Message from the Chairperson

Eileen M. Ouellette, MD, JD, FAAP

Greetings! This year, the National Conference & Exhibitions (NCE) is in New Orleans, LA from Friday, October 25 through Tuesday, October 29, 2019. For the first time in a long time there will be academic sessions on Friday afternoon.

I have very good news for our most senior members who were born in 1939 or earlier and who plan to attend the NCE. You now can enjoy either of two benefits available only to Section on Senior Members (SOSM). At its May meeting this year the Board of Directors voted to provide a 50% reduction in the full conference registration fee for the NCE, beginning this year. This means a registration fee of $305 for those registering by September 13 and $380 after September 13, 2019.

For the past two years, the AAP has given a free one-day registration to SOSM members who are 80 or older. It does not apply to those who attend 2 or more days of the meeting. This benefit is of most value to those of you who live within a few hours drive of New Orleans but weren't planning to attend the meeting. I strongly urge you to take advantage of this reward for your many years of caring for children.

If you are interested in obtaining this benefit, please contact AAP Registration at 1-800-433-9016. You must be a member in good standing of both the AAP and SOSM to receive either of these benefits.

I hope you will attend our SOSM Educational Program and Business Meeting that are scheduled for Sunday, October 27, 2019 from 9 AM to 1:30 PM. The schedule for the program is listed elsewhere in this SOSM Bulletin.

The Executive Committee of SOSM met for its semi-annual meeting at AAP headquarters in Itasca on May 10-11, 2019. The EC finalized the NCE Educational Program for 2019 and began planning for the 2020 Session. It further refined the SOSM Organizational Chart to reflect the expanded activities of the Section more accurately.

I am pleased to announce that Dr. Mary Ellen Rimsza has been selected as this year’s recipient of the Donald Schiff, MD, FAAP Child Advocacy Award. Dr. Rimsza's contributions in the field of child abuse, particularly her recognition that the lack of physical findings does not eliminate the possibility of sex abuse, have expanded the knowledge of child abuse and benefited many children. The Award will be presented at the SOSM NCE Educational Program and Dr. Rimsza will make a presentation at the meeting.

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Much of the meeting centered around further discussion of the establishment of an Advocacy Subcommittee for SOSM, which we hope to finalize at the National Conference & Exhibition. Dr. Renée Jenkins and Ms. Jamie Poslosky, Senior Director of Advocacy Communication in the Washington, DC AAP Office presented a preliminary plan for consideration.

A preliminary mission statement proposes that “the Advocacy Subcommittee of SOSM will coordinate involvement of section membership in AAP advocacy efforts at the federal and state/chapter levels, including a collaborative approach to advocacy activities and partnership with the AAP Section on Early Career Physicians (SOECP) and the Section on Pediatric Trainees (SOPT).”

We hope to “establish pilot partnerships among the Sections and selected AAP chapters to establish Senior Sections in selected Chapters to coordinate participation of the three Sections in Chapter Advocacy Agenda Priorities, such as serving on Chapter Advocacy Committees, legislative testimony, and representing the Chapters on task forces, commissions and at stakeholder meetings.”

We hope to “foster collaboration between SOSM members, SOECP and SOPT members through knowledge sharing and skills-building activities like webinars with AAP staff, and regional in-person partnerships facilitated through Chapters and Districts.”

We plan to establish goals and objectives for a SOSM-SOECP-SOPT Advocacy Partnership to include “partnering on key advocacy initiatives to advance the AAP and chapter advocacy agendas, and to teach other advocacy skills, such as utilizing digital media or developing long-term relationships with legislators and legislative staff.”

We are proposing the following Chapters and District for the pilot program, as they have strong legislative experience and SOSM members have expressed an interest in participating in the Advocacy Initiative. The proposed pilot programs are California District IX,
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Message from the Chairperson
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Georgia, Maine, Maryland, Massachusetts, New Mexico, Utah, Washington and Wyoming.

Our goal is to establish the SOSM Advocacy Subcommittee and to identify SOSM members in each of the pilot programs by the 2019 National Conference & Exhibition. If you are a member of any of these Chapters and District IX and are interested in becoming active in this endeavor, now is the time to volunteer. Please contact me at eouellette@aap.org or Katie Clark at kclark@aap.org. We will be happy to answer any questions you may have.

Summer 2019 Editor’s Note

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

Last week, we had 4 days of 90 plus weather here in San Francisco! Now the fog has returned, the furnace is on and summer is officially here.

Picking a lead topic for my note is often challenging, but not so for this summer issue. Summer once was a carefree time to slow down before the deluge of back to school physicals. It was a time to have more time to spend with family and friends with picnics and more carefree pursuits. But concerns about school shootings, gun violence and vaccines are rightfully at the top of our contributing writers’ lists.

I’m reminded by Dr. Schiff’s Advocacy column (“Mama, I’m afraid to go to school.”) of the note posted by my son several months ago stating that he was conflicted about whether to worry more about his 13 year old or his 8 year old as he sent them off to their respective schools. They live in a mid-sized middle American city which enjoys good public schools, pleasant residential neighborhoods, and should enjoy a sense of safety and well-being for families and children. The boys and their parents march in the Mothers against Guns events and make posters and write letters to Congress. Still more school shootings continue in American cities and towns. What has happened to our country? I’m increasingly convinced that the fault may not lie so much with the NRA as with a Congress and White House and Judicial system and Electorate unable or unwilling to stem the tide of epidemics of guns, opioids, and even measles.

Continued on Page 4
We feature a variety of subjects in this summer’s issue, including articles on gun violence and vaccines, and a welcome article from retired pediatrician John McCarthy citing the classical account of Cincinnatus plus a special two-part article from Dr. Robert Lerer about his 22 years of pediatrics in Cuba. Read his introductory paragraphs in this issue and look forward to Part 2 in the fall issue. You’ll find AAP-SOSM liaison reports enhanced by our new representative from the Section on Early Career Pediatricians (SOECP), Dr. Elizabeth Kuilanoff. Enjoy the movie review by an 8-year-old guest editor with recommendation for the summer viewing enjoyment of your children and grandchildren.

Thanks to all of our contributors and readers whose letters and comments brighten our days! We encourage your becoming more active in your own advocacy for children and families and remind you to vote in upcoming primary and national elections, as well as the AAP elections.

REMEMBER TO VOTE! Background and policy statements by both candidates for AAP President- Elect appear in each issue of the AAP News. I’d like to remind all of our readers to check the following link with details of the upcoming election (which will end just about the time that our fall Bulletin issue appears online) and VOTE!


2019 AAP National Candidates

The AAP National Nominating Committee has selected Lee Savio Beers, M.D., FAAP, of Washington, D.C., and Pamela K. Shaw, M.D., FAAP, of Kansas City, Kansas, as candidates for AAP president-elect.

Additional information about the candidates, including profiles and position statements, can be found in the June 2019 AAP News Issue and online at https://www.aap.org/en-us/my-aap/national-aap-election-center/Pages/National-AAP-Election.aspx

Voting will begin Sept. 7 and ends Sept. 21.
“Mama I am Afraid to Go to School”

Don Schiff, MD, FAAP – Advocacy Column

“Mama I am afraid to go to school”. The plaintive fear expressed by children who are well aware of the tragic school assaults, which have occurred in Colorado, Connecticut, and Florida and across the US permeates classes from kindergarten through high schools and colleges. The general public recognizes the horror and trauma that is now all too frequently a childhood experience. Sadly, all of us of every age have been made fearful as to when or where (school, workplace, church, or roadway) that the next seemingly inevitable attack may occur.

The daily morbidity and mortality because of an unsecured lethal weapon in a home or in a school which has been attacked has become in the words of many an “accident” or an aberration which is unpreventable.

Mijer and Wong’s informational brief (4/2019) from the Farley Center at the University of Colorado documents: The economic impact of gun violence every year is $229 billion. $8.6 billion of that figure was for direct medical care. Expenses. There have been 150 mass murders in the first few months of 2019. For the 20 years since “Columbine” took place, 55,000 children and teens have died in gun, homicides, suicides, and accidents. Gun violence was the leading cause of death in ages 10-24 with more than half suicides.

Our nation is in the midst of a public health epidemic that requires research and recommendations for programs that reduce the incidents and control this epidemic. Most observers agree that mental health and other behavioral aberrations play a major role in violent gun deaths although mental health specialists believe that most people who are mentally ill are not violent. However, history makes it clear that a single individual even in a temporary dangerous state of mind can produce horrific acts of violence.

Efforts to identify individuals on the brink of a violent act have broadened and include a program in schools- Safe 2 Tell where peer students are encouraged to report severely depressed classmates who need consultation and support.

Courts and law enforcement agencies are cooperating to control gun availability. The United States Supreme Court has ruled that the 2nd amendment to the constitution provides the right to own and bear arms. Additional legislation has proscribed circumstances which modify that right so that in many states’ severe mental illnesses, conviction of a felony or spousal abuse would preclude gun ownership. A fundamental question in any safety program remains the accessibility of guns. 75% of children 5-14 years old know where guns are in the house. 22% of children have handled these guns without their parents’ knowledge. A review of 37 school shootings from 1974-2000, 65% of the attackers got their guns from their own home or the home of relatives. More than half of the youth who committed suicide used guns from home usually belonging to the parent. A United State Child or teen is killed with a gun every 3 hours. Only motor vehicle accidents kill more children than guns. Studies which reveal that states which have loose gun safety laws have higher rates of firearm injuries have stimulated efforts to add gun safety legislation.

A number of specific gun safety laws have demonstrated a positive effect in reducing violence. None of the suggested laws and regulations prevent law abiding individuals from owning a gun. “C.A.P. (Child Access Prevention)” the fundamental requirements of this law are that gun owners must store their guns so that children and teens cannot access them. Unsupervised adults are held liable of children if children gain access to firearms in the home. States implementing this type of law reduce accidental shootings of children by up to 23% and suicide of teens by 8%. “Gun Safe Storage”, a related but specific safety law. Gun locks provide a significant protection. When laws require handguns to be locked states have seen 68% fewer firearm suicides per capita. Massachusetts is the only state in the nation that require firearms to be stored with a lock in place at all times when the firearm is not in use. Their suicide rate is 35% below the national average. “Waiting period laws” require that a specific number of days pass between the purchase and attaining possession of the firearm. This provides a cooling off period and may prevent suicides. “Red Flag Legislation” is an example of laws which are designed to prevent firearm violence by individuals who are judged to be dangerous to themselves or others by a judge. This extreme risk protection order allows law enforcement officers to remove guns for a designated period of time and allows them to be returned if/when that is determined to be safe.

Continued on Page 6
State level action is increasing as National efforts continue to be blocked in Congress and the White House. In Virginia, Governor Ralph Northam will call a special session of the legislature to deal with gun safety. They will attempt to secure universal background checks, ban silencers and high capacity gun magazines as well as Red Flag restrictions. Former Governor of Colorado, John Hickenlooper, now a candidate for President presented his recommendations which include a national standard for gun licenses which would require passing a safety test. He also would like to see universal background checks and limits on magazine size. An interesting recent development in the gun safety field is the appearance of citizen groups calling for safety legislation. One such group is called “Moms Demand Action” modeling itself on “Mothers Against Drunk Driving (MADD)”. Their membership now at 6 million has already publicized their opposition to arming teachers with guns. They are a group which may become powerful enough to make the changes which are needed.

End Measles...Once and For All

Beryl Rosenstein, MD, FAAP at Johns Hopkins Hospital

Like most pediatricians, I try to keep up with the latest developments in the vaccine/anti-vaccine controversy. It is especially disappointing that we are seeing a resurgence of measles, a completely preventable disease. The current issue with the measles vaccine jogged my memory back to the winter of 1965-6 when I was able to take part in the first statewide one-day measles vaccination program in the United States. After finishing my pediatric training at John’s Hopkins, I joined the Public Health Service, became an Epidemic Intelligence Service Officer at the Centers for Disease Control and Prevention (CDC) and was assigned to work with the Rhode Island Department of Health. It was at a time when measles was a major public health problem. From 1958 to 1962, the United States averaged 503,282 reported measles cases and 432 measles associated deaths each year. From 1961 to 1965, Rhode Island averaged 3,652 reported measles cases each year. In 1965, I took part in a household survey, which estimated that there were approximately 52,000 susceptible children ages 1-12 years in Rhode Island. Our plan was to a plan to try to immunize all susceptible children in the state in one day. The campaign, “End Measles...Once And For All” was sponsored by the Rhode Island Medical Society and its Women's Auxiliary Branch which recruited 2000 volunteers. Measles vaccine had been introduced into the United States in 1963, and in 1965-1966 three vaccines were available. The state chose to go with the Schwarz further-attenuated live virus vaccine, which required only one injection. Vaccine clinics staffed by volunteer physicians, nurses and support staff were set up at 37 sites throughout the state, primarily in schools and armories. A detailed operations manual was distributed to key personnel and a practice clinic was held for nurses and physicians.

There was an extensive publicity campaign organized by a professional advertising agency, which utilized billboards, newspapers, radio and TV spots, flyers in physician offices, school posters, announcements by clergy and registration forms sent out with utility bills. The honorary Chairman, then Governor John Chaffee, along with the vaccine developer Dr. Anton Schwarz spoke at a kickoff luncheon.

“End Measles Sunday” was held on January 23, 1966. Unfortunately, there was a 12-inch snowstorm that day but in spite of this, about 32,000 children were vaccinated. Even on Block Island, with snow and winds gusting up to 75 miles an hour, 12 children showed up to be vaccinated. Because of the weather, a make-up clinic was held the following Sunday and an additional 3200 children were vaccinated. Overall, 67% of estimated susceptible children received the vaccine. Total cost of the program was $68,897 or $2 per vaccinated child. The campaign was largely funded by surplus funds from a 1963 End Polio program. There was no charge, but families were asked to make a 25-cent donation, and this raised $8256. Children were rewarded with paper streamers of red dot candy that looked like a measles rash and with badges that made them a member of the “Free from Measles” red dot club. The clinics ran very smoothly with an average total time in clinic per child of three minutes. This was pre-HIV and pre hepatitis B and at the larger clinics, multiple dose jet injector guns were used to speed the process.

There was broad public support for the campaign as it took place at a time when vaccines were widely accepted as life-saving measures and there was no significant anti-vaccine sentiment. There was extensive national press coverage and even a photo of me using one of the jet injectors in the February 4, 1966 edition of Time magazine. Campaign results were published in JAMA and in Public Health Reports. From a public health standpoint, the campaign was a great success. In
the following year, there were only 75 reported cases of measles in Rhode Island for a 97% reduction. The campaign was the highlight of my brief but rewarding public health career.

Reflections on Immunization Acceptance

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

For the first time US public health is threatened by disease outbreaks due to the rejection of a vaccine by a minority of parents. In the 1970s in Europe, pertussis outbreaks followed rejection of whole cell DTP vaccine after reports of a link between DTP and encephalopathy. Then, in the UK, measles outbreaks followed rejection of MMR after the Lancet’s 1998 publication of a study by Wakefield linking MMR vaccine and autism. Around the world Wakefield’s infamous fraud served as the seed crystal around which a supersaturated solution of immunization concerns crystallized. Although these concerns were widely publicized in the US, there were few US outbreaks attributed to vaccine rejection until the Disneyland measles outbreak of 2015. Then the US began to experience sporadic measles outbreaks.

The disease was frequently imported by travelers to countries where measles remained endemic or had resurged due to a decline in immunization acceptance. At this writing US measles cases total 971 reported from outbreaks involving multiple states. The disease has occurred principally among those who are electively unimmunized, thereby prompting widespread reassessment of our immunization policies and practices.

Since the advent of smallpox immunization programs vaccine acceptance has been problematic. Indeed, the term conscientious objector first referred to rejection of smallpox vaccination. As immunization against tetanus, diphtheria, pertussis, and polio became universal, cultural awareness among US parents of the threat constituted by these diseases gradually waned. At about the same time, the post-World-War-II confidence began to fade that science and modern medicine, which had just developed antibiotics and corticosteroids, would rapidly find solutions for other health problems. Interest in complementary and alternative medicine surged. Then trust in government and its agencies was undermined by the Vietnam War, Watergate, and recently the pharmaceutical industry’s credibility was destroyed by the Vioxx™ and Oxycontin™ scandals. These disparate threads have all been woven into and strengthened the already all-too-durable fabric of vaccine hesitancy.

Communication also changed radically as internet access grew and social media burgeoned. Presentation came to trump content; prominent vaccine deniers were given voice by well-meaning but naïve journalists seeking to achieve balance presenting a controversial issue. Evaluating the credibility of an information source became maddeningly difficult. Repetition by familiar media figures served to validate vaccine safety concerns. By 2000, 19% of US parents reported thinking vaccines were unsafe; by 2004 an impressive 94% of pediatricians reported encountering parental vaccine refusal; and by 2010 about 30% of US parents delayed or refused some vaccines.

When current science no longer informs a community’s view of a controversial issue, science illiteracy is frequently blamed. For example, those who voice doubts about the safety of universally recommended vaccines have been characterized as: “ignorant about science”, or of “low cognitive complexity”. But science literacy account for only a small part of how the lay public forms opinions about controversial areas such as fluoridation, genetically modified foods, global warming, or vaccines. Values, ideology, partisanship, political context, religious identity are all important influencers of our decision making. When science-based information clashes with intuitive beliefs, people resist. Even when the weight of the science is overwhelming, people continue to resist particularly when the science is complex and cannot be verified by personal experience. And the language of science is off-putting: the null hypothesis cannot be proven. When we speak science, we must say there is no evidence of an association of a vaccine with an adverse event, rather stating simply the vaccine does not cause the event.

Today’s vaccine deniers – those who proselytize their negative views about vaccines - speak science, albeit pseudoscience. They cherry pick data, cite findings out of context, develop alternative facts, suggest conspiracies to fashion arguments that seem credible, and thereby reinforce parents’ doubts and fears and legislators’ concerns. Refuting their arguments in a public venue by naming the techniques they employ to distort the truth and correcting their misinformation is no
Reflections on Immunization Acceptance  Continued from Page 7

easy task even for an expert and in no way akin to communicating with a vaccine hesitant parent in a clinical encounter.

For today's parents vaccine decision making is a challenge. They are confronted with conflicting information from their community, from the media, from various providers: what to believe is a conundrum. Eula Bliss, in her 2014 book On Immunity characterized the parents' burden beautifully: I cast my mind ahead with each decision I make wondering what I might be giving or taking from my child in the future… But even when I do nothing I am aware, that I am irrevocably changing the future.

Multiple studies have established that a clinician's strong recommendation is the single best predictor of vaccine acceptance. A presumptive approach – which presumes parental acceptance – has been shown repeatedly to increase vaccine acceptance compared to a participatory approach, which invites parents to voice their concerns about immunizations. But perseverance pays off: parents who initially refuse some vaccines may come to accept. Respectfully countering their arguments, raising the issue in subsequent visits, employing the motivational interviewing techniques have all been shown to be useful.

Immunization, like all public health programs ultimately depends on a broad public consensus for support. Immunization policy is informed by both science and values. What should be the balance between the state's duty to protect the public health and an individual's right of free choice? In other words, when does the risk to public health trump free choice? What community disease risk balanced by what assurance of vaccine safety justifies an enforced mandate? What degree of coercion in warranted?

We need to create forums in our communities where we can have a respectful, productive dialogue about how best to balance these competing values. Until we find a way to address such values conflicts, we will not be able to derive the full benefits of 21st century vaccinology.

Balloons: Unsafe at Any Age
Catherine Bartlett, MD, FAAP

During my thirty years in primary care pediatrics, I regularly counseled parents on safety. I discussed car seats, cribs, foods and toys that were choking risks and the strangulation risks of hoodie strings. Later, as the babies began to explore, I discussed securing medicine and cleaning supply cabinets, bolting dressers to the wall, and safety issues of climbing structures, bikes and ATVs. I told them all to give their guns to some childless friend to keep for them until their youngest child turned 18.

When my own children arrived, I was astonished by their ingenuity and determination to find the most dangerous way to use all toys and found objects, and I redoubled my efforts to keep my patients safe. Although I was vaguely concerned about balloons, my own children loved them, particularly in the summer for water balloon wars, and I even occasionally blew up a latex glove and drew a face on it to coax a smile from a reluctant patient.

Everything changed when a three-year-old boy arrived on the 20-bed pediatric ward of the local nursing home. My partners and I took care of the children there. They had a variety of neurologic disorders due to accidents, illness, genetic disorders and prematurity. “Tim” had bitten into a balloon a year earlier at his six-year-old brother's birthday party, and a piece of latex had blown into his pharynx, wrapping itself over his larynx. No amount of effort by his parents could dislodge it, and by the time the paramedics arrived and performed an emergency tracheotomy, it was too late. Tim was resuscitated at the hospital and lived another 18 years in a persistent vegetative state.

After meeting Tim and his family, I became an anti-balloon crusader. In researching choking deaths due to balloons, I found that the AAP Policy Statement on Prevention of Choking Among Children contains statistics from an article published in JAMA, December 13, 1995. In ‘Characteristics of Objects That Cause Choking in Children,’ Frank L. Rimel, et al reviewed 449 cases of children who died due to choking on man-made objects between 1972 and 1992 as reported by the Consumer Product Safety Commission (CPSC.) They found that balloons caused 29% of choking deaths overall. Moreover, the deaths were not clustered in children under 3 years of age. The risk of choking to death on a balloon was much

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higher in children ages 3 to 8 years of age. Sixty percent of all choking deaths in this age group were due to balloons while only 33% of the fatalities occurred in children three years or under. Notably, two of the deaths, one in a 20-month-old and one in an eight-year-old were due to balloons made of latex exam gloves given to them by physicians. Dr. Rimel concluded, “Balloons pose a high risk of asphyxiation to children of any age.”

More recent data found in the yearly reports of the CPSC show that though the absolute number of deaths due to choking on balloons is relatively small, the percentage of choking deaths attributable to balloons has remained stable. Between 2009 and 2017, 20 children died due to choking on latex balloons. In 2011, balloons accounted for 23% of fatalities due to choking, and between 2001 and 2014, about 38% of all toy related choking deaths involved balloons. Those children who survived but were left in a persistent vegetative state are not included in the statistics.

Balloons, along with the stuffing from diapers are what are categorized by the CPSC as “conforming objects.” As such, they are nearly impossible to remove with finger sweeps or back blows once they have been aspirated. Children of all ages love chewing on inflated balloons, and when they pop, the rush of air can force a piece of the latex deep into the pharynx, beyond the reach of the parent. The child’s attempts to inhale suck the fragment firmly over the larynx, and the child's cough is often not strong enough to dislodge it. Balloon fragments also cause asphyxiation. When children put them in their mouths and chew on them, their slippery consistency can cause them to slide to the pharynx with subsequent choking and asphyxiation.

Although latex balloons are ubiquitous and deeply entwined in the culture of our celebrations, I feel it is time to explain the dangers of latex balloons to parents and grandparents and recommend that they buy only mylar balloons for children under 10. I realize this may sound like overkill; perhaps latex balloons could be used with great caution. However, balloon deaths are often particularly tragic. As in Tim’s case, many of the balloon choking deaths occur during a celebration for either the victim or a sibling.

The family mourns the loss of the child, and the sibling’s birthdate forever carries a shadow. At a party, no parent can watch every balloon and every balloon fragment, let alone the ones the guests take home. The time has come for latex balloons to go.

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**Balloons: Unsafe at Any Age** Continued from Page 8

**Tips on Mentoring**

Section on Early Career Physicians (SOECP) Liaison - Elizabeth Kuilanoff, MD, FAAP

In May, I had the opportunity to attend the spring meeting of the Section on Senior Members Executive Committee. It should come as no surprise that the goals of the early career physicians and senior members are similar - improve child health, provide excellent educational opportunities for section members, and promote partnerships between the groups. The senior members are a rich source of knowledge and experience, and in two short days I learned an incredible amount from them.

As we build our careers as physicians, the Academy is full of experts who can help guide us in contract negotiation, retirement plans, advocacy, patient stories, and so much more. As young physicians, we also have a lot of information to share. Many of us are expert users of our electronic medical record systems, use social media tools for patient advocacy, and have just completed residency with the most up to date evidence-based medicine.

The AAP has an ever-growing network of mentors and mentees and you can sign up to be a mentor at [https://aapmentorship.chronus.com/](https://aapmentorship.chronus.com/). The commitment is for at least one year with the expectation for the mentor to provide one hour
Tips on Mentoring  Continued from Page 9

of support and interaction per month via email, phone and other web-related tools (for example, instant messaging) or face-to-face interaction as appropriate.

Tips for mentors success:

1. Commit to at least one interaction or hour of support per month.

2. Take responsibility to initiate the relationship.

3. Set aside time for the mentoring process and honor all appointments.

4. Invite the mentee to meetings or activities, as appropriate. Schedule meetings with planned topics.

5. Be flexible on meeting times and places.

6. Arrange frequent contacts through telephone, email, fax, face-to-face, etc., as appropriate.

7. Respond to emails from your mentee within two days of receipt.

8. Keep information that your mentee has shared with you confidential. If something concerning the mentee needs to be discussed with others, it should first be discussed within the mentoring relationship.

9. Establish open and honest communication and a forum for idea exchange.


11. Provide honest and timely feedback.

12. Provide opportunities for the mentee to talk about concerns and ask questions.

13. Above all, listen.

Things to avoid:

1. Giving advice on everything.

2. Encouraging mentee to be totally dependent upon you.

3. Providing your personal history, problems, animosities, successes, failures, etc. unless they are constructive contributions.

4. Being too busy when the mentee needs your friendship or your support. If you do not have time, give the mentee a heads up, so that she or he knows when you can be reached.

5. Negative criticizing.

Please consider becoming a mentor and helping to meet one of our Section on Early Career Physicians goals to increase mentorship relationships. We would all benefit from sharing our experiences.

Together, we can continue to grow our profession and improve child health.
Is There a Doctor in the House?
Suzanne Boulter, MD, Senior Section Liaison to COFGA

How many of us have been on an airplane or at a large sporting event when we have heard a request for a doctor? With some trepidation knowing that the “victim” will most likely be an adult we sometimes have mixed feelings about responding. However, here is an update about a pediatrician who reached out to become a “doctor in the house” when she ran for US Congress to promote children’s issues and now, for the first time ever, a pediatrician is serving in the US House of Representatives.

Dr. Kim Schrier (D-Wash) has that distinction and she has already distinguished herself by signing on to introduce two bipartisan bills. First is a bill updating the Child Abuse Prevention and Treatment Act (CAPTA). This bill calls for the funding of the following initiatives:

- Improving the quality of federal and state data about child abuse
- Developing strategies and best practices to lower child abuse rates linked to substance abuse disorders
- Decreasing racial bias in the child welfare system
- Expanding preventive services and funding including tribal and migrant populations

In addition to CAPTA, Dr Schrier recently introduced bipartisan legislation to combat vaccine misinformation and hesitancy. This bill, called VACCINES (Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety) will authorize the following:

- Federal funding for CDC to establish a national vaccine rate surveillance system
- Funding for CDC to conduct research on vaccine hesitancy
- Establishment of a public awareness media campaign to disseminate information on the importance of vaccines

With measles cases in the US now totaling over 1000 passage of this legislation is crucial to protect our children from preventable and serious infectious diseases.

In addition to the initiatives being promoted by our “doctor in the house” there is also great excitement about legislation passed last year that will revolutionize foster care management. Family First Prevention Services Act is a federally funded program that will shift the funding from foster care homes to preventive services. Funds in this legislation can be used for evidence - based programs that will prevent children from having to be placed in foster homes by providing money to their parents and caregivers for mental health counseling, substance abuse services, home visiting and any other supports that would allow the child to remain in the home. States have to come up with matching funds and virtually all states are developing coalitions to plan for implementation. Please see the information on Family First by following the link below. This summer's district meetings are having a major discussion on state by state plans for Families First implementation.


Although gun safety, decreasing insurance coverage for kids and the prevalence of E-cigarettes continue to be challenging issues, the “doctor in the house” who is standing up for kids and the new Family First legislation that stands to revolutionize out of home care give us hope that as pediatricians we have made great strides in promoting optimal health for our patients.
Most of us senior pediatricians have led interesting lives. Some of us lived during the Great Depression and many of us during World War II. Quite a few had military service. Both sides of my family have records and anecdotes regarding my grandparents and aunts and uncles. Some of you undoubtedly have extensive genealogical data. When I reminisced about my parents, I realized that there were significant gaps. During World War I my dad was in the Royal Flying Corps in Canada, but I don't know any details - where was he stationed, was he a mechanic, a pilot, or what? I wished he had told me more. I also realized that our 4 children and especially our 9 grandchildren can't really relate to life during the Depression or World War II. Life without smart phones, GPS and Facebook can be a mystery. So, I wrote a family history for them. Its title, “My Stories” was hardly original. This took me several weeks. and took up 2 dozen pages the size of this article. I fact checked as much as I could. Google was quite helpful when referring to historical events. My children corrected some family details.

My grandparents and their children all grew up in the Toronto area, mainly on farms. After WW I my father went to medical school and entered general practice near Toronto. I was educated and trained in the Toronto area, with some residency training in Detroit and Minneapolis. In 1959 there were no appropriate openings in Canada for a pediatric cardiologist. I accepted a pediatric faculty position in the almost new 4-year University of Mississippi School of Medicine in Jackson, where I spent my professional career. We lived through the integration years in Mississippi. More than names, places and dates I wanted my family to understand more about life “back then”. For instance, about life in the ‘30s, I wrote “Dad charged $2 per office visit, $3 for house calls. Dad was sometimes paid in eggs or tomatoes, and mother fed us for about $5 a week. We had an ice box instead of a refrigerator, milk and bread were delivered by horse cart, our furnace burned coal and we heated with metal radiators circulating hot water.

Our laundry dried on a clothesline, which was a problem because we lived 1½ blocks from the railroad tracks and soot from the steam locomotives dirtied our sheets.”

I emailed “My Stories” to my children, grandchildren, my sister, and later to some more peripheral connections. They have enjoyed and appreciated this family background and related information. Perhaps your family might love to read your stories.

“Was This Life Worthwhile?”

Joseph R. Hageman, MD, FAAP

I was listening to National Public Radio (NPR) the other day as I was driving to University of Chicago and heard an interesting interview with an author of young adult novels, John Green by Terry Gross (‘Fresh Air’). Green talked about writing a book ‘The Fault in Our Stars’ which was about two teenagers with cancer, and he talked about a good friend who he thought the world of when he was a teenager who passed away with cancer. He emphasized that even though her life was short, she did her best to make it worthwhile.

I am now a clinically retired pediatrician who had the privilege of caring for infants and children for about 35 years. John Green stated the concern about whether a child who passes away from a critical or chronic illness can have a life that is worthwhile. I have vivid memories of remarkable babies, children and adolescents whose lives ended prematurely and, from my viewpoint, had lives that were definitely worthwhile.

A few examples follow:

1) He was a premature infant who had a long, complicated course in the neonatal intensive care unit (NICU) with

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multiple chronic problems including chronic lung disease and an intraventricular hemorrhage. He never got off of ventilator support and every time he seemed to make some progress which made all of us happy, he would have another setback. On the day his lung disease became more severe and he passed away at about 5 months of age, his family and all of his caretakers were deeply affected. I still remember when we had conversations about his ongoing problems, his family said, “He is our son and is an important part of our family.” He never got a chance to go home from the NICU and yet I think it is clear that his life was worthwhile for his family and I still remember him although this was over 20 years ago.

2) She was about 7 years old when she died with severe lung disease from Cystic Fibrosis which she had battled since infancy. In fact, she was waiting for a lung transplant at the time. I helped care for her intermittently when she was in the hospital and she always struck me a vibrant and sensitive young girl with very involved and dedicated parents. After she passed away, I decided to attend the service for her, which I generally had not done over the years. The auditorium was packed with family, friends from her school and church and the celebration of her life was amazing. I learned more about her as she had been writing a blog and had many friends during her “short life”. Again, I came to the conclusion that, although her life was too short, she had a significant impact and I think made the most of her time on this earth. Would you say she had a worthwhile life?

3) She was about 8 years old when I was involved in her clinical care. She had a malignant tumor and went through a long-complicated hospital course before she passed away. This was about 40 years ago but I still remember her and her clinical problems and also remember her Mother and the challenges they faced in dealing with her illness. I will never forget her, and I have thought about what she had to endure at times when I think about my chronic pain and challenges. She gave me strength to carry on after my cardiac arrest and bypass surgery and now with my cervical dystonia.

The impact that these children's' lives had on their families, their caretakers and on their community, is remarkable. I think John Green’s question is important and thoughtful and something we as parents, caretakers and medical providers should always keep in mind when we are dealing with the death of infants, children, adolescents and young adults. The criteria we use to decide whether children’s' lives, and for that matter, or own lives are worthwhile are relative and should be individualized on a case by case basis.

(By the way, I asked my wife Sally to review this and she was familiar with John Green's book. She is a nurse and cares for children with cancer and said she heard about his book from her nursing colleagues and that many of the youngsters with cancer they care for are reading or have read his book.)

References:

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**After Forty-three Years**

*Louis Borgenicht, MD, FAAP*

After forty-three years of solo pediatric practice I retired at the age of seventy-five. Looking back on my career, I realized that some of the most compelling and intense experiences had to do with patients’ deaths.

I have spoken at two patients’ funerals. One was a death resulting from a defective electric coffee maker which initiated a fire. At the time poet Mark Strand was on the faculty at the University of Utah, and I asked him to give me a poem that would be suitable to read at the funeral. As I recall he suggested a Rilke poem. The other funeral involved a sudden infant death. My job was to explain the inexplicable. I tried to talk about the issue of uncertainty as part of pediatric life.

Perhaps the most life changing experience involved the death of a five-year-old from neuroblastoma. The family were friends who lived a few blocks from my house. I spent most of his last two days at their house interpreting the end of his life for the family. In reality, I did not do much from a strictly medical standpoint. I was merely a presence and offered

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nothing I had learned to do in medical school.

After my retirement I took a course on palliative care at the University of Utah. A few months ago, I worked with the pastor at Primary Children's Hospital. We co-facilitated a series of sessions for fathers who had lost a child. There were three two-hour sessions and the discussions were wide ranging. One father had lost a teenager in a motor vehicle accident; another lost a child as a result of a failed heart transplant, and another lost a child as a result of drowning. The interesting thing about the experience was that all eight men were uniform in their belief that the discussions created an environment that felt “safe”. In general, they did not talk to their wives and were put off by well-meaning friends or relatives who told them “I know how you feel.” The reality was that the only ones who felt their loss were others who had lost child.

It is likely that next phase of my pediatric career will include end of life issues; it is a way of feeling connected with patients in a deep and meaningful way.

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**Global Health Issues**

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

Part 1

by Robert Lerer, MD, FAAP

My parents, both European-trained dentists, moved to Cuba in 1946. Dad was very successful in his practice, attracting many international clients. I was educated through the tenth grade in Havana and lived through the turbulent years of civil war. We left two years after the triumph of the communist revolution. I was 15.

After finishing college in Birmingham in 1966, I was the first Cuban American refugee accepted to John's Hopkins Medical School and I had only been in the United States for five years. I completed my pediatric residency at Yale in 1973 and moved to the Cincinnati area after joining an existing pediatric group with affiliation to Cincinnati Children's Hospital. For the next two decades, I concentrated on serving my community as a general and developmental pediatrician and growing the practice. I was content and busy but being generally aware of the huge health needs in poorer or developing countries, I yearned to engage in professional activities that would bring help to the sick and needy outside my community and our great country.

In 1992, I was invited to join a faculty team of short-term medical missionaries headed to Nicaragua. Our mission was to teach the AAP Neonatal Resuscitation Course in three hospitals. We attracted hundreds of professors, residents, students and nurses. I returned, over the next few years, and it was clear that our teaching had improved the quality of newborn care resulting in lower mortality rates. I was hooked! In subsequent years, I led a number of faculty exchange trips through a local faith-based NGO, Caring Partners International, to do public health projects and general medical teaching in India, Mexico, and the People's Republic of China. During my last medical mission to Nicaragua, a pediatric colleague who was Vice President of the Medical School in the western city of Leon, and who had spent time practicing medicine in Cuba urged me to return to Cuba and conduct similar programs as those our teams taught in Nicaragua. With the assistance of the government's Ministry of Public Health, I returned to Cuba in 1996 and organized a faculty exchange in 1997. Since then, I have led over fifty faculty exchanges to all eight university hospitals in western Cuba, and, have become very familiar with Cuba's health care system.

The health care system of Cuba is divided into primary care medicine, practiced at the community level by family doctors only. Any consultations needed are referred to multispecialty clinics where OBGYNs, pediatricians, internists and other medical and surgical specialists see out-patients. Health facilities are conveniently located and accessible to all Cubans. All health care is free. Medicines are priced by the state at minimal cost but are not free.

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Hospitals are described as teaching (tertiary) hospitals and small community level I or low-level II hospitals (according to our classification). The Communist party enacted laws in the early 1960s requiring involuntary relocation of physicians and dentists and nurses from their hometowns to work far away, in areas of shortages. This was very unpopular and done against the will of many doctors. Now, medical students are selected by passing an entrance exam, and are trained in their respective home provinces and by law are generally required to stay there for life. Free migration inside Cuba does not exist. Special permission from the government is required to move. Massive expansion in the number of medical and nursing schools followed. By the 1990s, Cuba was training more doctors per capita than anywhere else in the world in more than a dozen schools of medicine. With an excess of health care personnel trained, doctors became a tradable commodity. Today, the export of health services is the number one item in Cuba’s gross domestic product. Medical education begins after high school. The government health authorities use strict control of the country’s approved medicines in its pharmacopeia. There are frequent and chronic shortages of instrumentation, equipment, and tools of all types…. TO BE CONTINUTED IN THE FALL ISSUE

Cincinnatus: Lessons on Life Down thru the Ages

John McCarthy, MD, FAAP

When Lucius Quinctius Cincinnatus (519-430 BC) a humble Roman farmer repeatedly put down his hoe to assume the reins of power in the Roman Empire to lead the victory over a potent enemy, and then quickly relinquish this power to return to his humble agrarian roots, he unwittingly became a legend both in his own time and thru the ages. His qualities of humility, courage, leadership, and lack of lust for power, impressed his citizens.

Fast forward to the American Revolution when General George Washington, Commander in Chief of the Continental Army defeated the British at Yorktown, Virginia on October 12, 1781, and secured independence for the American Colonies. Emulating Cincinnatus, Washington at the height of his power, chose to promptly resign his commission and return to Mount Vernon as a citizen landowner and farmer. King George III of England, upon learning of General Washington’s bold action to relinquish power, exclaimed, “If he did that, he will be the greatest man in the world!”

As the 13 original colonies struggled to create a viable United States of America, George Washington again “stepped up to the plate” to become its first President. After serving for two 4-year terms, again he decided to step down and retire to his farm.

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In his “Farewell Address”, he warned against becoming entrenched in political office, ignoring the citizens you serve and making entangling alliances with other governments. He thus became the American Cincinnatus.

When I grew up in the Bronx during the 50s and 60s, history became one of my favorite subjects and the lessons of Cincinnatus and Washington seeped into my soul. Becoming a physician, I embraced service NOT power. As a resident of Honolulu, Hawaii during the 1980s, I took a “bite of the apple” and chose to run for office as an At Large member of the Hawaii Kai Neighborhood Board, a non-paying position.

Each community in Honolulu formed their own Neighborhood Board of its residents to be elected for a 2-year term to advise the Mayor of Honolulu about important issues affecting their district. My specific concern: how to improve the poor emergency ambulance service in Hawaii Kai.

I paid a small registration fee to become a candidate and wrote a one-page summary of why I wanted to serve on the Hawaii Kai Neighborhood Board. Without further campaign expenses, I won narrowly defeating an incumbent, a prominent lawyer. Although there were no term limits, I had already planned to serve a maximum of two terms and then voluntarily step down. Shades of Cincinnatus and Washington.

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During my tenure, I was joined by another member of the board, a Family Practice Physician equally concerned about the appalling emergency ambulance service to our community which had no ambulance-based services in Hawaii Kai which included Hanauma Bay, a popular snorkeling area. Every ambulance called into Hawaii Kai needed to come from another community, through heavy traffic, slowing the response time and seriously impacting outcome. We were stunned to find that this slow emergency ambulance service had resulted in several deaths. Most prominent among these casualties was my colleague and mentor during my Pediatric Residency, who ironically had moved to Honolulu for health reasons. While visiting Hanauma Bay to snorkel with physician friends, he had a heart attack and cardiac arrest, requiring immediate CPR, which was administered by his colleagues. Unfortunately, it took at least 30 minutes or more before the Ambulance finally arrived. ACLS was too late as they transported the now comatose Physician to the nearest hospital, where he died within 48 hours, never regaining consciousness. We wondered if the immediately rendered Basic Life Support had been quickly followed by ACLS, there might have been a different outcome.

This tragic case became our “icing on the cake”. We met with the Mayor to discuss the poor ambulance service to our community who expressed both shock and concern. Our meeting generated much helpful media coverage and ultimately resulted in Hawaii Kai finally getting its own EMS led ambulance service shortly after I had finished 4 years on the Board.

As I reflected on my Neighborhood Board experience, I observed how several of our members became entrenched in office and had formed what I would characterize as “entangling alliances” with local developers pushing for development that would quickly outstrip our resources. These members had seemingly forgotten the needs of the residents they swore to serve. Sound familiar? Was I experiencing the seduction of power that Washington warned against?

My eye-opening brush with elected office re-enforced my admiration for those two great men who taught me the importance of service over power. I am happy to report that I am retired- busy running our humble garden with hoe in hand. One never knows, however, when the next call for service might come!

References:


Did You Know?

Online Security
Tom Whalen, MD, FAAP

In 2018, adults aged 60 or more lost $649.2 million in Internet scams.1 We in the Senior Section live in the demographic that has a bull's eye on it for thieves across the globe. Cybercrime has become so common that the Federal Bureau of Investigation has a separate web site to report such occurrences.ii

Many techniques are used, but even those in place for years are still bilking the unsuspected for money. Who among us has not received an email from an unknown address purporting to be an international citizen who “needs” to have millions of dollars transferred to our accounts if we only supply the means to access that account? Such schemes still amount to over $700,000 per year to the nefarious requesters.iii

Why are we targeted? In part, it is Sutton's Law. When Willie Sutton was asked why he robbed banks, he answered “That's where the money is!” Many of us are fortunate to have accumulated wealth over decades of hard work. Additionally, many of us following decades of a loving relationship are widowed and are lonely. This can lead to the most reprehensible of cybercriminal's actions: imitating an online love interest and asking for money once trust is gained.v Other attributes among boomers that can lead to increased susceptibility include insecurity, faltering cognition, a trusting nature, and embarrassment after having been deceived.vi

We are in a digital age and retiring to the woods without online access is not a realistic technique to avoid these crimes. That said, there are some relatively simple measures that one can take to minimize risk:

1. Use strong passwords and change them regularly. If we are blessed with grandkids, we may sometimes take a moment to remember their names. It is much harder to remember complex passwords. Incredibly, the top four passwords in use are:
   a. 123456
   b. 123456789
   c. Qwerty
   d. Password

   There are at least two solutions. One is to use a password manager. There are several available. The concept is to have all of your passwords available on a secure, remote server in the cloud. You need only the one master password to access the stored passwords. Most products also will generate random passwords for sites. They cost a modest ongoing amount to use. Alternatively, use a combination of dates and words or names that are familiar but only to you or perhaps your loved ones. As an example, if you married in Atlanta on May 23, 1975, you could use 052375Atlanta. Add a common character at the end such as % or #.

2. Whenever offered, use two-factor authentication (2FA). This means that you will still enter your account name and password, but the remote web site, such as your bank, will then send a numeric code to your cell phone and you must enter that code. While anyone could access the site with your name and password, only you will have your phone for that numeric code. This technique is essential for your financial institutions. If the remote site does not offer 2FA, you can engage other services to have it apply to as many sites as you wish.

3. NEVER click on a web link on any email or web site unless you completely trust the source.

4. Perhaps most important of all, if it sounds too good to be true, it almost certainly is. The corollary to this is if it seems suspicious, be wary. A handy site to check authenticity is SNOPES.ix Copy the email text that seems suspicious and insert it into the top search bar.

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Online Security  Continued from Page 17

5. The Internet has transformed our access to the world. Scams have existed since the dawn of time, and Proverbs cautioned us to “Be very careful.”


6 Ibid.


9 https://www.snopes.com/

The Electronic Medical Record: Good or MEH* for Patient Care?

*MEH: An expression of indifference or disappointment

Catherine DeAngelis, MD, MPH, FAAP

In 2009 the Health Information Technology for Economic and Clinical Health (HITECH) was enacted under Title XIII as part of the American Recovery and Reinvestment Act. HITECH (indeed!) authorized incentive payments through the Centers for Medicare and Medicaid Services for clinical professionals and hospitals using Electronic Health Records (EHR) to achieve specific improvements in health care delivery. A large percentage of the $31.2 billion allocated for this bill was for promoting and expanding the adoption of EHRs, making available up to $44,000 for each professional clinician (primarily doctors) who displayed meaningful use of the EHR. There are also financial penalties written into the law for those who do not meet the requirement.

By 2015 $37 billion had been spent for EHRs with over 1,000 vendors, although only a few vendors currently provide the bulk of EHRs. The one thing that has been accomplished very well by these vendors and the EHR is rapid and effective billing of a patient or insurance company. Whether or not they have assisted doctors with the care of their patients is another matter, depending on who is asked, where they work and how they use the EHRs.

Up until 2005 about 90% of doctors entered information into patients’ records by hand. By 2017, approximately 87% of office-based doctors adopted EHRs, but about half of them only recorded patient’s demographic data omitting any clinical information. Clearly, this did not meet the criteria of meaningful use.

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For the first time in recorded history, in 2017 more than half of doctors worked for hospitals or other institutions rather than private practice. Many, if not most, left private practice because they were required to spend endless hours completing paperwork for insurance companies. That would not necessarily be the case for employed doctors, but the vast majority are required to complete EHR records. Does this mean trading one time-consuming chore (insurance forms) for another (completing EHR forms), and, if so, is it worth the effort? EHRs have great potential to improve patient care and allow doctors to have an easy and effective way to follow their patients. However, the fulfillment of this promise has yet to be fully achieved for all or even most doctors.

No doctor wants anything to come between her and her patients, but can the EHR make caring for patients more efficient and effective without doing so? In cases where the EHRs work well, doctors can enter the data required on the EHR form one time (the first visit) and then for that visit and follow ups, she can record the information for the visit, easily order tests, receive rapid results, order consultations, have computer-based interactions with patients, and patients can have easy access to their results and their doctors. Ideally, the recording of this information is done when the patient is with the doctor.

While this takes time, the patient can participate in what is recorded. This requires that the patient and doctor each can see the computer monitor. In this case, the computer does not come between the doctor and the patient.

Unfortunately, this scenario does not occur in many or perhaps most cases and results in doctors having a frustrating or negative experience with EHRs. In one of those frustrating cases, the doctor is rushed and must record the information after visiting hours, thereby adding extra hours to an already long day. Because the patient had been seen hours before, these recordings are often incomplete or take more time in recall. In addition, this potentially positive interaction between doctor and patient doesn't occur. In another negative situation, the computer is situated in the room so that the doctor is forced to face the computer rather than the patient, resulting in the EHR computer coming between the doctor and the patient.

Having experienced each of these scenarios as a doctor and as a patient, I have no doubt that the EHR, when used properly, can improve health care delivery and add significantly to patient care and satisfaction by doctors. However, until the persons in charge of choosing the right EHR vendor, of placing the computers in rooms where patients are cared for, and of setting the time allotted for each patient visit, this will never happen. If those three criteria were made by real doctors who care about patients and not only the bottom line, the EHRs would be all the positive things they're supposed to be. ... I can dream, can't I?

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**Movie Reviews**

**Summer 2019 Movie Reviews**

*Lucy Crain, MD, MPH, FAAP*

**RED JOAN:**
Starring Dame Judi Dench as Joan Stanley, an octogenarian whose memories are stretched to their limits (aided by flashbacks starring her young self-played by Sophie Cookson) when she is arrested and charged with being a traitor in her 80s and charged with spying during wartime in her youth. Based on the 2013 novel by Jennie Rooney of the true story of British spy Melita Norwood, the story relating her long life evolves gradually with her early years as an outstanding chemistry major in the late 1930s. At Cambridge, she meets the glamorous Sonya (Tereza Srbova) and handsome Leo (Tom Hughes as a Russian student/spy with whom she's infatuated) and then falls in love with her professor. Documents found after the professor's death confirm that he was a Russian spy with access to top secret information including work on development of the atomic bomb at the time he hired Joan to work with him. How remarkably naïve Joan came to have access to these secret documents and to their sharing with Russia makes an interesting plot. The plodding along of the story is unfortunate and perhaps due to the director (British theatre director Trevor Nunn) and screenplay writer Lindsay Shapiro. Despite the stodgy at times unraveling of the potentially exciting story, it's worthwhile watching the great acting and excellent cinematography. 2019 spring release, 110 minutes, R rating (for “tasteful” sex scenes)
AMAZING GRACE:
AMAZING GRACE is a concert movie, a collection of 1972 gospel music sung by a young Aretha Franklin, “the queen of soul”. The concerts were filmed originally by Warner Brothers for a television special accompanying release of one of her first albums. Apparently, the video recordings were kept by her family and not released until December 2018 for the movie. This film of two evenings of Aretha singing with all of her might songs with which she grew up in her minister father's Baptist church is a treasure trove of heartfelt American soul music history.

There are many shots of the audience, including a young Mick Jagger raptly entranced by the music. A brief few words from Reverend Franklin and powerful singing by a Southern California gospel choir accompanying Ms. Franklin comprise the film which was edited and condensed into 90 minutes. Rated G

POKEMON DETECTIVE PIKACHU:
(A children's movie for the summer and not one which I have personally seen. I was fortunate to enlist an interview with one of my favorite movie reviewers.)

-Interview with 8- year old movie critic Hugo Crain

Q: Did you enjoy the Detective Pikachu movie, and can you tell me what it is about?
A: It’s about a kid who is trying to find his dad who has disappeared, and he thinks that a mean Pokémon character Mew two has killed him.

Q: What makes him think that?
A: He goes to his dad’s house and finds a girl reporter along with Detective Pikachu. They are also looking for his dad and suspect Mew two. Detective Pikachu is a Pokémon character who always wears a Sherlock Holmes hat, so you know he’s a good detective.

Q: Does the movie contain much violence or scary parts?
A: There are no scary parts, but there are some bad guys in it.

Q. Is there any nasty language or bad words or drinking or smoking?
A: No. It has lots of action and has a good surprise ending.

Q: Would you recommend it for other 8-year olds?... Or older kids?
A: Yes, especially if they like Pokémon characters. My 13-year-old brother saw the movie, too, and he really liked it. He's been collecting Pokémon cards for a long time.

Q: What about your dad? Did he like it?
A: He would have liked it better if he knew the Pokémon characters as well as my brother and I do, but he said it was okay.

(PG) 104 minutes. Initial release May 2019 in Japan and based on the 2016 video game Detective Pikachu.
**Book Review**

*by Emanuel Doyne, MD, FAAP*

*Nemesis*

*by Philip Roth*

*Houghton Mifflin Harcourt 2010, 280 pages*

A fellow retired pediatrician lent me this book because he knew of my interest in the development of the polio vaccines and the Salk/Sabin battle. We both were born in the 40's and remember the days pre- and post-polio vaccine (I got the Salk vaccine at school in 1955 and the Sabin vaccine in 1962). Until Enders cultured the poliovirus in vitro in 1949 there was much frantic speculation about the actual cause of this frightening disease.

This novel is set in 1943 during the author's 10th year of life growing up in Newark, New Jersey (and was a fan of his New Jersey neighbor, Bruce Springsteen and vice versa- Wikipedia). Roth, a Pulitzer Prize winner, is known for approaching many untraditional and even controversial subjects but this novel captures a bygone time when the major terror threats were fear of polio (and German U-boats). Needless to say, this novel is more timely now than ever, particularly for those anti vaccine folks who are ignoring our history with infectious diseases which are no longer a major threat- whether it be tetanus, measles or of course polio. With the 1955 release of Salk's vaccine families could now sleep better at night knowing what caused polio and that a vaccine now existed to prevent it.

The protagonist, Bucky Cantor, was the only young man still in his neighborhood due to World War II and his 4-F status because of his poor vision (interestingly Roth suffered a back injury in basic training and was declared 4-F) and thus was the “big brother” to all of the young boys who populated the playground he supervised. Thus, as many of his charges became ill, including some who succumbed to polio, he became emotionally involved after visiting many parents and attending multiple funerals. He was often illogically blamed for these tragedies which took a terrible toll on him. Multiple causation theories flourished: stray cats; mosquitoes; getting overheated or chilled or dehydrated; poor hygiene; Italians, Jews etc. The author submerges the reader into this man's angst and as the book progresses you definitely get caught up in a real emotional roller coaster that involves Bucky's girlfriend, grandmother, neighbors etc.

For those unaware of the stressors of those times this would be a great learning experience to vicariously re-live the pre-vaccine world as we lived it as kids (the “Nemesis”) and the true national and international exhilaration that occurred when Salk’s “miracle” came to fruition. (Note: This was Roth's last published work before he died in 2018.)

**References:**

WILL Brown, 79 yrs native Kansan Heartlander, physician (Pediatrics and Adolescent Medicine), Viet Nam veteran, father/grandfather, volunteer medical school faculty member, political advocate and activist, retired in Honolulu with my partner of thirteen years, DOUG Gibson, himself a former elementary special education teacher.

My school safety and gun control history:

2/14/18 was my daughter's 45th birthday. I grieved at the tragedy/loss at Marjorie Stillman Douglass, while proudly celebrating Amanda's birthday here, several thousand miles distant at her home on the mainland.

3/14/18 Doug and I participated in our nearby 'Ioani High School Remembrance and lei ceremony. We strongly support the continued, courageous response of so many MSD students and staff.

4/10/18 I joined 400 American Academy of Pediatrics (AAP) colleagues from all 50 states, the District of Columbia and Puerto Rico meeting with our elected Congressional representatives and their staff to discuss school safety and gun control.

6/14/18 I spoke at our weekly pediatric departmental conference at Kai 'olani Medical Center for Women and Children on this topic, emphasizing that when our grandson, Charlie (to be 5 yrs 11/1/19) enters school, he and his mother, a teacher/coach, will N O T be targets of an onsite active shooter...ENOUGH!

In the past thirty-five years, I have personally and professionally been involved in a patient/family murder/suicide in Little Rock, Columbine, Sandy Hook, Charleston, San Bernardino, Orlando, Las Vegas, Parkland...and news of all those in between...E N O U G H!

Barack Obama: “Actively doing nothing is a decision” ...one I am unwilling to make. Currently, family, friends and colleagues are organizing on site high school and college campus eligible voter registration prior to the 2020 election. I write to a contact list exceeding 300, speak up and out, converse, attend town hall meetings, peacefully demonstrate, vote, promote voter registration/get-out-the-vote and strongly request others to do likewise.

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

I'm 207 lbs of stubborn ounces. There are 67,000 members of the AAP whose stubborn ounces are at your side and we have your back. You are NOT alone.

It is imperative to elect political leaders in 2020 who can unify our democracy to solve some of the major pressing problems which threaten our children, our nation and indeed the world. These problems include global warming, unequal justice for minority and/or poor offenders, gun violence, the loss of trust in and respect for many institutions, the lack of honesty, fair play, common sense, empathy, and personal integrity in government and more broadly. The health and character of our democracy is especially important for the future wellbeing of our children, young adults and indeed all of us.

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Don't be stupid, it still is the economy, but with a twist. Indeed, the economy seems to be booming for many. However, there is deep-seated anger not just with the profound and generally undeserved disparities in the standard of living between the hard-working population who make up the vast majority of individuals and the wealthiest individuals. It is becoming more and more difficult for many hard-working families, even those with two full time jobs, to: access high quality, affordable health care and appropriate housing; cope with higher and higher taxes; pay for college for their children; and the increasing costs of food.

An important part of the economic discussion is NOT replacing capitalism with “socialism” but the regulation of the ability of unfettered capitalistic greed to interfere with the basic quality of life for the majority.

This above noted anger has profoundly and dangerously eroded trust in institutions especially the government, the police and criminal justice system, the banks and financial system, etc. Our politicians seem to have lost touch with the majority of people instead sacrificing their integrity for political expediency or a “donation”.

What is needed includes funding to educate those members of society who cannot afford it at present, up through college and vocational training; to bring the national infrastructure up to date; to provide universal quality health care; and to maintain a well-functioning social security system. This will require cutting government waste, realistic military expenditures, and sharing financial responsibility for disaster and foreign aid with all the developed nations of the world. The very wealthy individuals will need to step up to the plate and shoulder a bigger financial tax burden. Loopholes in the tax code used by profitable industries and wealthy individuals to avoid paying their share should be closed. Finally, a bigger share of business profits should reward the productivity of all workers in terms of salaries and quality of life benefits.

In order to win the presidency, the successful politician must exude honesty, fairness, charisma, experience, intelligence, and a sense of humor. They should avoid intolerance and personal depreciation of others. This successful individual will need to be able to suggest specific, well thought out, and practical solutions to our problems while avoiding generalizations and platitudes. These characteristics could be an important model for our children and adolescents.

One of the most difficult issues with which the winning candidate will need to deal is immigration. First, the immigrant population, especially the undocumented immigrants, is largely perceived as non-white. In the face of the stunning growth of the non-white population in this country, due to both immigration and to the higher birth rate of children to individuals after they enter the US, many white citizens already here fear that they will become the minority, with its potential massive political, economic, and social implications. Specifically, that they will lose political clout, jobs, and status. Politicians must reassure this fearful population that they will not be financially or politically harmed with the passage of sensible immigration policies.

The winning candidate will need to reassure the voters that government and capitalism can be made to work and that all of the above can be accomplished with the support, dedication, and sense of purpose of our political leaders working together, not only for the present but also to insure a better future for our children.

**Letter to the Editor**

*Harry Laws, MD, FAAP*

I loved Dr. McCarthy’s story in the “Long term follow up of a Child’s Birth”. I hope others like me who have similar stories will chime in.

Mine begins in my military career as well when I was stationed in the Philippines. A female child was born with a congenital heart disorder elsewhere in the country to American missionaries. Through some influential US friends, they were able to get State Department and Department of Defense permission for the child to use our Air Evacuation system for transport back to a state-side cardiac surgeon for repair. The child was stable, but due to the changing cardiac dynamics our neonatologists decided a physician should accompany the baby back to the states, and I was volunteered. It was a 24-hour journey, but the child did well and was delivered to the cardiac team with resultant corrective surgery in a day or so.

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My part in that was basically nothing, but the state legislators were prompted (by the family’s friend) to give me a citation and a copy of the local paper that chronicled the event. Back to work it was and although it was one of many events that I was honored to take part in, I thought not much more of it. Almost 30 years later, after two more military moves, three career and geographic moves (Pharma, IT and administration), I finally moved once more to be closer to grandkids and settled back into a part time clinical setting. During this last move, as we were downsizing all the ‘stuff’ we seemed to accumulate, I found that old citation. It did not take long on Google to find the address of a local retired legislator who responded to my letter of thank you and perhaps a follow up. Not only did the baby survive, but she is married, has two children and lived 40 minutes from my new home! Yes, I wrote to her. Yes, she knew the story. Yes, we met at a Starbucks and had a nice chat, closing the loop for both of us.

It is rare that military members ever get any long term follow up of their patients... makes for an interesting and challenging practice. But occasionally the stars align ... and in my case, another validation of the honor and privilege we have in taking care of children, a feeling that even in the longest of days, can be brightened by the smile of a child, a high five of a toddler, or any one of a number of things the elicit the phrase “I love my job” each and every day.

We are most lucky....

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**Finance**

**Retirement Readiness: What Adjustments Should You Make?**

*Jeff Witz, CFP®*

Physicians contemplating retirement within a few years need to understand the future risks of the financial situation they may be facing. People are living longer, which means you may have to provide for a bigger cushion in retirement than you initially intended. In addition, uncertainty over the future of Social Security benefits as Baby Boomers continue to retire adds to the concerns. As a result, you could face a personal shortfall, especially if you incur unforeseen expenses from a medical condition or some other situation.

So, what could/should you do? Even if retirement is imminent, you may be able to make up lost ground quickly or take other steps to protect yourself. Here are several ideas to consider:

- **Maximize retirement savings vehicles:** Just a few years of making contributions at or near the maximum level can significantly bolster your account. If you have any qualified retirement plans that you are not fully funding, determine if your cash flow will allow you to do so.

- **Work on the budget:** If a financial planning retirement needs analysis determines that you may have a potential shortfall, you might want to dial down your expectations. Make realistic estimates about the income you expect to have coming in and the expenses going out. Although you will likely be paying less for housing (see below) and other items such as life insurance, especially if your children are already adults, consider the impact of potential increases in some expenses such as travel expenditures.

- **Move to a smaller home or condo:** For most people, housing is the largest overall cost, representing more than one-third of overall spending on average. If your kids no longer live with you, but you’re still living in the large home where you raised them, it may be time to downsize. In addition, you might want to move to a state with a different climate, taking state income taxes into account. Of course, various other factors such as proximity to family and personal preferences will come into play.

- **Refinance your current home:** If you decide not to downsize, you should consider refinancing an existing mortgage if...
you are paying a rate higher than those currently available. Mortgage rates remain historically low. Even though rates have increased slightly, you may save tens of thousands of dollars over time by refinancing. Keep in mind that your interest payments will generally continue to be tax-deductible if you itemize.

• Do not stop working altogether: Just because you have reached retirement age does not mean you have to stop working completely. If needed, you could pursue part-time employment. For some individuals, working full-time a little longer is also a viable option.

• Every physician's situation is unique, but the most important thing to do is assess your financial planning objectives, which includes a review of your investment portfolio. Planning involves assumptions about the future; assumptions that may not pan out. Although you cannot avoid making assumptions, you can evaluate whether they are realistic and consider how your lifestyle might change if future economic and financial conditions are much different than projected. And while you cannot fully control the factors involved in portfolio endurance during retirement, having more wealth can improve the odds of having a less stressful financial life. A more substantial nest egg might enable you to take fewer risks, enjoy a higher sustainable spending rate, or extend the productive life of your portfolio.

4 Benefits of Giving Life Insurance

Helen Eubanks, AAP Development Staff

Many people overlook life insurance as a giving option, but it's an easy way to make a difference at the American Academy of Pediatrics (AAP). Gifts to the AAP fund a variety of different initiatives, such as gun safety, advocacy, disaster recovery, global child health, and much more. A gift of life insurance has the following four additional perks:

1. Cost-Efficient
Life insurance allows you to make a significant gift even if your means are limited today. By making small premium payments each year for a limited number of years, you can leave a gift of sizable proportions.

2. Tax-Beneficial
For an existing policy, you may receive a federal income tax charitable deduction. For a new policy, with AAP named as the owner and beneficiary, your premium payments may be deductible as charitable gifts.

3. Secure and Confidential
Your life insurance policy is a contract and therefore cannot be changed by your heirs. If you make AAP the owner and beneficiary of the policy now, it will not be included in your probate estate and therefore will remain confidential.

4. Helpful to Our Mission
Life insurance gives you the option to make a gift with an asset other than cash, helping you to make a bigger impact than you may have ever thought possible.

Life Insurance Policies You Can Give
A recently issued policy
An existing policy in premium-paying mode A paid-up life insurance policy

For more information, please contact Helen Eubanks, Strategic Gifts Officer, AAP Development Office, at (630) 626-6411 or heubanks@aap.org.

The information in this publication is not intended as legal or tax advice. For such advice, please consult an attorney or tax advisor. Figures cited in examples are for illustrative purposes only. References to tax rates include federal taxes only and are subject to change. State law may further impact your individual results.
2019 National Conference & Exhibition -
Senior Section H Program Agenda (New Orleans)

7776 - Section on Senior Members Program – Are you Informed?
Sunday, October 27, 2019
9:00 AM – 1:30 PM

Description – Senior Pediatricians will learn about recommended adult vaccines and immunizations which are especially crucial for people who have close contact with infants younger than 12 months of age, including parents, grandparents, and child-care providers. Listen and weigh in on the proposed immigration rules and issues around global health education and research efforts. Learn how pediatricians across the country speak up for children and how you can too. Whether you are new to advocacy or a seasoned advocate this session is for you!

9:00 AM - Welcome Philip Brunell, MD, FAAP

9:05 AM - Adult Vaccines - Maintaining Pediatrician wellness.
Carol J. Baker, MD FAAP

9:55 AM - Presentation of Section on Senior Members Donald Schiff, MD FAAP Child Advocacy Award

10:10 AM – Why Advocacy is important! What can pediatricians do to speak up for children and advocate for families separated at the border.
David Clark, MD FAAP

11:00 AM - Break

11:15 AM – Principles of Global Child Health – hear about approaches aimed at changing the health status of children, their families and communities through effective models of research and education.
Danielle Laraque-Arena, MD FAAP

12:05 PM - Section business meeting and refreshments

1:30 PM - Adjourn

Suggestions Wanted

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

Member Stories

Check out how members are engaging with the AAP and what inspires them to stay involved. Visit our AAP Get Involved page and click on the “Member Experiences Gallery” in the upper right to see their stories. And while you are there... share your own! We'd love to hear from you.
Guidelines for Senior Bulletin Articles
Lucy Crain, MD, MPH, FAAP Editor

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

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

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

Questions about articles contemplated or in progress can be directed to me at lucycrain@sbcglobal.net 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 Senior Bulletin Schedule

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The Best of the Bulletin: Look for New Content in the Fall Issue!

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

If clicking on “here” above doesn't work, here's the link:
https://collaborate.aap.org/SOSM/Pages/Newsletters.aspx?RootFolder=%2FSOSM%2FSenior%20Bulletin%20newsletters%2FBest%20of%20the%20Bulletin&FolderCTID=0x01200092B0E35AC51B54987ABFBA9168EDA4B4&View=1E73B-6D0E-0A89-40C7-B9EC-AA09A2DA0B09

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

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

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

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

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

Start Them Reading Early and They'll Enjoy Reading for The Rest of Their Lives!