Message from the Chairperson

Eileen M. Ouellette, MD, JD, FAAP

Happy Spring! As usual, I am using this spring column to tell you about the Annual Legislative Forum (ALF), held this year for the first time at the new AAP headquarters in Itasca, Illinois and the Westin Hotel adjoining it. Approximately 300 pediatrician leaders attended the 3½ day meeting, which was divided among discussion and voting for resolutions, seminars, lectures and workshops.

One day was devoted to the discussion and voting on resolutions. Any pediatrician member of the AAP can submit a resolution. This year, 80 were submitted and voted upon. Successful resolutions are referred to appropriate Committees, Councils or Sections for disposition and then to the Board of Directors for their consideration.

The top 10 resolutions are referred directly to the Board for disposition. This year, the number one resolution was “Eliminating Religious Exemptions to Vaccinating Children”, The second was “Family Separations at the Border: Safeguarding Children’s Health” and the third was “Limitation of Prior Authorization Requirements for Medications”. A full list of the Top Ten Resolutions can be accessed at The Top 10 list.

Follow-up of the Top Ten Resolutions of 2018 can be read at: https://www.aap.org/en-us/my-aap/alf/Pages/2018 Resolutions.aspx

For the first time in several years SOSM introduced a resolution. Dr. Ed Marcuse submitted the resolution “Expanding Low Income Children’s Access to Dental Care”. RESOLVED “that the Academy address the public health problem of untreated dental disease by disseminating to AAP chapters, relevant sections, councils, and committees the evidence of the advantages of including dental therapists in the oral health teams providing services to children without access to traditional dental care.” It passed by a wide margin.

Lack of dental care is a public health problem throughout the country, particularly for low-income children in rural areas where there is a dearth of dentists. Dental therapists, working under the supervision of dentists, can provide routine dental care to these otherwise underserved children. Our resolution was timely, as, while we were at the ALF, the New Mexico legislature passed a law permitting dental therapists to provide dental care to its children. Dr. Lance Chilton, an active member of our Section was instrumental in the successful passage of this law.

Other successful resolutions that reflected current important topics included one on limiting prior authorization requirements for medications. Pediatricians objected to having to change children with chronic illnesses from medications that successfully controlled their symptoms to newer, less expensive drugs at the behest of insurance companies.

Others were to ensure access to affordable insulin for all children with diabetes and to provide guidance on school response to E-Cigarette use by students. Apparently, in order to discourage students from vaping in school bathrooms schools are removing bathroom doors. This practice seriously compromises students’ privacy and is not a realistic solution to the problem.

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Unintended injury prevention was a major topic of discussion at the ALF. Drowning is the number 1 cause of death in children 1 to 4 years old and a significant cause of death in older age children. In 2017, almost 1000 US children under the age of 20 drowned.

On Saturday, March 16, three parents whose children had drowned during the past year spoke to ALF attendees about the circumstances of their child's death. In each case, they had observed all the safety rules themselves, but were visiting friends who did not have a barrier between an outside door and their pool. The young children exited an unlocked door and drowned in the family pool before anyone noticed they were no longer inside the house. At the end of these courageous parents' presentations the AAP announced the publication of a new Policy Statement, “Prevention of Drowning” and the simultaneous publication of a “Drowning Prevention Toolkit” and “A Parent's Guide to Water Safety”.

With the approach of the swimming season, it behooves us all to read these new publications and educate our families and friends on water safety at Drowning Prevention.

We also heard from Mark Del Monte, JD, CEO/Executive Vice-President (Interim) on 2 occasions. He discussed the state of the AAP that now has a budget of $118 million and will attain 70,000 members before the end of the year. Medical student membership has increased 22% in the past year to 2,135. Our Section on Senior Members is up 2.9% and is now 4,345, making us the third largest Section. Pediatrics did very well in the recent Resident Match, with 97.3% of offered pediatric positions being filled.

He discussed 3 major organization initiatives. The first is a Digital Transformation Initiative, the second, a Clinical Data Health Registry, that will collect evidence, and the third is a Gun Safety and Injury Prevention Initiative that will document the increase in childhood suicide with guns.

In his second talk, Mr. Del Monte delivered an Advocacy Update. In January 2019, a bipartisan bill co-sponsored by Senators Feinstein and Grassley became law. It provides personal liability protection for those serving as consultants or experts in child abuse cases, whereas previously only the reporting clinicians were protected.

As usual, this year’s ALF was stimulating, exhausting and energizing.
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**Spring 2019 Editor’s Note**

Lucy Crain, MD, MPH, FAAP
Editor in Chief, AAP Senior Bulletin

Spring has sprung along with the spring issue of our Senior Bulletin! It’s packed with a number of articles on Measles including evolving epidemics among unvaccinated children and adults in the Pacific Northwest and various locations across the country as reported by Dr. Marcuse. Dr.’s Schif and Brunell share their historic perspectives and our new SOECP (Section on Early Career Physicians) Dr. Kuilanoff reassures that younger pediatricians are being taught how to more effectively encourage vaccination against measles and other “infectious diseases of childhood”. I felt compelled to share some of my own frustration about this resistance in “Don’t Bother Me with Facts!” (I don’t make this stuff up!) Dr. Boulter shares her report from COFGA (Committee on Federal Government Affairs.) and more thoughts in “Topsy Turvy”.

I won’t enumerate all of the interesting articles contained herein but be sure to read the Column of our Section Chair, Dr. Ouellette and congratulate her and Dr. Marcuse on their successful championing of the Dental Therapist resolution at ALF. Also, you may consider booking travel to Antarctica after reading Dr. Deangelis’ “Awesome” article! Just enjoy the wealth of experiences described by our contributors as well as a few movie and book reviews for your consideration. Join Drs. Manny Doyne, Cathy Deangelis, and me in welcoming Dr. Tom Whalen to our Editorial Board (succeeding Michael O’Halloran in the Section Webmaster role) and read his self-description. We’ll look forward to working with him and with Dr. Elizabeth Kuilanoff.

And, as always, we invite your contributions for consideration of publication in an upcoming Bulletin. Guidelines and word count details are included in this and every issue.
Your New Webmaster: Dr. Tom Whalen

Editor’s note: When asked why he choose to apply for the position of webmaster, Dr. Whalen responded, “I have had the privilege of involvement with some national organizations over my career. For reasons not obvious to me, I have never signaled my willingness to serve with the AAP despite being a specialty fellow since 1987. The time has come; better late than never!”

Tom Whalen, MD, MMM, FAAP, is Executive Vice President and Chief Medical Officer at Lehigh Valley Health Network (LVHN). He received his AB and MD degrees from Boston University in 1973 and 1976 respectively. After an internship at what is now Boston Medical Center, he entered active duty and then performed his general surgery residency at Naval Medical Center, Portsmouth, VA. This was followed by a fellowship in pediatric surgery at the Children’s Hospital of Los Angeles. In 1999 he completed a Masters of Medical Management at the H. John Heinz III School of Public Policy and Management of Carnegie Mellon University. He retired from the US Naval Reserve in February 2001 after 28 years as a commissioned officer in the medical corps of the Regular and Reserve Navy. Tom became Chairman of the Department of Surgery at LVHN in Allentown, PA in September 2006 after 17 years on the faculty of Robert Wood Johnson Medical School. He assumed the Chief Medical Officer position in April 2011. He is Past President of the Association of Program Directors in Surgery and was elected a Regent of the American College of Surgeons in 2003 serving three terms to 2012. He was a member of the Council of Medical Specialty Societies and also on the Board of Directors of the NRMP where he was President.

Tom has been married to Elaine Wilson Whalen for 42 years. They have three sons and four grandchildren (the latest – FINALLY- being a granddaughter). Doctor Whalen became interested in all things digital in college, studying FORTRAN and using punch cards for programming. The dawn of the PC heralded increased zeal and in the 1990s he created the first web page for the American Pediatric Surgical Association and served as its webmaster.

Meet Your New Section on Early Career Physicians Liaison – Dr. Elizabeth Kuilanoff

My name is Elizabeth Kuilanoff and I am a pediatrician. I am also a community medicine physician, child health advocate, educator, runner, and your new SOECP liaison. I am passionate about pediatrics, public health and improving the health of my patients, their families and their communities.

I am currently completing my second year as the Kaiser Permanente Community Medicine Fellow in Pediatrics. This is a unique position in which I am working in several community clinics throughout the Los Angeles area helping underserved populations. Every day, I work with the most vulnerable patients. As part of this work, I engage the community and support projects to improve health. As a fellow, I have further developed our KP Pediatric Residency Advocacy elective and developed a community medicine curriculum for our fellowship. I facilitated second year medical student Doctoring sessions at UCLA and started a Community Medicine Medical Student elective for visiting fourth year medical students. I also designed a mindfulness room at a high school clinic to improve the mental health of students, staff and teachers.

Prior to medical school, I received my Master of Public Health degree because I recognized early on that health was more than just prescriptions and what happened in clinic. Health is community, food security, resilience, stable housing, health literacy and so much more. As a recent graduate of the UCLA Pediatric Residency, I was a part of our primary care and public health track and had the opportunity to start working in our communities and advocate for our most vulnerable populations. Pediatricians are in unique positions to prevent disease and promote health in our patients, our families and our communities especially when we come together as a bigger voice like with the AAP. We need to engage the community, participate in local, state and federal advocacy, and mobilize resources to truly make a difference. The AAP helps us do that and I am excited to become more involved with such an incredible organization that supports these important values.

One of the biggest issues facing pediatricians today is decreasing vaccination rates. As a public health graduate student, Continued on Page 5
I learned about vaccine-preventable diseases in a historical context. We have very safe and effective vaccines to prevent these scary illnesses. A few years later in my first year of residency, we had a conference on identifying measles. It made me angry. We were learning about diagnosing a disease that I had written a paper on its near-eradication just a few years before. Often, parents think they do not need to vaccinate because those diseases are gone. They were gone because of our vaccines and unfortunately, they are back.

I currently live in California which is one of few states to limit personal belief exemptions for vaccines. SB 277 changed everything in California. Much of the discussing, arguing, convincing, and pleading with families dissipated because many vaccines are required to attend school. However, the law doesn't include vaccines such as HPV, meningitis or influenza. In residency, we did not get much training on vaccine counseling, administration, vaccine hesitancy or vaccine refusal. We were learning to identify and treat sick patients. We learned about vaccines from our own experience and from the example of our attendings in our continuity clinics. We tried to read articles in our spare time and maybe one of the co-residents gave a conference on the topic. We learned from experience. We picked up tips and tricks along the way, but I know we can do more. What if we integrated a short online module into pediatric advocacy rotations? How about a required shadowing experience in vaccine clinic just like we go to a lactation clinic? What if we required motivational interviewing and other similar trainings to equip pediatricians to better counsel our patients?

I know all pediatricians struggle with vaccine hesitant families, not just residents. The CDC and AAP offer informative resources for talking to families about vaccines and I reference them often when I am in clinic and also when educating residents. Given the increasing prevalence of vaccine-preventable disease, it is critical to have fair media coverage, logical policy changes, and continued education and research in this area. It is my hope that we can continue moving forward in creating a therapeutic relationship with our patients and families and continue promoting safe and effective vaccination strategies.

**COFGA Liaison Report – December 2018**

* Suzanne Boulter, MD, Senior Section Liaison to COFGA

COFGA met in Washington, DC, from February 24-26th. In attendance were committee members, staffers and many liaisons. As always, the meeting was an incredible update on legislative topics of interest and importance to children. We discussed child specific legislation from the 115th and 116th Congress. Here is a breakdown of some of the critical bills:

On the **positive** side several bills were signed by President Trump at the end of 2018 that are child friendly. Here is a summary:

- **Juvenile Justice Reform Act** providing protections for youth involved with the law
- **PREEMIE Reauthorization Act** providing wide supports for prematurity research, education and data collection
- **Protecting Maternal Deaths Act** establishing maternal mortality review committees
- **Congenital Heart Futures Reauthorization Act** (of interest in that this act supports increased awareness in adolescents and adults of the impact that their congenital heart disease will have on them as they get older)
- **Families First Prevention Services Act Implementation** – 1) allows states to use funds for evidence based preventive programs for caregivers to prevent foster care placement and 2) ensures that children can only be placed in non-family settings if these settings are accredited and have licensed staff. AAP will highlight this act at Legislative Conference and will offer chapter grants to promote implementation

These bills will be introduced or re-authorized in 2019:

- **CAPTA – Child Abuse Prevention and Treatment Act** – significant child abuse prevention protections
- **Autism Cares Act** – will provide increased expansion of scope of diagnoses covered and increased grants for research
- **Drugs and Devices** – several bills will be introduced to address OTC drug safety, drug shortages and drug pricing
• **REMOTEACT** – new bill that would require online training for border agents who have kids in facilities under their care and would also require 24 hour a day access to pediatricians
• **Newborn Screening Saves Lives Act** – funding and data collection to continue initiatives
• **Nutrition** – Farm Bill, new dietary guidelines including prenatal to age 2
• **EMSC** – Emergency Medical Services for Children
• **Pediatric Workforce** – provides financial support for sub specialty training in exchange for practicing in underserved areas – passed last year but not funded

On the **negative** side:

• **1115 waivers** for work requirement in Medicaid expansion – 7 states have approved; 11 are pending; after Arkansas waiver was approved 17,000 people lost coverage
• **1332 waivers** allow states to approve STLD (short term limited duration) health plans. These plans offer very limited coverage and no requirements for essential health benefits

**Immigration issues!**

• **DACA**
• Public Charge - this rule would require anyone in the family who has or could in the future have need for public services such as food stamps, SSI, TANF or housing assistance to be at risk for permanent resident status (215,000 public comments have been received and will be reviewed by the administration before any potential implementation)
• family separation continuation at the border
• lack of training about children for Customs and Border Protection staff

**Gun violence prevention** – AAP has 3 major legislative priorities:

• $50,000,000 for CDC to research gun violence,
• passage of Bipartisan Background Checks Act
• ERPO – Extreme Risk Protection Orders (allows removal of guns from people deemed to be at imminent risk to themselves or others)

If these bills pass, they will hopefully lead to more significant firearm violence legislation going forward.

**Tobacco**
There is great concern with the marked increased in usage of E cigarette products by youth. FDA has removed flavored E-cigarette product sales to underaged users in retail stores and has imposed stricter age verifications for on line sales but more needs to be done at the federal level!

**Immunization issues** – Immunization requirements are a state specific issue so there is no pending federal legislation on vaccines. However, because of the recent measles epidemic the House Energy and Commerce Committee held hearings on February 27th about vaccine issues. Experts from CDC and NIH testified about the effectiveness of vaccines in preventing illness and the importance of requiring vaccines as part of a public health strategy. The World Health Organization recently listed vaccine hesitancy as one of the top 10 threats to global health in 2019.

Every state and Washington, DC has school entry vaccine requirements with exemptions when medically necessary. Non - medical exemptions (religious, philosophical or personal beliefs) are also allowed in every state except California, Mississippi and West Virginia. Unfortunately, even in those 3 states some parents are seeking medical exemptions when there is no real medical condition to warrant non - vaccination and some physicians are charging parents a fee for writing those letters. In addition, sixteen states have already introduced legislation this year to address vaccine issues and most of the bills are anti vaccine.
Hill Visits – meetings with staffers to update them on child health topics
Our “ask” this year – fund the $50 million public health data collection about gun violence by CDC and support the Bipartisan Universal Background Checks Bill of 2019 (this bill did pass the House the next day but passage by the Senate will be problematic). Although these two requests seem straightforward to pediatricians and other child health advocates some of our elected officials are unwilling/unable to support these bills.

Once again it was evident that our Washington AAP staff is an excellent resource for us to promote federal legislative issues of importance to our patients and to move AAP’s advocacy agenda forward.

Measles – 2019 Outbreaks
Updated 3/13/2019

Pediatricians are advised to monitor multiple outbreaks of measles across several U.S. states.

Situation
• Main outbreak locations:
  • Illinois (more info)
  • New York State, Rockland County (more info)
  • New York State, Monroe County (more info)
  • New York City (more info)
  • Texas (more info)
  • Washington State (more info)
• Description: Multiple measles outbreaks
• Number of infections: 228 cases in 12 states (from 1/1/19 through 3/7/19)
• Pediatric population affected: All pediatric populations at risk
• The main outbreaks have been associated with travelers who brought measles back from Israel and Ukraine.
• Cases have been reported in California, Colorado, Connecticut, Georgia, Illinois, Kentucky, New Hampshire, New Jersey, New York, Oregon, Texas, and Washington.

Background
• Infants and children aged less than 5 years, adults aged more than 20 years, pregnant women, and people with compromised immune systems, such as from cancer, chemotherapy, or HIV infection, are at high risk for severe illness and complications from measles.
• Measles can cause serious illness requiring hospitalization, even in previously healthy children.
• Consider measles in patients with fever and rash and ask about recent international travel, exposure to international travelers, or exposure to people with measles.
• Airborne precautions are needed whenever there is any suspicion of measles exposure. Promptly isolate, collect specimens, and report patients with suspected measles.
• During an outbreak, MMR vaccine should be offered to all people exposed or in the outbreak setting who lack evidence of measles immunity. During a community-wide outbreak that affects infants, MMR vaccine has been shown to be effective in preventing symptoms after exposure and may be recommended for infants 6 through 11 months of age.
• Involvement of state and local health departments is often advisable for any diagnosis of measles, as there may be specific ways these departments wish to receive specimens and manage patients.
Measles Musings from Puget Sound

Edgar K. Marcuse, MD, MPH, FPIDS, FAAP

At this writing (2/27/2019) WA State's Clark County measles outbreak has involved 65 cases, of which 57 were unvaccinated, two had received one dose of MMR and six had unverified immunization histories. Forty-seven cases were children aged 1-10 years, fifteen were aged 11-18 and three aged 19 or older. Public exposures occurred at multiple health care facilities, schools, child care centers, churches, stores, a museum, fitness center, and sports arena.¹

Over the past decade the US has experienced outbreaks despite having eradicated endogenous measles in 2000. Many recent outbreaks have been traced to electively unimmunized international travelers who were exposed to measles and unknowingly imported the disease.

WA State's school Immunization law enacted 50 years ago, allows parents to claim an exemption for medical, religious or philosophical reasons. Over the ensuing decades the proportion of school entrants claiming an exemption increased statewide with enormous local variation, some communities having kindergarten exemption rates as high as 20%. Concern about suboptimal immunization rates led to legislation in 2011 requiring parents seeking a philosophical exemption to be counselled by a physician, nurse, pharmacist, naturopath or other provider licensed to administer vaccines. In the past eight years WA State's non-medical exemption rates have declined to 4%, still double the median US rate.²

Both WA State's experience and that of other states demonstrate that our current immunization policies have not protected our communities against measles outbreaks. Measles remains endemic in many countries, notably in Western Europe, Philippines, Japan, and China, so importations will continue for the foreseeable future.

This context and recent events prompted a seasoned WA State legislator to introduce a bill eliminating the right of a parent to claim an exemption only for measles-mumps-rubella vaccine. The rationale for such a narrow restriction of the right to opt out includes: the unique communicability of measles, the experience of recent outbreaks, the availability of a safe and effective vaccine that offers durable immunity, and that such a limitation of personal choice is the least restrictive option.³ Not surprisingly the bill proved very contentious. At this writing its fate remains uncertain.

As a society Americans hold two conflicting values: we support measures that protect the public health and we want to preserve individual choice. In a national survey in 2000, 75% of parents disagreed with the statement I am opposed to immunization requirements because [they], go against freedom of choice. Only 14% of parents agreed that parents should be allowed to send their child to school even if not immunized – evidence of broad societal support for school immunization requirements. But by 2010, the proportion of supporting for personal choice had increased to 35%.⁴ When does the risk to the public health trump free choice? What degree of societal consensus is required? What disease risk balanced by what assurance of vaccine efficacy and safety justifies an enforced mandate?⁵ These issues have been argued for 150 years and are now roiling the WA State Legislature's 2019 session.

Opponents of the bill came out in large numbers. Testifying against the bill were four persons from out of state one of whom had completed pediatric residency. Their testimony was flabbergasting. Noteworthy were statements suggesting that measles outbreaks in New York were attributed to transmission of measles vaccine virus, that adverse reactions to measles and other child vaccines were due to epigenetic factors, and that use of measles vaccine could not control an outbreak. A colleague observed that if a lawyer gave such testimony in court they would be sanctioned. The full hearing can be viewed on line.

Continued on Page 9
Should you have to engage with such a vaccine opponent in a public forum be certain to consult with WHO’s sage guidance. It suggests two simple rules: #1 the public is your target audience, not the vocal vaccine denier; #2 aim to unmask the techniques that the vocal vaccine denier is using and correct the content. Atul Gawande observed that the five hallmarks of fake experts are:

1. They argue that the scientific consensus emerges from a conspiracy to suppress dissenting views.
2. They produce fake experts, who have views contrary to established knowledge but do not actually have a credible scientific track record.
3. They cherry-pick the data and papers that challenge the dominant view as a means of discrediting an entire field.
4. They deploy false analogies and other logical fallacies and
5. They set impossible expectations of research.

When scientists produce one level of certainty, the pseudoscientists insist they achieve another. Sadly, it seems that in a democracy we are fated to have to endure periodic failures with their sometimes-tragic attendant costs in order to relearn lessons learned by our forbearers. This past January, demand for measles vaccine in Clark County soared, up 500% in January compared to the same month last year. Washington’s measles outbreak has made very clear that vaccine preventable diseases are only a plane ride away and that timely immunization of children protects both the individual and community. While the vaccine deniers have been energized it seems likely that this experience will result in the public becoming a bit more skeptical of vaccine deniers and vaccine hesitants more likely to accept recommended vaccines.

2. [https://www.doh.wa.gov/Portals/1/Documents/Pubs/348-682-SY2017-18immunizationgraphs.pdf](https://www.doh.wa.gov/Portals/1/Documents/Pubs/348-682-SY2017-18immunizationgraphs.pdf)
3. [https://pediatrics.aappublications.org/content/137/4/e20154230](https://pediatrics.aappublications.org/content/137/4/e20154230)
4. [https://pediatrics.aappublications.org/content/106/5/1097](https://pediatrics.aappublications.org/content/106/5/1097)
5. [https://pediatrics.aappublications.org/content/107/5/1158](https://pediatrics.aappublications.org/content/107/5/1158)

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**FACTS – True or Not!**

*Don Schiff, MD, FAAP – Advocacy Column*

It is not surprising that our time 2019 is one in which a confluence of technology and a general sense of disquietude and uncertainty has occurred. We face the everyday question of what is a true fact or a conflicting opinion? This conundrum has become an issue for parents and pediatricians as we experience the recent and ongoing measles outbreaks now involving over two hundred children with the certainty that this number will increase. Neither how we reached this point or what plans child health advocates can design to effectively prevent future outbreak is clear or simple. The unfortunate similar chronology of the onset of many childhood illnesses and/or disabilities with the best time to administer preventative vaccines has over decades led to many mistaken causation theories. The most controversial vaccine currently is measles usually administered as the MMR combination. A brief review of the origin of this inaccurate connection between measles and autism follows. A United Kingdom physician, Andrew Wakefield published a paper in The Lancet in February 1998. He studied 12 children with a variety of neurological and gastro intestinal abnormalities and concluded that measles
vaccine was a causative agent in the children with autism. Subsequent to this publication, measles immunizations rates declined significantly, and the incidence of the disease predictably rose in 2008-2009. Further examination of the basic science and circumstances surrounding the Wakefield paper led to the conclusion that the paper was corrupt, and the Lancet retracted the entire paper in 2010.

However, the idea that there was a connection between measles and autism was initiated and has persisted in spite of a large number of studies which disproved the alleged connection. The most recent of these reported studies was done on Danish children numbering 600,000. It found that children who received the measles vaccine were 7% less likely to develop autism than children who were not vaccinated with measles. The measles controversy has raised a number of societal questions including (1) Parental responsibility (2) individual freedom (3) public health and societal morality.

Many state legislators are now deeply involved in developing new vaccine policies. Minnesota, New Jersey, Vermont and Washington have had legislation introduced which would reduce exemptions for children. Other states have taken an opposite view, making exemptions easier to obtain. Those states are Hawaii, Arizona, Rhode Island, and West Virginia. New York is really uncertain as it has bills in the hopper which would loosen, and which would tighten their vaccine requirements.

Recent examinations of social media venues have surprisingly revealed multiple examples of vaccine misinformation. Organizations which have admitted they have allowed these errors to be on their screens include Facebook, WhatsApp, YouTube, Instagram, and Google.

The AAP has recognized this potentially dangerous state and Dr. Kyle Yasuda, AAP President has written to the CEO of each company explaining the harmful effects and offering the AAP resources as a source of accurate information. Facebook and Instagram have responded to our comments positively. Congressman Adam Schiff has reached Amazon CEO Bezos requesting that misinformation be removed from Amazon Products. 3 Amazon films were removed from their list.

Senator Lamar Alexander, Republican from Tennessee has spoken out against this misinformation blaming it on internet fraudsters. Epidemiologist Anders Hviid believes that the anti-vax movement is stronger now than any time in the past 15 years. A heartening experience recently was the appearance of 18-year-old Ethan Lindenberger, a high school student from Norwalk, Ohio who testified before a Senate committee on his accomplishments of achieving vaccinations in spite of the adverse teaching of his mother. He stated that he learned of their value and decided that he wished to be protected by receiving vaccines. The ultimate question is, who are the people in the face of overwhelming evidence of vaccine benefits maintain their own facts and beliefs to the determinant of their families themselves and our shared society? They are often in small groups and use one of the following reasons for their action or nonaction. (1) Religious belief (2) ignorance of the enormous capability of our immune systems (3) the increasing number and cost of vaccines (4) inability to achieve 100% protection (influenza) (5) the huge profits of Big Pharma (insulin) (6) the “oppressive” character of governmental regulations (7) the totally inaccurate belief that autism is caused by vaccines.

In response child advocates seek to overcome the current gaps in immunization rates and achieve herd immunity levels which for measles is 95% coverage. The New York Times in an editorial in January 2019 listed directions to an improved general understanding of vaccine issues. These suggestions concentrate on general public education which would provide support for the everyday experience of Pediatricians who continue their personal family education measures. Greater efforts from the CDC to provide accurate facts and expose misinformation is another mode of providing facts. Finally, well-drawn state by state legislation may be required as a final means of protecting our Nations children and avoid the dangers to our families and nation.
Andrew Wakefield’s paper suggesting that MMR might be the cause of autism was published in Lancet in 1998. English tabloids circulated this story which had contributed to a significant drop in children brought for immunization. At the time, I was working at Great Ormond Street Hospital in London and I was assured by one of my colleagues at the Hospital not to worry, as soon as we have a couple of deaths immunizations will pick up again. Needless to say, I did not find my English colleague reassuring but, in fact, he was correct.

We make decisions by weighing risks and benefits, whether it be to immunize our children or where to invest our money. One might understand why English moms stopped bringing their children for immunization in 1998. However, soon after (2010), the Wakefield paper was withdrawn due to a series of irregularities in the studies and following some wonderful investigative reporting by Brian Deer (BMJ 2011:342: c5347) detailing these irregularities. This, and the first death from measles in Ireland lead to a renewed desire to have children immunized.

My own balance sheet was different based on my experience before 1998. We had investigated the outcome of the introduction of a case of measles at two high schools in which 96% of the attendees were proven serologically to be immune. This introduction led to several generations of cases affecting 26 seronegative attendees (NEJM 1987:316, 771). It had been observed previously, that the occurrence of a case into a household generally lead to everyone being infected. Thus, relying upon your neighbors to immunize their children so that your children would be protected against measles, might not be prudent. What is more, the classical cough, coryza and conjunctivitis, when children are quite contagious, always precedes the rash. So, whisking a child away once the rash is noticed in a contact will be too late for protection. During the first two months of this year, more than 200 cases of measles had been reported in six states.

When I started my residency in the fifties, one of our patients recovering from measles encephalitis had been admitted some time previously. He was still there two years later and when I left was essentially unchanged. He might be considered more fortunate than the few hundred children who died as a result of measles each year at that time. There still is not an antiviral drug that is effective against measles.

Even uncomplicated measles is a serious illness. Temperatures as high as 105 are not uncommon and cough is usually quite severe. Bacterial ear infections were such a common complication that trials to prevent them with antibiotics given at the onset of measles were attempted but failed.

Finally, how safe is the vaccine? The early vaccines produced some fever and were replaced. The Wakefield study which suggested that autism might be caused by measles vaccine had been withdrawn. The relationship could not be proven in more than a dozen subsequent studies, including the most recent one which was published from Denmark involving more than 600,000 children over a ten-year period. Thus in 2019 the choice seems clear.

Don't Bother Me with Facts!
Lucy Crain, MD, MPH, FAAP

Several years ago, I was in the office of a California legislator in Sacramento advocating for the importance of immunization against “infectious diseases of childhood” and specifically for her support of the proposed bill requiring such vaccinations for school entry for California children. I presented the statistics, a few case studies, plus the impressive numbers of infant deaths and numbers of hospitalized children with an ongoing epidemic of pertussis in the state. She suddenly stood up and walked toward me, shaking a sharp pencil in my face as she emphatically stated: “Don’t bother me with facts!”

Despite her contention and those of the burgeoning “Anti-Vaxxers” who protested SB 277 - which eliminates all but medical exemptions from vaccines for school entry- was signed into law by then Governor Jerry Brown in 2015, following a significant epidemic of measles which originated with an infected visitor at Disneyland. Drafted by the only pediatrician in the California Legislature, Dr. Richard Pan, this bill has prevented more cases of the covered infectious diseases than any recent legislation in this populous state.
The article in this issue by Dr. Elizabeth Kuilanoff, our SOECP liaison, underscores the need for including education for all physicians and health care professionals as required curriculum on prevention of infectious diseases by effective vaccination.

Recent and ongoing case reports of measles and other “infectious diseases of childhood” in non-immunized adults as well as children in Oregon and Washington and now California and other states across the nation emphasize the need for universal immunization.

I still cannot resist “bothering with facts.” The WHO reports a world-wide average of 450 DEATHS PER DAY from complications of measles. There is as of yet no cure for measles, once contracted. Nor is there a cure for polio which is thankfully rare but still reported in remote countries of the world where global travel continues to increase. (The recent measles index case reported in San Francisco was in an adult with a history of such global travel and exposure.) The treatment for tetanus is challenging and extremely costly, as demonstrated by the 6-year-old son of a rural family in Oregon who contracted tetanus via a laceration at the family farm. Despite his near fatal experience and survival with the care of pediatricians and nurses and therapists, tetanus anti-toxin and extended life support plus a hospital bill in excess of a million dollars, his parents still refused to permit his pre-discharge vaccination with tetanus toxoid. [https://www.cdc.gov/mmwr/volumes/68/wr/mm6809a3.htm](https://www.cdc.gov/mmwr/volumes/68/wr/mm6809a3.htm)

Tetanus vaccine has been in use prior to WWII and confers long lasting immunity. But the disease itself does not convey immunity, contrary to the attestations of Anti-Vaxxers like Ms. Darla Shine, wife of the White House Communications director who just resigned last month. Ms. Shine thinks that “natural diseases build immunity “and make you stronger. [https://www.nytimes.com/2019/03/09/opinion/sunday/the-real-horror-of-the-anti-vaxxers.html](https://www.nytimes.com/2019/03/09/opinion/sunday/the-real-horror-of-the-anti-vaxxers.html). There is so much false information about the vaccine issues, those of us who in the pre-vaccine era experienced measles, mumps, rubella and have seen 3 siblings with measles encephalitis (2 died, one had irreversible brain damage) and another 2 children with meningococcal meningitis arriving by ambulance from the mountains of Eastern Kentucky (Both died shortly after arrival at the University of Kentucky Medical Center Emergency Department where I was then an intern.) must continue to emphasize these facts…. And don’t get me started on the epidemic of diphtheria in Scott County, KY in the Amish community, but the last case of fatal diphtheritic myocarditis I saw was in an un-immunized preschooler from Fresno, CA who had been exposed during a family visit to Mexico. Why is there not Federal legislation to eliminate all but medical exemptions from vaccinations? Why-as Bulletin editor Dr. Cathy Deangelis asks-is the prohibition by parents for their children receiving recommended vaccinations not child abuse?

The facts speak for themselves: VACCINES SAVE LIVES!

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**Reflections**

**Most Memorable Patient(s)**

*William R. Purcell, MD, FAAP*

Many years ago, in the very busy emergency room of Roper Hospital in Charleston, South Carolina I had the saddest and most memorable experiences of my forty-one years as an active physician.

The experiences involved two teenagers who were brought to the emergency room in shock on different days during my two-and-a-half-month rotation on the obstetrical service. Both patients died in front of me as we attempted CPR and pumped O Negative blood.

I shall never forget the facial expressions of dismay as they passed into unconsciousness. Each had ruptured their uteruses as they terminated their pregnancies using coat hangers.

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It is unknown to me why these pregnancies were so extremely threatening. Perhaps the girls had been raped or perhaps they had been impregnated by a family member. Perhaps they were afraid they would be physically punished if their parents found out about their pregnancy. Whatever the reason, they decided that their pregnancies had to be terminated. At that time with pregnancy termination through medical channels being illegal, only those with means could travel elsewhere for such medical services.

I do not know what is right in these cases, but I do know that it was not right for these young girls to die. I worried at that time if two such cases were seen in one American hospital in a two- and one-half months period, how often were similar cases occurring across America? More importantly, I now wonder how often this will occur if our government continues to decrease funding related to pregnancy prevention or repeals Roe v. Wade.

These were very sad and maturing experiences for me as a young physician and certainly experiences that I don't want others to have.

My Long-Term Follow-Up of a Child’s Birth*  
John T. McCarthy, MD, FAAP

Toward the end of my Pediatric Internship in 1970, I received a “Welcome Aboard!” letter from the United States Navy that they have drafted me in accordance with the Berry Plan. Wanting to make it interesting, I opted for a 6-month Submarine Medicine course at the Groton, CT Subase. On January 12, 1971, I joined 10 other like-minded physicians looking for adventure beneath the deep blue sea. Our 6-month “crash course” in the nuts and bolts of becoming a Polaris Submarine Doctor included basic submarine stuff like living quarters, other compartments, diving, surfacing, trim, port, starboard, forward and aft, etc. Of course, we learned about medical management of common health problems, environmental and radiation control, yadda, yadda, yadda.

Now here’s where my story gets interesting. During our 6-month indoctrination, we eleven newbies would pull night call at the busy Sub Base Clinic about twice monthly. As I recall, I, a partially trained Pediatrician and another classmate, a budding Psychiatrist, were on call on February 11, 1971, a bitter cold and snowy night. As we prepared to catch a few winks during a lull, we received an urgent page to the OB Delivery Room. The Psychiatrist pleaded with me to take the call. I entered the Delivery Room and encountered a friendly Nurse and a relatively calm mother to be in what appeared to be the final throes of labor. Her husband a submariner was out to sea on patrol and apparently her regular Obstetrician who lived off Base couldn’t get in because of the inclement wintry weather. The competent appreciative OB Nurse guided me every step of the way, and a healthy girl was born without any complications. Pleased but humbled by this experience, I said “Congratulations!” and “Have you already chosen a name for your baby?” “Betsy!” she replied happily. She was the very last baby I ever delivered.

Upon completion of my course, June 1971, I received orders to report to the USS James Monroe 622 Blue Crew in Hawaii. Having never been to the Hawaiian Islands, I looked forward to tropical adventures on Waikiki. But NOT so fast. Shortly after landing in Honolulu, I discovered that early the next day the Blue crew, including me, would be flying to Guam to relieve the Gold Crew who had just finished its 60 day fully submerged patrol. And before I knew it, I had completed two 60 day deterrent Polaris patrols and had become “Qualified on Submarines” as a Medical Officer, a rare accomplishment. For my final year before returning to my civilian career, I served as the doctor for Submarine Squadron 7 at historic Pearl Harbor. I treasured every moment of my brief 2½ year Navy career.

In 2011, my wife Jane, an Internist and I, a Pediatrician and Child Psychiatrist, retired from Medicine. Having nursed a nostalgia for my mini career in Submarine Medicine, I decided to join the Submarine veterans Association and attended their 50th annual convention in San Francisco.

What an experience. I met several retired Submariners who served on the USS James Monroe when I did, including the Executive Officer.

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One afternoon during a “downtime” Jane and I made a beeline for the hotel’s hot tub. “Ahh!” we sighed fully relaxed. Soon, an attractive friendly woman named Anne, joined us. She explained that she was helping her parents in one of the Submarine venues at the convention. Her mom was a seamstress and her dad, a retired Submariner, was a proprietor. I shared with her my brief Navy career including a stint at Groton Sub Base where I took a course in Submarine Medicine in 1971. “What a coincidence!” she exclaimed. I was born there on February 11th, 1971” “Wow!” I countered, “I was paged to the OB Delivery Room to help deliver a baby girl, but her name was Betsy.” My jaws dropped when Anne then said grinning “My name actually is Betsy Anne, but I got teased so much with being called ’Heavens to Betsy!’” that my parents started calling me Anne.” She then revealed that she is a Nurse and a happily married mother of 5 children and even has one grandson. That’s my 4 decades long term follow-up!

*This memoir is based on a true story, but the names were changed to respect the actual person’s confidentiality

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**Engaging and Empowering Youth**

*Wm. R. Brown, Jr., MD, MPH, FAAP*

**Stubborn Ounces (To One Who Doubts the Worth of Doing Anything If You Can’t Do Everything)**

“You say the efforts that I make will do no good; they never will prevail to tip the hovering scale where Justice hangs in the balance. I don’t think I ever thought they would, but I am prejudiced beyond debate in favor of my right to choose which side shall feel the stubborn ounces of my weight.”


During my recent three years as a member of the SOSM Executive Committee, I had the privilege to contribute to our bulletin regarding a number of issues pertinent to our membership, some of which have political overtones. At age 78, an important emphasis has been to promote activities for those of us retired from clinical practice to remain academically involved with youth and their families. I volunteer tutor PBL, interview applicants, lecture second year students, participate in the Partnership for Social Justice and sponsor student interest groups at the John A. Burns School of Medicine of the University of Hawai’i at Mānoa here in Honolulu.

I am an activist and advocate, concerned with issues effecting current and future generations: universal civil rights, the environment, affordable health care and education, school safety, gun violence, immigration, and military families.

My message to family, friends and colleagues is write, speak up and out, converse, engage, volunteer, contribute resources, register and vote to exercise your constitutional rights. The next general election is in twenty months. It is time now to plan for and prepare to register the millions of newly eligible first-time voters in 2020. Our AAP membership of 67,000 is a critical mass of “stubborn ounces.” It’s time and opportune for our membership to organize onsite high school and college eligible voter registration opportunities in conjunction with election boards, local health care colleagues, departments of education, parent/teacher associations, student governments and community service organizations.

“**Actively doing nothing is a decision.”**

Barack Obama

It’s a decision I’m not willing to make. Decades ago we “Senior Members” took the Hippocratic oath to “share such knowledge as is mine with those who are to follow.” Fifty plus years a pediatrician, this now has personal as well as professional implications. We are part of our own, extended health care community, as well as leaders in our neighborhoods, places of worship and among families and friends. Initiative and co-operation are part of our commitment to provide preventive care, anticipatory guidance and share our experience as well.

We are in a unique position to proactively participate in our democracy. Our individual ounces need be felt.
A Journey Exploring Concepts of Oriental Medicine

Kalpana Patankar, MD, FAAP, M.Ac, Dipl.OM. (Practice limited to Oriental Medicine.)

I wonder how many of us choose to explore distant concepts in medicine - distant in both place and time!

Perhaps you will allow me to share my travelogue. I started my medical training in 1965 at the age of 18 in Bombay (now Mumbai). Our curriculum was based on the strict Western Medicine paradigm: Gray's Anatomy, Goodman / Gillman Physiology, and Nelson's Textbook of Pediatrics were our standard texts among others. After graduation in 1970 I did my pediatric residency at King Edward Memorial Hospital in Bombay. I applied with zeal and keen study all the classroom knowledge to my day-to-day patient care: we admitted 40+ very sick children daily who had anything from tuberculous meningitis, malaria, empyema, severe anemia with ancylostomiasis to amoebic liver abscess. I saw the immense potential of concepts in medicine change the life of every sick child. I then had the good fortune of coming to the USA in 1973 and met Dr Nelson at St. Christopher's Hospital in Philadelphia and shared my personal application of his textbook with my very sick patients.

After completion of residencies, I began practicing first as a solo practitioner and then as a part of a group of pediatricians. I began dealing with a general pediatric population in suburban Philadelphia where we seemed to have conquered life-threatening infectious diseases for the most part. Much of my practice was coping with behavioral issues in young school-aged children - ADD, ADHD, OCD, anxiety and depression. The diagnostic criteria and drugs of choice were very much empiric and I saw older children (and their parents) being attracted to psycho pharmaceuticals. I was in my mid-fifties and was neither ready to give up hands-on patient care nor was I interested in changing careers. This was my passion and yet I faced a dilemma - I could no longer prescribe psychotropic drugs with a clear conscience that I would cause no harm. I struggled with the trends in medicine which to me seemed either dominated by the pharmaceutical companies or by insurance companies. In 1996 my19-year old daughter, who was then a U. Pennsylvania undergraduate student studying medical anthropology urged me to explore other ways in which people heal.

I took her suggestion and attended a multidisciplinary seminar exploring concepts in Oriental medicine offered by Johns Hopkins Hospital. Johns Hopkins Hospital doesn't offer courses or training. Was it Johns Hopkins School of Public Health? A whole new set of concepts based on observational clinical phenomena that work based on laws of nature opened the possibility of exploring ways of treating patients based on their individual unique constitution. Dr William Osler's words that echoed in the hallowed halls of Johns Hopkins now resonated in my heart.

It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has. One of the first duties of the physician is to educate the masses not to take medicine.

After much contemplation I chose to pursue a master's degree in acupuncture to discern how to help restore a balanced state of wellbeing in patients following natural laws. Oriental Medicine texts written 2000+ years ago still have application to our present-day issues, especially the chronic multifactorial diseases.

I realized that the root concepts of Ayurvedic Medicine from the country of my origin were no different than those from Chinese Medicine. In fact, Yoga, Qi Gong & Tai Chi are also based on achieving that natural balance. They acknowledge that illnesses are either caused or exacerbated by how we process stress.

Shifting the way, we process the bombardment of our senses in this noisy “information age” would benefit our bodies and our emotions. Acupuncture and Chinese herbal medicine shift ways of holding tension in the body to alter organ function and the emotional milieu. Calming emotional turbulence ultimately helps the body/mind/spirit heal - (psych neurohumoral axis).

Eighteen years after I embarked on this “retirement career” I have the deep satisfaction of treating patients suffering from a variety of conditions and educating them to understand what causes “stress” and how to nurture and support their own

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unique constitution through the paradigm of Five Element Style of Chinese Medicine. I treat people of all ages, including young adults and elders with chronic ailments like cancer, midlife and aging issues and am able to help them lighten their burden. I don't make as much money as before, but I feel much more engaged in my patients' wellbeing.

The best side effect of practicing this way is that I follow the advice I give my patients and reap the benefit of being in excellent health, not having to take any drugs! I prefer meditation to medication! I would like you to enjoy good health in retirement as well. Perhaps you might explore a different view of illness and health.

For those who are interested, I suggest two books to read:

*Power of the Five Elements: The Chinese Medicine Path to Healthy Aging and Stress Resistance* by Charles Moss M.D.


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### A Journey of Taste

*Robert C. Hauck, MD, FAAP*

24 hours before boarding our flight to Europe, the first symptoms of an impending viral respiratory infection hit me. As a Pediatrician once or twice a year I caught my patient's URIs but why did it have to happen on the eve of our long-planned vacation in France?

For two days during our stopover in London my URI was in full bloom and the meals were remarkably tasteless. What does a traveler expect in England? As we journeyed on to France, I developed a total loss of smell, and I was anosmic with nearly complete absence of flavor. There we were in fabled wine country-and a gourmand's paradise, but I couldn't distinguish a merlot from a chardonnay or a biscuit from a potato.

I grew up in a household where the sense of smell was valued almost as highly as vision and hearing. My mother was a highly gifted sniffer and taster, a true hyperosmic individual. She sniffed at everything about her, especially in the kitchen, with a skill that was both a blessing and a gift.

I partially inherited the gift, and I remember an intense interest in odors and flavors as a youngster. I believe I lost some of that ability in my teens when several concussions damaged those exquisitely delicate smell fibrils in the roof of the nose, but still retained odor perceptions above the norm. One of our five daughters, however, is a hyperosmic in the same league with her grandmother. As a toddler she could detect triple sealed chocolate gifts under the holiday tree to the wonderment of her older sibs.

Upon return home I visited my friend and colleague otolaryngologist who confirmed my loss and advised me that there was no treatment, and for an anosmic patient, patience was necessary for a prolonged recovery. A small percentage suffered permanent loss and for the rest it was a ploddingly slow recovery sometimes back to "normal," sometimes only partial return of sensation, and sometimes return with a scrambling of scents that didn't match our lifelong catalog of familiar odors.

Fortunately, my smell sense recovered. In the meantime, I over-dosed on salt, sugars, vinegars, umami attempting to stimulate the flavors I dearly missed. Mealtimes were mere exercises in fueling the body instead of the delicious experiences we all value so much. Over the next two years I slowly regained my sense of smell and flavor with some intriguing experiences along the way.

After six months I recovered one dominant odor that was triggered by any source: chocolate, coffee, cigarette smoke, fresh fruit, a dirty diaper, and perfume all smelled the same. I called it “Odor X,” a unique pleasant smell that was new and consistent. Once again, I was fortunate because some healing anosmic patients acquire a different transitional odor that is sickeningly unsavory. Because my single new odor was pleasant, I found myself really enjoying cigarette smoke which I

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formerly detested. One incident during this transition interval kept my wife and me laughing for weeks. While mowing the grass at our home I found myself actually salivating from an intense hit of “Odor X” only to realize that I mowed through a dog pile hidden in the grass. Yes, “Odor X” was nice but had unlikely triggers.

My solitary scent slowly gave way to differentiated smell sensations and most of the returning flavors in my lifelong catalog were the same, thank goodness. Dark chocolate had been a staple in my diet and now took a second seat to milk chocolate. Some odors disappeared and never returned. To this day I cannot smell watermelon, and other melons no longer have the distinctive flavors they once had. In my medical practice I had to recalibrate and re-learn: fresh urine, for example, had a consistently new odor unlike the one in my memory bank.

Several decades later I experienced another medical assault upon flavor perception. It seems that instead of an Achilles’ heel I was granted an Achilles’ nose/throat/mouth. That same friendly ENT specialist found a rare carcinoma in one of my submandibular salivary glands. The gland and its tumor were removed, taking away a significant portion of salivary production and leaving me with a somewhat dry mouth. Drier mouths do not favor good flavor and required me to adapt to new dining habits. Additionally, I underwent extensive radiation therapy to the lower face and mouth region. Once again, I noticed a temporary diminution of flavor sensation which thankfully returned after treatment.

Ever true to my early childhood training by a super-smeller mother, scents and flavors continue as an important part of my overall sensory experience. I can still play the “What is that seasoning?” game. I delight in the nuances of wines, the joy of eating fresh fruits, the distinctive flavors of ethnic dishes. And in spite of all those repeated challenges to my taste and smell organs I am reassured when I am recruited to serve as the Designated Taster in my wife’s gourmet kitchen.

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My Medical Bucket List as I Turn 70

Richard Young, MD, MPH, FAAP, Fellow, American Academy of Neurology Connecticut Children’s Medical Center

As I blew out the candles on my 70th birthday cake, I had two items in my medical bucket list: A Colonoscopy and a Mental Status Exam (MSE). The colonoscopy was a routine, every 5-year affair. The MSE was novel, a new initiative of the hospital’s credentialing committee. The salutation on the recredentialing packet read “Dear Late Career Practitioner.” Should my patients now address me as “Late Career Practitioner”, rather than “Doctor?”

Preparing for the two examinations would require different strategies. The prep for the colonoscopy was a 24-hour clear liquid diet and 4 liters of Golytely. Success was a “clear effluent.” But how do I prepare for the mental status examination? To warm up my gray matter, I attempted the New York Times crossword puzzle. Too stressful. I had more success challenging my 8-year-old grandson, Jimmy, to games of chess, Boggle and Scrabble. I researched a technique for memorizing lists of digits (the “memory palace”)¹. I doubled my gym workouts hoping to raise my levels of irisin, the protein which putatively reduces neuronal damage in Alzheimer disease.² On PBS, I viewed a presentation by psychiatrist Dr. Amen and contemplated ordering his “memory rescue” Master Package for $240.

As the examinations drew closer, I grew increasingly anxious. However, any anxiety I had about the colonoscopy floated away with one circulation of Fentanyl. Keeping my anxiety in check during the Mental Status Exam required a different strategy. I practiced clearing my mind with slow, deep breathing. Fortunately, the neuropsychologist had wonderful bedside manner. He put me at ease saying, “You’re a neurologist, let’s start with some of the questions you often ask your patients.” “Recite the months of the year backwards.” “What is 4 x 9 - 18?” “What is the value of pi to the fourth decimal?” He offered reassurance, “You don’t need to answer every question correctly.”

No timeout for my hippocampus. What are the four types of triangles? Name two marsupials. What is the most abundant element in room air? What is “c” in the equation, E = mc²? Thirty minutes; take another breath and exhale slowly. What is the blood volume of a 100 kg person? Name 3 characteristics of mammals. What is the difference between a “lame duck” and a “dead duck?” Define “red herring” and “red flag”? What do we mean by “cold turkey” and “dark horse?” What

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document begins with the words, “We the People”? Name the 6 noble gases. Tell me all the words you can think of which end with the suffix “-uck”. “Suck, muck, truck, duck, schmuck, luck, upchuck, woodchuck, f--k”. No, I decided, better not use this one, he might deduct points for vulgarity. After 45 minutes of inquisition, he smiled. I passed. I sighed.

What happens if your colonoscopy is positive? Once the shock has dissipated, you have a sober meeting with an oncologist to discuss surgery or chemotherapy. What happens to physicians who fail the Mental Status Exam? Some are in denial. Others are angry, believing this is a form of “age-ism”. Some terminate their hospital privileges or transfer to a practice that does not require a mental status examination.

My suggestion is “keep calm”. Gather more information. Are you APOE-4 positive? Once copy of APOE-4 doubles the risk of Alzheimer disease, while two copies increase the risk tenfold. Do you have Mild Cognitive Impairment, which can be a prelude to Alzheimer Disease? Do you have anosmia, constipation, tremor, or difficulty arising from a chair, symptoms that might indicate Parkinson’s disease?

Have a heart to heart with your spouse or partner. Do not travel this road alone. Consult your family attorney. Entrust someone with Power of Attorney. Name a Health Care Proxy. Study the chapter of life called “Retirement”.

The statistics are daunting. A quarter of U.S. physicians are > 65 years of age. Alzheimer Disease is present in 10% of persons aged 65 years, 17% of those 75-84 years, and 32% of those > 85 years. We physicians are aware that internal organs atrophy or become cancerous. We should take our own medicine: vigilance about the health of both our colon and our cerebral cortex. As one 83-year-old surgeon commented, “You think you’re invincible, but the clock ticks, and I’ve become an advocate for evaluation.”

References

A Place to Call Home for Retired and Retiring Faculty

Beryl J. Rosenstein, MD, FAAP
Professor, Johns Hopkins University School of Medicine

After retiring, have you ever thought that it would be nice to have a professional place to call home? In order to provide a functional home base for retired and retiring faculty of the Johns Hopkins School of Medicine, the Bloomberg School of Public Health and the School of Nursing, the University recently announced the opening of the Academy at Johns Hopkins. The goal of the Academy is to facilitate the continued academic engagement and scholarly productivity of retired faculty; smooth the transition to retirement; connect retired faculty with service opportunities in the University, the Baltimore community, and society at large; offer opportunities for continued learning; and help retired faculty maintain social and professional connections at Hopkins. The Academy’s physical home is in a beautifully refurbished area in the historic Welch library and includes comfortable spaces suitable for private meetings, individual study, small and large group gatherings, symposia, and social events. It incorporates a full business center, kitchenette, conference room with video and web conferencing capacity, computer work stations, storage lockers and an administration office. An on-site administrative program director is available to assist with requests relating to Academy activities and IT support for
personal computers which may be purchased for a fee. The Academy is accessible 24/7 and requires ID badge access. Academy members retain JHU e-mail access as well as electronic library privileges. There are regular e-mail alerts of Academy functions and a quarterly newsletter announcing Academy activities.

The Academy sponsors scholarly symposia, seminars and social events and maintains an inventory of post-retirement opportunities for service within the University and the greater Baltimore community. This opportunity bank is accessible to every Academy member through a web portal with user support available from Academy staff. Service opportunities include precepting and mentoring junior faculty, supporting faculty development activities, performing archival research or history of medicine projects, engaging in community service, serving on committees and advisory panels, reviewing documents such as clinical protocols, and reviewing applications and interviewing School of Medicine candidates.

There are two levels of Academy membership: Affiliate and Scholar. All School of Medicine, School of Public Health and School of Nursing retired faculty and faculty who are transitioning to retirement are eligible for Affiliate membership. Scholar membership is reserved for faculty who are retired from full time service and who are interested in ongoing engagement and service to the missions of the University. Scholars develop and implement programs, represent the Academy on relevant University committees and provide leadership for the Academy. Scholars receive an annual stipend of up to $3,000 to support scholarly activities and expenses. Affiliate membership is for 3 years and can be renewed every 3 years for life. Scholars are appointed for 3 years and membership can be renewed annually. There is no initiation fee or dues.

Johns Hopkins does not have a faculty club at the medical campus, so the Academy fills a much needed and much appreciated role. I would be interested to hear (brosenst@jhmi.edu) of similar programs at other academic institutions.

Trainees- What Can They Learn from Us?

Emanuel Doyne, MD, FAAP

I have had the privilege of teaching many hundreds of medical students, pediatric residents and nurse practitioners through my career. I have continued that activity in retirement as a “senior volunteer”. They are bright, motivated and very young. I ask myself every few months about what I have to offer other than “maturity?” I developed a few categories that I think summarize potential answers to my rhetorical question.

I. Appreciate what you don’t have to do:
   a. Work 36 straight hours
   b. Start IV’s and perform phlebotomies (all labs drawn before rounds)
   c. Read each other’s handwriting
   d. Transport patients
   e. Feel helpless in caring for premature infants who need ventilation (early ventilators were adaptations of the adult equipment and pneumothoraxes were the inevitable result)
   f. Watch a patient go through a pneumo-encephalogram (look it up)
   g. Perform CSF cell counts in the ED with a hemocytometer
   h. Do double exchange transfusions in older kids with Reye’s syndrome
   i. Search the Index Medicus (1879-2004) for the current literature
   j. Treat DKA in a treatment room with only Glucostix and urine dip sticks and regular insulin
   k. Transport a baby with an endotracheal tube in an Armstrong warmer in the older ambulances (i.e. hearses- i.e. low ceilings)
II. Appreciate what you have:
   a. Evidence based medicine
   b. Technology and its rapidity (I try to avoid the dreaded “Social Media”)
   c. Access to all information via a click (e.g. Google and PubMed replace Index Medicus) - if the Wi-Fi is working
   d. PIC lines
   e. Fantastic imaging advances: MRI’s, CT’s, Ultrasounds, Echocardiograms
   f. How much more you know than I ever did
   g. Simulation centers that help you develop skills before you have to use them in the field

III. Appreciate your profession:
   a. Pediatrics is still the best of all worlds
   b. You subconsciously become an advocate even if you only care for one patient
   c. Our patients make us all better people
   d. The miracles of making a baby well and a teenager happy cannot be equaled
   e. We are privileged to take care of the world’s children

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Attendings - What We Learn from Trainees

Lucy Crain, MD, MPH, FAAP

Like Manny Doyne, I practiced general pediatrics (i.e. Primary Care) and Developmental- Behavioral Pediatrics for 40+ years and offer my list of another aspect of learning as a clinical pediatrics faculty member teaching medical and nursing students, residents, and fellows.

EXPERIENCE: Today’s pediatric residents and many medical students have had exciting experiences, numerous publications and research and other careers before even applying to medical school and/or residency. One such recent student shared with our Introduction to Clinical Medicine group his motorcycle journey across the US and through Central America, learning about various styles of health care delivery.

ADVOCACY: Several of “my” medical students and residents have worked or volunteered as staff to legislators, helping to draft health legislation and learning the necessary grass roots lessons of effecting change in health care systems in their previous experiences. When pediatric residents Lisa Chamberlain, Richard Pan, and I along with pediatric residents from UC San Francisco, UC Davis, and Stanford launched the Northern CA AAP Chapter I Advocacy Committee nearly 20 years ago, medical schools and residency programs did not include advocacy rotations as part of their standard curriculum. Most if not all now do so. Partnering with other residency programs in California and jump started by the advent of mass communication via the internet, Twitter, and other media modes, the residents’ shared passion for child health advocacy has blossomed nationwide.

EVIDENCE BASIS OF INFORMATION AND CLINICAL EXPERIENCE: I’ve noted that pediatric residents ask fewer questions of faculty than in past years. They seek immediate answers from apps like UpToDate or Medscape or other valid sources. Libraries are now most useful for providing internet access quiet places to study, and who needs to buy text books to lug around? But beware: Some of the online answers given by non-peer reviewed sources are not correct, especially those about vaccines. Being able to share experiences and knowledge based on years of clinical evidence-based practice with younger pediatricians is especially important and one of the most fertile areas to share intergenerational learning and advocacy tactics.

LIFESTYLE: Today’s residents and students know that there is more to life than work! Many residents and fellows have children and families and household responsibilities of their own (a rarity 40 years ago). Rest and sleep (recently described in the New York Times as “Janitorial service for the brain”) are necessary. Better patient care and fewer errors

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result from doctors and nurses who recognize their own limitations. Regulation of residency on duty and on call hours plus hospitalists, phlebotomists, and other staff and services previously referred to those of my generation as necessary prep work have been replaced by automated systems of patient care and health care delivery. Attending physicians and nurse clinicians could benefit from such regulations and learn more from the younger generation about taking care of ourselves.

**HUMILITY:** My list cannot encompass all that I have learned from students and residents about digital searches, use of digital instruments, evidence-based information retrieval and opportunities for research and treatment methods (many of which they’re already involved with)! Much as I complained about having to learn and become reasonably proficient with electronic medical records systems, I admit that it’s easier, faster, and safer to use these records than having to dig through volumes of charts in the “old days”. I’m grateful for the opportunity to continue to interact with young, enthusiastic physicians and nurse clinicians and that I can continue to learn from them and with them.

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**Thoughts of an ‘Old School’ Child Abuse Doc**

*Harvey S Kaplan, MD, FAAP*

In a recent clinical report from the AAP titled ‘The Evaluation of Suspected Child Physical Abuse’ they state that there are over 2 million reports of suspected maltreatment in the USA annually that are investigated by CPS with over half a million cases substantiated and 1500 child deaths mainly in children under 4 years of age. My first case of child abuse in 1970 involved a young couple with a battered infant who told me that they believed in ‘spare the rod and spoil the child’ and that led to the abuse. Now we are learning much more about the root causes of early childhood trauma, the long-lasting effects of toxic stress and the need of all children for safe, sustaining and nurturing relationships. In a trauma informed community could we get to a ‘new normal’ where reports of suspected abuse are uncommon, not due to a reluctance to report and investigate but rather because families and children are experiencing good physical and mental health due to universal home visitation, universal access to quality health care, quality pre-school and child care, and agency and governmental policies that promote a ‘Pro-Kid’ agenda.

These thoughts came to me after reviewing ‘The California Children’s Report Card of 2018’ produced by ‘Children Now’, a California child advocacy organization led by Ted Lempert. All the wide range of programs and services for children are graded for progress made. Health care gets an ‘A’ due to Med-Cal, CHIP and the ACA. Home visitation, day care, early childhood mental health, developmental screening, oral health and the status of children in foster care however get D’s and C’s. Clearly, we have to do better for the 9 million children in CA, of whom almost half live in low-income families with 1 in 5 below the poverty line. You can add food and housing insecurity to the list.

As emphasized in the report card, influencing policy makers is essential and the good news is that a new governor and administration seems to ‘get it’ about the importance of early childhood. Appointed by Governor Newsom as CA’s first Surgeon General, Dr. Nadine Burke Harris of SF is a local and national leader in the science of early childhood trauma, ACE’s (Adverse Childhood Experiences) and developing resilience in children. Kris Perry who is a local and national leader in early childhood development and former ED of First Five of San Mateo is advising the governor on early childhood development. CA pediatricians now have friends in high places to help stressed children and families achieve success in their lives.

Locally I have been very privileged to be involved with First Five and CASA (Court Appointed Special Advocates) of SMC, The Keller Center for Family Violence Intervention, San Mateo Medical Center and the Sequoia Health Care District. Nice to be retired and have the time. First Five is developing ‘TRISI’ or Trauma and Resiliency Informed Systems Initiative which will be formulated by 2020 after an extensive period of community input. The goal is to educate, and train agencies involved with children and families in how best to reach out to parents and children who have experienced trauma in their lives. The hope is that by establishing meaningful contact, people will be more accepting of helpful intervention in their lives and make better choices for themselves and their children.
In my involvement with CASA we have established a program called ‘Healthy Futures’ supported by grants from Peninsula and Sequoia HCDs’ to inform CASA volunteers and foster parents about the challenges children in foster care face in attaining services for their often complex physical, mental and oral health care needs.

The SMC Health Care System has a grant supported pilot program at the county’s SSF clinic aimed at detecting potential trauma in young children especially those under 3 years when brain development is at a critical stage and connecting families with appropriate therapeutic resources. Dr. Beth Grady is leading this project. Another Chapter 1 pediatrician Dr. Neel Patel is organizing an effort to improve early childhood screening by pediatricians and also serves as an FF commissioner. I want to also acknowledge my colleagues and friends in Pediatrics at the SMMC for their life long dedication to improving the health of low-income children: Dr. Janet Chaikind, Dr. Hilda Dudum, Dr. Rachel Borovina, PNP Carol Tadla and many others.

The Keller Center is an invaluable community resource under the direction of Dr. Tricia Tayama. Children, adolescents and adults are seen by an incredibly dedicated staff of clinicians and therapists for forensic evaluation of suspected abuse. There is a protocol driven process of establishing and documenting an accurate diagnosis of injury and traumatic stress which is evidenced based and coordinated with the judicial process. Hopefully as a result, children and adults will be protected from further trauma.

For me, being involved in community programs that support the needs of children and especially getting to know the people involved is very rewarding and I hope to keep it up.

References:
2. **Trademark of “Children Now”

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**Practice Limited to Four-Year-Olds**  
*Frederick Bogin, MD, FAAP*

Fussing babies, vomiting children, parents convinced that the rash that only they can see, screams lethal disease … so where is the joy of pediatrics?

Each encounter can be seen as a potential mine field, but I am certain that most pediatricians walk into an exam room anticipating connection, warmth and at times, pure joy!

The Pediatric Primary Care Center at Saint Francis Hospital is where I hung my stethoscope for 15 years. The joy appeared in a beautiful human quilt of varying sizes, shapes and colors.

Tyrone was a handsome four-year-old African American boy who had always been outgoing, dynamic, a delight to see. He loved to vault onto the exam table *all by himself*; no small feat for a 36-pound preschooler. Tyrone was my first patient of the afternoon -- in for his pre- kindergarten well child visit. Nurse Noreen whispered that Tyrone had something special to show me that day.

With great anticipation, I walked into exam room #5 to find Tyrone, naked, save for boxer shorts, standing on top of the exam table. As I approached my young friend, he greeted me with gyrating hips, arms moving in perfect harmony, tracing horizontal circles in the air. In lieu of – “Hello Doctor Bogin”, Tyrone began singing in the deepest voice he could summon --

“I like to move it, move it, move it! I like to move it, move it, move it!”

It was difficult to contain my volcanic delight. I smiled at his mom, helped Tyrone down from the table and began our well child visit.

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Yutin was a precious Chinese girl. Her straight black hair framed her porcelain face perfectly. She was quiet as she fingered the fringes of her gown. I worked hard to get her to smile using my dancing, clip-on elephant. She maintained a stoic countenance. Perhaps she knew that the four-year visit would conclude with booster shots.

Yutin sat perfectly still on her mother’s lap while Noreen and I gave her simultaneous vaccines in her toothpick arms. A silent tear appeared at the corner of one eye. I touched her cheek gently and said – “I’m sorry Yutin. I know those hurt. You were sooo brave. I am really proud of you. Please tell mommy when your arms start to feel better.”

At the end of the visit, I turned to write in her chart while she got dressed. When I turned around again to see her, Yutin stood straight up, faced me, and bowed from the waist.

I was overcome. Now I was the one with a silent tear. I desperately wanted to pick her up and give her a huge hug, but reason and cultural sensitivity screamed “stop”! I looked at this darling child and bowed to her. My feet barely touched the ground as I floated from the room to see my next patient.

Sara was new to our practice. She skipped into the exam room, seemingly fearless. We were meeting each other for the first time. She had curly red hair and a face full of freckles – a future Annie. Sara radiated confidence and pizzazz. She appeared to be fully comfortable as she donned her tiny exam gown. She was four and she was in charge!

Turn the clock back twenty years. As a pediatric resident, one of my heroes was Leon Chameides, a kind and brilliant pediatric cardiologist. As I watched him listen to a child’s heart one day, I noticed that he closed his eyes. All attention was focused on the sounds filtered through his stethoscope. From that day on I closed my eyes as I listened to the sounds of my patients’ hearts.

When I got to Sara’s cardiac exam, as was my custom, I closed my eyes. I began to focus on her heart sounds, but Sara was in charge – “Wake up … wake up Dr. Bogin!” I smiled with delight as I thought to myself – and they pay me to do this!

Christopher is my own son -- our youngest child. I brought him to one of my partners, Dawn, for his four-year well child check. While we waited for Dawn, I suggested that Chris remove all his clothing except his underwear. I left the room briefly. When I returned, there stood Christopher, stark naked! “Christopher you didn’t have to take off all your clothes! I said you could keep your underwear on.” “No way dad…. I don’t want her to see me in my underpants!” I fought to bottle an emerging belly laugh, got Chris a little gown, and flashed to one of my favorite fantasies: I visualize myself in a quiet, secluded office with a large sign on the front door: PRACTICE LIMITED TO FOUR YEAR OLDS!

Like the Gilbert and Sullivan movie of the same name I experienced a Topsy Turvy event this winter.

As one of the almost 3 million people taking bisphosphonates for osteoporosis I was unaware that in spite of data documenting a significant reduction in incidence of fractures in bisphosphonate users, particularly of the hip and vertebral bodies, there is a rare paradoxical risk for “atypical” fracture of the femur with an incidence of between 3.2 and 50 cases per 100,000 patient years to about 100 per 100,000 patient years after 5 years of usage. The fractures occur with minimal to no trauma and are bilateral in about 25% of cases. See: Cleveland Clinic Journal of Medicine Vol 85 Number 11 November2018.

Criteria have been developed for the diagnosis of atypical femoral fracture and are published: J Bone Miner Res 2014; 29(1):1-23. They include:

- Fracture occurs with minimal or no trauma
- Originates at the lateral cortex and has a predominantly transverse fracture line
Topsy Turvy  Continued from Page 23

- Extends through both cortices
- Is noncomminuted
- Shows localized periosteal or endosteal “beaking” at the fracture site

Several minor criteria are important but not required for diagnosis:
- Cortical thickening of the femoral shaft
- Unilateral or bilateral prodromal thigh pain preceding the fracture
- Delayed fracture healing

So, what was my topsy turvy moment?

As a physically active person I had been enjoying the winter playing tennis and pickle ball and doing alpine and cross-country skiing. On January 7th I skied all morning and was looking forward to playing tennis that afternoon. While walking down the stairs to put my skis in the locker I suddenly found myself “topsy turvy” with my helmeted head on the floor and my femur disconnected – a new kind of “downward dog” yoga position. Instead of falling and sustaining a fracture the fracture came before the fall (more topsy turvy). What followed over the next few hours was a challenging stabilization of my leg on site in a narrow stairwell, placement in a splint to partially reduce the fracture, removal of my ski boots and 2 ambulance rides to get me to the OR with placement of a long rod. See X-rays of before and after. Note the hardware in the knee which is from a partial knee replacement on that side 12 years ago.

It’s been almost 2 months now since the unexpected fracture and physical therapy is getting me back to a reasonable level. Although I’m not able to ski or play tennis yet I can snow shoe and ride a stationary bike.

In retrospect I had been experiencing some thigh pain but had attributed that to less than full quad strength after a total knee replacement in June. This is my message to anyone taking bisphosphonates – **thigh pain is the tip off to micro/stress fractures that can lead to complete fracture**! If you or anyone you know experiences thigh pain and is taking bisphosphonates please report these symptoms to your physician so you can avoid a “topsy turvy” moment!
Awesome Antarctica
Cathy Deangelis MD, MPH, FAAP

At 79 years young, I thought I would be the oldest of 108 passengers on a recent photographic exploration to Antarctica, which my younger (at 78 years) husband and I ventured on recently. I was wrong because the ages of other adventurers ranged from 18 to 84 years... And an adventure it truly was.

You might well ask what such a trip has to do with senior pediatricians and global health. In addition to my attending to the relatively few and minor physical ailments (there was a ship doctor on board, after all) I was often asked health questions in conversations with the other passengers. It was interesting how open and trusting complete strangers were in revealing their sometimes very personal concerns. That gave me great confidence that the medical profession, per se, is still well respected and trusted.

Beyond this minor physician's role, the exploration of the white continent, as it is known, provided opportunities to learn about other cultures and how some of nature's precious creatures deal with life. All of us can learn a great deal about coping with frustrations and dangers from these sorts of interactions.

No one owns Antarctica, but seven countries have a pact to keep it as natural as possible; free from what humans have done to make a mess of much of the world. Unfortunately, the United States is not one of those countries.

It is not easy to reach Antarctica from anywhere in the world, which is probably why it remains wild and beautiful. We first flew from Baltimore to Santiago, and then took a charter flight to Ushuaia, Argentina, the southernmost city in the world. Their medical care is provided by a physician who visits for a few days a month. Incidentally, any physician interested in living there for a while serving the almost 60,000 citizens would be most welcome.

After touring that city, we boarded the ship that would transport us to Antarctica. That night and the next two days we traversed the Drake Passage, which could be a very rough sail. We came supplied with Meclizine HCL, which fortunately we didn't need. The Passage was considered by the navigator to be smooth as a lake. You could have fooled me as I was trying to shower in the rocking boat, but it was fun to juggle soap while hanging on the bars in the shower. I could only imagine showering in a turbulent sea.

After showering I would get a cup of cappuccino (how's that for mixing the wild with the wonderful?) and join the very kind female (hooray!) navigator on the bridge. Experiencing the beauty of the environment from that vantage point was amazing. Early one morning when we were in the Lemaire Channel, I walked out to the ship's rail and was greeted by one of the most awe-inspiring sighs and feelings I have ever experienced. The light playing on the water, icebergs and land and the complete silence was overwhelming, resulting in the second epiphanic experience of my life; the first having occurred on Huayna Picchu, high above Machu Picchu many years ago.

Our daily routine consisted of morning and afternoon trips via Zodiac boats to an island usually filled with penguins and occasional seals. At 6 pm there was a presentation by one of the naturalists on penguins, sea creatures, birds, or the sea below us.

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Penguins are among the cutest but certainly not the smartest of God’s creatures. Despite being birds, they don’t fly, but they can leap out of the water to land up to 20 feet or so on land. They waddle around always in a hurry, frequently traveling along a path that the naturalists called penguin highways.

We were told not to block those paths. One day Jim was sitting on a rock videotaping a group of penguins with their babies. He was not paying attention and had his foot on a path. I watched penguins come to a complete stop on either side of his leg despite their ability to easily maneuver around him. I called out to him, and when he moved, the penguins restarted on their hurried way. Go figure.

Another interesting thing about penguins is that they eliminate wherever they happen to be standing, creating a pungent fragrance (Eau de Penguin?). They frequently leap into the water to clean off the mess or to eat their diet primarily of krill. However, they only leap into the water in groups. They wait until a group gathers, then one leaps first, and others follow. I learned the wisdom of that habit when one day a group of penguins were swimming alongside the ship when one of them swam away from the group and was chased by two whales looking for lunch. The whales won.

There were so many interesting sea creatures and birds, including the incredible albatross, that I could describe but word count won’t allow. So, if you’re really interested in the Antarctic, I suggest you watch the movie, Shackleton, about the 1914-16 trans-Antarctic expedition to get the full force of that amazing continent.

What’s in a Name?
Joseph A.C. Girone, MD, FAAP

Americans love their pets. In 2018, 68% of households had pets. Sixty million households had dogs and 47 million had cats. There were 89.7 million dogs and 94.2 million cats living in these homes. The average annual expense for a dog is $1500 and $988 for a cat. When these treasures are acquired, they deserve a distinctive name. A single owner may mentally consider many names, trying to select one that best works for that pet. Naming a new family pet may generate a family meeting to get ideas from all. The best name may require compromise.

Naming more than one pet can be challenging. Some suggestions for 2 or possibly 3 pets are found in tables I and II. Read them aloud to know the sound of addressing your pet.

If you know you are likely to be a more than one pet person, you may want to consider a name from the Table for the first pet. Choosing a name from the suggestions will make the name selection of the next pet very simple. The names in the Tables will bring harmony to the pet’s home. Some combinations go well with pets of the same sex while others are better with different sex animals. Some owners will find satisfaction in choosing names from the Table for different animals, such as a dog and a cat.

You will be calling out the pet’s name many times so say the names in the Table aloud. Does it suit the pet and you? There is much more leeway than selecting a child’s name. The moniker you choose does reflect your personality and the name definitely plays a role in the enjoyment of pet ownership.

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Continued on Page 27
You can go online and Google “Naming your pet” and whip through the 39 million results or use Table I or II.

Table I
Names for Two Pets

<table>
<thead>
<tr>
<th>Armed and Dangerous</th>
<th>Tooth and Nail</th>
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</thead>
<tbody>
<tr>
<td>Rank and File</td>
<td>Leaps and Bounds</td>
</tr>
<tr>
<td>Hit and Run</td>
<td>Pride and Joy</td>
</tr>
<tr>
<td>One and Done</td>
<td>Each and Every</td>
</tr>
<tr>
<td>Pure and Simple</td>
<td>Nip and Tuck</td>
</tr>
<tr>
<td>Stop and Go</td>
<td>Fish and Chips</td>
</tr>
<tr>
<td>First and Foremost</td>
<td>Safe and Sound</td>
</tr>
<tr>
<td>Hither and Thither (Yon)</td>
<td>Fast and Furious</td>
</tr>
<tr>
<td>Muscles and Bustles</td>
<td>Mickey and Minnie</td>
</tr>
<tr>
<td>Willy and Nilly</td>
<td>Lo and Behold</td>
</tr>
<tr>
<td>Pins and Needles</td>
<td>Now and Never</td>
</tr>
<tr>
<td>Hugs and Kisses</td>
<td>Song and Dance</td>
</tr>
<tr>
<td>Dribs and Drabs</td>
<td>Nip and Bud</td>
</tr>
</tbody>
</table>

Table II
Names for Three Pets

<table>
<thead>
<tr>
<th>Hook Line Sinker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed Sealed Delivered</td>
</tr>
<tr>
<td>Live Love Laugh</td>
</tr>
<tr>
<td>Blood Sweat Tears</td>
</tr>
<tr>
<td>Lock Stock Barrel</td>
</tr>
<tr>
<td>Bell Book Candle</td>
</tr>
<tr>
<td>Ready Willing Able</td>
</tr>
<tr>
<td>Citius Altius Fortius (Faster Higher Stronger)</td>
</tr>
</tbody>
</table>
Movie Reviews

Spring 2019 Movie Reviews

Lucy Crain, MD, MPH, FAAP

ROMA: A leading foreign language Academy Award contender for this “slice of life” documentary style film stars Yalitza Aparicio, a 25-year-old previously unknown indigenous female from Oaxaca. She plays the role of a quiet nanny and housekeeper for an upper middle-class family, becoming the surrogate mother for the 4 children of parents whose marriage is rapidly falling apart. Her only close friend is the household cook, also from Oaxaca. Her friend introduces her to a young man with whom she falls in love, only to find that she is pregnant, and the father of her unborn child is only in love with becoming a soldier. The details of this brief but life-changing relationship are heart breaking within the backdrop of a student uprising and military shootings of students in Mexico City, where the film is set. The beautifully filmed scenes of everyday life, the dysfunctional family, the constantly defecating dog, the near drowning events at the children's day at the beach make this a fascinating film. Black and white, 135 minutes, R.

THE WIFE: Another Oscar-worthy performance by actress Glenn Close as the long-suffering wife of a philandering literature professor and acclaimed (alleged) author. As he receives the Nobel Prize for Literature, she seethes with quiet anger further exacerbated by her husband's blatant flirting with an attractive young woman. Flashbacks to her early attraction to her professor when she was the graduate student breaking up his first marriage interspersed with rare moments of marital tenderness and masterful performances by Close and the supporting cast make this well-constructed story worth watching and musing over gender inequities and other considerations of unfairness of life. R rating, 95 minutes.

CAN YOU EVER FORGIVE ME? Melissa McCarthy, well known for her comedy roles, stars in this noir drama about a writer who resorts to forging literary documents in order to support herself. Based on Lee Israel's personal memoir of her unsuccessful life as a New York writer, McCarthy portrays the desperation of Ms. Israel's status, frumpy appearance, and heavy drinking with impressive plausibility. Living in a small apartment with only her beloved cat as a companion and with a less than helpful literary agent (played with cool sophistication by Jane Curtin), she finds her real gift in imitating the prose styles of Dorothy Parker, Nora Ephron, Noel Coward and other well-known writers. Ms. Israel is readily befriended by a new drinking buddy acted by Richard Grant (on the Academy Awards list for Best Supporting Male Actor) who becomes her partner in crime as they successfully sell forgeries of literary importance until finally apprehended by the FBI. Lacking much of the promotion and hype for other Academy Award nominated films, “Can You Ever Forgive Me?” features an intriguing plot with outstanding acting. (Oscar nominations for Best Actress, Best Supporting Male Actor, and Best Adapted Screen Play) R rated, 106 minutes.

THE FAVOURITE: Starring Olivia Colman as Queen Anne and Emma Stone and Rachel Weisz as cousins who seek the Queen's favor and go to extremes to curry that favor. This is a rollicking comedy-costume drama which is more filled with vulgarity than any attempt toward historic correctness. Obscenities and sexual trysts abound to a fault and despite the extravagant costumes and scenery, I found this movie a disappointment. 119 minutes R.

THEY SHALL NOT GROW OLD: New Zealand filmmaker Peter Jackson's documentary on WWI reflects the most realistic war movie to date, following British recruits as they enlist in the British military until they die in the trenches or on the battlefield. Ironically, the movie begins with an amiable soccer game between a British team and a German team and quickly switches to announcements of war and recruitment efforts.

The film is restored from archival footage stored in the British Imperial War Museum and not previously viewed. Jackson and his team have worked for four years to correct timing to eliminate the jerky effect seen in old film clips. The film has been so effectively and naturally colorized that the first clips which the viewer sees in black and white seem literally to spring to life when replaced by the colorized version. This is not an easy movie to watch, with mutilated dead bodies of British and German soldiers dangling from barbed wire or in fox holes. The front-line cinematographers of WWI who survived to store their footage and Jackson, who rescued it from archives and restored it, have produced the most convincing visual reasons against war perhaps in our lifetime. (At end of the 99-minute film, there is an “optional” 30-minute discussion of the production details by Jackson. In this, Jackson explains the voice-overs recorded years ago by the War Museum of the original voices of WWI British soldiers in their regional accents, seemingly originating from the soldiers depicted in the

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THE OLD MAN AND THE GUN: Starring Robert Redford in what he has called his final film, this is based on the true story of a life-long bank robber named Forrest Tucker. The movie begins with Tucker being released from one of his several prison sentences. His fellow robbers of the “Over the Hill Gang” (played by Danny Glover and Tom Waits) await him and their next exploit. Redford plays Tucker with such style and charm, he can walk into a bank and rob it without even arousing suspicion of a guard standing in line behind him.

He meets a new lady friend (Cissy Spacek) who gives him a ride, never suspecting that she is aiding a criminal. Their friendship continues and their enjoyment of each other's company is a delightful distraction from his occupation. These experienced actors occupy their roles with natural ease, resulting in a thoroughly entertaining movie. Written and directed by the masterful David Lowery, it should be available now for viewing on Netflix or streaming. PG 13 (strong language) 93 minutes.

Book Review
by Karen Olness, MD, FAAP

The Woman Who Smashed Codes
by Jason Fagone 2017 HarperCollins, 464 pages

I have read several books about US and English code breakers. This was the first time I learned about the woman who was probably the most outstanding code breaker of the 20th century. This well written book contains an extensive bibliography.

Elizebeth Smith was born in Huntington, Indiana in 1893. Her father, a farmer, traced his lineage to an English Quaker who sailed to America in 1682. Elizabeth was the last of ten children. Her father did not want her to go to college, but she studied Greek and English at Wooster College in Ohio between 1911 and 1913. She transferred to Hillsdale College in Michigan to be closer to her ill mother. At both schools she earned tuition money as a seamstress. She especially enjoyed studying the works of Shakespeare, Tennyson and Erasmus.

After graduating in 1915 she went to Chicago where she was turned down at several job agencies. Before leaving she visited the Newberry Library because she heard that it owned a rare copy of the First Folio of William Shakespeare. The librarian, recognizing her intense interest in Shakespeare, told her about an unusual job. George Fabyan, a wealthy Chicago businessman, was seeking a female scholar to work with Elizabeth Gallup to prove that Shakespeare's plays were written by Francis Bacon. He brought Elizebeth to his country estate where he supported many laboratories (including some that tested ordnance), a farm, formal gardens and mansions. Mrs. Gallup taught Elizebeth to look for hidden messages that she believed Bacon had woven into Shakespeare's plays. Later Fabyan persuaded William Friedman, a geneticist working in one of the laboratories, to join the women. Elizebeth and William worked together on many code systems but were never able to prove that Bacon authored Shakespeare. In 1917 Fabyan volunteered their services and his center to teach WW I soldiers about coding. Soon Elizebeth and William were easily deciphering hundreds of messages.

Elizebeth and William were married and, in 1918, William was sent to France with the Army Signal Corps. After the war the couple moved to Washington where they both worked for the US Army. In 1925 Elizebeth began work for the Coast Guard and broke many codes of American gangsters. When WW II began, she continued her work with the Coast Guard and became the only person who broke codes of three different Enigma machines. The Germans never knew that these codes had been broken. William developed the M-134 cipher machine that evolved into the SIGABA, a cipher machine never broken by Germans or Japanese. Because the Friedman work was classified, and they could not discuss it publicly their remarkable talents were not generally recognized until long after WW II. The FBI insisted on having their intercepts and taking credit for breakthroughs. Eventually recognition went to William and the first NSA Auditorium -was named after him. In 1995 Elizebeth's name was added.
“The Moral Economy” requires some basic understanding of economics as well as an understanding of game theory, which is the study of mathematical models of the interaction between rational decision makers. Bowels explores “the paradigm of synergy between incentives and constraints, on one hand, and ethical and other-regarding motivation on the other.” How financial incentives and other rewards can backfire by undermining non-economic motives is an issue that we, as pediatricians, researchers, educators and policy makers face on a regular basis.

After his introduction to some classic economic principles and simple game theory game, Bowles moves on to real life examples and experiments. One example is the Boston fire department decided to end its policy of unlimited sick days. It hoped to decrease the sick days especially those taken around weekends. Firefighters taking more than 15 days sick days would not be paid for those additional sick days. The following year the number sick days taken more than doubled. The explicit financial incentive pushed behavior in the wrong direction. This change in the sick-day policy replaced a relationship that respected the obligation to others and autonomy with one that put a financial price on their service. Showing up for work before or after a weekend was no longer a duty, it became something they could buy their way out of. Thus, financial incentives crowded out moral/social preferences.

In an experiment based on the game theory game “the prisoner dilemma,” players, using real money, would act in a way that benefits other players while reducing their own rewards. Change the incentives and the behavior changes. Selfless behavior declines.

These examples demonstrate how incentives (financial) and moral/social preference (empathy, altruism, compassion, professionalism etc.) can interact by “crowding out” or “crowding-in” certain of these values. The widespread use of financial incentives may affect these broader values.

“The evidence suggests that ethical crowding-out effects can be substantial and that the lessons of our economic experiences are sometimes long-lasting and tend to be generalized to other domains of life.”

When we enter medical school, we bring and learn values that allow us to gain knowledge, skills, professionalism, decision making, lifelong learning and demeanor. We also bring and learn values of compassion, empathy, altruism, teamwork, diversity, inclusion and justice.

Today, residents coming out of training are burdened with huge amounts of debt. They often find work in programs that help pay off that debt. Often these programs stress financial incentives (pay for productivity) that “crowds out” some if not all the values that brought these early career pediatricians into pediatrics. This may certainly be one of the reasons for the increase in “burn out” that is occurring earlier and earlier in one’s pediatric career. “The Moral Economy” provides a framework that may allow for medical school deans, residency program directors, hospital and practice administrators, policy makers and pediatricians to “crowd in” rather “crowd out” these ethical, intellectual and societal values.
I loved Being Mortal and place it on my personal “All Time Favorite Books” list. Unified by an over-riding theme of end-of-life issues, it seemed to me that Dr. Gawandi’s award-winning novel is really two books in one: (1) facilities for seniors; and (2) the challenges of dying.

The early chapters are a preamble to both “books” in addressing the inevitability of aging and death, an intrinsic part of our life cycle that American society in particular refuses to accept. Gawandi’s graphic description of our later years characterized by frailty and diminishing capabilities was indeed sobering for this older reader.

The first “book” relates the 20th century evolution of hospitals in the U.S. and subsequent introduction of nursing homes as we know them today. Today’s nursing homes suffer from the “Three Plagues” of boredom, loneliness, and helplessness. Absent is personal autonomy and what he calls the freedom to be the authors of our own existence.

Gawandi describes enlightened efforts to create residences that maximize independence for frail seniors. As an example, he highlights the concept of “Assisted Living Facilities” developed in Oregon in the 1980s.

The second “book” is a highly personal discussion of the decisions made by patients diagnosed with life-shortening diseases, mostly cancer. The medical profession (and patients too) are frequently driven by the long skinny tail of possible survival --- the medical equivalent of lottery tickets --- says Gawande.

He then describes the roles that his fellow physicians can play: the Paternalistic Doctor (mostly in the past) who tells his patient what to do; the Informative Physician who provides all the essential information but offers little guidance (his role in his early years of practice); and the Interpretive Doc (also the Shared Decision Maker) who first determines what is most important to their patients at the end of their life and only then guides their decisions.

The centerpiece of the entire book is Gawande’s account of his personal journey as he learned to become the Interpretive Doctor. The catalyst was involvement in the prolonged passing of his physician/father who uneasily balanced his own Quality of Life ball as he lived with a slowly progressive cancer that eventually disabled him. Gawande’s account is as heartfelt as any story told by a physician/author.

In dealing with his own cancer patients Gawande strongly supports the role of Hospice Care whose objective is enabling people with terminal illness to enjoy the fullest possible lives right now.

In summary, as a fellow physician I found Being Mortal my best non-fiction medical read in decades. Although he often delves into medical detail he doesn’t “write down” to his lay reader and scrupulously avoids speaking in medicalese. His humility and willingness to speak openly from the heart is a refreshing departure from the “white-coated doctor on a marble pedestal” image of generations past.

Buried in Chapter Six I found this paragraph which summarizes Gawande’s philosophy as a caring physician:

Our responsibility, in medicine, is to deal with human beings as they are. People die only once. They have no experience to draw on. They need doctors and nurses who are willing to have the hard discussions and say what they have seen, who will help people prepare for what is to come

--- and escape a warehoused oblivion that few really want (pages 187-88).
I was pleased to read in the COFGA Liaison Report in the most recent edition of the Bulletin that Dr. Kimberly Schrier is the first pediatrician ever elected to the U.S. Congress. Congratulations to her on this great accomplishment! It is a further positive note that the 116th Congress will have 16 health care professionals, including 11 physicians, 2 dentists, 2 nurses and an optometrist. By comparison, this number is dwarfed by the 218 lawyers in the 115th Congress. In a recent article in the Lancet (390:1023, September 9, 2017) covering international political leaders spanning 71 years from 1945-2015, it was found that there have been 1254 presidents or prime ministers in 176 countries, of which 32 (2.6%) were physicians. Currently the best-known example is Bashar al-Assad, an ophthalmologist who is President of Syria. Interestingly, Chile has had two physician presidents, Salvador Allende from 1970- 1973 and Michelle Bachelet from 2006-2010 and 2014-2018. Of note, there has been no recent shortage of physicians running for President of the U.S., including Howard Dean (Internist) in 2004 and Rand Paul (ophthalmologist) and Ben Carson (neurosurgeon) in 2016.

Important New DTaP paper

Jim Cherry, perhaps the world's foremost pertussis expert has published in the Journal of the Pediatric Infectious Disease Society a review of studies of the efficacy of acellular pertussis vaccine. See: Cherry, JC, The 112 year odyssey of pertussis and pertussis vaccines - mistakes made and implications for the future: Publication Link piz005. Published: 22 February 2019.

The abstract concludes: Because of linked epitope suppression, all children who were primed by DTaP vaccines will be more susceptible to pertussis throughout their lifetimes, and there is no easy way to decrease this increase life time susceptibility.” He calls for ensuring maternal DTaP administration with every pregnancy and increase Tdap administration to every 3 years.

This is an example of science progressing and acknowledging we did not get it right the first time. This is very hard to do today knowing a vocal anti-vaccine lobby will trumpet the error, ignore science's ongoing scrutiny of the efficacy and safety of licensed vaccines, and disregard the author's recommendation for increased use of Tdap.

**Question:** Is the lifetime increased susceptibility to pertussis any different for those of us who were initially vaccinated with the DTP product and later boosted with DTaP or Tdap?

**Answer:** Yes: if an individual initially received whole cell pertussis vaccine their subsequent susceptibility is NOT impaired and perhaps even enhanced by later receipt of Tdap.

Cherry points out this business of epitope suppression is akin to the concept of the doctrine of original antigenic sin associated with influenza: one's lifetime response to influenza is modified - or sculpted - by one's original exposure to influenza virus antigens. It seems the same is true of our response to pertussis antigens.
Letter to the Editors
Eugene Raymond Wynsen, MD, FAAP

The overarching issue climate change Dr. Schiff referred to comes in last on multiple polls on items of concern. Many areas of land are sinking, including Norfolk, Miami, Bangladesh, and New Orleans. Pacific Islands are growing as shown by satellites. Sea level rise has been the same for 100 years, about 8-10 inches per century. Temps are less than in the medieval warm period, the Roman warm period, and the Minoan warm period.

CAGW advocates are wanting to spend 100 trillion dollars to achieve theoretical tenths of a degree less rise in Global temps. They want to change the whole world economy to a socialistic one and control energy and everything we do and redistribute wealth.

The hot spot predicted by the theory has not been found. There is no increase in hurricanes, tornadoes, floods, wild fires, tornadoes, or draughts as per the IPCC and Dr. Pielke Jr. A small trend in rise of global temps has been going on for 150 years, coming out of the Little Ice Age. The models are running too hot by a factor of two as shown by weather balloons and satellites, and reanalysis. The planet is greening. The two-degree temp limit was made up and has no scientific basis. Nordhaus is an economist, and he originally said +/-5 degrees. The models cannot model clouds, PDO. AMO. La Nino, El Nina, and have differential equations which do not have solutions, so they use “parameterizations.” They guess. Apocalyptic predictions have been being made for forty years and we are still here and thriving. Yes, children will be among those most affected, but not by climate, but rather the draconian measures being proposed.

Mental Test for Retirees
Submitted by Cathy DeAngelis, MD, MPH, FAAP Author unknown

This test is to ascertain your mental state now. If you get one right you are doing ok, if you get none right you better go for counseling.

Giraffe Test

There are 4 questions. Don’t miss one.

1. How do you put a giraffe into a refrigerator? Stop and think about it and decide on your answer before you scroll down.

   The correct answer is: Open the refrigerator, put in the giraffe, and close the door. This question tests whether you tend to do simple things in an overly complicated way.

2. How do you put an elephant into a refrigerator?

   Did you say, Open the refrigerator, put in the elephant, and close the refrigerator? Wrong Answer.

   Correct Answer: Open the refrigerator, take out the giraffe, put in the elephant and close the door. This tests your ability to think through the repercussions of your previous actions.

3. The Lion King is hosting an Animal Conference. All the animals attend. Except one. Which animal does not attend?

   Correct Answer: The Elephant. The elephant is in the refrigerator. You just put him in there. This tests your memory.

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Mental Test for Retirees  Continued from Page 33

Okay, even if you did not answer the first three questions correctly, you still have one more chance to show your true abilities.

There is a river you must cross but it is used by crocodiles, and you do not have a boat. How do you manage it?

**Correct Answer:** You jump into the river and swim across. Haven't you been listening? All the crocodiles are attending the Animal Conference. This tests whether you learn quickly from your mistakes.

According to Anderson Consulting Worldwide, around 90% of the Retirees they tested got all questions wrong, but many preschoolers got several correct answers. Anderson Consulting says this conclusively proves the theory that most Retirees do not have the brains of a four-year-old.

Send this out to frustrate all of your smart friends...

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**Finance**

Donating Life Insurance to Charity

Jeff Witz, CFP®

Life insurance can serve many purposes, the most common being the replacement of family income if the insured dies. Frequently, life insurance is purchased concurrent with a life changing event such as marriage or the birth of a child. A variety of formulas are used to ensure that, at the time of a premature death, the life insurance proceeds will be sufficient to meet the surviving family’s needs. These needs often include replacement of lost earnings to pay ongoing expenses, college education funding, pay off an existing mortgage, and provide future retirement income for the surviving spouse.

Therefore, it is not surprising that most individuals purchase life insurance early in their careers when they have not accumulated substantial assets. But as time passes and their assets grow, and those original “needs” such as education funding are handled through savings or investments, the need for life insurance may be drastically reduced. When this situation occurs, it’s time to reevaluate the role life insurance should play in your overall financial plan.

If you determine that the life insurance you bought years ago is no longer necessary to provide for a surviving family in the event of your death, it can be gifted to your favorite charitable not-for-profit entity. The policy owner, typically the insured, can transfer ownership of the existing policy to the charity and receive a tax deduction in the year the policy is donated. If you continue to pay the premiums, each payment is also a deductible charitable donation. With this unique gifting strategy, the donor benefits from both a current income tax deduction, as well as a feeling of satisfaction that they have given a much more substantial gift of death benefits at some point in the future. The charity benefits from receiving a large lump sum at the time of the donor’s death. If the charity’s needs are more near term, as the new owner of the policy they would have the ability to surrender the policy and receive any cash value associated with it. The amount of the current income tax deduction is based on a number of factors and is limited to the lesser of:

- The donor’s cost basis (the total amount of past premiums paid, less any policy dividends received in cash as well as any outstanding policy loans); **OR**
- The specific policy’s value, which will vary with the type of policy. For Ordinary Life, it’s the cash value of the policy, plus any pre-paid premiums. For a paid-up insurance policy, it’s the present cost of a comparable policy purchased at the donor’s current age.

The donor’s cost basis (the total amount of past premiums paid, less any policy dividends received in cash as well as any outstanding policy loans); **OR** The specific policy’s value, which will vary with the type of policy. For Ordinary Life, it’s the cash value of the policy, plus any pre-paid premiums. For a paid-up insurance policy, it’s the present cost of a comparable policy purchased at the donor’s current age.

For those who are not comfortable relinquishing ownership of a policy, another option would be to name the charity as the beneficiary of an existing policy. While this option does not provide the donor with a current income tax deduction, it does provide the donor with greater flexibility such as retaining the right to change the charitable beneficiary to another entity or individual, as well as having the ability to access any cash value within the policy. The tax advantages of this strategy are deferred until death, when there may be estate tax benefits based on the size of the donor’s estate.

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Donating Life Insurance to Charity  Continued from Page 34

Now may be a good time to assess your financial situation to determine if those old life insurance policies are still needed for their original intended purpose. Regardless if it's transferring ownership of the policy, or simply changing the beneficiary to a charitable organization of your choosing, you may find you can give a gift that may have a substantial impact for many. When contemplating such a change, be sure to consult with your tax and insurance advisors to determine the most effective way of utilizing insurance policies for your charitable interests.

Effective June 21, 2005, newly issued Internal Revenue Service regulations require that certain types of written advice include a disclaimer. To the extent the preceding message contains written advice relating to a Federal tax issue, the written advice is not intended or written to be used, and it cannot be used by the recipient or any other taxpayer, for the purposes of avoiding Federal tax penalties, and was not written to support the promotion or marketing of the transaction or matters discussed herein.

Can the Act of Writing a Will Spark Joy?

AAP Development Staff

Have you heard about the recent craze started by organizing expert Marie Kondo to clean your house and only keep the things that spark joy? Besides cleaning our closets, how else might we spark joy in our lives?

We find joy in being with family, learning new skills, perhaps trying a new recipe. Certainly, supporting organizations and causes we care about is fulfilling and brings happiness. But is there joy when making the ultimate gift, a gift in your Will?

A Will is your opportunity to honor the people and causes you've cared about your entire life. These are the people and passions that make you happy and providing for them as part of your final wishes should give you joy today.

Here's how you might spark joy when you think about your Will.

- When you include the AAP in your Will today, one day your gift will help advance the field of medicine and impact the health and well-being of children, possibly around the world. Caring for children has been your life's work. A gift to the AAP in your Will honors your dedication and achievements.

- Consider honoring a friend or family member who cares about children by naming them in a gift to the AAP.

- The actual giving of your gift occurs after your lifetime, so your current income is not affected. Affordable gift giving – that's joyful!

- People include the AAP in their Will and join the legacy society so their example can influence pediatricians to make the same commitment. Would this knowledge give you joy?

- You can give a specific item, a set amount of money or a percentage of your estate. You can also make your gift contingent upon certain events. You can always change your Will. These options allow you to create a Will that is ideally suited to your needs.

There are just three possible sentences you need to make your Will joyful by including a gift to charity. Please contact Helen Drew, Strategic Gifts Officer for the AAP, and she will send them to you right away. You can reach Helen at (630) 626-6411 or hdrew@aap.org. She welcomes the opportunity to answer questions you might have, in confidence, and at no obligation.

You can also learn more about making a gift to the American Academy of Pediatrics at aap.planmygift.org.
Suggestions Wanted

The Section on Senior Members Web site has a tab called Advocacy and Volunteerism. We are soliciting our members for other suggestions that have been fulfilling for them as they transition to retirement or actually retire. Examples could be participating in literacy programs for children, working with social services agencies such as Big Brother/Big Sister or YWCAs, YMCA’s or JCC’s etc. To access the SOSM collaboration site click [here](#). Please submit these suggestions to Manny Doyne ([Emanuel.doyne@cchmc.org](mailto:Emanuel.doyne@cchmc.org) or [emanueldoyne47@gmail.com](mailto:emanueldoyne47@gmail.com))

Member Stories

Check out how members are engaging with the AAP and what inspires them to stay involved. Visit our [AAP Get Involved](#) page and click on the “Member Experiences Gallery” in the upper right to see their stories. And while you are there... [share your own](#)! We’d love to hear from you.

Guidelines for Senior Bulletin Articles

*Lucy Crain, MD, MPH, 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, are 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.

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

Questions about articles contemplated or in progress can be directed to me at [lucycrain@sbcglobal.net](mailto:lucycrain@sbcglobal.net) or Co-Editors Dr. Manny Doyne [emanuel.doyne@cchmc.org](mailto:emanuel.doyne@cchmc.org) and Dr. Cathy DeAngelis [cdeange1@jhmi.edu](mailto:cdeange1@jhmi.edu). Articles and letters should be submitted to the Editor at [lucycrain@sbcglobal.net](mailto:lucycrain@sbcglobal.net) with cc to Susan Eizenga [seizenga@aap.org](mailto:seizenga@aap.org). We look forward to hearing from you and to reading your articles in the Senior Bulletin.

2019 Senior Bulletin Schedule

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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. 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.

If clicking on “here” above doesn't work, here's the link:
https://collaborate.aap.org/SOSM/Pages/Newsletters.aspx

A special THANK YOU to Manny Doyne, MD, FAAP for envisioning the Best of the Bulletin and seeing it through with a little help from his friends (Drs. Mike O’Halloran, Lucy Crain, Art Maron).

AAP Mentorship Program

Mentorship is an important tool for professional development and has been linked to greater productivity, career advancement, and professional satisfaction. The AAP recognizes that mentorship is critical in helping nurture future leaders and a key opportunity to engage existing members and leaders. The AAP Mentorship Program seeks to establish mentoring relationships between trainees/early career physicians and practicing AAP member physicians. A primary goal is to promote career and leadership development. Mentors will have opportunities to further develop leadership skills and learn about emerging trends from the next generation of their peers. Mentees will gain a trusted advisor and learn methods to enhance career advancement. And all parties will form professional relationships and share advocacy, professional, and research interests.

Becoming involved is very easy. The only requirement to participate is to be a national AAP member in good standing. Participants need only sign-up and complete an online mentor/mentee profile form (you can sign up to be both a mentor and mentee if you so choose). The profile form collects information on education/training, subspecialty interests, practice/professional/clinical interests, and the amount of time the participant is willing to commit. Mentors/mentee pairs will have the ability to meet traditionally in person if they choose a local match or use one of several online tools to meet virtually.

The program is set-up for both “traditional” long-term relationships, as well as short-term “flash” mentoring. The flash mentoring component allows for mentees to contact mentors for quick questions, set up 1-2 meetings, as well as participate in online topical forums and Q&A forums. Therefore, the time commitment and expectations can be tailored to fit each mentor/mentee pairs’ needs. [Please note: Administrators reserve the right to deactivate participants after 6 months of inactivity.]

Visit www.aapmentorship.chronus.com and sign up to be a mentor and/or mentee today! AAP login and password required.

SPECIAL NOTE: As we go to press, we cannot complete this issue without acknowledging the tragic mass shootings of this past weekend in New Zealand and the Netherlands. Firearm deaths and injuries whether by terrorist action here or abroad or by increasing episodes of domestic violence and suicide everywhere are another public health epidemic which impacts all of us and begs active solutions.

-Editor