Senior Bulletin

AAP Section on Senior Members

Editor: Lucy S. Crain, MD, MPH, FAAP
Associate Editors: Emanuel "Manny" Doyne, MD, FAAP and Catherine DeAngelis, MD, MPH, FAAP
Webmaster: Thomas Whalen, MD, FACS, FAAP
Advocacy Editor: Donald Schiff, MD, FAAP

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

Message from the Chairperson

Eileen M. Ouellette, MD, JD, FAAP

Greetings, fellow SOSM members! It is a beautiful autumn day in Nantucket and the leaves are beginning to turn their beautiful fall colors. If you haven't already done so, it is a perfect time to register for the National Conference & Exhibitions (NCE) to be held in New Orleans from Friday, October 25 to Tuesday, October 29, 2019.

Members of SOSM are eligible for a discount, which is now $595 instead of $755. SOSM members over 80 years of age receive a 50% discount. You can register at registration@aap.org or call AAP Registration at 1-800-433-9016, Option 3. I did something wrong online and couldn't proceed. I called the phone number and a very kind and competent member of Meeting Services signed me up in less than 3 minutes.

As usual, the program is exceptional. Dr. Kyle Yasuda will provide an Update on the Agenda for Children and reflect on his year as AAP President at the Plenary Session on Saturday at 10:40 AM.

This year there are two especially exciting plenary speakers. On Saturday, from 11:50 AM to 12:30 PM, US Supreme Court Associate Justice Sonia Sotomayor will participate in a moderated conversation related to her living with Type 1 diabetes. On Sunday, from 10:30 AM to 10:50 AM, Representative Kim Schrier, MD, FAAP (D-WA) will discuss her "Journey from the Clinic to the Congress". Congresswoman Schrier is the first pediatrician to be elected to Congress and is currently the only woman physician in Congress.

SOSM also has a particularly interesting program on Sunday, October 27 from 9:00 AM TO 1:30 PM. Dr. Carol Baker, Professor of Pediatrics at University of Texas Health Sciences Center, Houston, Texas will bring us up to date on Adult Immunizations from 9:05 AM to 9:55 AM. The Donald Schiff, MD, FAAP, Child Advocacy Award will then be presented to Mary Ellen Rimsza, MD, FAAP for her seminal work on child sexual abuse.

Dr. David Clark, MD, FAAP, Professor of Pediatrics, Albany Medical Center, will inform us on "What Pediatricians Can Do to Speak Up for Children and Advocate for Families Separated at the Border". Our educational session will conclude with Dr. Danielle Laraque-Arena, MD, FAAP, Past Alternate District Chairperson, District II, who will educate us on "Principles of Global Child Health: Approaches Aimed at Changing the Health Status of Children, Their Families and Communities Through Effective Models of Research and Education". The educational session will conclude with a Business Meeting.

On reviewing the data on NCE attendance by seniors, it is clear that the number of attendees drops off significantly after age 75 years. We don't have information as to why that is, but I suspect that two common reasons are that more pediatricians are retired and no longer require CME credits and that mobility issues become increasingly common with increasing age. SOSM has actively advocated for reduced NCE registration fees for its members and will continue to

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do so. AAP Meeting Services staff are extremely helpful in assisting members who require walkers, regular or electric wheelchairs or scooters. If you need some assistance, please contact Meeting Services to request a form I have used a scooter for the past 10 years and I can personally attest to the dedication of the staff in making certain that one's needs are filled.

SOSM has established an Advocacy Subcommittee chaired by Dr. Renee Jenkins-Woodard and it has had its first organizational teleconference. The Subcommittee will be coordinating with the Section on Pediatric Trainees (SOPT) and the Section on Early Career Physicians (SOECP) that are seeking assistance with their advocacy efforts. The SOSM Advocacy Subcommittee will draw up a Mission Statement, Goals, Objectives and Measurable Objectives in the near future. The Subcommittee has drawn up a list of potential pilot Chapters and Districts in which to establish Senior Sections/Advocacy Committees. The suggested initial list consists of California District IX, Georgia, Maine, Maryland, Massachusetts, New Mexico, New York District II, and the state of Washington. These Chapters and Districts have been chosen because of their strong advocacy history and/or because there are SOSM members who have a strong interest in establishing Senior Sections in their Chapter.

We are actively seeking SOSM members to work with their Chapter and District leadership to establish Senior Sections. Those of you who are members of the pilot Chapters and Districts and who are interested in working on the establishment of Senior Sections please contact Katie Clark at kclark@aap.org.

The Annual Legislative Conference is one of the truly outstanding educational offerings of the AAP. Until now, the focus has been on developing advocacy skills in young pediatricians. Only 2 of 500 attendees this year were seniors. With our new emphasis on developing Chapter and District Senior Sections, we are encouraging SOSM members to consider attending. The Conference combines lectures, workshops, discussions and informational events with members of Congress and culminates with meetings with individual attendees House and Senate representatives.

Editor's Note: Note there is no fee to just attend the Sunday SOSM session, The goal is to include some of local members who didn't want to pay even the reduced rate which is still significant.This is another benefit of membership of the Section on Senior Members! JUST REMEMBER TO REGISTER!

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Web Master • Thomas Whalen, MD, FACS, FAAP

Newsletter Editors

Lucy Crain, MD, MPH, FAAP
lucycrain@sbcglobal.net
Emanuel "Manny" Doyne, MD, FAAP
emanuel.doyne@cchmc.org
Catherine DeAngelis, MD, MPH, FAAP
cdeange1@jhmi.edu

Staff

Katie Clark • *Section Manager*
kclark@aap.org

Susan Eizenga • *Section Coordinator*
seizenga@aap.org

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

Fall 2019 Editor's Note

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

In response to our call for articles for this issue you'll find several articles on the politically popular topic of "Medicare for All" as well as Dr. Schiff's eloquent commentary on issues of race and/or ethnicity. Thanks to Dr. Steve Tarzynski for introducing me to the acronym "M4A" and to Dr. Doyne for educating us on "The Plurals". As you're reading these M4A articles, I call your attention to another article addressing pricing of care under M4A in the August 6 issue of JAMA (JAMA Network: August 6, 2019, Vol 322, No. 5, The Pricing of Care Under Medicare for All: Implications and Policy Choices).

The lack of civility in some segments of our political clime is explored by Dr. Olson Huff with his provocative admonition "Cowboy Change Your Ways" and we have a rich collection of book reviews, personal experiences, and reviews of some interesting movies for your late summer early fall reading.

In concert with Dr. Schiff's topic I observed the following today: Standing in line at our local COSTCO, I noted the amazing racial and ethnic diversity represented by the clerks and my fellow shoppers. It's a common experience in any neighborhood of San Francisco, where we've lived for 50 years after a year of living with a family in South Korea. But every now and then, the international variety of food products, shopping habits, and differences in dress of other customers strikes me with how much our country and I personally have changed over my lifetime!

We need to continue to educate ourselves and our children and grandchildren and future generations of physicians, nurses and other health professionals with the essentials of tolerance, acceptance, and understanding of racial and ethnic preferences and practices as well as the inevitability of change.

VOTE!!!

AAP Opposes Efforts to Roll Back Protections for Children Under the Flores Settlement Agreement

8/22/2019 by Kyle Yasuda, MD, FAAP, President, American Academy of Pediatrics

"The American Academy of Pediatrics (AAP) is speaking out against the Trump Administration's announcement to roll back critical protections for children put in place by the Flores Settlement Agreement, effectively allowing immigrant children to be held in unsafe federal detention facilities for months, years, or even indefinitely. This is inconsistent with the Flores agreement and federal law and puts children's lives and safety at risk.

"No amount of time in detention is safe for a child. When children are detained, they experience physical and emotional stress, placing them at risk for serious short- and long-term health problems, such as developmental delays, poor psychological adjustment, anxiety, depression and suicidal ideation. Even short periods of detention can have long-lasting consequences for children.

"Detention is no place for a child. Pediatricians have visited these centers, and what we saw was shocking and devastating to anyone who cares for children. Children are held in metal cages with fencing extending from floor to ceiling. They sleep on cold, concrete floors beneath thin Mylar blankets. Harsh overhead lights remain on 24-7. They have no access to pediatricians. They receive food that is often not palatable. Children don't have regular access to showers and must use toilets that are in semi-public locations. These conditions are commonplace for children detained in DHS-run facilities, which is why the agency is not equipped to detain children for even longer periods of time.

"Lack of sleep and stress can affect a child's ability to fight off infection, so it's no wonder that our pediatrician colleagues who care for children who have been through DHS-run detention facilities are reporting that they are in increasingly poor health. Six children have died in federal custody, some from conditions like dehydration and flu. We fear the consequence of the Administration's announcement will only further jeopardize children's health and safety.

"Weakening protections for children runs counter to the Flores Settlement Agreement, making it more likely that children would be detained for even longer in conditions unfit for any child. All attempts to do so should be rejected. Instead, the Academy calls on policymakers to work to protect and promote the health and well-being of immigrant children in federal custody."

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, visit www.aap.org and follow us on Twitter @AmerAcadPeds

Press Release reprinted with permission from AAP.ORG. The original article may be found at https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Opposes-Efforts-to-Roll-Back-Protections- for-Children-Under-the-Flores-Settlement-Agreement-.aspx.

Advocacy

Our Enhanced Awareness of Racism What We Can Do

Don Schiff, MD, FAAP – Advocacy Column

It is clear that racism is a prominent feature of our daily lives. Recently widely read and applauded articles have appeared in "Pediatrics", the New York Times and the publication of the National Academy of Science, Engineering, and Medicine on racism and its effects on developing children. Pediatricians are familiar with the substance of these reports as they have identified and treated the ill effects of this stress on the lives of children and their families. Racism is a critical social determinant as are family stability, poverty, homelessness, food security, immigration status, and health care access.

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The policy statement in the August 2019 issue of *Pediatrics* was developed by the AAP Section on Adolescent Health, Council on Community Pediatrics and Committee of Adolescence and entitled "The Impact of Racism on Child and Adolescent Health" brings into sharp focus the potential role of the Pediatrician caring for children in our increasingly multiplural practices. The definition of racism provided in the policy statement is "A system of structuring opportunity and assigning value based upon the social interpretation of how one looks (What we call race) that unfairly disadvantages some individuals and communities and unfairly advantages, other individuals and communities and saps the strength of the whole society through the waste of human resources." In spite of a clear direction of societal progress toward social equality there is currently an increase in public reports of racial incidents. These stories of violence against racial or religious groups and governmental action against immigrants are blatant examples of racism. The pediatric interest in child development, safety, and emotional health are reasons to add the effects of racism to our evaluation of a child health status and the possible need for individual special support. Minority children are likely to experience the influence of racism at an early age even in utero as they are more often delivered at a low birth weight. Their mothers also suffer an elevated maternal mortality rate. Maria Trent, a coauthor of the AAP policy documents the influence of parents who have been treated unfairly with children who are more likely to have behavioral issues (ADHD). Other studies reveal that 10-15-year-old African American boys who have had experiences with racism are more likely to exhibit aggressive behavior. Racism can also be linked to a state of hypervigilance in children who sense that they live in a threatening world. Pediatricians appropriately question what measures they can provide to help ameliorate the negative effects on their lives. Adelia I.A Spinks-Franklin, MD from the Baylor College of Medicine suggests providing in the office multicultural dolls and figurines to help present a feeling of a safe space where a child can express feelings such as a fear of bullying and other forms of discrimination. Selecting a staff which exhibits pluralism and including in their training a consideration of the effects of racism is fundamental.

Participation in community activities designed to achieve further progress toward equality can include becoming active in the school systems, justice courts, and mental health clinics. This may help introduce valuable pediatric policies and knowledge.

Dr. Trent offers a profound reminder that the most harmful effect on children is when they internalize racism. They often see so much negativity about people like them that they develop negativity about themselves. She reminds us that children are watching our words and our behavior. They are waiting for us to teach them differently for a healthy future.

Who Are the Plurals?

Emanuel Doyne, MD, FAAP

One of our sons mentioned to me that our grandchildren (who are teenagers) belong to the "Plural Generation" (also called generation Z) which caused me to give him a confused look. I knew about the "Greatest" generation (read Tom Brokaw's book of the same name), Baby Boomers (ages 48-66), Gens X (36-47), Y (24-32) and Millennials (16-36) (Yes- significant overlap occurs). My son explained that anyone born after 1997 is the last generation that will have a Caucasian majority. 2019 has a US. population that is 49.6 % Caucasian (Source; US Census 2013). Some of the experiences of the Plurals or Gen Z'ers include terrorism, green energy, Arab spring, economic uncertainty, the iPhone, social networking etc., Medicine and especially medical schools have clearly lagged behind this trend. As of 2017 U.S. medical schools finally achieved 50 percent female enrollment. Certainly, that trend in certain residency programs long ago surpassed that mark. (Pediatrics -70.2% in 2017, Ob-Gyn- 82% in 2018). Minority groups are still vastly underrepresented in U.S. medical schools despite a concerted effort by the AAMC. As of 2017 the overall student population was 58.9% white and 7.3% black. Latino (9.8%) and Asian (24.6%) students have clearly increased over the past 10 years.

The barriers are described frequently and sometimes appear insurmountable revolving around educational and financial disadvantages which obviously affect entry into many professions in addition to medicine (81% of lawyers-see the CNN Special "Notorious RBG", a vast minority in tech professions and dentistry for example).

One of the positive aspects of a "Plurality" may be what we have already had a hint about in the results of the 2018 midterm elections which sent to various legislatures around the country , including the U.S. House of representatives some

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"firsts" : Muslims, transgenders and MANY women. The prediction should be that the "Plurals" and whatever the succeeding generation is called will be accustomed to and celebrate diversity. I like this quote taken from an interview in the *New York Times*: "America becomes more multicultural on a daily basis," said Anthony Richard Jr., a 17-year-old in Gretna, La. "It's exponential compared to previous generations." (*New York Times* 9/28/15 "Move Over Millennials Here Comes Generation Z").

I have a good feeling about this generation and the positive things they will accomplish.

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"Cowboy, Change Your Ways..."

Olson Huff, MD, FAAP

The 40's and 50's were times when Western Ballads and Trail Songs enjoyed popularity as they spoke about iconic themes of the ever present need to act with courage, honor and integrity, else the persistence of evil ways would lead to tragic consequences.

With that courage, Marty Robbins "Arizona Ranger with the Big Iron on His Hip," dispatched the notorious outlaw "Texas Red" and brought justice to the mythical town of "Aqua Fina"

In a different scenario, like an ancient morality play, Burl Ives gave voice and song to the chilling ballad "Ghost Riders in the Sky" that warned an errant cowboy to "change your ways" else he too would join the awful band of riders forever "chasing the Devil's herd across the endless skies"

These ballads were meant to entertain but nevertheless they carried the powerful message that evil ways must change, or the consequences would indeed be graphic and forever.

So, what, one wonders, would the future generations, the likes of Burl Ives and Marty Robbins, make of today's evil ways that must be changed? Will they give words and song to the tragic tearing of children away from parents whose only crime was trying to seek a better and safer way of life? Or what about the stifling pollution and change of climate of the planet by forces driven by their economic greed? Will they sing of the massacres of school children, worshippers and those who are just going about their ordinary lives because "the right to bear arms" is more precious than human life? And there is the blatant racism and the hatred spewed towards those who have a different gender orientation and the sexual exploitation of young girls and women of all ages. Will these be the ballads sung around a campfire of the future that tell of the need to change such evil ways or else generations yet to come may also end up chasing the Devil's herd across those dark and endless skies?

Who knows?

What should be known however is that humanity cannot thrive, or even survive, where the message is hate and the actions are destructive and where leaders of nations are concerned only with themselves and not the people they are called to serve. Perhaps they should heed the warnings of those "Ghost Riders in the Sky" else they too will ride forever the consequences of their own destruction.

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Note: Reprinted with permission from www.olson.huff.com – Reflections on child health, child advocacy and physician activism. Posted on August 12, 2019 by Olson Huff, MD

Let's Talk: Medicare for All?

What Does Medicare For All (M4A) Really Mean?

Steve Tarzynski, MD, MPH, FAAP

In 1927 the AMA along with other conservative allies managed to repeal the Sheppard Towner Act on the basis that it was a socialist threat to the health care system. Sheppard Towner provided funding for public health nurses, visiting nurses, consultation centers, childcare conferences, distribution of educational materials on prenatal care, and the regulation and licensure of midwives. The Pediatric Section of the AMA was so angered by the AMA's position that it resigned from the AMA and founded the AAP.

We are now faced with a similar dynamic with respect to M4A. The same old arguments are being used against establishing a unified system of public financing.

There are several key arguments against M4A. I will try to counter them and hopefully we'll see what M4A really means.

- ***Taxes will go up!*** There will be a net decrease in health care expenses for most Americans. The "private tax" or pri-vate insurance premiums will be replaced by a "public premium" paid every April 15. There will be no more copays, deductibles, and out-of-pocket payments. $500 billion dollars will be shifted from private insurance bureaucracy, ex-cessive CEO salaries, skyscrapers, and shareholder payouts to pay for medical care. We know that Medicare's overhead is 2% compared with 12% for private insurance. Health policy should be evidence-based and not "unicorn-based" relying on magical thinking that the free market will solve every problem. The free market has never provided univer-sal, cost effective, and high-quality coverage in any country. It never will. Only a unified system of public financing like M4A can do that.
- ***M4A will take away the insurance plan you love!*** Let's be real. No one loves their insurance company. They love their doctor. What M4A will take away is the burden of private insurance hassles for patients and for doctors. People will have free choice of doctor and guaranteed comprehensive benefits as we travel through life's journey, change jobs, get married or divorced, have children, etc.
- ***There will be rationing!*** Nations ration health care one way or another. In the USA we ration by price and leaving 30 million people uninsured (even after the ACA!) or leaving 80 million under- insured. Should the US have irrational rationing or rational rationing? Depending on the study, and using the most conservative estimate, for every million uninsured about 500 people die annually solely due to being uninsured. That's about one person every 2 hours. How many people die in Canada, the UK, France, Germany, or Japan for the same reason? Zero.
- ***M4A will cut physician salaries!*** Under M4A there would be a huge decrease in malpractice costs and medical education debt. While it's possible that some super specialists' salaries may decrease, for primary care and many specialties income will increase. Doctor' times will be freed from hassling with insurance companies to see more patients (and bill M4A for them!) or for other pursuits like CME, family time, or even the AAP. The $100,000 per doctor per year in administrative costs will be slashed under single payer. Much of that savings will accrue to physicians.
- ***Why should I pay for someone else's care?*** We're already paying for it. Those costs are far higher than if everyone were insured. The bigger the risk pool the lower the costs. The biggest risk pool is the nation which M4A would establish. M4A opponents like to argue "moral hazard" but there's a worse moral hazard -- one person dying every 2 hours be-cause they're not insured.

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Why pay for a bridge that you will never cross, a sidewalk you don't walk on, a traffic light at an intersection you don't cross, a library book you don't read, a flower you won't smell, a park you won't visit, art you won't see, or a fire department you hopefully will never need?

- ***Quality of care will suffer***! The opposite is true. The US ranks 34th in overall quality. Overwhelming evidence from every other industrialized country shows single payer systems provide superior outcomes, access, and satisfaction compared to the US.
- ***M4A is a "one size fits all" system!*** On the contrary, it will create a space big enough to meet everyone's needs.

A brief word about the ACA, like past landmark legislation, it's a flawed yet important step forward. We should build on the strengths of the ACA as part of the strategy to get to M4A. It's wrong to place the two in opposition. We must find a way to all work together.

Finally, it's important for pediatricians and the AAP to support M4A. Since 1927, the AAP has always been in the forefront of bold and moral action to advance the health of children. Today we see the AAP taking the lead role in improving the medical care of and ultimately liberating immigrant children from detention camps. The AAP should persist on the cutting edge of history by supporting Medicare For All.

Steve Tarzynski is President of the California Physicians Alliance (CaPA) which works for health care reform up to and including a single payer system. www.caphysiciansalliance.org

Physician Advocacy: Access to Care

Eve Shapiro, MD, MPH, FAAP

I have been a pediatrician for 40 years and from early on in my career, I have been concerned about how access to care plays a significant role in the health care we can deliver. Although I love the one-on-one relationships we develop with patients and families over many years and even generations, I think it is important to step back and see how we can play a role in the larger issues facing our communities and nation.

I first got involved in this issue in a significant way in 2000, when I chaired the Healthy Arizona Initiative. This was a ballot initiative to increase Medicaid eligibility from 33% (which was the current level in Arizona) to 100% of federal poverty level, which was about $17,000 for a family of four. I learned a great deal about presenting arguments in a succinct way on TV, radio and debates (happily, before social media!) and how to work with a broad coalition with the same goals. We were ultimately victorious and over 250,000 Arizonans gained health insurance coverage. I also learned that these battles aren't over, and we were also involved in lawsuits to prevent the roll back of coverage.

I have also been a member of Physicians for a National Health Program since its inception in 1983. It was clear to me that a single-payer program, in which for-profit insurance companies do not play a role, would be the only way to improve coverage and quality of care while decreasing health disparities at a cost that was comparable or less than our current spending.

I have given many talks to medical and non-medical groups over the years, and there is a small but growing consensus that this is a reasonable approach. Bernie Sanders' entrance in the Democratic primary energized our movement by his eloquent calls for Medicare for All. Due to his support and for other policy issues, I was a Bernie delegate to the 2016 Democratic convention. This was a very interesting and somewhat discouraging view of party politics. Although his campaign was not successful in achieving the nomination, I believe it was phenomenally successful in bringing up many issues which have now been seized by more mainstream candidates.

Significant among these is Medicare for All. With the new House bill introduced by Pramila Jayapal, physicians have a real opportunity to advocate for a health care system that serves all people. This bill would do the following:

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1. Cover all medically necessary care, including hospitalization and doctor visits; dental, vision, and hearing care; mental health services; reproductive care, including abortion; long-term care services and supports; ambulatory services; and prescription drugs. Covers all U.S. residents. Coverage is portable and lifelong.

2. Provide free choice of doctor or hospital.

3. Eliminate all patient cost-sharing such as copays, premiums, and deductibles.

4. Pay institutions such as hospitals and nursing homes via lump sum global operating budgets to provide covered items and services. Funds capital expenditures such as expansions and renovations with a separate budget. Pay individual providers on a fee-for-service basis that does not include "value-based" payment adjustments.

I have been involved with a state-wide coalition that worked with Jayapal's office, including National Nurses United, PNHP, and unions. Our group was diverse in age, ethnicity and affiliation, which helped our argument. We met with our newly elected representative, Ann Kirkpatrick, after sending her extensive materials about the new bill and our current dysfunctional system. She signed on to the bill right away. We are also working with another representative, Tom O'Halloran, to see if we can get his support. Other members of the coalition have targeted the rest of the Arizona congressional representatives. We know we can't achieve success in the next 2 years, but we can lay the groundwork in helping to dispel the myths that are being spread by insurance and pharmaceutical companies. Our commitment to our representatives was that we would help with grassroots support of their position.

I would urge other physicians to consider being part of our efforts by first joining PNHP and joining other local physicians in promoting this issue. I would be happy to serve as a resource for anyone looking to get involved.

Funding Health Care for All

Catherine DeAngelis, MD, MPH, FAAP

No rational American physician should be against every person having access to health care, perhaps even one that would include all the items described by Dr. Eve Shapiro. That is, covering all medically necessary care, providing free choice of doctor and hospital, eliminating all patient cost-sharing, paying health care institutions via lump sum global operating budgets, funding capital expenditures with a separate budget, and paying individual clinicians and providers on a fee-for-service basis that does not include "value-based" payment adjustments.

The key obstacle to proving such care is funding, no matter if such care involves a single payor system or one that allows for keeping private health insurance. Several proposals for funding such care have been posited, including raising taxes only on the rich or eliminating the "middleman" (or woman), or various combinations of such. While I very much desire a program to provide health care for all, I don't believe any of these proposals would actually pay for such programs.

Let's look at the history of how other developed countries achieved such programs. In the early 1940's, proposals such as the Beveridge Report (1942) proposed that the government provide health care and public education to all citizens of Britain after World War 2 ended. As an aside, it is Interesting that it proposed a "welfare" state, a term(welfare) now considered with some disdain unlike "Fare Well" that is considered positively, even though both terms essentially connote the same meaning. As a result, the National Health Service Act was passed in 1946; the Education Act was passed in 1944.

By the mid to late 1940's essentially every developed country enacted a health care law except the United States, which chose to sustain the capitalistic manner of everyone having a choice of how to pay for health care or having none. We are only too familiar with what has happened in the US regarding health care. But what happened in the countries which chose government funded health care?

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Let's take Norway as an example of very good health care provided by government funding. In Norway, physician and other clinician education is very good by any comparison. Perhaps more to the point life expectancy in Norway, one of the healthiest countries in the world, is 81 years for men and 84 for women. In the US life expectancy is 78. According to the Organization for Economic C-operation and Development, the US spends more than any other developed country on per capita health care at a whopping $10,000 (2017 data, the latest available). Norway spends $6,400 per capita.

So how does Norway pay for this health care? Personal income tax ranges from about 30% to 55%, depending on income. Very important also is a 25% Value Added Tax (VAT), which is essentially a consumption tax based on the increase of a product's value from production to distribution. Currently, 166 of the 193 United Nations' countries have a VAT; the US is not one of them.

So, if we were to enact a health care for all program sponsored by the government, income taxes on essentially everyone would have to be increased. Even greatly increasing taxes on the very rich (which would take a great deal of political changes) would not be sufficient to cover the costs. Even Medicare, as it currently exists, is in danger of running out of money in the much too near future, so providing it for all would require a great influx of funding. The 2010 Affordable Care Act took a long time and a great deal of political prowess to enact. While it is certainly not perfect and needs many changes, it is where we have to start. Perhaps, with a new political team which has the know how to provide the funding, we can have a system of health care for all. I'd love to live long enough to witness it.

Editor's Note: *For further information see JAMA Network: August 6, 2019, Vol 322, No. 5, The Pricing of Care Under Medicare for All: Implications and Policy Choices.*

COFGA (Committee on Federal Government Affairs) Liaison Report September 2019

Suzanne Boulter, MD, FAAP, Senior Section Liaison to COFGA

Once again, the COFGA meeting was on target regarding key issues of importance for children. In the past year there have been some gains for children but there have been many setbacks as well. Several experts talked with the committee about current initiatives.

Here is a summary of some of the key issues:

Gun violence prevention: Although $50 million dollars in funding for research on gun violence for CDC and NIH passed the House the bill has not been introduced in the Senate.

Insurance coverage for kids: The 2018 data shows that over 425,000 fewer kids were insured counting both public (Medicaid and CHIP) and private insurance plans.

Immigration: Monica Sthanki, JD, summarized her 20 years of experience working on immigration issues. She framed the issue as not being a recent one but having a 30-year history starting with President Reagan's Amnesty Program. In 1987 President Reagan used his executive authority to legalize the status of minor children of parents granted amnesty under the immigration overhaul of 1986 and he announced a blanket deferral of deportation for children under 18 who were living in a two-parent household with both parents or a single parent applying for citizenship. His action affected an estimated 100,000 families. This executive action most likely started the racist, xenophobic mentality in many Americans that has mushroomed in recent years.

In spite of all the bad news including the repeal of some of the Flores protections and introduction of the Public Charge Rules in the past year Monica's advice was to step back from the details and focus on the ***values*** that Americans have had in terms of welcoming immigrants since WW II and hope that the legal challenges to the rulings will result in positive changes.

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E-Cigarettes: The vaping E cigarette epidemic is a health crisis with 28% of our high school students reporting regular usage and over 500 people having developed significant lung disease including 8 deaths that are thought to be due to E cigarettes. Several tobacco bills have recently been introduced in both the House and the Senate. The Academy is strongly supporting bills that would remove flavored tobacco products from the marketplace and bills that would raise the age of tobacco purchase to 21. Currently 18 states have already passed age 21 legislation.

Families First: In spite of the availability of major new federal funding to support services ***preventing*** foster care placement by providing funding for significantly expanded services to family members so that children can remain in their homes only 4 states have comprehensive plans that are ready for the funds which are available starting October 1st. Barriers include financial ones since states need to supply 50% of the funding for preventive services but there are also conflicts in many states thatneed to be resolved as the foster care community is not necessarily supportive of preventive services (which are evidence based) rather than more traditional out of home placement options.

Vaccine misinformation: Some good news here – in response to communication from the Academy Pinterest has championed putting only legitimate vaccine information on their web site search engine. Google and Facebook are also considering changes.

Hill visits took place on September 24th and the Senate staffers were asked for support from their Senators for re authorization of the Newborn Screening Saves Lives Act (which will expire on September 30th). Unbelievably a single Senator on the HELP (Health, Education, Labor and Pensions) Committee has held up the process by raising questions about privacy and confidentiality of the de identified blood filter paper samples. The Senators were also asked to co-sponsor Tobacco to 21 Act raising the age of purchase to 21 and the SAFE Kids Act removing flavored tobacco products from the market. On the House side the ask was to support the VACCINES Act of 2019 (funding vaccine refusal research and disseminating positive information about vaccines for the public) and the Youth Tobacco Epidemic Act which addresses age of purchase and removal of flavored products.

Our Washington AAP office does an amazing job tracking bills that affect children and they are viewed as the credible "go to" child health care promotion office in DC. If you aren't already receiving the weekly communication email summarizing what is happening at the federal level now is the time to sign up. It's been re -named Capital Check-Up so go to kids1st@aap.org and enroll.

Reflections

Grandparent Forum: Being There

Joseph A. C. Girone, MD, FAAP

Your 8-year-old goalie grandson is very upset that his soccer team was defeated in the championship game. Possibly your 12-year-old granddaughter is distressed after her "best friend" texted a nasty remark. There are times when children are faced with non-physical anguish that passes quickly. On occasion when it lingers and needs attention, what can a grandparent do?

Most grandparents have not prepared a plan to address these events. They usually respond by giving the child advice based on personal experience. What does a grandparent do when they have never lost a championship soccer game? Having a strategy that can apply to many childhood situations could be effective. The grandparent, even without an exact experience, can help the child to work through a problem.

A masculine tendency is to confront problems and provide solutions to fix things. This requires the grandparent to have an immediate, experience supported, logical answer for the child. This can be difficult. If the grandparent doesn't have

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the answer, this prompts feelings in the grandparent of inadequacy and ineffectiveness.
A feminine tendency is to understand the child's feelings and empathize with the distressing situation. The grandparent wishes the child to know there is an understanding of the upset and difficulty the child is feeling. This response can be helpful but may not reduce the stress.

The "built-in" response of the masculine and feminine tendencies, such as, let me fix it or I know how you feel, may work occasionally.

Another resolution to childhood distress is offered by some grands. It can be called the "Socratic" method. The grandparent proposes discerning queries to the child. The answers to these questions may help the child gain insight into the solution. The 8-year-old soccer player can be asked, "Why do you feel so bad?" The child may get to the basis for his feelings and take a step to deal with it. The "Socratic" method can have a place when the child is able to express answers. The child may learn to ask themselves the questions in future situations.

Whatever strategy is used, the "fix" method, "I know how you feel" or "Socratic", the first step and most important action is Presence…. just being there. The grandparent relationship may involve a long-range communication challenge. Communicating with the grandchildren in needy times may require technical creativity.

The upset child needs you to be there. This could be your physical presence or some kind of close technical communicative magic. Awareness of grandparental support is comforting. Even adults, who have been in distressing situations, will say having someone who cares be with them is what really matters. They will tell you some time after an event, they don't remember what you said when it happened, only that you were there. More serious stressful situations can occur in the teen years.

Grandparents of teenagers have to help their grandchildren confront times when their friends die of accidents, overdoses, and suicides. These are not times for "fixes" or "I know how you feel". The teenager knows you don't have a fix and it's unlikely you know how they feel.

At any age, it is best to encourage the child to speak. Presence and Listening are the first steps in healing the situation. Being there in some way and letting the child talk it through is the best support a grandparent can give. In these challenging situations, the pressing question for the grandparent is, "What can I say?" to the disturbed child? The answer is to listen and say, "Can I help?"

Grandparents speak of quality time with their children. The essential focus of quality time should be the child, not an activity. Real quality time is when the child is the center of the grandparent's attention.
This could be actually physically present or consider "face time", texting, Email or an "old fashioned" letter exchange. A child knows this. The goal could be to make all of the time with your grandchildren be quality time. Your grandchildren like receiving presents but they much more love and need your "Presence".

Land of Fire and Ice

Beryl Rosenstein, MD, FAAP - Professor Emeritus, Pediatrics Johns Hopkins University School of Medicine

This past summer our family embarked on a multigenerational journey to Iceland, a trip that I would highly recommend. Iceland, an island about the size of Kentucky just south of the arctic circle, sits at the junction of the north Atlantic and Arctic oceans between Greenland and continental Europe. Because it is in the Gulf Stream, winter temperatures along the coastline tend to be not much colder than New York. It is the most sparsely populated country in Europe with a population of about 350,000, 2/3rds of whom live in Reykjavik, the nation's capital. The island was settled in the 9th century by the Vikings from Norway. It claims to have the oldest and longest running parliament in the world dating back to the 10th century. It came under Norwegian rule in the 13th century and Danish rule in the 16th century. It became an independent Danish state in 1918 and an independent republic in 1944. Although Iceland has no standing army, it is a member

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of NATO and part of the European Economic Area. Important recent milestones include the cod wars with the UK in the 1970s overfishing rights and an economic meltdown in 2008 related to failure of its banking system from which it has fully recovered. During World War II, the island was briefly occupied by the British and in 1941 occupied by the United States which used it for an airbase and radar station.

The main reason to visit Iceland is to enjoy its geologic diversity. For a small island it has amazing natural features, including; six glaciers covering about 11% of the island's surface, glacial rivers, extensive lava fields, caves and tunnels, 10,000 waterfalls, fjords, geysers, beautiful national parks, black lava beaches and geothermally heated pools such as the famous Blue Lagoon. The island is volcanically very active with several recent eruptions. The most notable occurred in March-April 2010 when the eruption of the Eyjafallajokvli (E15) volcano spread ash over the north Atlantic and severely disrupted transatlantic air travel for about a week. The eruption also melted the overlying ice field creating the highest crater lake on the island. Iceland is the site of both the Eurasian and continental tectonic plates and is the only place where the drifting apart of the plates can be easily seen above sea level. Because of its unique natural resources, Iceland uses geothermal steam for heat and hot water and hydropower for electricity. With the exception of automobiles, it runs almost completely on renewable energy.

There is not a lot of wildlife on Iceland, but it was fun to visit a farm and see a show put on by the famous Icelandic horses with their unique five gaits. For the more athletically inclined, options include glacier hiking, kayaking, lava caving and riding Icelandic horses.

Reykjavik, the world's northernmost capital, is a charming city combining a variety of buildings from the 19th century with some architecturally stunning modern buildings. It definitely warrants a 1-2-day visit. Noteworthy sites include the cathedral which towers over the city, the waterfront area, city hall and the amazing all glass Harpa concert hall, home of the Iceland symphony orchestra. From the waterfront there are excursions for whale watching and viewing puffins. During our trip we visited several interesting museums including a very interactive volcano museum, outdoor open-air living museums and the informational National Museum in Reykjavik.

Getting around Reykjavik is easy. It is fairly compact, and all sites are easily walkable. Iceland is a very safe country to visit. Although it has one of the highest rates of gun ownership in Europe (mostly for hunting and sport), violent crime is almost non-existent. The official language is Icelandic, but Danish is commonly spoken by the older generation and English is widely spoken by the younger generation. I would not call Iceland a culinary destination but there are certainly many good restaurant options. The busiest eating establishment in Reykjavik was clearly the Baejarins Beztu Pylsur ("best hot dog") stand in the harbor area, made famous by Bill Clinton's visit. Fish is clearly plentiful and delicious along with local lamb and dairy products. However, much of the island's food needs to be imported making restaurant prices rather high. In the summer months there are about 21 hours of daylight, great for touring but maybe a little hard to get used to for sleeping. Weather can be problematic with rain, winds and clouds, but in the summer daytime coastal temperatures are in the 50s. We were lucky to see lots of sunshine. Iceland is a popular travel destination to view the northern lights but only from fall to spring.

All in all, three generations of our family greatly enjoyed their Iceland adventure. It is an easy travel destination from the northeast and Mid-Atlantic States with direct flights of 5-6 hours, and over 5-7 days one can get a good taste of all the island has to offer. Even on a day trip to the Golden Circle area, one can see many of the natural highlights. Iceland has become very popular (2.3 million visitors in 2018) and for good reason. Put it on your list!

Disney Grandparents

Debra Sowell, MD, FAAP

First of all, I love being GG to 4 precious grandchildren. Two years ago, for Christmas, we made the decision to take 3 precious ones (at that time) and their parents to Disneyworld. My daughter gave me all kinds of info from all of her friends who had already tackled the situation. We started planning in October for our February dates. At that time, the kids were not in public school yet…we had two boys one 5 and one almost 5 and an almost 3-year-old princess diva.

Some helpful hints:

1. Several websites have specific attractions not to be missed for preschoolers, school aged kids, teens, etc…
2. Sign up for as many fast passes as quickly as possible. These are particularly great for character lines and you have a princess in training with you.
3. Obtain walking maps of the parks ahead of time…so you can roughly track daily non-misses at the parks and other close attractions to your fast pass times.
4. According to age of children, it is much cheaper to buy single day tickets rather than a hopper pass. These kids were ready for nap, swimming and/or bed and no park hopping.
5. If possible, stay on property…so 5 adults and 3 children used the bus transportation everywhere. Renting a vehicle to handle these many kids with car seats and strollers is next to impossible.
6. When you go to the parks in the early am, go straight to the back and not right/left.
7. If you are getting your knees replaced soon, wait until after your recovery. I walked 21.7 miles mainly pushing the princess in a large stroller in 4 days. Now 2 years after surgery, we are planning another trip.

PS: The little princess did get us chosen as the family of the day at Movies Park, which included 50 fast passes, a private session with Woody and Buzz, riding their new ride with Buzz and Woody also and reserved seating at all of their live performances in that park for that day including the Lion King which really is not to be missed.

Global Health Issues

22 Years of Medical Missions to Cuba Have Taught Me a Thing or Two About Their Health Care System.

Part 2 by Robert Lerer, MD, FAAP

Some positive aspects of the health care system of Cuba include universal coverage, easy accessibility, affordability, and reasonable outcomes and quality indicators.

Medical care at all levels is free to Cubans, paid by the government. This is made possible by an enforced low pay scale for all health care personnel, leading to low labor costs. Primary care family doctors often live within walking distance to patients in the cities and towns, and not far in the countryside.

Consultations at multi-specialty clinics are easily obtained. Scheduled hospitalizations and emergency care are readily available, though plagued by many shortages. Simple items like surgical gloves, IV tubes, catheters, gowns, sutures, etc. are subject to periodic shortages.

Medical education is free to Cubans. Foreign governments pay Cuba directly the tuition costs covering foreign students. Cuba educates, assembly line style, thousands of doctors per year. Book knowledge is often very good, but practical one on one teaching by experienced mentors is often lacking.

Centers of medical research located in Havana are well regarded. Cuban scientists have developed a number of vaccines, including one sold commercially in Latin America against meningococcus. Also, of note, an agreement was signed 3 years ago by a New York state delegation led by Governor Cuomo, between Roswell Park Cancer Center in Buffalo and the Cuban National Institute for Applied Immunology for developing, after FDA approval, clinical trials of a novel lung cancer treatment immunologic product. More surgeons are performing minimally invasive surgery in many subspecialties. Hospital stays have shortened over the last twenty years.

Infant mortality rate is on a par with the U.S. So is life expectancy. Leading causes of death in adults are cancer, cardiovascular disease, and accidents. Tertiary hospitals are well equipped relative to level I and II hospital and polyclinics.

Cuba is now a poor country with many financial shortcomings, and it is no longer a leading world economy as in the 1950s. This limits government expenditures on health and education. Mental health services are challenging, and mental health hospitals are little more than custodial operations, though with very loving staff.

Services for children and adolescents with autism, developmental delays, learning problems or psychiatric diagnoses are very limited, without any guarantees of public education. Ten percent of Cuban families care for someone with a disability at home, affecting family income, and most get by with little government help.

Aging population, young people not having children, and emigration have affected the demographics. Abortion is widely used as birth control. Access to the global Internet became available only in the last few years and is still very limited. There is an internal network called Infomed. Many physicians work second and third jobs to make ends meet. Libraries are bare and have dated materials. Laboratories are very poorly equipped, and reagents are often in short supply. Furniture in hospitals and clinics is aging and falling apart. Even common items such as mattresses, linens, disposable supplies, surgical gowns, gloves, dental equipment are in short supply in all settings. Buildings and infrastructure within hospitals is in critical condition in most cities and provinces. Our colleagues in Cuba work under very challenging conditions. They have my admiration for working long hours, with limited tools, and low financial remuneration.

As our country considers socializing medicine with many politicians proposing a program dubbed “Medicare for All”, understanding how Cuba achieved its “free health care system “is worth noting. All hospitals and clinics are run by the government. All health care personnel are employees of the government. Equipment, supplies, medications are all subject to

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recurrent shortages. Extremely high taxation of individuals is essential to the success of the system, and this 90% tax rate comes in the form of extremely low salaries. Money that would be used for salaries is used instead to pay for programs in education and health. Our three educational exchanges per year help our colleagues in Cuba to keep up with the latest advances in pediatrics, surgery, and medicine. Given limited internet access and the poor state of libraries, our teaching and mentoring in Cuba over the past 22 years has improved quality of care and application of evidence-based science to optimizing the practice of medicine.

Did You Know?

Searching the SOSM Collaboration Page

Tom Whalen, MD, FAAP – SOSM Webmaster

When one wishes to search for information on any of the pages of the SOSM Collaboration site, go to the upper right corner of the home page. A search box is found there. Not all search engines are alike, and the rules for the AAP collaboration sites are governed by those of *Microsoft SharePoint*.™ Search constructions used in other locations, notably *Google*,™ have some subtle and some not so subtle differences.

The following information is heavily edited from the Microsoft site on Keyword Query Language (KQL) to highlight the very basics of searching. The reference at the conclusion of this piece contains the following information set amidst 12 total pages of search guidance.

As the webmaster for the SOSM I would be happy to extend further assistance to other Senior members, and I can be contacted at Tom@Whalen.name.

Constructing free-text queries using KQL[i]

Free text KQL queries are case-insensitive but ***the operators must be in uppercase***. You can construct KQL queries by using one or more of the following as free-text expressions:

A **word** (includes one or more characters without spaces or punctuation)

A **phrase** (includes two or more words together, separated by spaces; however, the words must be enclosed in double quotation marks)

Using words in the free-text KQL query

When you use words in a free-text KQL query, Search in SharePoint returns results based on exact matches of your words with the terms stored in the full-text index. You can use just a part of a word, from the beginning of the word, by using the wildcard operator (*) to enable prefix matching. In prefix matching, Search in SharePoint matches results with terms that contain the word followed by zero or more characters.

For example, the following KQL queries return content items that contain the terms “federated” and “search”:

federated search federat* search search fed*

KQL queries don’t support suffix matching.

Using phrases in the free-text KQL query

When you use phrases in a free-text KQL query, Search in SharePoint returns only the items in ***which the words in your phrase are located next to each other***. To specify a phrase in a KQL query, you must use double quotation marks.

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KQL queries don't support suffix matching, so you can't use the wildcard operator before a phrase in free-text queries. However, you can use the wildcard operator after a phrase.

KQL operators for complex queries

KQL syntax includes several operators that you can use to construct complex queries.

Boolean operators

You use Boolean operators to broaden or narrow your search. You can use Boolean operators with free text expressions and property restrictions in KQL queries. Table 5 lists the supported Boolean operators.

Table 5. Boolean operators supported in KQL

OPERATOR	DESCRIPTION
AND	Returns search results that include all of the free text expressions, or property restrictions specified with the **AND** operator. You must specify a valid free text expression and/or a valid property restriction both preceding and following the **AND** operator. This is the same as using the plus ("+") character.
NOT	Returns search results that don't include the specified free text expressions or property restrictions. You must specify a valid free text expression and/or a valid property restriction following the **NOT** operator. This is the same as using the minus ("-") character.
OR	Returns search results that include one or more of the specified free text expressions or property restrictions. You must specify a valid free text expression and/or a valid property restriction both preceding and following the **OR** operator.

Wildcard operator

You use the wildcard operator—the asterisk character (" * ")—to enable prefix matching. You can specify part of a word, from the beginning of the word, followed by the wildcard operator, in your query, as follows. This query would match results that include terms beginning with "serv", followed by zero or more characters, such as serve, server, service, and so on:
serv*

Inclusion and exclusion operators

You can specify whether the results that are returned should include or exclude content that matches the value specified in the free text expression or the property restriction by using the inclusion and exclusion operators, described in Table 6.

Table 6. Operators for including and excluding content in results

NAME	OPERATOR	BEHAVIOR
Inclusion	" + "	Includes content with values that match the inclusion. This is the default behavior if no character is specified. This is the same as using the **AND** operator.
Exclusion	" - "	Excludes content with values that match the exclusion. This is the same as using the **NOT** operator.

[i] https://docs.microsoft.com/en-us/sharepoint/dev/general-development/keyword-query-language-kql-syntax-reference

Movie Reviews

Fall 2019 Movie Reviews

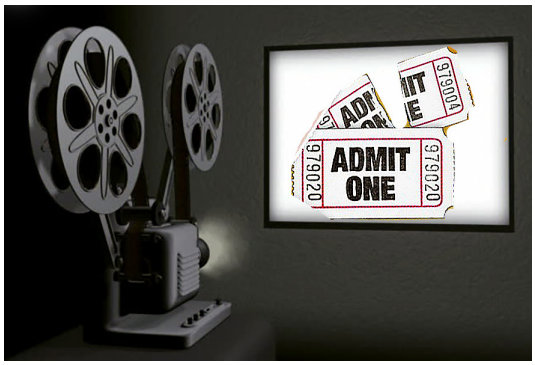
Lucy Crain, MD, MPH, FAAP

THE FAREWELL: Released summer 2019, described as a "drama/ comedy" in English and Mandarin with subtitles and directed by Lulu Wang, the Farewell is a unique cinematic achievement. The released trailers do not do justice to the sensitive, loving relationship of New York based granddaughter Billi (played by popular rap artist and leading actress in last year's "Crazy Rich Asians" Awkwafina) with her Chinese grandmother Nai Nai (acted to perfection by popular Chinese television star Zhao Shuzhen). Nai Nai has recently been diagnosed with metastatic lung cancer and given three months to live. Although her sister/caregiver and numerous family members in China and America all know about her terminal illness, she has been lied to and told that she is in good health. American family members have flown to China under the pretense of attending the wedding of Billi's young cousin whose family lives in Japan. (Complicated plot!) The message promoted by the film deals with differences in dealing with death in the Chinese and American cultures. 98 minutes of worthwhile watching, this film is recommended for depicting differences and ethical aspects of communication about death in different cultures posing challenges as well as the need to respect family wishes. PG

PAVAROTTI: The late Luciano Pavarotti is generally regarded as the greatest operatic tenor of our lifetime, and this bio-documentary confirms that contention. Produced and directed by Ron Howard and rich with historic footage, this is a lifespan tribute to him. Although some items about his childhood seem glossed over, the major details of his life and career are included and the attention to his less well-known philanthropic efforts is of special interest. Also, the film doesn't spare the details of his less than traditional Italian family personal life. However, opera fans will relish the segments of his performances and the compelling sound of his voice, and those less familiar with him should find this an informative introduction to the life of a true operatic superstar plus little-known insights of his personal life. 114 minutes, PG-13.

ECHO IN THE CANYON: Narrated and produced by Jakob Dylan, this movie reminds viewers of the golden age of rock and roll creativity in the mid-1960s throughout the Laurel Canyon neighborhood of Los Angeles. Archival footage of the Mamas and the Papas, the Byrds, Buffalo Springfield and others provides treat upon treat for that era's rock and roll fans. The film is enhanced by recent interviews with musicians Tom Petty, Brian Wilson, Ringo Starr, David Crosby and several others. It's a less than comprehensive history of the LA music scene of the 60's, but it's a totally entertaining trip down R&R memory lane. One of the questions left unsatisfactorily answered was why the scene disappeared as spontaneously as it evolved. There was no mention of the influence of the Vietnam War which introduced a new genre of music and artists. 82 minutes, PG-13.

ONCE UPON A TIME IN HOLLYWOOD: A nostalgic tribute to old Hollywood, starring Leonardo DiCaprio as a popular heart-throb actor in Western movies and TV series whose career is gradually declining as middle age strikes. Brad Pitt as his "stunt-man double" drives his boss's Cadillac around Hollywood, enjoys life, and communes with his real best friend—his dog. This is an entertaining and often laugh out loud funny film with shocking bits of reality. Parallel plots featuring encounters with the Charles Manson commune and Sharon Tate and Roman Polanski as DiCaprio's next-door neighbors in Hollywood lead to an unexpected surprise ending with a twist on reality. R rated for violence and excessive smoking. 2 hours 45 minutes and worth every minute of it! Don't miss the cameo cigarette ad with the credits at end of the movie.



Book Reviews

Book Review

by Jon Almquist, MD, FAAP

Elderhood
by Louise Aronson, MD
Bloomsbury 2019, 464 pages

This is a book that should be read by every member of our senior section.

Louise Aronson is an author and geriatrician, educator and professor of medicine at UCSF. She graduated from Harvard Medical School and the MFA school for Writers at Warren Wilson College.

This work is as thoughtful and revolutionary as Atul Gawande's Being Mortal. Dr. Aronson redefines aging and discusses resilience as critical to those who are aging to accept and enjoy themselves and their lives. Dr. Aronson uses cases she witnessed to point out the risk of dementia and other issues commonly found in the aging population, such as hearing loss, in making it more difficult for family members and home care providers to understand the wants and needs of the elderly, and for physicians to appropriately provide care for these patients.

She critiques her medical education and residency training exposing the gaps she finds critical for good care of our aging population in the lack of evidence for safety of drugs used routinely in this population, as well as the lack of awareness of the importance of their environment, their home care providers, their families, their diets and housing status, all the same things now found critical for infant and child well-being. She challenges societies disregard and antipathy for the ever-increasing elder population in this county.

The author recognizes that pediatrics has been developed in this country by physicians who would not accept that children were just small adults, and who have fought to have medicines tested to show safety in the population they serve, as well as having shown the critical nature of stressors and the environment in which the child lives as critical to understanding their lives. She is clearly urging more trainees to enter the field of geriatrics and pushing for this group to rise up and demand what pediatricians have demanded for the population they serve.

Dr. Aronson challenges medical thinking which values more tests, more procedures, more patients seen in shorter periods of time, to now recognize the importance of social issues that are critical for the appropriate care of our aging population, which is becoming close to 40% of the US population. She points out that today's physician salary profiles reflect the values of our medical establishment.

She reviews historical feelings about older members of society which contrasts with twentieth century and twenty first century attitudes in our county.

Burnout is discussed, something happening to 50% of physicians, and critiques the seminars and retreats that have been developed by managing groups in our large organizations, accepting their recommendations for individuals getting more rest, taking vacations, eating healthier foods and exercising for their health, but avoiding addressing the stressors that modern medicine in the US has become, a system where you are judged by the numbers you see, the tests you order and the boxes you have checked in the electronic medical record.

You will benefit personally by reading this book but will also rightly question many of the recommendations given by your internists, are they clearly in your best interest at this time in your life. Will that cancer therapy deplete your body resources so you can no longer enjoy your remaining time with your loved ones? How should you evaluate that nursing facility, what are the critical elements which might allow you to thrive there? Can you live at home safely? Do you really want to avoid death at all costs?

These are the questions this book will make you answer, for yourself and loved ones.

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Book Review

by Burris Duncan, MD, FAAP

Resilience: Hard-won wisdom for living a better life
by Eric Greitens, Ex-Navy Seal and Founder of The Mission Continues
Mariner Books 2015, 320 pages

Now What?

This book is a series of 'letters' to Walker, a fellow ex-Navy Seal who has returned home vegetating without a mission, unable to find a purpose in life. As a Navy Seal, his life was filled with one mission after another supported by comrades who respected and trusted each other. After discharge, all that was gone. Each letter sites philosophers and Greek mythology to drive the point that after the service, we need to find a purpose and re-create ourselves. He cites Viktor Frankl, the Austrian psychologist and Holocaust survivor who wrote "Man's search for meaning" and who said "Everything can be taken from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way."

Among other topics, the letters discuss resilience, happiness, identity, responsibility, and reflection. Resilience is not 'bouncing back' for "what happens to us becomes a part of us. Resilient people do not bounce back from hard experiences: they find healthy ways to integrate them into their lives". He quotes Aristotle's definition of happiness or flourishing as "a kind of working of the soul in the way of perfect excellence". It is created by the choices we make. He quotes a psychologist Mihaly Czikszentmihalyi "the best moments in our lives are not the passive, receptive, relaxing times…. The best moments usually occur when a person's body or mind is stretched to its limits in a voluntary effort to accomplish something difficult or worthwhile." In his letter on identify, Greitens discusses three words: feelings, action, and identity. By identity, he means what is your purpose, what do you stand for? Here he cites Gandhi who he describes as an angry man and quotes him: "I have learned through bitter experience the one supreme lesson to conserve my anger, as heat conserved is transmuted into energy, even so our anger controlled can be transmuted into a power which can move the world." The letter on responsibility tells the story of James Stockdale, a stoic Navy pilot who survived seven years in a Vietcong prison. He then tells the story of Epictetus a great Roman philosopher who said: "We live in an uncertain and hostile world, but we alone are responsible for our happiness, because each of us is free to choose and judge. Whatever the world sends us, we have power over our intentions and our attitudes." In reflections, he asks four questions: Why am I here? What is going on around me? What am I going to do about it? and How will my actions affect others?

When I read this book, I thought of those of us who have reached retirement age and left our practices, our mission of caring for others is over and we are asking "Now What"? A financial advisor once told me that those who have spent their lives helping others, must find another mission of service or they are "dead in two years". There is much to be done. After retirement, you still have much to offer. Seek the program or project that utilizes your talents, your skills, and ignites your passion. If not now, when?

Book Review

by Miles Weinberger, MD, Professor Emeritus, FAAP

Historical Fiction that Illuminates the Complex Evolution of our Country: The American Saga Series
by Richard Fitchen, Publisher: eFrog Press, October 2, 2015

This review is about 5 books that make up the American Saga series by Richard Fitchen, written by him after retiring from Stanford University. In the best tradition of the historical fiction genre, the fictional characters provide all the components that make for good storytelling. From the pre-revolutionary mid- eighteenth century to the Obama era, there is philoso-phy, economics, culture, politics, love, hate, heroes, villains, romance, and sex relevant to the period covered by each of the books. But additionally, as the fictional characters interact with real historical characters of the time, Richard Fitchen provides insights into the complex conflicts and successes of our country during that 300-year period of its development. Each book covers an era of our history.

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The stories begin with Staircase to Liberty where Joseph LaBarre progresses from seafaring trader to a brigand fighting the British during the revolution. The second book, Justice on Trial, finds Joseph's son, Louie LaBarre, seeking his future in the newly acquired New Orleans as the country expands west. The racial aspects of America in the pre-civil war era become apparent as Louie falls in love and marries a beautiful woman of mixed-race. Their child, Ben LaBarre, though hampered socially by his mixed-race background nonetheless thrives as an essayist successfully producing a crusading magazine expounding the concept of a covenant that binds together the disparate components of our country in United by Covenant.

Ben's daughter, Jessie LaBarre, finds success during the first half of the twentieth century as an attorney fighting for civil liberties. But she also has a fascination for fast cars and influences the development of the growing auto industry. She acquires wealth by learning to capitalize on the industrialization of the country and counsels presidents in the fourth book, Republic in Triumph. Jessie's granddaughter, Bibi LaBarre, inherits Jessie's acquired wealth, supports entrepreneurs in the growing tech industry, promotes the development of nonprofits and philanthropy interacting with private enterprise and government entrepreneurs in the growing tech industry. In Proof of Concept, she promotes the development of nonprofits and philanthropy interacting with private enterprise and government up to the Obama administration.

Each of the protagonists have complexities in their personal relationships and must deal with antagonists in the form of the Camerons. The family of Camerons parallels the LaBarres during the years of America's development. They were British loyalists, ardent racists, southern sectionalists, opponents of civil liberties, and are essentially evil incarnate, providing a contrast to the LaBarres.

In each of the books, the protagonists become real to the reader as they live their lives interacting with the complex and often erratic evolution of the America in which we live today. Neither their lives nor US history follow a straight line, but in each era covered by the 5 books, there is a theme consistent with the Hebrew phrase, Tikkun Olam, often translated to mean "repair of the world" or to make our world a better place. That is seen in the focus of the protagonists and the focus of our country as seen through the eyes of the author.

(Books available at Amazon)

Letters to the Editors

Letter to the Editors

Robert M. Reece, MD, FAAP

I read the Senior Bulletin eagerly each quarter, probably based on an accurate diagnosis of the interest and needs of the targeted audience. Dr. Lance Chilton, whose article on "praise addiction" was particularly apt. It helped me understand some things I've felt since retiring. The degree of our narcissism (we all have some) may predict the amount of "praise addiction" we have. Dr. Chilton describes the adulation we got regularly, whether in clinical encounters or teaching students, residents or fellows. Some of us have felt this praise after a particularly eloquent presentation at a conference, getting a paper or book published, or in making an interesting diagnosis. The absence of this stroking is a missing piece of daily pleasure in retirement. Having a diagnostic label for a feeling is helpful in dealing with it. Thanks, Dr. Chilton, for sharing the concept. (And that praise should feel good.)

Letter to the Editors

Judith F. Topilow, MD, FAAP

(***Author's Note:*** *A slightly less medically sounding "Letter to the Editor" is what I sent to the New York Times this past February. I started it by saying that the paper's measles epidemic coverage was plentiful, but did not address why getting the*

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vaccine was so important from the medical point of view, specifically why the disease itself could have so many serious consequences, even to the point of being life threatening. It was not published. A revised second attempt was, again, not printed.)

In fact, the "why" aspect of why we pediatricians recommend a vaccine is often not conveyed or deemed a "turn off" if discussed with parents or caretakers. That's too bad. Years ago another one of my "Letters to the Editor" of the Times was rejected after I admonished the paper for putting incomplete information on the HPV vaccine in the "Style" section, while the first page carried a story on how another country reviewed our restaurants.)

Here's what I wrote this past February:

I can still picture the rather long and narrow hallway to the Pediatric Emergency Room at the "old" Lincoln Hospital in the South Bronx in the late '60s. During frequent measles epidemics pediatric house staff was stationed in that hall to triage children. Koplik spots appearing on the buccal mucosa, the characteristic rash, and a "measly appearance" were dead giveaways. Children who appeared dehydrated, toxic, or in respiratory distress were brought in.

An unsure first-year pediatric resident rotating through Lincoln, I hovered over a toddler with severe measles croup struggling to breathe at about 2AM one night. My relief was palpable as I turned to see Chief of Pediatrics Arnold Einhorn (the pediatrician's pediatrician) behind me to provide moral support and medical expertise. During my residency a child "lived" on 8 West at Jacobi Hospital, permanently unable to communicate, sit up, or feed herself after developing SSPE, subacute sclerosing panencephalitis, post measles.

So, when my lovely granddaughter ran 102 with a mild "measly" rash under her ears seven days after she received measles vaccine at 15 months of age, the common benign side effect of the vaccine, I reassured my anxious daughter-in-law that all was well.

Best of the Bulletin

OUT OF THE MOUTHS OF BABES...

- While I sat in the reception area of my doctor's office, a woman rolled an elderly man in a wheelchair into the room. As she went to the receptionist's desk, the man sat there, alone and silent. Just as I was thinking I should make small talk with him, a little boy slipped off his mother's lap and walked over to the wheelchair. Placing his hand on the man's, he said, I know how you feel. My Mom makes me ride in the stroller too.
- As I was nursing my baby, my cousin's six-year-old daughter, Krissy, came into the room. Never having seen anyone breast feed before, she was intrigued and full of all kinds of questions about what I was doing. After mulling over my answers, she remarked, 'My mom has some of those, but I don't think she knows how to use them.
- Out bicycling one day with my eight-year-old Granddaughter, Carolyn, I got a little wistful. 'In ten years,' I said, 'you'll want to be with your friends, and you won't go walking, biking, and swimming with me like you do now. Carolyn shrugged. 'In ten years, you'll be too old to do all those things anyway.
- Working as a pediatric nurse, I had the difficult assignment of giving immunization shots to children... One day, I entered the examining room to give four-year-old Lizzie her needle. 'No, no, no!' she screamed. 'Lizzie,' scolded her mother, 'that's not polite behavior.' With that, the girl yelled even louder, 'No, thank you! No, thank you!
- On the way back from a Cub Scout meeting, my grandson innocently said to my son, 'Dad, I know babies come from mommies' tummies, but how do they get there in the first place?' After my son hemmed and hawed awhile, my grandson finally spoke up in disgust, 'You don't have to make up something, Dad It's okay if you don't know the answer.'
- Just before I was deployed to Iraq, I sat my eight-year-old son down and broke the news to him. 'I'm going to be away for a long time,' I told him. 'I'm going to Iraq.' 'Why?' he asked. 'Don't you know there's a war going on over there?'

Forwarded by George Cohen

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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 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?RootFolder=%2FSOSM%2FSenior%20Bulleti n%20newsletter%2FBest%20of%20the%20Bulletin&FolderCTID=0x01200092B0E35AC5C1B54987AFBA9 168EDA4B4&View={E73B-6D0E-0A89-40C7-B9EC-AA09A2DA0B09}

An Overview of The AAP Committee on Development

Robert Corwin, MD, FAAP

I am pleased to be given the opportunity to write an article about the Committee on Development (CODe) of the American Academy of Pediatrics (AAP) as its current Chairperson and a member of the Senior Section.

Our CODe has one member from each of the Academy's districts and a liaison from the Young Physicians Section. Members of the committee include, past presidents of the AAP, past district Chairs, and past ALF chapter & section & committee leaders. We are fortunate to have as our staff the Senior Vice President & Chief Development Officer of the Academy, Ms. Christine Bork.

Our mission is to raise funds and to be philanthropic ambassadors, stewards, and educators to support the mission of the AAP. We hope to develop a culture of philanthropy in all AAP members, and we hope that the Senior Section will become a leader for that goal and help us raise awareness of the import of charitable giving for Academy initiatives. We know that many of the members of the Senior Section contribute gifts as evidenced by their contributions to the recently concluded For Our Future campaign.

The current vehicles we have for charitable giving to the Academy include our annual fund, the Friends of Children Fund, celebrating its 30th anniversary this year, and our endowment fund, Tomorrow's Children Endowment. In addition, we have tribute giving honoring individuals, sections, and other academy groups. One example is the Dr. Errol & Judi Alden Endowment for Global Health Fund.

Dues contribute only 24% of the total budget necessary to fund the many programs of the Academy. Other sources of financial support include publishing, meetings, foundation and industry, as well as governmental grants. Therefore, many of our wonderful AAP programs rely on charitable gifts for their financial support. Although this article cannot list all the programs we support, the following give you some idea of the breadth of programs supported by charitable giving:

Friends of Children Healthy People 2020 Grants to Chapters and Members

- Gun violence prevention
- Decrease the number children living in poverty
- Addressing food insecurity which leads to deleterious health effects
- Respond to disasters affecting children
- Combating misinformation about vaccines, especially on social media
- Support programs to help teen parents
- Pediatric Residents Hardship Scholarships
- And so many more…

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So, what are the ways that members of the Senior Section can support the work of the Academy?

- You can make a gift today at donate@aap.org.
- You can volunteer as a fundraiser. Contact us at development@aap.org.
- You can learn more about how to make a gift from your IRA or other retirement vehicles to support children's health by contacting us at development@aap.org.

This year at our Donor Reception at the National Conference & Exhibition we will pay special attention to members who are counted as Champions for Children (consecutive years of giving) and the Tomorrow's Children Society (those who have made bequests and/or are beneficiary donors). We are currently developing special lapel pins to recognize these groups.

Whatever your passion, we hope you will help the children. Join the CODe in helping us to continue helping the children.

Editor's Note: *Another way to donate to the Academy of Pediatrics is to designate your tax-deductible contribution to the Don Schiff Senior Advocacy Award Endowment Fund.*

Finance

Trust Basics: Make Sure to Transfer Assets

Jeff Witz, CFP®

Trusts are frequently used in effective estate planning to provide management of assets as well as minimize probate expenses and estate taxes. Despite their apparent complexity, trusts can be extremely useful in many aspects of planning your estate.

To thoroughly understand trusts, you need to know the various roles of the parties affiliated with the trust in order to begin beneficial discussions with an estate planning attorney. First, there's the grantor. This is the individual who establishes the trust and usually transfers funds into the trust. Next is the trustee, who makes certain the terms of the trust, as outlined by the grantor, are carried out. Finally, there is the beneficiary. The beneficiary is the individual (or individuals) for whom the trust has been created. Often a minor, the beneficiary can also be a surviving spouse, adult child or any individual in need of financial assistance (or supervision) after the death of the grantor.

Knowing these basics, you can then focus on the different types of trusts most often used for estate planning purposes. The first is a testamentary trust. This trust is usually part of a will and comes into existence after death. With a testamentary trust, assets may pass through probate before being received by the trust. The trust can then help divide assets for each beneficiary, manage assets, or distribute assets as required by the directions of the trust.

A living trust, also sometimes referred to as an inter-vivos trust, is created during the life of the grantor. In addition, the grantor is usually also the trustee and beneficiary of the trust. Assets are transferred into the trust during the grantor's life to avoid probate at death. As an added benefit, living trusts provide benefits during life, particularly in the event the grantor becomes incapable of effectively managing the assets due to reasons related to health or competency. A living trust can identify contingent trustees who assume managerial responsibilities of the trust in the event the original trustee (usually the grantor) is unable to perform their duties. Such forethought will avoid the excessive legal costs involved if a grantor is declared incompetent, since in such cases, annual accountings to the court are required.

A trust can be a highly effective method of controlling the management and distribution of assets. However, a trust only works to the extent that assets have been transferred into the trust. Often, individuals spend hours in their attorneys' of-

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fices creating what they hope will be the perfect trust arrangement for their estate. Unfortunately, many never get around to transferring their assets into the trust. If you create a trust for your estate plan, make certain your assets are titled in the way necessary for the trust to work, since asset titling and beneficiary designations take precedence over the directives of your will or trust. For example, if you have a large life insurance policy naming your surviving spouse as beneficiary, a residence and summer home jointly titled with your spouse, and various investment accounts also jointly titled with your spouse, all of that will pass directly to your spouse, bypassing any trust arrangement you paid to put in place. Then whatever plans the survivor has made (or may make) will be the controlling factor for all assets going forward.

To control the distribution and management of the assets, to minimize estate tax liability and ultimately probate expenses, it is necessary to revisit all titling and beneficiary designations. Your estate planning attorney, working in tandem with your investment and insurance advisors, can assist in this process to ensure a well-coordinated and effective estate plan.

Note: The information provided does not, and is not intended to, constitute legal advice. Readers should contact their attorney to obtain advice with respect to any particular legal matter.

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 or Co-Editors Dr. Manny Doyne emanueldoyne47@gmail.com and Dr. Cathy DeAngelis cdeange1@jhmi.edu. Articles and letters should be submitted to the Editor at lucycrain@sbcglobal.net with cc to Susan Eizenga seizenga@aap.org. We look forward to hearing from you and to reading your articles in the Senior Bulletin.

2019-2020 Senior Bulletin Schedule

Winter Bulletin - Electronic
November 11, 2019 Call for Articles
December 9, 2019 Article Submissions Due
January 17, 2020 Bulletin Online

Spring Bulletin - Electronic
February 10, 2020 Call for Articles
March 9, 2020 Article Submissions Due
April 17, 2020 Bulletin Online

Summer Bulletin - Electronic
May 11, 2020 Call for Articles
June 8, 2020 Article Submissions Due
July 17, 2020 Bulletin Online

Fall Bulletin - Electronic
August 10, 2020 Call for Articles
September 14, 2020 Article Submissions Due
October 16, 2020 Bulletin Online

Winter Bulletin - Electronic
November 9, 2020 Call for Articles
December 14, 2020 Article Submissions Due
January 15, 2021 Bulletin Online

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.*