels of trust in the authorities, a measure in which the United States did not fare well.

If we are to reestablish trust, it would behoove us to acknowledge and be transparent about our failings. While there is a sense, even akin to a belief, that medical progress is always a positive, we have to appreciate that just like the old dogmas that we now ridicule as archaic, there are undoubtedly things we are doing now, and things we will be doing in the future, that will fall by the wayside as we continue to learn. In this light, I wonder what our next flub will be, how many will we have caused to suffer, and whether the damage we cause will be remediable. Might I suggest a tad more humility and a lot less hubris?

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## Reaching For a New High; The Salad Bowl Syndrome

*Niru Prasad, MD, FAAP, Bloomfield Hills, MI*

Have you ever heard of the "salad bowl" syndrome? If you are the parent of a teenager, and you notice your salad bowls missing from the kitchen, please check your teenagers' bedroom closets. You may find these bowls stacked up with stolen medication pills that have been taken from parents or grandparents. These may even be color-coded. In the past year, there has been an increasing trend of prescription drug abuse among our adolescents. As more prescription drugs fill our medicine cabinets, our kids have more of a chance to abuse them.

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Last February, I had the opportunity to visit Cancún, Mexico. On the day I arrived at the resort, I was sitting in the lobby and observed an airport shuttle drop off a group of about 20 teenagers. They appeared to range in age from 16-18. Later that afternoon, while I was relaxing at the beach, I saw the same group of teenagers. I noticed that most of them were carrying their own "salad bowls" filled with what I thought was different colored candy. They were tossing the bowls around and passing them back and forth to one another. A few of them were also popping the "candy" in their beer bottles.

My curiosity grew more and more since these kids were loud, laughing, giggling, and appeared to be getting very high. When I got closer to the kids, I was shocked to see that what I thought was candy was actually medication - all color-coded in their salad bowls.

Sadly, experimentation with drugs and alcohol among teenagers is very common due to their growing curiosity, peer pressure, and the availability of drugs.

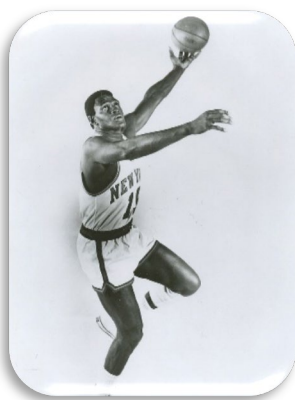
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## The Legend of Willis Reed

*Anthony L Kovatch, MD, FAAP, Pittsburgh, PA*

### Musical Accompaniment: "Basketball" by Kurtis Blow

"Or when, Willis Reed stood so  
tall Playing D with desire, it's  
basketball"



*Willis Reed, Jr. who grew up in Louisiana in the segregated South, was a star at Grambling State University before spending an illustrious 10 year professional career with the Knicks (1964-74). However, he will forever be remembered most for walking onto the court "one-legged" on the evening of May 8, 1970.*

Those of us who grew up during the turbulent 1960s and 1970s often considered ourselves a "generation lost in space." As an anxious, bookwormish kid hanging on by a thread in the New York Metropolitan Area, I relied on periodic distractions to find my way. The salvation for many of us - even if we were lousy at sports - was basketball, or "B-ball" if you wanted to appear cool. Every playground in New Jersey and "The City" had a full asphalt court and some of the backboards were lucky enough to still have chain nets on their rims. (These were rarely, if ever, replaced.)

On summer evenings we took to these hallowed watering holes to forget about life for a while. I imagined that I was the masterful Bob Cousy dribbling behind his back or the shifty Nate "Tiny" Archibald leading the NBA in scoring. However, when I was truly down-and-out, needed a kick in the keister, or felt physically or psychologically lame, I imagined that I was Willis Reed.

When Reed passed away on March 21, 2023, it jolted my memory into reliving an event that has inspired me for over 50 years and provided a tale of courage that I would narrate to my patients and their parents over 45 years of medical practice--- in my own words, to anyone who would listen. I have fondly called the revelation, "the legend of Willis Reed."

It was game 7 of the NBA finals and the series was tied at three games apiece. NBA icon Jerry West had made a full court shot for the favored Los Angeles Lakers (who had towering superstar Wilt Chamberlain dominating all other players in the series with his 7 foot 2 inch height) to send game 6 into overtime, which the Lakers won to tie the series. In game 5, Knicks star Willis Reed sustained a torn right thigh muscle serious enough to make him leave the contest and likely be out for the rest of the series; the prospects of winning the finals appeared dismal for the Knicks, in spite of the fact that the deciding game 7 would be played on the Knicks home court. The overall consensus was that it would take a miracle for the Knicks to

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win without #19 Reed, their all-star center, who at a “listed” height of 6 foot 10 inches was the only Knick capable of neutralizing Chamberlain.

The atmosphere in the Garden at pregame warmup time was foreboding---I remember that I could feel it just watching on television. All of a sudden (or “deus ex machina” as the ancient Greeks would have declared), Reed hobbled out of the locker room in his uniform. We assumed it was a psychological stunt contrived by the Knicks coaching staff. Next, Reed limped pathetically onto the court dragging his right leg in pain and started taking practice shots. The Garden crowd cheered ecstatically - part of the ploy, I thought. To everyone’s astonishment, #19 took the court to start the game and won the opening tipoff. The home team moved the ball around until Reed limped to the elbow of the foul circle. They fed him the ball, he took a jump shot with the Lakers dumbfounded, and “swish”—the Knicks are up 2-0! The crowd erupted into a frenzy that left the Garden vibrating! After the Lakers failed to score, the Knicks pulled off the same play with Reed hitting a jumper from the same left elbow. The crowd went wild, seemingly drowning out the noise of every honking vehicle in the Big Apple!

Although the score was only 4-0, the Lakers (already sensing a dire outcome) called an immediate timeout. However, they could not reverse the juggernaut of momentum produced by the heroics of one player, who risked the long-term function of his leg and his career for the hopes and dreams of his team, his city, his planet--and for a generation of kids for whom basketball was religion, politics, and almost everything else that mattered.

Willis Reed contributed very little more that night, as the Knicks never looked back. The dependable guard Walt “Clyde” Frazier took over the game and spearheaded the 113-99 “blowout,” scoring 36 points with 19 assists; unlike Reed, Frazier was a flashy, “Broadway-type” of personality, but his superior performance was dwarfed by the former’s display of courage that fateful evening at the Garden! The series MVP was awarded to #19.

When asked by the press after the game why he took the risk, Reed simply confided, “I didn’t want to look at myself in the mirror 20 years later and say I wished I had tried to play.” Now 53 years later, nobody would dare to argue with his decision!

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## A Doc Finds his Hog Heaven - Briefly

*Robert C. Hauck, MD, FAAP, Shoreline, WA*

Dr. Vern was my associate in the medical clinic where I practiced pediatrics. He was a highly regarded family medicine doc who had broadened his scope of care beyond traditional medicine with additional training in osteopathic and chiropractic medicine. He also had a subtle, disarming sense of humor.

We docs regularly lunched together and one day Vern related his exchange with a patient who presented with severe back pain due to a classic lumbar facet syndrome. As he was about to perform the remedial manipulation his patient blurted out, “I didn’t know you are *that* kind of doctor!” He reassured his patient that he was an “everything” kind of doc and proceeded to relieve the man’s agony.

Above all Vern was a cautious man who never took risks, most notably as a licensed private pilot. To survive as a small plane pilot Vern *always* followed a detailed protocol, and *never* took chances while flying. Caution was his mantra. That’s why we were shocked when he arrived in our doctors’ parking lot one morning driving the largest, grandest Harley-Davidson motorcycle then available. Earlier on he had frequently confided in us that his lifelong secret desire was to ride a *hog* but all his life he had been too careful --- and his pilot training had indelibly supported his cautious lifestyle.

Why this sudden change? Tragically a few days earlier his doctor had diagnosed an atypical melanoma which had already widely metastasized. With premature death looking him squarely in the eyes Vern was finally able to indulge his lifelong passion to be a biker and rode that Harley *hog* to work every day for his final weeks of practice.

Dr. Vern said a tearful “goodbye” to his panel of faithful patients who loved him and on his last day of practice, our entire

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clinic threw a goodbye party for him. During his final words to us he focused his attention on his medical assistant who had become a close friend, a petite and lovely young woman. “*Dear Friend, you can expect to see me back again because my ghost is returning to haunt you - but only when you’re in the shower.*” The tension of the occasion was broken by uproarious laughter. He turned to leave and stopped in front of Mike, the medex he had trained, mentored, practiced with for years. Ralph pulled from his pocket the keys for his newly acquired Harley, handed them to Mike with a warm embrace, and silently exited never to be seen by us again. No more laughter and no dry eyes in that crowded room. We had lost a treasured friend and colleague.

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## Under the White Hair: A Pediatrician’s View of Ageism

*Maggie Kozel, MD, FAAP, Jamestown, RI*

*Author of “My Legs are Crying: What a Pediatrician Learned About Emotionally-Based Illness.”*

My career in medicine included three decades of primary care pediatrics. In 2015, I switched course and accepted a position as Medical Director of the Inpatient MedPsych unit at Hasbro Children’s Hospital. It was an exciting capstone to my career – the chance to apply my wealth of experience and hard-earned wisdom in a remarkable, innovative program.

I was sixty years old, healthy and active. My thick white hair felt like a fashion statement more than an announcement of my age. My ego, having stopped serving any real purpose somewhere in my forties, had learned to take a back seat whenever one of my long-held professional mindsets was challenged by new approaches. I had learned over decades to question my clinical assumptions as carefully as I did novel-sounding approaches from others.

My sixty-year-old brain was, by then, a well-oiled machine, ready to assimilate new information into the pre-existing files that I had been busy establishing in my frontal lobes for decades. Instead of taking a sluggish couple of months to see the merits of these new MedPsych concepts and incorporate them into the complex cognitions of pediatric practice, my education moved at warp speed. I would argue that when it came to fundamental shifts in clinical mindsets, I learned much faster in my sixties than in my twenties. Yet to my dismay, my snowy hair and fine wrinkles combined with the audacity of my leadership role made me low-hanging fruit for a small handful of troublesome employees.

As in any other collision of human nature, small pockets of sexism and ageism emerged. I had dealt with sexism my entire medical career. The ageism I experienced in this leadership role, however, was new. Thinly veiled suggestions of inappropriate workplace attitudes were handy ways to gain traction with Human Resources. One especially painful complaint asserted that I had no idea what it was like to raise children as a working mother. It made me look up over my computer at the framed pictures of my two grown daughters with a sigh of frustration. I championed maternal rights in the workplace my entire career. It was hard not to react defensively. But I strived, with every ounce of maturity I could muster, to not take the bait and to stick to the facts of whatever problematic behavior was at issue.

Forgetfulness was the most demeaning accusation I experienced. When, as a young intern, I made a mistake writing an order, a white-haired wrinkle-faced oncologist told me, “It is better to be conscientious than to be smart.” That was some of the best advice I had ever heard. So at sixty, I might have had names and diagnoses swirling around in my head after admitting three girls of similar ages with similar complaints over a two-hour period late in the day, but I had also spent my career building guardrails. I knew to check a patient’s chart carefully before any intervention and refer to notes as I presented patients in rounds. What a number of the young unit staff didn’t understand was that that’s not a memory thing. That’s a conscientious doctor thing.

A [2022 AARP survey](#) of employees over 50 showed that 91% believed ageism was common in the workplace. [Other studies](#) have indicated that aging women endure ageism at a greater frequency than their male counterparts. Now, from the vantage point of retirement, I am proud of how I embraced the new and transformative MedPsych practice experience. It was painful to watch how easy it was for a small handful of employees to sow seeds of doubt about an older woman in a leadership

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position, but my reward for holding strong was that I earned the respect of the colleagues that I respected. In the process not only did I help build an innovative program and witness very sick teens become well, but I also continued my lifelong quest to become the best pediatrician I had ever been.

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## The Civil Rights Trail from Atlanta to Birmingham

*Beryl Rosenstein, MD, FAAP, Baltimore, MD*

To get a close-up look at the civil rights movement in the South in the 1950s and 1960s, my wife and I recently joined a 7-day group bus trip through Georgia and Alabama. We started in Atlanta, visiting the Georgia State Capitol where ironically, there was a portrait of former Governor Lester Maddox, a virulent racist, who operated the segregated Pickrick restaurant in Atlanta in the 1960s. We then visited the historic Ebenezer Baptist Church where Martin Luther King, Jr. served as co-pastor with his father. In the same area, we visited Martin Luther King, Jr.'s birthplace, historic site and memorial where he and his wife Coretta are buried. The next day we visited the National Center for Civil and Human Rights Museum, highlighting discrimination against multiple races and ethnicities. We then went to the Jimmy Carter Center, Library and Museum, featuring Carter's activities, both during and after his presidency as a champion of racial equality.

The following day we were off to Montgomery, Alabama where we explored the Alabama state archives and the State Capitol. In downtown Montgomery, we were able to walk the 900-foot bus route where, on December 1, 1955, Rosa Parks refused to give up her seat at the front of the bus to a white man setting off the 381-day boycott which led to the integration of the Montgomery Bus System. The boycott brought Martin Luther King, Jr., then preaching at the Dexter Avenue King Memorial Church, into a prominent role and proved to be the spark for the civil rights movement in the South.

Other stops in Montgomery included the Civil Rights Memorial Center honoring people who sacrificed their lives for the civil rights movement and the Freedom Riders Museum telling the story of a small interracial group of young people who in 1961 boarded a Greyhound bus in Washington, D. C. with a goal of going all the way to New Orleans. Their trip was marked by fire bombings and personal assaults by violent racist mobs. The freedom riders eventually ended segregation in interstate travel, and the Greyhound terminal where they arrived in Montgomery is now home to a museum.

Also, in Montgomery, we visited two outstanding museums sponsored by the Equal Justice Initiative: The National Legacy Museum of Peace and Justice which chronicles America's journey from enslavement to mass incarceration, and the National Memorial of Peace and Justice, also known as the National Lynching Memorial. The Memorial is located on a beautifully landscaped site overlooking Montgomery and serves as a touching memorial to the 4,400 people, largely African American men, lynched from 1877 to 1950. We discovered that one of the lynchings occurred only two miles from our home in Baltimore. The Memorial consists of 805 suspended 6-foot steel bars each representing a county in America where lynchings took place. These museums were the highlight of our trip.

In Selma, we had planned to walk across the Edmund Pettus Bridge, but this had to be canceled because of the threat of tornados. However, we did make several stops along the historic 54-mile, 5-day walk from Selma to Montgomery, including a visit to Alabama State University, an HBCU from which students made daily marches to the State Capitol. We learned that in March 1965, there were actually three marches in support of voting rights for African Americans. The first attempt was unsuccessful due to violent interference by the police on a day known as "Bloody Sunday," the second turned back to avoid a confrontation with police, and the third march started on March 21<sup>st</sup> and succeeded. A small group of 300 people completed the march and by the time they arrived in Montgomery, they were greeted by a crowd of about 25,000. Governor George Wallace kept Martin Luther King, Jr. from speaking to the crowd from the Capitol steps by surrounding the building with 300 Alabama state troopers.

Our last stop was in Birmingham, called the most segregated city in America by Martin Luther King, Jr. In the 1950s and 1960s, it was also called "Bombingham" because of the number of bombings by white supremacist groups, including the

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Ku Klux Klan. We visited the Sixteenth Street Baptist Church known for the September 1963 bombing by Klansmen which led to the deaths of four African American girls and probably hastened the passage of the Civil Rights Act of 1964. Next to the church is Kelly Ingram Park where police chief Bull Connor turned dogs and fire hoses on demonstrators, including many children who had gathered to protest segregation laws. Our last stop in Birmingham was the Civil Rights Institute featuring graphic highlights of the civil rights struggle.

We had a memorable trip, one that we would highly recommend. People are familiar with many of the civil rights leaders such as Martin Luther King, Jr, Ralph Abernathy, John Lewis, Julian Bond, and others, but during our journey, it became very clear that the civil rights successes were also due to the heroic actions of strong southern black men, women and children, who put their lives at risk on a daily basis to gain the civil rights denied them for so many years.

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## Israel's Doctors at War: Report From An American Pediatric Surgeon Volunteer

*Michael Fuenfer, MD, FAAP, Marblehead, MA*



It seems as though, in some parts of the world, as soon as one war ends, another begins. And so it was on the Black Sabbath morning of October 7, 2023, that Israel was once again forced to defend itself against an existential threat. Put into perspective, the attack on Israel that day would be equivalent to the terrorist attacks visited upon the United States on September 11, 2001...times twenty. The sheer magnitude of major traumatic injuries on that day threatened to overwhelm the medical resources of hospitals in southern Israel. In the ensuing weeks, thousands of missiles rained down upon cities, towns and kibbutzim throughout the country. At the northern border of Israel with Lebanon, Hezbollah terrorists were poised to launch thousands of Katyusha rockets into Israel, and there was growing unrest in the West Bank. Fearing a war on three fronts, the Israeli Ministry of Health solicited medical volunteers from around the world willing to provide medical assistance if needed. I raised my hand, and after a few administrative formalities, I was fastening my seat belt on an El Al flight from Boston to Tel Aviv.

Upon arrival in Israel, I boarded a train north for the two-hour journey to the city of Nahariya and the Galilee Medical Center where I would be working. As the conductor walked down the aisle, I noticed a 9 mm Jericho semi-automatic pistol tucked reassuringly into his back pocket. Welcome to Israel. Military service is compulsory for the majority of Israelis when they turn eighteen. Men are required to serve on active duty for thirty-two months and women twenty-four. After this period, they remain in the Reserve, subject to being called up to their units until the age of forty, but in this time of national emergency, many mobilized soldiers appear quite a bit older. In the weeks following the October attacks, over 360,000 Israel Defense Force (IDF) Reservists' peacetime lives were put on hold as they were recalled to active service. At each station, the train platforms were crowded with young Israelis clad in their newly-issued olive drab fatigues, combat boots, and overloaded rucksacks en route to their assigned units. As a general rule, terrorists don't wear uniforms or nametags, and throughout the country, there are daily reports of violent, unprovoked attacks on civilians in public venues. IDF soldiers carry their weapons with them everywhere, mostly M-16A1 rifles, M4 carbines and variants of the IWI X95 assault rifle. If you're one of those individuals who is prone to panic attacks at the very sight of an automatic weapon, a country at war is not a place you should visit.

Unlike the case in most countries, when Israel goes to war, everyone goes to war...the CEOs of companies, lawyers, students, rabbis, scientists, teachers, engineers, mechanics, shopkeepers, salesmen, and doctors...especially the doctors. The Galilee Medical Center (GMC) is situated only a few miles from the border with Lebanon, or put another way, an eleven-second Hezbollah rocket flight away. During the 2006 Lebanon War, Hezbollah fired 3,970 rockets into Northern Israel in a

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month, killing forty-three Israeli civilians. One of those rockets exploded in the ophthalmology clinic at the GMC. There were no casualties, but this provided the impetus for the hospital to convert the underground floors into wards capable of providing patient care as a contingency for future emergencies. In the days following the October 7 attacks, 96,000 residents of northern Israel were evacuated to the relative safety of the central and southern parts of the country. At the GMC, all patients, including those in the Neonatal and Pediatric Intensive Care Units, were transported to the confined subterranean maze of corridors and wards, protected by blast-proof doors, and reinforced walls. Due to limitations on space and resources, each morning ambulances transport the less seriously ill patients to other medical facilities. One of the largest of these is the expansive Rambam Medical Center in Haifa, where a massive, purpose-built underground hospital is capable of accommodating more than 2000 patients.

Many hospital staff doctors throughout Israel are IDF Reservists and quite a few from the GMC were mobilized to their IDF medical units, leaving some departments, including Pediatrics short-staffed. Several attendings had been working continuously without a day off for over four months, and although the physical and mental strain was evident, there were no complaints, and an atmosphere of camaraderie fostered by shared sacrifice and a commitment to patient care predominated. The medical staff, residents and medical students were fluent in English, but the majority of patients and parents were not. As someone not fluent in conversational Hebrew, the language barrier and the electronic medical record system served as obstacles to a certain extent, but other medical staff members were readily available to serve as translators.

The population of northern Israel is a very diverse one, comprised of Muslims, Jews, Christians and Druze sects who have been living and working together in peace for generations. This was clearly evident among the staff of the GMC whose inclusivity encompassed all religious affiliations and diasporas throughout the world. In the Operating Room, the surgeons were speaking Hebrew, the anesthesiologists were conversing in Russian, and the nurses conducted conversations in a language that I was unable to identify. The director of the GMC is a Christian Arab. Peaceful coexistence is an attainable goal when all parties commit to it.

As Israel enters its sixth month of war, blaring sirens warn of incoming missiles and rockets with regularity, terrorist attacks are a daily occurrence, over 134 people, including American citizens, remain hostages of Hamas in Gaza, and Hezbollah has thousands of Katyusha rockets aimed at northern Israel, Iran is on the precipice of having the ability to produce nuclear weapons, and its proxies in Yemen and Syria continue to attack U.S. troops, and disrupt seaborne commerce in the region.

This is the Middle East today. The IDF is conducting the most complex and difficult military campaign in the history of warfare. It is implementing extraordinary measures to minimize civilian casualties, even with the knowledge that in doing so, the risk to its own soldiers is greatly enhanced. Despite these many challenges, the Israeli military will prosecute this war on its own terms, and defend their country with resolve, strength, and the determination to achieve total victory, and freedom for the hostages. It was my privilege to be given the opportunity to contribute in some small way to the care of children caught up in this terrible conflict.

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## Medical Mission in the Dominican Republic

*Robert Ross, MD, FAAP, Bloomfield Hills, MI*



One of the most gratifying projects that I have done in my life was starting a volunteer medical mission to Santo Domingo in the Dominican Republic (DR) for heart care for the children in that country. I attended a charity dinner for Variety Club International and spoke to a board member who asked if I would be interested in doing this. As I had no experience, I joined a team from Hershey Medical Center led by my friend from fellowship, Steve Cyran, on their mission to Ecuador. There I soaked up as much information from all members of the team as to what worked and what didn't over their years there.

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I then contacted several teams that had been to the DR and arranged an exploratory visit in early 2003. We visited Santiago and Santo Domingo and while the need seemed greater in Santiago, we chose to set up shop at an institution called CEDIMAT in Santo Domingo because they had experience hosting foreign medical teams and we could get started sooner there. Over the next six months, I put together a team of 19, including a heart surgeon, three cardiologists, an intensivist, an anesthesiologist, ICU nurses, a pump perfusionist, and my organizational assistant who was our stress technician at Children's Hospital of Michigan (CHM), our home hospital in Detroit. With the support of Children's Lifeline International, led by Salah Hassanein, we shipped equipment and supplies and flew off that November. It was a remarkable feat, only made possible by the total dedication of every team member.

Our first day at CEDIMAT was pure chaos as families filled the hospital; we screened dozens of children with echocardiograms, decided on the surgical and catheterization schedules, and met with parents and the local medical team. The next day we operated on two young children and the response we received was that it seemed to the local team like we had been doing this there forever! The gratitude from the families, even those whose children could not have surgery due to intercurrent illness, was palpable. We were hooked and completed countless consultations, 13 surgeries, and multiple catheterizations, including placing the first ASD closure device in the country. It was such a success that a team member said that, after their marriage and the birth of their children, the trip was the most moving experience of their life.

Over 20 years have now passed since that inaugural trip, and we have returned once or twice every year since, including this past November, and have now brought over 200 people including many senior cardiology and ICU fellows. I love that even though I retired from CHM in 2022, I am able to continue this fantastic work in the DR.



Milestones over the years include the hiring of a dedicated pediatric heart surgeon there in 2014 and the opening of a dedicated new heart institute in 2016 with one floor of pediatric care. That floor is called the David Ortiz Pediatric Cardiology Unit in honor of the famed baseball player who leads the Heart Care Dominicana Foundation which raises funds to support the mission there. Dr. Juan Leon was the heart surgeon, was soon doing 250 cases a year, and even took his team to Mexico to teach them how to do this work. Imagine a second generation mission! I never dreamed this would go so far. Sadly, Dr. Leon passed away recently after a hard-fought battle with cancer. He will be greatly missed.

While we were there in November, CEDIMAT and the Foundation committed to hiring two full-time pediatric heart surgeons, one of whom is already in place. It is gratifying that they continue to invite us back to help with the most complicated cases and to continue to teach and mentor the faculty. In June 2023, I was invited to give a plenary address to their annual cardiology conference on the origins and utility of the Ross Classification of Heart Failure in Infants and Children which was based on research I did as a fellow in Cincinnati. Many of the cardiologists that we have been working with over the years came to Punta Cana specifically to hear my talk.



I have learned so much and feel like I have a second home and family in the DR from my many trips there and regularly communicate with the local team about patients, families, and life there. I feel blessed to have had this opportunity that has enriched my life so much. I heartily recommend that everyone find opportunities to volunteer in areas of need. Feel free to contact me with any questions as to how to get involved ([ross.robert86@gmail.com](mailto:ross.robert86@gmail.com)).

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## Magic Moments in Major League Baseball

*John McCarthy, MD, FAAP, Troy, NY*

### **“The Giants Win the Pennant!”**

During the regular 1951 baseball season, the Brooklyn Dodgers dominated the National League and the New York Giants lagged by as many as 13 1/2 games by mid-season. But miraculously, they surged, and by the end of the regular season the Giants were tied with the Dodgers. This triggered a best-of-three playoff. Over in the American League, The Yankees easily won the 1951 pennant and cooled their jets while the Giants and Dodgers played their playoff.. Well, the Giants won game 1 and the Dodgers took game 2. It’s game 3 for all the marbles.

Another nail biter as turned out. Going into the bottom of the ninth the Dodgers led 4-1 thanks to strong pitching from Don Newcombe. But the Dodgers made a fatal error by bringing in Ralph Branca who had only one day of rest. Alvin Dark and Don Mueller led off with a pair of singles. After Monte Irvin popped out, Whitey Lockman doubled to left center sending Dark home as Mueller slid safely into third but sprained his ankle. With runners on second and third, and the score 4-2, Bobby Thomson comes up to bat and on the very first pitch, he hits a “walk-off” line drive home run into the left field stands.

Russ Hodges the radio broadcaster went crazy and kept on yelling, “THE GIANTS WON THE PENNANT!” until he became hoarse. Sportswriter Red Smith called it “The Miracle at Coogan’s Bluff.” Others referred to it as “The shot heard around the world.” Moving on to the World Series against the Yankees, the Giants fell short thanks to Hank Bauer’s heroics on the field and at bat. It was also the last game for Joe DiMaggio before he retired after an incredible 13-year career.

### **Lou Gehrig “The Luckiest Man on the Face of the Earth”**

“Fans, for the past two weeks you have been reading about the bad break I got. Yet today I consider myself the luckiest man on the face of the earth. I have been in ballparks for seventeen years and have never received anything but kindness and encouragement from you fans..... So, I close by saying that I might have been given a bad break, but I’ve got an awful lot to live for you.”

Nearly 62,000 came to Yankee Stadium on July 4, 1939, (Lou Gehrig Appreciation Day) to pay tribute to a real hero. His performance that day was as remarkable as any he had as a player: .340 lifetime batting average, 493 home runs, 1,995 runs batted in, and playing in 2,130 consecutive games, a record not broken until Sept 6, 1995, by Cal Ripken, Jr as a Baltimore Oriole who ended up with 2,632 games.

On December 7, 1939, the Baseball’s Writers Association voted unanimously to admit Lou to the Baseball Hall of Fame. He died June 2, 1941, of amyotrophic lateral sclerosis (referred to now as Lou Gehrig’s Disease). He is buried at Kensico Cemetery in Valhalla, NY.

### **The “Bambino” Points the Way.**

In 1932, the Chicago Cubs won the National League pennant and were poised to play the World Series against the dreaded New York Yankees who still had remnants of the notorious. “murderers row” that had peaked in 1927 (considered the best baseball team in history). The Cub fans packed Wrigley Field (50,000) to root for the home team. They even constructed temporary bleachers to fill with avid Cub fans eager to taunt the Yankees, who had already won the first two games of the Series at Yankee Stadium. Whenever Babe Ruth came up to bat, the fans were especially nasty. The Cubs pitcher, Charlie Root, glared at Ruth, who already had homered against him in his previous at bat. Nevertheless, the Babe pointed to center field where he predicted he would hit the ball. Gehrig on deck confirmed Ruth’s intention. Sure enough, on the next pitch, Ruth hit his second home run of the day in the very spot he predicted. On the next pitch Gehrig hit his second home run of the day as the Yankees trounced the Cubs at Wrigley Field. They also won the next game to win the Series 4-0. Shades of Murderers Row.

### **The Stars are Aligned: Jackie Robinson Meet Branch Rickey**

Wesley Branch Rickey came into this world on December 20, 1881, as a Christmas present for Frank & Emily Rickey; their second son who immersed himself in both academics and sports, especially baseball. He had brief stints in the major leagues

*Continued on Page 21*

as a player for four seasons with a .239 batting average and graduated from law school, but baseball was his focus. In 1918, he joined the Army Chemical Corps in a unit with Ty Cobb and Christy Mathewson.

After the war, he became the field manager for the St. Louis Cardinals but eventually Branch was kicked upstairs as their general manager and developed the idea of creating a baseball farm system where young baseball players could be groomed to enable them to successfully join the major leagues. He proved to be a cold-blooded judge of talent. Branch came to believe that it is better to “trade a man a year too early rather than a year too late.” These skills ultimately resulted in Cardinals’ success between 1926-46 as they dominated the National League with nine pennants and six World Series wins.

In 1942 the Brooklyn Dodgers recruited him to be their general manager. Here he began to see the value in grooming players from the talented Negro leagues. He felt strongly that it was time to end segregation in baseball, a very controversial issue. He began his search in earnest. He looked not just for talent BUT for the best combination of on-field skills, maturity, and intelligence. His “torchbearer” should be college- educated and willing to accept this noteworthy plan. Ultimately, he chose Jackie Robinson, a graduate of UCLA where he had been a baseball and football star.

Jackie did not disappoint his mentor. He concentrated on being the best player on and off the field, not reacting to the protests from baseball fans and other players when he officially joined the Brooklyn Dodgers on April 15, 1947 at the age of 28. With Branch’s support, he ended racial segregation in professional baseball that had relegated Black players to the Negro leagues since the 1880’s, when Branch was a little boy. In addition to both being chosen to the Baseball Hall of Fame, I think that they deserved the Nobel Peace Prize.

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## **Chronicles of a Doctor-Patient (Formerly a Patient Doctor)**

*Frederick Bogin, MD, FAAP, Hatfield, MA*

### **PART 2**

In early January 2013, I was admitted to the hospital. Step one was the cardiac cath. The cardiologist who was head of the cath lab observed closely as one of the cardiology fellows carried out the procedure. I was sedated, given some pain medicine and the procedure was uneventful. Once complete, the senior cardiologist said to me –

“I’m jealous!”

I thanked him and told him that was exactly what I would hope to hear from the director of the cath lab.

The following day was my surgical date. I was wheeled on the wings of Dr. Groopman’s “hope”, from my room to the pre-operative preparation area. On the way into that location, we passed a large painting of a cardinal hanging on the wall. My family, for several years, has subscribed to the belief that my deceased mother periodically appeared to us in the form of a cardinal. I smiled as I rolled past and thanked her for watching out for me.

Once in a room the nurses welcomed me, checked my vital signs, and told me that my chest needed to be shaved. In walks a beautiful young lady, who I swear looked like Beyonce. When she had finished her job, I asked if she had a business card, in case I needed a follow-up chest shave in a month or so. She smiled politely and left.

I don’t recall anything that happened after that until I awakened in the coronary ICU which is where the cardiac surgery patients receive their first few days of post-operative care. The nurse who was to take care of me was extremely kind, conscientious, and had a delightful British accent. As I became more awake and alert it was clear to me that she was really the one who was directing my care. There was a surgical PA who stopped by but clearly was not “in charge”. I don’t believe I saw a physician until later in the day when my cardiology friend Rick Soucier stopped by.

After what seemed like a long delay my wife was allowed to come into the room. I learned that she, my son, and our

**Continued on Page 22**

daughter had been sitting nervously in the surgical family waiting room for an extra hour after I was on my way to the ICU. Dr. X never came out to tell them that the surgery was done and successful. It was only after waiting an hour longer than anticipated that my family was able to find out from one of the OR nurses that I had gone to the coronary ICU one hour earlier. I did not see my surgeon for the next three or four days. Rick's comment about "not having Dr. X for a friend" was now more understandable.

I sensed that the ICU nurses continued to be the main ones monitoring me and intervening as needed. I felt completely confident in their care and very grateful for their attention. Several weeks after I was home from the hospital, I wrote a letter to the hospital's director of nursing describing my experience as a physician-patient, praising the quality of nursing care that I had received and expressing my gratitude.

Over the next two to three days my condition became much more stable. I was more comfortable, and each day some of the multiple tubes, sprouting out of my body like porcupine quills, were removed. Each item removed was a cause for some celebration. On the third hospital day, I was sufficiently stable and "un-tubed" to be transferred to a regular surgical floor. I recalled my surgeon telling me before the surgery that the sooner I could get up and walk, the better my outcome would be. So, I began walking shortly after reaching the surgical floor.

I recall my first stroll with the all-too-revealing, open-in-the-back hospital gown, prompting me to ask the nurses' aide –  
"Does this gown make my butt look fat?"

While in the ICU I had visits from my wife and our adult children. My oldest son even spent a night in the ICU room with me. I believe it was my second night there and I much appreciated the company. Unlike my surgeon who never came to check me, Rick came in every day, often after he was done with his workday. It gave me great comfort to know that he was keeping an eye on my progress. Once I was on the surgical floor my co-workers from the Clinic were kind enough to visit me.

On the fourth hospital day, my surgeon finally appeared. He told me that everything was fine and that I could go home that day. I told him that I would like to stay another 24 hours as I was still feeling weak and somewhat uncomfortable. He agreed to the discharge being moved to the following day. I didn't see him again before I left the hospital. I had initially been receiving fairly strong meds for pain, but by the time of my discharge on day five, I was able to be comfortable with just Tylenol. In the blink of an eye, I was home. Comfortable, smiling, and very grateful for the excellent care that I had received. Little did I know that this was just the beginning of my ongoing medical journey as a doctor-patient.

## Second Acts

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### The Un-merging

*Carolyn Roy-Bornstein, MD, FAAP, Newburyport, MA*

Like many physician retirees, I have turned to volunteer work in my retirement. I've become the writer-in-residence at the same large urban family medicine residency program where I started my own career decades ago. Bimonthly, I lead young doctors-in-training in narrative medicine workshops. We read and discuss short stories or poems as a way to explore various aspects of their professional journeys: themes like grief, death and dying, transitions, and self-compassion. We write reflectively in response to prompts I create to help them connect the readings to their experiences as residents. Sharing their writing with each other forges bonds and brings them closer together on their collective journey.

This month I am preparing a session themed around identity. We will read an excerpt from Susan Onthank Mate's *The*

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*Laundry.* We will discuss how the personal identities they brought with them to medical school and residency must now merge with the professional identities they are cultivating as physicians.

As I draft notes, I can't help but think about my own process now of *un-merging*. In retirement, I must unspool my identities; pinpoint those true north aspects of myself that drew me to medicine in the first place and reclaim those that I've had to set aside but that can now flourish.

Curiosity is what first attracted me to medicine all those years ago. I was drawn to the sheer intellectual challenge of it. I loved that medicine was ever-changing; that there would always be something new to learn. I was a nurse before I went to medical school. I would watch the residents rotate through my pediatric ward and think I could write those orders. I knew what children with asthma exacerbations or dehydration from gastroenteritis needed. But what fascinated me was how they knew what to order to figure out a completely perplexing set of symptoms and come up with a diagnosis. How did they do that? Solving those enigmas myself has given me some of the proudest highlights of my medical career. Making diagnoses that multiple specialists had missed. Those are the moments I can tick off like the names of my children.

If curiosity and intellectual challenge drew me to medicine, it was the relationships with my patients that kept me tethered there. Being the trusted person on the team that parents come to for answers - even when the team consisted of some of minds far greater than mine - fills me with gratitude and satisfaction. Taking care of young children whose parents were also my patients is a special source of pride and, yes, love even. Seeing children graduate from college whom you also saw being born, well, there might be no words for that.

I've also been thinking a lot about what parts of my identity took a backseat during my career as a doctor. For me, the big one in that area was creativity. One can argue that there is an art as well as a science to medicine; that to entertain a broad differential diagnosis takes ingenuity and imagination; that the best self I brought into the exam room to listen to patients and write notes was an artistic being. But as a writer, I want more from my creative self. To be able to sit in front of an empty piece of paper or a blank computer screen and create a story from my own mind is a thrill like no other.

So to me, this un-merging I am doing is a kind of interoception: a re-examination of all the various parts of my career. I am figuring out which ones are essentially me at my core and can continue to grow in retirement. The intellectual curiosity will drive me to find the best readings for the residents, to create the most probing prompts, to ask just the right questions in our literary discussions. The relationships I am beginning to form there are nourishing to me and have great potential to grow. I can envision the graduation of the first class I taught filling me with the same sense of pride with which I watched my patients grow and thrive. I am also asking myself which facets of my identity have been stifled by the rigor and intensity of this challenging career. What part of myself is eager to be given space and time to blossom? My creative urges can also find space to take root in my role as writer-in-residence. Reading poetry and writing reflectively all feed my soul and give meaning to this next phase of my life.

Narrative medicine has helped me to find the throughlines in my life as a doctor and apply them to the profession's next generation. Merging past with future. Self with others. Experience with novelty. And find meaning in it all.

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## **My Retirement Occupation – Medicare Counseling**

*Joan Adler, MD, FAAP, Philadelphia, PA*

After a career in clinical/academic medicine as a pediatrician/adolescent medicine doctor, I left to work at several pharma companies doing clinical research and medical affairs on vaccines.

I retired in 2016 and immediately started volunteering as a Medicare counselor. I am part of a national organization called the State Health Insurance Assistance Program (SHIP). This is a federally funded agency that provides free Medicare counseling to anyone who requests it. We have different names in different states. In Pennsylvania, we are called PA MEDI (formerly APPRISE.) Volunteer counselors are extensively trained in Medicare issues and learn to do individual counseling with Medicare beneficiaries. Some of us also do presentations.

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Most of our counselors are former healthcare providers, social workers, or former insurance professionals. We are volunteers and so have no vested interests. We are more helpful than the salespeople at the numbers flashed on TV and the salespeople that answer phones at the insurance companies.

Who needs Medicare counseling? Everyone. Medicare is a very complex system with enrollment deadlines, penalties, different options for receiving Medicare, and lots of factors to consider when deciding what sort of plan is best for an individual.

I see the rich and the poor, people of all races and backgrounds. Often the beneficiary has received incorrect information from friends, family, employers, and even Social Security. I can guide the beneficiaries through the maze of Medicare and help them choose a plan that is best for them. We also do assessments of income levels so that we can help people apply for programs that may lower their costs. We are problem solvers.

I find this work very rewarding, especially when someone calls with a problem I can easily resolve. Everyone is confused by the Medicare system and it's great to be part of an organization that can help explain and advocate for Medicare beneficiaries.

If this kind of work interests you, go to [www.shiphelp.org](http://www.shiphelp.org) to find your local SHIP office and ask about volunteering.

# Movie Reviews

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## Spring 2024 Movie Reviews

*Lucy Crain, MD, MPH, FAAP*

### ORIGIN

Written and directed by Ava DuVernay and adapted from Isabel Wilkerson's book *Caste: The Origins of our Discontents*, this is a beautiful movie about a very serious subject. It also tells a personal story of the author's life complicated by family joy and tragedies. The cinematography by Matthew J. Lloyd is outstanding, as is the acting. Unlike the book, the film depicts Wilkerson's background research and data gathering as she writes her second best-seller. *Caste* illustrates her analytical premise that the underlying cause of divisiveness in the United States is caste, not race. The underlying love story rings true with outstanding portrayals of Wilkerson (Aunjanue Ellis-Taylor), her husband Brett (Jon Bernthal), her mother (Emily Yancy), her cousin Marion (Niecy Nash) and many others. As a writer, Wilkerson uses vignettes to tell her stories. As a researcher, Wilkerson travels to Mississippi, to Germany, and to the slums and sewers of India in her attempt to look beyond race. She defines caste as the "ranking of supremacy of one group against the presumed inferiority of others" as the underlying cause of divisiveness. The movie begins in 2012 with Professor Wilkerson lecturing on her first book *The Warmth of Other Suns: The Epic Story of America's Great Migration*. Following the lecture, her editor (Blair Underwood) encourages her to write about the recent murder of young Trayvon Martin in Florida. She resists initially, but then weaves this event into the story, making her point in a dramatic re-enactment of Martin's death complete with the actual 911 call recordings. This powerful episode, as well as tragic events both personal and otherwise throughout the movie make her premise of connectivity convincing.

This movie is a masterpiece.

Released in September 2023 but inexplicably not nominated for an Academy Award. PG 13, 135 minutes. In theatres.



## MAESTRO

Bradley Cooper's long-awaited cinematic tribute to Leonard Bernstein opened in December 2023 to mixed reviews provoking more discourse about Cooper's prosthetic nose than his remarkable portrayal of Bernstein. The movie surprises viewers with its focus on the troubled marriage of "Lennie" and his wife- accomplished actress Felicia Montealegre - who is exquisitely played by Carey Mulligan. Only 25 years old when summoned to replace the ill conductor of the New York Philharmonic, the film opens November 14, 1943 with Bernstein, in bathrobe and pajamas, dashing from his apartment to Carnegie Hall, beginning a career full of promise and musical genius. His conductorial debut for a program beginning with Schumann and concluding with Wagner was a roaring success, heralding a lengthy career filled with more accomplishments in composing and conducting. His marriage was less successful, complicated by the sacrifice of his wife's career, his bisexuality and recurring affairs, and finally the death of Felicia. This is not a film for those expecting an in-depth summary of delightful music, although snippets of *Candide*, his original *Mass*, and other well-known Bernstein masterpiece compositions were superbly performed. Beautifully filmed initially in black and white and later in color (Why?..), the film depicts previously unknown aspects of the personal life of the "first great American conductor" who was also a great American composer.

Rated R for excessive smoking and discrete nudity, 129 minutes. Limited release in theatres and streaming on Netflix and other platforms.

## THE BOYS IN THE BOAT

2024 starts with a feel-good patriotic movie that is well-done and entertaining. Based on the 2013 book by Seattle author Daniel James Brown, the plot is mostly true. During the Great Depression, Crew Coach Al Ulbrickson (Joel Edgerton) at the University of Washington in Seattle chose a junior varsity rowing team of nine inexperienced young men from a throng of UW students hungry for paying jobs and room and board. British actor Callum Turner plays Joe Rantz along with a talented cast including Hadley Robinson and Peter Guinness. The movie was filmed in the United Kingdom (which supposedly looks more like Seattle of the 1930s), so the ever-present rain, evergreens, nearby snow-capped mountains and other Seattle landscapes were missing. Attention to period settings and furniture, costumes, and style was excellent. Director-producer George Clooney gives brief attention to character development with views of dysfunctional families, oppressive poverty, and refreshing romance, but the primary focus is on team building his crew. Racing scenes were exciting and beautifully filmed on the Cotswolds lakes as the team achieved the desired synchrony and competitive spirit, rowing their way to the 1936 Summer Olympics in Berlin where they won the gold medal for crew (much to Hitler's chagrin).

PG 13, 124 minutes, Collaboration with Spyglass Media, Smokehouse Pictures and distributed by MGM. In theaters and soon Streaming. (If interested, you can view the authentic "Boys of '36" on PBS American Experiences and YouTube.)

## MAY-DECEMBER...

Directed by Todd Hayes (*Far from Heaven*) and screenplay by Samy Burch, this unsettling story is loosely based on the 1997 case of 6th-grade schoolteacher Mary Kay Letourneau, who was jailed for having sexual relations with her 13-year-old student. The movie character is Gracie, a professional baker (Julianne Moore). Like Letourneau at age 36, she had a sexual affair with Joe a 13 year old co-worker in a pet store and was arrested and imprisoned on child abuse charges. While in prison, she became pregnant with his child (or her husband's child?) and eventually divorced and married the younger man. The story is confusing, as Tom, her ex-husband, continues to be a part of her life along with their four other children. The tabloids were filled with lurid details of the so-called affair, but her marriage to Joe was treated mostly with acceptance and admiration in the deep South setting, where she and Joe seem to enjoy an idyllic relationship living in a riverfront mansion in Savannah. The musical score is haunting throughout, underscoring Gracie's psychopathology. Actress Elizabeth (Natalie Portman) enters the scene, intruding into the family presumably to study Gracie's mannerisms in order to portray her in an upcoming biopic of her life. Elizabeth ingratiates herself, copies Gracie's mannerisms and eventually demonstrates less than sympathetic intentions. Gracie continues in her seeming state of oblivion, concluding with her comment: "Insecure people are very dangerous. I am secure!"

R rating. One hour 57 minutes. Streaming

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## Movie Review

Robert C. Hauck, MD, FAAP Shoreline, WA

### THE BOYS IN THE BOAT

Daniel J. Brown in his 2013 novel with the same title engagingly told the story of a team of nine ordinary guys at the University of Washington who formed an unlikely championship rowing crew. He documented their growth as an underdog team that eked out wins against competitors from east coast Ivy elite to Germany's "master race," eventually defeating Hitler's select aryan crew at the 1936 Olympic Games in Berlin (based on actual events). Brown also convinces us that crew rowing demands ironman stamina and is the ultimate team sport: eight oarsmen and a coxswain who must cooperate with precision unmatched by any other group sport.

Brown's book was one of my best reads a decade ago. No wonder: rowing is a strong tradition in Washington state, especially in the Seattle area where waterways are numerous and never freeze in winter. It's impossible to live in this region and not be caught up in crewing competition (think baseball, soccer, football frenzy elsewhere). Rowing is a Pacific Northwest way of life. Little surprise that Seattle's pre-release screenings dominated local news speculating whether or not director Clooney captured the spirit of rowing competition as well as Brown did.

The movie was filmed in England where the production team succeeded in making the terrain look like Washington in the 1930s --- but without Washington's mountain ranges in the background (although I'm sure only WA locals will notice and be affected). A replica of the vintage crew house on the University of Washington campus is authentic and the locus of much of the movie.

What did my wife and I especially like about "Boys"? We were thrilled by the portrayal of the races. The photographic coverage was phenomenal, ranging from overhead views that kept the viewer in touch with the progress of each race to close-ups showing clenched jaws, powerful bodies straining to the max, the splash of the oars.

The role of Joe Rantz, the featured team member also in Brown's novel, was ably acted and exemplified the humble roots of an entire team. Scenes of Joe living in a junked car and inserting newspaper into his shoes to cover holes in the soles graphically showed his poverty. I felt short-changed, however, when only three of the nine team members were given an identity - we see all their faces and watch them row, but never learn their important backgrounds or know them as individuals. The film highlights legendary George Popock, master boat builder, who fashioned the world's best racing shell for the Boys and appears as an elder statesman subtly advising at key moments.

Overall this viewer thinks Clooney created a warm and entertaining film adaptation that I predict will fall short of being a top pick for the year. I believe the movie's basic shortcoming is its "Hollywood-ization." Throughout the film Clooney and the script writer dwell on a romantic relationship of featured rower Joe Rantz, which detracts from the primary rowing theme and is a minor event in the novel. I thought that many scenes in the movie were unnecessary "fillers" that added little to the ongoing tale but used up free space.

Judging the film as a movie production and an adaptation of a successful novel I rank it "average." I wish the movie-makers had not wandered so far from Brown's text. Judging "Boys" as a venture into the realm of world-class competitive rowing I rate it "excellent" as it relates the difficult course of hometown boys to Olympic Gold Medalists.

Released December 2023. Recommendation: *see it*.

# Poetry Corner

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## Seems

*Ronald Goodsite, MD, FAAP, Tucson, AZ*

It seems that time was slow to pass  
When we were younger, in our 'teens  
(We wished we were much older then),  
Until we were much older...when --

When years, it seems, fly quickly by;  
When mem'ries blur; when friendships pass,  
And end of days seems not, dear friends,  
So very, very far away.

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## A Youth's Wishful Thinking (Inspired by Ogden Nash)

*Yolanda "Linda" Reid Chassiakos, MD, FAAP, Los Angeles, CA*

Was so proud of my poetry,  
Thought rich and famous I would be.  
Went to a prophet, said "Old Man,"  
"Predict my future, if you can"  
I stood by waiting breathlessly,  
As he gazed in his crystal ball,  
He started, "Thy fate I can see--"  
I asked "When will I get the call  
To take my place among the Bards?"  
He shook his head and answered me,  
"Thy future lies in greeting cards."

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## Some (Sum) of It All

*Peter Gorski, MD, FAAP, Aventura, FL*

Through time and place,  
We all create and accumulate memories  
Some we carry for years  
Feelings and moments  
That lift us proudly onto our next rung of life.

At other times and places,  
We all create and accumulate regrets Some that  
trip our mindless steps  
Causing us to stumble  
To the ground that holds and levels our humility.

Each of those moments  
The major keys and the blue notes  
Define who we learn  
And who we become  
Summing countless reminders and remainders.

If only we could foresee  
Or even yet rewind  
How we will care  
For others beyond ourselves  
They who receive, store and affirm

How much love matters.

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## Healing Hand

*Michael Okogbo, MD, FAAP, Spring, TX*

Your touch is not a caress but  
An art in caring  
Your palpation is not poking but  
A search for answer

Percuss to elicit  
The mystery hidden under  
May you find the answer

Healing hand  
Your touch is an assurance of our humanity  
often lost to the cold metal,  
and zapped by magnetism

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Unspoken words  
That convey tenderness  
and ensure therapeutic alliance

Healing hand  
The blood draws and chemical analysis do not  
A clinician, make  
Your touch evokes a tender receptivity

You may be archaic  
But your touch is what we need  
In the age of insensitivity

Healing hand  
Stop not the palpation  
Lest we get treatment  
but not healing

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## Just Another Country Song

*(An homage to Roy Orbison)*

*Tomàs José Silber, MD, MASS, FAAP, Chevy Chase, MD*

Oh Rosie, I fear.  
that after what I did to you,  
you won't love me anymore.  
Oh Rosie, dear  
I saw my numbers climbing up,  
things will never be like before  
I did what I had to do,  
hoping, praying, I implore  
that I won't lose you.

Oh Rosie,  
Do you remember that night?  
We were only seventeen,  
we hid, not to be seen,  
our first kiss, our love so bright  
Oh Rosie  
Remember our first jealous fight,  
and the delight of making up

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Oh Rosie,  
We made love a thousand times,  
We loved each other always more,  
I filled your heart with many rhymes.  
And now it is over,  
quietly over like a crime.

Oh Tom, you silly goat,  
We made love a thousand times,  
I remember all your rhymes,  
that filled with love our tiny boat.  
My love for you will always shine.

Oh Tom, you silly goat,  
now your numbers are coming down.  
Let us celebrate downtown!  
We will go walking arm in arm,  
our love withstanding any harm,

So now Tom, don't fret, don't cry,  
We'll be together till we die.  
Join me Tom, let's sing along,  
Our life, dear Tom is  
just another country song

## Qualified Charitable Distributions and Avoiding Taxes on RMDs

*Jeff Witz, CFP®*  
*MEDIQUS Asset Advisors, Inc.*  
*RESULTS. ONE CLIENT AT A TIME.®*

The IRS is patient but not generous. They allow you to grow a pre-tax retirement account such as a 401(k), 403(b), or Traditional IRA tax-deferred until age 73. At age 73, they start forcing you to take distributions from the account in the form of Required Minimum Distributions (RMDs) which are typically taxable. This means you must include the RMD in your income and pay income tax on the distributed amount. Not only may this mean a larger tax burden than in previous years, but it can also impact Social Security taxation, Medicare calculations, and may even push you into a higher income tax bracket.

Fortunately, a law passed in 2015 provides an option for avoiding some of the negative tax impacts of RMDs. You have the option to make all or a portion of your RMD tax free by directing them to the charity of your choice. These are known as "qualified charitable distributions" (QCDs). This allows qualifying IRA owners to make IRA distributions of up to \$105,000 to charitable organizations. The amount counts toward satisfying your RMD yet is excluded from your gross income, as well as Social Security and Medicare calculations.

These distributions can be a convenient way to support charitable causes and get a tax break while meeting withdrawal requirements for IRAs. However, you must adhere to a number of criteria to capture the tax savings. You should be aware of the following:

- QCDs permit annual *direct* payments to qualified charities up to a total of \$105,000 that can be excluded from taxable income, but still count toward satisfying the Required Minimum Distribution.
- Funds distributed to the IRA owner first, no matter how briefly, then contributed to charity do *not* meet the criteria for a QCD.
- Checks issued by the IRA custodian must be made payable to the charity but can be mailed to the IRA owner to provide an opportunity to photocopy the check to maintain complete records (recommended).
- While RMDs may not begin until age 73, you can start making QCDs as early as age 70 ½. Many will choose to wait until they are forced to start taking RMDs, but the rules state that QCDs can begin after the day the individual turns 70 ½.
- The charitable entity must be a 501(c)(3) organization that qualifies for a charitable income tax deduction of an individual. Donor-advised funds, supporting organizations or private non-operating foundations do not qualify.
- The receiving charity must provide the IRA owner with the same contribution acknowledgment needed to claim a charitable income tax deduction, indicating that no goods or services were received in exchange for the contribution. Failure to produce this in the event of an IRS audit will disallow the QCD from being included in taxable income.
- QCDs can be made from any traditional IRA (including an annuity), but not from a SEP, Simple IRA or Inherited IRA.
- The QCD will generally be included in the distribution amount the IRA custodian reports on Form 1099-R. It's up to the IRA owner or their tax preparer to report how much of the distribution went to charity.

Other factors affecting the decision to make an IRA charitable distribution include whether your charitable contributions exceed your otherwise deductible limit, whether you itemize deductions, the potential loss of tax-deferred growth on the amount distributed from the IRA, and the effect on the size of future RMDs. All of these considerations should be discussed with your tax advisor.

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Jeff Witz, CFP® welcomes readers' questions. He can be reached at 800-883-8555 or at [witz@mediqus.com](mailto:witz@mediqus.com).

8750 W. Bryn Mawr Ave. Suite 325 Chicago, Illinois 60631

312-419-3733 - Toll Free 800-883-8555 - Fax 312-332-4908 - [www.mediqus.com](http://www.mediqus.com)

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## **Guidelines for Senior Bulletin Articles**

*Gilbert Fuld, MD, FAAP Editor*

Section members periodically ask for details of articles which are to be considered for publication in the Senior Bulletin. The Bulletin is published quarterly and, by popular request, is now all online but readily amenable to printing at home. Our Bulletin is not peer-reviewed, nor does it strive to compete with scientific publications.

There's an 850-word limit (with occasional exceptions) for articles to be submitted in MS Word format or double-spaced text. We welcome a wide variety of topics, including book reviews (500- word limit) and letters to the editor (350 words or less). We discourage lengthy life histories and scientific submissions which should more appropriately be submitted to peer reviewed publications. Generally, shorter is better and deadlines (published in each issue) are observed.

Submissions are not guaranteed to be posted in the Bulletin. The editor has the right to refuse publication of any article deemed inappropriate. Publication of articles may be deferred in order to reserve them for a periodic special focus issue. (Authors will be informed if this is the case.) 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 [gilfuld@icloud.com](mailto:gilfuld@icloud.com) or to Co-Editors Peter Gorski [pgorski@fiu.edu](mailto:pgorski@fiu.edu) and Richard Krugman [richard.krugman@cuanschutz.edu](mailto:richard.krugman@cuanschutz.edu). There is a new process for submitting articles. Please [CLICK HERE](#) to upload your article submission. We look forward to hearing from you and to reading your articles in the Senior Bulletin.



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## 2024-2025 Senior Bulletin Schedule

### **Summer Bulletin - Electronic**

May 6, 2024: Call for Articles  
June 5, 2024: Article Submissions Due  
July 26, 2024: Bulletin Online

### **Fall Bulletin - Electronic**

August 5, 2024: Call for Articles  
September 9, 2024: Article Submissions Due  
October 25, 2024: Bulletin Online

### **Winter Bulletin - Electronic**

November 4, 2024: Call for Articles  
December 9, 2024: Article Submissions Due  
January 24, 2025: Bulletin Online

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### ***The Best of the Bulletin***

Since its inception in 1992 the Senior Bulletin newsletter of the Section on Senior Members has been published quarterly. Since 2017, the Bulletin has been published online only. Hidden within the past issues are articles that needed to be unearthed for you, our members. We hope you find them thoughtful, memorable, entertaining, and educational. We have published an initial list of the “Best” and will add to it over time. We hope you will enjoy this new product, found [here](#) on our SOSM Collaboration Website.