

# SENIOR BULLETIN

## AAP Section on Senior Members

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### SOSM Chairperson's Column

*Renée R Jenkins-Woodard, MD, FAAP*

We can look back on some positive events, such as our National Conference and Exhibition program. Thanks to Jay and Tori, it went smoothly. Our presenters were thought-provoking and stimulated active discussion, which to me is the measure of a good presentation, getting the audience engaged. We added a new style of focusing on the business meeting by having an interview format featuring a section member who took a unique road in his later career journey. Whit Hall did an excellent job bringing out the steps in decision-making that senior career members face in his dialog with J. Gary Wheeler, MD, FAAP. Whit may turn out to be our Section “Terry Gross” for this project.

Lucy Crain accepted the Donald W. Schiff MD, FAAP Child Advocacy Award. She deferred to Lisa Chamberlain, one of her very successful mentees to give heartfelt remarks on Lucy’s advocacy work and her commitment to nurturing others in their advocacy journey.

We can look forward as we welcome and congratulate our new AAP Board of Directors members. Coming in as president-elect is, Susan J. Kressly, MD, FAAP of Florida. The new at-large members are Angela Ellison Chamberlain, MD, MSc, FAAP of Pennsylvania and Kristina W. Rosbe, MD, FAAP of California. We wish them much success in their new positions. As the New Year takes shape, the AAP articulates its focus for the coming year. The AAP Board of Directors has identified four strategic initiatives for 2024. <https://publications.aap.org/aapnews/news/pdfDownload/27270>

- Healthy Mental and Emotional Development,
- Environmental Health and Disaster Readiness,
- Equity, Diversity and Inclusion, and
- Safety and Wellbeing within the Pediatric Profession.

While the AAP has a broad agenda for children, each year the Board focuses more intently on several strategic initiatives to which the AAP will concentrate attention and resources.

The Section also directs its activities through an every-three-year strategic planning process. The objectives for the next three years are:

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**Advocacy & Communication:** Continue to expand opportunities for members of the Section to deepen their engagement in advocacy, both nationally and within their state chapters.

**Education & Resources:** Establish and/or strengthen the mentoring and educational opportunities for pediatric trainees, early career physicians, and mid-career physicians and provide opportunities for both virtual and in-person collaboration via SOSM programming and chapter initiatives.

**Member Value & Engagement:** Expand existing activities and create new opportunities to support Section members through late-career transitions.

The strategic process will continue through the formation of workgroups to develop action plans. You will see the workgroup membership invitation in this bulletin edition.

The four workgroups are:

1. **Advocacy Workgroup:** Focus on how to empower members through training and webinars, help determine the focus for the Section's yearly advocacy efforts, and encourage member involvement at Chapter levels.
2. **Career Transition and Mentoring Workgroup:** Focus on creating new opportunities to support Section members through late-career transitions and creating opportunities to expand the mentorship program to mid-career physicians.
3. **Member Engagement and Education Workgroup:** Focuses on creating promotional pieces explaining the benefits of being a section member, work on discovering ways to engage Chapters, and discover ways for SOSM to have more of a presence at the National Conference and Exhibition.
4. **Survey Workgroup:** Create a survey for the Section membership to better understand their needs at the different stages of their careers and their lives.

Through this workgroup process, the executive committee will promote inclusion and membership listening opportunities. We look forward to your participation.

And lastly, your appreciation and participation are more effective when they're part of your personal wellness plan for the New Year. Rather than a resolution checklist, invest your energy in a real plan. The AAP website has physician wellness resources for you to review to see what fits your career status, time and commitment. <https://bit.ly/3TKd10S>

Wishing you a revitalized Year of 2024 – Your SOSM Chair and Executive Committee!

## Section on Senior Members Executive Committee

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## Winter 2024 Editor's Note

*Gil Fuld, MD, FAAP*

*Editor, AAP SOSM Senior Bulletin*



January rings in a new year which promises to be a momentous one for all of us. I'm reminded of the apocryphal "Chinese curse", "May you live in interesting times." Several articles in this edition tackle issues relevant to our current interesting time.

Tom Whalen tells us how to stay safe in the digital age. Beryl Rosenstein discusses the difficulties of advocating for gun safety. Bill Marshall reminds us of the likely adverse effects due to the introduction of artificial intelligence into pediatrics. Linda Reid Chassiakos explains the need for respect and communication in patient encounters. Ed Marcuse eulogizes Abe Bergman, a lion of advocacy. The talks at the NCE's Senior Section program also illuminated fraught contemporary issues.

We also have Lynda Young's hopeful report from the AMA meeting, multiple interesting, informative, humorous, poignant, embarrassing, or mystical reflections; retirement activities; the usual movie reviews, a book review, and poetry.

The two sports articles personally resonate. John McCarthy continues his love affair with baseball, my favorite sport to play growing up, and Lou Borgenicht serenely golfs without practicing or keeping score. It's my favorite sport to play now, but I don't golf serenely. I'm intensely competitive, even though my abilities, never much to begin with, are annually eroding with age. Handicaps are my friend.

Read and enjoy the work of our regular contributors and the newcomers. Let us know what you know what you like or don't like. And why not write an article yourself?

# Member Involvement

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## THE SENIOR SECTION NEEDS YOUR HELP

To support and serve our members we're creating workgroups in these areas:

**Advocacy** - Focus on how to empower members through training and webinars, help determine the focus for the Section's yearly advocacy efforts and encourage member involvement at Chapter levels.

**Career Transition and Mentoring** - Focus on identifying new opportunities to support Section members through late career transitions and creating opportunities to expand the mentorship program to mid-career physicians.

**Member Engagement and Education** - Focus on creating promotional pieces explaining the benefits of being a section member, work on discovering ways to engage Chapters, and discover ways for SOSM to have more of a presence at the National Conference and Exhibitions.

**Survey** - Creating a survey for the Section membership to better understand their needs at the different stages of their career and their lives.

To apply or for more information [CLICK HERE](#) or contact Tori Davis by February 16th at [tdavis@aap.org](mailto:tdavis@aap.org).

# 2023 National Conference Recap

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At the Section business meeting during the 2023 NCE Lucy Crain received the Donald L. Schiff Child Advocacy Award. Here is Lisa Chamberlain's introduction.



*Lucy Crain receives Schiff Award from SOSM Chair Renée Jenkins*

## Donald F Schiff Child Advocacy Award – Lucy Crain

*Lisa Chamberlain, MD, MPH, FAAP*



Thank you Dr. Jenkins. I am very honored to introduce Dr. Lucy Crain on this very special occasion. Her distinguished career is synonymous with child advocacy. She is a remarkable individual who is a champion for all children, and especially children with special health care needs. In my brief remarks, I hope to bring to life the impact she has had on our field.

Lucy has mentored an entire generation of pediatricians – and I was fortunate to be one of those. As a fellow, I was ushered into “Lucy’s kitchen” which is where the magic happened. You see, Lucy would invite us to her lovely San Francisco home, warmly gathering us in. We would have monthly potluck dinners where we contributed what we could, and she would feed us her fabulous Kentucky cooking. Here over her kitchen counter, we would discuss the challenges that our patients faced, and she would teach us how to use our voice beyond the clinic walls – from school board meetings to Sacramento. This was in the days prior to advocacy training being a routine part of our peds training, so these conversations were novel and lit a fire in us all.

In addition to the didactic teaching in her home, she would drive carloads of us to Sacramento to do the work. She would hold a master class in child advocacy in that car during the two-hour drive up and then debrief us all during the drive home. Now, I had never done anything like this before, I had never even been to Sacramento before – and the next thing I know I’m roaming the halls with Dr. Crain, walking into legislators’ offices, putting her teaching into action. We were taught to be respectful to all, to listen, and to stand firm for our patients. Those trips changed my career – they showed me I belonged there and that the strong instinct that I had to fight for what was right for my patients was indeed a part of my job. I will never forget them.

Recently a group of us – now much older – returned to Lucy’s home for a potluck dinner to reflect on her amazing impact. We have grown into roles that include the president of the California Medical Association, a California assemblyman and senator, and the head of public health in a large California county, amongst others. The conversation brought her gifts to life – the themes that emerged are that Lucy is fearless and effective, she is a great doctor, and she is caring. Here I’ll share some meaningful outtakes:

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One mentee shared about her being fearless: “Lucy – I watched as you led with strength in a male-dominated world. You were often the only female – and if you noticed you didn’t show it. You gave me the courage to believe I could cross over; you helped me to believe I could do it too.”

Another person reflected that Dr. Crain is incredibly effective: “Fundamentally you stand for what is right. If something needs to be changed you bring people in, you build teams. You see the truth and you make it happen.” Another echoed this saying “Lucy just took the reins and led in California.” It was fun to learn what a great doc she is. One person shared: “Lucy is fabulous clinically. You cannot be a great advocate unless you are a great doctor. She is both and so much of how I practice came from her. She launched my career in many ways.”

Above all – Lucy is caring. This theme came up for us all. One colleague shared, “When I came to California from Boston you took me under your wing. You take us all in. You say “welcome” with your arms wide open and when you did that for me, I knew I had a home in California”.

From that kitchen counter we built the California Collaborative – uniting faculty across our 14 training programs, sharing curricula and building community pediatrics and advocacy rotations across our state. Together we train 800 pediatricians each year and have done so since 2007. We continue to advocate together in Sacramento annually – advancing the health for California’s kids. This statewide model has been adopted nationally – now in nine states. Today over half of all the training programs in the U.S. are united in a statewide collaborative, all working closely with their state AAP chapters. At this moment in time as our field faces many challenges – threats to science and to the well-being of our kids - the need for our solidarity has never been greater. Solidarity is never found – it must be built, and you showed us the way.

Lucy – thanks to your fearlessness, your effectiveness and your caring - what started at your kitchen counter is nothing less than a powerful movement for America’s kids. I cannot imagine anyone more deserving of this award. Please join me in congratulating Dr. Lucy Crain, this year’s Donald F Schiff Child Advocacy Award winner.



*Whit Hall interviews fellow Arkansas pediatrician Gary Wheeler about the work transitions he’s made during his career.*



*SOSM members Renée Jenkins and Karen Breach-Washington joined the AAP White Coat Rally for Child Health Advocacy*



*The slides for Walter Orenstein’s talk on polio [are available here](#)..*

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## Section on Senior Members Program - *Threats to Children's Health from Polio and Toxic Irradiation*

### **Pediatric Considerations for Radiological & Nuclear Events, Accidents, and Emergencies**

*Steven L. Simon, PhD, FHPS*

*National Cancer Institute, National Institutes of Health (ret.)*



This report briefly summarizes what I presented on Oct. 23, 2023, to the Senior Section at the AAP National Conference in Washington, DC. As a radiation physicist working in radiation epidemiology for the last 25 years, this is my interpretation of the issues important to pediatricians concerning radiological and nuclear events and accidents, and related exposures. I will emphasize environmental exposures that are almost always received without consent and sometimes without knowledge or understanding.

Readers should be aware of and peruse with some diligence two previous AAP publications (2003, 2018). These present many of my points in greater detail than I can in this short article.

#### **Radiation Risk**

Radiation risk is the concept that expresses the likelihood, i.e., the probability, of something unwanted happening to an individual (e.g., development of cancer) as a consequence of exposure. Our field, as in other specialties, uses data on the frequency of cancer development following exposure within a population of people of similar attributes and extrapolates from the observed frequency in the group to the individual level by redefining individual risk in terms of probability. There are hundreds of publications on radiation risks for specific exposures (see, for example, Simon et. al., 2023).

For most of the range of exposures, there is usually a clear linear relationship demonstrating an increase in risk with equal increases of exposure. What is important to know is that below a certain dose level, the data on cancer incidence is statistically unstable and some interpretations are necessary.

Many argue about what the true relationship is at very low dose levels, in the range, for example, of doses received from diagnostic x-ray imaging. Most, but not all, radiation health experts endorse the linear no-threshold hypothesis (LNT) which extrapolates the reliable data at somewhat higher doses to the intersection of zero dose and zero excess risk with a straight line. I endorse this concept as the best understanding we have given the limitations of our knowledge and I recommend you accept it as well. It forms the basis for radiation protection in the U.S. (Puskin 2009, Shore et al. 2018)

Age at time of exposure matters with children who are almost always more susceptible to radiation damage than adults. The reasons depend on biological mechanisms as well as behaviors. This is discussed more in the AAP statements.

#### **Basic Tenets of Radiation Protection**

The three most important principles to protect from the harmful effects of radiation are: (i) minimize the time of exposure (i.e., time near a radiation source), (ii) maximize the distance between the source of radiation emissions and the person potentially exposed, (iii) maximize the shielding between the source of radiation and the person potentially exposed. Shielding could be buildings, concrete, steel, lead, or any solid, dense material. These tenets apply equally to children as to adults.

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### **Defining Accidents**

Radiation incidents and accidents generally are unforeseen and unplanned releases of radioactive materials to the environment or unplanned exposures of people, usually, but not always, with a lack of intention.

The underlying causes vary tremendously and include poor judgment, engineering failures, and acts of nature and can even be extended to acts of political violence, i.e., radiological terrorism, designed to induce terror and inflict damage. Various technical definitions of incidents and accidents exist, usually based on the minimum radiation dose received.

### **Understanding Radiation Dose Units**

Radiation dose units are a confusing subject even for professionals, partially due to their technical definitions, but also to the changes in recent years from what were considered traditional units (e.g., roentgens, rads, rems) to the more modern and more widely accepted standardized (SI) units which are based on Gray (Gy) and Sievert (Sv) units. These are rather large units of dose so typically they are expressed as milliunits (mSv).

Some simple guideposts can give pediatricians a good sense of the magnitude of an exposure:

- Fractions of a mSv – typical doses received from transcontinental air travel, considered safe
- 1 mSv – typical ‘natural’ terrestrial radiation dose received in 1 year
- 2 to 4 mSv – typical ‘natural’ total natural radiation received in 1 year (including cosmic rays + radon)
- A few mSv – typical organ doses from CT exams or other medical imaging
- 50 mSv – annual occupational dose limit for workers in the US
- 1,000 mSv or more – can induce radiation sickness if the dose is received in a short time.
- Several thousand mSv or more – life-threatening.

### **Some Major Accidents and Radioactivity Releases**

Radiation accidents and unintended exposures result from several different types of activities including nuclear weapons testing, intentional nuclear detonations, nuclear reactor releases (accidental and intentional) such as occurred in the Chernobyl and Fukushima accidents, and the misuse of no longer needed radiation sources, often called “orphaned sources.”

Orphaned sources of Cesium-137, used for many years in radiotherapy machines (replaced today by accelerators) are sometimes discarded in developing countries resulting in serious and life-threatening exposures of people who unknowingly misuse the materials, either in the process of collecting scrap materials for recycling or for production of construction materials, e.g., rebar. Two notable accidents occurred in Goiania, Brazil in 1987 and in Taiwan in 1982.

### **Understanding Radioactive Iodine**

Iodine-131 (I-131) is but one isotope of about 37 known isotopes of iodine. All are chemically identical but differ in their atomic mass and all are radioactive except Iodine-127, which is a necessary nutrient for the human body.

The body, however, cannot discriminate between necessary I-127 and radioactive isotopes of iodine, making radioactive iodine that might be present in the environment or in foods a particular hazard.

Iodine is particularly soluble and once it enters the environment from a nuclear reactor release or from fallout originating from a nuclear detonation, it easily moves by rainfall into plants and can be subsequently found in cows’ milk due to contamination of pasture grasses. The pathway of exposure from radioactive fallout to children is well documented because of the cow-milk-man pathway and resulted in exposures across the U.S. during the 1960s when atmospheric nuclear testing took place.

The uptake of radioactive iodine into the thyroids of a person who may be exposed can be prevented by first saturating the thyroid gland with stable non-radioactive iodine by administering potassium iodide (KI) pills, a process usually called iodine prophylaxis. Dosages of KI are discussed in Yoshida et al. 2014. However, the window of opportunity to administer the KI is only within 24 hours of the expected exposure. Administration at later times serves no useful purpose. Furthermore, KI is not protective of any other radiation exposure.

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### **The “Elephant in the Room” of Radiation Protection**

My knowledge of possible exposures and negative health outcomes from accidents and releases of nuclear materials suggests that there is an elephant in the room of radiation protection today, i.e., a major problem that is present but avoided as a subject for discussion because it is not comfortable to do so. This elephant is the consequential radiation exposure that would result from the use of nuclear weapons in combat.

Today, with large-scale conflicts in Eastern Europe and the Middle East and with both conflicts sided by countries with nuclear weapon capabilities, an intentional nuclear exchange is possible. A scenario with potentially unfathomable consequence. Use of nuclear weapons could cause; immense physical and economic destruction and large numbers of fatalities; radiation exposures of large populations; and true global damage by inducing nuclear winter conditions resulting in mass starvation due to obscuration of sunlight from ash and debris released to the atmosphere. The severity of the conditions that would be induced by even a moderate usage of nuclear weapons in combat creates conditions for which I cannot offer any suggestions for individual protection, other than the simplest of guidelines already discussed.

Radiological terrorism might be thought of as the smaller and less dangerous sibling to nuclear combat. Terrorist actions could take the form of the IND (improvised nuclear device) – an amateur construction of a nuclear bomb, a dirty bomb (conventional explosives laced with radioactive materials), a targeted attack on civilian or military nuclear facilities resulting in releases of radioactive materials, hidden (clandestine) radioactive sources planted in areas of public gatherings, and radionuclide poisoning, for which only one case is on record. If such an event seems likely based on your observations, expertise should be sought from reliable authorities including experts at the U.S. national laboratories or REACT/S (Radiation Emergency Assistance Center/Training Site (REAC/TS) ([orau.gov](http://orau.gov))).

### **Looking Into the Crystal Ball for Radiation Protection Issues of the Future**

The science of radiation protection will need to continue to address numerous issues to ensure the safe use of radiation in our society. My ‘shortlist’ of issues that seem timely and important, and which will be particularly challenging:

- (1) future generations of nuclear power reactors and their safety,
- (2) the problems of radioactive waste, orphaned sources, and contaminated sites,
- (3) national security issues, e.g., dirty bombs, improvised nuclear devices, radiological terrorism, and
- (4) the use of nuclear devices in combat (nuclear war).

### **Resources for Your Further Education, Interest, and Use**

Below the reference list are links to websites that provide reliable information on radiation exposures and risks, as well as some possibly useful tools.

### **Conclusions**

Protection of the pediatric population should remain a priority and it is useful to recognize that radiation protection strategies for children are largely the same as for older age groups. The main difference in the application of radiation protection principles for children is that they are under the care and responsibility of adults and any exposures of children as well as the protective actions taken, are the responsibility and the outcome of the actions of adults.

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## **SUGGESTED INTERNET RESOURCES**

### **General information**

[Nuclear & Radiation Events | Disaster Medicine Section \(acep.org\)](#) [Radiation emergencies \(who.int\)](#)

[International Atomic Energy Agency | Atoms for Peace and Development \(iaea.org\)](#)

[Radiation Emergency Assistance Center/Training Site \(REAC/TS\) \(orau.gov\)](#)

[REMM - Radiation Emergency Medical Management \(hhs.gov\)](#)

[At-Risk / Special Needs Populations - Infants and Children - Radiation Emergency Medical Management \(hhs.gov\)](#)

[Ionizing Radiation Exposure of the Population of the United States \(NCRP\)](#)

[\(Nevada nuclear testing I-131 Thyroid Dose and Cancer Risk Calculator: National Cancer Institute \(NCI\)\)](#)

<https://ntsi131.nci.nih.gov/>.

### **Tools for dose and risk estimation and medical triage following group radiation exposures**

[REMM - Radiation Emergency Medical Management \(hhs.gov\)](#)

[Download Mobile REMM - Radiation Emergency Medical Management \(hhs.gov\)](#)

[Biodosimetry Assessment Tool \(usuhs.edu\)](#)

[Medical Management of Radiological Casualties, handbook \(usuhs.edu\)](#)

# Advocacy

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## **Abe's Advice**

*Ed Marcuse, MD, FAAP  
Seattle, WA*

Abe Bergman died at age 91 last November. His *New York Times* obituary cataloged his most notable achievements <https://www.nytimes.com/2023/11/30/us/abraham-bergman-dead.html>. He was my colleague for over 50 years. Abe championed the issues and fought for the values and people that mattered most to me: in our residency program, in the hospital, in this community and nation.

He was inspirational. He was provocative. But above all, he was effective, the quintessential child advocate. He was outraged by the treatment of parents whose babies died from SIDS; by children burned by sleepwear that caught fire; by bussing school children to address racism; by mass screening for heart disease which generated needless concern about incidental heart murmurs resulting in activity restriction for countless children while detecting little disease; by epidemic pediatric dental disease; by our failure to fluoridate community water; by our national failure to assure basic care for all children; by our failure to support public health nurses; and by our failure to recognize and address the toll of preventable childhood injuries. He bemoaned the growth of pediatric specialization, championed the office-based generalist, decried academic hubris, sit-down rounds, and regarding advocacy as a 'specialty' rather than a personal calling.

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For those who didn't know him I want to share some of Abe's oft-repeated advice:

All is not hopeless if we stop acting like bleating sheep.

1. All is not hopeless if we stop acting like bleating sheep.
2. Individuals can be more powerful than bureaucratic organizations.
3. Stop moaning and groaning about the fate of kids and learn how to be effective: build coalitions, work with media, consult lobbyists.
4. The greatest battles are waged against those supposedly on our side.
5. Work on issues you care about that are important and where a solution is possible. Pick the right goal:

*"You dream of a world where no children starve. I dream of a world where fewer children starve."*

(Attributed to Albert Camus addressing an assembly of bishops)

And what I believe was the core of his perspective:

*"Indignation without action is froth."* (Attributed to William Gladstone)

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## Artificial Intelligence: I See Digitalized Data

*Bill Marshall, MD, FAAP Professor of Clinical Pediatrics (emeritus), University of Arizona College of Medicine*

Artificial intelligence (AI) is the idea of the moment. Some aspects of care are already aided by earlier iterations of AI as part of our electronic health systems, such as immunization requirements and medication doses. Certainly, some diagnostic or treatment quandaries would benefit from a literature search of 10,000 articles that AI could analyze in an instant. (AI could certainly be an effective zebra hunter!). But many challenges in pediatric care do not involve novel, puzzling patient encounters that can be accurately transcribed into digital data. These challenges reflect complex interpersonal and healthcare system interactions that require higher-order emotional and subjective forms of intelligence. I worry that AI would not do well in some scenarios like those I encountered in the past:

1. Mrs. A called me at home night after night with concerns about her children, and initially, I didn't understand that she was an anxious mother with a mild developmental delay. Her children's mild illnesses or behaviors were frightening to her! I eventually realized that "she's been vomiting all night" was just one episode of vomiting, or that, "I can't wake her up" just indicated a tired teen who didn't want to be bothered. Would AI keep sending her to urgent care?
2. A teen with a reason for abdominal pain (polycystic kidney disease) visited often for 10/10 pain. However, her description of severe pain didn't match her surprisingly well appearance. We wondered about her home life; a visiting nurse found a huge stockpile of pain medications in the home. Would AI just keep writing for opioids?
3. It seemed like the mother and her three small, bedraggled kids practically lived in the clinic waiting room and play area that winter - frequent walk-in visits, all manner of minor URIs, abdominal complaints, and so on. How long would AI take to diagnose the real problem? They were living in their car. Full disclosure: the human doctor (me) involved didn't catch on immediately, but I did better the next time.

Where masses of labs and images can be interpreted and cohered into diagnoses, artificial intelligence may have the upper hand over an experienced pediatrician or even a "grand rounds" audience of pediatric subspecialists. Unfortunately, factors such as empathy, continuity, and biopsychosocial context are not seen as essential parts of the evolving digital healthcare system, and physicians who train using AI may not have the opportunity to develop these skills. (Just like my adult children rely on the car voice to tell them where to turn.) I worry that efficiency gained by AI will not be freed up for time with patients - that was the so far unfulfilled promise of EHRs.

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I'm reminded of the computer in *2001: A Space Odyssey* when I think about AI in medicine, but the trope of an overtly evil AI, a staple of science fiction for many years, is likely to remain fiction (fingers crossed). Perhaps a better movie reference for doctors is *The Sixth Sense*. It would be best for all of us if, instead of, "I see digitalized data," the governing paradigm for doctors and their artificially intelligent assistants would be, "I see (living) people."

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## Promoting Gun Safety is an Uphill Battle

*Beryl Rosenstein, MD, FAAP (Baltimore, Maryland)*

As pediatricians, we are aware of the toll that gun violence is taking on the youth of America. The statistics are frightening. According to provisional 2022 data from the Centers for Disease Control and Prevention analyzed by the Johns Hopkins Center for Gun Violence Solutions, guns remain the leading cause of death for children and teens ages 1 to 19, climbing 87% in the decade from 2013 to 2022 and accounting for 4590 deaths in 2022.

The data also show that gun violence continues to have a disproportionate impact on Black children and teens who have a gun homicide rate twenty times higher than their white counterparts. Additionally, the gun suicide rate reached an all-time high, and for the first time, the rate among Black teens surpassed the rate among white teens. The Black child and teen suicide rates have tripled over the past two decades.

There are evidence-based strategies that have been shown to lower firearm death rates, including: implementing permit-to-purchase laws; using Domestic Violence Protection Orders and Extreme Risk Protection Orders ("red flag laws"); investing in community violence intervention programs; investing in gun violence prevention research; and adopting child access prevention laws mandating safe firearm storage in households with children and/or teens. This last strategy is strongly supported by the American Academy of Pediatrics (AAP).

About one-third of American children live in homes with firearms, and of these households, 43% contain at least one unlocked firearm. Thirteen percent (13%) of households with guns contain at least one firearm that is unlocked and loaded or stored with ammunition. For safe and secure firearm storage, guns should be unloaded and locked up in a secure place such as a gun safe or secured by using safety devices such as cable locks. The key or lock combination should only be accessible to authorized users. According to the AAP, a large majority of the public supports a mandate requiring gun owners to safely secure their firearms. Most gun owners agree, but under intense political pressure from gun lobbyists in our politically polarized environment, less than half of the states have passed legislation mandating safe and secure storage of firearms.

Unfortunately, efforts by pediatricians and gun dealers to have meaningful interaction with families about gun safety have run into legal roadblocks. In 2011, the Republican-controlled Florida legislature, with the support of the Republican governor Rick Scott, passed a law, aimed primarily at pediatricians, restricting the First Amendment rights of medical providers to discuss the safe storage of guns with patients and families. Under the law, doctors could lose their licenses or face large fines for asking patients or their families about gun ownership and gun habits. The National Rifle Association supported the law, viewing the medical community's gun-related questions as discriminatory and a form of harassment. The law was appealed, and fortunately, in 2017, The United States 11th Circuit Court of Appeals overturned the 2011 law, concluding that doctors could not be threatened with losing their license for asking families about gun ownership and gun safety since doing so would violate their First Amendment right to free speech. For pediatricians, discussing the safe storage of guns goes to the heart of their ability to protect patients from harm.

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Recently, a comparable situation has arisen in Maryland under a 2022 law passed in Anne Arundel County (part of the Metropolitan Baltimore region). According to the law, gun shop retailers are required to display and distribute pamphlets created by the Anne Arundel County Health Department that provide information regarding suicide prevention, mental health, non-violent conflict resolution and gun safety. The law was challenged in the U.S. District Court of Maryland by four gun retailers and a non-profit called Maryland Shall Issue, advocating for the preservation and advancement of gun owners' rights. Their suit was based on a claim that the bill infringes on the First Amendment rights of gun shop owners by forcing them to become conduits for government messaging. In March 2023, a U.S. District Judge ruled in favor of the County, but the gun retailers and Maryland Shall Issue filed an appeal to the United States 4th Circuit Court of Appeals to reverse the judge's decision. Fortunately, more than twenty parties including various medical societies and a host of medical organizations, including the American Academy of Pediatrics, have filed amicus briefs in support of the Anne Arundel County law. Oral arguments are set to take place in December 2023 with a decision issued in early 2024.

The legal challenges that have played out in Florida and Maryland highlight the battles that gun lobby groups will wage to block gun safety laws that could save the lives of children and teens.

# Information

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## The Rise of Online Scams Targeting Seniors: How to Stay Safe in the Digital Age

*Tom Whalen, MD, FAAP*

The digital world has ushered in remarkable advancements, making information and services more accessible than ever. However, along with its benefits, the online realm has also birthed a darker side – a breeding ground for scams and fraudulent activities, particularly targeting vulnerable demographics, including us seniors.

### *Understanding the Vulnerability*

Seniors, often less familiar with the intricacies of technology, can fall prey to online scams due to their unfamiliarity with digital platforms and their inherent trust in others. According to the FBI, older adults are particularly susceptible to scams due to their polite nature and lack of tech-savvy skills. Scammers exploit these traits, using various tactics to deceive and defraud unsuspecting seniors.

### *Common Online Scams Targeting Seniors*

#### **1. Phishing Scams**

Phishing involves sending deceptive emails or messages masquerading as legitimate entities, aiming to trick individuals into revealing personal information like passwords or credit card numbers. Seniors may unknowingly disclose sensitive data, leading to identity theft or financial losses.

#### **2. Tech Support Scams**

Scammers pose as tech support representatives, claiming to assist in fixing non-existent computer issues. They persuade seniors to provide access to their devices, compromising personal data or installing malware.

#### **3. Romance Scams**

Fraudsters establish fake romantic relationships with seniors online, gaining their trust before fabricating a crisis and asking for money or personal information.

#### **4. Grandparent Scams**

Perpetrators pretend to be a grandchild in distress, requesting immediate financial aid due to an emergency, manipulating seniors' emotions to send money.

#### **5. Lottery or Prize Scams**

Seniors are notified of winning a non-existent lottery or prize but are required to pay fees or taxes upfront to claim their 'winnings'.

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### *Safeguarding Against Scams*

#### **1. Education and Awareness**

Be informed about the various online scams prevalent today. Leverage skepticism and realize the importance of verifying the identity of the person or entity before sharing personal information or sending money.

#### **2. Use of Security Measures**

Install and regularly update security software on devices to prevent malware (which can be different from antivirus software). Enable two-factor authentication where possible and use complex, unique passwords for different accounts.

#### **3. Caution with Personal Information**

Never share sensitive information online, especially when prompted through unsolicited emails, messages, or calls.

#### **4. Verify Before Taking Action**

Verify requests for money or information by directly contacting trusted sources or family members, especially when the request seems urgent or unusual.

#### **5. Stay Informed and Updated**

Keep abreast of the latest scams and fraud tactics. Several governmental and non-profit organizations provide resources and updates on common scams to watch out for.

### *Empowering Seniors in the Digital Era*

While it's crucial for seniors to stay informed about potential risks, it's equally important to be able to navigate the digital landscape safely. Here are some ways to do so:

#### **1. Tech Literacy Programs**

Attend workshops or classes specifically designed for seniors to enhance your digital literacy. These programs can cover basic internet safety, recognizing scams, and using online resources securely.

#### **2. Family Involvement**

Encourage open communication within your families about online safety. Encourage regular discussions and seek assistance in setting up security measures on your devices.

#### **3. Support Networks**

Engage in support networks among seniors, where you can share experiences and advice regarding online activities. This sense of community can provide an additional layer of protection against scams.

### *Conclusion*

The prevalence of online scams targeting seniors underscores the importance of proactive measures to protect this demographic. By raising awareness, fostering digital literacy, and building support networks, seniors can be empowered to navigate the digital world confidently and safely. While technology continues to evolve, vigilance, education, and community support remain invaluable shields against online scams.

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## **Report from the American Medical Association's House of Delegates (HOD) Interim Meeting**

*Lynda Young, MD, FAAP*

Wow! This Interim meeting was a doozie! The meeting was held from November 10th-14th in National Harbor, Maryland. The huge push was, "Fix Medicare Now!" and enough signs were hanging around to paper the Capitol building. Finally, Medicare was getting a lot of attention from Congress, including the introduction of several bills to increase physician payments instead of a 3% cut. But - and this is a big but- several resolutions concerning Medicaid passed and are now the policy of the AMA. You would have been proud of the pediatricians in the House of Delegates, especially the small but mighty AAP delegation. The major impetus for these changes was that Medicaid covers more people than Medicare and it's time for a change. Here's a summary of these new policies, which had overwhelming support in the HOD:

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- **Expanding AMA payment reform work and advocacy to Medicaid and other non-Medicare payment models for pediatric health care and specialty populations** asks that our AMA support appropriate demonstration projects, carve-outs and adjustments for pediatric patients, and services provided to pediatric patients within the payment reform arena. Included in this policy is the ask for the AMA to collaborate with state and national medical specialty societies (like the AAP) on physician-developed alternative payment models that address the distinct prevention and health needs of children and take into account the long-term impact of such models. Also brought up in testimony was the great diversity of payment among the state Medicaid programs.
- **Improving Medicaid and CHIP access and affordability** - The AMA supports continued state flexibility to waive copayments or impose minimal copayment amounts that are based on income and in limited circumstances including non-emergent, non-preventive services, excluding children, who should not be subject to cost-sharing in Medicaid. The pediatric testimony was for eliminating Medicaid copays, citing studies that have shown that even nominal cost-sharing can create barriers to care. Testimony also pointed out that state and federal Medicaid administrators aren't receptive to calls to eliminate all cost-sharing in Medicaid at this time, since everyone - including advocacy groups - is completely focused on and overwhelmed by the "unwinding".
- **Immigration status in Medicaid and CHIP** - The AMA advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP.
- **Youth residential treatment program regulation** - The AMA recognizes the need for licensing standards for all youth residential treatment facilities to ensure basic safety and well-being standards for youth. The AMA also supports recommendations, including patient placement criteria and clinical practice guidelines, as developed by nonprofit healthcare medical associations and specialty societies, as the standard for regulating youth residential treatment programs.
- **HPV-associated cancer prevention** - This was a report from the Council on Science and Public Health. The AMA supports that HPV vaccines recommended by the Advisory Committee on Immunization Practices be required for school attendance for all vaccine-eligible individuals.
- **Adverse childhood experiences (ACEs)** - The AMA supports collaboration with the CDC and other relevant interested parties to advocate for the inclusion of additional evidence-based categories to the currently existing ACE categories to continue to improve research into the health impacts of ACEs and how to mitigate them.
- **Social media impact on youth mental health** - this resolution was referred to the Council on Science and Public Health as the Council is currently working on a report for the next Annual Meeting in June 2024. So, stay tuned for more on this issue.

In my 12+ years as an AMA delegate, I have never heard such tremendous support for Medicaid reform. Of course, since Congress has bills out now on Medicare reform, we'll have to wait our turn until those get settled. Then Medicaid will become a huge issue for us.

# Reflections

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## Chronicles of a Doctor-Patient

(Formerly a Patient Doctor)

*Frederick Bogin, MD, FAAP*

### Part I

I sat poolside next to my daughter Stephanie.

“Steph,” I inquired, “if I take my shirt off and go for a swim, do you think anyone will notice my scars?”

Well aware of the expansive vertical scars running the full length of my chest as well as the full length of my back, she respectfully replied, “Dad, anyone who looks at you will undoubtedly conclude ‘there goes a magic trick that went horribly wrong!’”

This is how the “magic trick” scars came to be visited upon my body.

In the spring of 2012, I appeared at the office of my primary care provider. Walking up to the receptionist window I said, “Hello, I’m Fred Bogin here for my one o’clock appointment with Dr. C.”

Staring at her computer screen she stated uncomfortably that there was a mistake and I had been scheduled for my annual physical with Dr. Knoll. She offered to reschedule my appointment for a future date with Dr. C.

“No, that’s perfectly fine for me to be seen by Dr. Knoll today.”

I had been wanting to switch primary providers and I interpreted the mix-up as a sign that the Universe was looking out for me that day.

My visit with Dr. Knoll was most rewarding. I felt listened to, carefully examined, and the recipient of thorough care from an experienced, knowledgeable, and caring physician. After completing the exam and addressing my questions, the doctor shared with me one minor concern.

“I hear a soft heart murmur. I don’t think it’s significant, but to be certain I suggest that we get an echocardiogram.”

Several days later I had the ECHO done at St. Francis Hospital, where I was working in the pediatric primary care center. I checked the results on my hospital computer - mitral valve prolapse. I thought that the finding was not of concern, but I booked an appointment with a friend in the cardiology department, Dr. Rick Soucier.

“It’s the kind of thing that shouldn’t cause you any problems unless you live to be 150 years old,” Rick assured me. “But just to be cautious, why don’t we repeat the ECHO in six months.”

Sensing that I was entering the phase of life in which various body parts seem to fall apart, I followed Dr. Soucier’s recommendation and appeared for my repeat ECHO six months later. While I typically would look up the results of my own medical tests, for some reason I didn’t check the follow-up exam result. I was having no symptoms and felt confident that all would be fine. However, I kept my previously booked appointment with Rick. I sat calmly in the exam room, waiting for my cardiology friend.

“Well, the new study shows you have severe mitral regurgitation. You’re going to need open-heart surgery.”

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“Oh (insert f-bomb),” I exclaimed with heartfelt horror.

Several chordae had torn, and my mitral valve was “flapping in the breeze” with each contraction of my heart. Over time this situation would cause irreversible damage to my heart. Atrial fibrillation, pulmonary hypertension, and eventually heart failure, all could occur with untreated mitral regurgitation. Fortunately for me, thanks to Dr. Knoll and Dr. Soucier, no irreversible changes had yet occurred. Rick was astonished that I had no symptoms such as exercise intolerance or shortness of breath.

He went on to say, “If I were you, I would research the best valve surgeons around the country, but in the end, come back here and have the surgery done by Dr. X. He is not someone who you would want as your best friend, but he is an incredibly skilled cardiovascular surgeon, specializing in valve repair. So, I made an appointment with Dr. X and found him to be pleasant, attentive, and unrushed in answering my questions. He explained that I would need a transesophageal ECHO (TEE for those in a hurry), which would better visualize the relevant anatomy. I would also need a cardiac cath (to look at my coronary arteries) prior to the mitral valve operation. His goal was to repair the valve as opposed to replacing it. Would I evade the onus of chronic anticoagulation?”

A few days later I underwent the TEE with my buddy Rick. I learned that I would be sedated but awake for the study. Since the procedure involved passing a fair-sized tube down my pharynx into my esophagus it was necessary to numb my throat, knocking out my gag reflex (thus decreasing the chances of me barfing on my friend Rick, and increasing the chances of him passing the ultrasound device and tube easily into position). Rick handed me a cup of topical anesthetic and instructed me to gargle the liquid for five minutes. If you ever try gargling for five minutes, you’ll find that the experience seems to last approximately three or four hours. Since it was the Christmas season, I decided to entertain Rick and anyone else in the vicinity with a Holiday gargling medley.

I’m still waiting to hear from the Grammy people, or at least one of Santa’s helpers.

My surgery was scheduled for shortly after the Christmas Holiday. As I anticipated having my chest sawed open, going on a heart bypass machine, and having someone doing a “valve job” on MY heart, I . . . . shall we say . . . . began to freak out! Other than some one-day cataract surgery (in a surgicenter), my last operation was a T&A at age 4. How to deal with my mounting anxiety?

I walked into our den and stood staring at our large wall bookshelf. The Universe (I believe this) guided me to a book I had not read previously, *The Anatomy of Hope* by Jerome Groopman, MD. *The Anatomy of Hope* is a collection of vignettes describing a number of his former patients.

Through their stories he demonstrates the profound impact an attitude of hope and positivity can have on clinical outcomes. I am happy to report that I found the book to be transformative. My self-talk did an about-face. My anxious, disaster-filled thoughts gave way to a positive attitude fueled by courage, hope, and confidence that I would be in the best of hands. My friend Rick assured me that he would keep a close eye on me during my recovery. At the time I didn’t realize just how big a help that would ultimately be to me.

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## Golf As Meditation

*Louis Borgenicht, MD, FAAP*

To me golf is a solitary game. Even if you are in a foursome and watching your friends, the game is yours. You look where you need to go and size up the distance. You pick a club and address the ball at your feet. You relax, especially your grip on the club. You visualize your swing and follow through. Then you hit the ball.

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There are times when you are golfing with someone who has a range finder. “It is 156 yards,” they say out loud. The information does not compute. The ball is here and needs to go there and you pick up the club you think you will use. Distance is irrelevant. The ball flies into the air (if you are lucky) and lands wherever. You contemplate your next shot.

The only time I do a “practice swing” is when I address the ball on the first hole. Anything else is wasted. Likewise, I do not go to a driving range. Hitting a bucket of balls is never satisfactory. You hit some good balls, say with a seven iron, but you are not consistent. The next four hits are horrible. No lessons learned. I figure that you have limited swings in your life. Why waste them on the driving range?

If your twosome is unlucky enough to be paired up with some duffers who are apparently better than you, you can determine this if, feeling potentially cowed by them, you let them hit first.

Last week I found myself in that precise situation. My friend and I were playing 18 holes at Wasatch Mountain golf course, resplendent with autumn colors. I usually do not play 18 holes because I get bored and tired by the 14th.

But the day was gorgeous with wild turkeys and deer accompanying us as we played. I was anxious for the first three holes, feeling intimidated, and slowed the group down with my anxiety and crappy shots. As I regained my serenity all was well. The social repartee became easy and my game improved.

I have never kept score playing golf and have no idea what a handicap is, although that’s often part of some golf conversations. I play what I call intuitive golf. Despite that, two years ago I made a very unintelligible and probably serendipitous hole-in-one.

“Jody”! I exclaimed, proud as a peacock, “I got a hole-in-one.” “What is that”? she asked nonchalantly.

“I hit the ball and it went into the hole on the green. I didn’t know I had done it. Just hit the ball and it disappeared. My friends were amazed.”

“You got a hole-in-one”! they shouted in unison.

When I got home I immediately searched the Internet to find a suitable commemorative plaque on which to place my ball (appropriately a Wilson Mojo). It now sits on my desk, proudly displayed as a moment in time in 2021.

If make a par I keep the success to myself and do not announce it to the other three members of my foursome.

I have a few golf jokes which I tell at the appropriate time waiting for the raucous laughter. But the game is mine and kind of meditative.

I wonder how I will survive the winter - probably with anticipation of the first warm day of Spring.

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## **The School Health Clinics of Santa Clara County Reflective Practice Experience 2020-2023**

*Suzanne Frank, MD, FAAP*

### **School Health Clinics of Santa Clara County History:**

School Health Clinics of Santa Clara County (SHC) are six clinics located on school grounds in San Jose and Gilroy. Low-income children, adolescents, and adults have been served here for 35 years. The majority of patients and families are Spanish-speaking. SHCs participate in behavioral, medical and social programs for the homeless, provide medication for HIV prevention, medication-assisted treatment for substance abuse, reproduction services, behavioral health, social determinants of health services and navigation.

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**ACEs Work at SHC:**

SHC began assessing adverse childhood experiences (ACEs) in 2020 with the integration of behavioral health and its designation as a certified community behavioral health clinic. Primary care staff including medical assistants and receptionists were involved in additional patient mental health screening - for ACEs, depression, suicide, and substance use, as well as strengths screens. This work increased the identification of an increased number and severity of patients with more complex mental health problems. At the same time, the COVID-19 pandemic was unfolding and increasing numbers of homeless folks were accessing SHC services.

With the ACE screening, conversations and disclosures about child maltreatment and intimate partner violence, domestic violence, and gender-based violence became routine for SHC staff. During this time, SHC has been coached by the Resilient Beginnings Network of the Center for Care Innovation to implement trauma and resilience-informed care on the journey toward becoming a healing organization.

SHC provided many trainings for all staff working in this new integrated behavioral and physical healthcare environment. Staff meetings now begin with a 3-5-minute YouTube meditation followed by Moments of HOPE (Healthy Outcomes from Positive Experiences program of Dr. Bob Sege). This gave staff tools for this new work including engaging patients in behavioral health, substance abuse treatment, de-escalation, and trauma-informed care. A dignity framework was also introduced to decrease bias and disparities. All clinics became no-hit zones with associated training on positive parenting, positive childhood experiences, and de-escalation. Additionally, SHC is in the process of implementing dyadic care and adding community health workers to our staff with support from the UCSF Center for Advancing Dyadic Care in Pediatrics and the UCLA/UCSF ACEs Aware Family Resilience Network.

**Integrated Primary Care and Behavioral/Mental Health:**

The process of shifting this type of care and attention from traditional mental health clinics to what had been primary medical care clinics created stress, frustration and confusion. Traditionally, mental health workers have periodic supervision and reflection for support and growth. This begins in their training and continues throughout their careers. Supervision has also been used in education since the 1970s. Initially, SHC’s medically oriented workers lacked the skills and necessary training and supervision.

"Supervision" of health care workers can be accomplished by establishing a reflective practice in the clinic. Reflections of healthcare workers' reactions to intensive and stressful work with staff and patients are facilitated by a staff behavioral health clinician in group and individual settings.

**Resilient Beginnings Network Learning Session:**

Resilient Beginnings Network (RBN) learning sessions led by Dr. Ken Epstein, PhD, LCSW, and Dr. Irene Sung were invaluable. The SHC RBN team learned that the model in psychiatry for reflection involves transference and countertransference and finding out what is going on inside us. Staff need to talk about how a case is going for them and for the patient and how to look at the interaction between what is going on for us and them – essentially, seeing the doctor-patient relationship as a two-way street.

Furthermore, healthcare workers live in the clinic, a reactive space, with no resources for reflection, no director of reflection, and no space for reflection. However, reflection is part of healing, change, and interaction. To reflect on health care is to be disruptive.

SHC learned to reflect: “What was my view of what happened, which of my identities are in charge of this moment? How would I look at this differently if I use a different lens? What is happening in my body? What is the struggle? How does this intersect with my life at this moment? What happens to your body if you deal with an issue and don’t reflect? Initial subjective assessments may perseverate and create a narrative we believe to be true.”

In review, our own trauma and other experiences may disconnect us, and we may become fragmented. Healthcare can use reflective practice to build connection, coherence, and collaboration. The basic first steps include creating a space for reflective practice and developing intentionality and authenticity.

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### **SHC Reflective Practice Training:**

The overall concept was presented to the QI team in 2021 with a link to the basic RBN reflective practice video presentation. Six leads representing the staff began a three-part training with Dr. Epstein in May 2023 (3 four hour in-person sessions). The concept is that the leads will apply what they have learned and practiced in this training to their SHC interactions. Further basic training of the entire staff will follow, including monthly group reflective practice sessions while divided into a provider group and staff group. This will usually be done on Zoom with in-person sessions two times a year. Behavioral health staff will facilitate these sessions with the assistance of the six trained leads.

### **During the in-person training, Dr. Epstein demonstrated the principles of effective reflection:**

- When you feel reactive Practice seeing the dynamic and see all the complexities
- Being: How do I want to be in the moment? What are my values and feelings about what I see them do?
- Doing: Speak. Intentionally practice mindfulness and reflective practice. Silence is OK. Out of silence may come another idea. Listen and explore emotions. What is happening? Look at the options and opportunities. Explain, explore, and examine the options. What can you do differently?
- Then experiment.

### **During the in-person training sessions, guided by Dr. Epstein, SHC participants practiced skills such as:**

1. Reflect, don't react.
  2. S l o w down.
  3. Don't interrupt. Listen.
  4. Look at the staff's feelings.
  5. Add intentionality and let a question sit.
  6. Use comments like, "This is important. Can I slow down? So, I can really get what you are saying. And better understand."
  7. Take a pause. Create more space. Then, experience a feeling that you remember during an activity.
- A post-COVID recovery exercise helped participants realize that staff are in different places on the cycle of readiness, response, recovery, and renewal post-COVID. This discussion utilized our own personal post-COVID recovery mirror and the staff landscape to be more intentional in implementing new clinic programs and workflows.

### **Goals and Aspirations for SHC Reflective Practice:**

This unique implementation of a reflective practice in our integrated primary care and behavioral health clinics attending to ACEs, resilience and trauma work should result in less burnout, deeper patient relations, more staff and patient satisfaction and improved patient care. Reflective practice promotes less staff anxiety, more safety, and confidence. This tool can help maintain and enhance the mental and physical health of clinic staff responsible for providing care to an increasingly traumatized and trauma-aware patient population. SHC expects the staff will be more effective while increasing capacity to meet patient needs.

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## **“Yes, Virginia, There is a Santa Claus...Yes, Miles, There was a Virginia”**

*Anthony L Kovatch, MD, FAAP*

*Do you know about Virginia O'Hanlon, the little girl who in 1897 asked The Sun, a New York newspaper, if Santa Claus is real? The editorial response titled, "Is There a Santa Claus?", which contains the line, "Yes, Virginia, there is a Santa Claus," written by Francis Marcellus Church, a former Civil War correspondent, is still, a century and a quarter later, the most reprinted editorial in the English language. Here's a Christmas story about a real-life Virginia I wrote for Miles, my first grandchild, as an infant in 2015.*

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In the 1960s in New Jersey almost every household had a train set around the Christmas tree---some trains were electric, and some were imitations. Two bespectacled brothers of about 10-12 years of age were very fearful of what Christmas held in store for them. Their mother was slowly dying and there was a lien on the house to pay for the medical bills. They prayed that they would be able to keep their parents' favorite painting "Freedom from Fear," which hung on the living room wall.

The mother of the boys was named Virginia. She remained a proud, mind-strong woman despite her deteriorating physical and mental health and refused to see a super-specialist, a neurologist named Doctor Cooper, in New York City, who might be able to make a definite diagnosis of her genetic condition and therefore offer some hope of recovery. Her husband, a man of humble origins and limited means, promised Virginia a mink coat for Christmas if she would cooperate. The brothers were very skeptical that their father could afford such an extravagant present. They were fearful that an argument would erupt on Christmas Eve and that their father would leave them!

The situation that evening worsened still when the highly nervous older brother accidentally stepped on the track of the electric train that they had received as their "big" present and rendered the system dysfunctional. The preoccupied, angry father put on his coat, bolted out of the house with the broken track, and took what likely was the last bus of the night to town in the heavy snow; there was no car in the family. The family fearfully believed that they would not see hide nor hair of him that evening. The older brother who had absent-mindedly fractured the train track could do nothing but cry behind his spectacles! However, almost miraculously, two hours later the father returned from town covered with snow holding a new replacement track. "I got to Sears and Roebuck just before they closed!" he heartily exclaimed. All were relieved, but the tension was far from over.

Soon after settling down in bed for a "cold winter's nap," the brothers became aware of stirring in the living room. They sheepishly peered out from the adjacent hallway. Virginia's husband was placing a brand-new mink coat around her shoulders; as he kneeled at her feet in supplication, Virginia agreed that she would keep an appointment with Doctor Cooper, repeatedly shouting his name (in her dementia) as constituents do at a political rally. The brothers both came out of hiding and the little family was very happy. It was one of the last times the boys would ever see Virginia happy.

But Doctor Cooper could not save Virginia. She succumbed to the inevitable and died several years later in a hospice with her devoted husband at her bedside. Yes, he too died several months later of a ruptured heart---literally and figuratively. Both brothers were ultimately spared Virginia's highly inheritable disease---and, therefore, so are your Mommy, Mary, and you! The mink coat was worn by young women of the extended family at special events until its whereabouts became unknown. The electric train probably lies in its fraying box in the far reaches of a dusty attic; the fractured track is little more than a fleeting memory in the mind of the nervous lad who had stepped on it. However, "Freedom from Fear" still hangs on the living room wall, as it has done for over 60 years!

Yes, Miles, there is indeed a Santa Claus, and, as you may have guessed even at your young age, Virginia was your great-grandmother. The husband of exceptional devotion, sacrifice, and love was your great- grandfather. Santa Claus was indeed present that Christmas Eve, intervening in the lives of four desperate people, and bringing joy and peace (albeit fleeting) to a family who believed in everything that he stands for. I know that I am absolutely right because I witnessed it all through my own spectacles!

Love, PapPap

*Church finishes: "Ah, Virginia, in all the world there is nothing else real and abiding. No Santa Claus! Thank God! He lives, and he lives forever. A thousand years from now, Virginia, nay ten thousand years from now, he will continue to make glad the heart of childhood."*

*This winter season may every one of us worldwide enjoy the freedom from fear he abides.*



Mary and Miles

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## My Lifetime Love Affair With Baseball

### Part 3: “The Man Next Door”

*John McCarthy, MD, FAAP*



This is a true story my mother told me when, at 8, I expressed an interest in baseball.

Her parents were immigrants. My grandmother, Eliza Emily Thompson, born in 1872 came from England in 1889 with her parents and siblings on the HMS Servia which arrived passing the newly installed Statue of Liberty at the Port of New York. They soon settled in New Rochelle, NY.

My grandfather, Leonard Albert Tillman, was born in 1870 in Paris, and baptized at Notre Dame Cathedral, after his parents, Catholics, fled persecution from the German Emperor Chancellor Otto von Bismarck. Two years later, when his mother became pregnant again, they managed to board a ship that landed in New Haven, just in time to deliver a second son they named Gustave.

The Tillman family soon settled in Manhattan, New York where both boys grew to adulthood.

Leonard tried to pursue a career in art at Cooper Union but could not afford the tuition and ended up with Knickerbocker Publishing Company as a printer. When Knickerbocker relocated to New Rochelle, Leonard went with them.

Eliza and Leonard settled in the same neighborhood in New Rochelle, bumped into each other, fell in love, and married in September 1896. They moved to a home on Webster Avenue where they had lots of children, all born at home. Sadly, most died within the first year of life from a variety of infectious diseases for which at the time there was no treatment. Only three daughters survived to adulthood: Emily, born 1902, my mother Edna, born 1907, and Ruth, born 1910.

The friendly Wagner family next door had a daughter Elizabeth who at 5 enjoyed playing with Edna, then a rambunctious 3-year-old, “supervised” by her sister Emily, aged 7. The parents became fast friends. And here is where baseball comes in.: “The man next door” (drum roll!) **Charles Frederick “Heinie” Wagner** played baseball for the American League Boston Red Sox. Both Gustave and Leonard became die-hard baseball fans who rooted for the Sox.

Born in Harlem, NY, Wagner developed a passion for baseball, a genuine American sport. He broke into professional baseball briefly with the New York Giants in 1902. He then joined the newly created Red Sox in 1906, played shortstop, developed an exceptionally powerful and accurate throw, and had a respectable .250 career batting average. He also had the distinction of being the only Red Sox player to be in all four World Series (1912, 1915, 1916, and 1918) that the Red Sox won. Their subsequent World Series drought lasted 86 years. Cy Young and Babe Ruth were among the famous players on his team.

“Heinie” also coached and managed the Red Sox between 1920 and 1930 after which he “retired”. He worked in a nearby lumber store but managed to find time to coach baseball teams for the police, firefighters and Elks, who played regularly in the New Rochelle city park. My grandfather and great-uncle Gustave were regular attendees there. My cousin, Billy Mohr Winkel (now 87), vividly remembers our grandfather regularly taking him to these games. In 1940, while watching a game, Gustave had a heart attack and died (undoubtedly with a smile on his face). Charles Frederick Wagner (“the man next door”) died at his home in 1943 and is buried at The Gate of Heaven Cemetery in Valhalla, NY.

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## Memorable Interaction with a Family

*William Purcell, MD, FAAP*

Many years ago as the new, first and only pediatrician in a small community in North Carolina, I became ill one evening with severe nausea and vomiting. In an effort to control my symptoms, and with no one to cover my practice, I took the only medicine that I had available to help the nausea, which was a common barbiturate sedative capsule.

The medicine helped, but I was awakened about two hours later by a telephone call from a parent who said that their son had injured his arm earlier in the day and now was having so much pain that he couldn't sleep. I referred the child to the emergency room for an x-ray and told the parent that I would come over to check the child after the x-ray was taken. At that time we had no emergency room physicians in our hospital.

I fell back to sleep while waiting for the x-ray but shortly I was awakened by a call from a mother who was worried about her young daughter who had had a fever all day and that the child just wasn't getting any better. I promptly told the mother to take her daughter to the emergency room for an X-ray of her arm and that I would come over to check her after the X-ray.

Of course, I never heard from that family again, nor did I ever again in my 30-plus years of a successful pediatric practice self-prescribe sedative medications. What a way this was to begin a new practice, as I am sure the story spread throughout this small community.

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## Trust and Consent – The Swinging Pendulum

*Yolanda "Linda" Reid Chassiakos, MD, FAAP*

My story was classic. Slightly chubby as a young teen, I was spurred to diet when a friend of my parents whispered to me, "You'd look so beautiful if you lost a few pounds." Not schooled in #MeToo self-protection, I took his words to heart and flirted with anorexia. At 5' 4" and 95 pounds, I was visited by amenorrhea, and dragged by my anxious mother to the gynecologist for my first visit.

The GYN was a highly respected male doctor (as were most OB-GYNs in the late 60s). Polite, professional, and business-like. With my mother watching from behind him, he positioned me on the exam table and did a standard exam, quickly and efficiently. No, I cannot say that I was abused, by the standards of care of the day. Patients did what the doctor asked; after all, he was the doctor, and we patients had to trust him. I was humiliated, though. Not only by having my private parts examined for the first time, but by the sensation of losing control of my bowels on the table during the latter part of the pelvic exam. As a physician a decade later, I made a point of always letting my patients know when I was recommending a rectal exam, and that it would feel as if they were "going to the bathroom", but their sensations did not imply an embarrassing incontinence.

My teen GYN did not diagnose anorexia, as it was less well-known at the time. He prescribed hormone therapy and cheeseburgers, both of which contributed to weight gain that reestablished my menstrual cycle and my unhealthy eating habits, which accompanied me for many years. I did learn, however, to always talk to my patients and families and explain my differential and the exams I was recommending, allowing them to ask questions, and, in rare cases, decline my suggestions. And, with minors, to encourage parents to stay and observe and provide comfort to their children during our professional examinations.

But progress was slow in medical school and residency. In medical school at a major university, we were taken to the local VA hospital and asked to practice our rectal exams on comatose patients. Most of us, including me, were appalled.

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Two decades later, for a stint as a staff writer for the TV series “Family Medical Center”, I was inducted into the Writers Guild of America West. A fan of “Magnum PI’s” Tom Selleck, I found myself tuning into a couple of episodes of “Friends”, where Selleck guest starred as Monica’s temporary boyfriend. (RIP Matthew Perry.) One scene knocked me off my chair. Selleck played an eye doctor and performed an ophthalmoscopic exam on his girlfriend-to-be. He had probably been coached by the show’s medical consultant to hold the scope as we were taught in med school, i.e. in his hand while resting his fingers on the zygomatic arch and his eye against the viewing lens hole. This maneuver placed Selleck millimeters from Courteney Cox’s face, and—OMG!—he then, as per the script—continued forward and kissed her.

I immediately penned a letter to the editor of *Written By*, the WGA monthly magazine, explaining why this scene was not only inaccurate, but a terrible and frightening violation of patient-doctor boundaries. And, I begged future screenwriters to avoid conflating medical exams with romance. But, it was the 90s, and I don’t think I got much traction. I did note, however, over the next decades, that more and more women patients in my work settings with young adults were requesting women providers, especially for sensitive exams. Thankfully, the number of women in medical school and residency had grown. More of our male patients were comfortable seeing male doctors and leaving pelvic health to their female colleagues, even before the rise of #MeToo.

As a clinic administrator, though, I did see a couple more shifts in the care environment in the next few decades. We mentored our providers to communicate transparently with their patients and provide information and answer questions about suggested examinations. And to respect and document declined testing and exams as “Patient Declined \_\_\_\_\_, advised of risks of declination.” We also asked all our providers to engage one of our trained chaperones when performing a sensitive exam. Even so, I received a couple of anonymous complaints in our “Feedback Box” about standard medical procedures which were perceived by our young adult patients as intrusive and possibly inappropriate.

The first one was from a young woman who, like Monica on *Friends*, had an ophthalmoscope exam in the suite of a heavy-set older MD. Yes, like all our doctors, he had a chaperone and had explained the need to check the patient’s eyes. Hearing no objection, and not considering the exam sensitive, he completed it professionally. He and his chaperone testified that he did not do the “Selleck move”, of course. What the young woman *did* perceive was that this out-of-shape and tired doctor was breathing heavily when his face neared hers to check her retinas. I wondered how many other women feared their doctors during eye exams after the *Friends* scene, and again encouraged all the providers to ask for explicit consent for a broader range of exams.

After a different young woman complained that another doctor put his stethoscope under her blouse to listen to her lung sounds and touched her bra with it, I added the heart and lung exam to the sensitive exam list in women, and even men who did not want to undress. We changed our standard practice to perform our stethoscope exams on top of clothes or gowns, and to ask for consent for any such exams done scope-to-skin or even under a clean gown.

No providers were 100% immune anymore from perceptions of discomfort by patients with various aspects of standard medical care, so it became critical that all procedures would be fully explained, patients would be asked for consent, and advised that they could stop an exam they consented to at any time, as documented by the doctor and the chaperone. I remembered how, back during my military service in the 1980s, I had been tasked to do “short-arm exams” on young cadets in Officers Candidate School; young men who were lined up in a row in an open room. Now, all private exams, in men as well, were done under the consent rules we instituted, which included a gown or drape for every patient.

Partnership in healthcare between doctor and patient remains paramount. That does mean that we do need to take precautions to ensure our patients trust us once again and understand how our suggested and performed exams are for their benefit and only for their benefit. Yes, if I fear that delays or declinations could lead to permanent negative outcomes or death, I will be more dynamic in my discussions and try to address openly every area of concern. But, allowing our patients and families with non-emergent or non-urgent needs to take time to research and study the recommended work-ups and treatments can reduce mistaken perceptions about our actions and rebuild trust between healthcare providers and patients.

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# The Uncertain Book Club

Darryl A. Robbins, DO, FAAP

## Background and Context

When I retired (planned) three years ago following 45 years of general pediatric practice, my wife strongly urged me to have a “plan” for my retirement so that I would not drive her “crazy” at home. Well, I blew up the plan. I realized that my alternative was to be called a “process”. My planned retirement commenced three months following the frightening onset of the COVID-19 pandemic (unplanned).

## An Epiphany

Following 48 years of pediatric residency, I realized I knew nothing about children’s literature. So during the early part of my retirement, a sudden, unexpected idea crossed my mind. What about developing and implementing a children’s book club? (Note: I have never participated in any book club.) Thus, the Uncertain Book Club was born. Participants (guinea pigs) included my grandchildren and friends’ grandchildren. Social infrastructure for this endeavor was enhanced by home schooling during the early pandemic as well as the popularizing of Zoom.

## Preparation

Knowing nothing about book clubs, I began this endeavor with a clean slate. I needed assistance to discover excellent children’s literature to pull this book club off. Fortunately, I turned to two experts; one – Karen Sherman, a retired gifted-student teacher in the Columbus, Ohio, public school system; the other, Lexi Walters Wright, owner of High Five Books, a children’s bookstore in Florence, Mass. I found them both terrific in assisting me to explore wonderful children’s literature appropriate for 8 – 14-year-olds.

## The Process

Starting with this clean slate, I developed and refined a method to create a one-hour Zoom experience, exploring each book independently (and sequentially), utilizing up to 20-30 questions for discussion, avoiding a “right or wrong” answer approach, and utilizing what I called content questions and value questions (mostly). During each approximately one-hour Zoom experience, I had the small group of children rotate who would be first responder, and then add input from the other children only when they raised their hand, and then called upon them individually. Parents and grandparents have been welcome to actively participate in the last 5 – 10 minutes of each session to provide their insights to enhance this experience. The maximum number of children on our Zoom has been six.

## My Goals

Promote age-appropriate enjoyable and sometimes challenging reading experiences as part of our participants’ lifelong learning.

1. Discover the positive (and sometimes negative) values for each of the key characters in a given book through their reading experience.
2. Learn what each of the children appreciated from a given book, as well as each child’s critique of what they read.
3. Enhance learning of useful vocabulary (several words/phrases – my subjective choosing) separately for each book. Recent example: from *The Giver* by Lois Lowry: ambiguous; euphemism; dystopia; corporal punishment.

## Issues

I quickly learned to eliminate annoying and distracting emojis and changing backgrounds as well as verbal interruptions. From there, we developed guidelines to maintain an appropriate environment for working through our subject matter.

## The Q&A Approach

I worked on the questions as I read through each book. I also invited the participants and their parents to submit questions. Content questions were used to see how well the children comprehended what they were reading as well as maintaining focus on the content. Value questions reflected how different characters thought and behaved in certain situations.

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One of my key ongoing value questions was to provide a list of attributes, and then have each child respond in turn to what fit for a given character.

My last two questions would be to have each participant rate the given book from one to ten (highest), share why that number was chosen and then ask whether they would read another book by the author.

### **What Have I Learned?**

1. Each book should be an enjoyable and yet challenging read
2. The joy of working with children has extended me from being an overnight camp counselor to a pediatrician to running a book club,
3. There are many terrific children's books, comparable to excellent adult literature.
4. Getting help from content experts was key to this process.
5. Not to expect children whose brains are in the process of developing to necessarily pattern themselves on the positive values that were repeatedly inculcated within our one-hour Zoom meetings. At its best, this may be a lengthy developmental and adult modeling process.

### **Where Are We Now?**

To date, we have read and discussed 16 novels, half of them during our first twelve months through infrastructure support during the early part of the pandemic. Not one of the books was a disappointment to any of the participants, and the children were fully supportive of the continuation of the book club. One, through age and maturity, is likely to graduate out; and one, much younger, is matriculating in *Resistance* by Jennifer Nielsen, was initially and understandably quite terrifying to one participant due to its subject matter. Therefore, our book club postponed it and is reading it now.

It is now much more difficult to maintain our book club as the pandemic has subsided, the children are all back in school, and scheduling has become a greater challenge. Our future: Uncertain.

### **Appendix: Listing of Children's Novels Read (in order)**

*The Watsons Go to Birmingham – 1963*

*Bud, not Buddy*\*

both by Paul Curtis

*The One and Only Ivan* by Katherine Applegate \*

*New Kid* by Jerry Kraft

*The Boy, the Mole, the Fox, and the Horse* by Charlie Mackery

*Home of the Brave* by Katherine Applegate

*Tuck Everlasting* by Natalie Babbitt

*The Westing Game* by Ellen Raskin

*Hatchet* by Gary Paulsen

*Holes* by Louis Sachar \*

*Train I Ride* by Paul Mosier

*Where the Mountain Meets the Moon* by Grace Lin

*A Mango-Shaped Space* by Wendy Mass

*Jake and Lily* by Jerry Spinelli

*The Vanderbeekers of 141st Street* by Karina Yan Glazer

*The Giver 44455* by Lois Lowry

\**John Newberry Medal recipients*

# Second Acts

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## My Good Life After Retirement

*Sheldon Berkowitz, MD, FAAP*

*Past President, Minnesota Chapter of the American Academy of Pediatrics*

Having recently received my first AAP senior member newsletter, I thought I would add my summary of life after retirement. I retired from my clinical practice of general pediatrics in May 2020 after I turned 65 years old. I then continued to work part-time as a physician My advisor for our hospital (dealing with insurance company denials for provided care) until July 2022, when I fully retired. Retirement has been great and all I hoped it would be, including allowing me to keep my hand in pediatrics (other than answering texts, emails and calls from family members about their kids or themselves!), through AAP involvement, various state committee work and medical missions.

First, as I retired from my clinical practice in 2020, I assumed the presidency of the Minnesota Chapter of the American Academy of Pediatrics (MNAAP) for a two-year term. The timing was great, as my reduction in work time allowed me more freedom to devote to the MNAAP. My experience as president was wonderful and made me wish I would have become more actively involved with the MNAAP and National AAP at a much earlier time in my career. While I had been a dues-paying member of both and a longtime member of the Section on Bioethics, it was only in the last 10 years that I became more involved and learned the importance of and joy of doing advocacy work. Even in full retirement, I continue to be involved on our chapter's executive committee as past president and regularly testify at both our State Capitol and the city of St. Paul city council on various issues, especially gun violence prevention. While I always advocated for my patients while in practice, advocating for all our state's children is totally different and gratifying in a different way.

Second, until the last couple of months, I stayed actively involved in our state with efforts to improve transitions of care for pediatric patients with complex health care needs to adult care. This had been a long-standing passion of mine, and I was recently able to transfer this work on a state-wide level to a wonderful younger pediatrician. I have also been involved for the last 4 years with the Minnesota Rare Disease Advisory Council.

Finally, having always wanted to go on a medical mission, but never having found time or felt qualified to go on such missions, I finally made it happen. In the last nine months, I have been able to travel to Poland twice with International Medical Relief, to provide primary care for Ukrainian refugees living in Poland. The experiences were incredible both times and I felt fortunate to be able to help both the children and adults (as I needed to see some of them also) by providing medical care and, equally important, an empathetic ear. These experiences reminded me why I went into medicine – to provide needed care. On my first day I was told to spend as much time as I needed with each patient (something I don't think I was ever told in my career). Our documentation (by hand) was minimal and there were no billing issues. Oh, and the patients were all appreciative of the care they received. What more could a pediatrician ask for?

I don't have any more missions planned and my term on the MNAAP will be ending at the end of next June – but I'm sure there will be other opportunities to stay involved with medicine. Not sure how, but I'll be interested to find out.

# Special Contribution

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## Meeting in Virginia - A Prose Poem

*Tomàs José Silber, MD, MASS, FAAP Professor Emeritus  
George Washington University Division of Adolescent and Young Adult Medicine*

In Virginia there is a cemetery that is a green meadow, in which the tombstones, instead of appearing upright, are at ground level, creating an atmosphere of peace, limitless extension, and equality.

This endless horizontality, without having intended to, prevented the tombs from being differentiated from each other. It was not possible to distinguish more opulent tombs, nor to know which one was cared for and which one was neglected. In truth, this cemetery seemed like a place for the living, where the visiting children could run, and the grown-ups take their thoughtful walks amid the tamed nature of the manicured lawn and the flowering trees in the distance. Others, like me, lay down for a rehearsal nap.

It was as I was napping there that the meeting took place. Suddenly the cemetery was populated with groups like the families that gather at Mexican cemeteries for “Dia de los Muertos”. Only here, those who met me were my beloved dead, warmly inviting me to a reunion picnic. They carried a sign with the letters announcing, “Welcome Tommy.”

They were all dressed in their best clothes, the clothes they wore three times a year when they went to synagogue, but instead of the kippahs and hats of the time, their heads were surrounded by a brilliant multicolored areola.

All my dead were very excited to see me and were talking and gesticulating simultaneously. The clouds that had accumulated during the day had begun to descend over the field, so that from time to time their images were lost in the mist and reappeared intermittently. Even so, I immediately recognized my mother who had died when I was 7 years old. She looked at me with her beautiful blue eyes, which I could never forget, and with a melancholy tone she said: “Ach, Du bist so shoen!” (Oh, you are so handsome!). My more formal father said “Danke”, referring to the fact that I delivered his complete poetic work to the archive of the National Library of Germany.

It was very strange to see my mother so young, many years younger than my daughter is now, and to see my father, now fifteen years younger than me, as if he were my younger brother. But the one that caught my attention the most was a very small old woman, my grandmother, who told me “Sonnenschein, I am so proud of you. You know, I always wanted to be a doctor.” The surprise was that I suddenly realized that we were now contemporaries.

And it was then that I saw them coming from afar. They were dressed in rags, had a yellow Star of David on their chest and blue numbers tattooed on their arms. They marched together to meet me, solemnly and somberly singing the “Shema Yisrael” (שמע ישראל יהוה אחד יהוה אחד) (שמע ישראל יהוה אחד יהוה אחד). They were so many! I saw among them, the elderly, young men and women, adolescents, and children. Already next to me they begged me, “Vergiss uns nicht” and exclaimed, “Nie Wieder!” (“Do not forget us” “Never again!”). I felt immense love and heartache: these were my great-uncles, great-aunts, uncles, aunts, and cousins, about whom my family never told me, perhaps simply because they just couldn't. They came to see me from Auschwitz, from Theresienstadt, from Birkenau. Crying I went to hug them, but as soon as I came near they turned to ashes.

I carry them with me.



# Movie Reviews

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## Winter 2024 Movie Reviews

*Lucy Crain, MD, FAAP*

### **KILLERS OF THE FLOWER MOON**

Martin Scorsese has produced and directed an outstanding epic masterpiece with his latest 3-1/2 hour-long film about the 1920s murders of Osage tribe landowners after the discovery of oil riches on their properties. Starring Robert DeNiro as William “King” Hale and Leonardo DiCaprio as his gullible nephew Ernest Burkhart, the film is based on David Gram’s 2017 book: *The Osage Murders and the Birth of the FBI*.

The screenplay by Scorsese, Gram and Eric Roth follows the text fairly closely. The plot masterminded by Hale is for white men to marry oil-rich Osage women and inherit their property and oil rights. Ernest Burkhart truly falls in love with Mollie Kyle, played by the brilliant Lily Gladstone, one of four oil-rich Osage sisters, three of whom are murdered. Mollie and Ernest have a seemingly happy marriage with three beloved children, while Ernest secretly is Hale’s middleman arranging murders - even those of Mollie’s sisters.

Although having severe diabetes, Mollie travels with other tribe members to Washington and convinces the president to send J. Edgar Hoover’s federal investigators (precursors of the FBI) to investigate the two dozen-plus mysterious deaths and suspected Osage murders. This is a historically accurate movie with outstanding cinematography and acting and such good direction and action that its length is not of concern.

Of special interest, full-blooded Native Americans, even wealthy landowners, were declared “incompetent” and each had an appointed white guardian who oversaw their fiscal matters and other business. Also noted was the temporal overlap of the Osage murders with the massive destruction of the Black Wall Street businesses in Tulsa, Oklahoma, further confirming the racist mindset of the United States in the early 1920s.

Now playing only in theatres with eventual streaming on Apple. R rating for violence, smoking, and drinking.

### **ARE YOU THERE GOD? IT’S ME MARGARET.**

Based on author Judy Blume’s 1970 novel of the same name, this is a delightful coming of age film. Abby Ryder Fortson plays sixth grader Margaret, and her parents are played by Rachel McAdams and Benny Safdie. The mother grew up in an ultra-conservative Christian family who disowned her when she married a Jewish man. Among the many changes in pre-pubertal Margaret’s young life is the surprise discovery of her parents’ decision to move from New York City to the New Jersey suburbs. In her desperate wishes to stay in New York along with her growing questions about religion or lack thereof in her own family, she prays that God will stop the move. Margaret has been raised agnostic, although her parents have told her that she can choose a religion “when she’s old enough” if she wishes. This is addressed with great zeal by her Jewish grandmother, played by the terrific Kathy Bates. The 1970s book is timeless, with information about menstruation, pubertal changes, boys, and other early teenage challenges addressed so well in Blume’s straightforward but amusing style. This is an entertaining film for all ages and genders.

Released April 2023. 1 hour 45 minutes, G rating. In theatres and streaming on Apple TV and Prime Video.

# Book Reviews

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Reviewed by Robert Hauck, MD, FAAP

## **The Maid: A Novel (Molly the Maid)**

*Nita Prose*

*Ballantine Books, 2023, 336 pages (paperback)*

If you're looking for a lighter read that's engaging and fun, you'll find it in Nita Prose's *The Maid*. (Not to be confused with another recent novel, *Maid*, by Stephanie Land.) Several of our book clubs have read this popular first novel and everyone has enjoyed it.

*The Maid* is billed as a mystery "Who done it?" but in actuality, the murder plot is downplayed and only a secondary - but necessary - feature of the plot. The principal theme is the meticulous development of the endearing central character, "Molly the Maid." Molly is on the housekeeping staff of an elegant five-star hotel where she loves her work and prides herself on cleaning guests' rooms to perfection. She views herself as a room cleaning professional although she modestly introduces herself as, "I'm only a maid who cleans rooms."

In early chapters, this reader wavered in understanding Molly's portrayed personality. Is she on the autism spectrum? Is she obsessive compulsive? Her reliance on rigid daily routines both at home and at the hotel suggests she is a blend of the two characteristics. Her mentor was her late perfectionist grandmother who reared Molly, taught her to be a hotel maid like herself, and shared a routinized home life.

Molly the Maid is portrayed as naïve and unfailingly trustful of everyone in her workplace. Co-workers bully her because she is "different" and her immediate boss takes advantage of her. A friendly desk clerk supports her and a grand-fatherly doorman is her strong advocate. Molly rolls with the punches.

An important central theme involves the character of Molly's "friendships." A permanent hotel guest adores Molly but fails as a faithful friend. A co-worker feigns a possible romantic interest and unscrupulously takes advantage of her. A prior supposed boyfriend emptied her bank account. The hotel manager is sympathetic to Molly. The doorman is a true friend who rescues her after accusations of murder. The author's exploration of Molly's friendships, both genuine and false, is key to understanding Molly.

During her routine room cleaning chores maid Molly discovers the murder victim and becomes implicated in the investigation. A hardened detective targets Molly as the possible perpetrator while the investigation discovers intrigues within the hotel involving employees and wealthy guests - another secondary theme revealing dark deals lurking behind the hotel's facade of elegance. Molly is rescued by an unexpected twist in the plot, believable but not nearly as miraculous as solutions created by other mystery writers like Agatha Christie.

My final question at our book club discussions: Will folks still be reading *The Maid* five or ten years from now? Will this work be included in future lists of "Memorable Novels of the 21st Century"? Fellow readers didn't think so although we all enjoyed the story and recommended it to our friends.

# Poetry Corner

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## Distinction

*Joseph Girone, MD, FAAP*

To all who complete the course  
We call them doctor  
For they are all alike  
All have wisdom and knowledge  
No discernible differences

But are they the same?

We know they are not  
We recognize the best

What makes them best?  
They sit down and care  
They look for the heart of their patient  
They look for sorrow and joy  
They look for the true concern

They listen and see

## Undertones

*Peter Gorski, MD, FAAP*

Listen if you want to hear them  
Listen and you will surely hear them.  
Beneath the glare of life being lived  
Down below the currents streaming by  
Under all that rumble for attention  
Even within the drama of conflict and battle

Listen and you will hear  
Sounds that underpin a base  
A solid stable ground  
On which to raise a common compassion  
Create enduring achievement  
Advance and evolve

Bearing strength to differ  
Indeed to peacefully protest  
For harmony resumes  
As dissonance resolves

There they ring  
Notes that build symphonies  
To our deepest purpose  
And highest possibilities

Listen and you will hear them  
Pulsing in solemn cadence  
Toward a more noble condition  
Shouldering a universal anthem  
Rooted in the key of peace.

# Guidelines for Senior Bulletin Articles

*Gilbert Fuld, MD, FAAP Editor*

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

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

Submissions are not guaranteed to be posted in the Bulletin. The editor has the right to refuse publication of any article deemed inappropriate. Publication of articles may be deferred in order to reserve them for a periodic special focus issue. (Authors will be informed if this is the case.) Letters to the Editor are also sought for most issues and may relate to past articles or suggest topics of interest.

Questions about articles contemplated or in progress can be directed to me at [gilfuld@icloud.com](mailto:gilfuld@icloud.com) or to Co-Editors Peter Gorski [pgorski@fiu.edu](mailto:pgorski@fiu.edu) and Richard Krugman [richard.krugman@cuanschutz.edu](mailto:richard.krugman@cuanschutz.edu). There is a new process for submitting articles. Please [CLICK HERE](#) to upload your article submission. We look forward to hearing from you and to reading your articles in the Senior Bulletin.

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## 2024-2025 Senior Bulletin Schedule

### **Spring Bulletin - Electronic**

February 5, 2024: Call for Articles  
March 11, 2024: Article Submissions Due  
April 25, 2024: Bulletin Online

### **Summer Bulletin - Electronic**

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

### **Fall Bulletin - Electronic**

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

### **Winter Bulletin - Electronic**

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

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

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