

SENIOR BULLETIN

AAP Section for Senior Members

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DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Message from the Chairperson

Avrum L. Katcher, MD, FAAP

Chairperson, Section for Senior Members

As a person who is auditorily challenged [we do not need to hear from those who said my challenges go much deeper than the ears] I am perhaps more aware of situations that might have an unhappy influence on subsequent hearing. For example, a son-in-law is a professional musician—saxophone and jazz. He says that many musicians wear earplugs, effective enough to tone down the decibels, but not so effective as to preclude working together in harmony. Another example was recently described in *Pediatrics*, when Chung and associates described tinnitus or hearing loss after exposure to loud concerts or club music. *Pediatrics*, 2005;115:861-867. This was followed up by two letters to the editor in the January issue, p248 and 249. Both bemoan the lack of public awareness of the dangers of loud noise, particularly among children and adolescents, and call for education for parents, in school and through the media.

How many of you in the senior years are also auditorily challenged, and have wondered, as I have, whether this could be related to the influence of loud noises in the examining rooms where we have been occupied so many years, loud noises of babies and children crying. For the record, I have circularized every public and private hearing organization and source of expert advice I could find. None were able to say whether or not this sort of noise is loud enough to affect hearing. You are all aware that hospital associated noise is if nothing else, a source of irritation to

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those old enough to voice their responses, and has been found to be significantly high, particularly inside incubators.

If any of you have access to information about the impact of noise on subsequent hearing, arising at any age, do tell me about it. Call 908-782-3345, or e-mail stellave@earthlink.net.

Your Executive Committee will be meeting at the end of March for the usual busy agenda. Nineteen nominations for the Senior Advocacy award have come in. We'll select the one who seems best qualified, but we know, from past experience, that there will be many others equally deserving. We'll need to push forward with our goal to encourage as many Chapters as possible to form Senior Committees, because we recognize that much of the work of the Senior Section is best performed at Chapter or even local level. We have prepared a Chapter Guide to Forming A Senior Committee, which is in the hands of your Chapter leadership. Obtain a copy, think about it and what you can do to forward this project. One of the present or past members of the Executive Committee will serve as liaison to each Chapter, and is readily available to discuss this topic with you.

Tell us what other objectives are most important to the members of the Section. We know we should do all possible to enhance the ability of members to advocate on important issues for children, and to have available for them programs and learning opportunities on topics of interest. We are aware that as pediatricians, like everyone else ages, it is important to provide programs, resources and support as our members prepare to navigate transition points in career and personal life. For example, did you know that a packet of information about selling a practice has been prepared? Or that Federal legislation now offers malpractice insurance for seniors who no longer practice, but volunteer in public clinics? We feel it is vital to represent our constituency within AAP governance at all levels. We need to bring our opinions and needs to the attention of the AAP leadership. Speak up! Let me know where you feel hassled and itchy and want something done!

Executive Committee members have worked hard on all of these issues. David Annunziato on malpractice insurance. George Cohen is planning further efforts to make membership attractive to all AAP seniors. Arthur Maron has provided wise counsel in many areas. Jacqueline Noonan has offered thoughtful advice. John Bolton, our newest member, has brought his extensive experience in advocacy.

I am also delighted to say that the program of the National Senior Section at the NCE will be held on Monday afternoon 9 October 2006, in Atlanta. Room location not yet available. We have a wonderful program, on a somewhat downbeat subject, but one that is of great importance to each of us, in planning our lives, namely, planning for care when we are no longer as competent as we are now (no comments please). One speaker will address "The ABCs of Assisted Living, Long Term Care and Long Term Care Insurance." A second will be a physician to discuss advance

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directives, powers of attorney, and similar legal subjects. The third is a nurse practitioner who works in hospice, speaking on end of life issues and palliative care. We feel this will be of immense value to us all. Immediately after the program there will be a reception to which we are inviting Chapter Presidents, Executive Directors, and members who desire to be part of a Chapter Senior Section.

With best wishes,
Avrum L. Katcher, MD, FAAP
Chairperson, Section on Senior Members

**SECTION ON SENIORS CME PROGRAM
at NCE MONDAY OCTOBER 9, 2006, ATLANTA, GA.**

THE SECTION PROGRAM PLANNING COMMITTEE IS PLEASED TO ANNOUNCE OUR
2006 CONTINUING EDUCATION PROGRAM ON MONDAY AFTERNOON OCTOBER 9, 2006.
THIS IS A SPECIAL PROGRAM ENTITLED "THE ELEPHANTS IN THE ROOM!".

Recent studies have shown that fewer than 30% of physicians have living wills or advanced directives. Similarly, judicious planning for long term care of family members or ourselves is all too often neglected, as we care for our patients. While many of us have had first hand experience with these considerations, additional knowledge might still be valuable. Equipping ourselves with information about appropriate planning for ourselves and our loved ones in the event of chronic illness or disability is the intent of this unique program for any and all AAP members and guests, but especially for our Section on Senior members. Please plan to attend the program (3.5 hours of CME credit) and stay afterwards for an informal reception to meet faculty and friends.

THE ELEPHANTS IN THE ROOM

ABCs OF ASSISTED LIVING, LONG TERM CARE, & LONG TERM CARE INSURANCE:

Robyn Stone, Ph.D., American Association of Homes
& Services for the Aging

**ALL YOU SHOULD KNOW ABOUT LIVING WILLS, ADVANCE DIRECTIVES,
POWERS OF ATTORNEY, & HEALTH CARE SURROGATES:**

Thomas Finucane, MD, FAAP
Johns Hopkins University School of Medicine

PALLIATIVE CARE, TREATMENT OF PAIN, AND END OF LIFE CARE:

Sandra Wishon, RN, MS, PNP, Hospice of Marin

*We look forward to seeing you at the NCE Section on Seniors program.
Lucy Crain, MD, for the Section Program Planning Committee*

SECTION ON SENIORS SURVEY UPDATE:

The executive committee of the Section on Seniors sincerely thanks each of you who responded to the section membership survey, in its various formats.

We are in the process of collating the data and expect to have a full report and conclusions in the June issue of this Bulletin.

Seniors Chapter Activity

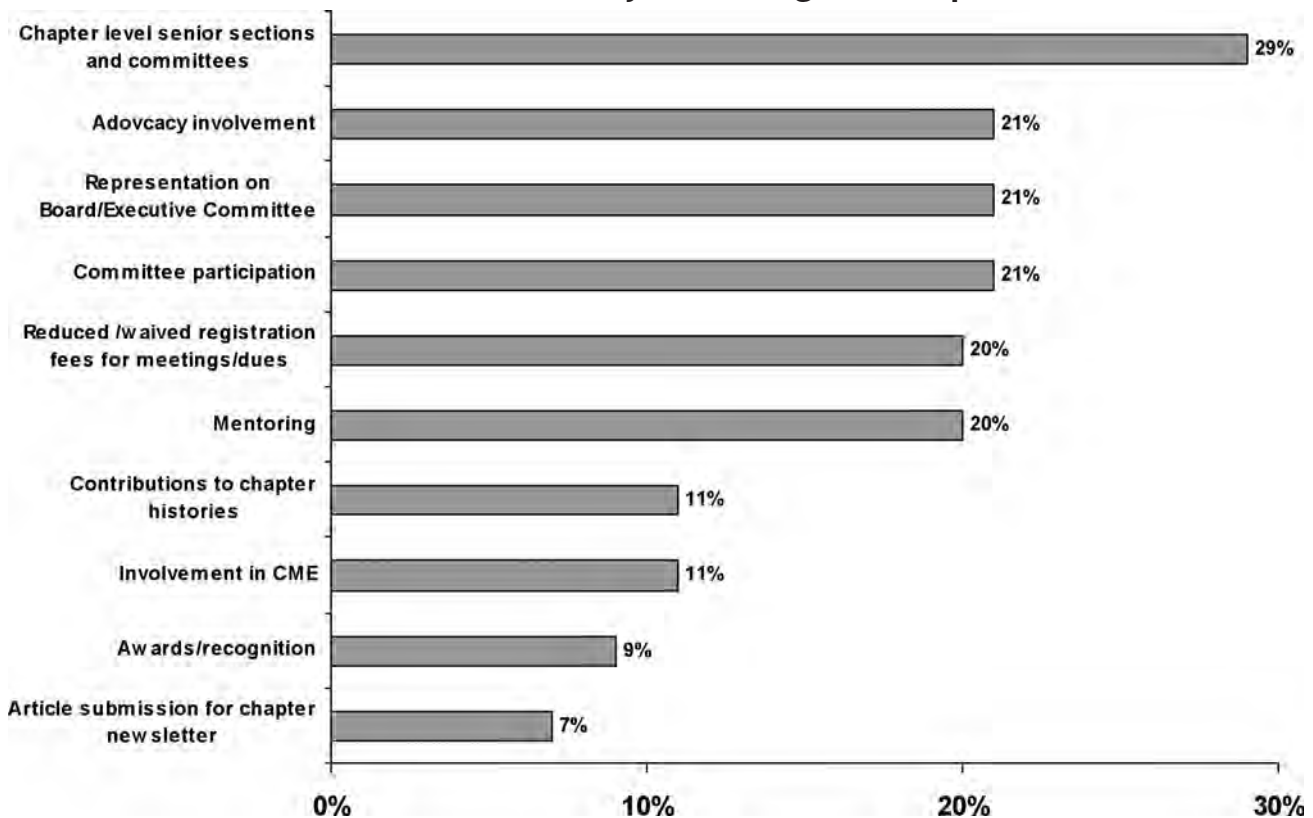
Arthur Maron, MD, MPA, FAAP

Chapters respect the knowledge, expertise and wisdom of their senior members. Seniors actively participate in a multitude of chapter activities, and are especially helpful in recalling earlier memories and stories from the chapter for chapter histories and serving as mentors to the younger members. Sixteen chapters also have formal senior sections or committees.

Listed below are the primary ways that seniors get involved in the chapters:

- Chapter level senior sections/committees (16 chapters)
- Contributing to chapter advocacy efforts (12 chapters)
- Involvement on chapter Board or Executive Committee (12 chapters)
- Participation in chapter level committees (12 chapters)
- Reduced or waived registration fees for meetings/dues (11 chapters)
- Serving as mentors (11 chapters)
- Contributing to chapter histories (6 chapters)
- Involvement in CME (6 chapters)
- Awards/special recognition at chapter functions (5 chapters)
- Submitting articles for chapter newsletter (4 chapters)

Senior Involvement (By Percentage of Chapters)



Senior Chapter Examples

- The seniors of the **Delaware Chapter** meet annually for a breakfast social prior to the Robert O.Y. Warren Memorial Seminar. Also, the chair of the Senior Committee has been actively interviewing seniors, writing

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their stories and compiling a history of the chapter.

- An emeritus member of the **Florida Chapter** continues to collate, edit and publish the chapter newsletter.
- The **Maryland Chapter** reports that legislative support and testimony during the 2005 legislative session was greatly enhanced by members of the Senior Section. They met with the chapter lobbyist at the beginning of the session to set priorities and discuss the ranking system for bills. The chapter also has plans to create an annual two to three day meeting with social events that will bring seniors together with the younger members.
- A senior pediatrician is invited to each **New York 2 Chapter** Executive Committee meeting to share his or her early experiences in practice in working with the chapter and the AAP. This has become a permanent agenda item and is entitled "Pediatrics – A Look into the Past."
- The chair of the **Wisconsin Chapter's** Senior Pediatrician Committee is beginning a chapter history project, has contacted several senior members for their input, and is working with the AAP staff to learn ways to proceed.

How It Was, and Will Never Be Again

by Bob Grayson, MD, FAAP

As I reach four score and six, allow me to reminisce a little. I consider myself one of a fortunate generation in spite of growing up when the economy was in the doldrums. I attended undergraduate and medical school when the professors were not only researchers but great teachers as well, and when the great war (WWII) was fought for a worthy cause. Princeton. Columbia P&S, and Duke were the sites of my professional growth.

Now, 20 years into retirement after almost 40 years of private community practice, and being involved in the present medical system as a patient, I have been urged to reflect on practice experiences in these 60 years.

In 1948 fresh out of my Duke residency, having served two years in the service, with a family of two children to feed, I was anxious to set up practice. We chose Miami Beach, my wife Shirley's hometown, a young city ready for new professionals. We rented a small

apartment on a street just rezoned for business, (local law prohibited practice in residential areas) and with little expense we converted it into an office of two examining rooms, a waiting room, the kitchen converted into the lab, and a small consultation room big enough for a desk, a book case, three chairs and wall for a couple of diplomas and the Florida medical license. No computer, no pager, no TV in the waiting room, and only one telephone line. Total expense, about \$1500.

On one of the first days, a person walked in as I was up on a ladder gluing acoustical tiles to the ceiling, and asked "is the doctor in?" I got down from the ladder, and said, "he is in now can I help you?" We had one employee, a friendly young lady, who did not know any more about running an office than I did, which was very little, but we learned together. Her salary was \$35 a week. Office calls were \$5, house calls \$10, immunizations \$3 and three days of hospital normal

new newborn care was \$25, if I remember correctly. Hospital privileges came next. The county public hospital was happy to have extra hands, but the two small private hospitals took some effort.

Practice was slow in developing. We did not have relatives with kids to help us get started even at no charge for service. (It would have been easier in my hometown with many relatives.) We went around, meeting other doctors, hoping for referrals. Shirley's school friends and family friends gave us our first patients. To help meet expenses, I signed on as a school physician, examining first and sixth graders in many schools as was required by Florida law. This was help in building practice since I got to know the teachers personally, and received referrals from them. Miami Beach was not an old well-established town then, and many new arrivals with family were glad to find a pediatrician. The three other pediatricians practicing on

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the Beach were most friendly and helpful, in contrast to the internists and surgeons who were concerned about competition. A partner joined me after four years.

Early on, I initiated a system of prepayment for well childcare for the first year. For a fee of \$100, I agreed to provide newborn hospital care, and routine first year care as recommended by the AAP well child schedule, including immunizations. Supposedly, the \$100 was to be paid in advance, but it never was. After a few years I analyzed the number of visits that I had been giving to the early enrollees, and found that I was not realizing an adequate return when compared to a pay for visit system. I discontinued offering the plan. This was my first and almost my last experience with managed care and capitation. (I retired in 1986 before managed care really took root.)

Our daily routine went something like this. Hospital rounds 7:30 to 9:30 AM. There was no set morning telephone hour. Folks phoned if it was important, but I did not have to sit around waiting if no calls came in. I had a live telephone answering service for incoming calls when we were not in the office, answered by mature medically knowledgeable women. They always knew where I was or where I was heading. This was far better than the later commercial answering services, which were cold and impersonal. Later came the automatic computerized telephone services, which I never employed, but which unfortunately I must use now to reach my own personal physicians. Press one, press two etc. and ending up with "if it is an emergency go to the emergency room of xyz hos-

pital." Our old system was better for both patient and doctor.

Yes, we made house calls. One of the first things I bought for my cars was the movable mounted spot light for finding house numbers at night. Even though we never had Chicago, Boston, or Buffalo winters, I would not like to ask a mother (or father) to take a sick kid out with a temperature, bad cough, or possible contagion. I did not want to expose other kids in my office if I asked an obviously sick kid to be brought in. (In our second office, which we built and owned, we added a separate waiting room with a separate entrance from the street) I was trying to prevent cross infection. If a telephone call sounded urgent, I might drop everything at the office and rush to make a house call. It was easier when a partner joined me in practice.

There were other advantages to making house calls. I could evaluate the household. Was it clean? Was it safe for kids? No toxic items lying around? No shade cords over the crib or bed? Were there books, cultural and educational items available? Were there pets? Safe or dangerous? Best of all, with certain families I could expect coffee and Danish after seeing the youngster. All of this meant that we could know the family better and observe factors that influenced the growth, development and behavior of the children.

The 50's and 60's were exciting medical times. Took written and oral boards in 1951, and joined the Academy at once. My board certification number was 3593. Sulfa drugs and penicillin became available. Streptomycin, chloramphenicol, and tetracyclines

followed soon after. A shot of long acting penicillin was often enough to cure a strep throat or red ear. We did blood agar plate cultures for strep or other pathogens and antibiotic disc sensitivities, especially for staph. (The two month rotation through the bacterial lab at Duke was good preparation for early practice days.) The most remarkable event in these years deserves mention. Whereas before Salk vaccine every febrile child was a potential polio case, after the vaccination campaigns of the mid 50's, both parents and pediatricians could breath easier with the polio threat much reduced. After treating approximately 150 cases of polio at Duke during the 1948 epidemic in North Carolina, I was happy to have cared for only five or six cases in the early years of practice.

My AAP activities started in 1955 with an appointment to the Florida Pediatric Society committee on poison control. We established ten Poison Control centers around the state, the first such network in the country. Involvement with the Academy since that time has brought us many friends, interesting projects, and the satisfaction of helping children. Academy activities were the other side of my pediatric coin. They prevented boredom, burnout and the disappointment that some folks now feel in practice. In addition, the University of Miami School of Medicine opened its doors in 1953, and I was invited to join the faculty and became involved in teaching and patient care until the mid 90's. It was great to be active at the very beginning of the medical school and to help in setting up the department of pediatrics. It is the way to become

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a senior staff member at a junior's age. In a way I'm still involved. The family of three kids I raised gave a \$100,000,000 (yes, 100 million) to

the University of Miami School of Medicine, now named the Leonard Miller School of Medicine.

All things considered, this has been a fruitful and rewarding career. I have been most fortunate.

New Realities in the World of Health Care

by Donald Schiff, MD, FAAP

The administration has identified 141 programs, which are to be cut or reduced in funding in the new budget year (2007). Thirty of these are programs from the Department of Health and Human Services. This is in addition to the negative fundamental changes to be implemented in the Medicaid, SCHIP and Medicare plans.

The budget reconciliation process, which brought together the Senate Budget Bill protecting children's essential health care elements, including EPSDT, fell to the onslaught of the House "budget cutters." States have now been given the authority to diminish benefits, which provide basic preventive care for our nation's neediest children. Other projected program cuts may include newborn hearing screening, rural health and pediatric emergency services.

These egregious reductions in health care for children are being pushed forward during a period when an increasing number of Americans (currently 46 million and increasing by a million each year, including over 9 million children) have no health insurance and are consequently vulnerable to both acute and chronic disease.

The administration's Health Savings Accounts, touted as a measure, which will enable more families to obtain health insurance at a lower cost and with

greater individual control, are a sad charade being foisted upon an uninformed public. Health Savings Accounts are designed to offer tax shelters for the economically comfortable and will further undermine the concept of preventive medicine, which is basic to pediatric care.

Public opinion polls tell us that the average citizen ranks significant concerns regarding paying for health care close behind concerns over terrorism and the general economy.

Previous attempts over the past 60 years to attain universal health insurance by Presidents Truman, Nixon and Clinton have floundered on the shoals of fears of "socialism," government controls and runaway budgets. Our nation's current budget deficits will soon be multiplied by the entitlement costs of the Baby Boomer generation as they become eligible for Medicare and Social Security. We can expect that additional restrictive changes in eligibility and benefits in these programs will be required to keep them afloat.

The competition for funds to keep Social Security, Medicare and Medicaid sustainable will increase the difficulty of gaining support for any movement in the direction of a universal health plan in the United States.

The business community, facing the necessity of cutting costs, has made a series of fundamental changes in their operations. The cessation of the provision of pensions, the outsourcing of work to third world countries, and the increase in the number of firms which are reducing or dropping their health insurance benefits will become the norm in all but a few select major companies.

Whereas employer provided health insurance was a major (65%) source of insurance for workers, the trend is moving rapidly away from this fringe benefit, and it appears that only a minority of employers will include this benefit in the near future.

Although it would be more efficient if the entire nation could be put into a universal health plan by a single stroke, the political climate will not allow this. In spite of the fact that the health care needs of children are relatively inexpensive, they can be packaged fairly easily and are a logical next step in the march toward universal care.

There is no certainty that any enabling legislation like the AAP supported Medikids plan will soon gain sufficient support to pass. It may take another decade of epidemic type increases in the incidence of preventable diseases such as morbid obesity and type 2 diabetes for our nation to recog-

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nize the importance of preventive health care achievable through a universal health insurance pro-

gram if we are to sustain a healthy citizenry.

Please contact me at donroschiff@comcast.net with your thoughts and ideas.

Problems in Foster Care in Arizona (and probably other states also)

by Margaret Gregory, MD, FAAP

This subject became apparent and important to me during my time as a CASA, a Court Appointed Special Advocate, for a child in foster care. CASAs are appointed by courts to advocate for and make recommendations to the courts for children who are in the custody of the state. They are unbiased representatives of the children alone, not parents or Child Protective Services, and as such their recommendations are received with respect by the courts and usually followed, within limits of practicality. Senior Section members would be ideally suited to be CASAs. The number to call is 800-628-3233 or visit CASA.net.org

During her first year in foster care, this three year old child was in three different foster homes and in the last one she was molested. She told no one about this at the time, and only told her mother after she had been back living with her for over a month. Naturally, I was extremely distressed and concerned when I learned of it and set out to find out how it could have happened. I interviewed the Case Manager, the Placement Coordinator, the mother, foster parents and the child. This is what I found: Foster parents are not selected, they are recruited. (I even met one who had been drafted). If foster parents were paid more this would ensure a bigger pool of candidates to choose from and selection would be possible. They are also not investigated properly after recruitment, with background checks, fingerprinting and polygraphs, as CASAs are.

Foster parents, having been recruited, are not thoroughly trained in this specialized form of parenting children with very high rates of preexisting medical, psychological and social problems. They receive (as of the time I inquired) 12 hours of instruction initially, then 6 hours annually thereafter. This is less than the training that CASAs receive. Having been given a child, or children, to care for, the foster parents are not supported by frequent contacts with a professional case manager or aide. They are also not monitored by a professional. When a placement fails, no attempt is made to fix it. There is an immediate rush to find another placement without any consideration of its suitability or even its conformity to the standards set by the child protection agency.

Suggestions for improvement include:

- Double the amount paid to foster parents. This would ensure the presence of a pool of applicants. (I know this seems a lot, but it could be a good initial bargaining point.)
- Double the training given to foster parents and ensure the fitness of the trainees by rigorous pre and post testing. Only use the best and most highly qualified instructors. Ensure the failure of some applicants to weed out those who are only interested in the money.
- Double (at least) the support visits by case managers. Require the managers to interview the children in private and to estimate the risk of placement failure of any kind, including abuse of the children. Require the managers to monitor the medical, dental and psychological needs of the children and ensure that they are being met.
- There are about 10,000 children in the foster care system in AZ alone. Now that legislation is ensuring that the stay of any child in the system is limited, it should be possible to find the money and resources to ensure that they are not damaged while they are in it.

Editor's Note:

The issue of hurricanes and especially the response to hurricanes after Katrina is still very much in the public eye. Here is a historical reminiscence on the subject.

Cuba Hurricanes

by James R. Hughes, MD, FAAP

In 1988, I first visited Sandanista Nicaragua, just after Hurricane Joan. I was in the first group of medical outsiders to enter the rural evacuation facilities near the Atlantic coast's major destruction zone. I learned a lot. At passable road's end a Cuban-trained public health officer in the regional hospital described the detailed, fulfilled plans for pre-emptive evacuation, triage, sanitation, and mosquito control. I visited the ward where pregnant women had been evacuated and safely delivered. There had been practically no loss of life. Nicaragua's Cuban-inspired response to—and preparedness for—Joan is an internationally acknowledged public health triumph.

In 1998 I returned to Nicaragua to provide clean-up medical care for the survivors of the Hurricane Mitch's devastating El Casito mudslide. The slide had wiped out more than a thousand poor peasants who had built high on the unstable slope. When the Cuban medical personnel left following the fall of the Sandanista government the enthusiasm of the medical care workers flagged, the care system became less well organized, and the people had less of the proud energy seen a decade plus earlier. Nonetheless, given the dreadful economy, things were still pretty good.

In 2003 I was on the Vermont Public Radio tour to Cuba (via Canada) for a first hand look at a nation where the public health statistics rival those of the United States—but at far less than 10% of America's per capita income. (After our VPR trip, American's freedom to travel to Cuba became even more tightly curtailed.)

From first hand observation and familiarity with health care delivery and health care outcomes, I say, "Bring on the Cubans"! They would get much done for our battered Gulf coast cousins and we could learn much from them. Although some Cuban doctors might jump ship to stay in America—Fidel seems prepared to take the risk. He seems more willing to build peaceful, constructive exchanges than we are. If our American government proves humble enough to welcome the Cubans, both nations—indeed the world—will be better off.

The AAP Historical Archives Committee and The Oral History Project

by Howard A. Pearson, MD, FAAP

In 1992 when I was president of the American Academy of Pediatrics, I had a number of discussions with Dr. James Strain, who was AAP Executive Director and David Annunziato, who was on the Board of Directors, about the Academy's lack of a commitment to preserve historical pediatric information and records. The Academy had just finished construction of a substantial addition to its headquarters in Elk Grove, Illinois, and it seemed that there might be some space to consider setting up a History Center. The AAP had a Division of Library

Services and the Bakwin Library which support the Academy's various missions with computer bases, a variety of government publications and professional and public journals. The library also has two professional librarians, one of these, Susan Bolde Marshall, MALS, has become indispensable in the Oral History Project.

In 1992, largely because of the recommendation of Jim Strain, Dave Annunziato, and me, the Executive Board established a Pediatric History Center, and des-

ignated a small room adjacent to the Bakwin Library for this. The room was only 15 by 18 feet, but it was a start. It has been tastefully finished and we have been assigned adjacent storage and shelf space.

In 1993 the Board approved creating and modestly funding a Historical Archives Advisory Committee, consisting of me as Chairman, David Annunziato, Larry Gartner and James Strain. Shortly after this the Committee was enlarged to include Doris

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Howell and Jeffrey Baker. Jeff Baker, from Duke, is the only one of us with formal training having earned a PhD in medical history. Susan Marshall is our faithful and effective staff person, and we have also been able to hire an excellent part time archivist, John Zwicky, PhD.

The Committee at its first meetings identified three projects that might be pursued:

1. To obtain oral histories of living pediatricians and other leaders who have made a contribution to the health care of American children
2. To collect important pediatric documents, books and memorabilia, including documents of the AAP.
3. To construct a central electronic archival catalogue of historically important pediatric documents located in other archives around the country.

Not much has been accomplished in establishing an electronic pediatric archival database, and we learned that this is already being done by the National Library of Medicine and other electronic libraries, and placed on the Internet.

We do have an interesting initiative in the second aim: collecting memorabilia. In 1973, Dr. Robert D. Gauchat donated his collection of more than 600 pediatric feeding utensils, so-called "baby feeders," to the AAP. Some of these have been displayed in Elk Grove Village and at the AAP Washington office. In 1998 at the recommendation of the Advisory Committee, the AAP purchased the large collection of feeders of Dr. Larrie Sarff

of Milwaukee. Our collection now includes some pieces that date back to the Roman Empire and Middle Ages. They give insights into how babies have been fed over many centuries. We are working with Dr. Darroll Erickson and the American Collectors of Infant Feeders, and hired Ms. Jennifer Searcy, a doctoral student in museum studies to organize and catalogue the AAP collection and put them all with photographs in proper historical context on the computer. Dr. Erickson is organizing "loaner" displays that can be lent to pediatric organizations, including AAP chapters, for public display. They evoke considerable interest, and are real conversation pieces.

We have acquired some historically important textbooks as gifts from pediatricians; but amassing an exhaustive historical library is not our intent – for space reasons if none other. If pediatricians wish to donate books from their library, the Committee and staff will be glad to review the titles and receive them as a gift to the Historical Library if they are especially important and not already in the collection. We have offered to be a repository for the records of pediatric organizations, such as the American Pediatric Society and the Society for Adolescent Medicine.

Our most important, and most successful, initiative is the Oral History Project. Oral History had its roots in the sharing of stories and legends over the millennia and has evolved into a respected academic area. Many universities have established departments in this discipline. The AAP oral history project was launched in 1993. There was considerable discus-

sion about how to do this. We had formal presentations from the private Winthrop Group and the Oral History Department of Columbia University who offered to conduct oral histories for us on a contractual basis. We hired the Columbia Group to do oral histories on Bill Nelson and Saul Krugman. The results were rather unsatisfactory and expensive. It should be admitted that both Drs. Nelson and Krugman were interviewed not long before their deaths and had difficulty with memory and concentration; but it was also apparent that interviewers coming from non-medical backgrounds were not familiar with many aspects of pediatrics that we were interested in. This led to a decision that we would utilize pediatrician interviewers, rather than professional historians. I think this was a good decision.

In late 1995 notices were placed in various AAP publications, soliciting volunteers to participate as oral history interviewers. Seventeen were chosen on the basis of a strong interest in medical history, and in many instances historical publications. In April 1996, these volunteers came to Elk Grove Village for a one day "crash course" in oral history taking given by Janet Nolan, PhD, associate professor in the Department of History at Loyola University in Chicago. The curriculum of this training session included defining the purpose of the project, points to cover and useful hints on interviewing procedures. The need for careful advance preparation was emphasized. During the same time frame, a list of potential interviewees was generated from the recommendations of individual AAP fellows, as well as from com-

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mittees, sections, chapters and districts. From a very long list, a shorter list was prioritized by the Committee on the basis of a number of considerations including their contribution to pediatrics and their age. There is some urgency to the task. We unfortunately lost Drs. Frank Oski, Jay Arena and Sydney Gellis before we were able to interview them. We were, however, able to take the oral histories of Drs. Tom Cone, Lou Gluck, Katherine Bain and Joe Butterfield before their, sometimes unexpected, deaths.

Prior to the interview, the Archives provide the interviewer with CV's and bibliographies, publicity articles from the AAP files and other materials. The interviews usually take between 4 and 8 hours, and are tape-recorded. The recording is transcribed and edited by both the interviewer and interviewee. We try not to edit too much, lest spontaneity and spirit be compromised. A penultimate version is proof read and indexed by Susan Marshall and printed in an attractive format which can be purchased. Completed oral histories are also available on the AAP Members Only web page. It has been estimated that it costs about \$4,000 to complete an oral history, even though all of the interviewers are volunteers. It has been possible to pay for some of these through contributions from colleagues and friends. Our original 17 interviewers has been truncated because of death, illness and time commitments, so there are currently fewer than 10. We have received Board approval and funding to train another 5 interviewers but we need more. If the Oral History project is to continue expeditiously, we are going to request that training be given to a

total of 10 new interviewers. As of today, 25 oral histories have been completed and about 50 are in various stages of preparation.

Several sub-projects have evolved. We especially would like to do oral histories of leading women pediatricians and have done 9. Funding for these has been provided by the Friends of Children, thanks to the intervention by Eileen Ouellette who has joined us as an interviewer. In 1996, the Section on Perinatology, donated funding for oral histories on leaders in neonatology. Dr. Larry Gartner is spearheading this project and doing many of the interviews himself. The Section on Surgery has commissioned oral histories on the winners of the Ladd Award, and the oral history of Dr. Ovar Swenson has been completed.

Even a brief reading of the Oral Histories reveals information and insight that serve to flesh out the bare bones of a curriculum vitae with personal recollections and anecdotes. Most of the oral histories describe people of modest financial backgrounds and a number of them came from rural backgrounds. A few were immigrants. Only a few had physician parents; but most had an early physician role model, sometimes a family doctor. All had strong academic performances in a wide variety of colleges. Entrance to medical school varied, from walking into a nearby Med School and enrolling on the spot to completing multiple applications – but nowhere near the 15-20 applications completed by today's students. Dr. Gerry Schiebler recalled that he got into Harvard as part of the "10% Pennsylvania quota." Several described a "10% cap" for

Jewish students that was operative in many medical schools in the 1930's and 40's. Two of these people directly attributed their ultimate acceptance into medical school to the direct intervention of religious non-Jewish college teachers, one a Jesuit priest. Several oral histories described wartime experiences. Milton Markowitz was on an LST off Omaha Beach on D-Day. Berry Brazelton was a physician on north Atlantic convoys for more than a year. Lew Barness spent two years in the occupation army in Japan mostly doing infectious disease. Henry Barnett was an army physician at Los Alamos during the Manhattan project and was an observer at the first A-bomb test at Alamogordo, New Mexico. He also went to Nagasaki shortly after the A-bomb detonation. Tom Peebles was a decorated bomber pilot in the South Pacific. Gerry Schiebler, a first generation German American, recalled that his family was reported for suspected espionage by his neighbors and his house was searched three times by the FBI.

The oral histories give personal accounts of interactions with some of the great names in pediatrics and describe some of the organizations and hospitals in which they worked. A number described private practice and house calls. But most tellingly, they reveal something of the personalities and recollections of very interesting people. They should be a significant resource for future medical historians who want to learn about American pediatrics as it was practiced in much of the 20th century.

QUESTIONS FOR RETIREMENT?

by Arthur Maron, MD, MPA, FAAP

**Q
&A**

When is a retiree's bedtime?

Three hours after he falls asleep on the couch

**Q
&A**

How many retirees to change a light bulb?

Only one, but it might take all day

**Q
&A**

What's the biggest gripe of retirees.

There is not enough time to get everything done

**Q
&A**

Why don't retirees mind being called Seniors?

The term comes with a 10% percent discount.

**Q
&A**

Among retirees what is considered formal attire?

Tied shoes

**Q
&A**

Why do retirees count pennies?

They are the only ones who have the time.

**Q
&A**

What is the common term for someone who enjoys work and refuses to retire?

NUTS

**Q
&A**

Why are retirees so slow to clean out the basement, attic or garage?

They know that as soon as they do, one of their adult kids will want to store stuff there

**Q
&A**

What do retirees call a long lunch?

Normal

**Q
&A**

What is the best way to describe retirement?

The never ending Coffee Break

**Q
&A**

What's the biggest advantage of going back to school as a retiree?

If you cut classes, no one calls your parents.

**Q
&A**

Why does a retiree often say he doesn't miss work, but misses the people he used to work with?

He is too polite to tell the whole truth.

Editor's Letter: Volunteer licenses for Physicians

Dr. Av Katcher requested information about the various states' provision of licenses for retired physicians who volunteer their services from Mike Glasstetter, staff of the AAP Division of State Government Affairs (mglasstetter@aap.org). As licensure is done state-by-state, this is a large and time consuming job. He has uncovered three states, which provide licensure without cost for retired physicians who volunteer their services, Nevada, Texas and New Jersey. The statute from Nevada is reproduced below. The other two statutes are very similar. If any of our readers know of other states which provide this service please respond to Av Katcher (stellave@earthlink.net), Jackie Burke (jburke@aap.org) and me (hodgman@usc.edu).

If you have suggestions about action that the Senior Section might take, Dr. Katcher would be pleased to hear from you.

Joan Hodgman, Editor

Nevada

630.258 Retired licensees: Issuance of special volunteer medical license.

1. A physician who is retired from active practice and who wishes to donate his expertise for the medical care and treatment of indigent persons in this state may obtain a special volunteer medical license by submitting an application to the board pursuant to this section.
2. An application for a special volunteer medical license must be on a form provided by the board and must include:
 - (a) Documentation of the history of medical practice of the physician;
 - (b) Proof that the physician previously has been issued an unrestricted license to practice medicine in any state of the United States and that he has never been the subject of disciplinary action by a medical board in any jurisdiction;
 - (c) Proof that the physician satisfies the requirements for licensure set forth in NRS 630.160;
 - (d) Acknowledgment that the practice of the physician under the special volunteer medical license will be exclusively devoted to providing medical care to indigent persons in this state; and
 - (e) Acknowledgment that the physician will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for providing medical care under the special volunteer medical license, except for payment by a medical facility at which the physician provides volunteer medical services of the expenses of the physician for necessary travel, continuing education, malpractice insurance or fees of the state board of pharmacy.
3. If the board finds that the application of a physician satisfies the requirements of subsection 2 and that the retired physician is competent to practice medicine, the board shall issue a special volunteer medical license to the physician.
4. The initial special volunteer medical license issued pursuant to this section expires 1 year after the date of issuance. The license may be renewed pursuant to this section, and any license that is renewed expires 2 years after the date of issuance.
5. The board shall not charge a fee for:
 - (a) The review of an application for a special volunteer medical license; or
 - (b) The issuance or renewal of a special volunteer medical license pursuant to this section.
6. A physician who is issued a special volunteer medical license pursuant to this section and who accepts the privilege of practicing medicine in this state pursuant to the provisions of the special volunteer medical license is subject to all the provisions governing disciplinary action set forth in this chapter.
7. A physician who is issued a special volunteer medical license pursuant to this section shall comply with the requirements for continuing education adopted by the board.

Generations United

By Douglas Lent, Manager of Communications

Generations United

dlent@gu.org

“We believe that the time is long past when advocates for children, families, and the elderly can afford separate agendas. We foresee a new and brighter America when children, youth, and senior organizations can join forces to strengthen our communities. That is exactly what Generations United intends to do.” This is what Jack Ossofsky of the National Council on the Aging along with his collaborator, David Liederman from the Child Welfare League of America, told a room full of reporters at a 1986 news conference announcing the formation of Generations United (GU). Amid an increasing climate of scarce resources attempts to pit the generations against each other were growing. GU was launched to provide a bridge between advocates for single age groups and offer a voice of reason to an otherwise inflammatory debate among policy makers.

Despite progress in the last two decades, the potential for further age-segregation and social isolation between the generations is still of serious concern. AARP Director of Policy and GU board chair John Rother describes GU as being, “The only organization that brings all the pieces together.” GU does this by encouraging the use of an “intergenerational lens” in the dual areas of public policy and practice. This is even more important as demographics change in the US and around the world.

By 2030, there will be 70 million Americans over the age of fifty. This can be viewed as a problem or an opportunity. Organizations

such as the American Academy of Pediatrics are rich with professionals who have left, or will soon leave, the traditional work force.

Never has there been a healthier cohort poised to begin an intergenerational revolution by simply sharing their experience, knowledge, and passion to help others. For example, a person’s lifelong enthusiasm for the arts can transform a child’s life when that interest is turned into an intergenerational after school program. Concern for the environment can connect the generations when a caring older adult works with young people on a water quality project. In a country where only 51% of 6th to 12th graders say they can turn to parents for support and advice, being that other caring adult in a young person’s life can make the difference in helping him or her reach successful adulthood.

Unlike previous generations, the vast majority of twenty-first century retirees do not plan to move to a new home or leave their current communities. Only 22% of Americans now see retirement as a time to start winding down. The rest see it as time to write a new chapter and will likely look for purpose while seeking to remain active and engaged. AAP’s Section on Seniors can help as its members transition. Generations United is here to help with building that bridge.

What began as a loose coalition twenty years ago is now a recognized force of more than 100



national, state, and local organizations representing more than 70 million Americans. By uniquely combining individual support for quality programs and effective public policy development, GU has played a pivotal role in leading the growing intergenerational field.

“Intergenerational programs and policies are a winning combination. They allow older adults to stay connected to their communities, feel hope for the future, and even experience improved emotional and physical health,” says Donna M. Butts, executive director of Generations United. “In turn, children and teenagers receive more individualized attention, grow up with less fear of their own aging, and receive much needed, wisdom and support from older adults.”

True to the vision of its founders, GU works to define the intergenerational field by identifying public policies and programs that benefit children, youth, and older adults. Grandparents raising grandchildren is one area of mutual interest GU and AAP share. GU’s National Center on Grandparents and Other Relatives Raising Children is a leader in addressing the issues facing the more than 4 million grandfamilies (grandparents, aunts, uncles and other relatives raising children) in

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the U.S. In 1998, GU convened the first national expert symposium on grandparents raising grandchildren. In 2004, AAP collaborated with GU to sponsor the second symposium, which resulted in a five year action plan to increase supports, including access to medical care, for these important families. In 2005, GU broke ground again by convening the first national symposium on Affordable Housing Opportunities for Grandparents and Other Relatives Raising Children. GU's Center responds to thousands of requests for information each year, has directly trained more than 6500 professionals and caregivers, distributed thousands of publications, and holds regular on-line expert chats. GU continues to advocate for supportive services for grandfamilies including access to medical care and affordable housing. There is great potential for AAP, given the organization's strong commitment to family centered pediatrics, and GU to work together to support grandfamilies. For example, Dr. Carden Johnston once suggested the potential for pediatricians to offer services such as flu shots to grandparents who bring the grandchildren in their care for office visits.

GU also promotes the development of intergenerational shared sites because we believe resources are better used when they connect the generations rather than separate them. Examples of shared sites include co-located child care

and adult day care, after school programs located in senior centers, and intergenerational community centers designed and built specifically for children, youth, and aging adults rather than segregated senior centers and teen centers. Shared sites yield positive staff attitudes, cost savings, enhanced employee benefits packages, and increased community involvement.

In 2005, GU began work on Seniors4Kids, an initiative to mobilize seniors to become champions for affordable high quality Pre-Kindergarten throughout Florida. This statewide campaign bridges the generations by raising the visibility of older adults in support of Pre-K and encourages the involvement of



seniors in creating a statewide network of community leaders and grassroots volunteers with the common goal of helping children. The methodology used in programs such as Seniors4Kids is an emerging way for AAP's Section on Seniors to serve as advocates for children and youth locally.

GU's International Biennial Conference and Awards Program held in Washington, DC, is a unique venue and a dream come true for the growing intergenerational field. The conference provides workshops, program showcases, and symposiums on subjects related to intergenerational trends, issues, and the latest research. The conference offers several options for AAP and GU to

collaborate and begin to integrate the interests of the Section on Seniors and the intergenerational field.

Finally, GU recently launched a new online community and program directory called i-PATH (*Intergenerational Programs, Actions, Technologies, and How-to*). Located at www.gu.org, GU's i-PATH is available to anyone looking for information about intergenerational programs around the world. In addition to sharing knowledge with the general public, GU's i-PATH provides special features for GU members. These include access to the most up to date information about training events, employment opportunities, do-it-yourself surveys, employment opportunities, an interactive community to share ideas and best practices, and on-line expert chats. GU's i-PATH is the most advanced tool there is to encourage connecting the generations. The resources available on line can be accessed by members of AAP's Section on Seniors to learn about programs in specific regions as well as identify intergenerational health program models.

GU founder Jack Ossofsky once said, "We formed Generations United to argue for a more caring society." This profound statement still rings true today but we can't do it without the support and partnership of individuals and organizations who share our vision of a world that values all generations. We would love to hear ideas from you about possibilities for AAP's Section on Seniors members and GU to work together. Please contact us at dlent@gu.org or 202/289-3979 for more information and to share your ideas.

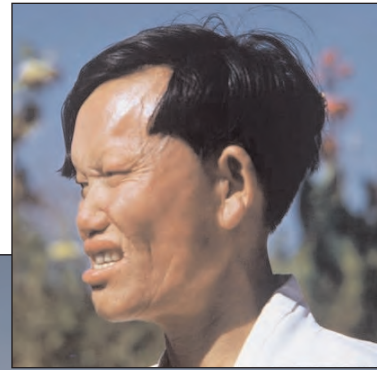
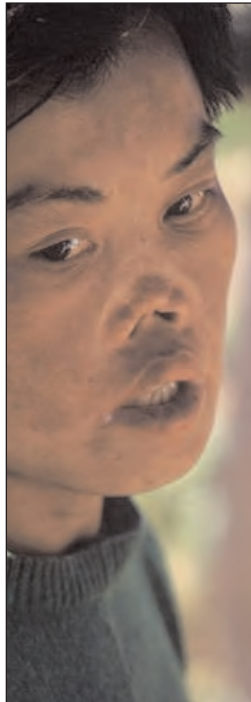
THE COLONY

by John Tayman • Scribner, NY, 2006

This is a remarkable story, exciting, well told by a splendid author, and filled with medical and pediatric references.

Beginning in 1866, the governments of Hawaii and the United States, acting jointly “forcibly removed more than eight thousand people to a remote and inaccessible peninsula on the Hawaiian island of Molokai, and into one of the largest leprosy colonies in the world. The governments did so in the earnest belief that leprosy was rampantly contagious, that isolation was the only effective means of controlling the disease, and that every person it banished actually suffered from leprosy and was thus a hopeless case. On all three counts, they were wrong.” In a slender volume of just over 300 pages, heavily buttressed with notes and references, Tayman tells us not only the story of this colony, but also provides us with references from experts to enable us, the readers, to understand about the epidemiology, pathology and natural history of infections with *Mycobacterium leprae*.

Along the way, we learn how social and medical attitudes towards leprosy intertwine, to the detriment of patients, and how this came about. Perhaps the earliest reference is found in Leviticus 13, in an extensive discussion of cutaneous lesions, under the heading of the Hebrew word *tsara’at*, which, according to Robert Alter’s definitive translation of the first five books of the Old Testament, was thought by all the older translations to represent “leprosy.” Alter



"These three pictures are of patients resident at a "leper colony" which I visited when I was on duty with US 8th Army in Korea, in 1953. I had met a very capable senior physician in the field of public health who invited me to see the residential care center, for which he was the senior physician and administrator. At that time treatment was not as advanced as at present, and in addition there was much more concern about the communicability of the infection. I have no clinical information about the patients. The pictures show strikingly the erosion of the nasal bone and cartilage which is characteristic, and also in some instances thickening of the skin of the forehead and perhaps also the lips. I did not prepare the book review with these photographs in mind. Only later did I remember having made photographs of these patients. The pictures were done with a Leica IIIA on 35mm color slide film, and just a few weeks ago translated to a CD and also 4x6" prints by a local camera service."

goes on to say that modern scholars almost all reject this translation. None the less, it was the governing meaning of the term for many centuries, thus making understandable the wording that when the priest, who decided what the infections were, concluded that the patient had *tsara’at*, “The priest shall surely declare him unclean...and the person...in whom the affliction is, his clothes shall be torn and his hair disheveled, and his moustache he shall cover, and he shall

call out ‘Unclean! Unclean!’...He shall dwell apart. Outside the camp shall his dwelling place be.”

The earliest account of true leprosy was described in the first century CE by an Alexandrian physician named Areataeus of Cappadocia. Tayman gives us an extended quote describing the condition, which we now know. It was the Hebrew scholars who translated Leviticus into Greek, who chose the Greek word, *lepra*

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with the meaning of 'rough and scaly,' who brought together Leviticus and our modern attitudes. It was here that the intertwining of social isolation and medical care began. For those who wish to explore the social isolation in greater depth, there is no better reference than *Stigma, Notes on the Management of Spoiled Identity* by Erving Goffman.

Tayman continues with extensive descriptions of how the isolation colony for persons with leprosy began, the brutal methods used to enforce and maintain living there, and the enormous death rate of sick persons who had no treatment (none was available) and also had the most appalling living conditions. Leprosy was wide-

spread in Asia, the Pacific and the Americas, and patients were typically isolated, but perhaps nowhere as roughly as described in this eminently readable volume. A major character was Joseph de Veuster, who on entry into the Society of the Sacred Hearts of Jesus and Mary, took the name of Father Damien. He lived the remainder of his life in the Colony, which is the subject of this book, and after his death was recognized by the Church as a Saint. In discussion of Father Damien, Tayman brings in the explanation of susceptibility to the *Mycobacterium*, recounting the work of a Canadian group just two years ago, to identify two genes which when replaced by an abnormal form allow both infection and dis-

ease. In many other portions of the book, the description of the Colony, and the important actors there and in government, is intertwined with a splendid non-technical discussion of the medical facts as known in the early years, and today.

In my personal experience, I have not encountered a book which as brilliantly describes the relationships between social, psychological and biological features of disease in the sick, and of the responses of those who deem themselves well. All physicians should read this book. It is truly enlightening. Tayman has done a splendid job.

ABUSE

by Gene Wynsen, MD, FAAP

Abuse is a complex subject. In Africa one can observe the male lion who just took over the head of the pride, after evicting the previous male either by physical force or killing him, as he then proceeds to kill the young sired by the previous male. He does so without making any moral judgment. It appears to be built into his makeup and a matter of survival of the fittest. Or one can observe lions kill the young of leopards if they should happen to come upon them. Again there is no moral judgment and it is just a matter of survival of the fittest. It tends to assure them of more food supply and eliminates some of the competition. In old Roman times, if a family had a new child and they were so poor that they could not support another mouth to feed, they would simply leave the infant out on the street, and if anyone wanted it, they could take it away,

or it would die. They called it "exposing" the infant (1). According to current societal norms, we would call this neglect or infanticide, forms of abuse.

In human society, there is a wide variety of abuse. It ranges from sibling rivalry to child abuse, sexual abuse, spousal abuse, killings of all kinds, neglect of elderly, and the grandiose abuse of warlords, dictators, and power hungry tyrants. It is not a new idea. One can find examples in historical writings. In the Old Testament there are statements like "yesterday we killed 12 thousand", "an eye for an eye", "destroy your enemy". Other writings detail the killing, pillage, rape, and looting of whole populations. Frequently they were proudly depicted as the successful doings of prominent warlords. Many cultures used excessive and abusive physical means to control

the young children in homes, schools, and orphanages under the guise of necessary discipline. In some areas women were and still are treated with derision and disregard for their welfare and dignity. Racially, religiously, and culturally based abuse occurs all over the world.

One is hard pressed to explain the maiming or killing of one's own offspring as we see in much child abuse. What possible value or advantage to the population could this have? What is the reason for such behavior? Is there a deeper meaning behind it? I asked a lecturer at a recent child abuse meeting that I attended, "what could be the value to a population to kill or maim by it's own young?" It was met with a somewhat derisive answer that there was none. But there is frequently a value or

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advantage in a behavior that eventually might benefit the population, not necessarily the individual. Is this behavior a mechanism for population limiting? Or is this destruction of one's own offspring a way of eliminating future such behavior in those offspring of that destructive person? In other words, is this a way of reducing the destructive trait in that population? Or are there other reasons for it? It is complex and there will not be a simple answer.

C.H Kempe M.D. originated the term of the battered child syndrome (2), brought attention to the problem and started a program to deal with the issue. As I understand it, he had a team of experts jump in to try to treat the victim and also the victimizer. If the perpetrator was not cooperative, then the legal system was brought in. He felt that it was a medical problem, and sought to treat it accordingly. But at present it has come to be primarily a legal problem, and the law is used to bring justice to the perpetrator. It may be in the form of restrictions, imprisonment, or even execution, which are really forms of legally sanctioned abuse. Little effort is expended to treat the abusers medically. Perhaps this reflects society's frustration with its inability to adequately prevent and treat problems of abuse. All abusers are automatically labeled as incurable, but studies do not always support this concept. Recidivism can be prevented in 90 percent of some groups of child sexual abusers with proper treatment programs (3). But this zealous approach to use punishment has resulted in excessive restrictions for some individuals, and has resulted in abuse to some fami-

lies. I recall several families in my practice that were destroyed in the process. Whatever was left of the family was destroyed by the legal approach, in my opinion, inappropriately applied.

Physicians are placed in a dilemma. On one hand we are all under the onus to see that no harm comes to patients, and on the other hand we are obliged to see that all patients receive good care without judgment about the patient's value in society. In other words, we are not their judge, but rather their physician. Yet we are bound to make judgments about whether there has been abuse, and to report that if we think it is so, realizing what a serious import the investigation would have on the individuals involved, especially if we are wrong. So it is very important to be aware of the seriousness of such a diagnosis, and to be sure that we do not overlook the conditions that mimic abuse. There are many such conditions including bleeding disorders, skin conditions, cultural treatments, congenital traits, and others. We also have the obligation to see that the abused patient is adequately protected from further abuse.

Then there is the problem of defining what is abuse. We have not been able to clearly come to agreement on what constitutes abuse. Where do we place these various forms of abuse? Are they simply mental illness, or just uncontrolled deviant behavior deserving of proper justice measures? Can individuals really control them? Or is it somewhere in between? For example, there is still no unanimous opinion about whether it is permissible to spank children. A more extreme example is the issue of abortion. There

is no question that the fetus is abused when it is aborted. When I was an intern, the most heinous crime was the back alley abortion with resulting sepsis. Now, abortion is not a crime, it is a right. It seems to be a question of expediency. In Roman times, "exposing" was considered the right thing to do, as it would prevent the disaster in the family that would surely occur. It was not a crime then. The strict disciplinary measures including physical punishment in the past were justified on the basis that it was necessary and for the good of the child. Torture of criminals, witches, and those who defied various religious points of view were justified by saying they deserved it. One thing is clear. There is a lot of abuse occurring, and the price is enormous in terms of suffering and economic pain.

Abuse in all forms has become a media panacea. The Media goes into a feeding frenzy. Whole programs are devoted for days on end to the detailing of these incidents ad nauseum. Stories about kidnappings, killings, and sexual abuse have become the current fad of the day. Now I suppose that someone will come forward and say that I am in favor of abuse or that it should be overlooked, which is ridiculous. But I do think it is time to look at the problem, research the causes, and try to find better ways to manage them. I am not so naïve that I think we will find all the answers in a short time, but I think that cultural learning may be a good part of the answer. Raised in an environment of cultural rejection of abuse, and respect for others, one might expect a reduction in such behavior (4). To make such social

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changes is a real challenge and will not occur without extensive effort. Very likely there will be found more medical and/or psychiatric treatments that will be successful. However, the problem has been with us for a long time, and since social behavior is so difficult to

predict or control, I readily admit that I do not have the ultimate answers.

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Computer Savvy for Seniors Personal Financial Management Software and Web Sites

by Jerold M. Aronson, MD, FAAP

One of the most popular and useful computer applications is personal financial management. Remember VisiCalc? VisiCalc for the Apple IIe or IBM PC created the first growth in sales of PC's. VisiCalc was a user-friendly self-calculating spreadsheet. We've come a long way since then. This article (2 Parts) will discuss several common personal financial management challenges, and identify popular on-line web sites or software applications that address these challenges. The articles will be accompanied by a chart of "Useful Personal Financial Management Web Sites and Software" that can be viewed and downloaded from the AAP Senior Section website.

In Part 1 of this 2 Part article (Part 2 in Summer Edition of Senior Bulletin) we will cover:
Web Portals for General Financial Management Information
Home Banking on the Computer
Retirement Planning
Portfolio Tracking and Asset Allocation

In Part 2 we will cover some additional topics for the more sophisticated, senior investor. These topics will include:
Selecting a Financial Advisor
Mutual Fund Selection
Bond Investing
Selecting 529 College Funds

Are you tired of attempting to balance your checkbook with limited success to the chagrin of your spouse? Concerned about whether you are either saving enough for retirement, or have enough saved to allow you to live a full life? Do you travel and either would like access to your bank statements or be able to track and pay your credit cards without having to wait for forwarded mail? Are you considering providing some financial support for grandchildren's college education but need some unbiased information about 529 Plans or other? Do you assid-

uously track your investments and/or trade stocks/bonds regularly? If you've answered Yes to any of the above, computer and web-based technology is available to help you with these issues and more! We will not provide financial or investing advice; we will show you resources to facilitate an informed decision on your part.

Web portals are plentiful. Your ISP (AT&T Worldnet, Earthlink, MSN, SBC Yahoo) will be your first choice; however, you can change to any portal that you wish as your Home Page, the first page that you

view on web login. Your Home Page portal will contain general news and information, and a variety of navigation tools to check your e-mail, search the Web, manage your financial accounts, check the weather, find a local movie theatre, etc. They will usually have specific sections for Business News and/or the latest Stock Exchange prices. Financial or business web portals (CNNMoney.com, <http://finance.yahoo.com/>, or Money Central at MSN.com) are designed to be one-stop financial and investing sites. These sites

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are comprehensive and can keep you up to date on the markets and business news, but also will help you manage your portfolio, pay bills and research stocks and funds. They frequently include free access to certain popular business magazines, e.g. Business Week, Forbes, etc. Portals can be very popular (MSN Money), funny (Motley Fool) and informative as they provide generic, helpful planning tools/calculators that one can use, e.g. Retirement Planning, Refinancing a Mortgage, Investing for College. Barrons Magazine (2002) called the MSN Investment Toolbox “(The) most customizable, robust portfolio tracker on the Web”. These sites are usually free, although they may require registration. The free sites often have premium subscription services that offer expanded services. I suggest that you explore free areas of these sites until/unless you have determined that this is your “site of choice”. Serious investors may prefer sites like SmartMoney.com, (see Investing 101 at Smart Money University) or Morningstar.com. These sites offer sophisticated tools and intuitive interactive charts that colorfully “Map the Market” or enable one to identify the “best” mutual funds by category, performance, or popularity.

Home Banking software should be a central part of a senior couple's financial management strategy. Home banking organizes your financial files and performs most (if not all) personal financial management tasks automatically including: banking and bill paying, budget management, tax planning and planning for the future (college tuition, retirement, home/auto purchase, etc.). Write and send checks safely (and save

\$0.39/check), reconcile your checkbook automatically, and categorize your expenses for taxes with one or two keystrokes. Create an inventory of financial or other assets to determine your net worth, and to aid others in locating family assets if necessary. Each spouse should become educated in family financial issues. Home banking software provides immediate access to banking, portfolio, net worth information, etc. in the event of unexpected illness that interferes with the primary “home money manager” abilities to fulfill their duties. Indeed, one can also place this information securely on the web and permit children (or others) to securely manage the assets remotely. Use the software to download and reconcile bank statements, brokerage statements, obtain investment quotes (at the close of the market), and receive reminders for recurring payments, e.g. mortgage, cable TV, automobile through automatic entry into your “checkbook” at the appropriate time. Keep your money earning interest in your account until the last moment by securely paying bills electronically to arrive on the last day of the credit period. Annual accountant visits for tax return preparation becomes less onerous when, with a single push of a button one can prepare categorized lists of expenditures. Even better, do and pay your own taxes with many popular programs (Intuit TurboTax, TaxCut by H&R Block)! Finally, back up your financial files on non-hard drive media like CD's, DVD's, or flash drives. Popular home banking software (Microsoft Money, Quicken) often link with excellent web sites that provide for secure, off-site backup storage of your financial data making the data accessible to you wherever you may be as long as

you have access to an internet-connected computer and remember your User ID and Password as well as additional financial management.

Retirement Planning is a continuous and iterative process. Whether you are attempting to determine when you will have enough money to retire, or how to make your money last as long as you do during retirement, the computer can help. Home Banking software has retirement planning calculators built-in that automatically import all of the data that you've previously entered into your Home Banking software. Moreover, excellent Retirement Planning tools are usually available on your investment broker's website (Fidelity, Vanguard, Schwab). These tools automatically import your brokerage account information from all of your banking and brokerage sources upon your secure entry of UserID and Password Information. They are usually free (without needing to have an account at the broker). Try several different brokerage tools to reassure yourself that you are either saving enough for a secure retirement or that your current retirement budget withdrawal and spending plan still makes sense in the context of a changing stock market and the current performance of your investments. Test out whether or not the “4% Retirement Assets Withdrawal Rule of Thumb” is applicable to your personal situation. Also explore whether or not the state in which you reside provides protection against one spouse bankrupting the other due to high “end of life expenses” and/or nursing home costs. Factor this into your retirement asset

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withdrawal plan. Note – if you have an account at that broker, then the tool will automatically import your information from that broker and even, with your permission, import information from other brokers/banks with whom you have accounts!

Although not exhaustive, even if exhausting, this information should provide you a start and may make you a better personal money manager. For additional information and a chart of specific web sites/tools of interest, go to the AAP Senior Section Web Page.

You might also want to check Forbes Magazine “Best of the Web” – their annual review of financial help on the web. As always, your questions, comments, and suggestions for future topics are welcome at jmaronson@aap.net.

THIS IS FOR ALL US OLD PEOPLE.; WE NEED ALL THE HELP WE CAN GET.

by John Bolton, MD, FAAP

I just found this out and thought I'd pass it on. It's very useful when trying to read small print. If you hold down the Ctrl key on your key board and then turn the scrolling wheel in the middle of your mouse away from you or towards you, the print size will change. It will either get larger or smaller, depending on which way you turn the wheel Try it, it really works! That is, it works if you have a mouse with a scrolling wheel.

“ In - flu - Enza ”

by Maurice Liebesman MD, FAAP

A few months ago I remember receiving stern warnings from the C.D.C., the State Health Department and even e-mails from Avrum Katcher in reference to the imminent flu epidemic. Not in the United States but some cases had already been reported in Hong Kong, mainland China and Vietnam and the threat was to be taken seriously. That reminded me of a story I wrote when the Delaware Chapter of the A.A.P. asked me to compile its local history. Apparently they trusted I was one of the senior members that still conserved his long time memory.

When planning for the writing of the history of the Chapter I decided to begin by telling the story of whoever happened to have been the very first Pediatrician to come to Delaware. It was not too difficult; everybody knew it was Dr. Margaret Handy (Andrew Wyeth, who was one of her patients, painted 2 portraits of

her, both of which presently hang at the Brandywine Museum, in Chadds Ford, Pennsylvania). Dr. Handy was born in 1889 in Smyrna, a small town a few miles south of Wilmington where her father, a prominent lawyer, had his office. She was educated at Johns Hopkins University Medical School where she received her medical diploma in 1916. She also completed her Residency at the same institution (her roommate was Helen Taussig who later became a renown pediatric cardiologist). Her father had rented an office for her in Wilmington where she was remembered to have said, “I sat in that bleak office wondering, who in the world would come to see me as a patient”. That was in August of 1918.

On Wednesday, September 25, 1918, the front page of the “Wilmington Morning News” announced: *“There is no denying that there are quite a few cases of Influenza in Wilmington and*

vicinity”. Charles Silliman, in his book “The Story of the Delaware Hospital” recorded some of the events of that epidemic. The situation was very confusing because influenza was not yet a reportable disease; therefore, the State Board of Health had no idea how bad the situation was. Dr. Ellegood, Director of the City Board of Health appealed to all the doctors to report all the cases suspected to be influenza. The laboratory of The Delaware Hospital (still at 14th and Washington St. and now called The Wilmington Hospital) offered to run all the bacteriological tests since the Board of Health did not have a laboratory of its own. Emergency plans were made to take over the buildings of the Wilmington Country Club and of the New Century Club and to make them “temporary hospitals”. Things got even more complicated since there were not enough nurses to keep up with the increased demand. Women from

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the community were asked to volunteer and even housewives with no experience were welcomed.

On October 2, the Board of Health declared quarantine in Wilmington closing all public places including churches. Two days later the quarantine was extended to the whole State. "People were dying like flies", said Dr. Handy, - "the back porch of the Wilmington Country Club was full of bodies waiting to be buried". Many of the doctors fell victims to the epidemic and those who were not sick divided the city in sections for each one of them to cover. At one point 23 of the nurses at the Delaware Hospital were sick and, by the end of the epidemic, two of them, sisters (Ruth and Carrie Dybeck) were dead. The treatment for influenza, as you can imagine, was very limited: bed rest, aspirin, fresh air, sometimes liquor but mostly bed rest. The smell of disinfectants hung like a cloud over the city. Even the trolley cars smelled of carbolic acid. Dr. Handy had been working for only 10 days into the epidemic when the Board of Health, given her interest in children, opened a Pediatric ward at the Peoples

Settlement on East 8th Street. She was give 30 cribs but not much more, no personnel. She was the doctor, the nurse, the janitor, the cleaning lady and the baby-sitter. Other cities did not fare much better. Apparently the epidemic had started at Fort Riley, Kansas where sailors overwhelmed the resources of the Chelsea Naval Hospital. Sailors would arrive displaying a bluish complexion with purple blisters and having a hoarse, hacking, shallow breathing barely supplying enough air to keep them alive. Doctors realized this was not an ordinary flu. Within two weeks 2000 officers and men from the First Naval district contracted the disease and from the dead, in autopsies, what was found was lungs soaked with a bloody, foamy fluid, which seeped blood beneath the physician's scalpel Reports showed cases appearing on the eastern coast from Rhode Island to Florida. In Boston, by the end of September of 1918 one thousand people were dead.

In Philadelphia, some cases of "Spanish Influenza" ("La grippe") were reported as early as July 1918. Complicating matters, there was a serious personnel shortage, due

to many doctors and nurses having being sent to Europe to serve the nation's war effort. Churches, schools, and theaters were closed. By October the count of dead was 4500 and by the end of the epidemic Philadelphia had lost 13000 people. The effect of the influenza epidemic was so severe that the average life span in the US was depressed for the following 10 years. People would be struck with the illness on the street and died rapid deaths. It was a struggle for air until they would suffocate.

I wonder how many of you, my fellow seniors, know of stories of this epidemic in your state or town. If you do, please share them with us. Your story may appear in a future issue of this Bulletin, which will make you famous with your grandchildren. I will finish this story with a rhyme, which, by the end of 1918, became very popular with children while skipping rope:

"I had a little bird,
Its name was Enza.
I opened the window
And in-flu-Enza".

Remember: close your window,
wash your hands frequently and.
...stay healthy!

"Even when poetry has a meaning,
as it usually has, it may be inadvisable to draw it out....
Perfect understanding will sometimes almost extinguish pleasure."

A. E. Housman [1859-1936]

The majority of seniors will suffer from one or more chronic illnesses,
some progressive, some painful, some static though unpleasant.
This web address links to several useful articles about how to cope, as a person,
with something that will not go away,
and how to live as good a life as is possible.

The site is:

<http://www.nlm.nih.gov/medlineplus/copingwithchronicillness.html>."