SENIOR BULLETIN

AAP Section on Senior Members

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DEDICATED TO THE HEALTH OF ALL CHILDREN®

SOSM Chairperson Column

Laurence Shandler, MD, FAAP
Santa Fe, NM

On August 13th of this year, I presented to the AAP Board's Committee on Member Engagement about the Section's activities concerning member value and engagement. I spoke about the section's member engagement work group and its efforts to attract members aged 55 to 60 years. I mentioned our new outreach to AAP board members and committee, council and section leaders, encouraging them to join the Section on Senior Members. They were also interested in the career transition presentations at the section's NCE educational program and our developing webinars. Our new education strategy team is developing a new webinar on "volunteering during retirement."

I ended my presentation by informing the board members that we have increased our membership by about 8% to over five thousand members. In addition, we received the outstanding service in membership award at the recent Annual Leadership Conference in Itasca. A week after my presentation we posted a letter to the section's email and discussion board by Larrie Greenberg, MD et al, from the May 2024 issue of the *Journal of Pediatrics.* The letter was in response to a prior *Journal of Pediatrics* article, "Supporting Career Transitions of Senior Faculty: Perspectives of Chair and Full Professors," which appeared in the January, 2024 issue.

The article dealt with senior research pediatricians who considered retirement when their research funding was no longer available. Doctor Greenberg noted that the article did not consider clinical educator faculty who were not dependent on research funding. More importantly, retirement planning was not discussed for late-career pediatricians at any yearly evaluations. The comments on our discussion board included a wide variety of replies. Click here to take a look at the discussion board and join the conversation.

Fall 2025 Editor's Note

Gil Fuld, MD, FAAP
Editor, AAP SOSM Senior Bulletin

The continuing series of Bulletin articles, titled "Blast From the Past," depicts unexpected encounters with former patients. Many of us have experienced these delightful surprises. Living in the same small city for over fifty years, I frequently run into past patients or their parents, including many I've known and have been friendly with over time. But there are surprises - the new ski shop owner who I hadn't seen for decades or someone recently moving back to the area. Just this week; "Gil Fuld?....Oh, you're Doctor Fuld!"

And we're fortunate to have a locally-owned daily newspaper, the *Keene Sentinel*, much shrunken from what it was a generation ago, but still publishing. Through its pages I've followed the exploits of past patients; athletic accomplishments, mentions of college graduations and awards, and significant adult activities. But not all mentions are positive. Familiar names turn up in court reports

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WHAT'S INSIDE

or other crime articles. Unfortunately some of these are predictable. (Choose your parents well.) And recently I was stunned to read that a former patient was sentenced to life imprisonment in a distant state for killing his wife.

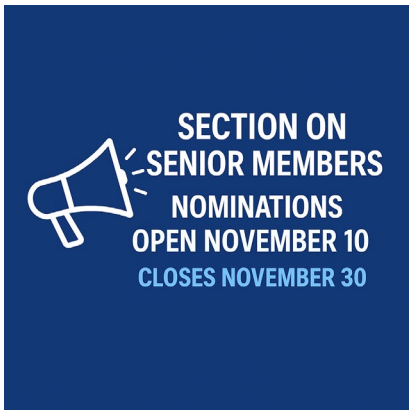
The flip side of hearing from or learning about long-ago patients is wondering what happened to children we once cared for, lost contact with, and never heard from again. Several articles in this issue allude to that, including Tony Kovatch's third installment of "Thursday's Pap." And indeed, as Quentin Humberd's essay demonstrates, we can hear from a patient but still not know how he's turned out.

We have concerns that we're becoming "all vaccines, all of the time." I wish we weren't, but immunization issues are reaching a crisis point with no improvement in sight. Read John Olsson's piece about a fatal infection that has all but disappeared but will return as immunization rates decline. Meg Fisher gives us an insight into the current machinations of Kennedy's newly constructed ACIP.

See also Paul Rogers' plea for more spirituality in medicine, Dan Levy's missive to a young pediatrician, and Eliasar Simon's brief but detailed summary on the effects of sound on the developing brain. It's different from our usual emphasis on stories and opinion. What do you think?

Plus the usual poetry, book and movie reviews, and more.

Read, enjoy, and consider contributing your thoughts to the Bulletin. We love our readers and we cherish our writers.



Call for Nominations – SOSM Executive Committee

The Section on Senior Members (SOSM) will be seeking nominations for one open voting member position on its Executive Committee. The official call will go out on November 10, and eligible members are encouraged to apply by November 30, 2025. This is a 3-year term, beginning November 1, 2026, and is renewable once. More details, including responsibilities and eligibility, will be shared with the call.

Immunizations

Concerns of a Pediatric Infectious Disease Physician

Meg Fisher, MD, FAAP
Long Branch, NJ

For decades, the Advisory Committee on Immunization Practices (ACIP) provided evidence-based guidance regarding the use of vaccines, immunoglobulins, and other antibody products to the Centers for Disease Control (CDC), to physicians, and to the public. Members were chosen based on their expertise; vetting occurred to identify conflicts of interest. Member terms were staggered to ensure institutional memory. Workgroups were established well in advance of the licensure of new products. The workgroups met regularly to examine results of studies, discuss findings, and make recommendations to the ACIP regarding use of the product when the product was licensed. The system worked well because of the integrity of the process, the reliance on science, and the dialogue among members, CDC scientists, and liaisons from many medical organizations.

Suddenly and without reason, this well-running system was first ignored and then destroyed by Robert F Kennedy, Jr., a political appointee with no scientific or medical training and with clearly stated opinions about vaccines that run counter to the evidence. On May 27, 2025, Mr. Kennedy announced that the COVID-19 vaccine would no longer be recommended for children, pregnant women, and young adults. The workgroup, which had for years examined COVID-19 epidemiology, vaccine efficacy, and evolving changes in the virus, was not consulted; the ACIP was not consulted.

Then on June 9, 2025, Mr. Kennedy dismissed all of the sitting members of the ACIP. Two days later he appointed 8 new members. How these members were selected and vetted is not clear. The robust expertise of the prior 17 members was gone without justification.

The Committee met in June. The meeting was unlike those we have come to know and appreciate. The ACIP now consisted of 7 members, as one new appointment dropped out before the meeting. On day one there were presentations by CDC experts regarding COVID-19, concluding with a presentation of the Evidence to Recommendations (EtR) Framework for the COVID-19 vaccine. This framework includes discussion of whether there is a public health problem, the benefits and harms of the product, the value of the product, acceptability of the product, feasibility of the intervention, reasonability of resource use, and impact on health equity. The framework was developed by the work group and presented by a CDC expert. Presentations were made by CDC experts regarding respiratory syncytial virus (RSV), RSV vaccines, and nirsevimab, concluding with the evidence to recommendations framework for clesrovimab, the newly approved monoclonal antibody, and the proposed ACIP recommendation.

Day 2 started with further discussion of RSV and then presentations by CDC experts regarding the 2024-2025 influenza season and updates regarding influenza vaccines. The next agenda item was a presentation by Lyn Redwood regarding thimerosal. There was no input from CDC experts. In fact, the CDC website pages regarding this topic were not accessible on June 26. There was no discussion of public health issues, benefits of the product, or feasibility. The final presentation was by the new ACIP chair who discussed the measles, mumps, rubella, and varicella vaccines. Again there was no workgroup and no CDC input. The chair made his own proposed recommendation. Throughout the meeting the new members often asked each other for information rather than asking the CDC subject matter experts.

There were six votes taken at the meeting. The first vote regarding clesrovimab was taken following presentation of the Evidence to Recommendations (EtR) Framework. The second vote ensured the vaccine would be available in the Vaccines for Children program. The third vote reaffirmed past recommendations for the use of influenza vaccines. This vote followed presentations by CDC experts regarding the most recent influenza season. Then there were three additional votes which followed the presentation by Lyn Redwood regarding thimerosal. (*Editor's note: Lyn Redwood is a former president of the Children's Health Defense, the anti-vaccine organization founded by Kennedy, She contends that autism can be caused by the mercury in thimerosal.)* There was no evidence framework.

Unfortunately, we can no longer count on the ACIP. The committee was scheduled to meet in mid-September. *(Editor's note: Rescheduled for December. Date TBD.)* In early September, seven additional members were appointed by Mr. Kennedy; again, the selection and vetting processes were opaque. It is almost certain that this group will discuss the vaccine schedule as well as several vaccines.

Mr. Kennedy has made it clear that he does not believe in vaccine mandates. Currently, school mandates vary by state. The Florida surgeon general has indicated that he will stop all school mandates in that state. It will take a little time to accumulate susceptible populations, but there is no doubt that the amazing progress of the last century is now being turned around. It will break my heart to see disease due to *Haemophilus influenzae* type b return; more importantly, it will once again destroy the lives of children and families.

As pediatricians, we are fortunate to have a Committee on Infectious Disease which continues to look at the evidence and make recommendations that are based on the science. It will be up to other societies to develop recommendations for pregnant people and other adults. It will be up to physicians to strongly recommend vaccines and to counter vaccine misinformation. We have done it for decades; it is essential now more than ever.

Vaccine Peddler's Regret

Amar Davé, MD, FAAP
Ottawa, IL

Ever since I started practicing general pediatrics about 44 years ago in a small Midwestern town of 18,000 people, the one issue that continues to depress, demoralize, and give me a sinking feeling is vaccine refusal. Families often reject vaccines despite lacking knowledge of their remarkable history and how effectively they have reduced mortality from countless infectious diseases; smallpox no longer exists because of vaccines. Not only do many lay people not know this, but many do not want to know.

Examples from Practice

- Just last week, a father brought his two-month-old baby and refused vaccines because they contained aluminum. Ironically, he was drinking from an aluminum can of soda at the time. Even after explaining the non-toxic amount of aluminum in vaccines, he was unconvinced.

- Two months ago, a mother with a two-month-old infant claimed vaccines increased the risk of SIDS by 50% if given before one year of age. In reality, vaccines reduce SIDS risk by 50% in early life, with the highest natural risk between 2–4 months. I was unable to convince the parents otherwise.

- There is near-universal resistance to the HPV vaccine. Despite clear scientific data showing its safety and cancer-preventing benefits, parents consistently reject it.

- More mothers now refuse Vitamin K and hepatitis B vaccines for newborns.

- In 44 years, not once has a parent come asking me to give their child a vaccine of their own initiative. The refusal of lifesaving interventions remains mind-boggling.

Common Attitudes Encountered

- Some parents declare they 'never get flu' and therefore do not need the vaccine. When I question this reasoning, they doubt me in return and expect their unverified claims to be trusted.

- Others reject vaccines on the basis that 'nothing should be injected into a child's body,' while readily accepting antibiotic or vitamin injections.

- Many of these individuals have a college education but little science background. They embrace science when it comes to cars, phones, and conveniences, but not vaccines.

Analogies I Share with Families

At times, I tell families: the cars we drive killed 50,000 people last year and seriously injured 2.5 million, yet people continue to drive. That risk has been normalized. Vaccines, by contrast, save lives - yet are rejected.

Reflections

In my opinion, rampant scientific illiteracy combined with the American belief that 'mom knows best' has created a culture where parents feel their instincts override medical science. While mothers indeed provide the best care for their children, they do not inherently know best about diseases, vaccines, and safety measures. Physicians have sometimes reinforced this belief, and we are now paying the price.

One Life, Many Lives

John Olsson, MD, FAAP
Raleigh, NC

It was an unusually light day on my service; rounds were completed by 11 AM, and we were the admitting team for that day. I was a third-year senior resident managing my team of two interns and four medical students. It was always nice to finish rounds before admitting new patients.

I received a page from our pediatric emergency department (PED) and recognized the number for the clinic senior. I picked up the phone and called immediately. Tom told me that they had a very sick, febrile, 15-month-old boy arrive who would need to be admitted, and asked if I could come down and help with his early evaluation and management. I grabbed my team, and we went down the stairs from the inpatient ward to the PED. When we arrived in the treatment room, we saw a fussy baby, a tearful mother, and all the staff engaged in drawing labs, starting an IV, and preparing care for a baby with sepsis/meningitis. Antibiotics were infused as we obtained cerebrospinal fluid that appeared cloudy. Fluids were administered to stabilize vital signs. Once clinically stable, we moved the baby up to our pediatric ICU. All of this had been completed within 40 minutes of arrival at the hospital.

It's important to note the history of this patient. He had been a previously well baby who was developing normally. He had been well until around 10 am that morning. He had had his breakfast and had been playful, but suddenly appeared tired, and his color was poor. His mother, who lived three blocks from our hospital, scooped him up and ran to the hospital, not waiting to call for an ambulance. Her maternal instincts told her that something was seriously wrong.

Once in the Pediatric ICU, his blood pressure was noted to be decreased, so he was started on vasopressor agents, and an arterial line was placed. He was electively intubated and ventilated when his respiratory status showed signs of instability. It was not quite noon, and we had provided the best of care in less than two hours from when he began to be sick.

His labs began to come back. His cerebrospinal fluid was purulent with a left shift, and the gram stain showed gram-negative pleomorphic rods. His white blood cell count was elevated and he was mildly anemic. As was common at that time, we felt that he most likely had *Haemophilus influenzae* type B meningitis. Over the next several hours, he became more medically stable, but paradoxically his mental status worsened. By the next morning, our neurology consultants were concerned that his condition met the criteria for brain death. We continued to provide the state-of-the-art care we had all along while discussing his prognosis with his mother and family.

Coincidentally, we had a visiting professor at that time. Dr. Sam Katz had given Grand Rounds that morning and was rounding with my team afterwards. We presented the case of this little boy to him and expressed our frustration with how quickly and appropriately we had treated this baby, yet he was going to die. Dr. Katz was kind and comforting, but he shared with us that the only way to conquer a disease like *Haemophilus influenzae* type B was to prevent it from occurring in the first place. A vaccine, not yet developed, was the only way to avoid tragedies like this from happening in the future.

It was from that moment in time that I became a strong believer and advocate for childhood immunization. Just a few years later, while I was in private practice, Hib vaccine became available, and we gradually saw diseases caused by *Haemophilus influenzae* type B less frequently. Later, in academic practice, there was a remarkable disappearance in all diseases caused by *Haemophilus influenzae* type b.

The same has been true of other vaccine-preventable diseases - measles, varicella, meningitis and pneumonia caused by pneumococcus and meningococcus, diphtheria, and tetanus - with some virtually disappearing. It really sickens me to see the misinformation about vaccines and vaccine hesitancy on the rise, because if unchecked, it means that someone else will have a child arrive in their emergency department that may die despite the best that medical science has to offer.

Blast From the Past

The Power of Connection

Quentin A. Humberd, MD, FAAP
Developmental Behavioral and General Pediatrician
Clarksville, TN

Although I retired nine years ago, I find it hard to let go of many of the habits developed in 37 years of pediatric practice. Even habits that I once felt were tiresome, like checking email. My practice career spanned the beginning and subsequent widespread adoption of email and I have a hard time recalling how my practice functioned before email. So, every morning, before most everything else, I check my email.

It used to be a surprise, but not so much anymore; this August morning there is an email:

dear dr.humberd
how are you

Simple, direct and nearly always lowercase. That is my patient and longtime email friend, Naveed.

What makes this notable is that these emails have been coming to me since I shared my personal email address with Naveed sometime in the late 1990s, before I transitioned from private practice to full-time developmental pediatrics working with the military. I was still writing in a paper record and didn't really use the internet very much.

His mother was in the exam room on our initial visit. Naveed was in his early teens and appeared very anxious, with repetitive behaviors and chewing on his knuckles. At my initial greeting, he averted his gaze and would not talk. His mother explained that his prior doctors had a hard time communicating with him, and they never really got a complete medical evaluation. She stated that with all his difficulties, the family had decided to keep him at home. Her only concerns were his anxiety, his incessant questions for her, and his focus on computers.

When I turned my attention to Naveed and indicated that I had a computer, he began to interact more, asking what kind of computer and the type of network and internet I had, and if I had email. I pulled out my business card, wrote my home email address on the back, and gave it to Naveed. He was overwhelmed with joy, got very excited, and began to talk with me about some of his anxieties and problems. He even agreed that I could examine him. After the exam I developed a plan with his mother and with Naveed and told them I would see them in a couple of weeks.

When I got home that night I got the first email:

DEAR DR HUMBERD
HOW ARE YOU

SINCERELY NAVEED

I responded and explained that all CAPS in an email usually indicated shouting or loud talk, and thought he should know. Soon I got a reply:

hi dr.humberd
can you please give me your vanderbilt email address that i can email you there and
sincerely naveed

Now it was all lowercase, so I thought some progress was being made, but despite explanation subsequent emails have always been lowercase, and subjects have mostly been about computers, emails and the internet. I would see Naveed every few months to discuss possible interventions and educational options, but his mother would always politely decline and say the family was looking after

him and seeking work opportunities for him. She did share that the majority of this fell to her, and that it became tiresome at times. She added that Naveed had never wanted to see a doctor until I shared my email and apologized if this was bothering me. I told her I was happy to try to help him however he was comfortable.

When I left private practice in 2004, I did my best to talk to Naveed and set him up with another doctor, but I found out that it did not go well. He continued to email me intermittently, often when he was ill:

hi dr.humberd

my blood presure is high and

sincerely Naveed

hi dr.humberd
i am worried about peopel that why my blood presure is high and how can stop worry about people and
sincerely naveed

I would always respond and direct him to his doctor and his family, but I never really found out what he did, as the next email in a few days was always completely disconnected:

hi d.humberd
what kind router you have at home and
sincerely Naveed

Hi dr.humberd
Please download gmail app on your iPhone today and
you can go to App Store to download gmail app on your iPhone today and
Sincerely naveed

Then when my retirement arrived in 2016, I notified Naveed and wished him well. I got no emails for a long while, and then about 3 years later:

hi dr.humberd

when did you retire and

sincerely naveed

We were back on again, it seemed, and it continues to this day:

hi dr.humberd

today is my birthday and

sincerely naveed

I got this one about a week ago:

Dear dr.humberd

how are you and please email me to make me happy and

sincerely naveed

Naveed and I have been emailing for more than 25 years. I always respond and never initiated an email until last month when I asked Naveed if I could tell our email story:

Hi Naveed,

Hope your year is going well. I have moved so wanted to make sure I have your correct email address.

My Academy of Pediatrics is wanting me to write up something about how long I have known you and how we have connected over the years. Is that OK with you? I will give them no personal information as that is confidential.

I have enjoyed our email connection over the years and hope you have as well. Best wishes to

your family.

Dr H

I got no response for several days and then:

Dear dr.humberd

How is your summer and sincerely naveed

I took that as a yes and noted a few uppercase letters were working their way back. Progress, I think.

Reflections

Home Management is Key to Treatment in ADHD

Alfred L. Scherzer MD, EdD, FAAP
Ormond Beach, Fl

I sat in the office of the pediatric department chair wondering why I had been asked to make this appointment. While waiting, I thought back to a previous unscheduled visit not long ago. At that time, I was summoned due to pediatric resident complaints that I had been skeptical about the current reported frequency of autism, ADHD, and other developmental disabilities. And some also disagreed with my view that “different” behavior was often medicalized by the public and sometimes led to medication being prescribed unnecessarily.

I remembered explaining my view that several factors contributed to an inaccurate elevation of the data and the general perception of a very high frequency of affected children and especially of adults. I felt these included expanded medical diagnoses made through parent or patient complaints and only clinical observation rather than closely following diagnostic criteria indicated in the Diagnostic and Statistical Manual of Mental Disorders (the DSM); a separate diagnosis of ADHD listed, for example, although it was part of a broader genetic condition; frequent and often inappropriate public use of terms like ‘hyperactive’ and ‘autistic’ applied to people who were ‘different’; or diagnoses made simply to obtain special education and treatment services.

My thoughts turned to the chair when she finally sat down behind her desk and looked at me with a shake of the head. “The last time we spoke,” she said, “you were having trouble with the residents. Now I’m getting complaints about you from parents.” She went on to explain that an irate parent called to complain I had refused to increase medication for her child. The mother felt I had not really evaluated her child properly. Also, she had added a very negative critique to my online Google resume, with complaints about the quality of our pediatric department as well.

“That’s the reason the dean just called me. He was very unhappy about negative comments like that online. What do you have to say about that?” My chair stared at me.

I tried to visualize this parent. I said, “The mother had been seeing another pediatrician who refused to change the medication, and in spite of the travel involved, decided to transfer to me. While her child did well in school and had good attention, Walter’s home behavior was terrible. I listened carefully and then suggested counseling for the mother in home management. She wasn’t satisfied and just left without comment.”

The chair was not satisfied with my response and told me to contact the parent with an apology and urged her to come for another visit.

I used my best skills during the call to overcome the initial negative reaction of the mother. I tried to point out that ADHD, like other neurodevelopmental conditions, is affected by several things, including the home environment and parent involvement. "Medication," I said, "can help with attention and behavior only to a certain extent. But a positive home environment and parent involvement must also be considered." I went on, "He seems to be managing well in the school environment, so obviously, something is working out well in that situation."

The mother hesitated and, with a sigh, asked for my recommendations about where she could obtain counseling therapy. I also urged her to consider a return for a re-evaluation with me at her convenience. Of course I assumed that I would never see them again.

About six months later I noticed the name, "Walter" on my schedule for the day. It sounded familiar, but I couldn't quite place it. As they entered my office the previous complaint that resulted in a nasty session with the department chair suddenly came back to me. This time the mother was smiling, and Walter seemed to be in a good mood as well.

After examining Walter we sat for a moment to reflect on progress. I confirmed that, indeed, he was doing well. I gave the mother my teacher evaluation form for use in the next follow-up visit. I also congratulated her for being engaged in counseling and urged that she continue.

"I will tell my department chair that you have returned and that Walter is really doing very well. Of course, she would like to see those negative remarks about me and the pediatric department removed from Google."

She smiled, looking at me, "Oh," she laughed, "I'll see what I can do about that."

My Second Act as "Thursday's Pap" Part III: The Surrogates

Anthony Kovatch, MD, FAAP
Pittsburgh, PA

"As our children grow and develop into themselves, they begin to chart their own life courses. They find, express, and follow their own will, their own thoughts, their own road. Naturally, then, they also become more distant from their parents in time, space and life lived. Suddenly, eventually, our children become relative strangers to us who raised them."

When I read this comment by Dr Peter Gorski from "The Parenting Paradox" in the Summer, 2025 edition of the SOSM Bulletin, I was greatly relieved that the angst and disillusionment I had experienced as an "empty nester" - whose four children had "deserted" their nuclear family in Pittsburgh, PA and settled happily and profitably in other states to achieve their heart's desires - were part of the natural evolution of successful parenting and shared by my contemporaries.

Oscar Wilde, the renowned Irish playwright, once said, "Children begin by loving their parents; after a time, they judge them. Rarely, if ever, do they forgive them." Fortunately, my biological parents died when I was in my first year of medical school, before I had acquired the psychological skills necessary to be judgmental; furthermore, I was blessed with a series of "surrogate" parents who lovingly filled that void until I was in a position in my own life as a pediatrician to be able to reciprocate. My philosophy has always been that our lives are propelled forward by surrogates, be they parents, children, uncles, aunties, teachers, pets, divine powers, or models of saintliness.

After 15 years of functioning as a part-time "surrogate" pediatrician as "Thursday's Pap," I have become somewhat comfortable envisioning this old man as a "surrogate grandfather." I will always remember cases where a strange magic seemed to be operative - like that of the 11-year-old boy in the residential treatment facility (RTF), whom I will call "Willy."

When Willy was court-ordered to be an inpatient at my facility, his short life had already had all the upheaval of a William Faulkner novel or a "Willy" Shakespeare tragedy (hence my moniker for him)! His primary diagnosis was post traumatic stress disorder, having been forced to drown several puppies - surrogate siblings - when he was five years old; his biological parents were in jail. Willy appeared somewhat shell-shocked when I first encountered him and looked at me like I was a creature with two heads. I was not fazed, however, since I had recently identified myself as the "doctor with two brains" - a conventional brain for standard medical practices and a radical one for promotion of alternative approaches to cure. He seemed to enjoy the individual attention he received in the medical office, and he loosened up after a few weekly evaluations for self-inflicted injuries, including a fractured finger.

"Willy, who is your best friend here?" I asked thoughtlessly during a Thursday exam. "You," he responded point-blankly. "Me?" I smiled and left it at that. His new moniker became "Willy, my best friend here" and it stayed intact until the sad day six months later when he was released from the RTF and "deserted" us elderly caretakers, whose hearts he had insidiously won and were now gently weeping inside.

I gifted him (as I did with all the discharged kids) with a black football shirt I had been awarded for performing youth football physicals 20 years ago, and for which my expanding waistline prohibited further use. He wore it for a week straight before he was released from captivity - to an unsettled future, fraught with uncertainty.

I offered him a red version of the same shirt as an extra gift the day he left, as well as a prepared statement of my feelings: "Willy, you were NEVER my best friend here---you were my grandson!" The wry expression he usually wore on his face changed to a look of preoccupation and reverie.

I learned later that Willy would be raised by his true grandparents at the other end of the state, and I realized that I had been their short-term substitute and maybe his surrogate older brother and surrogate father as well. He left the red shirt behind, I think, so that we might never forget him. Or maybe, in haste to get out of captivity, he merely forgot to pack it. Or perhaps it was a little bit of both. Whatever the reality, I would gradually be capable of casting aside my disillusionment, forgiving my grown children, and relying on "the surrogates" - to this day!

CLICK HERE to enjoy the theme song "I Was Meant for You" from the 1941 movie *Penny Serenade* (1941) about adoption, starring Irene Dunne and Cary Grant.

Letter to a Young Pediatrician

Daniel Levy, MD, FAAP
Columbia, MD

Having practiced pediatrics most of my adult life, I witnessed the evolution of the most wonderful discipline I could have chosen for my life's work. In so many ways, much has changed. Pediatric and adolescent medicine has become more complex, and the challenges are increasingly difficult, complicated, and administratively byzantine. Still, the joys of caring for kids are so vivid, and this has sustained me in 46 years of pediatric practice.

I had the privilege of welcoming many young pediatricians into community pediatrics through teaching, collaboration, advocacy and employment. My mantra has always been, "You have been superbly trained in your residency, and you have learned the essentials of pediatric and adolescent medicine. Now your real education begins." Here's what I learned in 46 years of post-residency, and what has kept me engaged, passionate and invigorated.

The essence of community pediatrics has always been relationships; getting to know a child and his/her family from the beginning of life; experiencing the "goodness of fit" challenges of new parenthood and seeing that journey through to young adulthood. These relationships impelled me to stay current and recertified in my profession and provided the gravitas for all my work in research, teaching, advocacy, and leadership. I have a stake in keeping "my kids" healthy. The satisfaction I get from making a child well or solving a problem for a youngster and his/her family has been the key to a long, rich career.

To reach this point in my life as a pediatrician, I had mentors. All were great teachers. Each was a humanitarian and scholar who took the time to reach out and check on my progress. To this day, many still provide direction and encouragement.

Community pediatrics has never been just about going to the office, then going home at the end of the day. To me, it's not a job, it's a calling. Living where I practice has nourished my commitment to make the world a better place for my patients and their families. Getting to know how people live, what they depend on, and what motivates them has been intrinsic to my understanding of the myriad roles of a pediatrician. I have been asked to give benedictions. I have been asked to give eulogies. I have developed networks and teams to solve problems that posed barriers to a better life for a child.

I have always viewed community pediatric practice as a canvas on which I could use all of my accumulated experience, reading, imagination, and humanity to network and solve problems. Pediatrics can't be practiced in a vacuum. My work has always been about collaborations. If I saw a wrong, my first impulse was to figure out how to make it right. Invariably this was through the relationships I made in the community.

I've often had to take time away from my family to help someone's child, family, organization, or community. My family was always supportive, but I knew they missed dad…and I missed them. My wife and kids would see me on TV or read about me in the newspaper, and feel proud, but we were all aware of the sacrifice and toll pediatrics takes on family life. So, that's my life as a pediatrician.

Now, my young colleague, I have a few recommendations as you consider your walk through a pediatric life.

Goal one is, "Take care of yourself." So many of our young and mid-career colleagues feel "burned out" because their work has become so overweening. Make time to eat well, get a decent night's sleep, exercise, and do what pleases you. Personal time has to be inviolate.

Take strength from your beliefs and those who believe in you. Believe in yourself. Craft your career, monitor its progress, and make changes to stay parallel with your life. What you feel passion for today may change. Hopefully, the energy and purpose you find in your profession will deepen.

Early in my career, I believed I should be a pediatric jack-of-all-trades. I thought I should practice, do research, write and publish, teach, and advocate. I quickly lost direction and spread myself too thin. Pick one thing professionally, do it well, and see it through to completion.

Learn to say, "No." You have wonderful skills and a strong sense of purpose, but community or organizational work can become a bottomless pit. You will be flattered. You will be praised. Five-star Google ratings will come your way. Accept the acclaim but maintain boundaries.

At this point in your career, and for the next 10-15 years, you may have a lot in common with your families - age, education, personal beliefs and philosophy. Professional boundaries can become blurred. This is the process of transference, often discussed in psychology. People begin to see you as family. You become the parent/sister/brother/love object that people didn't have, or with whom there was a difficult history. Maintain boundaries.

There are many ways to make a difference in the life of a child and a family. It could be through writing; rendering information or an informed opinion; testifying at the community, state and federal level for any issue that could benefit a child. Very often it means organizing and leading efforts to make a wrong right.

Make decisions that maintain your equilibrium. Be yourself and make decisions you can live with. Stay with your best instincts. It's admirable that you chose to be a doctor for children and teens and be an important part of a community. It's a huge responsibility. Just stay in your lane and do your best.

Don't expect anybody to do anything you're not willing to do. Read widely, attend meetings, speak to colleagues. Keep your interests varied and changing. Enjoy your life.

I wish you the rich, eclectic, unpredictable but rewarding career that has made my personal and professional life so wonderful.

As the great Yogi Berra once said," It ain't over 'til it's over."

Healing Medicine: 2 Kings 5:1-14

Paul Rogers, MD, FAAP
Ocean Pines, MD

Naaman stares at his arms, heart pounding as he traces the constellation of angry red sores spreading across his skin. He presses his fingers to the blotches - numb, unfeeling. He realizes this is the first physical sign of leprosy. He has witnessed this disease before, watching it devastate the bodies and lives of men, women and even children. Next the sores will thicken, swelling grotesquely, and his hands and feet will refuse to obey his commands. Depressive thoughts race through his mind. The mighty Supreme Commander of Syria's armies, despised by the Israelites for his army's destructive and murderous raids on Israel, feels his status slipping away and the respect of thousands of cavalry, chariots, and infantry dissolving. The great commander of victories will be reduced to a shadow of former glory - a battle he will not win. Finally, he experiences the greatest suffering, not in his flesh, but in his soul. He faithfully attended many ceremonies at the temple of Syria's pagan god, who now is powerless to cure Naaman.

In the quiet corridors of his household, a household servant girl - just twelve - watches her master with gentle eyes. She is a captive taken from Israel during one of Naaman's raids. Her voice is soft with concern. "Go to the prophet in Samaria," she says, "He would cure you of your leprosy." Her words spark a flicker of hope in his darkness. He obtains a letter of introduction from his king and sets out for Israel with a treasure chest brimming with silver, gold, and fine garments, (worth today $7.7 million) to pay for the expected cure. He journeys for seven days to reach Tirzah, where the king of Israel holds court. However the king of Israel sees the letter as an impossible demand for a cure. "Am I a god to cure a man of leprosy?" Is this a pretext for an invasion by Syria? With no hesitation, he accepts the prophet Elisha's message to send Naaman to him.

Naaman reaches the home of the prophet Elisha. The prophet does not emerge to greet the great commander but sends a message to Naaman. "Go, wash in the Jordan seven times." Naaman's pride makes him bristle. The Jordan? That meandering, muddy creek?

Are not the rivers of Syria grander and crystal clear? He is a man used to giving orders, not following them.

Reluctantly, Naaman follows the advice of one of his servants and wades into the waters of the sacred Jordan. When he emerges the seventh time, he gasps. His flesh is smooth, unblemished - like a young boy's. Awe and gratitude flood his soul. He returns to Elisha who tells Naaman to keep the gold and silver. Naaman, humbled, declares, "Now I know there is no God in all the world except in Israel."

The story of Naaman's healing reminded me of my first experience of spiritual healing. My journey began when my wife and I embarked on a medical missionary trip to Liberia, Africa. We were working in a rural hospital where resources were scarce and the staff stretched thin. Yet, what the hospital lacked in equipment, it more than made up for in the unwavering dedication and compassion of its nursing and medical team.

One day a medical missionary invited me to attend a C-section for a woman whose labor had failed to progress with signs of fetal distress. Just before the procedure began, he gently asked us all to bow our heads in prayer. Together, we called upon God's presence in that operating room - asking for wisdom, steady hands for the medical team, swift healing for the mother, and peace and strength for her family. Our prayer was simple, yet profound. When the surgery was complete, the mother awoke from anesthesia and was able to cradle her healthy, vibrant newborn son in her arms. The room filled with the sound of new life and hope. Surely the presence of the Lord was in that place. That day, a new mom was healed - not only of the body, but of the spirit. And I carry it with me still, like a candle burning in the depths of my spirit

This holistic approach is absent in most medical care today. How can we make spirituality a part of our complete medical care? How do we make God part of the medical treatment plan? Naaman's experience can help guide us.

1. Many hospitals automatically record a patient's faith in the medical record and provide a visit for every patient from the pastoral care team. If not, patients can give a gentle reminder of their faith's importance to healthcare decisions
2. We do not have Elisha available today. However, hospital chaplains are trained to provide spiritual care, prayer, and meditation inclusive of all beliefs, and pastoral care, which includes religious rites and rituals rooted in specific religious traditions.

Naaman almost missed his miracle because the method did not match his expectations**.** How often are we like Naaman, looking for God in the thunder and overlooking Him in the quiet whisper of a twelve-year-old child? Healing often arrives quietly - in prayer.

Welcome to the USAF

Gil Fuld, MD, FAAP
Keene, NH

On a Tuesday in July 1965, fresh from my pediatric residency at New York's Babies Hospital, I showed up at Forbes AFB in Topeka KS, dressed in slacks and a golf shirt, to begin my two years as an Air Force captain under the Berry Plan. I was one of a group of inductees selected to bypass basic training, so I arrived at the airbase without any military preparation, ready to start work.

The next four days were a whirlwind of activity - a crash course in all things military - from learning how and who to salute, getting fitted for uniforms, finding my office, and meeting my physician colleagues.

Not long before my arrival Forbes changed from a SAC base (long-range bombers) to a TAC base (fighters and transport planes). This involved a culture change which I did not witness but soon became aware of. With the change, the existing two-year medical specialists rotated off, so when I arrived, all holdover medical staff members at our 50-bed hospital were flight surgeons and general medical officers. I was the first of the new specialists to arrive.

By Friday I was feeling like a seasoned veteran, expecting to start seeing patients on Monday, and looking forward to a relaxing weekend. For reasons known only to senior officers, the entire medical staff assembled in formation on the hospital parking lot Friday evening. Not me. I was urgently called away to see Teddy.

A two-year-old with biliary atresia, Teddy had developed esophageal varices. While current surgical techniques are much more sophisticated and effective than those available sixty years ago, surgery to bypass the hepatic obstruction should have already happened. My predecessor, like me a two-year captain, had alerted Dr. Thomas Holder, the pediatric surgeon at the University of Kansas Medical Center in Kansas City. But Teddy had not been seen at KU.

Why the foot-dragging? Referrals to civilian doctors apparently required approval by the hospital commanding officer. But the outgoing CO, a bird colonel, was an aggressive general surgeon who believed he could and should operate on anything and everything. (Never mind the impossibility of providing adequate post-op care in our tiny hospital for a toddler following complicated surgery.) So rather than confronting his superior and insisting that Teddy go to KU, the pediatrician essentially hid him, leaving it for the next pediatrician (me) to make all the arrangements. That would have been no problem, as my commanding officer was an ophthalmologist who knew he knew nothing but eyes.

Teddy wouldn't wait for a routine referral. On that Friday his varices started to bleed. He vomited copious amounts of blood and was immediately too unstable to be moved. Obtaining IV access was a challenge. We had only three 21-gauge scalp vein needles and a screaming toddler, who eventually lost so much blood that he became shocky. He stopped fighting. Fortunately we were able to get into a vein and start blood before his circulation shut down.

Throughout the evening and night we infused what amounted to twice his blood volume before he eventually stopped bleeding and was stable enough so we could take him the 70 miles to Kansas City. To my great relief, even though it was 6 AM on a Saturday, Tom Holder was waiting for us, and I could finally relax.

Teddy did well postoperatively. After that, I don't know. His father was transferred and I lost contact with the family.

Fast forward to 1997. I'm the District I Chair and a member of the Board of Directors of the AAP. Tom Holder was the recipient that year of the surgical section's Ladd Medal. Board members could opt to present section awards if they wished. I jumped at the chance. Holder was as I remembered - a courtly Southern gentleman. But he had no recollection of Teddy. What was a unique and memorable event in the career of a primary care pediatrician - maybe the sickest child I ever cared for who survived - was all in a day's work for him.

The Effects of Sound Exposure on Fetal and Infant Brain Structure

Eliasar A. Simon, MD, FAAP
Waipahu. HI

Introduction During prenatal and early postnatal development, the brain undergoes rapid structural maturation. Auditory input is among the earliest sensory experiences, originating as early as the third trimester. The quality, timing, and intensity of sound exposure can direct neural architecture, influencing cognitive, linguistic, and emotional outcomes.

Prenatal Auditory Development By around 27–29 weeks of gestation, fetuses demonstrate measurable auditory brainstem responses (ABRs), indicating functional prenatal hearing.**1** Low-frequency sounds—such as maternal speech and heartbeat—transmit well in utero and shape early auditory processing. Indeed, newborns show a preference for maternal voice and familiar speech patterns heard prenatally.**2**

A more recent study revealed that prenatal exposure to bilingual speech enhances infants' sensitivity to acoustic variation. Newborns of bilingual mothers exhibited broader neural encoding of pitch and vowel sounds, compared to newborns of monolingual mothers.**3**

Neural Plasticity and Critical Periods Sound exposure during critical developmental windows significantly alters auditory cortical organization. Studies in rodents show that rearing in moderate-level continuous noise (e.g., ~70 dB) disrupts the emergence of frequency-specific tonotopy and functional response selectivity in the primary auditory cortex (A1).**4**

Similarly, long-term noise exposure during early postnatal days elevates hearing thresholds, delays auditory brainstem response maturation, alters neural oscillations in A1, and reduces key glutamate receptor expression.**5**

In a stereological analysis, rats exposed to moderate (~90 dB) white noise from late gestation through early postnatal life showed decreased neuronal density in the medial geniculate body (MGB) and auditory cortex layers, despite no significant change in cortical volume.**6**

Prenatal Noise vs. Music: Divergent Effects on Hippocampus Prenatal sound can differ widely in effect depending on its nature. In rats, prenatal exposure to environmental noise led to growth retardation, reduced hippocampal neurogenesis, and impaired spatial learning. Conversely, prenatal exposure to music enhanced hippocampal neurogenesis and improved spatial memory in offspring.**7**

Similarly, prenatal noise stress in rats disrupted hippocampal long-term potentiation (LTP) and spatial memory, while increasing corticosterone levels—linking auditory stress to altered synaptic plasticity and HPA-axis dysregulation.**8**

Fetal Exposure to Intense Noise: Cochlear and Brainstem Injury In fetal sheep, exposure to intense in-utero noise resulted in persistent elevation of ABR thresholds and histologically confirmed hair-cell damage in the cochlea, providing direct evidence of physical auditory system vulnerability during fetal development.**9**

Behavioral and Memory Effects of Prenatal Sound Stimulation A recent systematic review found that prenatal sound stimulation—through music or speech—can induce stimulus-specific memory traces detectable neonatally using EEG, ECG, habituation tests, and behavior. Some infants triggered by prenatal stimulation performed significantly better in neonatal behavior assessments.**10**

Long-Term Developmental Implications Animal studies show that early structured sound—not merely exposure—influences cortical synaptic refinement. Tonotopic organization, response specificity, and temporal processing of auditory cortex neurons depend on early sound environment; noise exposure can prolong immature cortical states, while enriched acoustic stimulation accelerates precision and may close critical periods sooner.**11**

Clinically, in human preterm infants, music interventions in neonatal intensive care units have enhanced functional brain connectivity. In one study, specially composed music boosted network coupling among salience, auditory, sensorimotor, and thalamic regions—making brain network architecture more similar to term infants.**12, 13**

Clinical and Practical Considerations The balance between beneficial and harmful sound exposure is vital. Structured auditory stimulation—such as maternal voice, music therapy, or controlled sensory input—can support brain maturation, particularly in NICU settings. In contrast, uncontrolled mechanical noise, alarms, and excessive environmental noise may disrupt auditory development, particularly during sensitive periods.

Conclusion Sound exposure during fetal and early infant stages exerts profound and lasting effects on brain structure and function. Prenatal and postnatal exposure to structured, meaningful auditory stimuli—speech, bilingual input, music—can enhance neural connectivity, memory, and cognitive outcomes. Meanwhile, noise exposure— particularly moderate to intense, unstructured or stressful noise—can hinder auditory pathway maturation, reduce neurogenesis, and impair learning. Future research should continue refining safe and optimal sound-based interventions during prenatal and neonatal development, to harness neuroplasticity and protect developing brains.

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Movie Reviews

Fall 2025 Movie Reviews

Lucy Crain, MD, FAAP
San Francisco, CA

MISSION IMPOSSIBLE: THE FINAL RECKONING

Ushering in the summer 2025 blockbusters, the so-called final chapter of the *Mission Impossible* series stars Tom Cruise as the indomitable Ethan Hunt. Beginning with a somewhat confusing review of previous chapters in this series, along with the even more confusing plot introduction of man's battle against AI, Hunt was appointed as the only man capable of saving humankind from the sinister takeover by artificial intelligence. At age 63, Cruise still insists on performing his own death-defying stunts. He survives near drowning in sub-zero waters of greater depth than ever possible, hangs from the wing of a propeller plane piloted by his arch enemy flying across vast countryside, and finally parachuties to safety and his next adventure. Unlike many of the previous *Mission Impossible* and *Top Gun* movies, this eighth and final (?) episode has less plot and more spine-tingling action. PG 13, Two hours 40 minutes. In theaters. Recommended for the big screen.

THE PHOENICIAN SCHEME

The latest Wes Anderson film, co-written by Roman Coppola, is set in the 1950s. Benicia del Toro stars as Anatole Zsa Zsa Korda, an unscrupulous arms dealer from the fictional desert country of Phoenicia. Korda is on a mission to find his novitiate nun daughter Liesl (Mia Threapleton) and to convince her to succeed him as chairperson of his unsavory business endeavors. He trusts her more than his nine sons, although she seems quite uninterested in his proposition. Unless she can turn his schemes into good, she is more inclined to return to the nunnery and take her vows. The repeated attempts to assassinate Korda by planting explosives in his several mid-century-modern airplanes become almost comedic. Along with brief glimpses of the pearly gates where St. Peter (F. Murray Abraham) debates allowing Korda's entry to Heaven, God (Bill Murray) and a biblical troupe (Willem Dafoe, Charlotte Gainsbourg, and Hope Davis) add to the confusion. If you follow Wes Anderson's quirky style of writing/directing you'll find this weirdly entertaining. There's even a strange appearance by a second cousin (Scarlett Johansson), whose role seems at best unnecessary. Now in theaters, soon to be streaming, where you might be advised to view this film. One hour 41 minutes, PG-13 for violence and constant smoking.

THE MATERIALISTS

An entertaining rom-com which depicts a somewhat true-to-life New York City dating scene for those in their mid-thirties. Lucy (Dakota Johnson) is a young matchmaker in a coveted agency in Manhattan. Unfortunately, her career is more successful than her nonexistent dating life. The movie begins with Lucy and John (Chris Evans), her beau of five years, in his old worn out car trying to find a parking spot in the city. Their argument focuses on cater/waiter/striving actor John refusing to pay $25.00 for parking (Only $25.00?) and Lucy's disgust with their lives about never having enough money. They break up, her career blossoms, but she can't personally find love. The comic aspect of the film is delivered in a series of film clips with clients who admit what they really seek in a mate: "Must be at least 6 feet tall," "Must be in her early 20s, but not immature," etc. Lucy finally confesses that she will only marry for money and lots of it. She finds the answer to her quest in successful businessman Harry (Pedro Pascal). They have a seemingly perfect relationship until she discovers something about his legs, which demonstrates the shallowness of her expectations in a mate. On the other hand, the decision of

whether to marry for love or for money is the deciding factor. Written and directed by Celine Song (*Past Lives*), one might have expected a more complicated plot, but this is a good one to watch at home when available on streaming. One hour 49 minutes, R rating.

THE NAKED GUN

Not since I took my grandsons to see *Captain Underpants* have I endured such a display of immature slapstick humor. If you like slapstick, this is your movie! Starring Liam Neeson as Frank Drebin Jr., the NYC detective who seems never to get anything right, and the voluptuous Pamela Anderson as co-star, the movie is seen as a semi-sequel to the earlier *Airplane*. There's enough action, sex, drinking and smoking to justify an R rating, but it was assigned a PG-13. I'd suggest waiting until it's available on streaming. Then, you won't have to be embarrassed by re-playing the numerous jokes and sight gags (or paying theater ticket prices). The good news is that it is one hour and 15 minutes long.

SUPERMAN

Wrapping up the summer's blockbusters is the long-awaited man of steel's latest cinema. Released July 11, in time to more than break even in production costs, the film continues to enjoy limited audiences in theaters and somewhat mixed reviews. Produced and written by James Gunn, mastermind of the DC Universe, the cast stars not only David Corenswet as America's favorite superhero, but the Justice Gang arrives on the scene to save Superman from his arch enemy Lex Luthor (Nicholas Hoult). Lois Lane (Rachel Brosnahan) makes no secret of loving Superman/Clark Kent and snags coveted interviews with our superhero, to the dismay of her fellow reporters. Time spent in the *Daily Planet* with editor Perry White (Wendell Pierce) and Jimmy Olsen (Shyler Gisondo) would have been more satisfying than that spent with the noisy and violent attacks of Luthor's henchmen, including shape shifter Metamorpho who molds an effective version of the lethal (to Superman) kryptonite. He renders Superman weak and defenseless as he's thrown to the pavement by masked paramilitary strong robots. He is then tossed into a cell with dozens of other inmates, where he bonds with Metamorpho after rescuing his infant son. He escapes to briefly visit his parents, the loveable Kents of Kansas, who nurse him back to super health with the assistance of Lois Lane and Krypto the Superdog (who really steals the show). There is a lot going on in this movie, much of which reflects today's political climate. Two hours nine minutes, PG-13.

Book Reviews

Reviewed by Jonathan Caine, MD, FAAP

The Preventive State: The Challenge of Preventing Serious Harms While Preserving Essential Liberties

Alan Dershowitz

Encounter Books, 2025, 240 pages

For decades Alan Dershowitz was a law professor [now emeritus] at Harvard Law School. His focus has consistently been defending civil liberties, often with high profile, yet controversial or notorious, clients. *The Preventive State* is his self-described magnum opus synthesizing his thoughts on how society and the law confront preventive actions by the Government.

He boils it down to Predictions [preventive actions] and Outcomes [consequences]. There are four:

Predictions: It will rain; It will not rain; **Outcomes**: It did rain; It did not rain

Will Rain/Did Rain: **TRUE** Positive

Will Rain/Didn't Rain: **FALSE** Positive

Won't Rain/Did Rain: **FALSE** Negative

Won't Rain/Didn't Rain: **TRUE** Negative

Much of the book deals with several historical legal cases where preventive decisions were made or not made and how those decisions affected the outcomes. It would be Utopia if all our decisions were either true positives or true negatives, but life and the law are all about balancing false positives and false negatives.

Some examples:

Chapter 7 deals with **preventive medical intrusion**. Naturally, Dershowitz discusses the history of compulsory vaccination. This goes back to Revolutionary War times when General George Washington wrote: "Finding the smallpox to be spreading much and fearing that precaution can prevent it from running thro' the whole of our army, I have determined that the troops shall be inoculated." This idea was extended to the civilian population in the 1905 Supreme Court decision where Cambridge, MA resident Henning Jacobson refused a smallpox revaccination ordered by the public Board of Health. He was charged criminally, convicted, and required to "pay a fine of $5 and the court ordered that he stand committed until the fine was paid." It was eventually appealed to the US Supreme Court, which "upheld the Cambridge compulsory regulation as constitutional"

Shockingly, that decision was cited to justify another case, Buck vs Bell (1927), where the Court ruled "in support of mandatory sterilization of 'epileptics and feeble minded' persons". Dershowitz writes, "It reminds us that we must be skeptical of scientists (and judges), and the abuse of science."

Chapter 10 concerns **red flag laws and gun violence**. "The answer to the provocative question, 'Do guns kill or do people kill?' is obvious: guns kill when they are in the hands of violent, unstable, and dangerous people. This reality has led to two rather different approaches to preventing or reducing gun crimes. The first focuses on the guns; the second on the people. Both have predictive and preventive elements that include false positives and negatives. Both are controversial. Both raise constitutional concerns."

In response, about half the states have enacted "extreme risk protection orders" [ERPOs]. Some claim that they can save lives. Others say "that they violate due process because they produce too many 'false positives'- too many people have their guns taken away who would never misuse them". Data is hard to come by to know if there are too many ERPOs (false positives) or too few (false negatives).

Chapter 5 concerns **the preventive state and military action**. Pre-emptive military strikes are not new. Dershowitz gives examples as old as the Bible and the Roman Empire. Failure to act can also have its consequences. He discusses the provocative idea that Britain and France should have pre-emptively struck Germany in 1933 when it began its military buildup in violation of the Treaty of Versailles. It would have likely cost thousands of lives in the near term, but may have prevented the deaths of millions.

Although he does not give definitive answers to all the various types of preventive actions, he does suggest a jurisprudential framework for society to discuss the alternatives. It all boils down to how we approach "mistake preferences", which will inevitably occur:

How many false positives are we willing to accept for how many false negatives?
That is the question.

Reviewed by Mark A. Goldstein M.D., FAAP, FSAHM

If I Betray These Words: Moral Injury in Medicine and Why It's So Hard for Clinicians to Put Patients First.

Wendy Dean, M.D. Simon Talbot, M.D.
Steerforth Press, 2023, 269 pages

At the end of the Hippocratic Oath, in a translation by Amelia Arena for *Arion*, a journal of humanities, is the phrase "May I be destroyed if I betray these words." Dr. Wendy Dean believes that betraying the Hippocratic Oath "forsakes our identity, which can unmoor us and threaten our dissolution." Moral injury, according to Dr. Dean, is the source of the crises in our healthcare system such as physician burnout. And moral injury to physicians can come from many sources, including corporate control, legal issues, system, and financial problems.

Dr. Dean started a residency in surgery, but before completion worked for 15 years as an emergency room physician. Subsequently she trained as a psychiatrist, left clinical practice, and currently works to make medicine better for patients and physicians through technology, ethics, and system change.

The text consists of 13 well-written and interesting narratives about physicians and how they endured moral injury practicing their profession. There is Matt, who worked harder and harder each day for his institution to deliver basic care "with the dignity, respect, and compassion his patients deserved." Or Stuart, who practiced primary care at a major teaching hospital in Boston and "despaired at the toll the workload was taking on the clinicians who worked there and how powerless he was to do anything about it." Or Jay, a pediatric rehabilitation specialist working in a rural hospital, where he took call alone for six months and ended up being called an "impaired physician" by administrators. Reported to the state licensing board, he was required to undergo inpatient rehabilitation to

keep his license. Two days after discharge from a lengthy hospitalization, broken both physically and mentally, he died by suicide.

Moral injury can occur when physicians cannot deliver the health care that patients require. It may be as common as a prior authorization denial on baseless grounds, or recently during the pandemic: two patients require a ventilator, only one is available. This life-or-death decision could easily provoke moral injury.

Moral injury does not account for all causes of burnout or the conflict-ridden healthcare system, as Dr. Dean writes. Rather, the evolution of the doctor-patient relationship, the health insurance industry, politicization of healthcare, corporatization, the electronic health record, and social media are a few examples that contribute to physician burnout and disruptions for our profession.

During our careers, all of us have probably witnessed or endured some of the issues described in these true stories. I am reminded about advice I recently wrote for incoming medical students as they donned their white coats for the first time: 'You are not alone.' On reading this book, may you have even more compassion and empathy for our colleagues who have experienced such struggles, as they may have felt alone.

Poetry Corner

Love Lost

Chris Kjolhede, MD, MPH, FAAP
Cooperstown, NY

We sat on either side of our dying daughter's bed. Her mom's wife on her side, my wife on my side. Our daughter, a middle child, was always the peace maker.

Our two other children were holding their sister's hands, kissing her cheeks, saying good-byes.

The nurse shown a penlight into her unresponsive eyes. Her mother and I glanced at each other knowingly.

And in that brief glance, all the love of a marriage since gone wrong and for a life all be over flashed between us.

76 Years On

Joseph B. Philips, III, MD, FAAP
Birmingham, AL

Stiff in mornings

Rehab in shower

Rotator cuffs shot

Cane for balance

Sit for rounds

No, no falls

Yes to transfusions

No spiritual issues

Sciatica, epidural steroids

Enlarged prostate embolized

Pills for hypertension

Prilosec is great

Tadalafil even better

So is wine

Brain still works

Love my job

Panorama

Tomas Jose Silber, MD, MASS, FAAP
Professor Emeritus, George Washington University
Chevy Chase, MD

My love and I watch,
from the top of a great mountain,
(Sinai? Olympus? Ararat?)
our extensive colony of descendants.
Through centuries they carried some of our genes,
until those gradually faded away,
only to suddenly reappear
in a dimple,
in a loving look,
in a contagious laugh.

The variety we saw was astonishing.
While it's not surprising,
that among them there were many chubby men and women,
there were also among them
tall and muscular ones.

By the next millennium, they were thousands upon thousands,
of the most diverse ethnicities,
with more than five hundred different surnames,
scattered across five continents,
and two of them
in a Martian colony.

Among them the number of doctors was remarkable,
Also, there were several writers,
one of whom won the Pulitzer Prize for Poetry,
and even one solitary soccer player
who played with distinction for Galaxy Juniors wearing the number 10 jersey.

In an almost unfathomable distant time,
in a brief instant of extreme unusual light
followed by absolute silence,
(Nuclear Holocaust? Meteorite? Twilight of the Gods?),
everything ended.

But, you know what?
In the multiverse
it exists, it will exist, it existed, and it was
wonderful!

2025 NCE SOSM Program

For the 2025 AAP annual meeting, Senior Section program chair Whit Hall combined with the Section on Integrative Medicine to present a joint program, “Sustaining Joy and Wellness: Integrative Strategies for a Thriving Pediatric Career.” The speakers were Dr. Sarah Webber of the University of Wisconsin and Dr. Michelle Loy of the Weill Cornell Medical College in New York City. In addition, Whit interviewed Dr. Marta Illueca, a former academic and drug-industry pediatrician who has transitioned to a role as Clergy Medical Liaison of the Episcopal Diocese of Delaware. And the Donald Schiff Child Advocacy Award was presented to Seattle's Dr. Edgar Marcuse.

We always ask our speakers and award winners to write something about their talks (or in the case of the Schiff awardee, something about their careers) for the *Senior Bulletin*. These comments usually appear in the winter issue, but because we will not be publishing a 2026 winter issue, we have added them as appendix to this edition. As you’ll discover, articles were written both before and after the program.

Whit Hall, Sarah Webber, Michelle Loy, Marta Illueca

Joy of Pediatrics as Antidote to Burnout

Sarah Webber, MD
Director of Well-Being, Master Certified Physician Development Coach
University of Wisconsin School of Medicine and Public Health
Madison, Wi

The Institute for Healthcare Improvement’s Joy in Work course outlines how to use quality improvement methodology to improve clinician well-being by identifying the small but persistently frustrating “pebbles” that get in the way of joy. When I first found this work, I was a recovering burned-out early-career physician and honestly didn’t see how *joy* fit into burnout recovery or professional well-being. While I’d experienced satisfaction, compassion and excitement from work, joy hadn’t felt very accessible to me.

What is joy?

Joy is an emotion on the "enjoyment spectrum" - a more subtle emotion than elatement, excitement and wonder. As with all emotions, joy is an inner reaction pattern informed and in response to external and internal conditions: culture, interpersonal interactions, things we see, touch, and smell, and intercept, as well as habits and conditions we have learned. People have described joy as something we feel when connected to a person, place or thing, while others say that joy comes from an inner rather than an external circumstance.

Barriers to joy in medicine

Although pediatricians tend to have better well-being as a group than other medical specialties, I've met plenty of pediatricians who struggle to connect to joy, are burned out, and exhausted. Observing my colleagues and coaching clients, I see three main barriers to joy in modern medicine:

1. Black and white thinking
2. Joy resistance
3 Optefficientivity culture

Black and white thinking

There is a pernicious and slippery slope from joy into the area of toxic positivity (an orientation that favors what is 'pleasant' and ignores what is hard, unpleasant, or downright bad). An example of this thinking - that joy or gratitude are felt *in place* of things like cynicism or anger - occurred one morning at my institution's grand grounds. A well-being speaker shared with the audience that physicians shouldn't keep being angry about the state of healthcare, suggesting they focus on what is good. While taking a positive mindset helps some folks, others felt unheard and frustrated by this approach. It's unnecessary to have the viewpoint that emotions are dualistic - joy doesn't require that we shut down or block negative feelings and experiences. You can be angry or sad and still experience joy.

Joy resistance

All medical professionals experience vicarious trauma in their work. For some, these experiences can result in significant emotional numbness or hypervigilance - psychologic responses to maintain a sense of safety. While these responses can serve us at times in our lives and careers, long-term habits of numbing and hypervigilance can interfere with feeling positive emotions. This may be especially true for emotions like joy that require a greater degree of vulnerability than excitement.

Optefficientivity culture

We work and live in a culture that worships optimization, efficiency, and productivity. While these orientations can have benefits, their supremacy in our culture can interfere with joy. Joy requires presence and seeing the good in simple things. It can become difficult to access joy within a culture that values constant progress, output, "using time well", and technological connection. Consider how much joy you get from your email vs cup of coffee with a colleague? One is more efficient, but the other offers a more fertile ground for joy.

Why joy *is* the antidote to burnout

Though a simple emotion, joy offers us so much in medicine. Joy is there, often hiding alongside daily life. It isn't an emotion meant to balance sadness or frustration, and certainly doesn't push them out. In fact joy is so simple it's frightening that we can feel so disconnected from it. The beauty of a drop of rain falling down a window; a pudgy foot of a toddler with a devastating diagnosis; a child singing "Rings of Fire" while he gets his BOTOX injections. Joy doesn't replace the pain and sorrows of our world, but instead sits alongside it. As Ross Gay states, "Joy is what effloresces from us as we help each other carry our heartbreaks."

In this way, joy is a conduit to our humanity; it is a part of what makes us feel human. And it's that connection that makes joy the antidote to burnout. At its most basic level the symptoms of burnout - a disconnection from our own worthiness, from our emotional landscape and that of other people, and of our ability to have hope - represent a disconnection from our humanity. It's a distancing from ourselves, each other, and our collective goodness. Burnout is a flavor of exhaustion that comes forth to help us self-preserve when pushed beyond our human capacity. It happens for good reason and not because we are broken. But if we see it as a sign of disconnection from innate worth and wholeness as humans, then reconnecting to joy may be both a pathway to and a signal of burnout recovery.

How we cultivate joy in work and life
Claiming joy, valuing joy - whether as individuals, teams, or institutions - is essential. Naming joy as a value means we want to prioritize it with action; creating moments and spaces where vulnerability is welcome; recognizing that if all moments are defined by productivity, we will never have space for the immaterial but priceless aspects of our humanity that can't be easily "counted". This might mean slowing down, "wasting time", healing trauma, and connecting more deeply with others.

Practically creating an environment where joy resides requires systemic commitment and action. Examples include choosing and training leaders in the interpersonal skills needed to create psychological safety on their teams; letting go of older mantras of stoic heroism, which can further perpetuate systems of hypervigilance and emotional numbing and keep us distanced from joy communally and individually. A recent study showed that one of the biggest barriers to accessing individual mental health support was a lack of system mechanisms for people to have time to access that help. Institutions can support individuals by providing PTO systems that allow for coaching and therapy appointments. As smaller communities of clinicians, we can create spaces to share what is hard, our grief and fears, kindling the joy that comes from helping each other through. We can make it an intention to notice joy, to make space in ourselves and our lives for joy, and to let joy lead us through change and transition.

Conclusion
It's easy in this world of upheaval and harm to let joy lie on the sideline as a luxury. But I think that is not only a mistake, but a missed opportunity. What if shared joy is what gets us through, is what inspires our work, is what keeps us going? What if joy is the point?

Vital Pediatricians: Lessons from Blue Zones and Integrative Medicine

Michelle Loy, MD, FAAP
Weill Cornell Medical College/New York Presbyterian Hospital

In a time when clinician burnout is increasingly common, how can pediatricians - especially senior members - sustain vitality, joy, and purpose across the arc of their careers? At this year's AAP National Conference & Exhibition, Dr. Michelle Loy offers a compelling and practical roadmap to thriving in pediatrics, drawing from the science of integrative medicine and the wisdom of the world's longest-lived communities: the Blue Zones.

This joint session is designed to inspire and equip pediatricians with evidence-based strategies for self-care, longevity, and professional fulfillment. Dr. Loy will explore how lifestyle medicine, cultural wisdom, and personal reflection can help clinicians rediscover meaning in their work and lives.

Session Objectives:

Prevent Burnout by Cultivating Joy and Wellness Learn actionable steps to cultivate joy throughout your pediatric career. From career transitions to leadership mentorship and life coaching, the session will highlight shared lived experiences that foster resilience and fulfillment.

Enhance Vitality Through Integrative Medicine and Blue Zone Principles Discover how food, movement, rest, connection, and purpose - core elements of both integrative medicine and Blue Zone lifestyles - can be adapted to support clinician health. These practices are not only restorative but also deeply rooted in evidence.

Identify Shared Lived Experiences That Promote Thriving From narrative medicine to multigenerational mentorship, Dr. Loy will highlight the experiences that help pediatricians flourish, even in the face of professional challenges.

Highlights of the Session Include:

Nutrition for Longevity and Vitality What is the best diet for health? Dr. Loy will explore the dietary patterns of Blue Zone communities and U.S. Blue Zone cities, offering practical guidance on what and how to eat wisely. Topics include plant-forward diets,

the role of legumes, and the impact of food timing and joyful meals. She'll also address common questions about protein, collagen, and creatine - what's hype, what's helpful, and what's backed by science.

Lifestyle Medicine in Clinical Practice Learn how evidence-based shared medical appointments can be used to promote bone and brain health, reduce fall risk, and support aging well. These group visits foster community, accountability, and education - especially valuable for senior pediatricians and their patients.

The Role of Connection, Pets, and Nature Social connection is a powerful predictor of longevity. Dr. Loy will discuss the health benefits of pet ownership, time in nature, and spiritual practices, all of which contribute to emotional resilience and physical health. Downshifting - intentional slowing down - is another Blue Zone principle that supports stress reduction and clarity.

Multigenerational and Faith-Based Health Communities Explore how intergenerational relationships and faith-based wellness initiatives can create meaningful support systems for clinicians and patients alike. These communities offer a sense of belonging and purpose that is essential for long-term well-being.
Narrative Medicine and Healing Through Story Dr. Loy will share her research on narrative medicine, illustrating how storytelling and reflective writing can promote healing, empathy, and connection. These practices help clinicians process their experiences and reconnect with the deeper meaning of their work.

Ikigai: The Joy of Purposeful Living What gets you out of bed in the morning? The Japanese concept of Ikigai - a fusion of passion, mission, vocation, and profession - offers a framework for aligning work with joy and purpose. Dr. Loy will guide attendees in exploring their own Ikigai and how it can sustain them through the ups and downs of a pediatric career.

Fun "Real Age" Tests and Vitality Assessments You may be aging far better than you think! Dr. Loy will introduce engaging tools to assess biological age and vitality, offering a fresh perspective on health and aging. These tests are not only informative but also empowering, helping clinicians set personalized goals for wellness.

Why Retaining Senior Pediatricians Matters Dr. Loy will also address the critical need to retain senior pediatricians in the workforce. Their wisdom, mentorship, and lived experience are invaluable assets to the profession. By supporting their health and well-being, we strengthen the entire pediatric community.

Whether you're navigating a career transition, mentoring younger colleagues, or seeking renewed purpose in your work, this session offers inspiration, practical tools, and a sense of community. It's a celebration of vitality, longevity, and the joy of practicing pediatrics.

2026 Donald Schiff, MD, FAAP Child Advocacy Award
Advocacy: Serendipity, AAP, and Me

Edgar K Marcuse MD, MPH, FPIDS, FAAP
Emeritus Professor, UW Medicine
Seattle, WA

If, in your ninth decade, your work is recognized by your colleagues, the validation is very welcome. I am grateful. Thank you

Advocacy was among the most rewarding facets of my career. I want to highlight the central role of serendipity and the AAP in my advocacy work.

Serendipity, according to Wikipedia, is more than pure chance: *there is also the crucial role of acting upon unexpected opportunities.*

In 1967, when I graduated med school, the air was redolent with possibility. The torch had indeed been passed to a new generation: it was the time of the Peace Corps, the civil rights movement, the Model Cities program, and Head Start. I gravitated to pediatrics, influenced by Robert Greenberg, an inspiring teacher and champion for social justice.

For an intern, Viet Nam would come next unless you were granted a deferment. I was selected as a CDC medical epidemiologist for Washington state. As I was a pediatric resident, my first assignments related to rabies, whooping cough, diphtheria, and promoting measles and rubella vaccination. My two-year stint as a novice epidemiologist was followed by a third year of residency and an epidemiology fellowship.

I soon recognized I was at heart a clinician, not a researcher.

I was hired by Abe Bergman to oversee a new Model Cities clinic in Seattle's Central Area. The University of Washington Pediatric Department chair, Bill Robertson, declined to offer me a regular faculty appointment, foreseeing I was unlikely to succeed academically running an inner-city clinic. So, I went to work at Seattle Children's with no clear pathway to continued employment. However, so long as my work brought credit to the hospital, I was free to do as Joseph Campbell advised, "Follow your bliss." He noted "The universe will open doors where there were only walls," and advised that "True happiness and purpose are found by pursuing what is most deeply important to you." I had the incredibly good luck to be able to do just that for 45 years.

Seattle pediatrics was welcoming. My sons' pediatrician, Ralph Luce, invited me to continue my immunization work and succeed him as chair of the Washington state AAP Chapter's Committee on Infectious Diseases. Throughout my career I had one foot in clinical pediatrics, the other in public health; one hand in academics, the other in hospital administration.

My boss Abe Bergman, already a legendary child advocate, travelled a lot and asked me to fill in for him at various gigs and to review manuscripts sent to him. My reviews were well received, and I ended up on the *Pediatrics* Editorial Board - my first contact with the national AAP. I engaged with the Washington chapter successively as a trustee, vice president, and president over 20 years

An immediate challenge was ensuring access to the new vaccines against Hemophilus B, and pneumococcus. In 1990 the state had a budget surplus and our AAP chapter played a role in convincing state officials to provide all recommended vaccines to all children in the state; a system which endures today, albeit tenuously.

Serendipity led me to doorways and relationships that ordinarily would have been beyond my reach. Pivotal was being appointed to the Red Book Committee. During the 1980s the association between aspirin and Reyes syndrome was revealed. The committee proposed that the AAP recommend against the use of aspirin as an antipyretic, but the Board refused, and the committee chair, Vince Fulginiti, resigned, creating an opening for a member from District VIII. The committee traditionally had one slot for a general pediatrician. With the support of District VIII chair Don Schiff, I was appointed in 1987 and served six years, collaborating with subsequent chairs Neal Halsey, Stan Plotkin, Carolyn Breese Hall and editors Georges Peter and Larry Pickering, and co-editing the 1994 Red Book.

My time on the Red Book opened the doors to serving on the HHS National Vaccine Advisory Committee (NVAC), succeeding D.A. Henderson and Vince Fulginiti as its chair, and later to serving on the FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) and CDC's Advisory Committee on Immunization Practices (ACIP) during the years when we helped to build much of the immunization infrastructure that is now being dismantled.

My day job was as a general pediatrician on the clinical faculty, overseeing at various times a Seattle Children's general pediatric clinic, ER, and general inpatient medical service. In 1994 the hospital was "reengineered", and because I was not generating substantial revenue, my continued employment after 23 years was uncertain. My academic colleagues, led by UW General Pediatric Division chair Fred Rivara and department chair Herb Abelson, stepped in and orchestrated an appointment to the regular faculty as a full professor in the then-new clinician educator track, enabling me to continue for 20 more years.

My work as an academic general pediatrician led to opportunities to serve on the AAP Committee on Scientific Meetings and the Committee on Quality Improvement/Management, and to co-edit *AAP Grand Rounds* with Lewis First.

My day job brought me into contact with an extraordinary group of pediatric residents; most notably three who became nationally recognized bioethicists - Chris Feudner, Doug Diekema and Doug Opel. These three deepened my understanding of the immunization policy challenges I had long confronted.

Through their tutelage, I came recognize that public health policy was an amalgamation of science and values; that it was inherently political because it involved balancing risk and benefits and individual liberty versus societal constraints; and that discussion of values was as important to sustaining the public consensus supporting public health as good science.

Although I wrote and talked about vaccine hesitancy and resistance, I did not recognize the enormity of its malevolent potential, and so failed to fully leverage my opportunities to sound the alarm. Had I known then what we all know now, I wonder what I might have done differently?

Events of the past six months seem to me akin to the burning of the Paris Notre Dame Cathedral. I am obsessed today with trying to figure out how can we rebuild our cathedral; what might we do to restore the processes and rebuild institutions worthy of the public trust?

My greatest satisfaction is having played a role in preserving the values I cared about and now watching others I mentored sustain them.

In his first inaugural address immediately prior to the outbreak of the Civil War, Lincoln considered how to restore harmony to a divided nation. He suggested we must wait until "we are again touched, as surely [we] will be, by the better angels of our nature." The events that followed then suggest that, faced with today's crisis, we must seek a more active strategy.

I confess I am at a loss, but am heartened by Jared Diamond's and David Brooks' analysis that cycles of national rupture and repair are common – citing England, Japan, Germany, Australia, Chile, and Rwanda; and by Richard Goodwin's observation that, *"*The end of our country has loomed many times ... America is not as fragile as it seems."

I will close two quotations that continue to spur me to action in these times of despair:

"Words without actions are the assassins of idealism." (Herbert Hoover)

"Indignation without action is froth!" (William Gladstone)

Philanthropy

From the AAP Committee on Philanthropy

J. Gary Wheeler, MD, MPS, MARS
Little Rock, AR

When Abraham Jacobi settled in New York City and made it his home, he sought to establish the care of children as a focused specialty of medicine. A man of enormous and diverse talent, his take on child health included the need for specific treatments and guidance, as well as the impact of social forces on the health of his chosen subjects. He concluded that a pediatrician would not be a complete physician without speaking to the social forces that shaped children: poverty, hygiene, child employment, etc. He argued that our profession should be experienced in leveraging a voice for children in the halls of power.

Many years ago, I first attended the AAP legislative conference in Washington DC. I was moved by the examples of David Tayloe, Marsha Raulerson and my own colleague Betty Lowe as they led the AAP in advocating at the state and federal levels. My eyes were further opened when I served on the AAP State Government Affairs Committee and realized the critical role the AAP played at the legislative level. Katie Matlin, a staff member of SGA, illustrated that role as she worked with multiple groups to overturn the Florida law prohibiting pediatricians from discussing gun safety with parents.

My appreciation for the work of the Academy only grew as I learned the vast scope of influence and knowledge brought to bear on behalf of children in state capitals and in Congress by highly committed and talented individuals.

I decided to make a monthly commitment to Friends of Children and have not stopped giving. This program gives the AAP funds to deal with legal, social, medical and aid situations faced by children whether at the border, in climate crisis, or trans children in existential crisis. I encourage all of you to consider this as a monthly tithe to help our most vulnerable charges.

As I begin my seventh decade, I want to distribute some of my wealth to create a secure future for the AAP. This allows the AAP to continue to secure the prospects of my grandchildren and great-grandchildren. Rather than wait for my will to be read, I am giving now through a Qualified Charitable Distribution instrument. This allows a tax-free gift from my required IRA distributions. That way I get to see my gift in action as I watch all the activities of the AAP and know that my dollars are helping to fund those programs. They are helping Joe Wright wrestle with inequity, Mark Del Monte navigate our vessel through very difficult waters, or Jamie Poslosky strategically guide advocates through the halls of Congress to improve children's welfare.

I hope you will consider a similar gifting strategy. Baby boomers own an enormous amount of the country's wealth. Now is the time to share and help our radically challenged children and grandchildren meet the storms ahead.

To learn more about gifting options contact Jill Taylor, Director, Philanthropy. You can reach her at jtaylor@aap.org or (630) 626-6033.

Smart Ways to Give Before 2025 Ends

Jill Taylor
AAP Director of Philanthropy

A little planning now will benefit both you and the organizations you support.

Charitable giving is top of mind as we approach the end of the year. It's the season of generosity and gratitude, of course, but it's also a great time to look at how donations figure into your financial goals.

We've rounded up a few tips for maximizing your charitable impact at the American Academy of Pediatrics while supporting your own fiscal health.

Consider Tax Law Changes When You Donate
A gift that may reduce your taxes helps both you and the AAP finish the year strong. Review recent tax law changes (see addendum for details) and consider how they might affect your giving in 2025.
Important note: Many of the most dramatic changes to the tax code don't take effect until 2026, so you could see a bigger tax benefit by giving before the new year.

Make an Immediate Difference
Support the AAP with a cash gift via check or online. Your gift may qualify for a federal income tax charitable deduction. Unsure of whether your gift is tax-deductible? Contact your financial advisor or tax consultant.
Important note: If sending by mail, your envelope must be postmarked by the U.S. Postal Service on or before Dec. 31 for your donation to qualify this year.

Use Appreciated Stock
Donating appreciated stock that you have owned for longer than one year allows you to qualify for an income tax deduction and eliminate any tax on the appreciation.
Important note: If the stock is electronically transferred to the AAP, the gift date is the day the stock enters our account, not the date you ask your broker to make the transfer. Give us a heads up that you've arranged a gift so we know it's from you.

Recommend a Grant from Your Donor Advised Fund (DAF)
A DAF, which is like a charitable savings account, gives you the flexibility to recommend how much and how often money is granted to the AAP and other qualified charities. You can recommend a grant or recurring grants in 2025 to make an immediate impact or use your fund as a tool for future charitable gifts.
Important note: You qualify for an income tax deduction only when you *contribute* funds to an existing DAF. Through your grant recommendation, however, you get the satisfaction of making a difference at the AAP before the year ends.

Make a Gift from Your IRA
If you are 70½ or older, you can give any amount up to $108,000 from your IRA directly to the American Academy of Pediatrics. You will not pay income taxes on the transfer. This gift can also count toward your required minimum distributions.
Important note: Your IRA administrator must transfer the funds by Dec. 31. If you have check-writing features on your IRA, your check must clear your account by Dec. 31 to count toward your required minimum distribution for the calendar year. Remember to always consult your tax adviser before giving from your IRA.

For guidance on the best ways to leave a legacy at the American Academy of Pediatrics as we approach the end of the year, reach out to Jill Taylor at 630/626-6033 or jtaylor@aap.org. We are happy to help ensure that you realize the greatest benefit for your kindness. Thank you to the Stelter Company for helping us compile this information. For more on estate giving, visit aap.planmygift.org.

Addendum
Untangling the Tax Code
Changes to the tax code made big headlines in 2025, but many of them don't actually take effect until next year. The upshot: In most cases, you'll get a bigger tax benefit by giving to the AAP now. Here's what to know.

Change: New floor for itemizers Starting with the 2026 tax year, you'll need to give at least 0.5% of your adjusted gross income (AGI) to claim a charitable deduction. **What it means for you:** Consider maximizing your giving in 2025 before this new threshold takes effect.

Change: New limit for top earners Currently, top earners get a 37-cent tax benefit for every dollar deducted. Starting in 2026, that drops to 35 cents. **What it means for you:** If you are in the highest tax bracket, consider giving more this year for greater tax savings.

Change: Higher standard deduction made permanent and will be indexed for inflation For 2025, the deduction will be $15,750 for single filers and $31,500 for married couples filing jointly. If you are 65 or older, you may qualify for a bonus deduction of up to $6,000, although it begins to phase out at higher income levels. **What it means for you:** Even if you don't itemize, you may still benefit if you give appreciated stock, real estate, or, if you are 70½ or older, from your IRA.

Change: Deduction limit for cash gifts made permanent
What it means for you: You can still deduct cash gifts of up to 60% of your adjusted gross income. Consider a blended gift strategy that combines cash and non-cash assets to maximize your tax benefits as well as your impact.

Guidelines for Senior Bulletin Articles

Gilbert Fuld, MD, FAAP Editor

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

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

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

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

2025-2026 Senior Bulletin Schedule

Winter Bulletin - Electronic
December 9, 2025: Call for Articles
February 9, 2026: Article Submissions Due
March 24, 2026: Bulletin Online

The Best of the Bulletin

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