

weillcornellmedicine

THE MAGAZINE OF
WEILL CORNELL
MEDICAL COLLEGE AND
WEILL CORNELL
GRADUATE SCHOOL OF
MEDICAL SCIENCES

WINTER 2009/10

Dressed to Cure

Inside:

Update on
Weill Cornell's
response to
the crisis
in Haiti



What's the
prognosis
for the
white coat?



DISCOVERIES

THAT MAKE A DIFFERENCE

THE CAMPAIGN FOR WEILL CORNELL MEDICAL COLLEGE

Advancing science, enhancing health

Building on **excellence**

Adding 30 new scientists

Doubling our research space

Transforming
bench-to-bedside research

Rendering of new
Medical Research
Building planned for
East 69th Street

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Campaign Initiatives

Cancer

Cardiovascular
Disease

Children's Health

Diabetes, Metabolic
Disorders and Obesity

Global Health and
Infectious Disease

Molecular Therapeutics

Neurodegenerative-
Neuropsychiatric Diseases,
and Aging

Stem Cell, Developmental
Biology, Reproductive and
Regenerative Medicine



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Joey Alsberge '13



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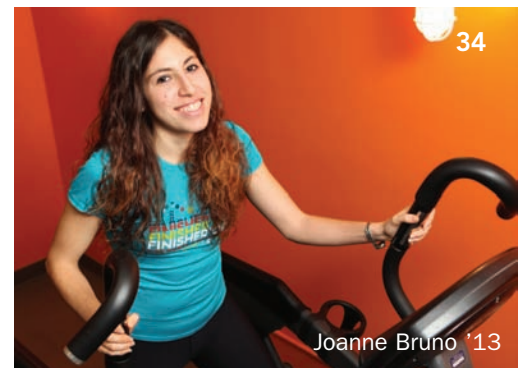
BETH SAULNIER

With many students eager to train abroad, the field of global health is taking off. At Weill Cornell, half of the first-year class has signed up for a new global health curriculum—on top of their usual course load. The department has launched a comprehensive website to showcase its offerings, with opportunities to study at sites from Munich to Mwanza.

28 COAT OF MANY MEANINGS

BETH SAULNIER

It has been the physician's uniform for more than a century. But with the AMA reviewing a proposal to ban the white coat as a disease vector—and some doctors-in-training decrying it as outmoded and uncomfortable—is the venerable garment on its way out? *Weill Cornell Medicine* asks faculty and students to weigh in.



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Joanne Bruno '13

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SHARON TREGASKIS

Forget the stereotype of overworked doctors who tell their patients to adopt healthy habits but don't practice what they preach. As it turns out, physicians are more likely to eat well and exercise than other highly educated professionals—and even with the pressures of medical school, many Weill Cornell students are passionate advocates of healthy living.

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THE MAGAZINE OF WEILL CORNELL MEDICAL
COLLEGE AND WEILL CORNELL GRADUATE
SCHOOL OF MEDICAL SCIENCES

www.weill.cornell.edu

Published by the Office of Public Affairs
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Graduate School of Medical Sciences

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Weill Cornell Medical College

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clinic.

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Weill Cornell Medicine (ISSN 1551-4455) is produced four times a year by Cornell Alumni Magazine, 401 E. State St., Suite 301, Ithaca, NY 14850-4400 for Weill Cornell Medical College and Weill Cornell Graduate School of Medical Sciences. Third-class postage paid at New York, NY, and additional mailing offices. POSTMASTER: Send address changes to Public Affairs, 525 E. 68th St., Box 144, New York, NY 10065.

Light Box



JOHN ABBOTT

On the move: Third-year medical student Nakesha King (center, in striped sweater) attends an exercise session in East Harlem as part of the Movement Against Childhood Obesity (MAChO), a volunteer group that encourages inner-city kids to eat right and exercise. For more, see page 38.

Antonio M. Gotto Jr.,
MD, DPhil, Dean of the
Medical College

Training for an Uncertain Future



Madelon Finkel, PhD

JOHN ABBOTT

The words “health care” and “reform” seem nearly inseparable these days. When one appears, the other is sure to follow.

While many agree that a reevaluation of the current health-care model is long overdue, there is little agreement about how reform should be administered. Some people argue for greater involvement from the federal government. Others say Washington already plays too large a role and Americans would be better off choosing their own health-care options. Many doctors worry that Medicare reimbursements, already on the decline, will continue to fall, forcing them to take on even greater patient loads and further stressing all aspects of the health-care process. New legislation seems likely, but the debate will hardly end there.

Whatever the immediate outcome, Weill Cornell Medical College is not taking a passive role. Change is coming to health care, and as we train the next generation of physicians and researchers, it is our mission to ensure that the doctors and scientists of tomorrow not only keep pace with the shifting world of medicine, but also continue to push the boundaries of discovery and patient care.

Our fourth-year students take a two-week

health policy clerkship—taught by Madelon Finkel, PhD, for more than ten years—that offers an overview of the non-clinical side of practicing medicine and exposes them to some of the issues they may be facing as they treat patients. This includes the confusing, and at times conflicting, restrictions placed on physicians and patients alike. “With the current debate among policy-makers and others about how our health-care system should be reformed, it is ever more important to give our students the skills necessary to navigate the increasingly complex health-care system,” says Dr. Finkel, who is a professor of clinical public health and director of the Office of Global Health Education at Weill Cornell. (For more on global health, see page 20.)

Student response has been enthusiastic. “The health policy course forced us to step back from our basic science and clinical courses and put our training into a real-world context,” says Anthony Rosen ’10. “We met industry experts who shared their often dramatically differing viewpoints on health care. The timing for the course was perfect, as we were discussing these issues as the health-care reform debate unfolded. I think that understanding health policy will be invaluable for me as a practicing physician.”

Productive Partnerships

David P. Hajjar, PhD,
Dean of the Graduate
School of Medical Sciences

Science and medical research are highly collaborative endeavors.

At the Weill Cornell Graduate School of Medical Sciences, our students work closely with faculty mentors and fellow students as well as with researchers and scientists from neighboring institutions. In a stretch of First Avenue no longer than a mile, one encounters some of the finest medical and research facilities in the world: NewYork-Presbyterian/Weill Cornell, Memorial Sloan-Kettering, the Rockefeller University, and Hospital for Special Surgery.

While that proximity is a great asset, one of our most valuable partners lies 260 miles beyond the sometimes insular community of Upper East Side Science—our parent institution, Cornell University. It should surprise no one that the Graduate School would work so closely and fruitfully with the Ithaca campus. But the distance between the campuses at times makes it easy to forget that each offers a rich source of talent and resources to the other. Collaborations between the Graduate School and the various colleges in Ithaca have worked splendidly, and you can count on even more significant partnerships down the road.

One current effort has taken shape in the Outreach Office of Weill Cornell Graduate School, which is cooperating with Cornell's Institute for Biology Teachers. Through this partnership, professional development workshops are held annually in which secondary school science/biology teachers visit both campuses. The goal of the program is to update these teachers in topics related to biomedical science, so their lessons remain as current as possible. The program provides classroom lab exercises and connects the faculty with local secondary school teachers and students.

Students who are interested in combining the strengths of the field of psychology and cognitive science in Ithaca and the neuroscience program in Manhattan are encouraged to consider the IMAGINE program (Ithaca Manhattan Graduate Initiative in Neuroscience). In Ithaca, the program specializes in basic analysis of perception, cognition, communication, and decision making, grounded in developmental and evolutionary perspectives, with a strong computational emphasis. The Graduate School provides an outstanding research facility for investigation of the development, structure, and function of the nervous system, drawing from a variety of scientific disciplines including pharma-

cology, neuroanatomy, electrophysiology, imaging, and genomic and transgenic approaches within animal models and specific clinical populations. IMAGINE students receive exceptional training in both how to choose and design research questions and how to apply this skill in clinical settings with the most current and powerful techniques.

No great milestone in medicine or science was achieved alone. The work can often seem solitary—all those days and nights in a lab—but it helps a great deal to know that we are part of a team, an entire school dedicated to solving the world's medical dilemmas. We have excellent partners in that endeavor, be they down the street or hundreds of miles away.

JASON KOSKI / CORNELL UNIVERSITY PHOTOGRAPHY



Duffield Hall on the Cornell campus

From the Lab Bench to the Classroom and Back

The Story Behind the *Discoveries* Campaign

Weill Cornell's \$1.3 billion *Discoveries that Make a Difference* Campaign is dedicated to building on our world-class strengths in research, education, and clinical care to move breakthrough discoveries faster from the laboratory bench to the patient bedside.

Alumni play a unique and critical role in this research-focused Campaign. There is a direct connection between the robustness of our research programs and the quality of our students' medical education, a strong thread that alumni—most of all among our friends and supporters—can appreciate from first-hand experience.

"The vision of the *Discoveries* Campaign to expand research opportunities and mentors here, and especially the construction of a new research building, will be extremely helpful to MD students and is something we are all looking forward to," says Ankit Patel, a fifth-year MD-PhD student in the Department of Physiology and Biophysics and a former student representative on the Weill Cornell Board of Overseers.

From the first year of medical school, our students are exposed to research professors in the classroom, and their choice of specialties is often inspired by the compelling research they hear about and visits to their professors' laboratories. For Sharline Madera, a second-year MD-PhD student, this has helped her understand how patient care and research are intertwined. Researchers who also see patients "can ask questions that are more pertinent to the disease, and then take the patient's answers back into the lab," she says. "This can definitely lead to more quickly finding ways to improve patient treatment overall."

Expansion of research space and recruitment of additional talented scientists will also enhance the rankings of the Weill Cornell Graduate School of Medical Sciences, because rankings are based largely on scientific awards, new research grants, and number of publications.

A related goal of the Campaign is to build endowments for scholarships, which help to give students the financial freedom to choose clinical and research specialties of genuine interest to them without laboring under a six-figure loan debt after graduation. The average indebtedness of Weill Cornell graduates is \$128,000—lower than the national average of \$170,000, but still daunting. This financial burden is too often a factor that drives students into specialties based on earning power rather than on interest or where they think their medical skills will be of most benefit.



Fifth-year
MD-PhD
student
Ankit Patel



Second-year MD-PhD
student Sharline Madera

Third-year medical student Joseph Pale, whose interest is global health, was able to pursue his dream because he received the Thomas P. McGovern, MD '74, Scholarship. "It literally opened the world to me. I have the freedom to focus on the medical specialty that interests me, instead of worrying about what specialty will help me pay off my school debt," he says.

Dr. McGovern, clinical assistant professor of urology, for whom the scholarship was created by grateful patients, marvels at the ripple effect of scholarship endowments. "It's the gift that keeps on giving through the generations," he says.

Dr. McGovern, along with Paul F. Miskovitz, MD '75, clinical professor of medicine, Division of Gastroenterology and Hepatology, are co-chairs of the new Alumni Campaign Committee, which was created to encourage Weill Cornell alumni to become involved in the *Discoveries that Make a Difference* Campaign. This dynamic group consists of

alumni who serve as faculty and volunteers, and who work in a wide range of specialties. All are deeply committed to Weill Cornell and to the urgency of our scientific mission.

Explains Michael H. Lavyne, MD '72, who recently joined the Alumni Campaign Committee: "When I heard Dean Gotto's vision behind the *Discoveries* Campaign—to expand our capacity for ground-breaking research—it resonated with me immediately. I felt not just obligation but excitement. Weill Cornell deserves to be ranked among the top medical schools in the country."

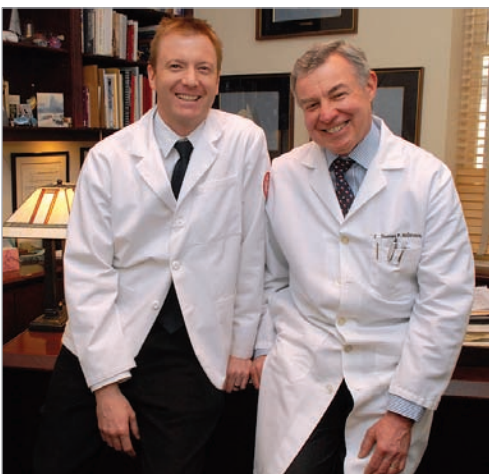
Antonio M. Gotto Jr., MD, DPhil, the Stephen and Suzanne Weiss Dean of Weill Cornell, says it best: "At the end of the day, our goal is

conducting the research and educating the students needed to drive home the next levels of prevention, treatments, and cures for people everywhere. Our alumni and their families have been extraordinarily generous with student support, and research as well as scholarships are an integral part of that. I urge all alumni to join us at this exciting moment in our history."

For more information on opportunities for alumni giving to the Campaign, please contact Amy Buick, Director of Alumni Relations and Giving, at 646-962-8216 or Christine Larchian, Director of Major Gifts, at 646-962-3577.



Weill Cornell Medical College



Third-year medical student Joseph Pale and Thomas P. McGovern, MD '74, whose grateful patients created an endowed scholarship in his name.



Rendering of the projected Medical Research Building on East 69th Street between York and First avenues.

REDSQUARE, INC. FOR POLSHEK PARTNERSHIP ARCHITECTS

'If one looks at medical research citations in the literature per square foot of research space, Weill Cornell is top-notch. But if one examines the total NIH funds invested here, we are less competitive. The only thing stopping us from being in the upper echelon of medical schools now, as it has been for decades, is the lack of research space that will allow us to enhance our already robust collaborations and attract more top scientists.'

— Michael H. Lavyne, MD '72
Clinical Professor of Neurological Surgery

GHESKIO Treats Earthquake Victims

Refugees flock to clinic seeking
medical help and humanitarian aid



PROF. KEN HOVER / CORNELL UNIVERSITY

Help for Haiti: Earthquake survivors fill the grounds at GHESKIO. Right: Marie-Marcelle Deschamps, MD (in white coat), shown treating patients on “NBC Nightly News.”



NBC NIGHTLY NEWS

The devastating earthquake that struck Haiti in mid-January left the Weill Cornell-affiliated GHESKIO clinic damaged but functioning. In a message posted on the Medical College’s Global Health website, medicine professor and GHESKIO co-founder Jean Pape, MD ’75, reported that the clinic was “very lucky.” Although its two sites—the original, in the heart of Port-au-Prince, and a new facility north of the city named in honor of tropical medicine professor Warren Johnson, MD—were both damaged and will likely need millions of dollars in repairs, most of the staff and their families were unharmed.

Pape—who was meeting with the prime minister, minister of health, and international aid officials when the quake occurred—suffered a minor knee injury when he was struck by a piece of concrete that fell from the ceiling. Everyone present was able to escape before the room collapsed. “All the walls around both GHESKIO sites

are broken,” said Pape, a native of Haiti. “Buildings have been structurally damaged, particularly at the old GHESKIO.”

With many of the nation’s medical facilities destroyed, Pape and his staff worked tirelessly to treat survivors, as well as provide humanitarian aid to the more than 1,000 refugees who came to GHESKIO seeking help. The clinic also sought to continue treating its regular patients on drug regimens for HIV and tuberculosis. Said Pape: “We are doing all we can to fulfill three missions at the same time.”

In the wake of the disaster, the Center for Global Health has been collecting donations to fund GHESKIO’s relief efforts. Donors can give online through the Global Health website (weill.cornell.edu/globalhealth) or send checks, made out to “WCMC-GHESKIO,” to Weill Cornell Medical College Center for Global Health, 440 East 69th Street, New York, NY 10021.

Weills Honored with Carnegie Medal

Sanford and Joan Weill were among the recipients of the 2009 Carnegie Medal of Philanthropy, awarded to individuals and families with outstanding records of philanthropic giving. The Weills' generosity, which has spanned more than half a century, has totaled more than \$800 million. In addition to the Medical College, beneficiaries of their largesse include Carnegie Hall, the Alvin Ailey American Dance Foundation, Memorial Sloan-Kettering Cancer Center, and Weill Bugando Medical Centre in Tanzania. Other recipients of the 2009 award were Mayor Michael Bloomberg, the Koç family of Turkey, and Intel founder Gordon Moore and his wife, Betty.

In First, Tumor Drug Delivered Directly to Brain

Neurosurgeons from NewYork-Presbyterian Hospital/Weill Cornell Medical Center have performed the world's first infusions of the drug Avastin directly into malignant brain tumors. The procedures, one of which was described in an extensive piece in the *New York Times* in November, are aimed to offer new hope for patients with glioblastoma multiforme, a common type of brain cancer that does not respond well to current therapies. Principal investigators John Boockvar, MD, and Howard Riina, MD, are now leading a Phase I study of safety, tolerability, and dosage. The present standard of care is intravenous Avastin; intra-arterial cerebral infusion, which breaches the blood-brain barrier, could make it much more potent. "This new technique may be a way to get through that barrier and deliver higher doses of the drug to the tumor with less toxicity to the patient," says Boockvar.

Eating Disorders Center Reopens in White Plains

Weill Cornell's seventeen-bed residential eating disorders program has reopened on the Westchester campus, with refurbished facilities and a new name, The Outlook. It will operate under the umbrella of an integrated eating disorders center in collaboration with Columbia University College of Physicians and Surgeons and be overseen by Evelyn Attia, MD, professor of clinical psychiatry at Weill Cornell and director of the Columbia Center for Eating Disorders. According to psychiatry chairman Jack Barchas, MD, the new center will "bring together unprecedented clinical, research, and educational expertise and resources so that we can better provide comprehensive and compassionate treatment that addresses each patient's specific needs." Five to 7 percent of American females are estimated to have an eating disorder in their lifetimes.

Institute to Focus on Elderly Pain Control

Improving pain management for older adults is the focus of a joint effort by Ithaca-based gerontologists, geriatrics experts at Weill Cornell, and public health researchers at Columbia. Funded by a \$2 million, five-year grant from the National Institute on Aging, the Cornell-Columbia Translational Research Institute on Pain in Later Life will be a community-centered effort expected to reach more than 300,000 seniors in the New York metro area. "Pain is a prevalent, costly, and woefully under-addressed cause of suffering in older adults," says Cary Reid, MD, PhD, the Joachim Silberman Family Clinical Scholar in Geriatric Palliative Care. "Its deleterious consequences are far-reaching and include impaired quality of life and sleep, as well as decreased immune function, cognition, and mobility. Through the Institute's expanded nexus of participating researchers and care providers, we will be able to implement an array of new interventions aimed at improving the health and well-being of older New Yorkers in pain."

Pardes to Retire as NewYork-Presbyterian Hospital President

Herbert Pardes, MD, will step down as president and CEO of NewYork-Presbyterian Hospital next year, trustee chairman John Mack has announced. In a message to the NYP community, Mack praised Pardes—who has led the hospital since January 2000—for his "unique energy, deep compassion, and executive leadership skill," noting his successful shepherding of the hospital merger, his ability to instill a patient-focused culture, and the implementation of health programs to serve residents of Northern Manhattan. Pardes will remain in his position until the end of 2011, to smooth the transition to a new executive, and will continue to play a vital role in the hospital beyond that time. A psychiatrist, Pardes is former dean of the Columbia medical school. "While Dr. Pardes certainly measures his success by the quality of care that every one of our patients receives each day," Mack said, "the strong performance that NewYork-Presbyterian has delivered across the entire organization is a powerful testament to his achievements as a leader."



HANNAH THOMSON

Medal of honor: Joan and Sanford Weill accept the Carnegie Medal of Philanthropy.

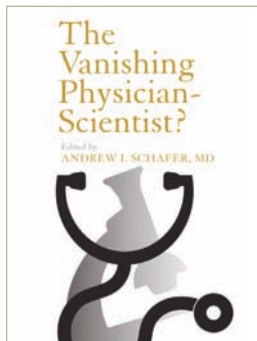


PROVIDED

Evelyn Attia, MD

MDs Doing Less Research, Book Argues

The diminished role of physicians in medical research is the subject of a new book edited by Department of Medicine chairman Andrew Schafer, MD. Published in December by Cornell University Press, *The Vanishing Physician-Scientist?* chronicles a movement away from bench research by MDs and offers ideas for spurring their participation. "In the last thirty years, there has been a dramatic increase in the number of non-physician PhDs conducting medical research that starts in a laboratory, while the number of physicians in academic medical centers conducting research has declined," says Schafer, physician-in-chief at NYP/Weill Cornell. "This is a major shift from the previous era, when physicians often initiated research based on patient observations and led the research effort from clinical studies to laboratory work."



Hospital Power Plant Goes Green

In November, NYP/Weill Cornell unveiled the first hospital-based co-generation plant in Manhattan. Located at 70th Street and York Avenue, the plant will generate 60 to 100 percent of the medical center's electricity and help fulfill its pledge to decrease carbon emissions 30 percent by 2018. The 7.5-megawatt plant burns natural gas to generate electricity, then captures heat from the turbine to create steam for heating and cooling. It will cut 20,000 tons of pollu-

tants per year and save millions of dollars. Says NYP executive vice president Steven Corwin, MD: "The Medical College is a direct beneficiary of this technology since it shares power and heating systems with the hospital, its next-door neighbor on York Avenue."

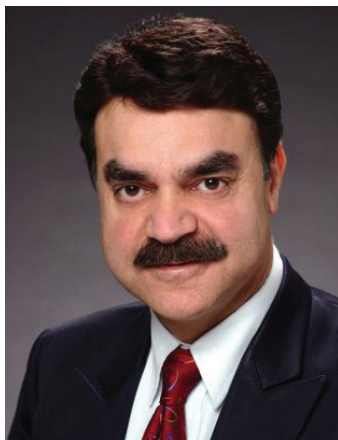
Center Unites Physicians and Engineers

The National Cancer Institute is funding a new Center on the Microenvironment

and Metastasis, which will be headquartered at Cornell University in Ithaca in partnership with Weill Cornell and the University at Buffalo. One of twelve nationwide, the \$13 million research center will focus on using nanobiotechnology and other physical science approaches to advance cancer research. "By partnering engineers with physicians, this grant is, in essence, inviting a whole new discipline of scientists to the cancer table," says Barbara Hempstead, MD, PhD, co-chief of the Division of Hematology and Medical Oncology, who will serve as senior co-investigator. "Through this innovative collaboration, we hope to gain new insights into how cancer cells migrate and form malignant metastases."

Corrections

"To Shatter the Ceiling" (Fall 2009) included an incorrect title for Randi Silver, PhD. Her correct title is associate dean of the Graduate School. In the same issue, we mistakenly omitted the name of David S. Blumenthal, MD '75, from our list of 2008–09 donors. We are most grateful for the long-standing, generous support of Dr. Blumenthal and sincerely regret this oversight.



Javaid Sheikh, MD

Sheikh Named Dean of WCMC-Q

Javaid Sheikh, MD, interim dean of the Qatar branch since January 2009, has been appointed to the position on a permanent basis. A psychiatrist with expertise in anxiety disorders, Sheikh joined WCMC-Q in 2007 as vice dean for research. He succeeds Daniel Alonso, MD, the branch's inaugural dean.

TIP OF THE CAP TO...

Peter Adamson, MD '84, a pediatric oncologist at the Children's Hospital of Philadelphia Research Institute, named head of the Children's Oncology Group, which unites more than 5,000 experts in the field worldwide.

Ronald Arky '51, MD '55, dean of curriculum at Harvard Medical School, winner of the Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award from the AAMC.

Psychiatry chairman **Jack Barchas, MD**, recipient of the Academy Plaque for Exceptional Service from the New York Academy of Medicine.

Joseph Fins, MD '86, chief of the Division of Medical Ethics, elected president of the Amer-

ican Society for Bioethics and Humanities.

Public health chairman **Alvin Mushlin, MD**, elected to the American Clinical and Climatological Association.

Elizabeth Nabel, MD '81, named president of Brigham and Women's/Faulkner Hospitals. Nabel was also selected as a torchbearer for the relay leading up to the 2010 Vancouver Winter Olympic Games.

Gene Resnick '70, MD '74, winner of the Outstanding Alumni Award from Cornell's College of Agriculture and Life Sciences.

William Schaffner, MD '62, given the American College of Preventive Medicine's Ronald Davis Special Recognition Award for his public health leadership.

FROM THE BENCH

Conference Examines Medical Consequences of War

The toll of war on psychological and neurological health was the subject of the Association for Research in Nervous and Mental Disease's annual meeting, held at the Rockefeller University in December. Organized in collaboration with NYPH/WCMC, the event featured a talk by a Marine colonel and panel discussions on topics such as the treatment of traumatic brain injury and the use of emerging technologies to aid PTSD patients. "In the context of ongoing military conflict and extremist violence in Iraq, Afghanistan, and elsewhere, it is ever more important

that we work to ameliorate the consequences of war as it affects the physical and mental health of combatants and noncombatants alike," says Jack Barchas, MD, conference coordinator and chairman of psychiatry at Weill Cornell. "At the same time, we endeavor to better understand and address some of the underlying motivations that perpetuate violence."



Jack Barchas, MD

Laparoscopy Successful in Rectal Cancer Patients

In a seven-year study of 103 patients, researchers at NYPH/WCMC have found that minimally invasive surgery is as effective in rectal cancer cases as the traditional open procedure. "More than 90 percent of the patients in our study were able to undergo laparoscopic surgery successfully," says Toyooki Sonoda, MD, one of the study's lead surgeons. "We define 'success' in both the short- and long-term sense: More than 95 percent emerged with an intact and functioning rectum and, as expected after a minimally invasive procedure, recovered rapidly. None had cancer-positive tumor margins, which has been a major concern in the medical literature all along. In fact, after five years, overall survival has remained high at 91 percent, with more than 73 percent of patients completely free from disease." The results were reported in the journal of the American Society of Colon and Rectal Surgeons. Researchers at Weill Cornell and elsewhere are following up with larger, randomized studies.

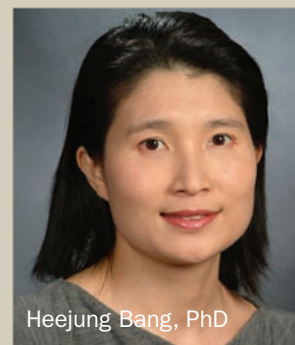
New Compound Shows Promise for Non-Hodgkin's Lymphoma

Nature Medicine has published findings on a newly discovered molecular mechanism that may offer a target for treating non-Hodgkin's lymphoma. The work in lab testing and animal models by Weill Cornell associate professor of medicine Ari Melnick, MD, and colleagues has led to an upcoming clinical trial on a compound, PU-H71, that is part of a new class of drugs called heat shock protein inhibitors. With current treatment—which includes chemotherapy, radiation, and monoclonal antibodies—only about half of non-Hodgkin's lymphoma patients are cured. "We observed almost complete tumor regression after treating the animals with PU-H71," says Melnick. "I hope that clinical testing will have similar results for human participants."

Questionnaire Could Catch Undiagnosed Diabetes

A new screening tool aims to boost early detection of diabetes, which currently goes undiagnosed in nearly a third of patients. The simple, six-item questionnaire rates risk factors such as age, gender, and exercise level; those with elevated scores are instructed to consult their physicians for further testing. It was developed via statistical analysis of data on more than 5,000 American adults compiled by an arm of the CDC.

"Our goal was to develop an accurate and easy-to-use screening tool that can be used in a wide variety of community and clinical settings, including patient waiting rooms or online, or by using pencil and paper," says lead author Heejung Bang, PhD, associate professor of biostatistics in public health. "By highlighting risk factors for diabetes, this tool is designed to motivate people to be screened, or at least to spark a discussion with their doctor and encourage them to adopt a healthier lifestyle."



Heejung Bang, PhD

WEILL CORNELL ART & PHOTOGRAPHY

NIH Award Funds Work on Novel Testing Tools

Pharmacology professor Samie Jaffrey, MD, PhD, has received a five-year, \$1.7 million grant known as an NIH Director's Transformative R01 Award—given to "encourage investigators to explore bold ideas that have the potential to catapult fields forward and speed the translation of research into improved health." The award, one of forty-two given by the NIH totaling \$30 million, will fund Jaffrey's work on methods to speed up lab testing by instantly measuring proteins within biological samples. His lab is developing new tools that rapidly emit light upon binding with specific target proteins. "The ability to simply add a sensor to a biological sample, and monitor the level of a given protein in minutes, would allow clinical diagnosis and medical decision-making to occur much more rapidly," Jaffrey says.

Consensus Reached on Value of Diabetes Surgery

In November, the findings of the Diabetes Surgery Summit were published, offering a consensus statement on treatment for the disease. Participants at the meeting, which was held in Rome and included dozens of experts in the field, recommended that the criteria for bariatric surgery be expanded to include diabetic patients who are not clinically obese. "With an emphasis on caution and patient safety, the position statement boldly advances a revolutionary concept: the legitimacy of gastrointestinal surgery as a dedicated treatment for type 2 diabetes in carefully selected patients," says lead author Francesco Rubino, MD, director of the gastrointestinal metabolic surgery program at NYPH/WCMC. "The recommendations from the Diabetes Surgery Summit are an opportunity to improve access to surgical options supported by sound evidence, while also preventing harm from inappropriate use of unproven procedures."

Talk of the Gown

Insights & Viewpoints



What's Cooking?

In the Burn Center's rehab kitchen, it may be nachos—
or virtual minestrone

Weill Cornell Medical Center's Greenberg Pavilion may seem an unlikely place for cooking, but that's just what occupational therapists and patients were doing there one morning in late fall. Held on the eighth floor in the William Randolph Hearst Burn Center, the cooking group is designed to help people recovering from burn trauma exercise their healing bodies and re-acclimate to the kitchen.



JOHN ABBOTT

Cooking light: Senior physical therapist Sam Yohannan (left) watches certified occupational therapy assistant Kimberly Hill and patient Ebony Mohammed cook on a virtual stove using the Wii game system.

The weekly program was started eleven years ago with the help of Kimberly Hill, a certified occupational therapy assistant whose goal was to get patients out of their rooms—and give new meaning to the term “hospital food.” The menus run the gamut from snacks to desserts; the main criterion is for the dishes to have enough steps to give patients an opportunity to move their bodies while they become re-accustomed to working near the stove, where some of them were injured.

Such was the case with Taciana Stewart. Stewart sustained burns to her torso as the result of an accident with a pressure cooker—but she approached the rehab kitchen without hesitation. A nineteen-year-old student from Brooklyn, Stewart has been hospitalized since the beginning of October, and admits that the daily routine of the burn unit can at times get monotonous. She says she’s thankful her injury wasn’t worse, and she’s ready to get back to her life. “Can we turn this up?” Stewart asks when tasked with scrambling eggs at the unit’s electric stove. She admits she’s not an avid cook, although being in the group may change that. “I’ve never made scrambled eggs before, and now I know how,” she says. “Plus you get a chance to meet other patients and get out of your room.”

Her reaction is exactly what Hill hopes for. She and Burn Center director Roger Yurt, MD, have evaluated the effectiveness of the group by asking participants to rate whether it reduced their anxiety in the kitchen and distracted them from pain they might feel during movement. The results, which appeared in the *Journal of Burn Care & Research* in spring 2007, were positive. “There is definitely some apprehension with patients who were burned in the kitchen,” says Hill. “This is a controlled environment, and one of our goals is for patients to go home and feel comfortable. I might give them a task near the stove, not necessarily build up to tasks that are closer to the stove. Once they feel comfortable with that, they can go on to the next step, like putting a tray of nachos in the oven.”

In the hope of expanding the benefits of such courses beyond the rare burn units equipped with kitchens, senior physical therapist Sam Yohannan has been exploring a technological alternative. After the #44 Engine of the Fire Department of New York donated a Nintendo Wii console to the same rehab gym that houses the cooking group, Yohannan began using a

game called “Cooking Mama: Cook Off” as a novelty treatment. He and Yurt were intrigued enough by the results to launch a study comparing the benefits to patients who used the Wii versus the real-life version. “I think it complements the standard group,” Yurt observes. “Patients are diverted from the pain they may be feeling, and they’re able to do repetitive movements for longer.”

In the game, players choose a dish they want to cook—choices range from flan to sushi—then use the handheld “Wii-mote” to mimic the actions needed to peel and chop vegetables, stir pots, and plate the finished items. Therapists use this game, which may require standing and twisting, to help prevent scar tissue from stiffening as it forms. The versatility of the virtual group also makes it an appealing alternative to traditional therapies. “We’re noticing benefits to the virtual cooking group, such as improved socialization and participation,” says Yohannan. “We can also bring the game into a patient’s room and work one-on-one to distract them from their injury.”

Stewart, it turns out, is already a pro in the virtual kitchen, having played the game at home with her younger sister. She handily turns out a complex—albeit imaginary—minestrone. “It’s a fun game, and it’s more competitive than the regular cooking group,” says Stewart, twisting her arm sideways to take the skin off a pixelated potato. The irony isn’t lost on the group. When another patient cringes at the idea of peeling skin, they burst into laughter. “Ultimately, we want our patients to go back to the activities of daily life,” says Yohannan, “and cooking is a large part of that.”

The study subjects take part in both the real and Wii groups, then complete a questionnaire that asks them to rate, on a scale of one to five, the benefits of each. The review also takes into account how effective the group is at reducing their stress in the kitchen and distracting them from the pain of movement. While the Wii can be helpful with younger patients like Stewart, those who aren’t familiar with gaming have a steeper learning curve. Back in the regular group, another benefit becomes apparent as the smell of cranberry bars wafts out of the oven. “You get to eat food in the traditional cooking group,” Yohannan says. “That can be hard to compete with—but at least with the virtual group there’s no cleanup.”

— Liz Sheldon

The Bionic Man

Colonel Geoffrey Ling wants to create a robotic human arm—and that's just one of his big ideas

This is not a project for the faint of heart," says Colonel Geoffrey Ling. Ling, MD, PhD '83, is an Army officer, a neurologist, and a master of understatement. The effort he's spearheading aims to create nothing less than a functional, lightweight robotic human arm—and fast. Ling works for the Defense Advanced Research Projects Agency (DARPA), where he and a team of collaborators are bringing prosthetics into the twenty-first century. But unlike many civilian research projects, Ling's work isn't open-ended. With hundreds of Iraq and Afghanistan war veterans returning with lost limbs—due in part to the advances in body armor that saved their lives—the mandate is to have the arm in clinical trials with all deliberate speed. "Upper extremity limb replacement has not really progressed since the days of Captain Hook," says Ling, who has served in combat support hospitals in both conflicts. "What it needed was a concerted, goal-oriented effort to move prosthetics research forward."

One of those goals has already been met. As viewers of "60 Minutes" saw last April (and again when the story was rebroadcast in September), the first iteration of a prosthetic arm—devised in just twenty-four months by the same engineer-

ing firm that created the Segway—has been delivered and is now being tested in collaboration with the Department of Veterans Affairs. On the TV program, the VA's head of prosthetics, Fred Downs, was shown using the arm to pick up a soda bottle and drink from it. Since being injured by a landmine in Vietnam, Downs had worn the same type of hooked arm that has been issued to veterans since World War II. "The feeling is hard to describe," Downs said on the show. "For the first time in forty years, my left hand did this. I almost choke up saying it now."

The prosthetic that Downs wore—Ling calls it the "strap and go" arm—is controlled by flexing shoulder muscles and pressing buttons concealed in a shoe. But another version, due forty-eight months after the project's launch, is planned to work with a surgically implanted neural interface. "What I like about this is that it's a program of choice," says Ling. "A patient may say, 'I don't want surgery. I want something I can just put on and get a good level of function.' Another patient may say, 'I'm a concert pianist' or 'Working a keyboard is critical to me,' so they're willing to get surgery for a neural interface. All of these arms are modular; if you've lost your hand, your arm above the elbow, or your whole arm, we've got a replacement for you."

The prosthetics research is just one of the many projects Ling has initiated at DARPA—where, he notes, "I get graded by how many new ideas I come up with and how many new research projects I execute." Others include work on traumatic brain injury, for which he drew on lessons learned from his grad school professors. "They would always challenge me to ask: What's the mechanism? What's the underlying process? So I took a look at this blast-brain problem and said, where is the first principle? Nobody knew. DARPA allowed me to start an effort where we were trying to elucidate the basic mechanism of how the brain is injured—from a molecular, structural, and clinical standpoint—by explosive blasts."

That work, by collaborators at institutions including Walter Reed Army Institute of Research, Harvard, Yale, and Johns Hopkins, comprised more than 240 blast experiments. In DARPA fashion, the project was goal-oriented and finite, lasting just twelve months. "They

Arms race: Colonel Geoffrey Ling, MD, PhD '83, greets a patient testing DARPA's new robotic prosthetic limb.



DARPA

defined what is a limited traumatic brain injury, what is moderate, what is severe. And they did this on the cellular, biochemical, macro-anatomical, and critical outcome levels. They know when the brain starts to react negatively to a blast explosion. They know the level of it. They know what that first response is—it's inflammatory, not unlike any other trauma, like spraining your ankle."

Just as DARPA's creation of global positioning systems led to cell phones that offer turn-by-turn directions, Ling is confident that the work on injured soldiers will soon point the way to civilian treatments. Researchers are currently working to identify drugs to mitigate brain trauma, which he says could be as simple as anti-inflammatories like Motrin. "If your son or daughter has a mild brain injury from a sporting event, your local emergency department has nothing to offer," he says. "But at the end of next year, I bet the drug that we give to our soldiers will be available to kids who get soccer injuries."

As ambitious as the prosthetics and brain injury initiatives are, Ling says they're just the tip of the iceberg. "I've got a lot of projects," he says, "some of them pretty wacky." Another he's especially passionate about is called PHD, for Predicting Health and Disease. Researchers, including collaborators at Duke, are working to devise a pinprick blood test that can diagnose impending illness—be it cancer, heart disease, or viral infection—while it's still subclinical. The team has already published the results of a study in which healthy volunteers were exposed to three types of viruses, those causing influenza A (H3N2), bronchitis (RSV), and the common cold (rhinovirus). "After one year, we found biochemical markers that are classic for being exposed to a virus and also submarkers that say it's H3N2, RSV, or rhino," he says. "And get this: within a few hours of exposure, we can tell who will get sick and who will not—and who will ultimately become contagious." The work, he says, has profound implications for management of outbreaks like H1N1 influenza. "If I knew you would be sick, I could treat you with Tamiflu right away—and I'd need a lot less to cure you because your viral load is so low," Ling says. "You'd never lose a day of work. Even though you were destined to be sick, I could change that by treating you early. It changes the definition of illness."

After completing his PhD in pharmacology at Weill Cornell, Ling did a postdoc at

Sloan-Kettering, then returned to the Graduate School as faculty; he joined the Army in 1985 to finance his MD at Georgetown. Having fulfilled his military commitment, he was pondering leaving the service when the September 11 attacks occurred. "It changed everything," he says. "Here I was in uniform, about to get out, and then 9/11 hits. So I stayed in, and it was a smart decision. I was able to respond meaningfully—to go to war and be a doctor for these kids, as

well as do research that I think is going to help them." At Weill Cornell's 2009 Commencement, Ling was honored for his efforts with the Graduate School's Distinguished Alumnus Award. "The research that DARPA is enabling is not just for the military or for Americans," he says. "This is the American taxpayer providing the resources, and American scientists and engineers providing the intellectual horsepower, to advance medicine in the whole wide world."

— Beth Saulnier

Trash to Treasure

Saving lives with America's unwanted medical supplies

At the 2005 Clinton Global Initiative, former President Bill Clinton asked participants to help the developing world—and Bruce Charash, MD '81, took the request to heart. He founded Doc to Dock, a nonprofit that sends surplus medical supplies from America to needy countries. The organization collects two types of donations: new disposable supplies and used equipment. Although used disposables—such as gloves, syringes, and IVs—must be thrown away for regulatory reasons, he notes that hospital beds and other capital equipment are often discarded just because they aren't shiny enough. "It's amazing how much is thrown out that is still perfectly good," says Charash, a cardiologist at Lenox Hill Hospital, noting that 7,000 tons of supplies are disposed of every day in the U.S. "Our philosophy is that, if someone's dying across the world who needs these things, it's immoral to send them to a landfill."

Doc to Dock conducts needs assessments at more than 300 hospitals in a dozen developing countries, mostly in Africa; with the help of other nonprofits in the U.S. and abroad, it ships containers filled with everything from surgical kits to sonogram machines. The organization depends solely on contributions, collecting money from donors—which it uses to cover shipping costs—and surplus supplies from hospitals. "For every dollar we collect, we're able to supply twenty times that in medical supplies," says Charash, who earned an undergraduate degree from the Ithaca campus in 1977.

Charash frequently visits the recipient countries, where he gets a firsthand look at the impact of Doc to Dock. After sending one of the nonprofit's first containers to Benin, a stable democracy in West Africa, Charash met a four-year-old boy who was gravely ill with malaria. The anti-malarial drug was in a storage room nearby, but the hospital had no intravenous lines available. The Doc to Dock package, containing more than 200 IV lines, arrived just hours after Charash met the boy, who survived. Since then, Charash estimates that thousands of lives have been saved by the organization's efforts. Says Charash: "Like our tagline says, 'Convert surplus into survival.'"

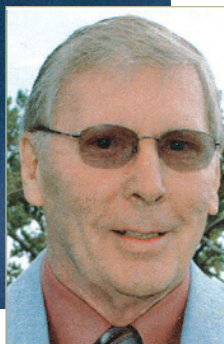
— Rebecca Coffman



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James Ketchum, MD '56

Long, Strange Trip

A former Army psychiatrist chronicles government research into psychedelic weapons

A couple of hours after taking the drug, the patient was unsteady on his feet. By hour seven, he wouldn't sit still for a blood test. Not long after that, he was drawing in the air with an invisible pencil and making music on a nonexistent violin. "Playing with small imaginary animal in palm of hand, telling it to be good," observers noted in his chart at hour 43:35. "Removed sheet from bed. Picked up mat-

tress and put it off angle to box springs." Then the patient announced: "Holy hell, I've got to get home and help milk the cows!"

The chronicle of the man's seven-day foray into psychedelia is just one chapter in a detailed account of the U.S. Army's Sixties-era research into hallucinogenic drugs, by a physician who spent a decade in the program. Entitled *Chemical Warfare: Secrets Almost Forgotten*, the text-

book-sized hardcover was written by former Army psychiatrist James Ketchum, MD '56. Now retired and living in Santa Rosa, California, Ketchum worked at Maryland's Edgewood Arsenal from 1961 to 1971, conducting research on hallucinogens that might be used to subdue the enemy. "I felt we were doing a noble thing, possibly providing an option to more lethal weapons in the field," he recalls. "I didn't have any qualms. It was a positive, patriotic mission approved from the top." Ketchum cites an Army general who offered Congress a vision "of this new drug 'LSD' being released over a small city, causing everyone to be temporarily disabled—making it possible to go in and round up bad guys, and then everyone would return to normal."

Run from 1955 until the early Seventies, the program tested more than two dozen drugs, including LSD and synthetic marijuana. Its most viable pharmacological weapon was 3-quinuclidinyl benzilate (BZ), a member of the belladonnoid family—the drug that the mattress-skewing patient was given in February 1963. That test subject, a soldier whom Ketchum calls John Blake, was injected with BZ and spent the next seven days in a padded room under close observation. At times there were glimpses of lucidity, but for much of the experiment he was all but incapacitated—wetting his pants, talking nonsense, and failing a battery of performance tests. In any event, he was incapable of making war on anyone. "The atmosphere in the Sixties was quite different," Ketchum notes. "The Cold War was a real thing; everyone was anxious about having to face the Soviet Union. So what we were doing was viewed as a reasonable response to the threat. It wasn't until the Vietnam War began to change public sentiment that we had any real problem, and the Army decided to pull in its horns and not do any further testing."

It took Ketchum four years to write the book, which runs 360 densely packed pages and weighs in at three-and-a-half pounds. (Although it includes some formerly classified material, Ketchum says that as a civilian he was free to write about the program, though there would have been restrictions had he still been on active duty; he left the Army in 1976 and went on to private and clinical practice.) He had long been meaning to chronicle the drug research, Ketchum says, but the September 11 terrorist attacks spurred him to start writing. "I realized that there was going to be a lot of concern about chemical weapons, so I thought the story of

what we did in the Sixties ought to be available to the public," he says. "That was my primary motivation—trying to reconstruct that period from the inside."

When he didn't find interest from publishers, Ketchum opted to self-publish the book and sell it via his website, forgotten secrets.net; he says he's sold about 600 copies and distributed 300 more. It has attracted some national media attention, including a piece in *USA Today*. "I've had surprisingly positive reactions from various quarters," he says. "The Army actually liked what I did, even though I didn't have official clearance. And I've had good reviews from people in the counterculture, many of whom I've become acquainted with, including two who made underground LSD in the Sixties. So I've made some new friends."

One of Ketchum's main goals in writing the book was dispelling what he calls a common misconception about the Army's drug program: that its experiments were conducted on unwilling subjects, hapless soldiers who hadn't given informed consent. "We probably gave more information and opportunity to choose to participate than most civilian programs," he says. "You had to go through a number of hoops to get into the program to begin with. Only one of four was chosen. Their reactions during testing were very positive—a number of them saying they enjoyed the experience and would like to come back. So I don't think it's fair to say that these individuals didn't know what they were getting into."

Another point that Ketchum emphasizes is that the Army and CIA programs on chemical weapons were separate entities; the CIA, he notes, did dose unwitting subjects with drugs like LSD, in some cases causing lasting harm. "The Army program was basically a scientific research project designed to find a low-lethality weapon that could be used in the field and reduce casualties," he says. "The CIA's goal was to find a drug that would change people's personality and behavior—in other words, put them under control of the CIA agent. That was an entirely different goal."

So did Ketchum ever try the drugs himself? Just once, he says, and it wasn't much to write home about. "I took eighty micrograms of pure LSD in the way volunteers were tested, in the same environment with performance tasks to carry out," he says. "But I didn't get any major hallucinations, so it was little anticlimactic. I really wanted to see what an LSD trip was like."

— Beth Saulnier

Secret Identity

A cardiologist solves an eighteenth-century mystery

As medical mysteries go, cases don't get much colder than that of "Dr. Anonymous," the nameless patient who went unidentified for more than two centuries. The puzzle's solution, by a Weill Cornell cardiologist, was the result of a quarter-century of research—and more than a little luck. "The strange case of 'Dr. Anonymous' is a tale of discovery, of medical history, of bibliomania and serendipity," says Paul Kligfield, MD, who described how he and medical student Konrad Filutowski solved the mystery in a Heberden Society lecture at Weill Cornell in October.

The tale begins with William Heberden, the elder (father of the namesake of the society, established in 1975 to promote interest in the history of medicine). Heberden was a London physician who was among the most famous of the late eighteenth century. In 1772, he published "Some Account of the Disorder of the Breast" in *Medical Transactions* of London's Royal College of Physicians. Heberden's description of angina pectoris due to coronary artery atherosclerosis has been described as "the most concise and precise original description of disease in the history of medicine."

Soon thereafter, Heberden received an anonymous letter that described the correspondent's own chest pain, along with associated palpitations, in extraordinary detail. (It was so clear that Kligfield can diagnose it today: ventricular arrhythmia with postextrasystolic potentiation.) The anonymous author expressed fear that he would die suddenly and offered his body for autopsy, in a benevolent attempt to help uncover the cause of the disease. Indeed, three weeks later, the correspondent died; his will requested that Heberden be notified. Heberden reported the results of the autopsy by the noted surgeon John Hunter in *Medical Transactions* in 1775.

Over the next 200 years, scholars speculated about who the correspondent—who became known as "Dr. Anonymous" because of the medical language in his letter—might have been. Guesses abounded, but no one made a definitive identification. Then, while nosing around a London bookshop in 1982, Kligfield found a first edition of *Medical Transactions*, which included a reprint of the correspondence. Under the closing salutation "Unknown," this was written in a neat eighteenth-century hand: "Mallet/formerly of Exeter."

Kligfield and Filutowski searched the *London Evening Post* obituaries for a Mallet who had died three weeks after the date of the original letter. Sure enough, the paper had reported the death of "Mr. John Mallet, formerly of Exeter, merchant." Eventually, Mallet's grave was located in a cemetery in central London—and a 1770 edition of *Baldwin's Complete Guide*, essentially a *Who's Who* of London business of the period, listed "John Mallet, formerly of Exeter" as a prominent merchant who lived on Aldersgate Street, not far from the cemetery in which he was buried. Subsequent investigation by Kligfield, including talks with contemporary members of the Mallet clan, established John Mallet as a grocer of substantial means. So, as Kligfield discovered, for all his storied history in the annals of cardiology, "Dr. Anonymous" was no doctor at all.

— Gabriel Miller



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Numbers Up

Recruitment efforts enrich the pool of prospective PhDs

This year, almost 700 prospective students applied to the PhD programs at the Weill Cornell Graduate School of Medical Sciences, reflecting a 50 percent increase in applications from just four years ago. Under the leadership of Dean David P. Hajjar, PhD, enrollment has also doubled over the past ten years. Randi B. Silver, PhD, the associate dean of the Graduate School, says a number of new recruiting initiatives have helped to get out the word about the School and its seven doctoral programs. “We’ve been reaching out by hosting an open house each fall for students from the tri-state (New York, New Jersey, Connecticut) area, introducing students from other parts of the country to the School through our summer programs, and enlisting our current students as ambassadors who talk with prospective students at recruiting events,” says Silver. “Over time, these efforts have made a difference.”

The Graduate School’s admissions process identifies undergraduates with strong science backgrounds by seeking students with high GPAs and asking colleagues at other institutions, including the Cornell campus in Ithaca, for recommendations. They send out personalized letters and encourage the students to explore the Graduate School’s website, which was relaunched in 2009 with an updated design and more user-friendly navigation.

Several of the new initiatives are aimed at encouraging more underrepresented minority students to apply. Along with Francoise Freyre, the assistant dean, Silver makes presentations about the School to science undergrads at the campuses of the City University of New York (CUNY). For example, they speak to students in the Minority Access to Research Careers program—an NIH-funded honors program that helps prepare students interested in



JOHN ABBOTT

Grad student life: Kelly Yule, who works in the Sloan-Kettering lab of molecular biologist Prasad Jallepalli, MD, PhD

biomedical research to apply to graduate school—at the City College of New York, Hunter College, and Brooklyn College. Freyre and Silver also attend the Annual Biomedical Research Conference for Minority Students, where they meet with potential applicants from across the country. “We talk with students who may not have considered a doctorate and make them aware of our programs,” says Silver. “That has increased our applicant pool as well.”

For more than a decade, the Graduate School has offered a ten-week summer internship program for underserved students who have excelled in their sophomore or junior years in college. Participants in the program, called Summer Access, conduct basic research in labs at the Medical College or Graduate School and attend lectures, workshops, and journal club meetings.

Over the past few years, the program has increasingly focused on recruiting and selecting students who are interested in pursuing a PhD rather than an MD, and as a result more Summer Access alums have been applying to the Graduate School. The Tri-Institutional MD-PhD program hosts a similar summer program called “Gateways to the Laboratory” for underrepresented minority and disadvantaged college students who are interested in pursuing the dual degree.

When speaking with prospective students at recruiting events, members of the admissions team describe the unique partnerships the Graduate School has with neighboring institutions and point out that PhD candidates are free to work with any faculty member affiliated with the School, including those at the Sloan-Kettering Institute, the Rockefeller University, and Hospital for Special Surgery. “There’s an openness and flexibility here that’s a real draw for students,” says Silver. “If they’re interested in stem cell

research or angiogenesis or neurological diseases, there’s more than one lab for them to choose from.” For Jeffrey Russ, a second-year MD-PhD student, that was a key reason he chose the Tri-Institutional Program. “Because of the collaboration with nearby institutions and all the opportunities to talk with their faculty members at lectures and other events, you are exposed to so many more ideas and research approaches,” says Russ.

Silver says that the Graduate School aims to recruit more students from other countries and is exploring the possibility of creating new programs or events that would introduce them to the School. In November, her team traveled to India in an effort to develop relationships with outstanding universities there. “We want to identify top students who are interested in biomedical research,” she says, “wherever they may be.”

— Jen Uscher

Heart of the Matter

For cardiologist Holly Andersen, it's all about prevention

Holly Andersen, MD, says that when she was offered the position of director of education and outreach at the new Ronald O. Perelman Heart Institute, she pondered taking the job for about thirty seconds. The opportunity to champion prevention, to reach people *before* they fell ill, was irresistible. “No one pays doctors to prevent disease,” she says, citing an insurance system that necessitates seeing more patients in shorter periods of time just to make ends meet. “As a physician, it’s incredibly frustrating.”

When Andersen accepted the position, she added the Institute’s goals to an already crammed dance card. She has 2,600 active patients in her Weill Cornell cardiology practice, consults for news shows (on ABC, NBC, CBS, Fox, MTV, and the BBC), hosts medical webcasts, blogs for two websites devoted to women’s issues, and sits on several boards, including that of the Michael J. Fox Foundation for Parkinson’s Research. On a typical day, Andersen might field questions about the flu for “Good Morning America” and then turn the microphone around to interview cardiologists for ORLive, a website for physicians and surgeons. But she most often focuses on her personal passion: women’s heart health.

Fifteen years ago, as a senior resident at Weill Cornell, Andersen started talking about gender differences in cardiac disease. It took nearly another decade for research to quantify what Andersen already knew: that men’s and women’s bodies react differently to heart disease. In 2003, the American Heart Association published research documenting that nearly 43 percent of women do not experience chest pains during a heart attack, and that women more often complain of heartburn, neck and jaw aches, fatigue, and breathlessness than their male counterparts. Since then, more differences have been documented. For reasons that remain largely unidentified, women having a heart attack take longer before calling 911, are 55 percent more likely to suffer a delay getting to the hospital after medical help arrives, and are less likely to have certain diagnostic tests than their male counter-



JOHN ABBOTT

Holly Andersen, MD

parts. Andersen’s to-do list now includes implementing a tracking system at Weill Cornell to identify why female patients exhibit such dramatic differences in the emergency response process.

Ideally, Andersen would like to improve women’s health through prevention, and her position at the Perelman Institute has given her the opportunity to do so. Located at the heart of Weill Cornell, the Institute is architecturally centered around a five-story atrium. The design gives patients a view of a Chinese garden with trees, lit by natural light—but it’s also intended to be a hub of education and outreach. The counseling and prevention area has interactive computer kiosks that provide in-depth health information. On weekdays, anyone can speak with a dedicated, full-time nurse educator about medical procedures and seek advice on preventing cardiovascular disease. “When patients

come in with a heart attack,” Andersen observes, “their families and friends are a captive audience whom we can try to teach about prevention.”

Andersen and her staff—along with nurses volunteering their time—have also been brainstorming ways to reach out to a broader audience. A Perelman-specific website is in the works, and Andersen wants to create more webcasts and Internet-accessible videos about heart disease and prevention. She also sees a huge opportunity to promote the automated external defibrillator, an easy-to-use device that can increase the chances of surviving cardiac arrest from 6 percent to 36 percent. In the meantime, Andersen will continue to spread the word about the importance of quitting smoking, eating well, getting enough sleep, managing stress, and controlling weight. Says Andersen: “Everything that’s good for your heart is good for your life.”

— Shelley Stuart

The Wide World

With students more eager than ever for experiences abroad, global health has become a major force in medical education

By Beth Saulnier

Joe Alsberge comes from a family of physicians—his father and grandfather were doctors—but it wasn't until he worked with an environmental conservation group in Ecuador after high school that he seriously considered following in their footsteps. "I was working at a biological field station in the western lowlands, and I met a German doctor who was doing work on malaria in the local community," recalls Alsberge, who grew up on an island near Seattle. "That struck me as something interesting and compassionate to be doing. It was the first time I got really excited about medicine."

After studying premed and cultural anthropology at Lewis & Clark, Alsberge applied to medical schools. He got into Weill Cornell—and promptly asked for a two-year deferment so he could travel to Burundi. In the East African nation, he helped establish a clinic in a remote area, where he worked to conduct needs assessments, manage community health workers, and launch programs in nutrition and food security. Now a first-year, Alsberge says that going abroad has immeasurably enriched his medical studies. "The global health experience can open your eyes to health-care injustices," he says. "What's going on in places like Burundi is just unconscionable. There's absolute poverty and lack of health care, and people are dying of readily treatable and preventable diseases. In my mind that shouldn't be happening in 2010. When you go over there young you make an



PROVIDED BY JOSEPH ALSBERGE

Home visit: During his time in Burundi before medical school, Joey Alsberge '13 went out into the community to meet local families, learn about their needs, and tell them about the clinic he was helping to found through the nonprofit Village Health Works.

early connection, before you get into a career that may not allow you to do that later in life."

Alsberge praises the Medical College for granting him the deferment without a hassle or miles of red tape. For him, as for many of his fellow students, Weill Cornell's commitment to global health was a major factor in choosing a medical school. "A large percentage of applicants indicate that one of their reasons for applying here is our extensive global health program," says Liliana Montano, assistant dean of admissions. "And many of those who opt to matriculate have already had international clinical experiences and are interested in continuing them."

As of this academic year, interested students can enroll in a dedicated global health curriculum on top of their regular coursework. Spearheaded and designed by students, it includes three courses, attendance at global health grand rounds, a clinical preceptorship with underserved minority populations in New York City, and field

work, either in the U.S. or abroad. "It's really good, because in our regular curriculum we're studying the basis of disease from a biological standpoint, but we don't talk a lot about broader issues like social policy," says Alsberge, fresh from a lecture on health systems by a representative of UNICEF. "The global health curriculum is giving us an opportunity to explore that." According to Madelon Finkel, PhD, director of the decade-old Office of Global Health Education, half of the Class of 2013 has signed up. "It has taken off," she says of the curriculum. "The response has been phenomenal."

In July, the Medical College launched a comprehensive website (weill.cornell.edu/globalhealth) that showcases global health offerings. It includes everything from practical information on affiliated programs abroad to first-person reports from those who've done field work. "In talking with the students, I make the point that we certainly know that they're not all going to go into global health or international medicine," says Warren Johnson, MD, the B. H. Kean



JOHN ABBOTT

Above: Global Health Education head Madelon Finkel, PhD.

Lower right: Medical student Benigno Varela, currently taking time off between third and fourth years, does a physical exam on a sick child in the village of Oyenano, Gabon, about two hours from the pediatric clinic where Varela worked in Lambaréné.

Professor of Tropical Medicine and a longtime advocate for global health issues. “But it can still have a transforming effect on you. It will be something that you’ll carry with you regardless of what you pursue in your future career.”

When Johnson was a medical student at Columbia, his interest in infectious diseases like malaria inspired him to spend three months working at a mission hospital in Liberia. Back then, he says, such trips were highly unusual. “There were few opportunities,” says Johnson, director of the Center for Global Health. “Columbia had a program that would send two students a year to this particular hospital. They paid a little of our transportation, we paid the rest, and we were on our own.”

But these days, for many students, time abroad is an integral part of medical school. Ac-

cording to Finkel, 30 to 40 percent of each class studies outside the U.S. in the final year, and the number of students who take time off after third year to go abroad—eight in 2009–10—is on the rise. “Many undergraduates have gone abroad, either in university or after graduation,” says Finkel, a professor of clinical public health. “So in a sense, the students are driving this whole global health initiative. They’re the ones who are saying, ‘I’ve lived in Africa, I was in the Peace Corps, now I want to continue this as I’m training to be a physician.’ So we’re responding to what the students are demanding, and we’re also opening the eyes of those who haven’t had as much global experience—showing them that as a physician-to-be, you can make a difference.”

Benigno Varela, a native of Puerto Rico who earned his undergraduate degree from Harvard, is currently taking a year off between third and fourth years. Most of that time will be devoted to research, but Varela was also able to spend more than three months in Gabon on an Albert Schweitzer Fellowship. For part of each week, he worked in the pediatrics ward of a hospital Schweitzer himself founded in Lambaréné, four hours from the capital. “I was given a lot of independence, and that was phenomenal,” he says. “I developed confidence in my clinical decision-making.” The rest of his time was spent in outlying villages, treating children who were unable to travel to the hospital. “On those days, I served as the doctor, providing the consultations, which was a huge responsibility,” he says. “It was intimidating at first, but in the end it was the most enriching part of my experience.”

Weill Cornell has a long history of international involvement: one of its earliest female graduates, Ida Scudder, MD 1899, founded India’s Christian Medical College, and the two institutions have been connected ever since.

PROVIDED BY BENIGNO VARELA



Other programs trace their roots to Benjamin Kean, MD, the much-beloved professor of tropical medicine and public health whose influence is still felt sixteen years after his death. "Over the years many of the faculty had programs and interests

globally, but it was diffuse," says Finkel. "When the dean set up the Office of Global Health Education, it became an umbrella to make it more unified."

Today, Weill Cornell has exchange programs and research partnerships with

institutions around the globe. In addition to its own campus in Qatar, the Medical College is affiliated with Weill Bugando, a hospital and newly established medical school in Tanzania. It has a long-standing program in Brazil, training local researchers

'We Live in One World'

A conversation with Warren Johnson, MD,
director of Weill Cornell's Center for Global Health

Weill Cornell Medicine: Why is global health such an important topic in today's world?

Warren Johnson: Disease doesn't recognize international boundaries. That has been most strikingly demonstrated with HIV/AIDS over the past thirty years. People who were prepared to hunker down and disregard what was going on in the rest of the world found out in a dramatic fashion that these diseases traverse borders. We've seen swine flu, bird flu, multi-drug-resistant tuberculosis. And health is broader than just medicine. You have to have proper nutrition, security, education. If you take away any of those elements, it destabilizes the others. It's the recognition that we live in one world. We cannot live in isolation.

WCM: How did your first international experience, at a mission hospital in Liberia during medical school, affect you?

WJ: It opened my eyes to a whole other world, how people live with so little. People are no different the world over. The things they cherish most—their family, their relationships—are no different in a dirt-poor village in Tanzania or Haiti or Brazil than in the U.S. The accoutrements are add-ons, but the basic values—a better life for their children, better education, more work opportunities—are universal. Health is part of that.

WCM: One of your most visible initiatives has been the GHESKIO project in Haiti. How would you sum up its past three decades?

WJ: It was like the development of an infant. You have a newborn who learns to roll over, then crawls, stands, and takes a few steps. In February 2009 I was honored with the naming of the new medical center there. As I said at the time, the Haitian team has persevered through adversity and has thrived. We were told many times that it couldn't be done, let alone be done in Haiti. But it was done, and often for the first time anywhere.

WCM: What are some of the problems being faced by Weill Cornell's newest major affiliate, Weill Bugando Medical Centre and College of Health Sciences in Tanzania?

WJ: This center serves the western third of the country, about 15 million people. It's an 850-bed hospital, and like so many institutions in developing countries, it's resource-poor in terms of personnel. The focus has been on training their students, interns, residents, and assistant medical officers, including a subset we see as future teachers and leaders. We're introducing residents not just to clinical medicine but to research, and a select number are coming to Cornell for training. This year we're sending forty of our senior residents to Weill Bugando, where they're teaching on the

floors in the hospital and classrooms just as they would here.

WCM: At the center you're now heading, how do you define global health?

WJ: We use the definition of health problems that transcend national boundaries, disproportionately affect the resource poor, and are best addressed by multidisciplinary solutions—research, service, and training. This is the target group that we focus on. They have 5 percent of the world's resources and 90 percent of the disease burden.

WCM: What is the center's mission?

WJ: It's a way to say to the institution, the Ithaca campus, and the external community that there is a focus, a place to go within Weill Cornell if you're interested in program development, regardless if it's medical or not. Whether it's someone from the Ag school focusing on nutrition, or someone from the Law school interested in ethics, it's a way to say that we have similar interests and would like to work with you. It's built on the pillars of the three major programs—Brazil going back forty-five years, Haiti going back thirty, and Tanzania four.

WCM: What are the most pressing issues in global health today?

WJ: They haven't changed in the last decade. We still have malaria, tuberculosis, HIV/AIDS. Those diseases are so devastating, in so many countries, that they threaten economic health and political stability. One of the things we're seeing for the first time is that economists at the highest levels are taking a serious interest in global health. When you have that trio of diseases and it's as ravaging as it is in some places—you can lose a third of your school-teachers, your police force, your most productive young adults, leaving 20 percent of the children as orphans—that is devastating to a country.

PROVIDED



Warren Johnson, MD

and clinicians and investigating such diseases as leishmaniasis, leptospirosis, TB, bacterial meningitis, and schistosomiasis. In Haiti, a program founded in the Seventies by Johnson and medicine professor Jean Pape, MD '75, has branched out from its initial work on infantile diarrhea and HIV/AIDS to encompass a wide variety of medical services and social programs. Students seeking an elective abroad can choose from established partnerships with institutions in cities in the developed world such as London, Paris, Vienna, Munich, and Sydney—where participants study comparative health systems—or communities in resource-poor countries like Peru and India. Some opt to go abroad the summer after first year, others for a few weeks during

fourth year, and some do both. “First-years clearly do not have the skills necessary to do any sort of clinical medicine, but they do have the skills to become involved in population-based, epidemiologic studies,” says Finkel. “And certainly when they go abroad in the fourth year, they have the clinical skills to assist in providing care in many of these places.”

For many students, practicing medicine with limited resources offers the chance to hone their diagnostic skills. A major part of the experience is learning to work without the infrastructure of a modern medical center—which is reflected in the fact that one of the global health electives is a joint course with Ithaca-based Cornell Outdoor Education

on wilderness medicine and environmental preparedness, where participants learn to improvise with whatever they have at hand. “Here we learn a lot about radiology—that’s a huge part of our education, learning to look at CT scans and MRIs,” says Nora Ward, a second year who worked at Tanzania’s Kilimanjaro Christian Medical Center last summer. “That’s not something they have to consider there, so their form of diagnosis is quite different. I enjoyed being able to see that more basic form of examining a patient, having to go from what you see on the physical exam.”

Since there are many underserved populations in the U.S., students don’t necessarily have to leave the country—or even the city—to experience such challenges. Before

Remembering Rosa

A pediatrician aids sick children in Bolivia, in honor of a special patient

Doing good: Jonathan Lee-Melk, MD '03, with Bolivian children helped by the Rosa Vera Fund

PROVIDED BY JONATHAN LEE-MELK

When Jonathan Lee-Melk was a fourth-year medical student, he spent two months in Bolivia working with the Rural Andean Health Council. There, he met an eleven-year-old girl named Rosa Vera Marino who suffered from Tetralogy of Fallot, a congenital heart defect. “If that same girl had been born in the U.S., she would have received a surgery when she was approximately six months old and possibly another at eighteen months,” says Lee-Melk, MD '03, “and she would have had a normal life.”

But as the child of an impoverished, Quechua-speaking family in rural Bolivia—a country Lee-Melk had chosen because it was the poorest Spanish-speaking nation in Latin America—Marino had never had corrective surgery, and her health was failing. So Lee-Melk sent out a mass e-mail asking friends and family to donate funds for her treatment. He raised about \$3,500 and Marino had the operation—but sadly, her heart was so weak that physicians were unable to take her off bypass, and she died in the OR. “It was devastating,” recalls Lee-Melk, now a pediatrician in rural Arizona.

The operation, which would have cost more than \$100,000 in the U.S., had used up less than \$1,000; after paying her funeral expenses, much of the donated funds remained. Lee-Melk used it for operations on other children, organized by the health council. “I was impressed by how little effort it took me to make a difference,” he says. “I sent an e-mail. They did all the work; I was basically a fundraiser.”



The experience inspired Lee-Melk to found the Rosa Vera Fund in Marino’s memory. Run entirely by volunteers, the nonprofit raises more than \$30,000 a year to fund the efforts of community health workers and pay for surgeries for dozens of chronically ill children in Bolivia—where, he notes, the low cost of health care means that the money goes at least fifteen times farther than it would in the U.S. Says Lee-Melk: “This was a beautiful thing that grew out of something tragic.”

Alessandra Kostolias got to experience Weill Cornell as a visiting student—and as a patient. During a month studying high-risk obstetrics at the Medical College, the Rio de Janeiro native spent long hours on her feet; it exacerbated an injury from two years earlier, when she'd ruptured a ligament in her ankle. After it got so swollen she could barely walk, Kostolias went to the Emergency Department at NewYork-Presbyterian Hospital/Weill Cornell Medical Center. "It was interesting to invert the roles and be a patient," says the twenty-four-year-old, who also spent two months at Sloan-Kettering. "I've worked at ERs in Brazil and seen terrible things, but here I had such an amazing experience. The ER doctor was kind and he explained everything. They had a patient-care lady who asked if I'd had any breakfast and if I needed anything. Everyone was so thoughtful."

Kostolias, who earned her medical degree in December, is among the more than 150 international medical students who visit Weill Cornell each year. The students, who hail from some thirty countries, take clinical electives lasting up to a few months. "The feedback we've gotten from our faculty mentors is that the students are bright, appreciative, and eager to learn," says Madelon Finkel, PhD.

Kashif Anwar came to campus in fall 2009 to study orthopaedics trauma at Hospital for Special Surgery. A native of Karachi, Pakistan, he had earned undergraduate and medical degrees from Aga Khan University, where he's now an orthopaedics intern. "Undoubtedly, it was the best learning experience of my life," says Anwar, who also did stints at Brigham and Women's Hospital and Massachusetts General before returning home. "The patient management there is gold standard and comparable to the best hospitals in the world."

For Kostolias, coming to Weill Cornell was an eye-opener. Although she was in her final semester—in Brazil, med students study for six years, beginning immediately after high school—she was seeing many devices and procedures for the first time. "I wanted to be in touch with the top technology in medicine," she says. "I know that we don't always have that in Brazil. I learned practices and disease-management that are not available back home, like lab and radiologic tests that are common protocols in the U.S. It was exciting to see things that I'd only read about in books. This has definitely been important in my medical career." She found herself



Equal exchange:
Brazilian medical student Alessandra Kostolias spent the fall at Weill Cornell and Sloan-Kettering.

JOHN ABBOTT

amazed every time she walked into the medical library, which she says is ten times the size of the one back home. "Here you have so much access to information," she says. "They subscribe to more than 200 journals. There's any information you need from every field of medicine and six people in the library to help you. I don't know if American students are aware of how different this is, and I hope they appreciate the chance that they have to be so up to date."

Another perk of the program, Kostolias and Anwar say, was the chance to meet other visiting students from around the world. "It was interesting to know about the different cultures and traditions from students who did their clerkships at Cornell, and I got a great opportunity to learn languages like Spanish and Portuguese," says Anwar. He calls a get-together sponsored by the Office of Global Health Education, "exceptional and simply awesome." As he puts it: "We felt like a family throughout our stay."

Now back in Brazil, Kostolias hopes to apply to ob/gyn residencies in the U.S.—specifically at Weill Cornell, though she knows she'll face stiff competition. She says she wouldn't hesitate to recommend the international program to students back home. "I'd say, 'Go right away, because you will have the greatest experience,'" she says. "It has expanded my horizons. I can't put into words how excited and happy I was to be there."

medical school, Jonathan Lee-Melk, MD '03, not only worked in an orphanage in Mexico but spent summers aiding migrant workers in the Midwest and mentored underserved high school students in New York City. When he was accepted to Weill

Cornell, he deferred for a year to do a water sanitation project in Costa Rica and hone his Spanish; during his fourth year, he worked with an indigenous medical organization in Bolivia. Now he practices pediatrics in an impoverished

Arizona town, his clinic just four blocks from the Mexican border. "Children who live in poverty, no matter what country they're in, have a lot of similarities," he says. "Whether a child is in Bolivia or Arizona or New York, they all have the

same medical, social, and psychological needs.” He calls his experiences abroad “absolutely integral to the kind of pediatrician I am now.”

Last fall, Lee-Melk came back to Weill Cornell for the first time since he graduated

to speak about his work in Arizona, where he is developing a model to provide optimal pediatric care for families that face such barriers as poverty, lack of transportation, multiple medical issues, and lack of insurance. After his talk, he

was surrounded by an eager scrum of future doctors that reminded him of his own crowd from his student days. “They were hungry about this as a career possibility,” he says. “Medical students are intensely interested in this.” ●

Danger to Life and Limb

In Tanzania, a student explores the threat to albinos, who are being killed for their ‘magical’ properties

It was never easy to be an albino in sub-Saharan Africa, with its blistering sun and lack of resources to treat and prevent skin cancer. But in recent years, it has gotten even more dangerous. In Tanzania, dozens of albinos have been murdered for their body parts, which local folklore holds to have magical powers that can increase wealth. In the summer after her first year at Weill Cornell, Nora Ward '12 went to Kilimanjaro Christian Medical Center in Moshi; as part of her rotation in the hospital's dermatology center, she conducted a survey of local albino schoolchildren.

Ward, a Syracuse native and Dartmouth grad, had heard about the threat to albinos during a first-year class. With a strong interest in genetics, she wanted to learn more. “One of the things we asked them was, ‘Are you afraid of being killed?’ And, ‘What have you done to change your life since the killings began?’” she says. “Some of them have started attending boarding school and are not being allowed out at night or alone.”

For her survey, Ward interviewed sixty-two albinos and an equal number of non-albinos to serve as controls. (The genetic disorder is much more common in Tanzania than in the U.S., affecting one person out of 3,000.) With widespread reports of albinos being killed and mutilated, Ward found that many were “pretty scared,” she says. “Approximately two-thirds said they were afraid of the killing. A lot of them couldn't go outside

as much anymore or have as much flexibility with activities.”

In a culture where albinos have long faced prejudice, though, Ward was surprised to find that their self-esteem seemed undiminished. “We asked a few questions to assess that, and we found that they were just as likely as their non-albino peers to see themselves going to college and finishing their schooling—which typically hasn't been the case, because they have a lot of trouble in school,” she says. Her survey also asked about skin cancer prevention strategies and the eye problems common to albinos, who are often

severely nearsighted. “We were exploring things like, ‘Do you wear sunscreen? Are you able to see the board in school?’”

Ward's other activities included participating in albino outreach clinics; the dermatology center visits about ten sites twice a year. Staff do full skin screenings and treat precancerous lesions with cryotherapy, as well as hand out sunscreen, hats, and sunglasses. “It has decreased the number of inpatient albinos they have at the hospital,” she says. During the rest of her eight weeks in Tanzania she worked with the residents in the dermatology center—the nation's only teaching facility for the specialty. “Kilimanjaro Christian Medical Center gets patients from all over; it has a catch population of 12 million people,” Ward marvels. “It's the only place in Tanzania where they train dermatology residents, which was just unfathomable to me—and they had five residents in their entire program. People would travel days to see these doctors.”

She notes that in Africa, HIV and other infectious diseases are often treated by dermatologists, because in their more advanced stages they can cause skin problems not often seen in developed nations. Other

conditions she helped treat included vitiligo, scabies, and eczema. “I used to think that the only way I could go abroad and be useful was as a surgeon—you hear about those operational trips that people go on,” she says. “But I found that they needed help in every category. You can serve as another set of eyes for a few weeks at a time in any department, and that would be very much appreciated.”



PROVIDED BY NORA WARD

Survey subjects: Nora Ward '12 with albino children from Mwereni Primary School for the Blind and Visually Impaired

Reports from the Field

Medical students share their experiences abroad

Tiyatien Health, Zwedru, Liberia

By Carlo Canepa '12

Liberia: it's hard to know what to expect. A few ideas come to mind: bucket showers, friendly faces, a rich culture, crippling poverty exacerbated by civil war. But what do I, a first-year medical student, know beyond that? And where do I fit in? Not even the visa application offers direction: am I a tourist or here on business?

Tiyatien Health (TH) means "justice in health" in the dialect of the Krahn people of southeastern Liberia. Since 2007 TH has been serving a community of mostly farmers and unskilled laborers in a town called Zwedru. Initially it focused on HIV and AIDS treatment, but it had to expand to tuberculosis, maternal mortality, chronic illnesses, and mental health. I offered my services to the executive director of Tiyatien; my one stipulation was that my projects would have lasting impact.

One would figure that after the first year of medical school you'd be capable of doing things that were once a distant dream. The reality is more mundane. After one year of intense biochemistry, molecular biology, anatomy, and immunology, my most important skill set is the same as when I entered high school: the ability to read and a facility with computers. These are skills most American youth take for granted, yet in Liberia they are rare. And that is how I found myself near the border with Cote d'Ivoire, working with an NGO dedicated to improving the lives of the rural poor.

It started with me leading computer classes for community health worker leaders. Three times a week, I taught four students how to turn on a computer, type up reports, and create spreadsheets of home visits. Slowly we ventured into presentations, the Internet, and Skype. The next step was training them to use solar panels and rechargeable batteries for their headlamps. It went into full gallop when TH's main physician and I created a digital database of all 396 patients who had come for HIV/AIDS treatment.

A typical day involved me teaching class, collecting headlamps, conducting interviews for our community health workers, having a rice and palm butter lunch, and then spending most of the afternoon at the hospital copying charts into the database. All the while I'd troubleshoot the realities of life in rural Liberia: Our generator is down, so where do I hold class today? It's been raining for six days straight, so where can we charge the solar panels? And how can I slip in some time at the office of the U.N. High Commissioner for Human Rights so I can check my e-mail and Skype my mother?

It wasn't what I expected of my only medical school summer. I didn't climb a mountain or go on safari. There weren't even souvenirs to buy. But I am proud of what I left behind.



PROVIDED BY CARLO CANEPA

Kilimanjaro Christian Medical Center, Moshi, Tanzania

By Lisa King '11

I met my first pediatric AIDS patient today. She's in the bed by the window wearing a red jacket, and that's not her mother sitting on the foot of her bed, it's a woman from the orphanage where she lives. Her smile charms me instantly—melts me to the core, really. I flip through her chart: only eight years old, but she's already battled HIV and tuberculosis. Now she's back in the hospital with a probable case of pneumocystis pneumonia, too much for her weak immune system to handle. I'm listening to the resident, learning about how her pneumonia will be treated and which antiretroviral drugs she is taking. I can't take my eyes off her smile—she's a beautiful little girl, and I know I'll never forget her face.

This is the pediatrics ward of Kilimanjaro Christian Medical Center (KCMC) in Moshi, Tanzania. I came to Tanzania for nine weeks to learn about the Prevention of Mother to Child Transmission of HIV programs here. I am interested in global health, particularly maternal and young child health, and I came to Tanzania because I wanted practical experience working in international health. I wanted to see how medicine can be practiced effectively in a resource-limited setting, understand the unique daily challenges, and learn to think in an innovative way about improving health in third-world settings.

I worked under the supervision of Dr. Oneko, chair of the obstetrics department. A warm, kind man, and an excellent clinician, his charge to me was to "learn something!" during my time in Tanzania. The prevalence of HIV infection in Tanzania is 7 percent, so HIV in pregnancy is something that every obstetrician has to manage. The prenatal clinic, always full to overflowing, offers voluntary counseling and testing to pregnant mothers, along with presumptive treatment for malaria as well as iron and folic acid supplements. On the obstetrics ward upstairs, HIV-positive pregnant women are counseled, their CD4 counts measured, and antiretroviral medications initiated if indicated.

During my time at KCMC, I wanted to spend time in the pediatrics department learning about HIV/AIDS in children. During ward rounds, I found myself lingering in the patient rooms. The mothers taught me bits of Swahili, usually making fun of my "Swahinglish"; they let me hold their babies, and the older girls would hold my hand and not let go.

I sometimes felt useless as a foreign medical student, not speaking the language, but I learned that you can communicate with almost anyone if you have enough patience and understanding. I know this is just the beginning—my first taste of what it feels like to work in this kind of setting, in the face of significant challenges, but not without hope.



PROVIDED BY LISA KING

Coat of Many Meanings

By Beth Saulnier

Photographs by John Abbott

When it comes to symbolism, the doctor's traditional garb is weightier than the *Physicians' Desk Reference*. With the AMA pondering its possible danger as a disease vector, is the white coat on its way out?

Richard Cohen, MD '75, still remembers the first time he donned the uniform of the physician. Formal white coat ceremonies hadn't yet become the norm, so Cohen and his fellow first-years just went to the campus bookstore and bought their own. Still, he recalls, "I felt like a million dollars."

A longtime clinical professor of medicine at Weill Cornell, Cohen remains a devoted fan of the white coat. In July, when the *New York Times* published a piece on an American Medical Association proposal to ban the coat as a disease vector, it was Cohen who was quoted in passionate defense of the traditional physician's garb. "What I said to the reporter is something that I've said to medical students for a long time," says Cohen. "You come into my office, I've never met you before, and you have a belly ache. I ask you questions, and I start to think that this might be pelvic inflammatory disease. I ask whom you've had sex with, when you've had sex with them—and four minutes later you're in an exam room naked and I'm poking around in your belly. I don't think I ought to look like I'm pouring coffee at Starbucks. I ought to look like a doctor."

It's the quintessential symbol of the medical profession—more than the stethoscope, the tongue depressor, or the black bag. For more than a century, doctors have worn white coats to define themselves as masters of the healing arts. But in recent years, the garment has come under fire for its potential to spread germs from patient to patient. In fall 2007, the United Kingdom Department of Health issued guidelines instructing clinical staff to eschew not only the white coat but also long sleeves, wristwatches, jewelry, and



Dean Antonio Gotto, MD, Baxter Allen '10, and Bracken Babula '11

neckties; its catchphrase is, “Bare below the elbows.” The AMA’s Council on Science and Public Health is currently pondering whether to eliminate the coat, with results expected sometime next summer.

With the fate of the white coat still unknown—and the question of whether it poses a threat to patient health very much up for debate—*Weill Cornell Medicine* asked some faculty and students to weigh in on the subject. The responses were all over the map—from those who, like Cohen, prize the coat to others who’d just as soon hang it up for good. “It’s a big and complex question,” says the senior associate dean of education, Carol Storey-Johnson, MD ’77. “For physicians, it has a lot of meaning, both symbolic and emotional.”

Once upon a time, doctors wore black. Though it may seem unimaginable to today’s health-care professionals—not to mention patients—white didn’t become the physician’s defining color until the late nineteenth century. In a historical piece on the coat published in the AMA bioethics journal *Virtual Mentor* in April 2007, Mark Hochberg, MD, observes that, as the doctor’s uniform, black connoted a variety of meanings—both intentional and ironic. Since the color implies formality (like the modern tuxedo), physicians wore it to indicate that medical encounters were serious matters. “An additional or alternative possibility for the dark garb might be that until the late nineteenth century seeking medical advice was usually a last resort

and frequently a precursor to death,” Hochberg notes. “Until the last third of the 1800s, an encounter with a physician rarely benefited the patient.”

But as the age of quackery and useless cures gave way to an understanding of the underpinnings of disease and the transmission of infection, doctors adopted white as a symbol of their profession’s purity and basis in science. (At the same time, he notes, sisters in religious nursing orders switched from black habits to white ones.) Hochberg points out that the color’s symbolic power goes back millennia. “The word ‘candor’ is derived from the Latin *candidus*, which means white,” he writes. “In fact, the foundation of all professional societies is candor or truth. The term ‘candidate’ comes from the fact that Romans seeking public office wore white togas.”

Today, the vast majority of the nation’s medical colleges hold white coat ceremonies for incoming students. Weill Cornell held its first in 1997 for members of the Class of 2001; as Dean Antonio Gotto, MD, noted at the time, the ceremony was especially appropriate given that the new curriculum brought students into physicians’ offices their very first week of school. “The goal is for them to appreciate that medicine is a profession that has certain obligations to it, and certain expectations from society,” he says today. “This

Above right: Jay Lopez ’12
Below right: Ramana Gorrepati ’13 and Lena Makaroun ’12

Opposite: Sarah Yagerman ’13

is all part and parcel of their transition into medical school. It’s not just a day in their lives.”

But Gotto and others stress that the point of the ceremony goes far beyond donning the coat itself. Some new students invite their families to attend, celebrating the successful end of the long, challenging road to medical school admission. (This fall, for the first time, Weill Cornell’s future doctors received another symbol of their profession: the stethoscope.) The event also includes inspirational remarks from senior faculty, which some say is the most important part of all. “The white coat ceremony was certainly important to me as an event, a milestone, but it wasn’t the white coat that made it special,” says Baxter Allen ’10. “It was the speeches, the camaraderie, the welcoming into the medical profession by the physicians at the front of the room.”

Allen is no fan of the coat in general; in fact, he calls it “a drag.” “It serves as a barrier, both literal and metaphorical, between doctors and their patients,” he says. “It serves as a marker of hierarchy, as if we really need one. It gets dirty easily, sopping up germs, blood, and sweat. And, worst of all, it makes me hot.” If the AMA’s proposal is adopted, he says, he’ll be “immensely happy.” “Instead of carrying around this bulky—and, frankly, ugly—coat, I’ll be free to roam the hospital in real physician’s attire, whether that be scrubs or a professional outfit,” he says. “Sure, I’ll have fewer pockets, but most of that stuff is just in the way. Leave me what I really need: a stethoscope around my neck, a penlight and pen in my shirt pocket, and my desire and ability to build a trusting relationship with my patients. Everything else is just superfluous.”

Of course, some specialties already eschew the white coat, on the grounds that it could intimidate patients. (There’s a familiar name





for the negative effect it can have on blood pressure: white-coat hypertension.) Psychiatrists, especially those in private practice, tend not to wear them; pediatricians often avoid them, to be more approachable by children. When Bracken Babula '11 did his pediatrics rotation at the Brooklyn Hospital Center, he found that the lack of the white coat offered other benefits. "It also created a less intimidating environment for students," says Babula, a Maine native who plans to specialize in internal medicine and has an interest in oncology. "I wasn't identified by my 'short white coat' or by the red Cornell patch on my shoulder. It was my responsibility to dress appropriately and introduce myself as a medical student. There was never any confusion with the medical team or our patients, but I know I was more comfortable. I think it would be great to keep white coats as a tradition for the white coat ceremony and graduation, but remove them from the clinics and hospital floors."

A distaste for—or apathy toward—the white coat isn't limited to students. Although Carlyle Miller, MD '75, an assistant professor of medicine, appreciates its symbolic value and echoes the importance of the white coat ceremony, he says he wouldn't shed a tear if it went away. "I wear it because it seems like the thing to do; patients feel comfortable with the white coat," says Miller, who is the associate dean for student affairs and equal opportunity programs. "But I don't think it would make a bit of difference in how I treat my patients if I wore a white coat or a blue shirt or whatever." Dean Gotto, on the other hand, feels that if the white coat were eliminated, it would be a loss. "I think it has a positive impression," he says. "Physicians are recognized as one of the more admired professions in our society. And just as you expect policemen to wear blue, you expect doctors to wear white."

Beyond identifying physicians to the general public, the coat can serve as a semaphore declaring an individual's level of training: at Weill Cornell, medical students wear a short coat before graduation, a long coat afterward. Decades ago, Cohen notes, there were other delineations as well. "When I was a resident, you wore a short white coat and white pants," he recalls. "And when you became an attending, you switched to street clothes with a long white coat." Storey-Johnson points out that even today, standards

'It almost has a spiritual feel to it. When you put it on, you are transformed—in your own eyes and those of the people around you.'

Carol Storey-Johnson,
MD '77

vary from one institution to another. "If I went to a hospital in Boston, I might not know the significance of the different garb," she says. And even if you're conversant with a hospital's guidelines, a long white coat may not necessarily indicate an MD. "Physician assistants wear white coats," she points out. "Nurse practitioners wear white coats."

For Storey-Johnson, the coat personifies the concept of professionalism, synthesizing many disparate elements—from having the requisite medical expertise to displaying an altruism that puts patients' interests first. "So it's a complex concept," she says. "And it's an interesting one, because when you ask someone what they mean by professionalism, they have to stop because they're flooded with all these different ideas they have to distill. The white coat is emblematic of that." She recalls that the first time she donned the coat as a medical student, she felt an overwhelming sense of responsibility. "It almost has a spiritual feel to it," she says. "When you put it on, you are transformed—in your own eyes and those of the people around you. Even today, if I come to work and I'm not in my white coat, I can slip around unnoticed. But when I'm in my white coat, almost everybody who knows me says something to me. It's a fascinating phenomenon. What it speaks to is the idea that when you have a white coat on, people look to you for certain kinds of comportment. They attribute to you certain kinds of knowledge. And they likely give you their respect automatically."

But might that symbol of a doctor's expertise be harming patient health? Although studies have found that physicians' clothing does harbor bacteria, the extent to which it's a viable threat remains an open question. "The evidence is inconclusive that it's a significant factor in spreading germs," says Gotto. "You can't have a completely germ-free environment. The level of evidence for hand-washing in preventing the spread of disease is what we would call Class 1-A, but there's very flimsy evidence that wearing a white coat contributes to the spread of disease." Says Cohen: "Show me the facts. Show me that my white coat is more dangerous than my white shirt. My coat may be colonized with bacteria—but if you're not going to show me that it's causing disease, I don't see the downside."

But for David Slottje '12, the white coat seems a clear and present danger to patient health. The Ithaca native feels strongly that, although the coat is a powerful symbol, it's an equally powerful vector for disease. "Even as a person who is cognizant of the potential to transmit infections, I have to admit that my white coat is not washed frequently enough," says Slottje, who earned a BA in history from Cornell in 2008. "I would be glad to see the

white coat phased out in favor of a more hygienic uniform, which ought to be bare below the elbows and devoid of a necktie."

And the question remains: If physicians no longer wore white coats, what would they wear? Their street clothing? Wouldn't that pose its own dangers? "You'd find bacteria on your pants when you sit down in the subway," says Gotto. "It's just that in the hospital setting, the bacteria are potentially more dangerous." One option—admittedly cumbersome to the point of being untenable—would be for physicians to change between patients, like surgeons donning new scrubs between procedures. "Any clothing is a vector for disease," says Miller. "That's just a fact. I don't know how you get around it. No matter what you do, a person still has to wear clothing. And even if everyone were naked, there'd still be a chance of spreading disease."

In general, the medical students at Weill Cornell seem less attached to their white coats than older, established physicians. The common denominator among their responses: the coat has its symbolic meaning and traditional charms, but if it's in any way a threat to patient health, it should go the way of the mustard plaster. "During the white coat ceremony, more than being draped with this emblem of the medical profession, we spent time exalting the ideals and goals of the career path we are embarking on," recalls Lena Makaroun '12, a Pittsburgh native who co-founded a Weill Cornell student group devoted to analyzing health policy issues. "These goals begin and end with the patient. If there is strong evidence to suggest that the white coat may be detrimental to patient well-being, it goes. No physician's pride, ego, love of tradition, or love of multiple convenient pockets should take precedence." As classmate Jay Lopez puts it: "My generation is one that normally dresses casually, and I don't believe that we necessarily associate appearance with professional competence."

Still, many continue to prize the coat for one feature in particular: those deliciously deep pockets. Sarah Lewis, president of the Class of 2010, reports stuffing hers with "pens and pagers and patient sign-out lists, to the extent that my jacket has weighed more than ten pounds during certain rotations and caused some mild neck injuries." Associate professor of clinical psychiatry Joseph Murray, MD, lists other swag that physicians-in-training stash in the pockets: index cards, small reference books, tourniquets, protein bars. "Surgeons often use the coat to spiff themselves up if they are still wearing scrubs," Murray points out. "Coats hide stains and are warm. The times I do wear my coat in the office are when we have no heat, or when I spilled coffee on my tie." ●

Carol Storey-Johnson, MD '77



Be Well

Despite the stereotype of overworked docs who ignore their own health, Weill Cornell students are a clean-living bunch

By Sharon Tregaskis

Photographs by John Abbott

When it comes to rigor, Weill Cornell students and young alumni agree, no course tops the eleven-week Brain and Mind module at the start of the second year. For Sydney Rose '12, the course that integrates basic neuroscience, gross anatomy of the head and neck, neurological diagnosis, and psychopathology was all the more difficult due to other concerns competing for her attention.

That fall, the Manhattan native and her family ran the emotional gamut as a loved one fell ill and died in the span of a few months. "I was dealing with a family issue, taking the hardest course in medical school, and preparing for a marathon," recalls Rose, currently devoting a year to skin cancer research at Memorial Sloan-Kettering. "I would have fallen apart as a person if I hadn't fit in training."

The workouts furnished a vital opportunity to blow off steam and maintain perspective, says the twenty-nine-year-old,



David Saunders '12

Good Advice

Students share their strategies for staying healthy during med school



Joanne Bruno '13

Stay on schedule. “I usually go running at five o’clock at night,” says food blogger Joanne Bruno ’13. “Because it’s already part of my schedule, it’s a semi-nonnegotiable activity. If you say, ‘I’m going at this time,’ and orient everything else around that, like a class, it becomes easier to do on a regular basis.”

• **Plan ahead.** On third-year rotations, speed-eating becomes an art. To make sure her diet didn’t consist of fast food interspersed with candy bars, Sydney Rose ’12 packed healthy alternatives. “I learned to stuff my pockets with granola bars and snack throughout the day,” she says. Quick-to-eat peanut butter and jelly sandwiches stashed in her locker became a staple during surgery and ob/gyn. “If you don’t think about it and don’t plan, it’s easy to get the garbage from the vending machine.”

• **Start small.** “For a lot of doctors, their only means of exercise is going up the stairs in the hospital,” says twenty-four-year-old Marissa Velez ’12, who credits a regular meditation practice and workouts with the Leukemia and Lymphoma Society’s Team in Training with improving her powers of concentration. “I think as a person starts feeling better, it’s an internal motivator and you can take more steps to being active.”

• **Multi-task.** El Paso native Christopher Robinson ’13 brings a textbook to the gym and reads while running on the treadmill. “At first, it hurt my eyes—all the bouncing,” he says. “Now I can read and concentrate for twenty or thirty minutes.”

• **Take a breather.** For David Saunders ’12, meditation has proved vital to managing anxiety and making the most of study sessions. “I’ll look back at the previous few weeks and think about whether I put in enough time on the cushion,” he says. “If you’re not meditating or going to church, just take time for yourself by going on a walk or reading a book for pleasure, instead of cramming for an extra ten minutes in neuroscience.”

• **Give yourself a break.** Velez, a triathlete, skips the guilt trip when a hectic schedule cuts into training time. “It’s hard to stay on any kind of routine, and you have to be forgiving as far as eating, sleeping, and exercise goes,” says the Manhattan native. “If you take care of yourself 80 percent of the time, that’s pretty good. I can’t get seven or eight hours of sleep every night, but I try to counterbalance it, maybe eating a little better or fitting in a run.”

• **No excuses.** It’s easy to be lulled into skipping a workout or grabbing a fast-food burger and fries because you’ve been on your feet all day, says Rose. But that’s liable to perpetuate the exhaustion. “If you get into that unhealthy rut, you’re tired all the time,” she says. “If you push yourself to try and be a little healthier, that’s addictive, too.”

even if she did miss some sleep to accommodate longer weekend runs. “The hour I spent running was more helpful than another hour sitting there studying, getting crazed that I wasn’t doing stuff for my body,” says Rose, who lettered in high school soccer, basketball, and softball and took up running as an undergraduate at Columbia. “If I was feeling guilty about running, I’d put the MP3 of a lecture on my iPod.” She notes that during third-year rotations—especially ob/gyn and surgery—long hours at the hospital meant skipping the park and opting for an 8 p.m. jog on the Upper East Side. “Even if it were only forty blocks, at least I went for a run. I was keeping my body healthy.”

Despite the stereotype of workaholic docs who neglect their own health, statistics tell another tale: medical students and physicians boast both healthier lifestyles and greater longevity than the rest of the nation. More than two-thirds of Americans are overweight or obese—conditions that heighten the risk of diabetes, cardiovascular disease, and other chronic problems. But with lower rates of smoking, more frequent exercise, closer adherence to nutritional guidelines, and lower body mass index scores, practicing and aspiring physicians seem to have healthy habits that outpace even those of other highly educated professionals. “Physicians, in general, practice what they preach,” says cardiologist and epidemiologist J. Michael Gaziano, MD, a principal investigator of the Physicians’ Health Study II, which began tracking 14,600 male doctors in 1997. “They’re a very healthy group.”

What about all the times you’ve spotted someone in a white coat eating at McDonald’s or puffing on a cigarette outside the hospital entrance? Gaziano cites a cognitive bias known as the Von Restorff effect—whereby we remember more keenly what catches our attention—and notes that such behavior is not actually widespread. “Sure, there are anecdotes, which are striking to some people, but the proportion of plumbers and lawyers who smoke or eat poorly is higher,” says Gaziano. “It’s just that those professionals aren’t telling their clients not to do those things.”

In fact, evidence of a physician’s overall fitness seems to boost her credibility when she urges a patient to adopt healthier habits. In 2000, a study demonstrated that patients counseled by an apparently active doctor tend to take the advice more seriously: subjects shown a brief educational video featuring a physician who disclosed her own diet and exercise strategies and had an apple and a bicycle helmet on her desk were more motivated than control patients who saw a version that lacked clues about the doctor’s lifestyle. The work led to the launch of the Healthy Doc–Healthy Patient Project, a four-year study of 2,300 students at eighteen medical schools documenting how their personal practices correlated with their health-



Student Health Services director Edgar Figueroa, MD '00

promotion and patient counseling strategies in the clinic. Among its findings: as with practicing physicians, medical students who eat a healthier diet, get more sleep, and exercise more regularly are more likely to urge their patients to do the same.

While Weill Cornell doesn’t have any formal health-promotion programs for students, the college’s health-insurance plan offers discounted prices for gym memberships, and students are eligible for smoking cessation programs at NewYork-Presbyterian Hospital—though not many find themselves needing to quit. “We tend to catch people fairly young, before a whole lot of bad habits are ingrained,” says Student Health Services director Edgar Figueroa, MD '00. Most rely on family and peer relationships, athletics, and



Sydney Rose '12

'MACHO' Mentors

Student volunteers
inspire Harlem's kids to
eat well and exercise

As the holiday season hit its stride, Nakesha King '11 and nine fellow members of the Weill Cornell chapter of the Student National Medical Association embarked on a weekly pilgrimage to East Harlem's Settlement Health Clinic. Their goal: combat the burgeoning childhood obesity epidemic in a series of fun, educational sessions known as MACHO—the Movement Against Childhood Obesity.

Since the early Eighties, the obesity rate has tripled among teens, while the rate for younger children has more than doubled. By 2006, there were more than nine million children over the age of six who fit the criteria for obesity and an additional 3.5 million who were overweight. Meanwhile, the cumulative health effects of weight gain and inactivity afflict ever-younger populations. Adult-onset diabetes is now so prevalent in the playground set, it's officially known as type 2 diabetes; pediatricians also increasingly confront high blood pressure, high cholesterol, and cardiovascular disease among their patients. Over the next decade, the associated medical costs—among both children and adults—are expected to grow to 20 percent of the nation's annual health care expenditure, as much as \$344 billion in 2018.

Inspired by a science enrichment program for minority youth launched by the Weill Cornell SNMA chapter in 1989 that matches medical student mentors with high school students throughout the country, King and her classmates designed MACHO as a pilot program slated for replication. Funded by a \$5,000 grant from the Robert Wood Johnson

activities like making music to manage stress, says Figueroa, and the student culture at the Medical College seems to promote a rich array of intramural and pickup sports.

Stress levels ebb and flow with the curriculum, spiking with such classes as the first-year Human Structure and Function course and Brain and Mind in the second year, as well as the third-year clerkships in medicine, surgery, and obstetrics and gynecology. Student Health Services traffic tends to correspond with those high points, says Figueroa, who sends monthly e-mails promoting self-care and highlighting the importance—especially during the H1N1 outbreak—of preventing the spread of germs by staying home when symptoms warrant. (“We got the message out,” he says. “If you’re sick, don’t come in.”) In appointments, rather than offering strict advice about diet or exercise, Figueroa asks students to ponder what works for them. “I encourage a lot of self-reflection,” he says, “journaling, writing about patients and patient encounters. There’s a body of literature on reflective practice to help you become more self-aware, become a better doc.”

Twenty-five-year-old David “Dash” Saunders ’12 trained for and ran both a half and a full marathon during his first year at Weill Cornell, and heralded the start of summer with a marathon in Duluth, Minnesota, the day after classes ended. The day before classes resumed in the fall, he competed in the Louisville, Kentucky, Ironman triathlon, comprising a 2.4-mile swim, a 112-mile bike ride, and a marathon. “You have to be dedicated to school, but I was really into training hard,” says the Minnesota native, who competed in his first athletic event at age seven and ran between thirty-five and seventy miles a week during his first year of medical school. Disappointed with his academic performance and anticipating the challenges of Mind and Brain at the start of his second year, the aspiring psychiatrist cut back on his athletic pursuits this fall. In retrospect, it wasn’t a great decision. “I didn’t fail or anything, but I certainly didn’t do better than I did first year—maybe worse,” says

Saunders, noting that he doesn’t think the challenging course content is to blame. “When I was studying, it wasn’t as efficient. I would fall asleep more, I was a lot more jittery in class, couldn’t pay attention as well, and my appetite went way down, so I probably wasn’t eating enough.”

After every test, Saunders reviews his performance as well as the lifestyle variables he controls: sleep, nutrition, exercise, his meditation practice. “I look back to see what I did to make the test better or worse,” he says. “I’ll stick with a change only if I see results. It’s been nice to see that nutrition and changes in sleep definitely matter.” Ultimately, he says, managing the stress of medical school boils down to trial and error. “You can use the busy-ness of med school as an excuse to not do something, but you can also use it as a reason to do something,” he says. “It can drive you to have healthier habits or worse habits. It’s a highly individualized thing.”

For first-year MD-PhD student Joanne Bruno, healthy habits are a relatively recent acquisition. The twenty-two-year-old grew up in an Italian-American family that eschews vegetables, and for her first two years of college she daily indulged a weakness for double-stuff Oreos and Chex Mix. Until her junior year, the five-foot-three Queens native had never set foot in a gym. “I woke up one day and said, ‘I weigh 150 pounds,’ ” she recalls. “ ‘I’m going to start going to the gym, thinking about what I’m eating.’ ”

Today, Bruno blows off steam with thrice-weekly runs of eight to ten miles and equally frequent posts about her culinary escapades on the blog joanne-eatswellwithothers.blogspot.com. In October, her time in the Nike Women’s Marathon in San Francisco—her first on the circuit—was fast enough to qualify for the Boston Marathon this spring. In November, she posted her musings on—and recipes

for—bourbon pumpkin cheesecake, coconut cupcakes, butternut squash baked ziti, cranberry chutney, and spinach orzo. “Health and nutrition are insanely important to me,” she says. “I cook all my own food and am obsessed with incorporating as many veggies into my meals as possible.”

To accommodate her class and study schedule, Bruno cooks in volume, preparing two or three entrees each weekend and eating leftovers during the week. Paired with strategic grocery shopping and a predominantly vegetarian menu, the approach also helps balance her budget. For Bruno, it’s hard to imagine giving a patient a message about healthy living if she can’t walk the walk herself. “The more you learn about the obesity epidemic, it’s harder and harder to throw exercise to the wind and think it’s for everyone else,” she says. “It’s also a ‘practice what you preach’ kind of thing. If I say you need to eat right or exercise and a patient asks what I do, they’re not going to listen if I say I never exercise.” ●

Foundation and the Institute for the Advancement of Multicultural and Minority Medicine, the eleven-week program outfits self-referring Settlement Health patients aged eleven to thirteen with pedometers and food journals and incorporates a curriculum on healthful habits with workout sessions, field trips, even a meal home-cooked with parents from ingredients that MACHO participants buy on a grocery run in the neighborhood. “We’re trying to encourage teamwork and advocacy among the kids,” says King, an aspiring cardiothoracic surgeon currently doing an internship in the Clinical Scholars program at Rockefeller. Perhaps even more important, the MACHO organizers have determined to lead by example. “We realized we can’t preach to these kids and then go down to the corner bodega for a bag of chips,” says the Boston native. “We started working out together, trying to employ these principles in our own lives: cooking meals for ourselves, passing up the unhealthy choices when we go out to eat.”

While Weill Cornell seems to be brimming with marathon runners, triathletes, and yoga instructors, the medical students come in a range of shapes and sizes. MACHO organizers decided to celebrate that variety, says King, who started boxing in high school and continues the sport at a gym on the Lower East Side. “A few of us are overweight,” she says. “I think it’s key for the kids we work with to know that you don’t have to have a perfect body shape to be an active person. Try your best, be active, and eat healthy. It doesn’t mean you’ll look like Arnold Schwarzenegger, but you need to take care of your insides.”

Notebook

News of Medical
College and Graduate
School Alumni

Dear fellow alumni:

The year seems to have gone by so quickly. It is time for me to reflect on what has happened during 2009, my first year as president of the CUWMC Alumni Association.

The year will certainly be remembered for the worldwide financial crisis, the inauguration of President Obama, the wars in Iraq and Afghanistan, the H1N1 epidemic, the rising unemployment rate, and the debate over health-care reform. What we have done as an alumni association may seem insignificant when compared to everything that is going on around us. However, I feel that our goals are very relevant in these uncertain times.

The Alumni Association provides the networking that is so important in connecting with others. We recently hosted an event in Boston during the annual meeting of the AAMC in November. It was especially exciting that two of our alumni, Ronald Arky '51, MD '55, and David Asch, MD '84, received the 2009 Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award for excellence in medical student education.

Dean Antonio Gotto was there to greet alumni and present the news about the latest develop-

ment at Weill Cornell, the Medical Research Building that is under construction on East 69th Street. This much-needed space will allow the recruitment of more than fifty researchers who will lead programs in key areas addressing pressing public health needs, including cancer, cardiology, metabolic diseases, children's health, and neurodegenerative diseases. Under the leadership of Paul Miskovitz, MD '75, and Thomas

McGovern, MD '74, alumni are doing their part to help with the *Discoveries that Make a Difference* campaign.

At the Boston event were two alumni who currently serve in the Medical College administration: Carol Storey-Johnson, MD '77, senior associate dean of education, and Carlyle Miller MD, '75, associate dean of student affairs and equal opportunity programs. A big surprise was the attendance of Javaid Sheikh, MD, dean of Weill Cornell Medical College in Qatar, as well as several faculty and administrators from Doha. It was a great opportunity for alumni to find out what is happening on both campuses.

During this period of economic uncertainty, we are grateful that many alumni have continued to contribute and help the medical students. Through a \$50,000 grant from the Buster Foundation in honor of Paul Miskovitz and contributions from several alumni, members of the Class of 2013 received stethoscopes in addition to their white coats during the traditional ceremony. This was much appreciated by the students, and you are all invited to help by making a gift to the Paul F. Miskovitz, MD '75, Stethoscope Fund for Medical Students.

I am pleased to share with you one student activity that has impressed many members of the Alumni Association board. The students opened a clinic four years ago that serves uninsured New York City residents, providing extensive medical services at no cost to patients. Although the clinic was started with a grant from the AAMC, that is being phased out and the students are trying to secure additional grants and contributions. What started as a small volunteer program has become the most popular student activity, and the clinic is looking for additional financial support. The students would certainly welcome a helping hand from alumni.

Ending on that positive note, I wish you all a Happy New Year and look forward to seeing many of you at Reunion 2010. Stay in touch by visiting our website (www.med.cornell.edu/alumni), Facebook, or Twitter pages!

*With warmest regards,
Hazel Szeto, MD '77, PhD '77
President, CUWMC Alumni Association
hhszeto@alumni.med.cornell.edu*

Hazel Szeto, MD '77, PhD '77



JANET CHARLES



FRANK MONKIEWICZ

At the AAMC meeting in Boston last November, Weill Cornell alumni and friends gathered for a cocktail reception. The attendees included (left to right) Carlyle Miller, MD '75, associate dean for student affairs, Gregory Faust, MD '86, Cyril Burke, MD '86, and Cyril's wife, Leeanne.

1930s

Augustus W. Sainsbury, MD '39: "Somewhat less active, but still getting around after 26 years of happy retirement. Live with my dog, Baxter, manage my condominium, and continue to drive my car. Have wintered every winter thus far in Florida, and would love to hear from any of my classmates extant."

1940s

Earl J. Netzow, MD '43: "Lucile ('Cindy') and I are still holding on. She is 88 years old and I am 90, and we have been married for 68 years. We are residing in the Alexian Brothers Village and receiving assisted living. Our best regards to all."

David R. Tomlinson, MD '43: "We spend the winter in Fort Pierce, FL. No change in our lifestyle."

Frederick D. Haffner, MD '44: "Since I retired from a successful pediatric practice some 15 years ago, I've found a new career on the fairways that also embraces good fellowship and the sporting life. Although I've had my share of health problems, I seem to be a 'survivor,' which is becoming more and more the ultimate measure of success."

Douglas E. Johnstone, MD '45: "Happily retired 18 years as emeritus professor, University of Rochester School of Medicine."

Herbert I. McCoy, MD '45: "Mostly traveling. Just back from scuba trip to Bonaire. Next to Irian Jaya."

William C. Robbins, MD '45: "On our way back to Florida in July from the cooler North Carolina mountains, Dagny and I stopped in Macon, GA, for a pleasant visit with **Rudy Jones, MD '45**, and his wife, Dorothy."

Harry M. Depan, MD '47: "Sorry I was unable to attend my reunion due to acute illness. Hope to make it next time around. Now 86 years old. I miss not being able to practice my vocation, surgery. I try to keep up on journals."

Ernest Gosline '43, MD '47: "The loss of our good friend and colleague **Jon Cole, MD '47**, this year was a sad event for all who knew and loved him. He was indeed a giant in psychopharmacology and a great educator with a lifelong devotion to psychiatry."

Susannah Krehbiel Horger '43, MD '47: "I am going to be a great-grandmother. My oldest grandchild, Lydia Horger Buckler, has an EDC

I've found a new career on the fairways that also embraces good fellowship and the sporting life.

**Frederick D. Haffner,
MD '44**



MONKIEWICZ

At the Boston AAMC meeting, Dean Antonio Gotto (left) greeted Steven Gabbe, MD '69, and Steven's wife, Patricia.

**I'm as happy
as when I was
first admitted
to medical
school.**

Susannah Krehbiel Horger
'43, MD '47

March 29, 2010. It is just three years since her marriage to Blake Buckler, which occurred on March 31, 2007. I have eight grandchildren, but this is my first great-grandchild. I'm as happy as when I was first admitted to medical school."

Edwin M. Knights, MD '48: "See www.gene.saver.com."

Joseph A. Worrall, MD '48: "All is well here. I continue to do ob/gyn sono with great pleasure."

Abraham Blumer, MD '49: "I'm retired. Joyce and I teach country western and ballroom dance three times a week. Enjoying a great-grandchild."

Margaret S. Norris, MD '49: "John, MD '43, had his 90th birthday last March. At our age we are living quietly, enjoying our children and grandchildren. We are still in our own home near Vanderbilt University. I enjoy the lifelong learning courses offered by Vanderbilt."

Alan D. Shafer, MD '49, moved to a retirement village in October 2008. He was the primary founder of Dayton Children's Medical Center and helped organize Wright State University's School of Medicine. Dr. Shafer published 35 papers on many medical procedures and was a charter member of the American Pediatric Surgery Association.

David H. Sonabend, MD '49: "I retired in 1991 and spent half the year in Florida and half in New York; now only Florida. My wife, Roslyn, has been with me for 65 years. Twin daughters born in New York Lying-In Hospital (my second year at CUMC), aged 62, still live in New York City."

1950s

William C. Porter, MD '50: "Retired now four-and-a-half years. Still 'hangin' in there.' Swimming and working out in the gym four days a week. Regards to all of my half-century colleagues."

Henry L. Hood '43, MD '51: "Jane died December 19, 2003. Married Nancy Alcock, a native of Tasmania, on August 26, 2006. She spent her career at the Rockefeller Institute in New York City and retired from the University of Texas Medical College in Galveston. The Henry Hood Center for Health Research was dedicated January 23, 2007, at Geisinger in Danville, PA. I was president and CEO of the Geisinger Health System from 1974 to 1991."

Patrick J. Mulrow, MD '51: "I am professor emeritus at the University of Toledo College of Medicine, where I was chairman of medicine for 20 years and received an honorary doctor of science degree. I still do some teaching, but my main activity is establishing a Motor Vehicle Accident Center and developing a curriculum for medical students and residents that teaches prevention of accidents. Surprisingly little is taught at medical schools about prevention despite the fact that motor vehicle accidents are a major cause of death and injury worldwide."

Edward B. Swain, MD '51: "My wife and I attended the Class of '51's 50th Reunion in 2002. When the invitation came for the next biennial reunion in 2004, there we were on the cover of the brochure dancing (black tie and the works). How can I get a copy of that photo?"

Alan Van Poznak '48, MD '52: "Happily retired for the last nine years, after a total of 52 wonderful years at Cornell Medical Center. Was delighted to attend the festivities for the establishment of the Russel and Julie Patterson professorship in neurological surgery."

Virginia D. Weeks, MD '52: "I keep in touch with Beth, the wife of **Jim Mertz, MD '52**, who is living in Seattle in an apartment with her neonatologist son and his family. She's looking for a house to buy on the Maine coast. I'm coping with geriatric 'conditions' and no energy. Fortunately, I'm still working part-time in addiction medicine and enjoying my family. I will spend the sixth Christmas in Norway with son John and his family. My best to you all."

George Dermksian, MD '54, emeritus clinical professor of medicine at Columbia University College of Physicians and Surgeons and emeritus senior attending physician at St. Luke's/Roosevelt Hospital Center, was honored on April 30, 2009, at the Century Association by the Alumni Society of St. Luke's/Roosevelt Hospital Center as their Distinguished Alumnus.

William H. Gordon Jr., MD '54: "I was in internal medicine and established nuclear medicine departments at Fontana and Riverside, CA, at Kaiser Permanente Medical Centers before retiring. I reside in Upland, CA, with my wife, Jean. We have two sons and two daughters, as well as

two granddaughters.”

Ronald A. Arky '51, MD '55, received the Association of American Medical Colleges' Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award on November 6, 2009. He is the Charles S. Davidson Distinguished Professor of Medicine and dean of curriculum at Harvard Medical School, and former chief of the diabetes section at Brigham and Women's Hospital. In addition, he holds a joint faculty appointment as professor of medicine, health sciences, and technology at Harvard and MIT. Dr. Arky is one of the principal architects of Harvard's New Pathway in General Medical Education program.

William S. Augerson, MD '55: “We are fine. Still working a little. Busy on county board of health, trying to get fluoride into city water. Working on local emergency planning.”

Cedric J. Priebe, MD '55: “I'm now an emeritus professor at Stony Brook and retired from clinical pediatric surgery practice. I continue part-time for the Dept. of Surgery.”

Artemis Pazianos Willis, MD '55: “I retired completely last December and am enjoying every day. I miss my patients, but not the responsibility. In February, I went to Tunisia with my daughter and several friends. In order to escape part of the New England winter, I also spent three weeks in Florida in March. While in Washington in June for the national Endocrine meetings, I had a lovely visit with **Maury Hanson, MD '55**, at his beautiful farm in Madison, VA. He keeps busy mowing five acres of grass weekly and is involved with the restoration of early buildings in his area. In October, I am going on a Wellesley trip, Women of Antiquity, to Turkey, Syria, and Alexandria, Egypt.”

Frank G. Moody, MD '56: “Still enjoying life as a professor of surgery at the University of Texas Medical School in Houston. It's a great treat to interact with medical students and surgical residents as they care for their patients. Cornell has served me well for this privilege.”

William H. Graff, MD '57: “Enjoying golf this summer. Strange to have extra time.”

Bernard S. Siegel, MD '57: “Recently published my twelfth book, *Faith, Hope and Healing*, inspiring lessons learned from people living with cancer. Still running support groups for people with cancer. My website is www.berniesiegelmd.com. My organization is ECAP (Exceptional Cancer Patients).

Robert A. Levine '54, MD '58: “After 38 years as chief of gastroenterology and professor of medicine at SUNY Upstate Medical University in Syracuse, I'm moving to Boston University School of Medicine. I'll be near my two sons and four grandchildren in Needham, MA, and closer to our condo in Ogunquit, ME. My other son and two grandchildren live in New York City. Besides Simmons Lessell, MD '58, any Bostonites, please say hello.”

George E. Shambaugh III, MD '58: “I have passed a milestone in my 'retired career' and have been awarded the Nanette Wenger Award from the Dept. of Medicine at Emory University Medical School for outstanding service throughout my career there (10 years of volunteering in teaching and patient care, following my retirement from Northwestern). A year ago I received a 2008 Class President of the Year award from the Oberlin College Alumni Association, and this spring the Henry G. Heedy 1933 award from the Asheville School for service to the school. In reflecting on this, it gave me great comfort to see Beverly Dean and **David Berler '55, MD '58**, standing together at our 50th and to see her tenderness as she looked at the photographer. That photo, now over my desk, is a constant reminder that all of you are part of my life and have shared in these awards as well, for what are they but recognition of our living out the words of George Reader, who in his Comprehensive Care program said, 'Go out and serve. This is what you are in medical school to learn how best to do.' And this is what you all have done. As long as I am able, I hope to continue to teach and in that way contribute to the care of the needy to give back what was given to me a half-century ago by both my mentors and, by their subsequent example, my classmates.”

James E. Shepard, MD '59: “I recently received lots of encouragement to attend my college reunion. I'm surprised they are still speaking to me. After the last commencement reunion I attended, they asked what I liked best. I truthfully replied, 'Sneaking out to play golf with a CUMC classmate' (**Mike Conroy, MD '59**).”

James K. Van Buren '55, MD '59: “Enjoying full retirement. Handicap down almost to single digit. Saw **Eddie Krawitt '55, MD '59**, briefly this summer in

Burlington, VT, and had a nice visit here in Atlanta with **Hunter Black, MD '59**. Looking forward to reunion next year.”

1960s

Elizabeth Barrett-Connor, MD '60: “Still working full-time trying to understand sex differences in longevity and health in old age. My husband is enjoying his retirement, and we are spending quality time with seven grandchildren ages 1 to 18 (and their parents). In 2009 I was named a Living Legend (along with Harry Riggs) by the National Osteoporosis Foundation, and in November I gave the American Heart Association Distinguished Lecture talking about our 40-year Rancho Bernardo Study.”

W. Eugene Sanders '56, MD '60, continues to write on the subjects of antiques and philately, while assisting his wife, Christine, in her second career as an artist.

Roger D. Soloway '57, MD '61: “Still working as a hepatologist at the University of Texas Medical Branch in Galveston. Our staff has shrunk from 11 to four clinicians, but we are rebuilding after Hurricane Ike. Our home is rebuilt better than ever under Marilyn's direction. We also have a condo in Haverford, PA, near two of our three sons. We have three wonderful grandchildren. Looking forward to returning for our 50th Reunion.”

Laurance B. Nilsen, MD '62: “Retired from private practice (endocrinology) in 2003. Working once a month at St. Vincent de Paul Medical Clinic at their Tuesday morning endocrine clinic. I still enjoy the patient contact, but glad to be away from the mounting problems of maintaining a private office.”

Barry D. Smith, MD '62: “I have been retired from my position as chair of ob/gyn at Dartmouth for four years. I continue to work half-time doing patient safety, quality improvement, and risk management work at Dartmouth and in New England.”

Donald Catino, MD '64: “Pamela and I went to Cornell's Bugando medical school in October to teach for six weeks. Pamela also worked in an orphanage. In January, we will go to Tasmania to teach and do geriatric patient care at the Royal Hobart Hospital. Retirement is sweet.”

Frances J. Storrs, MD '64: “In 2008 I received the gold medal from the American Academy of Dermatology, its highest honor. That same year an endowment in my name was established at Oregon Health Sciences

University. The first lecturer started in September 2009. I work three days a week, garden, and spend time with family."

Nicholas J. Fortuin, MD '65: "I was honored by Johns Hopkins University School of Medicine with the establishment of the Nicholas J. Fortuin MD Professorship of Medicine (Cardiology), funded by grateful patients. First recipient is Dr. Hugh Calkins. I am delighted to remain in active academic practice at Johns Hopkins."

Ronald H. Geiger, MD '65: "I retired two years ago from an active orthopaedic surgery practice. Teaching first-year medical students one day a week in a course covering the many facets of the patient-doctor relationship is a joy. My wife, Gisela, and I enjoy traveling and spending time with our three children and three grandchildren, who all live in the Boston area."

Deborah Pavan Langston, MD '65: "I'm still at Harvard Medical School as professor of ophthalmology, specializing in transplantation surgery. Just got a new grandchild (Seneca Breonna Ayares), and am about to get two new hips. Approaching 70 is not all that much fun."

Robert M. Farrell, MD '66: "I am still working with no letup in sight. Youngest daughter is entering her third year at Boston College. Newest addition to the family is granddaughter Caroline, who joins grandson Kevin and granddaughter Maggie. Did you know I am one of only three doctors who operated on and retrieved a live grenade out of a living person (during my Vietnam service) and lived to tell the tale?"

Jacqueline G. Parthemore, MD '66: "On July 31, 2009, I retired from the VA San Diego Healthcare System after 37 years of service, 25 of which were spent as chief of staff/medical director. I continue to hold an appointment as professor of medicine at UCSD School of Medicine and will serve as a member of the voluntary faculty at both institutions. My husband, Alan Blank, Weill Cornell resident in ob/gyn, patiently waited ten years for me to join him in retirement. It's a blast."

Orlo H. Clark '63, MD '67: "Enjoying partial retirement at UCSF. Recently was president of the Pacific Coast Surgical Association."

Robert Ennis, MD '67: "After hours I'm president of the Sherlock Holmes Society of Miami and the South Florida Astronomers Association, on the board of directors of several philanthropic organizations,

and chairman of AIPAC Broward County, FL. Also working out at the gym regularly. Retired from surgery, but still teaching, lecturing, and consulting in orthopaedics. My area of research is risk management for VTE in orthopaedic surgery. I'm doing just what I would like, including spending time with Lorelei, my wife of 45 years, my daughters, and grandkids (one of whom is college bound next year). I still have a picture on the wall of my office of Drs. **Preston Wade '22, MD '25**, Frank Glenn, Ernest Lampe, and Elliot Hochstein. They were the best. Sadly, my roommate, Nicholas Vianna, MD '67, passed away several years ago. I think of him often. It is hard to believe that more than 40 years have passed since graduation. I am forever thankful that Cornell gave us the tools and the guidance to become good physicians."

Charles H. Hennekens, MD '67, was recognized for his contributions to medicine by Marty Markowitz, president of the Borough of Brooklyn: "On behalf of Brooklynites, I salute a true son of Brooklyn, Charles H. Hennekens, whose incredible journey and contributions to medicine began with his birth in Bushwick Hospital in 1942, the son of immigrants, who was infused with the values of hard work and determination, graduated from Queens College, Cornell University Medical College, and Harvard School of Public Health. I commend him for his accomplishments that include becoming the first John Snow as well as the first Eugene Braunwald Professor of Medicine at Harvard Medical School, the first chief of preventive medicine at Brigham and Women's Hospital, the first to discover that aspirin prevents a first heart attack, and his current position as the first Sir Richard Doll Research Professor in the Charles E. Schmidt College of Biomedical Science at Florida Atlantic University."

Katherine S. Lane, MD '68, retired in September 2008 after 29 years working for the State of Maine, providing primary general medical care to the patients at the state psychiatric hospital. "Now happily taking care of cows on my small saltwater farm on the Maine coast."

1970s

William W. Goodhue, MD '70, was reappointed first deputy medical examin-

er of the city and county of Honolulu by incoming mayor Mufi Hannemann. As such, Bill, who retired as a colonel in 2001 from the Army, is a de facto mayoral cabinet member. He is clinical assistant professor of pathology at the University of Hawaii Medical School and divides his time between Honolulu and his Anini Beach house on the North Shore of Kauai.

Eric J. Thomas, MD '70: "Active practice, mostly surgery and psoriasis, consults and cosmetics. Website is middlesexdermatology.com. Bike trip to Umbria in September."

Dennis J. Lutz, MD '73: "I am serving as the 74th president of the Central Association of Obstetricians and Gynecologists (founded in 1929). My wife, Meryl (Steinberg), and I were married shortly after graduation 36 years ago and are expecting our fourth and fifth grandchildren by year's end."

Michael K. McLeod, MD '75, is the program director, Michigan State University Integrated Residency program in general surgery, and professor of surgery, Dept. of Surgery, MSU College of Human Medicine.

Martin R. Leopold, MD '78: "I have retired and moved to Colorado to be near my children and grandchildren."

Ann W. Schongalla, MD '79: "I continue in the private practice of adult psychiatry on the Upper East Side. Daughter Sarah, 26, just began law school at Berkeley after three years working in Mexico, including two years with the Center for Sustainable Transportation. Rebecca, 24, played for the Washington Freedom in the first year of the Women's Professional Soccer League and is currently training in Japan. Nathan, 22, is in his senior year at Boston University. Dan works in the Neurology Clinic at Mt. Sinai and in the pharmaceutical industry."

1980s

Barbara A. Phillips, MD '80: "Happy news: All is well with my three children—Ben, Olivia, and Ian—and I am newly married to a wonderful gentleman and relocated to Savannah, GA. Having retired from clinical practice a few years ago, I've become involved with wilderness medicine, dive medicine, travel medicine, infectious and tropical disease medical societies, and CME. It seems you can take the doc out of medicine, but not medicine out of the doc. Regards to all."

Karl Weyrauch, MD '80, was profiled in the August 2009 issue of *Hemispheres*

magazine for his work with Coffee Rwanda, a nonprofit that helps 400 Rwandan coffee farmers and also supports a group of local doctors who serve the Batwa Pygmies. The American outlet is based in Seattle and sells Musasa Nectar, a highlands coffee, and Kivu Bourbon, from Rwanda's lake district.

Elizabeth G. Nabel, MD '81, was appointed president of Brigham and Women's Hospital and Faulkner Hospital in Boston and will begin the new job in January. She is the former director of the National Heart, Lung, and Blood Institute at the National Institutes of Health. Dr. Nabel completed her internship and residency in internal medicine and a clinical and research fellowship in cardiovascular medicine at Brigham and Women's. Before working at NIH, Dr. Nabel served on the faculty at the University of Michigan, where she did research in vascular biology and molecular cardiology.

Charles M. Rosenthal, MD '81: "Still practicing radiology in a small community hospital in Rhode Island. Two of three children are trying to make it on Broadway. Maybe the baby (still in high school) will be interested in medicine."

Elizabeth A. Wuerslin, MD '81: "Working for Children's Hospital in Aurora, CO. Locums service and covering practices in Colorado and Wyoming. Primary pediatric care is treasured health care for our families."

Walter E. Donnelly, MD '82: "My patients are consistently surprised that I favor health-care reform. From my (rare for Cornell) family medicine perspective, Yeats had it right—'Things fall apart; the center cannot hold.' Personally, things are great. Both sons are National Merit scholars (thank goodness for academic scholarships), and our daughter is a delightful high school freshman. We hope to make it to New York City this year."

David A. Asch, MD '84, the Robert D. Eilers Professor of Medicine and Health Care Management and Economics at the University of Pennsylvania School of Medicine and the Wharton School, received the 2009 Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award at the annual meeting of the Association of American Medical Colleges in November.

Elena M. Kamel, MD '84: "Perry Kamel, MD '83, and I just celebrated our 25th anniversary."

Lawrence W. Robinson, MD '84: "I will be starting my program for an MBA at Rensselaer Polytechnic Institute's Lally School of Management in January 2010. My long-term goal is to organize surgical services for a larger health-care consortium. I'll let you know in 18 months when the program is completed."

Roger S. Blumenthal, MD '85: "I am looking forward to our 2010 reunion and will work with **Bob Bully, Dave Blaustein, Steve Berger**, and



Also on hand for the festivities in Boston were (left to right) Lewis Drusin, MD '64, Thomas Lee, MD '79, and Stanley Ashley, MD '81.

Melissa Ashlock [all MD '85] to contact our classmates. My son, Ross, is now a fourth-grader and loves soccer, basketball, and lacrosse. I have been working hard on a new cardiology textbook as editor-in-chief. It will be out before our reunion."

Montgomery B. Douglas, MD '86: "Due to the closure of my hospital, I am no longer at Mary Immaculate and St. John's Queens hospitals (formerly St. Vincent Catholic Medical Centers). I'm now full-time at New York Medical College in Valhalla, Westchester, as chair of the Dept. of Family and Community Medicine."

Lisa Lavine Nagy, MD '86: "I'm an environmental health activist and educator. I was just appointed to a government working group on the scientific understanding of the effect of chemicals and mycotoxins on public health. Also held a meeting at NIH with Linda Birnbaum, the director of NIEHS, the AMA, and environmental medicine physicians (Bill Rea and others). This is the first time these players have ever sat together at one table. We discussed CFS, chemical sensitivity, Gulf War Syndrome, and the available treatment for these conditions via the environmental medicine approach. Hope to start practicing medicine again this year at my Comprehensive Medicine Clinic of Martha's Vineyard. Hope to help people get well from chronic inflammation, environmental exposure, and you name it. I remember most anatomy class and the smell of first-year students' clothing. I couldn't stand up when all the bodies were open because the smell

I've become involved with wilderness medicine, dive medicine, travel medicine... You can take the doc out of medicine, but not medicine out of the doc.

Barbara A. Phillips, MD '80

of formaldehyde made me dysautonomic. Now that is my medical specialty. Funny how things come around. After hours I ride my horse, Noodle, over really big fences."

Neil L. Watkins '82, MD '86: "Son Christian is now in his first year at Maryland Institute College of Arts (MICA) in Baltimore."

Theresa M. Rohr-Kirchgraber, MD '88: "Two kids off at college, one left at home. **Paul, MD '88,** and I stay busy. He was recently promoted to a global position with Covance Labs, and while that is great, he now has three jobs to do. He enjoys the travel and the work. I am working more with patients who have eating disorders and will work more with our teen bariatric surgery program. Enjoying teaching, writing, and seeing patients in Indianapolis. Am now the director of girls hockey in Indy!"

Phyllis L. Townsend, MD '88: "I am currently a partner in a suburban pediatric practice in Tennessee, Pediatric Associates of Franklin. I've been here 11 years. I have faculty privileges at Vanderbilt Medical School and supervise students and residents in my office. I'm married with two girls, 13 and 11. Life is good."

1990s

Philip A. Goldberg '92, MD '96, is now a full partner of Endocrine Associates of Connecticut (New Haven, CT), as well as an assistant clinical professor of medicine at Yale University. And he can still "shoot the three-ball."

Mary Beth Lewis-Boardman, MD '98: "After four years of living in Florida, I officially feel more like a Floridian than a native Northeasterner. My private practice in ob/gyn is flourishing. I am looking forward to a long weekend in New York City in April to show my 8-year-old daughter, Annabella, the city in which she was born. I welcome contact from any of my classmates who travel to the Orlando area (mblboardman@gmail.com).

Maithily A. Nandedkar-Thomas, MD '99: "What a busy year! I was selected to be one of six dermatologists who make up the dermatology section of CCHIT. My paperless practice has become a model for how to do medicine in the modern era. So far it has been a great year. I'd love to be a part of the ASK program. Please visit my website at www.professionaldermatologycare.com."

2000s

Steven Milman '98, MD '02: "Nicole and I have recently moved to Baltimore, where I'm a thoracic surgeon. Our daughter, Grace, also just welcomed a little brother, Aarre. Would love to hear from my classmates; e-mail is the best way to get in touch (milman_s@hotmail.com)."

Helen Azzam, MD '03, and **George Koenig** were married one year ago in historic Gettysburg, PA. Guests were treated to a Labor Day weekend of apple-picking and relaxing in quaint environs, culminating in a beautiful lantern-lit ceremony at a small ski resort outside of Gettysburg. **Kelly Krueger Barrows '99, MD '03,** was also in attendance. After graduating from Weill Cornell, Helen went to the University of Pennsylvania for residency in internal medicine and a fellowship in infectious diseases. She is currently at Johns Hopkins studying public health and preventive medicine. George completed medical school training at the Philadelphia College of Osteopathic Medicine and a surgical residency in the Mercy Health System of Southeastern Pennsylvania. He is currently doing a fellowship in trauma and surgical critical care at the Johns Hopkins Hospital. They live in Baltimore, halfway between their two sets of families in Pennsylvania and Virginia. They are very busy but very happy.

Matthew J. DiPaola '98, MD '03: "Just finished a fellowship in shoulder and elbow reconstruction at NYU Hospital for Joint Disease. Ready to start repaying my loans. I am now in the Cincinnati-Dayton area working with Wright State University and the Dayton VA system as assistant professor of orthopaedics. My wife, Krystene, is a reproductive endocrinology fellow at the University of Cincinnati, and we are expecting our first baby in January. To top it off, I started a blog at matthewdipaolamd.com. Check it out if you have time."

Catherine L. Harrison-Restelli, MD '04, is completing a fellowship in psychosomatic medicine (consult-liaison psychiatry) at the University of Maryland and has started a small perinatal psychiatry clinic seeing pregnant and postpartum patients with a range of mood, anxiety, psychotic, and substance use disorders with the ob/gyn clinic.

In Memoriam

'27 MD—Lyman G. Fussell of Amherst, NH, formerly of Mineola, NY, September 24, 2009; general practitioner; chief police surgeon, Nassau County Police Dept.

'35 BA, MD '43—Philip H. Voorhees of Midlothian, VA, formerly of Morristown, NJ, July 16, 2009; retired urologic surgeon; veteran.

'44 MD—Allan L. Goulding of Billings, MT, September 8, 2009; practiced internal medicine; president, Billings Deaconess and St. Vincent hospitals medical staffs; medical director, St. Johns Nursing Home; chairman, St. Johns Foundation; first director, Deaconess Hospital Elder Care Assessment Clinic; established first isotope lab in Montana at Deaconess Hospital; veteran; active in community, professional, and religious affairs. Wife, Natalie (Sundberg) '45.

'44 BA, MD '46—Theodore E. Hauser of Carlsbad, NM, March 20, 2009; chief of staff and president, Carlsbad Medical Center; established ICU and CCU units at Carlsbad Medical Ctr.; also practiced at New York Hospital and Fitzsimmons Army Hospital; veteran; helped to found Living Desert Park; active in civic, community, professional, and religious affairs. Sigma Chi. Wife, Ruth (Bowman) '45.

'47 MD—Jonathan O. Cole of Cambridge, MA, May 26, 2009; psychiatrist; pioneer in psychopharmacology; former chief of psychopharmacology, McLean Hospital; first director, psychopharmacology research branch, Nat'l Institute of Mental Health; veteran; author; active in community and professional affairs.

'47 MD—Joseph L. Gluck of West Grove, PA, formerly of New Bern, NC, and Red Bank, NJ, November 23, 2009; practiced internal medicine and cardiology; taught medicine at East Carolina U.; veteran; active in community affairs.

'45, BA '44, MD '47—William J. Grant of Fort Myers, FL, March 19, 2009; physician. Sigma Pi.

'47 MD—Thomas R. Hedges Jr. of Cherry Hill, NJ, September 10, 2009; established and ran the ophthalmology section,

Pennsylvania Hospital; professor of ophthalmology, University of Pennsylvania and Cooper Hospital CMDNJ; researched the effects of intracranial pressure on the optic nerve, Coriell Laboratory; co-founder, Int'l Neuro-ophthalmology Society; author; active in professional affairs.

'47 MD—Claude O. Truss of Birmingham, AL, September 12, 2009; chief of cardiology, US Air Force Hospital, Maxwell Field, AL; practiced internal and allergy medicine; researched the role of *Candida albicans* in illness; author; active in professional and religious affairs.

'49 MD—Frances Capron Korb of Santa Rosa, CA, September 21, 2009; psychotherapist; pediatrician; trained therapists; helped establish Thomas Creek Ranch; developed an interactive science program for Sonoma County (CA); docent, Bouverie Preserve and Audubon Canyon Ranch; active in civic, community, and professional affairs.

'50 MD—Claude W. Trapp Jr. of Lexington, KY, December 13, 2009; ophthalmologist; veteran; aide to General Chiang Kai-shek; recipient of the Brotherhood Award from the National Conference of Christians and Jews; jade collector; active in civic, community, professional, and religious affairs.

'46 BA, MD '50—Joan Rider Trapp (Mrs. Claude W., MD '50) of Lexington, KY, November 4, 2007; pediatrician; practiced with Rider and Ramsey and Westside Pediatrics; active in civic, community, professional, and religious affairs.

'51 MD—William A. Triebel of Port St. Lucie, FL, August 17, 2009; retired psychiatrist; teacher; author.

'52 MD—Arthur Carlson of Wyomissing, PA, formerly of Glen Cove, NY, October 27, 2009; chief of pathology, New York Hospital and Community Hospital (Glen Cove); attending-in-charge of nuclear medicine, Community Hospital; pioneer in diagnostic nuclear medicine; worked on the Manhattan Project; cardiovascular researcher; chemical engineer; active in community and professional affairs.

'52 MD—Clinton B. Potter of Warren, RI, August 26, 2009; physician.

'50 BA, MD '54—David H. Law IV of Seminole, FL, August 22, 2009; associate chief of staff for education, VA Medical Center (Bay Pines, FL); director of medical service, Dept. of Veterans Affairs; chief of medicine, Albuquerque VA Medical Center;

vice chairman, New Mexico School of Medicine; medical director and outpatient chief, Division of Gastroenterology, Vanderbilt U. Hospital; special consultant to the Nat'l Institutes of Health and the Interdepartmental Committee on Nutrition for National Defense; veteran; active in professional affairs. Beta Theta Pi.

'55 MD—Stephen M. Ayres of Hampton, VA, September 12, 2009; cardiologist and critical care specialist; dean, Medical College of Virginia; worked on global health initiatives in Azerbaijan, Belarus, and Chernobyl; served on the US Science Advisory Board, Environmental Protection Agency; chairman, department of internal medicine, St. Louis University; medical director, St. Louis University Hospital; also worked at hospitals in Massachusetts, New Jersey, and New York; active in professional and religious affairs. Wife, Dolores (Kobrick) '53.

'55 MD—John B. Lange of Hendersonville, NC, October 24, 2009; director, Western Carolina Occupational Health Center, Pardee Hospital; corporate medical director, Inland Steel Co.; staff physician, Newport News Shipbuilding; veteran; raised Angus cattle; photographer; gardener; active in community, professional, and religious affairs.

'56 MD—Harry G. Browne of Reno, NV, formerly of Diablo, CA, August 27, 2009; pathologist; expert in tropical medicine; co-founder, Int'l Clinical Laboratories and Therapeutic Antibodies; director, Dept. of Parasitology, US Naval Medical Research Unit #3 (Cairo, Egypt); former assistant professor, Vanderbilt University Medical School; veteran; active in professional and religious affairs. Wife, Jean (Kerstetter) '55.

'57 MD—Raymond M. Biggs of Covina, CA, September 14, 2009; president, Magan Medical Clinic; active in civic, community, and professional affairs. Wife, Barbara (Burton) '58.

'57 MD—John A. Gerda of Stratford, CT, October 25, 2009; retired physician, US Food and Drug Administration; staff surgeon, St. Elizabeth's Hospital; surgical program director, National Cancer Institute; veteran.

'58 MD—Ari Kiev of Park Ridge, NJ, November 18, 2009; associate professor of psychiatry, Weill Cornell Medical College; TV host, "Sunrise Semester"; founder, Life Strategy Workshops; founder and director, Suicide Prevention Clinic, NewYork-Presbyterian/Weill Cornell; first psychiatrist appointed to US Olympic Sports Medicine Committee; founder, Kiev Foundation, which donated over 15,000 rare books on Jewish theology to George Washington U.; author of *Strategy for Daily Living*, *Trading to Win*, and many other books; trading coach, SAC Capital; lecturer; veteran; active in community, professional, and alumni affairs.

'61 MD—James W. Brown of New York City, July 30, 2009; clinical associate professor of psychiatry and associate attending psychiatrist, NewYork-Presbyterian Hospital; associate attending psychiatrist, Hospital for Special Surgery.

'76 MD—James W. Hare of Mequon, WI, August 10, 2009; clinic director and physician, Concentra Occupational Health; regional medical director, United Health Care; clinic director, Family Health Plan Cooperative; medical missionary; veteran; active in civic, community, professional, and religious affairs.

We want to hear from you!

Keep in touch with your classmates.

Send your news to Chris Furst:

cf33@cornell.edu

or by mail:

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A Mile in Their Shoes

Dr. Desiree Pardi didn't just lead palliative care;
as a cancer patient, she also lived it

Desiree Pardi was a third-year medical student when she was diagnosed with stage-three breast cancer. The thirty-year-old had been on an airplane, en route to the United Arab Emirates, when she felt a sharp pain under her left arm. A week later, doctors in Dubai biopsied an egg-sized lump in her breast. When it came back malignant, they scheduled a lumpectomy for the next day—and when they found that the cancer had invaded her lymph nodes, a radical mastectomy for the day after that. As Pardi recalled in a 2005 article in *Fitness*: “Almost overnight, I’d gone from being a happy and fun-loving doctor-in-training to a lopsided, disfigured cancer patient fearing for my life.”

The experience not only changed the course of Pardi’s life, it inspired an abiding passion and formed the basis of a career. After completing her MD and PhD at Mount Sinai, an internal medicine residency at NewYork-Presbyterian Hospital/Weill Cornell Medical Center, and a fellowship in pain management at Sloan-Kettering, she was hired as director of the palliative care service at NYP/Weill Cornell—a job she held until September, when she passed away at age forty-one. At her memorial, Ronald Adelman, MD, co-chief of the Division of Geriatrics Medicine and Gerontology, recalled her initial interview, in 2005. “Given her minimal experience, her youth, and concerns about her potential health issues, we paused for just one second,” he said. “But her sense of mission, her charisma and passion, were so powerful that my co-chief Mark Lachs and I hired her to direct our new service—one of the best decisions we have ever made.”

The memorial was held on October 15, 2009, what would have been Pardi’s twentieth wedding anniversary. She and her husband, Robert, a portfolio manager for a Dubai-based finance firm, had met during her first day at SUNY Stony Brook; she was a freshman, he a sophomore. Robert recalls that she struck up a conversation with him, but he was preoccupied with another girl. “Six weeks later,” he says, “I told my mother I’d met the woman I was going to marry.”

Asked to describe his late wife’s interests, Pardi laughs; there were just too many to count. Belly dancing lessons. Learning the guitar. Singing in a choir. “Knitting, drawing, you name it,” he says.



PROVIDED BY ROBERT PARDI

Desiree Pardi, MD, PhD

“She had more hobbies than I’ve ever seen anyone have.” She traveled to India to volunteer in hospitals, orphanages, and soup kitchens. She loved yoga so much that she paid an instructor to lead a monthly class for her palliative care team. She founded a charity whose members would fast one day a week and donate the money they had saved to local food banks. Just before her death—which, though it followed a long illness, was unexpected—she was talking about leading walking tours of New York City and getting a pilot’s license. “If she saw something she liked, she’d dive into it,” her husband says. “She had a passion for life, learning, and service.”

The illness that curtailed Pardi’s life gave her a rare insight into the patient experience, enriching her ability to help people as they grappled with pain and disease. Pardi felt strongly that palliative care isn’t just for the end of life—it’s essential to the treatment of chronic conditions. “She took what could have been an embittering experience,” says Lachs, “and made it into something beautiful.”

As much as her disease informed her practice, watching her husband cope gave her immense empathy for how illness affects families. But Robert Pardi notes that only rarely did she share her diagnosis with the people she treated. “I think there was only one patient she ever told,” he recalls. “It was because it was the only way to get through, because the woman had so much anger. My wife lifted her wig and said, ‘You know, I really do understand.’ She said the woman broke down and was so thankful. She called my wife an angel for understanding things she couldn’t put into words.”



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30 th	35 th	40 th	45 th	
1979	1974	1969	1964	
1980	1975	1970	1965	
50 th	55 th	60 th	65 th	
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