

SENIOR BULLETIN

AAP Section for Senior Members

Editor: Arthur Maron, MD, MPA, FAAP
Associate Editors: Carol Berkowitz, MD, FAAP
James Reynolds, MD, FAAP
Donald Schiff, MD, FAAP

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DEDICATED TO THE HEALTH OF ALL CHILDREN™

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

Message from the Chairperson

Lucy S. Crain, MD, MPH, FAAP
Chairperson, Section for Senior Members

Maintenance of Certification: I hope that all of you have read the winter issue of the *Senior Bulletin* online and have noted that more than 20% of our entire section membership responded to comments about lifetime certification and the American Board of Pediatrics Maintenance of Certification (MOC) program. It appears that this is a topic which is not going away until those of us with lifetime certificates are all gone. (Hopefully, that won't be in the immediate future!) Meanwhile, there were some excellent suggestions submitted by our members, which will be conveyed to leadership of both the AAP and the ABP. For starters, the leadership along with our membership is invited to re-read the winter issue of the *Senior Bulletin*.

While there have been several appreciated modifications made on the ABP website regarding descriptions of participation in MOC by pediatricians who earned permanent ABP certificates (awarded only up until 1988), the ABP website still prominently notes: “*Not participating in MOC*” next to the name of any of the 22,000 (of 25,000) permanent certificate

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**Section for Senior Members
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Eau Claire, WI

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and Muriel Wolf, MD, FAAP

Web Master • Jerold Aronson, MD, FAAP

History Center/Archives
David Annunziato, MD, FAAP

Newsletter Editor
Arthur Maron, MD, MPA, FAAP
561/394-6114
artmaron@aol.com

Staff

Jackie Burke
Sections Manager
jburke@aap.org

Tracey Coletta
Sections Coordinator
tcoletta@aap.org

Mark A. Krajecki
Pre-Press Production Specialist
mkrajecki@aap.org

Message from the Chairperson

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holders who have chosen not to participate. Our respondents have indicated that this seems redundant and frankly insulting to those so identified. It is suggested that the ABP instead note: “*Not required*”, as there already is linked explanation that such participation is “optional, although recommended”.

The Social Network: My husband and I recently watched the DVD of this movie about the founding of Facebook and associated social intrigue, alleged intellectual property theft, and double crossing of friends. It's an interesting movie, but it left me feeling rather old! Well, after all, I am significantly older than the subjects of the movie, which may be based more on fiction than fact, but the issues of trusting friends (or not), betrayal of trust, and making obscene amounts of money in the process are ageless. (Watch the movie if you haven't seen it already, and don't be so bored with the first half hour or so that you give up on it. Also, check out the bulleted article on Social Media on our SFSM website.)

Watching *The Social Network* this week when the national news is filled with proposed draconian federal and state budget cuts targeting health, education, and social services raises all sorts of questions about monetary and moral priorities. That news, of course includes dire observations that our nation/states/cities are “broke” and is juxtaposed upon world news of the overthrow of Egypt's government by largely peaceful protests, followed by Nicholas Kristof's headline article, “Blood Runs Through the Streets of Bahrain” (New York Times 2/18/11). The international applications of Facebook, Twitter, and other forms of internet communication have made possible

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up to the minute sharing of news which otherwise would have taken hours, if not days. Much has been stated regarding the role of poverty as well as oppression in these revolutions. Noting US statistics about numbers of children and families living in poverty, persistently high rates of unemployment (although perhaps slightly improving) and threats of removal of support systems by budget cuts when there are no jobs to be had makes it more understandable when we read that more than 600,000 children in this country reside in the care of their grandparents and thousands more reside in multigenerational families due to economic or social factors.

Section Strategic Plan Review:

The Senior Section Executive Committee will meet in mid April to conduct various matters of business, including review of the 2008-2011 section strategic plan. We have discussed preliminary consideration of amending goals to include a new initiative addressing ways in which our section can be instrumental in promoting the AAP becoming a major resource

of information for grandparents of all descriptions. Your executive committee would appreciate your input and suggestions for this new initiative. Please send comments via Tracey Coletta (tcoletta@aap.org) to attention of the executive committee regarding your experiences as grandparents, foster grandparents, clinical practice observations and experiences. We appreciate your assistance.

AAP Development Opportunity:

Our Section is grateful for all of our members who contribute to the Friends of Children fund and other AAP philanthropic entities. It's concerning that so few members of the AAP overall have included such tax deductible donations in their charitable contributions, since these funds directly contribute to child health services. Recently, you may have received a flyer from Joseph Like, Director of Individual Giving and Major Gifts of the AAP about the 2011 IRA charitable rollover extension. If you wish to learn more about this opportunity, please e-mail jlike@aap.org.

2011 Senior Bulletin Schedule

We welcome contributions to the Bulletin on any topic of interest to the senior community. Articles for consideration should be sent to the Editor at artmaron@aol.com with copies to the Academy headquarters tcoletta@aap.org

Summer Bulletin

June 1 articles due to Arthur Maron MD, MPA, FAAP
July 1 mailboxes

Fall Bulletin

August 15 articles due to Arthur Maron MD, MPA, FAAP
September 15 mailboxes

2012 Winter Bulletin - *Electronic*

December 1 articles due to Arthur Maron MD, MPA, FAAP
January 6, 2012 online

The Budget Battle: A View of its Effect on Health Care

By Donald W. Schiff, MD, FAAP

As the temperature rises and we move forward toward spring, we should anticipate a heat wave from the unprecedented nationwide furor over budgets for the next two years.

The election of 2010 turned over control of the national House of Representatives, as well as most state legislatures and a majority of governorships to the Republican Party. This political change, added to the very slow improvement in the economy, has produced an explosion of demands to curtail expenditures and reduce governmental budgets.

The Bowles-Simpson Commission recently pointed out the necessity of the significant changes needed in entitlement programs, including Social Security, Medicare and Medicaid, as well as non-entitlement (defense spending); if we are to effectively alter our current pattern of spending more than our revenue. Neither Democrats nor Republicans have stepped forward to take the lead in what is perceived to be dangerous political waters.

However, a bipartisan task force of Senators Coburn, Saxby and Crapo (Republicans), Durbin, Conrad and Warner (Democrats) are now working together as a “gang of 6” to advance the Commission’s recommendations to reduce the debt by \$4 trillion over the next decade. This would be accomplished in part by charging seniors more for Medicare and closing expensive tax breaks.

The congressional leadership has temporarily put aside the entitlement and defense portion of the budget to concentrate on the 12% of the \$3.4 trillion annual budget which is labeled non-security discretionary. The House of Representatives has passed a bill which slashed \$61 billion from the budget for the remainder of this fiscal year (2011) and has promised to cut at least \$100 billion from next year’s budget.

These measures would result in severe reductions or deletions of important health programs.

House Appropriations Committee Chairman Hal Rogers released on February 9 his list of proposed cuts which would reduce current federal spending by \$32 billion and would have a devastating effect on children’s health.

Proposed cuts:

- \$27 million from Poison Control Centers;
- \$96 million from the Substance Abuse and Mental Health Services Administration;
- \$210 million from Maternal and Child Health Clock Grants, which is a 32% cut;
- \$220 million from the Food and Drug Administration;
- \$327 million from family planning accounts, completely eliminating funding for Title X;
- \$405 million from Community Services Block Grants;
- \$755 million from the Centers for Disease Control and Prevention;
- \$758 million from WIC;
- \$1 billion from the National Institutes of Health, leaving FY11 funding at FY10 levels; and
- \$1.3 billion from Community Health Centers.

The AAP is gearing up for a major effort to modify the budget to one more favorable to children. This would be done by educating congress on the critical nature of these programs for children and by developing support in the Senate and the administration.

The first target of the House Republican Majority was the Health Reform Act (ACA). They fulfilled their promise of repealing this legislation as one of their “first accomplishments.” It should be noted that most observers believe

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that the Senate will not agree to a repeal, and that if that unlikely action did occur, President Obama would veto the bill.

Additional attacks on the ACA have begun at both the federal and state levels. The House has removed from the budget all funds needed for planning and implementation of the ACA. Many states have declined to budget or work toward the required 2014 opening of state insurance exchanges.

The Congressional Budget Office has calculated that a repeal of the ACA would add 32 million more Americans to the 50 million currently without insurance. At this time there is no concrete alternative to the ACA.

The courts have responded to the 26 state attorneys general suit questioning the constitutionality of the portion of the ACA which mandates almost universal insurance purchase. Two judges have upheld and two have denied the constitutionality question.

Alaskan Governor Sean Parnell found the Florida court decision an opportunity to jump into the fray with his own interpretation, stating that the Florida ruling is now the law of the land in Alaska. However the ultimate decision on the question of the mandate will be from the U.S. Supreme Court. At this time, in the opinion of Tim Jost, Professor of Law at the Washington and Lee University School of Law, ACA is the law to be followed.

On a more positive note, with the implementation of the ACA, the administration estimates that tens of thousands of children previously uninsured will become insured due to the ban on exclusions for pre-existing conditions and an additional 1.2 million young adults up to age 26 will achieve coverage under their parents' policies.

The administration's nuanced budget struck a positive note, clarifying for at least two years the controversy over the Medicare SGR (Sustainable Growth Rate), which has threatened a 20% cut in reimbursement for Medicare patients. A specific allocation of \$54 billion is designed to eliminate this issue for 2012 and 2013.

But the administration's budget has incomprehensibly quashed the \$318 million dollar program that supports pediatric residency programs at the nation's children's hospitals. This budgetary line item helped pay for 5,631 residents annually. "Cutting this program across the country would have a dramatic negative effect on the pediatric workforce pipeline at a time when children's timely access to care is already impaired," states Larry McAndrews, President of the National Association of Children's Hospitals. Hopefully we can turn this one around, also, and avoid a national shortage of pediatricians. More to come!

Please e-mail me with your thoughts and suggestions at donroschiff@comcast.net.

Section For Senior Members Election Results

Election results for member of the Executive Committee of the Section for Senior Members have named Allen (Buz) Harlor to a second three-year term, starting in the Fall, 2011. Congratulations and best wishes to Buz.

BOOK REVIEW

By Arthur Maron, MD, MPH, FAAP

Diamonds of Death

John Luck, MD

Five Star Publications, Inc., Chandler, AZ, 2008

Upon his return from the Korean War, scarred by horrible memories and the experience of a surgical disaster on the battlefield, Dr. Tom Slocum is eager to return to the normalcy of surgical practice. Instead, he unexpectedly encounters a scenario which becomes the subject of this novel. Set in post-Korean War Chicago, it portrays Tom's efforts to survive in an atmosphere of a city deeply involved and overwhelmed by organized crime.

Written in classical gangster parlance and sprinkled liberally with colorful expletives, it is reminiscent of the "Godfather" genre. If you liked "The Godfather", you'll love "Diamonds of Death". Meet Louie Campione, high-ranking—albeit diminutive—member of the Chicago Mafia. Rocco is Louie's over-muscled driver. Tuna is the powerful head of the Chicago mob. Frank and Betty Jean have stolen the diamonds. "The Geek" (William Dretsch) has the diamonds. Dr. Tom Slocum, erswhile young surgeon trying to regain his confidence after the war, comes into possession of the diamonds at mortal risk to his well-being. Laura Nordstrom, the reporter assigned by the Chicago Tribune to cover the diamond heist, interviews Tom and subsequently finds herself in danger. There are numerous additional characters (using that term in its several meanings) who are woven into this fast-moving, page-turning, exciting novel.

Needless to say, the diamonds are ultimately saved, but not before death and destruction are encountered and avoided. You are encouraged to read this novel and follow the plot to its satisfying climax.

"Diamonds of Death" is the most recent novel by the author. The pseudonym John Luck, was chosen by John Raffensperger, a prominent pediatric surgeon and long-time member of the AAP. John is now retired in sunny Florida but has lost none of his vigor and enthusiasm.

Did You Know . . . ?

A neat shortcut is available to allow you to get to our
Section for Senior Members web site really fast.

Try it, you'll like it!

Happy browsing.

www.aap.org/seniors

Save Taxes on Your IRA Withdrawals

If you are 70 ½ or older and have an Individual Retirement Account (IRA), you are required to take a minimum distribution from your IRA each year. Because the income put into your IRA was not taxed when you earned it, income taxes are owed when it is withdrawn from your IRA. Even if you do not need the income, you are required to withdraw the minimum distribution each year after age 70 ½. And you must pay taxes on that income.

Recent tax legislation now allows you to direct part or all of your required IRA distribution to a qualified charity, such as the American Academy of Pediatrics for the Friends of Children Fund or Tomorrow's Children Endowment. The transfer of funds will be excluded from your gross income and count towards your minimum IRA distribution for calendar year 2011.

This "IRA Charitable Rollover" is only available for calendar year 2011. After 2011, this tax savings may expire as Congress looks for new streams of tax income.

To qualify for this tax break:

- You must be 70 ½ or older when you make your gift
- Your total IRA gift cannot exceed \$100,000 for the year
- The transfer must go directly from your IRA custodian to the charity
- Your gift must be outright, with no expectation of receiving any good or service in exchange for the gift

You will not receive a charitable contribution credit for the IRA charitable rollover. With the IRA Charitable Rollover, you may be able to reduce your income and not pay taxes on your required minimum IRA distribution for the year. This may allow you to stay below the alternative minimum tax (AMT) levels for 2011.

Another tax savings idea you can consider is giving your appreciated securities owned outside of your IRA directly from your broker to the American Academy of Pediatrics Friends of Children Fund. Then, you can use your IRA distribution to repurchase those securities and establish a new, higher cost basis. When you transfer the stocks directly to a charity you pay no capital gains taxes on their appreciation, and you will lower future taxes on the new securities you purchase.

Likewise, if you have Series E or EE U.S. savings bonds that are not earning income anymore, you can offset the increased income taxes owed on the sale of these bonds by making a gift through your IRA Charitable Rollover and reducing your total income tax liability.

For more information about this and other ways your giving can benefit you and the American Academy of Pediatrics, please call Joseph Like, CFRE, Director of Individual Giving and Major Gifts, American Academy of Pediatrics, at 847/434-4740.



*His is
a poignant piece
by Michael Gartner,
president
of NBC News.
In 1997,
he won
the Pulitzer Prize
for editorial writing.
It is well
worth reading.*

My father never drove a car. Well, that's not quite right. I should say I never saw him drive a car.

He quit driving in 1927, when he was 25 years old, and the last car he drove was a 1926 Whippet.

"In those days," he told me when he was in his 90s, "to drive a car you had to do things with your hands and do things with your feet and look every which way and I decided you could walk through life and enjoy it or drive through life and miss it."

At which point my mother, a sometimes salty Irishwoman, chimed in: "Oh, bull shit!" she said. "He hit a horse."

"Well," my father said, "there was that, too."

So my brother and I grew up in a household without a car. The neighbors all had cars — the Kollingses next door had a green 1941 Dodge, the VanLanings across the street a gray 1936 Plymouth, the Hopsons two doors down a black 1941 Ford — but we had none.

My father, a newspaperman in Des Moines, would take the streetcar to work and, often as not, walk the 3 miles home. If he took the streetcar home, my mother and brother and I would

walk the three blocks to the streetcar stop, meet him and walk home together.

My brother, David, was born in 1935 and I was born in 1938 and sometimes, at dinner, we'd ask how come all the neighbors had cars but we had none. "No one in the family drives," my mother would explain; and that was that.

But sometimes my father would say, "But as soon as one of you boys turns 16, we'll get one." It was as if he wasn't sure which one of us would turn 16 first.

But, sure enough, my brother turned 16 before I did, so in 1951 my parents bought a used 1950 Chevrolet from a friend who ran the parts department at a Chevy dealership downtown.

It was a four-door, white model, stick shift, fender skirts, loaded with everything and, since my parents didn't drive, it more or less became my brother's car.

Having a car but not being able to drive didn't bother my father, but it didn't make sense to my mother.

So in 1952, when she was 43 years old, she asked a friend to teach her to drive. She learned in a nearby cemetery, the place where I learned to drive the following year and where, a generation later, I took my two sons to practice driving. The cemetery probably was my father's idea. "Who can your mother hurt in the cemetery?" I remember him saying more than once.

For the next 45 years or so, until she was 90, my mother was the driver in the family. Neither she nor my father had any sense of direction, but he loaded up on maps — though they seldom left the city limits — and appointed himself navigator. It seemed to work.

Still, they both continued to walk a lot. My

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mother was a devout Catholic and my father an equally devout agnostic, an arrangement that didn't seem to bother either of them through their 75 years of marriage.

(Yes, 75 years, and they were deeply in love the entire time.)

He retired when he was 70 and nearly every morning for the next 20 years or so he would walk with her the mile to St. Augustin's Church. She would walk down and sit in the front pew and he would wait in the back until he saw which of the parish's two priests was on duty that morning. If it was the pastor, my father then would go out and take a 2-mile walk, meeting my mother at the end of the service and walking her home.

If it was the assistant pastor, he'd take just a 1-mile walk and then head back to the church. He called the priests "Father Fast" and "Father Slow."

After he retired my father almost always accompanied my mother whenever she drove anywhere, even if he had no reason to go along. If she were going to the beauty parlor he'd sit in the car and read, or go take a stroll or, if it was summer, have her keep the engine running so he could listen to the Cubs game on the radio. In the evening, then, when I'd stop by, he'd explain: "The Cubs lost again. The millionaire on second base made a bad throw to the millionaire on first base, so the multimillionaire on third base scored."

If she were going to the grocery store, he would go along to carry the bags out — and to make sure she loaded up on ice cream. As I said, he was always the navigator and once, when he was 95 and she was 88 and still driving, he said to me, "Do you want to know the secret of a long life?"

"I guess so," I said, knowing it probably would be something bizarre.

"No left turns," he said.

"What?" I asked.

"No left turns," he repeated. "Several years ago your mother and I read an article that said most accidents that old people are in, happen when they turn left in front of oncoming traffic.

As you get older your eyesight worsens and you can lose your depth perception, it said. So your mother and I decided never again to make a left turn."

"What?" I said again.

"No left turns," he said. "Think about it. Three rights are the same as a left and that's a lot safer. So we always make three rights."

"You're kidding!" I said, and I turned to my mother for support.

"No," she said, "your father is right. We make three rights. It works." But then she added: "Except when your father loses count."

I was driving at the time and I almost drove off the road as I started laughing.

"Loses count?" I asked.

"Yes," my father admitted, "that sometimes happens, but it's not a problem. You just make seven rights and you're okay again."

I couldn't resist. "Do you ever go for 11?" I asked.

"No," he said ". If we miss it at seven we just come home and call it a bad day. Besides, noth-

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ing in life is so important it can't be put off another day or another week."

My mother was never in an accident, but one evening she handed me her car keys and said she had decided to quit driving. That was in 1999, when she was 90.

She lived four more years, until 2003. My father died the next year, at 102.

They both died in the bungalow they had moved into in 1937 and bought a few years later for \$3,000. (Sixty years later, my brother and I paid \$8,000 to have a shower put in the tiny bathroom — the house had never had one. My father would have died then and there if he knew the shower cost nearly three times what he had paid for the house.)

He continued to walk daily — he had me get him a treadmill when he was 101 because he was afraid he'd fall on the icy sidewalks, but wanted to keep exercising — and he was of sound mind and sound body until the moment he died.

One September afternoon in 2004, he and my son went with me when I had to give a talk in a neighboring town and it was clear to all three of us that he was wearing out, though we had the usual wide-ranging conversation about politics and newspapers and things in the news.

A few weeks earlier, he had told my son, "You know, Mike, the first hundred years are a lot easier than the second hundred." At one point in our drive that Saturday, he said, "You know, I'm probably not going to live much longer."

"You're probably right," I said.

"Why would you say that?" He countered, somewhat irritated.

"Because you're 102 years old," I said.

"Yes," he said, "you're right." He stayed in bed all the next day.

That night, I suggested to my son and daughter that we sit up with him through the night.

He appreciated it he said, though at one point, apparently seeing us look gloomy, he said: "I would like to make an announcement. No one in this room is dead yet"

An hour or so later, he spoke his last words: "I want you to know," he said, clearly and lucidly, "that I am in no pain. I am very comfortable and I have had as happy a life as anyone on this earth could ever have had."

A short time later, he died.

I miss him a lot and I think about him a lot. I've wondered now and then how it was that my family and I were so lucky that he lived so long.

I can't figure out if it was because he walked through life, or because he quit taking left turns.

Life is too short to wake up with regrets.

So love the people who treat you right.

Forget about the one's who don't.

Believe everything happens for a reason.

If you get a chance, take it & if it changes your life, let it.

Nobody said life would be easy, they just promised it would most likely be worth it.

ENJOY LIFE NOW -
IT HAS AN EXPIRATION DATE!

Letter to the Leadership

March 7, 2011

Errol R. Alden, MD, FAAP,
AAP Executive Director/CEO

O. Marion Burton, MD, FAAP,
AAP President

James Stockman, MD, FAAP,
Executive Director,
American Board of Pediatrics

Dear Drs. Alden, Burton, and Stockman,

As you know, the Section for Senior Members (SFSM) recently had an unprecedented volume of feedback from our membership regarding the issue of Maintenance of Certification (MOC) as it pertains to those 25,000 FAAPs with lifetime ABP certification.

Our Section membership, our AAP President, AAP Executive Director, and Dr. James Stockman of ABP, asked that I write on behalf of the SFSM to note consistent themes and highlight any specific recommendations to either AAP or ABP in the wake of the recent outpouring of comment from over 20% of our Section membership. That is the intent of this letter.

It is clear that the issues of MOC and lifetime certification are unlikely to go away until all of us with lifetime or permanent certification from the ABP are gone or no longer involved with any active aspect of pediatric practice. We know that there have been previous collaborative efforts by the AAP and ABP leadership to address the grievances regarding modification of language on the ABP website, and these are appreciated.

The item that continues to garner the most significant focus from our membership is that there still is a prominent note next to the names of individuals with permanent certificates who

have chosen not to participate in MOC, stating “This individual does not meet the requirements of maintenance of certification”. This statement is interpreted as offensive by the majority of members who submitted comment. Moreover, several members navigated the ABP website and duly noted that in its “learn more” subsection, it clearly states participation in MOC is optional for permanent certificate holders.

We believe this clear reference makes the more offensive note next to the individual’s name redundant. On behalf of the Section for Senior Members we request that the ABP remove the statement, “This individual does not meet the requirements of maintenance of certification” next to the names of those with lifetime certification. We will continue to actively advocate on behalf of our Senior members to accomplish this.

There were other items of contention in the feedback from our membership, as well as positive suggestions about improving the opportunity for senior members to choose to participate in MOC. We invite you to review those on the Section for Senior Members website and in the summaries in our online winter edition of the Senior Bulletin.

Since you noted that there is an AAP-ABP liaison committee, we would appreciate knowing whether we should be corresponding with that committee directly in the future. If so, it would be helpful if you can provide the contact information for the liaison committee if you wish for us to share this letters with those members. Meanwhile, we trust that you will forward this letter to their attention as well as to the attention of the AAP Board of Directors. Thank you again for addressing our concerns.

Sincerely,
Lucy S. Crain, MD, MPH, FAAP
Chairperson, AAP Section for Senior Members

The Inspiration for Sherlock Holmes

By John Raffensperger, MD, FAAP

Arthur Conan Doyle was a student at Edinburgh Medical School during the 1870's and after graduation established a successful general practice in a suburb of Portsmouth. In 1890, Conan Doyle abandoned medicine to write full time. His literary success was due to the Sherlock Holmes stories, beginning with "A Study in Scarlet" published in 1887. The inspiration for Holmes came from Edgar Allen Poe's detective, Dupin, who solved The Murders of the Rue Morgue and Dr. Joseph Bell, a talented and charismatic Edinburgh surgeon.

Joseph Bell, a master at observation and clinical diagnosis, held outpatient clinics for students in the old gas-lit surgical amphitheater of the Royal Infirmary. He theatrically seemed to taste a foul yellow liquid with his index finger and then passed the liquid around to the students to "taste". No one noticed that he inserted his index finger into the liquid, but put his middle finger into his mouth. Bell used this "trick" to impress his students on the need to carefully observe minor details. He could determine the occupation, nationality and where a patient lived by observing the calluses on his hands, his accent, clothing and the mud on his boots. In 1878, Joseph Bell appointed Arthur Conan Doyle to be his outpatient clerk. At the time, Bell was thirty six years old, sparse, lean, tall, with an angular nose and unkempt black hair. He had long sensitive fingers and his grey eyes "twinkled with shrewdness". This is almost exactly the description that Dr. Watson made of Sherlock Holmes in their first meeting at 221B, Baker Street in the story, "A Study in Scarlet."

Later, when asked about his inspiration for Holmes, Doyle replied, "I thought of my old teacher, Joe Bell, of his eagle face, of his curious eyes, of his eerie trick of spotting details. If he were a detective, he would surely reduce this fascinating but unorganized business to something nearer to an exact science." In another interview concerning his inspiration for Sherlock Holmes, Conan Doyle said, "Sherlock

Holmes is the literary embodiment of my memory of a professor of medicine at Edinburgh University." In a letter to Bell, Conan Doyle made the point even more forcefully. "It is most certainly to you that I owe Sherlock Holmes and though in the stories I have the advantage of being able to place him in all sorts of dramatic positions, I do not think that his analytical work is in the least an exaggeration of some of the effects which I have seen you produce in the outpatient ward".

Dr. Joseph Bell was descended from a long line of surgeons who were closely associated with the Edinburgh Medical School. He graduated in 1859 when he was twenty one years old when Joseph Lister was doing his research which led, in 1866, to the use of phenol to prevent wound infections.

Joe Bell distinguished himself in surgery and while in school was a "dresser" for Professor Syme, the chief surgeon. After graduation, he became a house surgeon and from the beginning was especially gifted with a gentle touch for women and children. In 1864, during an epidemic of diphtheria he worked around the clock taking care of children with tracheotomies. There were no suction machines to remove the thick membranes which occluded the tubes, so Dr. Bell developed a pipette for sucking out "the diseased, poisonous mass". As a result of close contact with infected patients he contracted diphtheria and was left with partial paralysis of a vocal cord and a weak leg.

In 1865 Bell became a clinical assistant surgeon and in 1871 was appointed full surgeon and put in charge of the wards. He one of the first surgeons to embrace Lister's antiseptic surgery and understood how hospital infections were transmitted through doctors and nurses. Lister wore the same fashionable swallow tail coat from one operation to the next but Bell rolled up the sleeves of his immaculate white shirt and

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scrubbed his hands.

Dr. Bell published "A MANUAL OF THE OPERATIONS IN SURGERY" for students, house surgeons and junior practitioners. His descriptions of operations were anatomically precise and could still be used by students. In the 1883 edition, his concern for the social aspects of disease was illustrated in his remarks on tuberculosis of the joints. "In our cold climate, so cursed by scrofula, and especially among the children of the laboring poor such joint diseases are very prevalent. Whether the disease commences in the synovial membranes or the articular cartilages or the heads of bones, it so frequently disorganizes the joint as to make it a question of whether something must be done to preserve the life of the patient. The patient has youth on his side, could we give him fresh sea air, good diet, cod liver oil, etc. we might very likely obtain an ankylosis, but he may die while trying for his ankylosis and also, this ankylosis may so lame or deform him that resection may still be required." Bell also noted that removal of the epiphysis in a growing child shortened of the limb. Amputation through healthy tissue was safer and easier but left the patient with a wooden leg. Joint excisions required the removal of the articular cartilage and all diseased tissue back to healthy, bleeding bone. The operation might leave a flail limb, but in the upper extremity, the child had a useful hand. Bell recommended bed rest and diet for disease of the hip, because hip excision in children under sixteen years of age carried a mortality of 40%. For cleft lip, he delayed surgery until the infant was two months of age, then excised the mucosal edges of the cleft and united the edges with metallic sutures. He said, "tonsillectomy is sometimes rendered difficult by their struggles and movements of the tongue." The operation must have been done without anesthesia because he advised seizing the redundant portion of the tonsil with a clamp and with one downward sweep of the bistoury cut it off. He applied cold water or styptics to stop the bleeding. Tracheotomy was performed

for the removal of foreign bodies and for diphtheria. He claimed that circumcision might cure obstinate enuresis in cases in which the prepuce is very long or redundant, even when it is not too tight. He advised trusses for inguinal hernias except in cases of incarceration, which he reduced with manual reduction with the patient in the inverted position, aided when necessary by warm baths and chloroform anesthesia. If the hernia couldn't be reduced, Bell operated by cutting through all layers to the sac under antiseptic precautions. If the intestine was still pink and glistening, the internal ring was opened and the bowel reduced into the peritoneal cavity. Gangrenous bowel was kept outside in the hopes that an intestinal fistula would form. He wrote that some surgeons had removed the gangrenous bowel, but with great mortality. In children with bladder stones, he preferred a perineal approach which cut through the neck of the urethra and the prostate so that a finger could reach into the bladder and remove the stone.

His manual describes only two abdominal operations, gastrostomy for foreign bodies or esophageal obstruction and colostomy for imperforate anus. "In children, the condition known as imperforate anus may sometimes be remedied by exploratory operations in the perineum, guided by the protrusion caused by the distended intestine. There are other cases, however, in which the rectum as well as the anus seems to be deficient; there is no warrant for attempting an operation.

Dr. Bell believed in operating rapidly to reduce blood loss and the effects of anesthesia. As an example, he reported the case of a man whose legs were crushed under loaded wagons. After applying tourniquets to the thighs, and with the "strictest antiseptic precautions" Bell amputated both legs above the knees and had the patient back in bed within twenty four and a half minutes from the time he entered the hospital gate. The stumps healed by first intention

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and the patient was in the hospital garden on the seventh day after the operation.

When Dr. Bell retired from the Royal Infirmary he took charge of the first surgical ward in the Royal Edinburgh Hospital for Sick Children. The hospital was founded in 1860 to care for poor children with typhus, typhoid fever, scarlet fever and other infectious diseases. The surgical ward opened in November, 1887 under the direction of Dr. Bell, was soon filled to overflowing, mainly with children suffering with tuberculosis of joints or lymph nodes. There were also children with burns, hernia, hare lip, spina bifida, cleft palate, phimosis, hydrocele and club foot. He said, "The two great classes of disease which throng the waiting rooms and almost choke the beds are joint diseases and glandular swellings and suppuration. Had I four times the number of beds at my disposal, I could fill them all in a week with cases of spinal and hip joint disease. Only the very worst can be admitted where psoas abscesses have to be opened or hip abscesses to be drained or joints to be excised. Scraping and excision of the swollen and suppurating glands of scrofulous children are daily duties. A depressing lot of cases, some will say; but for the child's marvelous good nature and infinite fun once they recognize you mean friendship, their exuberant vitality renders it almost impossible for a child to die if only you can avoid shock and hemorrhage." He went on to say, "No case has yet died in my wards from an operation or within three months of one. Our ward deaths have been almost exclusively cases of hopeless burns. We have lost no burn cases that have survived the week. At that time, however, cases of empyema, peritonitis, intussusception and rectal atresia were considered terminal diagnoses and were not operated upon.

In 1895, Dr. Bell's house surgeon described their results; one child with burns, who died with pneumonia and intestinal bleeding, had at autopsy a duodenal ulcer. One child with otitis media died with meningitis after drainage of

his mastoid. Three patients were treated for empyema by thoracentesis; one eleven month old baby died with empyema and multiple abscesses. Others were operated upon for lumbar abscess, tubercular tenosynovitis, syphilitic gumma of the tibia, curvature of the tibiae due to rickets and tenotomy for talipes. Many children with hernias were treated with trusses, but one incarcerated hernia was reduced under chloroform anesthesia and another was operated upon. There were ninety three admissions to the ward; eight children died, but all deaths were related to infections such as meningitis, tuberculous peritonitis or pneumonia. There were no deaths directly related to an operation.

In his book, "Notes on Surgery for Nurses" Dr. Bell demonstrated his keen insight into children's psychology. He said, "Never deceive a child, tell it honestly that the dressing or movement you are going to make will hurt...but also that you will hurt it as little as possible, and it will help you loyally. Don't make favorites; children are much sharper than you think, and a quiet...child may soon get a sore heart if you take less notice of it than of the more cheerful one in the next bed. You must always have the one great rule to guide you about sick children—that they don't cry or moan for fun, but because they are ill and in pain, or from a nameless weariness if not in actual pain. Healthy children may yell and scream as an evidence and result of original iniquity, but sick children don't...If once you get a child's confidence and love it, it is marvelously loyal and utterly trustful...Adults can read and amuse themselves, but a child's convalescence will often be much hastened by toys, cheering words, and fun of the mildest type. The stages in sick children are more rapid. Death is imminent before you are aware; yet if staved off, recovery is like a miracle. They stand loss of blood very badly, and yet they remake blood very quickly." As an example of his keen skill at observation he wrote, "Children suffering from diarrhea of a wasting type sometimes take a strong fancy for old

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green-molded cheese and devour it with the best effect. Is it possible that the germs in the cheese are able to devour in their turn the Bacilli tuberculosis?" Was Dr. Bell foreseeing antibiotics?

Joseph Bell resigned as the active surgeon to the children's hospital in 1897, but continued as a consultant until his death in 1911. He continued with charitable work at the Royal Hospital for Incurables and in his busy private practice cared for rich and poor alike. His colleague and rival, Dr. John Chiene, said of him, "Every child in Edinburgh is indebted to this great man, rich, poor, church and unchurched." At his funeral, an undertaker's helper wept huge tears into the open grave. Dr. Bell had treated his son, free of charge for many years.

We may say, without hesitation that Joseph Bell, the real Sherlock Holmes, by way of his compassion for children and by his surgical skill was a pediatric surgeon. If he were a contemporary, he might be a member of our organization.

The original version of this paper, "WAS THE REAL SHERLOCK HOLMES A PEDIATRIC SURGEON?" with a complete list of references appeared in the Journal of Pediatric Surgery, vol. 45, 2010, pgs. 1567-1570

John Raffensperger, MD
4771 Tradewinds
Sanibel, FL. 33957

MOVIE REVIEW

By Lucy Crain, MD, MPH, FAAP

The King's Speech

Written by David Seidler, who requested permission of England's Queen Mother Elizabeth I to write a screenplay based on the details of her late husband's severe speech impediment. She agreed to his request contingent on his waiting until after her death to proceed with the project. He waited 25 years until her death to complete the screenplay and proceed with film production. This historically accurate movie is supported by a wealth of correspondence exchanged by King George VI of England and the speech therapist. The plot addresses the incapacitating stutter had by the King, leading him to a remarkable speech therapist and the relationship of the two. While the action focuses primarily on this relationship, the context is that of the beginning of World War II. The movie stars Colin Firth as King George, Helena Bonham Carter as Queen Elizabeth, and Geoffrey Rush as the most animated of all speech therapists, all of whom have received Academy Award nominations. (The R rating is solely due to an obscenity practiced in the speech therapist's unconventional vocal exercises.) The movie has received a total of 12 nominations, including one for best picture of the year. See it!

**The AAP Section for Senior Members would like to thank
Mead Johnson Nutrition
for their support of the Child Advocacy Award.**

Modern Job Search

By Alex Cvijanovich, MD, FAAP

Member of the Section on Young Physicians

Let me start by telling you a little about myself. I graduated from the University of North Carolina at Chapel Hill in 1992. During college, I scoured the employment ads in the school newspaper for a part-time job. My first job after college was as a counselor at a camp for children and adults with autism. I applied for this job after I saw a flyer on a bulletin board in the Psychology building on campus. Conveniently, this job gave me connections with the autism research group at UNC, so when I decided that I wanted to continue working with people with autism; I was simply able to contact this group. After completing a graduate program in Early Intervention, I was able to work full-time at the agency where I had completed an internship. In other words, before I started medical school, I had found jobs through the newspaper, word of mouth, and experience.

I completed residency in 2005, and, since I received a National Health Service Corps scholarship for medical school, my job hunt consisted of going through an electronic list of practices that qualified for scholar repayment and making many phone calls. This list, although electronic, was not kept up to date, posing many challenges. However, once I had finished my obligation, I started to look for a job again, this time with no limitations. The first place I turned to was a website sponsored by the AAP, <http://www.pedjobs.org>. I found this to be very useful because it includes a number of key features, including the ability to download my curriculum vitae and cover letters, as well as search features which allow me to look at jobs limited to certain states. I was also able to receive emails with instant job alerts so that



I didn't have to get on the website on a daily basis. Another website I found useful was <http://www.healthcareers.com> which has similar features, but different jobs are posted there than on PedJobs. There are many, many web-based job search sites these days, some easier to use than others. Of course, you can't forget doing a simple Google search!

Although this technology has been useful, there are always certain positions that never get advertised and simply get filled by word of mouth. I found multiple leads by telling my colleagues that I was looking for a job. For this type of job search, making connections at CME meetings and AAP leadership meetings is invaluable.

Beyond making personal connections, I have learned that some things haven't changed since I found my first job in high school in the 1980s, and probably since before then! Phone interviews and in-person interviews are still nerve-wracking. These days, there are certain topics that are supposed to be taboo, like marital status, the ability of a spouse to find a job in the same city, and family life in terms of kids, but they are still discussed. Women still get paid less than men, even though the pediatric workforce has ever-increasing numbers of women. Moving is still a challenge, although house-hunting now can be done partially online. However, when it comes to making a final decision on a job, nothing has changed; much time is still spent discussing my options with my husband, my family, my friends, and my lawyer, as people have done for a long time, even if now the discussions take place over email!

Family-to-Family Health Information Centers

Family-to-Family Health Information Centers (F2F HICs) are non-profit organizations that help families of Children and Youth with Special Health Care Needs (CYSHCN) and the professionals who serve them. F2F HICs are typically staffed and run by parents of CYSHCN who have traveled through the maze of services and programs designed to help their children and youth with chronic and complex health care needs. They understand the issues that families face, provide advice, offer a multitude of resources, and tap into a network of other families and professionals for support, information, and training.



Each F2F HIC reflects the needs of the community and state that it serves. Organizational structure, locations, partnerships, and specific initiatives may vary. However, all F2F HICs provide:

- Assistance to families and professionals in navigating health care systems
- Information, education, training, support and referral services
- Outreach to underserved / underrepresented populations
- Guidance on health programs and policy
- Collaboration with other F2F HICs, family groups, and professionals in efforts to improve services for CYSHCN
- Evaluation and outcome assessment

F2F HICs were established in all states by the Family Opportunity Act / Deficit Reduction Act of 2005. The Affordable Care Act of 2010 extended the F2F HIC Program through fiscal year 2012. Primary funding for F2F HICs is provided by the HRSA MCHB. Family Voices through the National Center for Family/Professional Partnerships provides technical assistance, training, and connections to other F2F HICs and partnering organizations. To learn more about your state's F2F HIC, visit: <http://www.familyvoices.org/f2f-grantees>.

Have an Issue?

Join the Section for Senior Members Listserv by contacting tcoletta@aap.org

For more information or to join the section...
visit our website at: www.aap.org/sections/seniormembers/

Food For Thought?

The fattest knight at King Arthur's round table was Sir Cumference.
He acquired his girth from too much pie.

I thought I saw an eye doctor on an Alaskan island,
But it turned out to be an optical Aleutian.

She was only a moonshine maker,
But he loved her still.

A rubber band pistol was confiscated from algebra class,
Because it was a weapon of math disruption.

No matter how much you push the envelope,
It'll still be stationery.

A dog gave birth to puppies near the road
And was cited for littering.

A grenade thrown into a kitchen in France
Would result in linoleum blown apart.

Two silk worms had a race.
They ended up in a tie.

A hole has been found in the nudist camp wall.
The police are looking into it.

Time flies like an arrow.
Fruit flies like a banana.

Atheists belong to a non-prophet organization.

I wondered why the baseball kept getting bigger.
Then it hit me.

A sign on the lawn at a drug rehab center
Said: 'Keep off the Grass.'

The midget fortune-teller who escaped from
Prison was a small medium at large.

A backward poet writes inverse.

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In a democracy it's your vote that counts.
In feudalism it's your count that votes.

If you jumped off the bridge in Paris,
You'd be in Seine.

A vulture boards an airplane, carrying two dead raccoons.
The stewardess looks at him and says,
'I'm sorry, sir, only one carrion allowed per passenger.'

Two fish swim into a concrete wall.
One turns to the other and says 'Dam!'

Did you hear about the Buddhist who refused Novocain
During a root canal? His goal: transcend dental medication.

There was the person, who sent ten puns to friends,
With the hope that at least one of the puns would make them laugh.
No pun in ten did.



AAP 2011 National Conference and Exhibition

October 15-18, 2011

Boston, MA

Section for Senior Members Program

Pediatricians in Transition: The Challenges of Change

Saturday, October 15, 2011

8:30 am - 12:30 pm

Building Portfolio Endurance Isn't Just a Pre-Retirement Exercise

By Joel M. Blau, CFP®

Ronald J. Paprocki, JD, CFP, CHBC®

MEDIQUS Asset Advisors, Inc.

"Results. One client at a time."^(sm)

The need for retirement planning doesn't end with the onset of retirement. A new retiree's focus should shift from building wealth to managing and preserving it. One major challenge is making the investment portfolio supply cash flow for the duration of life—and through various economic and market conditions.

Factors that drive a portfolio's longevity include asset mix, spending level, and the investment time frame. Certain aspects of these factors are within an investor's control while others are not.

Asset Mix

Asset mix refers to the ratio of stocks to bonds in a portfolio. This determines risk exposure and expected performance, and is one of the most important decisions investors of all ages make when constructing an investment portfolio. Historically, stocks have outperformed bonds and outpaced inflation over time. Consequently, the larger the equity allocation, the greater a portfolio's expected return—and risk.

Keep in mind that risk and return go together. A higher allocation to equities increases the risk of experiencing periods of poor returns during retirement. But if you can handle the risk, having more equity exposure in a portfolio enhances its return potential. Growth can bring higher cash flow, inflation protection, and portfolio endurance over time. While it is logical that investors should have an equity component in their portfolios, the actual weighting should be dependent on one's time frame, risk tolerance, and spending flexibility.

Spending Level

Portfolio withdrawal is typically described in terms of either a specified dollar amount (e.g., \$100,000 per year) or a percentage of annual portfolio value (e.g., 5% of assets each year).

- Specified dollar amount: withdrawing a fixed amount each year and adjusting it for inflation can provide a stable income stream and preserve your living standard over time. But the portfolio may survive only if future withdrawals represent a small proportion of the portfolio's value.
- Percent of annual portfolio value: withdrawing a fixed percentage of assets based on annual asset value makes it unlikely that you will deplete retirement assets because a sudden drop in market value would be accompanied by a proportional decline in spending. But this method can produce wide swings in your living standard when investment returns are volatile.

Retirees who need relatively consistent cash flow may want to combine both of these methods.

Investment Time Frame

Investment time horizon may be the hardest to estimate, especially if it is the same as your lifespan. In this case, you can only guess how long your portfolio must support spending. If you plan to bequeath assets, your investment timeframe may extend beyond your lifetime. This may influence your risk and spending decisions as well.

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Timeframe forces a tradeoff between the short and long term. Retirees with a longer investment time horizon might choose a higher exposure to equities. But they may have to offset this risk by being more flexible about spending over time. Elderly retirees and others with a short time horizon may choose a less risky allocation or a higher payout rate, although they can experience rising spending levels, too. In any case, retirees should think carefully about equity exposure and avoid taking more risk than they can afford.

Planning involves assumptions about the future—assumptions that may not pan out.

Although you cannot avoid making assumptions, you can ask whether they are realistic and consider how your lifestyle might change if future economic and financial conditions are much different than projected.

Although you cannot fully control these and other factors involved in portfolio endurance during retirement, having more wealth can improve the odds of having a less stressful financial life. A more substantial nest egg might enable you to take fewer risks, enjoy a higher sustainable spending rate, or extend the productive life of your portfolio.

Mr. Blau and Mr. Paprocki welcome readers' questions. They can be reached at 800-883-8555 or at blau@mediquis.com or paprocki@mediquis.com.

Securities offered through Joel M. Blau, CFP® and Ronald J. Paprocki, JD, CFP®, CHBC registered representatives of Ausdal Financial Partners, Member FINRA/SIPC. MEDIQUIS Asset Advisors, Inc. and Ausdal Financial Partners, Inc. are independently owned and operated.

AMA Seeks Clear Path for Doctors' Re-Entry into Medicine

Submitted by The American Medical Association Senior Special Interest Group

Dear Senior Physician Group Liaison Members:

Several of you provided excellent input into our request for interviewees on the topic of senior physician reentry. Below is the [link](#) to the article from Victoria Stagg Elliot, published in the March 7th issue of AM News, entitled "AMA Seeks Clear Path for Doctors' Re-entry into Medicine."

<http://www.ama-assn.org/amednews/2011/02/28/bil20228.htm>

Again, we would like to thank all of you who responded with your suggestions and ideas for this article.

Best regards,
Alice E. Reed, Program Administrator, Senior Physician Services
515 N. State Street, Chicago, IL 60654

AAP Releases Free Online Culturally Effective Care Toolkit for Practicing Pediatricians!

Learning to deliver culturally effective care is considered by many to be a lifelong journey. The new AAP Culturally Effective Care Toolkit is a practical, hands-on resource to help practicing pediatricians and their office staff provide culturally effective care to their patients and families.

Information, resources, and tools are included for the following topics are included in this free online toolkit:

- What is culturally effective care?
- Health beliefs and practices
- Nutrition, feeding, and body image perspectives
- Behavior and child development
- Interpretive services
- Literacy and health literacy
- Medical education
- Tips, tools, and resources for implementation in an office setting
- Continuing Medical Education opportunities

Hear what other practicing pediatricians are saying about the Toolkit -

“As pediatricians we strive to improve health equity for all of our patients and families. Maintaining a focus on culturally effective care in culturally appropriate settings in our office, clinic, and hospital practice platforms will continue to reduce disparities and improve equity in our health care delivery to all children.”

~ O. Marion Burton, MD, FAAP (South Carolina)

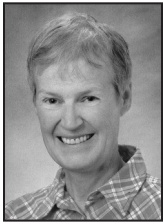
“This Culturally Effective Care Toolkit with its electronic access on the Practice Management Online (PMO) site will be useful to every pediatrician. It consolidates tools and resources into one place and addresses most issues relating to cultural competency.”

~ Mary Brown, MD, FAAP (Oregon)

To access the *Culturally Effective Care Toolkit*, visit the Practice Management Online Web site at: <http://practice.aap.org/content.aspx?aid=2990>. For questions about the Toolkit, please contact Regina Shaefer, MPH, Manager, Council on Community Pediatrics at rshaefer@aap.org.

AAP President-Elect, The Candidates Asked . . .

What would you say to general pediatricians and pediatric subspecialists who look at the cost of membership and wonder whether being a member of the AAP is really worth it?



Brown

Mary P. Brown, MD, FAAP
Bend, OR

The AAP influences politics and society as no single pediatrician can. Sixty thousand voices can and do make a difference for children and for pediatricians! For the individual generalist, there is the support of a large organization, information regarding the specifics of practice management, and educational materials providing current medical information. For the specialist membership is a win-win relationship—the specialist wins because the AAP adds strength to the voice of their smaller numbers, and the Academy wins because of the expertise the specialist brings to the organization.

For both generalists and specialists many health policy decisions are made at the state level (each state with its' own political atmosphere). The Academy has a staff dedicated to following and understanding these individual challenges and supports the chapters as they work to promote child health. On the state and federal level the Academy is active in advocating for access, quality, appropriate payment, and funding for pediatric practice, education and research.

The AAP provides the most extensive pediatric educational information available anywhere in the world. CME, scholarly journals, review courses and Pediatric Care Online give useful point-of-care information relevant to generalists and specialists. With PediaLink-on-line an individualized CME is available and Member-Choice allows personalization of benefits.

Pediatric Research in the Office Setting provides the standard for office-based research and gives pediatricians the opportunity to participate in large scale research. The AAP advocates

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McInerny

Thomas K. McInerny, MD, FAAP
Rochester, NY

It is best to think of the cost of AAP membership as an investment with a high return rate (ROI, in business terms) of many times that of your dues expenses. This return is in the form of real dollars based on better payment rates from public and private payers which improve your practice's bottom line as a result of the AAP working hard for you and improved healthcare for our nation's children. Even a casual review of the AAP Website amply illustrates the many activities of the AAP on behalf of children and pediatricians.

First is advocacy for children and children's healthcare at the national and state (chapter) levels. The Committee on Federal Government Affairs and the AAP's Washington Legislative Office have successfully persuaded Congress and the Administration over the years to pass important measures such as SCHIP, the strengthening of Medicaid, and inclusion of many important child healthcare measures in the Affordable Care Act. Similarly the Committee on State Government Affairs and chapter and district leadership have successfully implemented child healthcare programs at the state level which have provided high quality health insurance to over 30% of our nation's children who would be otherwise uninsured.

Secondly, the Academy has been a strong advocate for pediatricians' needs as they endeavor to deliver high quality healthcare. The Committee on Child Health Financing and the Private Payer Advocacy Advisory Committee have worked hard to ensure that pediatricians are appropriately paid for their services by both public and private payers and that plan benefit designs enable high quality healthcare for children.

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AAP President-Elect, The Candidates Asked . . .

Mary P. Brown, MD, FAAP
Bend, OR

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for fair payment and provides tools to measure quality meeting maintenance of certification requirements.

The Academy staff is dedicated to the health and well-being of children (and pediatricians). During my six years on the Board of Directors I have come to appreciate their knowledge and support. The AAP may be the only organization of its size in which each member is valued and can influence change.

Our membership fee is a bargain for the advocacy, education, research, service and practice improvement tools it makes available to the practitioner or academician—generalist or specialist— both during training and throughout years of practice. The Academy gives much to its members (including life-long friendships), but also gets much in return.

Thomas K. McNerny, MD, FAAP
Rochester, NY

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Similarly, the over 30 Pediatric Councils at state and local levels are meeting regularly with insurers to ensure that processes and procedures are in place to facilitate pediatricians' efforts to provide good care for their patients.

Thirdly, the AAP provides numerous educational activities for pediatricians, both primary care and specialists, through conferences, seminars, webinars, Pedialink, EQIPP, Practice Management Online, Pediatric Care Online, textbooks, and publications such as "Pediatrics", "AAP News", "AAP Grand Rounds", "Pediatrics in Review" and PREP. In addition the Academy provides many authoritative educational materials for parents.

Did You Know?

The Academy Travel Office is here to serve your travel needs Monday thru Friday from 8:00 am till 4:30 pm CST. Receive air discounts to AAP meetings and car discounts through Avis and Hertz.

We also offer reservations through RESX on line, for those who prefer to book their own travel. If taking a vacation is what you are looking for then contact Elizabeth Harrison for air, cruises or land packages.

Our toll free number is 888-227-1772.

