Message from the Chairperson

Avrum L. Katcher, MD, FAAP
Chairperson, Section for Senior Members

It is a pleasure to send a spring time greeting, just before the vernal equinox, not only to all members of our Section, but indeed to all senior members of the American Academy of Pediatrics, and, to be sure, to all Fellows. We see our role as supportive of the Academy and its several internal groups, in any way possible to help with the primary objective to improve the health of children, and by extension, families. We also see our role as supportive of senior members, in any way possible, to help with our primary objective to improve the ability of all members to navigate life changes associated with getting older while continuing to enjoy the best possible health for, and by extension, their families.

Our Section has been encouraging all Chapters of the AAP to build Chapter Senior Committees. For this purpose we have prepared a manual—a Chapter Guide—for use by Chapter leadership in developing a Chapter Senior Committee. One example of the first role is taking place in my home state of New Jersey right now. Chapter leadership, including past President Bipin Patel, current President Janice Prontnicki, in partnership with Chapter Senior Committee Chairperson Lawrence Frenkel, are in the process of creating a Rapid Reaction Team of seniors, who will be available on short notice to meet with key legislators and administrative leaders, for the purpose of helping these leaders to see what actions, by legislators and administrators, will best provide for the welfare of all children in our state. There, that is a long sentence, a mouthful. Next month, with the support of the Section, we will be meeting with experi-

Continued on Page 2
enced legislators and advocates to gain their help for our members in learning how to put their best foot forward (not in the mouth) when conferring with these state figures.

Another very active Chapter is in Texas. President Molly Droge, of The Texas Pediatric Society (the Texas Chapter of the AAP) says that Texas has an active group of senior pediatricians who participate in extensive committee activities, advocacy, and TPS Foundation fundraising. They act as mentors who provide collective memory, experience and wisdom for the younger pediatricians. The majority of these active senior pediatricians (10-15) are past presidents of the TPS and/or the Texas Chapter and meet at our Annual Meeting at the Past Presidents’ Dinner. But all are welcome.

In Northern California Chapter I, a Seniors Committee, known as the “Vintage Doc’s,” was formed in February, 2006. There are currently 22 pediatricians in the chapter who have either attended meetings or otherwise expressed an interest in being involved. The co-chairs of the committee are Harvey Kaplan and Bill Feaster. At the Chapter’s annual meeting, “Vintage Doc’s” met with the “Young Physicians” to develop a combined educational symposium geared not only to the needs of pediatricians just entering practice, but also to include senior pediatricians either retired or leaving full time practice. The common theme is, “Transitions, a Continuum from Life after Residency to Life after Practice.” Topics of interest to both groups will include, financial planning, contract analysis, satisfying medical licensure or re-licensure requirements, continuing education, practice insurance, medical liability and other practical matters. And this active group has been participating in many other activities.

The Section for Senior Members has joined with the Strang Cancer Prevention Center, associated with Sloan-Kettering Cancer Hospital in New York City, and Generations United, to create a program for grandparents raising grandchildren. Pediatricians in New York, Chicago, and Houston will be teaching this material to grandparent volunteers. The objective is to help these “second-time around” grandparents in turn teach their grandchildren about healthy diets, and healthy life styles, with particular emphasis on being physically active as well as eating well balanced meals. The aim is to prevent the appearance of obesity in these children, or reverse it if it has already appeared. I have had the privilege of representing the Academy by serving on the advisory committee that has put this project together.

Lucy Crain of California, and George Cohen of District of Columbia, have created a wonderful program for the NCE in San Francisco, this year. Three excellent speakers will discuss, in order:

1. Genes, Aging, & Disease: Audience will learn status of current research and possible clinical potentials for prolongation of longevity. Faculty: Dale Bredesen, M.D.

2. Strategies for Staying Sharp: Diagnosis & Treatment of Memory Disorders: Outcome: New information and review of current competencies for personal and clinical practice application to improve cognitive function. Faculty: Bruce Miller, M.D.
Message from the Chairperson  Continued from Page 2


We look forward to seeing you there, and learning about these important topics for us all.

Jerold Aronson of Pennsylvania, working with staff members of the Academy, has continued to produce an ever more effective web site. Run, don’t walk, to your browser to see what he has been up to now. Joan Hodgman and Arthur Maron have, as you know, also, continued to produce one of the best quarterly periodicals of any Section—our Section for Senior Members’ Bulletin.

Let us hear from you! Speak up! Write to Joan and Arthur about what you can produce or would like to see in the Bulletin. We all want to hear from you, particularly if you are producing an article of interest to all. If you have access to E-mail, write to Joan at hodgman@usc.edu. Write to Arthur at artmaron@aol.com. If you do not, write by United States Postal Service to Jacqueline Burke, Section for Senior Members manager, American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, IL 60007-1098, Telephone 847/434-4000.

A Happy Spring for all of you.

Avrum L. Katcher, MD, FAAP
Chairperson, Section for Senior Members

2007 Senior Newsletter Schedule

Articles for consideration should be sent to the Editor at hodgman@usc.edu with copies to the Associate Editor artmaron@aol.com and the Academy headquarters tcoletta@aap.org

Summer Newsletter
June 1 articles due to Joan Hodgman, MD, FAAP
July 2 mailboxes

Fall Newsletter
July 15 articles due to Joan Hodgman, MD, FAAP
(this deadline is early because the editor spends August at her mountain cabin away from computers and email and must have the bulletin prepared before she leaves)
October 1 mailboxes

Winter Newsletter
December 1 articles due to Joan Hodgman, MD, FAAP
January 1 mailboxes

Letter from the Editor

Waltzing is as beneficial to health as working out on treadmills and stationary bikes. People are more apt to do it because it is fun, says researcher Romualdo Belardinelli MD of Lancisi Heart Institute in Anaconda, Italy. In a report to the American Heart Association in November, Belardinelli said the Waltzers had better oxygen uptake and less muscle fatigue than a group doing more traditional exercises and a group that didn’t exercise. They also reported better quality of life. “Maybe we should try that here” cardiologist Robert Bonow MD of Northwestern University Medical School told the Associated Press. “I’m not sure we can get Americans to waltz, but they certainly can dance.”

Submitted by Editor Joan Hodgman who loves to dance.
Meet Your Executive Committee

Arthur Maron, MD, MPA, FAAP

Arthur Maron, MD, MPA, FAAP, a member of the AAP Section for Senior Members, was born in New Jersey. At a very young age, his parents were very proud, but his four older brothers were unimpressed. Growth and development proceeded through public schools and Rutgers University, to be continued at Albany Medical College. His love of Pediatrics was kindled during internship and two years in the U.S. Public Health Service; it was consummated by pediatric residency at Babies’ Hospital in Newark, New Jersey under the tutelage of Dr. William J. Barba, III.

Established in a traditional primary-care pediatric practice, which would continue for 33 years, Arthur soon expanded his horizons to include community activism, medical education and long-time involvement with the American Academy of Pediatrics. As rewarding as one-on-one pediatrics can be, the opportunity to make a difference in a broader environment was at once challenging and immensely gratifying.

First inducted as Program Chairman for the New Jersey Chapter, he soon moved to the Pediatric Practice Committee, where he inspired and founded one of the only not-for-profit Medicaid-subsidized health care clinics (Lyons Health Center) in the country. The unique concept of a health center in the late 60s staffed totally by volunteer suburban pediatricians was acknowledged in *Medical Economics* and several years later was a factor in the Outstanding Chapter Award for New Jersey.

Arthur was elected to the AAP Board of Directors after leading the New Jersey Chapter, and spent six years representing District III (Mid-Atlantic) on the national AAP scene. The opportunity to work with so many committed and inspirational pediatricians, devoted to the health and welfare of children, was truly gratifying. Issues such as the aspirin-Reye Syndrome correlation, the vaccine liability legislation, and the “Baby Doe” federal newborn nursery oversight were representative of the impact one can have upon entire populations and policies.

Leaving the AAP Board of Directors with fond memories and a sense of some accomplishment, and continuing his pediatric practice and community activities at full speed, there remained one road untraveled. In pediatric residency and practice and as a faculty member and administrator, he was troubled by the increasing disparity between the educational curriculum mandated in residency training and the clinical competencies required in actual pediatric practice. In the decades of scientific explosion, trainees were being prepared more and more for clinical practice, which was less and less consistent with their residencies. As an example, a chief pediatric resident manages the Newborn Intensive Care Unit until graduation and, as an attending pediatrician, is excluded from NICU management. As a member of the Residency Review Committee for seven years, with two years as Chairman, Arthur guided the RRC through a dramatic reform of pediatric residency training. Newly-adopted requirements provided for a minimum of 50% ambulatory care experience, specific curricula in adolescent medicine and behavioral-developmental pediatrics, and a limit on NICU experience. These significant changes, among others, required a delicate strategy through the understandable bureaucracy, and Arthur found the results to be exciting and gratifying. Coincident with his tenure as Chairman of the RRC for Pediatrics, he held rewarding positions in the AMA and the AHA, including the Presidency of the National Resident Matching Program (NRMP).

Meanwhile, back at home, Dr. Maron concluded his pediatric practice—but not his commitment to pediatrics—in 1994 to join the Saint Barnabas Medical Center (later to grow into the Saint Barnabas Health Care System) as Vice-President for Medical Education and Chief Academic Officer. He was named Associate Dean at Mount Sinai Medical School and retained his position as Associate Professor of Clinical Pediatrics at UMDNJ-New Jersey Medical School.

In addition to his professional activities over a long and rewarding career, Arthur enjoyed civic and community endeavors as well as family interests. He served as President of his synagogue, B’nai Shalom in West Orange; chaired the community and physicians divisions of United Jewish Federation of MetroWest; and was the Medical Professions Chairman for State of Israel Bonds for over ten years. He and his dear wife, Ruth, were honored with the State of Israel Jerusalem Medallion Award in 2004. Arthur and his late wife of 38 years, Lynn, shared many AAP experiences as well as world travel with their three children. Arthur and Ruth reside in sunny Florida but are never too far from their five children and ten grandchildren, ages nine to 23.

The story would not be complete without the news that Arthur remains involved and productive. In 2001, he was named Executive Dean of Saba University School of Medicine, a Caribbean medical school based in the Netherlands-Antilles. He and Ruth can be found there about three times a year. And the crowning glory, no doubt, has been his membership on the Executive Committee of the AAP Section for Senior Members, under the tutelage of David Annunziato and Avrum Katcher, where he also helps Joan Hodgman in editing this Bulletin.
September 2006


by Jessica P. Vistnes, PhD and Jeffrey A. Rhoades, PhD

Introduction

The State Children’s Health Insurance Program (SCHIP), enacted in 1997, expanded eligibility for public coverage to low income children. Previously published findings from the Medical Expenditure Panel Survey indicate that between 1996 and 2002, the percentage of all children eligible for public coverage rose from 28.6 percent to 47.1 percent, and that efforts to improve outreach, simplify enrollment, and retain eligible enrollees in Medicaid and SCHIP likely contributed to increases in the rate at which eligible children enrolled in public programs.*

This Statistical Brief presents updated evidence on trends in children’s coverage for 1996 to 2005 by race/ethnicity status, showing that continued growth in public coverage has been a major factor in improving rates of health insurance coverage for children. These changes have been particularly dramatic for minority children.† All differences between estimates discussed in the text are statistically significant at the 0.05 level unless otherwise noted.

Findings

Between 1996 and 2005, rising rates of public only coverage offset declines in private coverage for non-Hispanic white and Hispanic children and reduced the likelihood that they would be uninsured. Non-Hispanic white children experienced a decline in private coverage since the late 1990’s (from 75.0 percent in 1997 to 71.6 percent in 2005) (figure 1) and an increase in public only coverage (from 13.6 percent in 1996 to 20.5 percent in 2005) (figure 2). As a result, their rate of being uninsured declined from 12.6 percent in 1996 to 7.9 percent in 2005 (figure 3).


Highlights

- Non-Hispanic white, non-Hispanic black, and Hispanic children’s rates of being uninsured dropped substantially between 1996 and 2005. Non-Hispanic white children’s rates of being uninsured fell from 12.6 percent to 7.9 percent, while non-Hispanic black and Hispanic children’s rates fell from 17.6 percent to 11.3 percent and 28.1 percent to 19.7 percent, respectively.

- In 1996, rates of private coverage exceeded rates of public only coverage for Hispanic children (39.4 percent versus 32.6 percent, respectively). However, by 2005, public only coverage was a far more important source of health coverage for Hispanic children compared with private coverage (49.9 percent versus 30.5 percent, respectively).

- In 1996, Hispanic children were less likely to be covered by public only coverage than non-Hispanic black children (32.6 percent versus 40.8 percent, respectively). The large rise in rates of public only coverage for Hispanic children from 1996 to 2005 more closely aligned their rates of public only coverage with that of non-Hispanic black children by 2005 (49.9 percent versus 48.3 percent, respectively).
this same time period, 1996 to 2005, non-Hispanic black children's rate of being uninsured declined from 17.6 percent to 11.3 percent due to large increases in their rate of public only coverage (from 40.8 percent to 48.3 percent). Hispanic children's rate of being uninsured also declined, from 28.1 percent to 19.7 percent. Nevertheless, Hispanic children remained the most likely to be uninsured among the three-racial/ethnic groups.

Rising rates of public only insurance shifted the relative importance of private and public only health insurance in covering minority children between 1996 and 2005. Starting with a sharp increase from 2001 to 2002, rates of public only coverage rose by nearly 17 percentage points for Hispanic children by 2005 (33.1 percent in 2001 to 49.9 percent in 2005) (figure 2), offsetting a decline in rates of private coverage (39.4 percent in 1996 to 30.5 percent in 2005) (figure 1). In 1996, rates of private coverage exceeded rates of public only coverage for Hispanic children (39.4 percent versus 32.6 percent, respectively). However by 2005, public only coverage was a far more important source of health coverage for Hispanic children compared with private coverage (49.9 percent versus 30.5 percent, respectively). Similarly, in 1996 non-Hispanic black children had roughly equivalent rates of private and public only coverage (41.7 percent and 40.8 percent, respectively), but by 2005 non-Hispanic black children were more likely to be covered by public only health insurance than private coverage (48.3 percent versus 40.5 percent, respectively). Rates of public only coverage increased for non-Hispanic white children as well (from 13.6 percent in 1996 to 20.5 percent in 2005); however, they remained far below rates of private coverage (71.6 percent in 2005).

In 1996, Hispanic children were less likely to be covered by public only coverage than non-Hispanic black children (32.6 percent versus 40.8 percent, respectively) (figure 2). The large rise in rates of public only coverage for Hispanic children from 1996 to 2005 more closely aligned their rates of public only coverage with that of non-Hispanic black children by 2005 (49.9 percent versus 48.3 percent, respectively). In 1996, Hispanic and non-Hispanic black children did not significantly differ in their rates of private coverage (39.4 percent versus 41.7 percent, respectively), but over the period 1996 to 2005 Hispanic children's rates of private coverage declined (from 39.4 percent to 30.5 percent) while non-Hispanic black children's remained fairly stable (from 41.7 percent to 40.5 percent) (figure 1).

Continued on Page 7
Data Source

The estimates shown in this Statistical Brief are drawn from analyses conducted by the MEPS staff from the following 1996 to 2005 point-in-time public use files: HC-001, HC-005, HC-009, HC-013, HC-022, HC-034, HC-053, HC-064, HC-075, and HC-084.

Definitions

Uninsured
Individuals classified as uninsured throughout the first half of the year did not have public only or private health insurance coverage during the period from January of the survey year through the time of their first interview in that year. Interviews were typically conducted from February to June. Individuals covered only by noncomprehensive State-specific programs (e.g., Maryland Kidney Disease Program) or private single-service plans (e.g., coverage for dental or vision care only, coverage for accidents or specific diseases) were considered to be uninsured.

Public only coverage
Individuals were considered to have public only health insurance coverage if they were not covered by private insurance and they were covered by Medicare, Medicaid, TRICARE, or other public only hospital and physician coverage.

Private coverage
Private health insurance coverage was defined as nonpublic insurance that provided coverage for hospital and physician care (including Medigap coverage).

Racial/ethnic classifications
New standards for racial/ethnic classifications were used by the U.S. Census Bureau in the 2000 decennial census. All other Federal programs adopted the new standards by 2003. These changes conform to the revisions of the standards for the classification of Federal data on race and ethnicity promulgated by the Office of Management and Budget (OMB) in October 1997. For 1996 through 2002, racial and ethnic classifications were Hispanic, white non-Hispanic, black non-Hispanic, Asian non-Hispanic, and other non-Hispanic. As of 2003, the racial and ethnic classifications are Hispanic or Latino, white non-Hispanic or Latino single race, black non-Hispanic or Latino single race, Asian non-Hispanic or Latino, and other single race/multiple race non-Hispanic or Latino. Because of sample size among the population, age 0 to 17 analyses were limited to Hispanic, white non-Hispanic, and black non-Hispanic.

About MEPS-HC

MEPS-HC is a nationally representative longitudinal survey that collects detailed information on health care utilization and expenditures, health insurance, and health status, as well as a wide variety of social, demographic, and economic characteristics for the civilian non-institutionalized population. It is cosponsored by the Agency for Healthcare Research and Quality and the National Center for Health Statistics.

For more information about MEPS, call the MEPS information coordinator at AHRQ (301-427-1656) or visit the MEPS Web site at http://www.meps.ahrq.gov/.

References

For a detailed description of the MEPS survey design, sample design, and methods used to minimize sources of non sampling error, see the following publications:

AAP Introduces New Student Loan Consolidation Program

As the cost of higher education continues to rise, so does the amount of loan debt with which the average student graduates. In fact, many members of the American Academy of Pediatrics (AAP) emerge from medical school and/or pediatric residency with a balance of more than $125,000 in student loans.

In response to our young members’ request for assistance, AAP has partnered with the Student Assistance Foundation (SAF), to create a student loan consolidation program that features the simplicity of one loan, one lender, and one payment. SAF is a nonprofit corporation based in Montana dedicated to providing students with the knowledge and tools to finance and pursue their postsecondary education.

Our innovative program offers these benefits:

- **Significant cost savings:**
  - A 2% principal reduction on balances between $12,500 and $99,999 after the first on-time payment.
  - A 2.5% principal reduction on balances of more than $100,000 after the first on-time payment.

- **OR**
  - A 1% interest rate reduction after 35 on-time payments.

- **Plus, a .5 percent interest rate reduction for signing up for direct payment**
- **Fully automated, online account access.**
- **Flexible repayment plans, including deferment and forbearance options.**
- **Life-of-the-loan servicing.**
- **Exceptional customer service.**

We have done the homework for you! All members, eligible medical students, and residents interested in more information should call (866) 869-0671, or visit the Web site at www.aapstudentloans.org.
The State of Aging and Health in America 2007 Report

It is our pleasure to share with you *The State of Aging and Health in America 2007*. This report was released by the Centers for Disease Control and Prevention (CDC) and The Merck Company Foundation at the 2007 Joint Conference of the American Society on Aging and the National Council on Aging in March 2007.

We anticipate that *The State of Aging and Health in America 2007* report will be a welcomed and useful resource for a variety of audiences committed to improving and preserving the health of older adults, including public health and aging professionals, policymakers, and researchers. This report updates a similar report released in 2004 and is designed to present information and data from a variety of sources in a straightforward, easy-to-read format.

The United States population is rapidly aging. By 2030, the number of Americans aged 65 and older will more than double to 71 million older Americans, comprising roughly 20 percent of the U.S. population. In some states, fully a quarter of the population will be aged 65 and older. An enhanced focus on promoting and preserving the health of older adults is essential if we are to effectively address the health and economic challenges of an aging society. The cost of providing health care for an older American is three to five times greater than the cost for someone younger than 65. By 2030, the nation's health care spending is projected to increase by 25% due to demographic shifts unless improving and preserving the health of older adults is more actively addressed.

*The State of Aging and Health in America 2007* report presents the most current national data available on 15 key health indicators for older adults related to health status, health behaviors, preventive care and screening, and injuries. The “State-by-State Report Card” provides similar information for each of the 50 states and the District of Columbia, and enables states to see where they are on each indicator as well as in relation to other states.

The report includes bold “Calls to Action” and a “Spotlight” on reducing injuries associated with falls. These features highlight model intervention programs and thoughtful recommendations for policymakers, health care providers, and older adults themselves to ensure not just longer, but healthier lives. Emerging public health opportunities such as promoting cognitive health and addressing end-of-life decision making issues.

This report is intended to reflect not only challenges but also optimistic reasons for healthy aging. We already know much about how to reduce illness and functional decline among older Americans. The real challenge is to more broadly apply what we already know about helping to ensure that added years are healthy years. We are happy to have you as a partner in this effort.

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To the Editor:

In around the year 1955, when I was commencing private practice, a colleague, rather older than I, asked me to see an infant in the nursery with early jaundice. I can't remember how high the bilirubin was, but it was high enough that an exchange transfusion was warranted. The procedure went off without incident, and the infant subsequently thrived.

We were at that time involved in a study being conducted by a nearby academic hematologist, who was looking at some of the less well studied blood types and their genetic background. Blood was sent from mother, father and infant.

The report showed that the baby could not be this young man's child. Although I cannot remember the specific types, but the professor was very definite. We confirmed. Before discussing with parents, I spoke to the family physician, who would care for the infant when out of hospital. He knew the family well. He said he would not be surprised at all. Guess I was innocent. I gulped.

Returned to parents in the hospital room. Discussed erythroblastosis at length, gave a positive prognosis, asked for questions. None came about parenthood. Ma was silent and it never occurred to Pa to question.

So, I learned.

*Constant Reader*
The 110th Congress began Jan. 4. As you know, the Democrats are now in charge of both houses of Congress for the first time since 1994. There are also 65 new members of Congress. Democrats control 51 seats in the Senate, and 233 seats in the House. Republicans have 49 seats in the Senate and 202 in the House.

The new Congress presents renewed advocacy opportunities for many issues of importance to pediatricians and children's health. The State Children's Health Insurance Program (SCHIP) must be reauthorized and fully funded as soon as possible in 2007. The Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act, both important pediatric drug research and labeling legislation, must be renewed by October. Pediatric medical devices legislation should also be reintroduced in the 110th Congress. The bill could provide a true benefit to children in dire need of medical devices that adequately address their physical size and biological needs.

The Academy's federal legislative agenda is largely wrapped up in the jurisdiction of several key congressional committees. The Senate Committee on Health, Education, Labor and Pensions oversees issues relating to public health, and is chaired by Sen. Edward Kennedy (D-MA). Sen. Max Baucus (D-MT) is chairman of the Senate Committee on Finance, the committee that deals primarily with federal funding for children's health care programs, including SCHIP.

The House Committee on Energy and Commerce, which oversees a variety of issues related to product safety, communications and disaster preparedness is chaired by Rep. John Dingell (D-MI). Rep. Henry Waxman (D-CA) chairs the House Committee on Government Reform, which has oversight over multiple government agencies such as the Food and Drug Administration, the National Institutes of Health and the Centers for Disease Control and Prevention.

The Academy, in part through its Web site, provides pediatricians the resources they need to get active and stay involved with members of Congress throughout the year. Log on to http://www.aap.org/moc (Member Login required, use your AAP member ID, it can be found on the AAP News or Pediatrics mailing label) and click on “Federal Affairs.”

Some of the actions pediatricians can take online include:

• **Becoming a Key Contact** - AAP members interested in taking their advocacy to the next level are encouraged to sign-up for the Key Contact program. Key Contacts receive all the latest information and news from the Federal Advocacy Action Network (FAAN), as well as advocacy tips and tools, suggestions for improving relationships with members of Congress, the latest up-to-date information on legislation impacting pediatricians, and more sophisticated advocacy assignments. Pediatricians whose members of Congress are party or committee leaders in the House or Senate are encouraged to become Key Contacts.

• **Looking up Elected Officials** - Look up contact information for senators and representatives in the congressional directory, and then take action by writing, telephoning, e-mailing or faxing your thoughts to them!

• **Taking Legislative Action** - Read the status of key AAP legislative efforts, and, again, take action by submitting letters to members of Congress.

For more information about the Key Contact program, or the AAP 2007 federal legislative agenda, please contact the AAP Department of Federal Affairs, (800) 336-5475, or kids1st@aap.org.

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One summer evening during a violent thunderstorm a mother was tucking her son into bed. She was about to turn off the light when he asked with a tremor in his voice, “Mommy, will you sleep with me tonight?”

The mother smiled and gave him a reassuring hug. “I can’t dear,” she said. “I have to sleep in Daddy’s room. A long silence was broken at last by his shaky little voice: “The big sissy.”
The two AAP president-elect candidates are requested to address the following question.

WHAT WOULD YOU SAY TO PEDIATRICIANS WHO LOOK AT THE COST OF MEMBERSHIP AND WONDER WHETHER BEING A MEMBER OF THE AAP IS REALLY WORTH IT?

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<tr>
<th>James E. Shira, MD, FAAP</th>
<th>David T. Tayloe, Jr, MD, FAAP</th>
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<td>Denver, CO</td>
<td>Goldsboro, NC</td>
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Yes, the cost of AAP Membership is significant…but I can’t think of a more valuable and rewarding investment for all pediatricians, be they in primary care or a subspecialty. First and foremost, you join forces with 60,000 professional men and women who share your dedication to children and your commitment to pediatrics. You become part of a robust, visionary organization that continues to grow more vibrant with increasing numbers of young people, especially women. Your membership includes benefits that are specifically tailored for pediatricians and unavailable through any other resource.

As a member, you have ready access to:

- AAP News, Pediatrics and the Red Book and, at discounted prices, more than 400 educational products and publications for you and your patients.
- Policy Statements, Clinical Reviews, Technical Reports, Clinical Practice Guidelines and practice management tools written by pediatric clinical scholars, and specifically designed to expand your acumen and to advance the quality and efficiency of your practice.

In addition, Academy membership provides countless opportunities for you to:

- Stay current and earn CME credits through online study (Pedialink and EQIPP) or PREP at home or through participation in cutting-edge CME courses offered around the country.
- Contribute to the enrichment of pediatric health care through participation in clinical research in your office as part of the PROS program or through implementation of a community project funded by a CATCH grant.
- Expand your subspecialty or pediatric practice interests through participation in Section, Council and Committee activities.

And, perhaps most important, you join fellow pediatricians in well planned, well orchestrated, data-driven advocacy efforts to benefit children and those who provide their health care.

There is much more. The AAP is a unique organization. It is the convening, synthesizing body of our discipline, bringing together pediatricians from diverse backgrounds to pool their expertise and energy principally to advance the health and welfare of children everywhere and, at the same time, to enhance the professional and personal lives of its members. From my perspective, AAP membership is far more than a business consideration for the pediatrician; it is an essential investment!

I believe the AAP gives pediatricians an excellent return on their investment. From the challenges of coding and reimbursement to the rigors of federal government lobbying, the Academy helps us work together to serve children, families, and pediatricians.

The extremely competent and dedicated AAP staff brings us together with our volunteer leadership (Chapters, Sections, Committees, Councils, Task Forces) to share our thoughts about pediatrics. Our lives are often frustrating and exhausting. Through meetings, teleconferences, and listservs, we obtain the support of colleagues in user-friendly formats. We need the stabilizing power of fellowship with like-minded professionals as we struggle with business and market forces, political realities, and educational challenges to develop health systems that benefit children, families, and pediatricians.

The Academy provides superlative educational programs for health professionals who are focused on the needs of children and families. From face-to-face CME to a variety of on-line opportunities, general and subspecialist pediatricians can be assured that their practices are “state of the art.”

The AAP prepares pediatricians to be effective leaders and advocates, and coordinates national and state advocacy efforts. As a member of the North Carolina Chapter’s leadership since 1985, I could not imagine trying to address the advocacy agenda in our state without the assistance of the AAP and the Chapter. Our collective advocacy benefits children and their families, AND assures that pediatricians are adequately paid for working daily to improve the child health system.

The Academy’s strategic plan assures that we know where we are in our pediatric journeys, where we hope to go, and what kind of child health system we are leaving for our children. My pediatrician father worked with the national AAP and the NC Chapter to leave me a better system than the one he inherited in 1955. I would like to think that we can advocate for, and play a leadership role in developing, a child health system that my pediatrician children will find superior to the one I entered in 1977. We need our Academy to lead us to a brighter future for all the children, families, and pediatricians of the next generation.
In our previous two articles, we have discussed,

• Right Plan
• Right camera
• Right technique
• Right PC
• Right Software to: i) organize your photos, and ii) edit them
• Right on-line photo-editing and storage

Each of the above topics is archived and available online at www.aap.org/seniors in the Living Well Section or in the Senior Bulletin archive at www.aap.org/seniors in the 2006 Fall and 2007 Winter Issues.

This article will complete the series and present some ideas on:

• Right photo printing and on-line photo-sharing strategies
• Right Place to Buy

**Right Photo Printing and On-line Photo-sharing Strategies**

My experience may be yours. I tried printing at home with the new types of photo printers that are either enhanced ink jets or the compact type. I found that, over time, it was too expensive, too time consuming, and too much hassle to constantly buy paper and new ink. Disposable printer supplies, e.g. color ink cartridges and photo paper are costly and don't last long. A print can cost up to $1.00 print when you take into account the cost of the printer, ink and paper.

Instead, take your pictures (by camera or memory card) down to your local photo store or photo kiosk in the drug store to make prints. The photo kiosks allow you to crop, edit, and enhance the image before printing and selectively print only the best ones in your choice of sizes! Wow! The time is the same but the kiosks are very easy to use. Kodak or Fuji Print kiosks can be found in drug stores, some super markets, and even the mall. An alternative choice is the online photofinishers,

If one has a broad band hi-speed internet connection, it is extremely easy and convenient to upload photos to the printing service's website and presto—a few days later your film-quality prints arrived in the mail. Signing up and uploading images is free, and most photo companies offer free prints, on-line storage, personal web addresses, or other specials when you join. Mailing costs can even be avoided. Wal-Mart Photo Center or CVS Photo Center and others, offer the option or ordering online and picking up your prints at a local retail outlet.

Reviews of the following popular services can be viewed by clicking on the hyperlinks below:

**Snapfish** ([www.snapfish.com](http://www.snapfish.com)) for low cost prints and photosharing
**Shutterfly** ([www.shutterfly.com](http://www.shutterfly.com)) for low cost prints and photosharing
**PhotoWorks** ([www.photoworks.com](http://www.photoworks.com)) for low cost prints and photosharing
**Kodak EasyShare Gallery** ([www.kodakgallery.com](http://www.kodakgallery.com)) pick up your pictures at the local CVS Pharmacy.
**Wal-Mart Photo Center**

Finally – share your digital photos with the world via PhotoStamps.com. This new product allows you to make stamps from your favorite photos. Paste the stamp on the envelope and your friendly mail person will deliver it to any address!

Continued on Page 13
Finally – how to find the Right Place to Buy

You have made your decisions and you have the right plan. Now it is time to buy your equipment. Once again, your PC to surf the web comes to the rescue. Price comparison web sites, sometimes called shopping agents, scan other Web outlets for products and prices. If you're looking for a specific item, these sites are a good place to start. Just be aware that payments or other favors may be exchanged behind the scenes that affect listings and rankings. View several different sites and use these sites as a guide, not as the last word. (Note – Google the product below or click on the shopping agent hyperlink.)

- **CiNet Shopper** (a techies dream site: select category, view by price, popularity, etc. and read professional and user reviews and comments)
- **Price Grabber** (select your category, sort by rating, price, popularity!)
- **Price Watch** (select your category of purchase, pick your price range and view your choices)
- **Shopnow** (provides a list of current buying sites once you select a product category)

Buying online is generally safe. However, remember to:

**Check reseller** rankings at the shopping agent or at [www.resellerratings.com](http://www.resellerratings.com) to evaluate companies who sell computer products (e.g. hardware, software, etc.). Shop the ones that are good, trustworthy companies and avoid retailers with bad consumer ratings. The ResellerRatings.com database covers nationally advertised mail-order companies, and/or companies who do business on the Internet. All of the evaluations on the ResellerRatings.com site are submitted by fellow Internet users. Find out what they think, where they shop, and where they’ve been burned, so you won’t be. Alternatively, check Google Groups ([http://groups.google.com/](http://groups.google.com/)). Enter a name to search for and it then lists all of the postings containing that word. Here you can find a multitude of sites that address your concern. For example, it may be difficult to choose between two cameras, Google Groups provides you the option to surf to a Digital Photography Review site that enables you to view a side-by-side comparison of cameras that you select at [http://www.dpreview.com/reviews/sidebyside.asp](http://www.dpreview.com/reviews/sidebyside.asp). This site allows you to search on-line retailers such as PC Connection, just enter PC Connection. This gives you a chance to hear what other people's experiences have been. Every company has dissatisfied customers so don't let one or two put you off. What you want to know is how a company handles complaints and if there is a pattern to the complaints, e.g. shipping delay, product out-of-stock, etc.

**Explore on-line auctions (e.g. eBay)**

Some people swear by Web auctions as a way to get the lowest possible price. There are even people addicted to these sites. The best thing about them is that you can enter low bids and maybe get a real deal. Before beginning, be aware that the National Consumers League, in a United States Senate hearing, listed Web auctions as the No. 1 fraudulent scheme on the Internet based on the number of complaints they and state attorney generals received. According to the League, common complaints are that items bid for are never delivered by the sellers, the value of items is inflated, shills are suspected of driving up bids, and prices are hiked after the highest bids are accepted. Here are some of the better-known on-line auction sites.

**Watch out for unbundling**

When you buy a digital camera, the basic package almost always includes extras such as a battery charger, lens cap, batteries, flash memory card, and software. One of the more disreputable practices a dealer can engage in is called unbundling. These dealers remove items from the package that are normally included in the price and price them separately. To find out what should be included in the package, visit the camera manufacturer's Web site and check their specifications page. The included items are almost always listed. The user's guide that comes with the camera will also list the items that should be included as part of the camera price.
Avoid gray market products

When camera companies introduce new cameras, they frequently use different product numbers, names, and prices in different markets around the world. Some dealers buy cameras in countries with the lowest prices and then sell them in another country. Since these cameras are bought and sold outside of the manufacturer's normal distribution channels, prices may be lower but you almost always lose warranty coverage and technical support.

Check postage rates

When purchasing a camera you have three components of the price to consider—the camera price, postage and handling, and taxes. When you purchase over the Web or by mail order from an out-of-state-company, you and not the dealer are responsible for paying state and local sales taxes. Most people aren't aware of this responsibility, or choose to ignore it. When it comes to the price and postage and handling, the dealer is in control. Many dealers lower the price to make the camera more attractive, and then increase the postage and handling to boost their profits. With the popularity of price comparison sites, the temptation to do this is even stronger. Be sure you ask about these additional costs and take them into account when comparing prices. Most companies have deals with firms such as UPS or FedEx so their costs are $5 or so for second day shipments. Anything over and above that is pure profit to the dealer.

Avoid extended warranties

Hesitate before accepting extended warranties. Every knowledgeable consumer expert says it's better to gamble. Most of a company's profit is in the sale of these warranties so they press, and press hard. Your job is to resist, and resist hard. The only thing to keep in mind is that digital cameras can be horribly expensive to repair. If you want peace of mind, you may want the warranty, even though it's probably overpriced. The cost of a repair can approach, or even exceed, the original purchase price.

Check return policies, restocking fees

When you buy a camera from a reputable dealer, you expect to be able to return it if you aren't satisfied. Some dealers try to discourage this by requiring a restocking fee for returned merchandise. This is always explained as a way to recover their costs of checking the merchandise and restoring the packaging you may have opened. If a dealer requires a restocking fee, my advice is to find another dealer.

Don't buy extras

Don't buy extras without doing research. A few dealers low-ball camera prices and make their profit on accessories or other things their high-pressure sales people can stick you with.

Shop locally—support your local economy

There's no question that you can save a little money by shopping by mail order or over the Internet. However, keep in mind that the dealers in your local community also deserve your support. Their prices aren't always higher because they are more profitable. More likely, they are higher because their costs are higher. As often as possible, it makes sense to support your local merchants. They are part of the community you live in and your dollars circulate locally, not in a distant place you care nothing about.

Happy Picture Taking!

For more information on technology for seniors, visit the Living Well Section at the AAP Section for Senior Members at www.aap.org/seniors.
What the 2008 Election Can Mean for Children's Health Care

by Donald W. Schiff, MD, FAAP

The 2008 campaign for political control of our nation is in full swing. Candidates of both parties are spending their time raising huge sums of money ($250,000/day) and elbowing their way into the media and their perceived bases. It appears now that there will be two phases to this next critical election. First is the preliminary stage where each of the two major parties and at least one minor party will choose their candidate (probably by March, 2008), and then what follows will be an unending horrific barrage of ads in every venue, with each candidate attempting to smear their opponent and win the race.

Many candidates, especially Democrats, i.e. Clinton, Obama and Edwards, have chosen universal health insurance as a key issue in their attempt to step out ahead on this major concern for low and middle income Americans.

As health care in our country becomes more complex and costs continue to escalate at 5-10% per year, increasing numbers of voters are becoming more attentive to the issue and more open to the various approaches that a number of states have initiated. The administration's proposal to use a form of tax adjustment to reduce the number of uninsured below the current 47 million has received little support among the Congress or the people. A rising tide is running toward coverage for all Americans if we can afford it, and if not all Americans, all of our children.

A few states such as Vermont and Hawaii have achieved the goal of coverage of over 95% of their children, and Massachusetts and Illinois are attempting to reach similar levels with new programs.

While pediatricians and dozens of child advocate groups are individually and in coalitions supporting legislation to assure that all of our children have health insurance, there is a counter current of belief in our nation that this essential coverage is not necessary or is not affordable. The Academy and coalition participants have made the reauthorization of the State Children's Health Plan its immediate highest priority. This plan, created in 1997, is now covering almost six million children, most of them previously uninsured. The administration's penurious 07-08 budget recommendations would damage and diminish the current program. Pediatricians and congressional supporters are attempting to save the present program and, if possible, increase funding to enroll an additional two million children who are eligible.

The Medicaid Budget Reduction Act passed by congress last year with many onerous identification rules is being interpreted in some states with requirements which make it extremely difficult for many US born newborns to be covered by Medicaid. These rules are being challenged by state AAP chapters.

These opposing views demonstrate that we are without question on the edge of a divide. If the nation chooses to elect a president and a Congress which understand the vital importance of a healthy workforce, then we will probably see the passage of legislation which will provide quality health insurance for all of our children. If we choose otherwise, the competition for dollars to fight terrorism, pay for Social Security and Medicare will serve as an excuse to undermine our long delayed obligation to protect our nation by assuring our children good health.

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

A Kindergarten pupil told his teacher he’d found a cat, but it was dead.
   “How do you know that the cat was dead?” she asked him.
   “Because I pissed in its ear and it didn’t move,” answered the child innocently.
   “You did WHAT?” the teacher exclaimed in surprise.
   “You know,” explained the boy, “I leaned over and went ‘Psss!’ and it didn’t move.”
“What do you want to be when you grow up?” How many times did we hear that question when we were kids? And how often did we ask the same question to our own kids and to our patients? I, personally, don’t ever remember saying that I was going to be a fireman, or a policeman. Nor did I consider being a teacher or a doctor (all, the typical answers to that question). I do remember my fascination by insects, spiders, toads and snakes, and was certain that I would do some kind of work with animals as an adult. Perhaps as a veterinarian. Either that or as a circus animal trainer.

For some reason that I still can’t explain, after graduating from high school (and with honors in mathematics) I started college determined to end up as a chemical engineer. But, World War II was still going on (it was winding down), and I was about to be drafted into the military service. So I enlisted into the Navy and became a “Hospital Corpsman”, the track that eventually steered me into a medical career. I did become a doctor, after all. However, I continued to have vague ideas about becoming a veterinarian. Now, looking back after twenty-five years as a pediatric practitioner and then another twenty-five years in clinical genetics, I knew that my career as an animal doctor was not to be.

So, what next? A couple of years ago, after I gave a talk to some medical students at the hospital where I was based as a geneticist, I was eating lunch: A friend of mine, a psychologist, who had recently retired, came into the cafeteria wearing a big smile and also wearing a burgundy colored jacket with a logo on it saying “Central Park Zoo”. When I asked him about the things that he was wearing, his reply was that he had found out about becoming a volunteer wild life guide at the zoo after he had retired and had moved into Manhattan. It took me all of about five seconds to ask him how to become a wild life guide, then I called the coordinator of volunteers and signed up. The first step was, as usual, an educational course. We had to learn to tell the difference between a polar bear and a penguin! But, seriously, the new volunteers spend eight full Saturdays in February and March learning about zoos, including where and when they first existed, the animals that were kept in early zoos, their sponsors.

I must insert a small personal anecdote at this point. Many years ago, when my son (who is now a practicing radiologist) was in college, he was preparing to do some work in a primate research center. I sent him a gift, an identification bracelet. When he thanked me, he asked why I had given him that gift; I jokingly told him that the bracelet would help his co-workers tell him apart from the other primates. When I completed my initial education at the zoo, I received a small box in the mail from my son. Yes, you guessed it. The box contained a similar ID bracelet for me to wear.

We were informed of all the animals within the Central Park Zoo (which, at six and a half acres must be one of the smallest zoos in the world) where they live in the wild, their niche in the scheme of animal things, their life cycles, mating habits, their natural predators. We have to be prepared to answer all of the many questions we are asked after we give short educational talks at the various habitats, or stationed at the information booth or while roving through the zoo. Often we guide school groups. One of the most frequent questions is “Where is the rest room?” Yes, we do have polar bears and penguins, but not in the same habitat. We no longer keep any zoo animals in cages. The attempt is made worldwide in credible zoos to prepare habitats, for all of the animals, that are very similar to their natural environments. We allow them (indeed, encourage them) to live much the same as they would in nature. Actuarial data has shown that animals in contemporary zoos live longer (and, apparently, happier) than in the wild, and we do not have any of their natural predators sharing their habitat or making a meal of them.

The Central Park Zoo is a small jewel of a zoo. It is located in the south east corner of Central Park and gets visitors, not only from New York City but from all over the world. There is quite a wide selection of animals within our collection: red pandas, river otters, California sea lions, colobus monkeys from Africa, snow monkeys from the northern islands of Japan (and the only primates other than man that thrive in such variable climates). There is an enclosed “Rain Forest” (tropical jungle) with tamarins, snakes, fish, many types of birds, poison dart frogs, and two species of bats. There is a polar habitat, with the polar bears, and a separate cold building housing our penguins and puffins.

We do not have any other large animals (other than the polar bears). No lions, tigers (just bears, oh, my). No elephants or giraffes either. But we do have a small self-contained petting zoo adjacent to the main zoo grounds. The petting zoo contains docile farm animals such as cows, goats, sheep and alpacas as well as pot-bellied pigs. The animals can also be hand-fed by the visitors with animal health-food pellets that we provide.

As you can realize by now, the zoo is an educational and a fun place enjoyed by children and adults alike. It is also enjoyed by all the volunteer guides. Including me! Where else could I have so much fun on Wednesdays, doctors’ day off, which is my day at the zoo. On that day, my “significant other” doesn’t call me Dr. Sherman, but does call me Dr. Doolittle. And, on Halloween, I do not have to wear a policeman or fireman uniform as a costume. I can put on my wild life guide jacket and feel good about it.

Come and join us as a visitor or as a volunteer guide. Come share our fun.

**Another Zoo Story**

*With major apologies to Edward Albee*

*by Jack Sherman, MD, FAAP, FACMG*
I interviewed Dr. Sheldon Winnick to learn more about his Step Up for Kids 501 C.3 non-profit charitable corporation, which has announced interesting events and opportunities in the Section for Senior Members list serv. Dr. Winnick is an energetic, committed pediatrician who has practiced in Lafayette (about 30 miles east of San Francisco), California since 1981.

While completing his pediatric residency (1978-81) at Oakland Childrens Hospital, Dr. Winnick became impressed with the numbers of “social admissions” necessitated by risk-filled domestic situations, where the role of parental guidance was absent or lacking. He observed psychosocial contributors to asthma and other diseases, and was determined to create a “social vaccine”, which could address what an individual child's needs are, so as to prevent future unnecessary hospitalizations. While initially envisioning charitable events which could raise funds for children's hospitals, he was increasingly convinced of the need to change attitudes in communities and to develop interventional means to prevent pediatric illnesses or situations which might necessitate hospitalization.

Decrying the decline of family life in America, he stated, “Nuclear families have been nuked!” He became increasingly convinced of each pediatrician in his or her practice making differences one child and one family at a time. When listening to Dr. Winnick, it’s clear that his commitment to children and families, as well as to his life long interest in sports are complementary.

It was easier to understand the sports angle, as he explained his childhood in Minnesota, noting that his father was a professional softball player in his earlier years. In fact, Dr. Winnick was offered a baseball contract with the Minnesota Twins, but declined in order to complete his education, pursuing a Ph.D. in Neuroendocrinology at U.C. Davis. He then taught in graduate school and worked in clinical trial design and program administration with the National Children's Cancer Study Group before applying to medical school at George Washington University. Despite his decision not to be a professional ball player, he became aware of sports as a means to cultivate life long friendships with other senior professionals and celebrities in various sports, including baseball, football, and golf.

Dr. Winnick reports that Step Up for Kids is currently offering fellowships to senior pediatricians (those with 20 or more years of practice) who want to find ways to better serve their communities. At risk families are identified by obstetricians, social workers, other at-risk families, employers, and other sources and referred to the senior fellow/pediatrician for initial contact and follow up. He explained how his current associate, with support of such a fellowship, returned to practice part time after retirement. He quickly noted that this was a unique kind of pediatric practice, emphasizing a sliding fee scale approach to charges for house calls and personalized service which isn't routinely supported by current managed care benefits. He describes this as a “cottage industry with a social mission” and encouraged senior pediatricians who are interested in learning more about eligibility for such fellowships to contact him personally at 1-888-918-2671.

I still felt a lack of understanding of how golf tournaments could offer the means of impacting child health in South Africa, one of the Step Up for Kids target areas, Dr. Winnick explained that a friend, an Oxford educated psychologist, approached him to discuss his desire to do something worthwhile for children and families. He was aware of the decline of family structure in South Africa, due to HIV related illness and other causes. He and Dr. Winnick and other partners then went about establishing golf tournaments in various parts of the world as the means to raise funds to support “one to one mentoring to strengthen families from within”, linking with social services, and helping to provide food and other necessary services for identified families in communities in South Africa and elsewhere. For more information, see: www.rawmedia.co.za/generationscup

Step Up for Kids is hosting its annual dinner, lecture, and golf tournament at the Pebble Beach golf course on November 4 and 5, 2007, and Dr. Winnick extends his invitation to members of the Section for Seniors to attend the lecture and dinner as his guests, following the annual NCE in San Francisco at the end of October. If you’re interested, or want to join the Step Up for Kids effort, phone Dr. Winnick at 1-888-918-2671. Stressing his belief that senior pediatricians have much to offer, he noted that senior pediatricians convey more authority because of their experience. Dr. Winnick then said, “You need experience to have wisdom and to know how to provide guidance!”
Preparing for retirement is an arduous task. First, there is a visit to your Financial Advisor to discuss how much money you will need to maintain your current lifestyle. (Remember; in retirement you do have a lot more time to spend money). Next, you are off to your Internist, Cardiologist and all your other doctor friends to get their estimate of how long you are going to live! A careful review of your ancestry will add an important dimension to your longevity plans. When you ask your only surviving great aunt what was the cause of her husband death and she says, “oy -don't ask”, you have probably hit a road block. Your dentist will be happy to let you know how many crowns you’ll need between retirement and a liquid diet. Your call to the Social Security Administration brings some cause for concern. After you give them your Social Security number they ask if you are sure that you have been contributing during your work life. After they establish that you do, in fact, have an account, you ask the amount of your monthly check when you turn 65. They clarify the exact date of your 65th birthday and then you hear a very loud laugh and “are you kidding”. With great trepidation you next call Medicare. After you establish your date of eligibility, the operator asks if you are basically healthy. You tell her that currently you are feeling quite well. She sounds pleased and then tells you that you are fortunate, because Medicare will certainly not be able to afford any significant benefit payments by the time you become eligible. Recognizing the risk, you then ask about Medicare Part D. When she asks if a move to Canada is in your long-term plans, you decide to hang up.

Everyone you know seems interested in your retirement plans. There is always the insufferable question about what hobbies you have cultivated while working 80 hours a week for 40 years (No, I will not be getting an R.V. or a boat).

While many of these and other issues are important and must be addressed during the retirement process, one single issue trumps all of them. This issue relates to a personal sense of RELEVANCE. For busy practitioners, educators or administrators, during each moment of every workday, you are considered relevant (and necessary) to a huge number of people. Your patients and their extended families, colleagues, staff members, professional and business associates and, residents in training, medical students and, fellow researchers all consider you to be quite important to their health, professional success, job security, education or financial security. Many busy professionals find these varied roles and their wide circle of influence to be a burden or an annoyance, leading to regular complaints. However, at some level for almost all successful physicians, there is a certain pride in their status and their relevance to so many people. As a matter of fact, for many physicians, professional roles define who they are, far beyond their personal desires.

Ultimately, retirement day arrives; Of course, there are always professional loose ends that require attention. As you visit the site of your employment, the busy pace continues and you begin to notice that people relate to you differently. They verbalize how much they miss you, but have no pressing questions or demands for your skills and talents. You leave with a sense of loss of relevance for all the activities that required YOU just a few days or weeks earlier. After a few months, you truly realize that you are no longer relevant to the organization that just a short time ago could not survive without you.

Your transition to retirement is complete and the system you left manages to struggle along without you. At home, your role certainly has changed??? Your major job is to stay out of your partner’s way, so they can continue managing your home in their previous efficient manner. Your love, emotional support and companionship is still highly desired, but being relevant, in the production column, may not be as essential as you imagined.

None of these observations are intended to be humorous (well, not entirely) or depressing. In fact, the loss of employment relevance is a natural by-product of the overwhelmingly concentrated and intense work-life requiring continuous multitasking that most busy physicians have lived for so many years.

This scenario represents the experience of many who have survived the retirement process. Those who have succeeded in finding other venues in which to establish their relevance, typically have the most gratifying over-all retirement experience. Voluntarism represents an opportunity to satisfy relevance needs, while contributing the overall well being of the selected individuals or organizations. Certainly, many individuals and organizations can benefit from the highly sophisticated professional and life experiences a retired physician has to offer.

The author would be most interested in communicating with retired Pediatricians to confirm or negate, whether the above observations represent reality. Learning how individuals have personally managed their own sense of relevance could provide a meaningful lesson for others. It would also be helpful to learn about individual volunteer experiences that have satisfied one’s relevance needs, so that those opportunities can be shared with others. The author's e-mail address is mwc@msn.com.
In case you missed it on 60 Minutes, this is what Andy Rooney thinks about women over 40:

by 60 Minutes Correspondent Andy Rooney (CBS)

As I grow in age, I value women over 40 most of all. Here are just a few reasons why:

A woman over 40 will never wake you in the middle of the night and ask, “What are you thinking?” She doesn't care what you think. If a woman over 40 doesn't want to watch the game, she doesn't sit around whining about it. She does something she wants to do, and it's usually more interesting. Women over 40 are dignified. They seldom have a screaming match with you at the opera or in the middle of an expensive restaurant. Of course, if you deserve it, they won't hesitate to shoot you if they think they can get away with it. Older women are generous with praise, often undeserved. They know what it's like to be unappreciated. Women get psychic as they age. You never have to confess your sins to a woman over 40. Once you get past a wrinkle or two, a woman over 40 is far sexier than her younger counterpart. Older women are forthright and honest. They'll tell you right off if you are a jerk if you are acting like one. You don't ever have to wonder where you stand with her. Yes, we praise women over 40 for a multitude of reasons. Unfortunately, it's not reciprocal. For every stunning, smart, well-coiffed, hot woman over 40, there is a bald, paunchy relic in yellow pants making a fool of himself with some 22-year old waitress. Ladies, I apologize. For all those men who say, “Why buy the cow when you can get the milk for free?”, here's an update for you. Nowadays 80% of women are against marriage. Why? Because women realize it's not worth buying an entire pig just to get a little sausage!

Andy Rooney is a really smart guy!

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A blonde enters a store that sells curtains. She tells the salesman, “I would like to buy a pair of pink curtains.”

The salesman assures her that they have a large selection of pink curtains.

He shows her several patterns, but the blonde seems to be having a hard time choosing.

Finally she selects a lovely pink floral print. The salesman then asks what size curtains she needs.

The blonde promptly replies, “Fifteen inches.” “Fifteen inches???” asked the salesman.

“That sounds very small - what room are they for?”

“The blonde tells him that they aren’t for a room, they are for her computer monitor.

The surprised salesman replies, “But Miss, computers do not need curtains!”

The blond says, “Hellllloooooooooo. I’ve got Windooooowwws!”
edited by Gene Wynsen MD, FAAP

You all have probably heard of the new nano-technology that is currently in the news these days. You probably think that it is a new area of chemistry. But, you would be somewhat wrong. At least one core of ice from 10,000 years ago shows that nanoparticles were there in that ice, similar to the particles that we see today. So nanoparticles are not really new, which supports the old axiom that very little is really new.

These tiny particles are commonly known as nanomaterials. There are a number of designations of them, including those called carbon nanotubes, which are one layered and multi-layered carbon products of combustion and they are made in various ways including chemical vaporization, laser vaporization, and arc discharge, as well as ordinary combustion of gases like propane, methane, and the usual gas burning in gas stoves. There is ten times the concentration of these particles in the home with gas burning stoves than the outside air. I wonder how much of these particles are formed in gas buses, autos, railroads, airlines, gas furnaces, incinerators, power plants, volcanoes, and the myriad of other possible sources, and is it important? Those made synthetically have been called synthetic graphite, but differ from graphite in that they conduct electricity and form fibers, whereas graphite does not. They form a hexagonal/honeycomb structure.

Carbon nanotubes are being used more and more in commercial products. One authority (Dr. Smalley, a Nobel laureate and pioneer in carbon nanotube research) has been cited as saying that they will be produced in the millions of tons worldwide in the not too distant future. Therefore they may pose significant exposure problems in those working in the industry. Tentatively, the toxic limits have been suggested at 15mg/M3 (total dust) and 5mg/m3 (respiratory fraction). Structurally they resemble rolled-up graphite sheets, usually with one end capped, and individually they are about 1 nm in diameter and several microns long. But they often bind up tightly together to form rods or ropes of microscopic sizes. Carbon nanotubes exist in two forms, a single-wall and multi-wall forms. Special configurations exist such as nanocoils, nanohorns, bamboo-shaped forms and carbon cylinders. (All the prepared products contain residual catalytic metals, including Fe, Ni, Y, Al, Cu, Mo, An, and CO, which in themselves have toxic properties.) They have unique electrical, thermal, and mechanical properties that make them useful in many potential applications in computers, electronics, and aerospace technology. For example, they can be used to impart strength and toughness to hydroxyapatite bioceramic coating. They have been used to culture osteoblast cells and do not inhibit growth claiming to promote cell growth and proliferation. They can be used in sensing devices, have potential use in cancer therapy, and acting as defect detectors in composite materials. The preparations are described as clumpy or fluffy black powder or small black spheres with molecular weight of 840 to over 10,000,000, insoluble, odorless, and specific gravity greater than one. They are thirty times as strong as high strength steel, and 1000 times more efficient in conducting electricity than copper. The chemical name is Fullerene, formula is Carbon, and chemical family is Synthetic Graphite, and a synonym is Carbon Nanotubes.

These particles are very light and could become airborne to potentially reach the lungs. The toxicity in the lungs is not really known, but these particles have also been implicated in toxic reactions, especially in the lungs of animals. Extensive investigations are taking place to determine the risks and potential safety problems in handling and manufacturing them. In mice, which weighed about 30 gms, given intratracheal amounts of carbon nanotubes as little as 0.5 mg there is definite damage to the lung with granulomas and fibrosis which tends to progress with time. In fact almost half of the animals died with this dose. Even smaller amounts can cause granulomas when given in bolus amounts. It has been speculated that they may act as an asthma trigger, and they have been implicated in possible toxic reactions in the skin. On the positive side, research is being done to determine possible therapeutic and diagnostic uses. When functionally modified chemically, for example using peptides or ammonium, they are non-toxic in animals when given IV with radioactive tracers and are excreted unchanged primarily by the kidneys. They are excreted fairly rapidly, but remain long enough that it has been suggested they may be useful in gene transport. In unmodified forms, they have been shown to accumulate to cytotoxic levels in many animal model organs. Exposing cells to some of these particles results in cell cycle arrest and increases apoptosis and necrosis. Exposure activates genes involved in cellular transport, metabolism, cell cycle regulation, and stress response, as well as other

Continued on Page 21
responses. In mice given inhaled bolus doses of these particles there follows acute inflammation with early onset progressive fibrosis and granulomas. The particles accumulate in the interstitial macrophages in the alveoli rather than the alveoli, and therefore are very difficult to eliminate and thus would likely cause continuing toxicity. This contrasts with carbon black, which accumulates in the alveoli. Carbon nanotubes are non wettable and very nonbiodegradable.

The responses when given by intratracheal bolus have been compared to inhalation of carbon black and crysolite asbestos crystals. The nanoparticles have been shown to be more toxic than the crysolite asbestos crystals. Carbon black is generally benign compared to them. It is interesting to note that these particles are ubiquitous in nature and result from most any source of gas combustion. However, since the studies on toxicity have usually been done with bolus administration by the intratracheal route, it is not known what effects chronic inhalation of small amounts over time would have. Graphite inhalation, as in miner’s disease, is well known, but carbon nanotubes are not the same as graphite.

It has also been shown that single-walled and multi-walled carbon nanotubes produce respiratory function impairments, retard bacterial clearance after bacterial inoculation, damage the mitochondrial DNA in aorta, increase the percent of aortic plaque, and induce atherosclerotic lesions in the brachiocephalic artery of the heart. It is speculated that exposure to combustion-generated multi-walled carbon nanotubes may play a significant role in air pollution-related cardiopulmonary diseases.

As one might expect, a lot of research is being done on uses and also the potential toxicology problems that their use may present. In industry, where they are synthesized, there may be hazards that are as yet unknown. One wonders if some of the disease processes seen in medicine are a result of these particles. For example, chronic obstructive lung disease, asthma, and pulmonary fibrosis, and respiratory illnesses come to mind as well as cardiovascular disease. Are children in a home with gas stoves and gas furnaces more at risk for asthma and other respiratory diseases? Are the granulomatous diseases a result of patients being more sensitive to these particles? Can these particles be used to treat cancer by utilizing their toxic qualities with target chemicals techniques or combined with antibodies? Or, as mentioned, they may be useful in gene transport and other therapeutic techniques.

What uses these particles will eventually have and in what ways they will be incorporated into products and uses is yet to be determined. But it will be interesting to keep a close watch for developments in this field and the possible implications for medical diseases, diagnoses and treatments.

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An older, white haired man walked into a jewelry store one Friday evening with a beautiful young lady at his side. He told the jeweler he was looking for a special ring for his girlfriend.

The jeweler looked through his stock and brought out a $5,000 ring and showed it to him. The old man said, “I don’t think you understand, I want something very special.”

At that statement, the jeweler went to his special stock and brought another ring over. Here’s a stunning ring at only $40,000,” the jeweler said. The young lady’s eyes sparkled and her whole body trembled with excitement.

The old man seeing this said, “We’ll take it”

The jeweler asked how payment would be made and the old man stated, by check. “I know you need to make sure my check is good, so I’ll write it now and you can call the bank Monday to verify the funds and I’ll Pick the ring up Monday afternoon,” he said.

Monday morning, a very teed-off jeweler phoned the old man. “There’s no money in that account.”

“I know”, said the old man, “but can you imagine the weekend I had?”

Don’t mess with Old People!!!!!
Choosing the Right Ruler to Measure Your Portfolio's Performance

by Joel M. Blau, CFP™

Ronald J. Paprocki, JD, CFP™

MEDIQUS Asset Advisors, Inc.

“Results. One client at a time.”

All investors have done it at one time or another – grabbed the morning paper and torn through the financial section to see how their investments are doing in comparison to the “market.” Unfortunately, it just isn’t that easy to make an apples-to-apples comparison when evaluating your individual stock performance to various market averages or indices. Often times, a portfolio’s return will differ from the averages published in the newspaper or quoted on television and radio. Those reports focus on the movement of groups of stocks, not individual issues. When you hear about the performance of a specific average or index, that information relates to the general direction of the market but may not be indicative of your specific holdings. While both the published averages and indices measure changes in market values of certain stocks, it is important to keep in mind that there is a difference between an index and an average.

An “average”, as the name implies, is the arithmetic average price of a group of stocks. The most quoted average is the Dow Jones Industrial Average (DJIA), which is comprised of just 30 large industrial based stocks. The DJIA was originally calculated by totaling the price of the stocks included in the average and dividing by 30. The divisor has since been adjusted a number of times to account for mergers, additions, deletions, as well as for other technical factors. An “index”, on the other hand, is an average value expressed in relation to a previously determined “base” number. The widely publicized Standard & Poor’s 500 Index (S&P 500) uses a base value of 10, which was actually determined during the period of 1941 to 1943.

An index or average may also be classified according to the method used to determine its price. In a price weighted average index, such as the Dow Jones Industrial Average, the price of each component stock is the only consideration when determining the value of the average. The price movement of higher priced stocks influences the average more than lower priced stocks. In contrast, a “market-value” weighted index, such as the S&P 500, factors in a stock’s total market value, equal to the share price times the number of shares outstanding. In this type of index, a relatively small shift in the price of a large company can significantly influence the value of the index.

When comparing portfolio performance, it is important to understand the components of the various indices and averages.

**Standard and Poor's 500 Index:** Comprised of 500 “blue chip” stocks, separated by industry, so that almost all key industries are represented. Included are 400 industrial type stocks, 60 transportation stocks, and 40 financial stocks (which would include banks and insurance companies).

**Dow Jones Industrial Average (DJIA):** This commonly quoted average tracks the movement of just 30 of the largest blue chip stocks traded on the New York Stock Exchange.

**NASDAQ Composite Index:** Tracks the movement of all companies traded on the NASDAQ National Market System, which often tends to be smaller and more volatile stocks than those in the S&P 500 or DJIA. The NASDAQ Composite is market-value weighted, which gives a greater weighting to larger and higher priced stocks.

**NYSE Composite Index:** This is the index for the trading of all New York Stock Exchange stocks. It is market-value weighted and is expressed in dollars and cents.

**AMEX Composite Index:** This index tracks the averages of stocks traded on the American Stock Exchange (AMEX), which tend to be medium and smaller sized growth stocks. The index is weighted by the market capitalization of its components. Stocks with a larger number of shares outstanding and with higher stock prices affect the index more than smaller companies with lower prices.

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Wilshire 5000 Equity Index: The broadest measure of all indices and is market-value weighted. The Wilshire includes all major NYSE, AMEX, and NASDAQ stocks and is used as an indication of the overall direction of all stocks, regardless of size.

EAFE: The Europe, Australia, and Far East Index, is an unmanaged, market-value weighted index, designed to measure the overall condition of overseas markets.

There are also a number of published averages and indices for other sectors of the market that may prove useful in evaluating portfolio performance. This data can be found in the Wall Street Journal, Barron’s, and a number of different financial websites.

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

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This one is pretty slick since they provide YOU with all the information, except the one piece they want

WARNING...New Credit Card Scam

Note, the callers do not ask for your card number; they already have it. This information is worth reading. By understanding how the VISA & MasterCard Telephone Credit Card Scam works, you’ll be better prepared to protect yourself.

One of our employees was called on Wednesday from “VISA”, and I was called on Thursday from “MasterCard”.

The scam works like this: Person calling says, “This is (name), and I’m calling from the Security and Fraud Department at VISA. My Badge number is 12460 Your card has been flagged for an unusual purchase pattern, and I’m calling to verify. This would be on your VISA card which was issued by (name of bank). Did you purchase an Anti-Telemarketing Device for $497.99 from a Marketing company based in Arizona?”

When you say “No”, the caller continues with, “Then we will be issuing a credit to your account. This is a company we have been watching and the charges range from $297 to $497, just under the $500 purchase pattern that flags most cards. Before your next statement, the credit will be sent to (gives you your address), is that correct?”

You say “yes”. The caller continues - “I will be starting a Fraud investigation. If you have any questions, you should call the 1-800 number listed on the back of your card (1-800-VISA) and ask for Security. You will need to refer to this Control Number. The caller then gives you a 6 digit number. “Do you need me to read it again?”

Here’s the IMPORTANT part on how the scam works. The caller then says, “I need to verify you are in possession of your card”. He’ll ask you to “turn your card over and look for some numbers”. There are 7 numbers; the first 4 are part of your card number, the next 3 are the security numbers that verify you are the possessor of the card. These are the numbers you sometimes use to make Internet purchases to prove you have the card. The caller will ask you to read the 3 numbers to him After you tell the caller the 3 numbers, he’ll say, “That is correct. I just needed to verify that the card has not been lost or stolen, and that you still have your card. Do you have any other questions?” After you say No, the caller then thanks you and states, “Don’t hesitate to call back if you do”, and hangs up.

You actually say very little, and they never ask for or tell you the Card number. But after we were called on Wednesday, we called back within 20 minutes to ask a question. Are we glad we did! The REAL VISA Security Department told us it was a scam and in the last 15 minutes a new purchase of $497.99 was charged to our card. Long story made short - we made a real fraud report and closed the VISA account. VISA is reissuing us a new number.

What the scammers want is the 3-digil PIN number on the back of the card. Don’t give it to them. Instead, tell them you’ll call VISA or Master card directly for verification of their conversation.

The real VISA told us that they will never ask for anything on the card as they already know the information since they issued the card! If you give the scammers your 3 Digit PIN Number, you think you’re receiving a credit. However, by the time you get your statement you’ll see charges for purchases you didn’t make, and by then it’s almost too late and/or more difficult to actually file a fraud report.

What makes this more remarkable is that on Thursday, I got a call from a “Jason Richardson of MasterCard” with a word-for-word repeat of the VISA scam. This time I didn’t let him finish. I hung up! We filed a police report, as instructed by VISA. The police said they are taking several of these reports daily! They also urged us to tell everybody we know that this scam is happening.

Please pass this on to all your family and friends. By informing each other, we protect each other.
A concern has been buzzing over my head like a fastidious fly and for quite a while already, it is about my memory. Last week I forgot to bring milk on my way home from the office and despite my friends telling me not to worry, it is not unusual to forget things like that, it keeps on bothering me.

Last month, while I was waiting for my turn at the dentist office, I picked up a recent issue of “Scientific American”, it was the May issue. I was looking through its pages when I stumbled into an article that caught my attention, it dealt with memory and Alzheimer.

I know of too many people that have been touched or are acquainted with a family that has been affected by this dreadful disease and knows how devastating it could be, not only to the sufferer but for all the immediate family as well. The article tells of the latest research and compares this problem to the erasure of the hard drive of a computer beginning with the most recent files and working backwards. An initial sign of this disease is the failure to recall events of the past few days like forgetting to bring milk on your way home from the office. As the illness progresses the old memories usually and progressively disappear. Unfortunately, like the author of the article says, one can not reboot the human brain and reload the files which are composed of more than 100 billion neurons. (1)

The story should probably start in 1907 when Dr. Alois Alzheimer, a German psychiatrist and neurobiologist, in the post-mortem examination of the brain of some of his patients, described finding neuritic “plaques” clustered around a central amyloid core and also that after intense intraneuronal staining he could see neurofibrillary “tangles”, twisted strands of protein formed inside of the brain cells.

More recently, during the late 1960s, three British scientists: Drs. Blessed, Tomlinson and Roth demonstrated a correlation between the amyloid “plaques” in the cerebral cortex and the severity of cognitive impairment. (2)

Research has not been too promising but it shows a few rays of hope since investigators are exploring new drugs that could clamp the molecular cutting that appears to initiate the disorder. Another interesting development involves cell therapy. In the same paper from “Scientific American”, Mark Tuszinski and colleagues report their taking skin from biopsies of patients with mild Alzheimer disease and inserting the gene Encoding Growth Factor. These genetically modified cells were surgically implanted into the forebrain of these patients. Although this study was limited in numbers, research showed a slowing of the cognitive decline. They also speculate that the cholesterol lowering statins may lower the risk of losing our memory; this is science at work.

For the fiction part of this essay I would like to share with you a synopsis of a story written by one of the most prominent figures in the literary world, Jorge Luis Borges (1899-1986) born in Buenos Aires, Argentina and who, although nominated for the Nobel Prize of Literature in the 1980s, was never elected and joined the list of many other non-winners like Leon Tolstoy, Graham Green and James Joyce. His prolific work have been translated into many languages and some of his stories can be read in English in “The library of Babel”, “The book of imaginary beings” and “The Aleph”.

The story in question is called “Funes, el memorioso” (“Funes of amazing memory”). It tells of the last three years in the life of Ireneo Funes who lived in Fray Bentos, a small town in Uruguay; a poorly educated young man, the son of a laundress and who, during a “doma de potros” (the taming of wild horses) fell of a horse and suffered a head injury and trauma to the spine which left him paralyzed from the waist down. He spent his days and nights lying in bed and looking through the window of his room. He eventually recovered form the head injury but never from his paralysis.

The following summer, narrates Borges, I was vacationing in that little town with my cousin Bernard when Funes’s mother, who used to do my laundry, told me her son, upon learning of my studying Latin requested to borrow some of my books. I did not know how to avoid being rude so I lent him the first tome of Lhomond’s “De viris illustribus”, Quincherat’s “Gradus at Parnassum” and Pliny’s “Naturalis historia”(3).

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A few days later when I went to retrieve the books, to my surprise, Funes spoke to me in Latin! I was further amazed when he told me of Cyrus, the Persian King who is believed to have known, by their names, each one of the soldiers in his army. He told me of Mithridates Eupator who administered justice in the 22 different languages on his empire and of Metrodorus who could repeat, word by word any speech after listening to it only once.

He told me that after his head injury his memory became so active, so clear, so vivid that even the most trivial incident of his past appeared spontaneously and magnified; his perception of all the details of every minute of his life had miraculously increased. He could count and remember all the shades of green, blue and purple of every grape covering the alcove of his patio; he could describe the color and shape of every single leaf of his fig tree of any given day; he could describe the cloud formation in the sky of every day since the accident. He could not help it, the pages of his memory were flipping so fast that his mind could not rest; he was afraid he would die before remembering every minute of every day of his life. Too much memory, it was overwhelming.

I left him facing the window but with his eyes closed; he did not want to count the leaves of the fig tree any more. Later on I found out Ireneo Funes, “el memoria”, the man of amazing memory died in 1889 of pulmonary congestion. (4)

How many times we remember things we try to forget? Memory… too much, too little…, it keeps on playing tricks on us.

After reading Borges story I promised myself not to get upset any more about forgetting to get milk on my way home from the office.

That's only 52 years ago! — Comments made in the year 1955

“I’ll tell you one thing, if things keep going the way they are, it’s going to be impossible to buy a week’s groceries for $20.”

“Have you seen the new cars coming out next year? It won’t be long before $2000 will only buy a used one.”

“If cigarettes keep going up in price, I’m going to quit. A quarter a pack is ridiculous.”

“Did you hear the post office is thinking about charging a dime just to mail a letter?”

“If they raise the minimum wage to $1, nobody will be able to hire outside help at the store.”

“When I first started driving, who would have thought gas would someday cost 29 cents a gallon. Guess we’d be better off leaving the car in the garage.”

“Kids today are impossible. Those duck tail hair cuts make it impossible to stay groomed. Next thing you know, boys will be wearing their hair as long as the girls.”

“I’m afraid to send my kids to the movies any more. Ever since they let Clark Gable get by with saying ‘damn’ in ‘Gone With The Wind,’ it seems every new movie has either “hell” or “damn” in it.”

“I read the other day where some scientist thinks it’s possible to put a man on the moon by the end of the century. They even have some fellows they call astronauts preparing for it down in Texas.”

“Did you see where some baseball player just signed a contract for $75,000 a year just to play ball? It wouldn’t surprise me if someday they’ll be making more than the president.”

“I never thought I’d see the day all our kitchen appliances would be electric. They are even making electric typewriters now.”

“It’s too bad things are so tough nowadays. I see where a few married women are having to work to make ends meet.”

“It won’t be long before young couples are going to have to hire someone to watch their kids so they can both work.”

“Marriage doesn’t mean a thing any more; those Hollywood stars seem to be getting divorced at the drop of a hat.”

“I’m just afraid the Volkswagen car is going to open the door to a whole lot of foreign business.”

“Thank goodness I won’t live to see the day when the Government takes half our income in taxes. I sometime s wonder if we are electing the best people to congress.”

“The drive-in restaurant is convenient in nice weather, but I seriously doubt they will ever catch on.”

“There is no sense going to Lincoln or Omaha anymore for a weekend. It costs nearly $15 a night to stay in a hotel.”

“No one can afford to be sick any more; $35 a day in the hospital is too rich for my blood.”

“If they think I’ll pay 50 cents for a hair cut, forget it.”

Know friends who would get a kick out of these? Pass it on!
The Anatomy of Today's Suicide Bomber

by Sol Browdy, MD, FAAP

Suicide terrorism existed in the eleventh century, when the Assassins, the disciples of the Persian master Alamut, conducted suicide raids against neighboring fortresses, but in our lifetime Japanese kamikaze gave us our first taste of suicide bombing at Pearl Harbor, chiefly directed against our fleet. 9/11 will go down in history as the day we lost our vulnerability on our own soil when terrorists hijacked four jetliners, two smashing into the World Trade Center in New York City, one attacking the Pentagon in Washington, D.C. and one crashing somewhere in Pennsylvania. This was the first time multiple terrorists in planes participated in concert as suicide bombers, the collisions killing the terrorists and passengers aboard and many civilians at work in targeted buildings.

Since the current intifada between Israel and the Palestinian Arabs erupted in September 2000 and through October 2003, over 70 Palestinian bomb attacks aimed at the Israelis have been documented. Their targets are cleverly geared to maximize the number annihilated as possible: packed restaurants; popular cafes; a student cafeteria at Hebrew University, Jerusalem; social clubs; crowded railway and/or bus stops; on buses; popular discos; resort hotels; fast-food stores; popular markets. Surprisingly, women bombers are on the rise. Some disguises are employed, e.g., posing as a religious Jew or in Israeli army uniform. Mostly, cars are used; occasionally, bicycles. In the forefront claiming responsibility: Islamic Jihad and Hamas.

Readers of USA TODAY have been privy to rare insights gleaned from interviews with knowledgeable authorities. Contrary to what might be imagined, suicide bombers are not commonly downtrodden or uneducated. Nor are they brainwashed (although they do undergo elaborate preparation rituals). Strict Islamic injunctions against suicide have been watered down, as have the equally-strict Islamic rules governing combat. Mohammed warned, “Do not kill yourselves; a suicide cannot go to paradise.” But radical Islam considers suicide not only legitimate but highly commendable when taken for reasons of holy war. It argues that going into war knowing with certainty that one will die, is not suicide (intihar) but martyrdom (isthad) a much-praised form of self-sacrifice in the path of God.

A leading Islamist authority explains the distinction as follows: attacks on enemies are not suicide operations but “heroic martyrdom operations,” in which the individuals act not “out of hopelessness and despair but are driven by an overwhelming desire to cast terror and fear into the hearts of the oppressors.” In other words, Islamists find suicide for personal reasons abominable; suicide for jihad admirable. (The term “suicide bomber” has been replaced with “martyrdom operation” in many newspapers in the local Palestinian territories.) The newspaper tells the story of a family preparing for a party to celebrate the killing of 21 Israelis by their son, a suicide-bomber. Neighbors hang pictures on the trees of the family’s property of the son holding seven sticks of dynamite. They spray-paint graffiti reading “21 and counting” on their stone walls. And they arrange flowers in the shapes of a heart and a bomb to display on their front doors.

“I am very happy and proud of what my son did and frankly I am a bit jealous,” says his father. (On June 1 the young man carried out the attack outside a disco in Tel Aviv.) “I wish I had done it. My son has fulfilled the Prophet’s wishes. He has become a hero. Tell me, what more could a father ask?”

Would-be suicide bombers are lured by the promises of financial stability for their families, eternal martyrdom and unlimited sex in the afterlife with 72 virgins in heaven. (The Koran, the sacred book of Islam, describes the women as “beautiful as rubies, with complexions like diamonds and pearls.” Their goal is to kill or maim as many Jews as possible in the hope that Israel will withdraw from Gaza and the West Bank. Since the time of Mohamed, martyrs have always been considered those willing to die defending Islam. (As is well documented, Israel captured the land in 1967 in the process of defending their half portion of land awarded to them by the Balfour Declaration.)

Israeli officials believe that at any given time, Hamas has from five to twenty men, ages from 18 to 23, awaiting orders to carry out suicide attacks. They also claim to have “tens of thousands” of youths ready to follow in their footsteps. “We like to grow them from kindergarten through college.” In Hamas-run kindergartens, signs on the walls proclaim, “The children of the kindergarten are the shaheeds (holy martyrs) of tomorrow.” One classroom sign says “Israel has nuclear bombs; we have human bombs.” An eleven-year old Palestinian of small frame

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and boyish smile says “I will make my body a bomb that will blast the flesh of Zionists, the sons of pigs and monkeys.”

According to USA TODAY, a would-be bomber is selected for his mission only days, sometimes hours, before it is to occur. As part of the preparation, the recruit is taken to a cemetery, where he is told to lie between gravesites for hours. He wears a white, hooded shroud normally used to cover bodies for burial. The recruit is then taken to a safe house. A video is made in which he states his consent to become a suicide bomber and his devotion to Islam. It will be played in public after his death. A still photograph is taken, which will be displayed in public after his death throughout the West Bank and Gaza. Because secrecy is paramount, Hamas leaders will not allow the recruit to say goodbye to his family or tell them his plans. Once at the target site the recruit is encouraged to remain calm, and blend in with the background as much as possible. Once surrounded by Israeli, his instructions are to press a switch to explode the bomb.

No end is in sight to end our war on terrorism or disengage honorably, particularly since the warfare in Iraq has deteriorated into secular civil war compounded by insurgency against U.S. forces. Regardless of the outcome of the Israeli-Palestinian conflict or the war in Iraq, it is now abundantly clear that the suicide bomber is merely one of the weapons in the arsenal of radical Islam as it wages its jihad against all infidels (non-believers in Islam). The fierce determination and irrational mentality of radical Islam cannot be overcome by complacency, appeasement or naivete. All “infidels” are in mortal danger unless moderate Islam repudiates the radical fringe.

### THE YEAR 1906

**This will boggle your mind, I know it did mine! One hundred years ago.**

**What a difference a century makes! Here are some of the U.S. statistics for the Year 1906:**

- The average life expectancy in the U.S. was 47 years.
- Only 14 percent of the homes in the U.S. had a bathtub.
- Only 8 percent of the homes had a telephone.
- A three-minute call from Denver to New York City cost eleven dollars.
- There were only 8,000 cars in the U.S., and only 144 miles of paved roads.
- The maximum speed limit in most cities was 10 mph.
- Alabama, Mississippi, Iowa, and Tennessee were each more heavily populated than California.
- With a mere 1.4 million people, California was only the 21st most populous state in the Union.
- The tallest structure in the world was the Eiffel Tower!
- The average wage in the U.S. was 22 cents per hour.
- The average U.S. worker made between $200 and $400 per year.
- A competent accountant could expect to earn $2000 per year, a dentist $2,500 per year, a veterinarian between $1,500 and $4,000 per year, and a mechanical engineer about $5,000 per year.
- More than 95 percent of all births in the U.S. took place at HOME.
- Ninety percent of all U.S. doctors had NO COLLEGE EDUCATION!
- Instead, they attended so-called medical schools, many of which were condemned in the press AND the government as “substandard.”
- Sugar cost four cents a pound.
- Eggs were fourteen cents a dozen.
- Coffee was fifteen cents a pound.
- Most women only washed their hair once a month, and used borax or egg yolks for shampoo.
- Canada passed a law that prohibited poor people from entering into their country for any reason.
- The American flag had 45 stars.
- Arizona, Oklahoma, New Mexico, Hawaii, and Alaska hadn’t been admitted to the Union yet. The population of Las Vegas, Nevada, was only 30!!!
- Crossword puzzles, canned beer, and ice tea hadn’t been invented yet.
- There was no Mother’s Day or Father’s Day.
- Two out of every 10 U.S. adults couldn’t read or write.
- Only 6 percent of all Americans had graduated from high school. Marijuana, heroin, and morphine were all available over the counter at the local corner drugstores. Back then pharmacists said, “Heroin clears the complexion, gives buoyancy to the mind, of health.” (Shocking? DUH!)
- Eighteen percent of households in the U.S. had at least one full-time servant or domestic help.
- There were about 230 reported murders in the ENTIRE U.S.A.!

Now I forwarded this from someone else without typing it myself, and sent it to you and others all over the United States, possibly the world, in a matter of seconds!

Try to imagine what it may be like in another 100 years.

**IT STAGGERS THE MIND, EH....!??**
Opinions expressed are those of the authors and not necessarily those of the American Academy of Pediatrics. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
Senior Citizen Scholarship. Senior citizen applicants, aged 62 or older, are provided a full tuition scholarship by Northern Michigan University. The scholarship covers tuition only for on-campus classes; it does not provide for books, fees or tuition for off-campus or web-based classes. To be eligible for this program, the senior citizen should submit an application for admission (no application fee) to the Admissions Office. SENIOR BULLETIN. Click Here for Class of 2019 Info. Click Here for Senior Bulletin. South Terrebonne High School. 3879 Hwy 24, Bourg, LA 70343 (985) 868-7850 Phone (985) 868-1691 Fax. Senior Bulletin - AAP Section for Senior Members - June 2004. 13. Editors' Note: The prior issue of the Bulletin included an article on ELECTRONIC MEDICAL RECORDS. Apple took the proprietary approach and, despite an arguably superior. Continued on Page 15. 14 Senior Bulletin - AAP Section for Senior Members - June 2004. FURTHER COMMENTS ON ELECTRONIC MEDICAL RECORDS Continued from Page 14. Apple users are LOYAL, didn’t do as well.