

The Inside Story

Most men take better care of their cars than their bodies—but attitudes are changing

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A handwritten signature in red ink, appearing to read "Marc Krause". The signature is written in a cursive style and is positioned below the printed contact information.

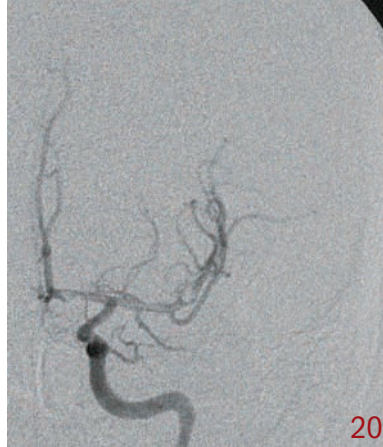
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THE MAGAZINE OF THE JOAN AND SANFORD I. WEILL MEDICAL COLLEGE AND GRADUATE SCHOOL OF MEDICAL SCIENCES OF CORNELL UNIVERSITY

20 TIME=BRAIN

BETH SAULNIER

For stroke patients, the clock is the enemy. Patients who arrive at Weill Cornell's Stroke Center soon after the onset of a stroke have a far better prognosis than they did only a few years ago. But even for those who have already suffered serious brain damage, the Center offers the latest in treatments and rehabilitation—as well as a sympathetic staff.



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C. A. CARLSON

Most men are cavalier about their health, and they often skip annual physical exams and put off diagnostic tests until it's too late. Weill Cornell physicians are working to change those attitudes, striving to get men to pay more attention to such important problems as prostate cancer, infertility, heart disease, and high blood pressure.

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BETH SAULNIER & MICHAEL SELLERS

A look back, in words and photographs, at the early days of the nursing profession, including the founding of the Training School for Nurses at New York Hospital in 1877. The archival material is complemented by two profiles of contemporary nurses, one female and one male, who work at NewYork-Presbyterian Hospital/Weill Cornell Medical Center.



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Cover illustration by Robert Neubecker

Growing for the Future

ANTONIO GOTTO JR., MD
Dean of the Medical College



WEILL CORNELL MEDICAL COLLEGE'S LOCATION on the Upper East Side of Manhattan has afforded many unique opportunities for the College, from establishing a groundbreaking partnership with the former New York Hospital in 1927 to the more recent Tri-Institutional affiliations with neighboring Memorial Sloan-Kettering Cancer Center and the Rockefeller University.

Through those affiliations and other endeavors, the Medical College has continued to grow—particularly over the last ten years—at a phenomenal rate. One way of measuring our growth is the ever-present need for new facilities, a “bricks and mortar” approach that reflects the increasing number of students and faculty and a greater need for more research space within the community.

Currently the Medical College has several major facilities projects under way, collectively called the Major Upgrade Projects, all of which have begun construction since the first of the year and are expected to be completed by the end of 2007. These projects will consolidate and rationalize research space in several Medical College buildings on York Avenue, resulting in 94,000 square feet of new and renovated laboratory space.

One major element of the Major Upgrade Projects is a three-story addition to the Medical College's E Building, an effort to build vertically rather than horizontally into the neighboring community. The rooftop addition, which will utilize glass and brick to create a modern interpretation of the original 1930s building, provides office space for the Research Animal Resource Center, as well as research

space for neurology, pharmacology, pediatrics, and dermatology.

Many of the physicians and scientists who will be conducting research in these facilities will also benefit from Riverwalk Place, another recently completed project. This condominium building on Roosevelt Island features eighty-eight apartments reserved for our faculty, postdoctoral trainees, and their families. This residence is a major part of the Medical College's faculty recruitment effort, since it offers young faculty and their families an affordable place to live that's just minutes from York Avenue.

Additional projects include the creation of two Distance Learning Broadcast Studios to deliver real-time instruction from faculty in New York to medical students at the Medical College's Qatar campus, as well as the expansion of the Department of Information Technologies and Services, which provides technology support for faculty and students.

In addition to these facility improvements, we are thrilled to report that our 300,000-square-foot, state-of-the-art Ambulatory Care and Medical Education Building, the centerpiece of the recently completed \$750 million capital campaign, is slated to open in December. Servicing Weill Cornell's million-plus ambulatory and clinical patient visits each year, this wonderful building will serve as the flagship educational building for Cornell University in New York City.

Expanding our facilities has also contributed to other projects closely linked to the College's growth. Over the last twelve months, four Weill Cornell Medical College start-up companies were formed and forty-eight patents were granted for Weill Cornell innovations. Because of several major gifts to the institution, the Medical College also established new centers and core facilities, including the Lehman Brothers Lung Cancer Research Center, the Abby and Howard P. Milstein Chemistry Core Facility and Program in Chemical Biology, and the Arthur and Rochelle Belfer Institute of Hematology and Medical Oncology.

The College's growth is also measured in myriad other ways, beyond “bricks and mortar,” that include the growing number of students and faculty and the size of the Medical College's endowment, among others. But these much-needed expansions and renovations, several of which have been funded entirely through philanthropy, will benefit all three areas of Weill Cornell's triple mission of education, research, and patient care.

— Dean Antonio Gotto

Career Pathways for Our Recent Graduates

DAVID HAJJAR, PHD

Dean of the Graduate School of Medical Sciences

AT OUR COMMENCEMENT EXERCISES THIS spring, the Graduate School conferred thirty-nine doctoral degrees and twelve master of science degrees in a joint ceremony with the Medical College at Carnegie Hall. This year's graduates were an especially impressive group, collectively publishing sixty research papers and participating in research symposiums (here and around the country) in record numbers. On commencement day, our new graduates celebrated their superb achievements with family and friends as they contemplated their next steps in biomedical research.

Most graduates go on to postdoctoral positions at prestigious institutions that value the training they received during their years at Weill Cornell. Graduates will join laboratories at the Salk Institute, UCLA, MIT, Harvard, and the University of Chicago, to name just a few. Some will stay right here in New York City, beginning fellowships at Columbia, NYU, Sloan-Kettering Institute, and Weill Cornell.

Typical of the search for the perfect postdoctoral fellowship is that of our new graduate Li Ma. Li studied with Dr. Pier Paolo Pandolfi in the Sloan-Kettering division, focusing on cancer models and mechanisms. Her current research interests lie at the intersection of two fields of biology: cancer and stem cells. Li applied for five postdoc positions, but was most intrigued by the work of Dr. Robert Weinberg at the Whitehead Institute at MIT. His lab focuses on cancer metastasis and cancer stem cells. At Li's interview with Dr. Weinberg in March, he showed particular interest in her research, and she accepted a position in his lab a month later. She's looking forward to her new position and hopes one day to become an independent researcher with her own laboratory.

Graduate Karen Wu, who was honored this year with a Julian Rachele Prize, will travel uptown to Columbia University to join the laboratory of Dr. Peter Scheiffele in the Department of Physiology and Cellular Biophysics. There, she will continue her training in neuroscience, deepening her understanding of synapse formation.

Adriana Galvan is moving across the country to continue her neuroscience training. She'll be doing a postdoc at UCLA's Human Brain Mapping Center with Dr. Susan Bookheimer

and Dr. Russell Poldrack. She tells us that her research project will build on the training she received with Dr. B. J. Casey on adolescent brain development and will study atypically developing adolescents with psychiatric disorders. Adriana will start her postdoc in September, after getting married this summer to Bill Lowery, a 2002 graduate of Weill Cornell, who, after completing a postdoc at the Rockefeller University this spring, has accepted an academic appointment at UCLA in the Department of Molecular, Cellular, and Developmental Biology, where he will concentrate his research on stem cell biology.

Academic postdocs are the choice of many, but our graduates are also taking full advantage of other options open to them. Some are jumping into biomedical careers in the private sector, accepting jobs at established companies or taking the lead in smaller start-up companies. Some are interested in public policy and have taken jobs advising the government on science issues. A few are continuing their education by pursuing additional degrees in law or business.

In every case, our graduates are poised to take leadership positions in basic and translational science, making important discoveries that will contribute to health care for decades to come. Training at the Graduate School is a fertile ground for success in all of the career choices our graduates have made, and we wish them all the best.

— Dean David Hajjar



Moving on: Dr. Li Ma (left) celebrates commencement with Dr. Dandan Shan and Dr. Randi Silver, associate dean of the Graduate School.



EILEEN MILLER

Benefactor: Howard Milstein announces the presentation of a gift that will establish two new programs in chemical biology.

Milstein Gift Boosts Biomedical Research

a \$7.25 MILLION GIFT FROM LONGTIME BENEFACTORS ABBY and Howard Milstein will establish two programs named in the donors' honor: a Chemistry Core Facility and a Program in Chemical Biology. The two entities will expedite the discovery of new drug treatments, foster collaborations, and bolster the fight against disease. The Milstein gift came as part of the Medical College's recently completed "Advancing the Clinical Mission" capital campaign.

The Core Facility, located in the Department of Biochemistry and Structural Biology, will be open to all Cornell faculty in support of diverse types of biomedical research. The Program—which will combine chemical biology with genetics, biochemistry, molecular biology, and immunology—will initially focus on such infectious diseases as malaria and tuberculosis, which kill millions every year, especially in Africa.

A Clean Bill of Health

IN HIS TENTH ANNUAL STATE OF THE MEDICAL COLLEGE AND GRADUATE School of Medical Sciences speech on June 7, Dean Antonio Gotto highlighted Weill Cornell's growth over the last decade. Topics included student performance, financial strength, and goals in research and recruitment, especially in relation to the "Advancing the Clinical Mission" campaign.

As seen in MCAT scores of incoming classes that are consistently above the national mean, the Medical College continues to attract students from around the globe who outperform their peers, Gotto told the capacity audience in Uris Auditorium. Other key accomplishments, he noted, include a drop of approximately 5 percent in student indebtedness over the last year—thanks to an increase in scholarships—and the continued success of the Tri-Institutional MD-PhD Program, which at 22 percent has the highest proportion of underrepresented minority students of any such program in the country. The Medical College has grown significantly over the last decade—especially the Graduate School, where enrollment has jumped more than 40 percent since 1997. There have also been major upgrades to the physical plant, Gotto said, including the renovation of nearly 25 percent of the research spaces in the hospital and the Whitney building.

Looking to the future, the dean outlined Weill Cornell's short-term goals, which include increasing funding for new research cores and facilities, retaining and recruiting faculty, and bolstering the school's commitment to information technology. "It is the network of Medical College departments, working together, that has helped us grow," Gotto said. "We face a bright future together."

New Development Director Named

PATRICIA GUTTER HAS BEEN APPOINTED DIRECTOR OF THE OFFICE OF Development at the Medical College and NewYork-Presbyterian

Hospital/Weill Cornell Medical Center. Gutter has held a number of positions during her six-year tenure at the institutions, most recently serving as director of major gifts. In her new post, she oversees development and fundraising, including major gifts, planned gifts, and corporate and foundation relations. She holds a master's of social work from Fordham University and a BA from the College of Mount Saint Vincent.

MD-PhD Student Elected Student Overseer

ANKIT PATEL, A FIRST-YEAR STUDENT IN the Tri-Institutional MD-PhD Program, has been elected student representative to the Medical College's Board of Overseers. As an undergraduate, the twenty-three-year-old Patel served a term as president of Cornell's College of Agriculture and Life Sciences honor society. He has pledged to "work tirelessly with the administration to assure that the students' voice is heard."



WEILL CORNELL ART & PHOTO

Psychiatrist Ballard Retires

AFTER THIRTY YEARS OF SERVICE AND commitment to medical education and equal opportunity, Dr. Bruce Ballard was honored on May 31 at a retirement reception in Griffis Faculty Club. Students, staff, and faculty paid tribute to the associate professor of clinical psychiatry through speeches and gifts, including a portrait of Ballard signed by the Class of 2009. Ballard had also served as associate dean of the Office of Student Affairs and Equal Opportunity Programs since 1981.



AMELIA PANICO

Gifts Aid in Cancer Fight

TWO MAJOR GIFTS ARE HELPING TO GIVE WEILL CORNELL SCIENTISTS THE tools they need to unlock cancer's secrets. In March, the Lehman Brothers Foundation announced it had pledged \$6 million toward the Lehman Brothers Lung Cancer Research Center, a core component of the newly established Lung Cancer Research Institute. A month later, the College announced an \$8 million pledge from the Belfer Foundation to create the Arthur and Rochelle Belfer Institute of Hematology and Medical Oncology. "Both of these initiatives will spearhead research that can have a real impact in the prevention,

diagnosis, and treatment of two major killers: lung and blood cancers," says Dean Antonio Gotto. "These generous gifts will help us expand and improve our world-class research programs, and translate new insights into interventions that can aid patients at the bedside as soon as possible."

The Lehman Brothers gift—boosted by a significant contribution from Medical College Overseer Dr. Madelyn Antoncic and her late husband, Dr. Albert Johnson—will speed the groundbreaking of a new state-of-the-art cancer research laboratory and help recruit some of the world's top experts in lung oncogenesis. The Belfer pledge will fund an extensive renovation of the Medical College's hematology and medical oncology labs, and also help to purchase new equipment for its tissue bank and aid in the recruitment of eight new faculty members focused on translational and clinical research.

Hamburg Works to End Genocide

A WEILL CORNELL SCHOLAR WITH AN EXTENSIVE BACKGROUND IN psychiatry and public health has been appointed by Secretary General Kofi Annan to chair the newly formed United Nations Advisory Committee on Genocide Prevention. The committee will provide guidance and support to the Secretary General's Special Adviser on the Prevention of Genocide, and contribute to the U.N.'s efforts to avert crimes against humanity. David Hamburg is a DeWitt Wallace Distinguished Scholar at Weill Cornell Medical College and president emeritus of the Carnegie Corporation. "David Hamburg is a wise and tireless activist in the cause of peace," says Vartan Gregorian, president of the Carnegie Corporation. "His history of leadership in the fields of research and public policy, and his preventive orientation to serious global problems, make him the ideal choice for this prestigious appointment."

HIV Pioneer to Lead Research Publication

AWARD-WINNING HIV/AIDS RESEARCHER Dr. Jeffrey Laurence has taken over as editor-in-chief of the newly re-christened journal *Translational Research*. The monthly journal of the Central Society for Clinical Research was published for ninety years under its former title, the *Journal of Laboratory and Clinical Medicine*. Laurence's appointment, says Department of Medicine chairman Dr. Ralph Nachman, "reflects the strong commitment he and others at Weill Cornell place on translational medicine, with breakthroughs in the lab leading to practical applications in the clinical setting."



WEILL CORNELL ART & PHOTO

from the bench

Simulating Surgery



Training with computer-based “surgery simulators” may create better surgeons. A double-blind study at NewYork-Presbyterian Hospital/Weill Cornell Medical Center found that residents trained with the device—a mannequin with lifelike interactive anatomy—performed procedures to repair blockages in the legs faster and more accurately than their peers without the simulator training. “We have come a long way from the ‘see one, do one, teach one’ days of surgery,” says Weill Cornell surgery professor Dr. K. Craig Kent, the study’s principal investigator. “With simulators, surgeons in training can become very good at a particular technique before actually laying hands on a real patient.”

During the training, residents practice on a “virtual patient” on an operating table, surrounded by working monitors. The surgeon pierces the simulator’s “skin” with a needle, inserts a catheter into an “artery,” snakes it to the indicated area, and executes a repair. The study followed twenty residents of equal ability, divided into two groups—one group trained on the simulator and the other not. Following training, each resident performed two consecutive procedures on actual patients. The surgeries were mentored by attending surgeons who graded each resident’s performance. The results were presented at the annual meeting of the American Surgical Association in April.

EC Does It

Research into the body’s endocannabinoid (EC) system shows promise in combating obesity and its associated health risks, says the director of the Comprehensive Weight Control Program

at NewYork-Presbyterian/Weill Cornell. “The picture that is emerging is that there’s a cascade of events that occur as a result of an overactivated EC system,” says Dr. Louis Aronne, clinical professor of medicine. “As we learn more about this system, I believe we’ll see a shift in the treatment of obesity, which will effectively reduce cardiovascular disease.”

Researchers believe that the EC system acts as a modulator and coordinator of a variety of processes that regulate weight, energy, and glucose, as well as the production and accumulation of triglycerides in adipose tissue and liver—all of which appear to play important roles in insulin resistance and diabetes. “It seems as though the EC system receptors are overactivated when ‘fattening’ foods are consumed and weight is gained,” Aronne says. “This overactivation leads to an increase in food intake and more fat production in the liver. Eventually, what starts out as just eating the wrong foods will lead to the development of obesity, cardiometabolic risks, and heart disease.”

Aronne stresses that the discovery of the EC system is not a “miracle” for those struggling with obesity, and that many questions remain. Clinical trials of receptor-blocking drugs, some already in Phase III and IV, are currently under way.



Birch Bark vs. Cancer

A compound found in the bark of the white birch tree, long known to be a powerful anti-cancer agent, may finally have been made suitable for drug development. For decades, scientists have been trying to turn betulonic acid—a stubbornly water-insoluble compound—into a form that can be readily absorbed by the body. “Already, in mouse studies, we’ve found that our water-soluble compound—called Boc-lysinated-betulonic acid—has achieved up to 92 percent inhibition of prostate tumor growth compared to controls,” says lead researcher Dr. Brij Saxena, the Harold and Percy Uris Professor of Reproductive Biology. His team, which has been working on the problem since the mid-1990s, published its results in *Bioorganic & Medicinal Chemistry* in July.

While the acid has proven effective in culture against a wide range of cancers, Saxena’s team focused on prostate cancer because it is so widespread and there are no drugs that can stop it once it metastasizes. In cell culture, Boc-lysinated-betulonic acid inhibited the growth of human prostate cancer cells by nearly 96 percent. And in the first-ever *in vivo* trial conducted with the compound, the new drug inhibited the growth of grafted human prostate-cell tumors in mice by up to 92 percent, with no apparent toxic effects.

Combat Pay

Because U.S. soldiers in Iraq and Afghanistan are surviving injuries that in previous conflicts likely would have been fatal, the number of wounded with major tissue loss has never been so high. Recognizing the need for novel approaches that might restore lost or damaged tissue, the Defense Advanced Research Projects Agency (DARPA) has awarded a \$3.7 million grant to fund a multi-center initiative with scientists from six institutions, led by the University of Pittsburgh's McGowan Institute for Regenerative Medicine.

The team includes Dr. Lorraine Gudas, the Revlon Pharmaceutical Professor of Pharmacology and Toxicology at Weill Cornell and an expert in retinoid pharmacology, stem cells, and cell differentiation. Much of its efforts will concentrate on examining the systems that allow certain animals, such as salamanders and newts, to completely regenerate lost tissue. The grant supports the project for one year; the agency could provide additional funding for up to three more years.



Dr. Lorraine Gudas

WEILL CORNELL ART & PHOTO

In the Blood

New research shows that a novel secreted protein helps build new blood vessels by encouraging the migration of cells from the marrow to tissues in need of new vasculature. Investigators say the protein, stromal-derived factor 1 (SDF-1), does so independently of another growth factor already known to be involved in the process.

The finding, reported in the May issue of *Nature Medicine*, may bring scientists closer to treatments for vascular diseases afflicting patients with diabetes or atherosclerosis and others threatened by dangerously poor circulation; it may also have significant implications for cancer research. "Up till now, we've been looking for a 'missing link' in the process whereby blood-forming cells in the marrow head to the site of injury to rebuild and sustain the vasculature," says lead researcher Dr. Shahin Rafii, the Belfer Professor of Genetic Medicine. "SDF-1 looks like it could be that missing link."

Inside Alzheimer's

Experts have long known that a buildup of beta-amyloid protein "plaques" around and between neurons is a hallmark of Alzheimer's disease. They've also known that neurological decline can occur prior to this buildup. Research on mice engineered to develop an Alzheimer's-like illness has now shown that beta-

amyloid builds up *inside* neurons—specifically, on intracellular trafficking structures called multivesicular bodies.

"The brain cell isn't killed, but it is impaired in its function," says Dr. Gunnar Gouras, director of the Laboratory of Alzheimer's Disease Neurobiology and associate professor of neurology and neuroscience. "And all of this occurs long before we see any evidence of plaque buildup outside the cell." The work, reported in the April 26 issue of the *Journal of Neuroscience*, could lead to new ways to fight the disease. According to the Alzheimer's Association, more than four million Americans suffer from Alzheimer's, with that number expected to quadruple by mid-century. Presently, a few drugs can temporarily ease symptoms, but there is no effective treatment or cure.

Myeloma Therapy Approved

The FDA has approved Revlimid (lenalidomide) as a treatment for multiple myeloma. The oral regimen, which includes a combination of Revlimid and a steroid, is indicated for relapsed patients who have not responded to other chemotherapy agents. Of all the centers participating in the Phase III clinical trial, NewYork-Presbyterian/Weill Cornell had the greatest number of enrolled patients in the U.S.

FDA approval came after trials in which patients who took Revlimid and dexamethasone survived an average of nearly thirty months. In contrast, those on dexamethasone and placebo survived a little over twenty months. Multiple myeloma is incurable and one of the most deadly cancers, with a typical life expectancy of four years. The results were presented at the American Society of Clinical Oncology's annual meeting in June.

Secrets of SARS

The SARS coronavirus that sparked a global panic three years ago uses a key coat protein, called S2, to gain entry into human host cells. Now, a team of Weill Cornell biochemists has identified four important steps in this process, each of which could be a target for drugs or vaccines.

Severe acute respiratory syndrome was first reported in Asia in February 2003. Over the next few months, the illness spread to more than two dozen countries before the outbreak was contained. According to the World Health Organization, some 8,100 people became sick and nearly 800 died. Although there has not been another outbreak since then, scientists have worked to find ways to fight the disease if it reappears.

"Because it lies on the outer membrane, S2 is really *the* prime target for neutralizing antibodies," says Dr. Min Lu, associate professor of biochemistry, whose team published its findings in the journal *Structure* in May. "Right now, development of a SARS vaccine remains a long shot, but this kind of research at least gives us a place to start."

tip OF THE cap to...

Dr. **Joseph Fins**, chief of the Division of Medical Ethics and professor of medicine, public health, and medicine in psychiatry, named to the editorial board of *BMC Medical Ethics*, a peer-reviewed online publication focused on the ethics of medical research and practice.

Dr. **Michel Gagner**, professor of surgery, recipient of the silver medal and honorary membership of the Asociación Mexicana de Cirugía Endoscópica (Mexican Association of Endoscopic Surgery), presented at the opening ceremony of the association's international congress in Zihuatanejo, Mexico.

Dr. **Robert Grant**, adjunct associate professor of clinical surgery (plastic surgery), named chief of the combined Division of Plastic and Reconstructive Surgery at NewYork-Presbyterian/Weill Cornell Medical Center and NewYork-Presbyterian/Columbia University Medical Center.

Frederick Maxfield, PhD '77, the Israel Rogosin Professor of Biochemistry and chairman of the Department of Biochemistry, recipient of a \$2.8 million NIH MERIT Award to support research on intracellular trafficking, or the ways in which cell receptors, transporters, lipids, and other key molecules move within and between cells.

Carlyle Miller, MD '75, clinical instructor in medicine, named associate dean of student affairs and equal opportunity programs in the Department of Academic Affairs. He replaces Dr. Bruce Ballard, who retired.

NewYork-Presbyterian Hospital, ranked first in New York City and sixth in the nation, according to the 2006 *U.S. News & World Report* "America's Best Hospitals" survey. It is the sixth consecutive year that NewYork-Presbyterian has been the only New York metropolitan area hospital on the list. NY-P also ranked among the top ten hospitals in eight specialties.

Bruce Schackman, assistant professor of public health, named chief of the Division of Health Policy in the Department of Public Health. The Division, previously called the Division of Health Services and Policy Research, focuses on allocation of scarce resources, financing and reimbursement, health-care technology assessment, program evaluation, and organization of the health-care delivery system.

Nitsana Spigland, MD '76, associate professor of clinical surgery, appointed chief of the Division of Pediatric Surgery in the Department of Surgery. She served as the Division's acting chief from 1997 to 2000.

Dr. **Linda Vahdat**, the Madeline and Stephen Anbinder Clinical Scholar in Hematology/Oncology and associate professor of clinical medicine, awarded a \$250,000 grant from the Susan G. Komen Breast Cancer Foundation for her study on reducing the ability of dormant cancer cells to reactivate after treatment or remission.

Dr. **Jonathan Weinsaft**, assistant professor of medicine and of medicine in radiology and director of the cardiac MRI program at NewYork-Presbyterian/Weill Cornell, winner of a Doris Duke Charitable Foundation Grant, one of twenty-three given this year. The \$400,000 award will support his research into new imaging techniques to detect heart blood clots in patients recovering from heart attacks.

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Published by the Office of Public Affairs
Joan & Sanford I. Weill Medical College
and Graduate School of Medical Sciences
of Cornell University

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Issued four times each year. Printed by The Lane Press, South Burlington, VT. Copyright © 2006. Rights for republication of all matter are reserved. Printed in U.S.A. Send address changes to Public Affairs, 525 E. 68th St., Box 144, New York, NY 10021.

Pressure Point

Disputing the link between stress and hypertension



fOR TWO YEARS, DR. SAMUEL Mann had been treating the fifty-six-year-old woman for borderline hypertension. During a routine visit, the patient—"Susan" (not her real

name)—shared some terrible news: her adult son had been diagnosed with advanced malignant melanoma. He died a year later. "During that year, Susan was upset and angry and frightened and dis-

tressed to the limit," Mann writes in an essay he contributed to Dr. John Sarno's recent book *The Divided Mind: The Epidemic of Mindbody Disorders*. "She frequently cried in my office. Yet her blood pressure did not budge a millimeter."

That fact made Mann wonder. Conventional wisdom had always held that stress has a deleterious effect on blood pressure over the long term. The assumption has been the subject of decades of research, and whole industries have arisen to advise people on how to lower their BP through meditation, biofeedback, and other mind-body techniques. After all, it makes sense: if a fight with your spouse can elevate your pressure in the short term, why shouldn't chronic stress have chronic effects? "Most researchers believe it, because it seems intuitive," says Mann, a professor of clinical medicine at Weill Cornell. "And there's no doubt that anxiety or tension raises blood pressure in the moment. Nobody disputes that. But the question is, does that translate into people being more prone to develop hypertension? Researchers have been trying to prove it for forty years, and they've been unable to—but not for lack of studies."

In May, Mann published an article in the journal *Current Hypertension Reviews* that casts serious doubt on the link between high blood pressure and one of the most common sources of anxiety in American culture: workplace stress. "We spend eight or nine hours a day on the job," he notes. "If one wants to posit that day-to-day stress causes hypertension, and you can't find it in job stress, it raises a question about that whole hypothesis, because job stress is one of the big ones."

Mann analyzed data from forty-eight studies on job stress and blood pressure



JOHN ABBOTT

Dr. Samuel Mann

published in English-language journals from 1982 to 2004—research that comprised more than 100,000 subjects. His conclusion: most studies found no relationship between job stress and hypertension, and those that did reported a very weak link between them. So why has the assumption persisted? The issue, he says, lies not in how the studies were designed but in how the data is interpreted. “Bias is a huge problem,” Mann says. “A lot of studies are quoted simply because they reported a positive association, but you have to look at what that association was. If a study has thirty women and eighty men, and overall there was no association except in a small subgroup of women, you have to be wary. That positive finding is probably a fluke, and it can be overemphasized.”

Although he doesn’t dispute that certain kinds of stress can cause high blood pressure, Mann’s take on the issue is entirely different from the conventional wisdom. He believes that it’s the emotions we don’t feel—not the ones that make us cry or fume or pound a fist on the dashboard—that are actually responsible. Eighty percent of hypertension cases, he says, are caused by conventional physical and lifestyle factors—genetics, weight, salt

‘We spend eight or nine hours a day on the job. If one wants to posit that day-to-day stress causes hypertension, and you can’t find it in job stress, it raises a question about the whole hypothesis, because job stress is a big one.’

intake, lack of exercise—and they respond well to medication. The other 20 percent are more intractable—and, he believes, can be traced to the psychosomatic effect of repressed emotion. “You have two kinds of people: one that feels the emotion, and one that doesn’t,” Mann says. “You can have somebody who’s always upbeat—never tense, no matter what happens. That’s wonderful, but some of them can

be harboring a lot of emotion that never gets to the surface and can stimulate the sympathetic nervous system, even without conscious awareness.”

Mann says that much psychosomatic research fails to consider childhood history. “Patients can suffer enormous abuse and trauma, and they’ll tell you it left no mark,” he says. “But it does affect people, particularly if they’re not consciously aware of the emotional impact. If I have a patient with rip-roaring hypertension that nobody can control, disproportionately I will find there’s a history of abuse or trauma. But the patient never went to a therapist, because he didn’t feel it.”

Mann recognizes that his theory can be hard for people to accept; after all, many patients have seen their blood pressure rise right before their eyes, with so-called “white-coat hypertension” reflecting the stress of being in the doctor’s office. “Most people believe it, because they see their pressure go up when they get tense,” he says. “It’s a widespread belief. It’s not going to disappear overnight, and there’s a whole psychosomatic industry trying to prove it. But even after forty years of research, it’s as cloudy as ever.”

— Beth Saulnier

Family of Nations

With international adoption on the rise, psychologists examine its impact on children

WHEN CHERYL ESNES AND HER HUSBAND adopted a six-month-old girl from China in 1996, they noticed that the child made an odd gesture over and over. "She kept looking at her hands as if she had just had her nails done," says Esnes. "She had never really seen her hands before." In many Chinese orphanages, infants—95 percent of whom are girls, because of the country's population-control policies and a cultural preference for sons—spend most of their time swaddled, hands and feet restrained. The overcrowded institutions offer little individual attention, and many children have health problems. Esnes didn't learn until after her family had returned to their home on Long Island that the social workers accompanying them on the trip had doubted that their daughter, malnourished and suffering from pneumonia, would survive.

Ten years later, the girl is a happy, sweet-tempered fifth-grader—still small for her age, but in good health. She asks occasional questions about her past, but doesn't seem to be troubled by it. Esnes can't help worrying, though, that those early months had a lasting effect on her daughter's development. "I know that it's normal for kids to get scared by a movie or not want to be alone," says Esnes. "But it's always in the back of your mind: is this a result of her time in the orphanage?"

Esnes and her daughter are participating in a Weill Cornell study that may offer some answers. Dr. B. J. Casey, director of the Sackler Institute for Development Psychobiology, and Dr. Nim Tottenham, assistant professor of psychology, are using a variety of methods to investigate how early life in an orphanage can affect the cognitive and emotional development of children adopted from overseas.

As international adoption becomes increasingly popular—last year, more than 20,000 children from overseas became part of U.S. families—stories of developmental problems such as anxiety and attention disorders have concerned both parents and pediatricians. While some orphanages offer good care, a lack of resources and staff can lead to neglect, malnutrition, disease, and even abuse. The goal of the Weill Cornell study, say the investigators, is to bring a scientific perspective to a deeply emotional conversation. "These parents are concerned about their children, and we want them to have empirically grounded data on a large sample population, not just anecdotal reports," says Casey. "We also hope to show how placing a child with a stable family can, over time, ameliorate the effects of the orphanage environment."

In designing the study, Casey and Tottenham worked closely with Dr. Jane Aronson, clinical assistant professor of pediatrics and a leading expert on international adoption whose

patients include actress Angelina Jolie's adopted children Maddox and Zahara. A pediatric infectious disease specialist by training, Aronson started getting calls from parents in the mid-1990s, when overseas orphanages began placing more children with American families. "Most pediatricians in this country have never seen a case of tuberculosis," she says. "I was able to talk to parents about health problems that they and their doctors didn't recognize."

Over time, families also began to ask her how the children's early lives might affect their long-term well-being. For Aronson,



LISA FRANK

herself the adoptive mother of sons from Vietnam and Ethiopia, the questions struck close to home. "I know what orphanages are like, and I've seen the effect on many of these children," says Aronson, who has evaluated more than 4,300 adopted children in person and screened videos and health records of thousands more. "This study can give us the hard evidence we need to provide better services for families."

Aronson has helped Tottenham and Casey recruit subjects for

the study. So far, about fifty families have participated in the project, which asks parents and children to make two visits to Sackler. At the first, the parents are interviewed about their child's history, both pre- and post-adoption. Meanwhile, the kids play computer and word games designed to test how they regulate behavior. "We are still gathering data, but it seems that children who have spent time in institutions may react more quickly to negative information," says Casey. "That may manifest itself as anxiety; some kids are incredibly vigilant to any sign that something is wrong."

On their first visit to the institute, the children also spend time in a mock MRI machine, so they can get comfortable with it. On the second, they watch movies inside the machine while researchers take structural images, then play video games as the MRI tracks activity in the brain. It's a process that the children seem to enjoy, says Tottenham. "I had a mother ask me once if we did birthday parties," she says with a laugh.

The researchers are already noticing parallels with recent research on animal responses to stress. Studies have shown that animals in restrained conditions experience an enlargement of the amygdala, an area of the brain linked to regulation of emotion, particularly fear. "The amygdala is usually associated with

'We are still gathering data,
but it seems that children
who have spent time in
institutions may react more
quickly to negative information.'
— Dr. B. J. Casey

the fight-or-flight response," says Casey. "We're finding that the longer a child was in an institution, the larger this area of the brain is." Casey and Tottenham are also looking at the hippocampus, which plays an important role in cognitive learning. In stressful situations, development in that region is diminished, but it can rebound if the environment changes. The researchers hypothesize that children may experience great gains in their cognitive develop-

ment the longer they're with an adoptive family.

Although Casey cautions that the study is in its early stages, she notes that it may offer insight not only into the development of adopted children, but into the brain in general. The researchers have been collecting DNA samples and testing levels of the hormone cortisol to see if resilience to stress is influenced by genetic factors. To expand their data, Casey and Tottenham have teamed up with a group conducting similar studies at the University of Minnesota, and they'd like to find at least forty more subjects. Cheryl Esnes, who calls the study "educational and fun," is glad that her family has participated. "I know that uncertainty is always part of parenting," she says, "but it will be great if we can help other families like us."

— C. A. Carlson

'The Double Serpent'

Bardes offers meditations on medicine



EVERY ONCE IN A WHILE, ONE OF MEDICINE'S FAMILIAR ASPECTS strikes Dr. Charles Bardes as odd. Why, for example, do doctors wear white coats? Why do they test urine when the results are usually inconsequential? "As you begin to ask questions like that," Bardes says, "the whole face of medicine changes, and the stories that we tell about medicine change."

Those stories are the subject of ninety essays that Bardes, Weill Cornell's associate dean of admissions and a professor of clinical medicine, has written over the past eight years. The Boston University literary magazine *Agni* has published twenty of them (thirteen online at www.bu.edu/agni/ and seven in its Spring 2006 print issue) in a series titled "The Double Serpent: Subtexts in Medicine." "This is a doctor," writes *Agni* editor Sven Birkerts, "a man of science, speaking to us with compassionate intimacy, taking as his revolutionary premise that the truth of what happens to us is found outside the narrowed bounds of specialization."

The essays often uncover the layers of history and myth that underlie contemporary practices, such as telling a patient not to eat before surgery. "Fasting has a whole set of ritualistic and spiritual echoes that are hidden from that simple order, until you just lift the lid," Bardes says. "And then there they are: you find Percival fasting before he goes off on his vision quest." Some essays simply reflect on what it feels like to witness an autopsy, or to watch an elderly patient listen to a twenty-year-old recording of himself playing the violin.

Many of the pieces are short, some only a few sentences—a testament to squeezing writing time into Bardes's busy days. He often writes late at night or early on weekend mornings. But if writing and medicine compete for his time, they also nourish each other, Bardes says. Medical practice provides the material for reflection, while writing sharpens his skills as a healer by giving him an awareness of the ambiguity that often laces his patients' lives. "Science has no room for contradiction," Bardes says, "but literature deals with it all the time."

— Susan Kelley

Convenient Care

Student-run clinic treats needy New Yorkers

IN HER YOUTH, MARIA WAS A SELF-confessed “wild child”—she used drugs and abused alcohol. Now retired from a secretarial job, the Upper West Side resident is battling hepatitis C, contracted more than three decades ago from sharing dirty needles during her years as a heroin user. She also suffers from pancreatitis and fibrosis of the liver. Today, on a Saturday morning in mid-July, she has come to the Weill Cornell Community Clinic to seek treatment for her liver disease. “I’ve quit drinking,” says Maria, an African American woman with salt-and-pepper hair coiled into a bun. “I don’t want to die.”

Every Saturday, the medical students and physicians at the clinic treat about a half-dozen patients like Maria—adult city residents without health insurance or the means to pay for care out of pocket. Open since April, the clinic is run by a team of medical students who devoted more than a year to getting it off the ground by writing grant proposals, recruiting volunteer doctors, and creating links with community organizations. In addition to offering basic care, the clinic gives referrals to other providers and helps steer clients toward the services they need—such as free or low-cost dentistry, psychological counseling, immunizations, glaucoma screening, or breast cancer exams. “Our main goal is to get patients enrolled in Medicaid or pharmaceutical-assistance programs for chronic medications, and to help them to better manage their health care,” says Connie Chen, a third-year student. “As medical students, we’re almost like case managers. We get to learn more about the opportunities that are out there and work as advocates for our patients.”

The clinic is located on the first floor of the Helmsley Tower at 70th Street and York Avenue. Funding comes from grants and private donations; these funds cover the cost of most medications. The Weill



JOHN ABBOTT

Consultation: Second-year medical student Justin Paul (left) meets with fourth-year students Jennifer Lesko, Caroline Chang, and Randy Longman to discuss a patient’s diagnosis.

Cornell faculty and administration provided much-needed support to help get the clinic off the ground. Thanks to Dr. Carol Storey-Johnson, senior associate dean of education, and Debra Gillers, associate dean of academic affairs, third- and fourth-year medical students who volunteer at the clinic receive elective credit toward graduation. In addition, the leadership of the Ambulatory Care Network of NewYork-Presbyterian Hospital, including Dr. Daniel Hyman, Dr. Ann Beeder, Brian Hale, and Eugenia Curet, worked with the students to ensure that the necessary procedures and services were in

place prior to opening the clinic.

Physicians donate their time to serve as supervising attendings, social work interns from NewYork-Presbyterian volunteer to offer counseling, and medical students do the bulk of the hands-on work—everything from taking histories and doing initial exams to greeting patients and restocking shelves. “This is a tremendous learning experience because the students gain practical experience in doing things that they otherwise would not have the opportunity to do, such as administering flu vaccines and taking urine sam-



ABBOTT

Practical experience: Second-year medical student Meredith Bergman prepares to check a patient's blood pressure.

ples," says Dr. Carla Boutin-Foster, an assistant professor of medicine who serves as the clinic's faculty adviser along with Beeder, an associate professor of clinical public health and clinical psychiatry. "They're learning how to provide care when you have limited resources."

Since its opening, the clinic has drawn patients from every borough but Staten Island. And though Weill Cornell's immediate neighborhood may seem affluent, Boutin-Foster notes, appearances can be deceiving. "If you walk around the Upper East Side long enough, you'll see there are a lot of homeless people," she says. "There's still a population that remains disenfranchised and needs help." She emphasizes that uninsured patients aren't necessarily homeless; many are retirees or working poor, and the clinic's clientele includes a fair number of underemployed actors and artists—people not old enough for Medicare or needy enough for Medicaid, or simply unaware that they qualify for benefits. "It's a unique opportunity for students to work with patients outside the hospital," Boutin-Foster says. "It helps them understand some of the challenges our patients have to go through to receive health care."

On this Saturday, Alexia is back for a

ABBOTT



follow-up visit a week after her initial appointment, when she had a routine physical and was treated for a women's health problem. A soft-spoken artist who works in gouache and ink, the twenty-seven-year-old resident of Manhattan's Gramercy neighborhood was referred to the clinic by an acquaintance; she had last seen a doctor in 2004. Until recently, she'd always had health insurance—something she'd taken largely for granted. "An appointment was more of a choice before," she says. "Now, it's like, 'Thank God, I can go to the doctor.'"

By design, the clinic emphasizes quality over quantity: although organizers are still spreading the word about its services, its capacity will ultimately be capped at about seven patients for each 9 a.m.-to-noon shift (typical numbers are now four to five). Each patient is seen by two medical students—one is usually a fourth-year, the other more junior—under the supervision of the attending physician. "It's empowering, because we're seeing the appointment from start to finish," says Chen. "We're following up with them, maybe for a year or longer. In the hospital, you may see a small segment of their treatment, but here you're invested."

Because the clinic is housed in shared space used for other activities during the week, the students must reorganize the space in preparation for seeing patients: the receptionist sits at a portable desk and patients wait in a small enclave off the main corridor that's lined with stackable chairs. As they enter, they're seen by the student serving as receptionist, who takes vital signs in the waiting room. Demographic information is collected for quality assurance reviews, and patients then see a volunteer who confirms their eligibility and counsels them about benefits. After being examined by the students and attending, any needed labs are drawn and treatment is discussed; before leaving, each patient sees a social worker. "It's been better than my experience in doctors' offices when I was insured," Alexia says. "There's an actual curiosity; they ask questions and really listen. I can't say enough about how kind and helpful everyone has been. My stress level has gone down so much in the last week, knowing I have someone to talk to."

— Beth Saulnier & Gabriel Miller

Body Double

Transplant patients share a rare bond



Fred D'Amico (left) and Izya Dukorsky

CHESTER HIGGINS JR. / THE NEW YORK TIMES / REDUX

tHREE DAYS A WEEK FOR A YEAR AND A HALF, BROOKLYNITES IZYA Dukorsky and Fred D'Amico had the same conversation at a nephrology center where they both had dialysis. "We'd ask each other about our treatment," says D'Amico, a retired clerk for the International Longshoremen's Association. " 'Did you become ill? Did your blood pressure go down?' We had nothing else in common." But since December 6, they've had a lot more to talk about.

That's when they ran into each other at NewYork-Presbyterian/Weill Cornell. Each man had received a call saying he should rush to the hospital: a donor kidney had become available. They both knew several potential recipients are usually called—and only the closest match gets the transplant. "We thought that just one of us was going home with a kidney," D'Amico says.

In fact, the hospital had two kidneys waiting—from the same donor. The chances that kidneys from one donor would go to the same hospital are slim, especially in New York, which has the country's longest waiting time—five to seven years. The chances that the recipients would attend the same dialysis center are slimmer still, says Dr. Michael Goldstein, assistant professor of transplantation surgery and assistant attending surgeon. "I was pleased to have any two patients of mine get transplanted," says Goldstein, who performed Dukorsky's surgery. "That they knew each other was just an added benefit."

The two men, who live one mile apart, now share rides to their follow-up appointments. Together they've met the donor's family—also a rarity, as most recipients remain anonymous. He was Bob Thomas, a fifty-three-year-old from Manitou Springs, Colorado, who fell off a ladder while hanging Christmas lights outside the motel he managed and sustained severe head trauma. When Dukorsky and D'Amico traveled to Colorado, Thomas's family greeted them with flowers, fruit baskets, and balloons that said "Welcome" and "I love you."

That meeting spun another web of connections: in October, D'Amico and Dukorsky, a tool and die maker, will return to Colorado to meet the surgeon who removed Thomas's kidneys and to speak at a tribute to organ donors. In the meantime, they speak twice a week with Thomas's girlfriend, mother, and son. "These kidneys created a new family," says Dukorsky.

— Susan Kelley

Dramatic Eye

For ophthalmologist Dr. Jonathan Javitt, penning a thriller is the latest chapter in a varied career

tHERE ARE FEW PLEASURES IN LIFE AS CERTAIN AS A cup of coffee and a good book. But if you pick up *Capitol Reflections*, a new thriller due out from Savage Press this fall, you might want to forego the java. In the book, genetically modified coffee is suspected in the death of a young lawyer—but as the victim’s best friend, an FDA scientist named Gwen Maulder, investigates, the trail leads from Princeton in the 1970s to the highest reaches of industry and politics. With the help of a secret epidemiological database and a band of friends and colleagues who share her suspicions about a biotech disaster in the making, Gwen goes on a mission. The government, the narrator says, needs “real doctors, not bureaucrats, to take the pulse of the nation’s health.”

That thought is dear to the heart of Gwen’s creator, Jonathan Javitt, MD ’82. For him, the novel’s publication is the latest twist in a career that has taken the ophthalmologist from field study in India to, well . . . the highest reaches of industry and politics. As a researcher, he has been responsible for a new understanding of the connection between blindness and poverty. He was one of the first advocates for using information technology (IT) to improve health care. And, since he was tapped to join the White House Health Reform Task Force during the Clinton administration, Javitt has served in a series of advisory roles to the federal government. In 2002, he became a senior fellow of the Potomac Institute, a think tank best known for its work on global terrorism; last year, he concluded a term as chairman of the health subcommittee of the President’s Information Technology Advisory Committee.

“It was a great honor to be asked to serve the White House,” says Javitt. “When I began working with the domestic policy staff in 2001, health-information technology didn’t even pass the giggle test as a key component of transforming health care—but the tools we have today for reducing error and improving care are extraordinary. To cite just one example, the Veterans Administration ‘borrowed’ bar-coding technology from the car rental industry and has successfully deployed it at 1,200 sites of care, reducing prescription errors from 19 percent to 0.001 percent.

“Health policy in the previous administration focused on attempts to manipulate payment to caregivers, driven by economic theorists. My approach was to bring panel after panel of diverse citizens—caregivers, hospital executives, IT executives, community leaders, ordinary patients—to meet with White House staff. The policy staff then started to focus on the extraordinary price we pay to run the health-care system. The president acted decisively, appointing a national coordinator for health IT and identifying a national commitment to electronic health records as one of the three key approaches to transforming the U.S. health-care system.”



Jonathan Javitt, MD '82

A third-generation physician, Javitt fell in love with medical research in the lab run by his father, hepatologist Dr. Norman Javitt, first at NYU and later at Cornell. As a medical student, the younger Javitt connected with two faculty members, tropical disease specialist Dr. Benjamin Kean and ophthalmologist Dr. Robert Ellsworth. “In medical school, you usually pick a hero or two, and you follow them,” says Javitt. His heroes, though, weren’t leading him in the same direction. When Javitt proposed a project to treat blindness in India, Kean wrote a personal check for the airfare to India. “But Bob Ellsworth asked,” Javitt recalls, “‘What is the point of turning a blind beggar into a seeing beggar?’”

That question inspired Javitt to examine the economic impact of restoring sight. “If one member of an Indian family is blind, another member has to stay home, and another has to earn enough to support those two in addition to himself or herself,” he says. His study, conducted at the Aravind Eye Hospital in Madurai, showed that 85 percent of male patients were able to

work again after successful cataract surgery, with an economic benefit valued at nearly 2,000 percent of the procedure's cost. "Curing and preventing blindness can have a greater impact on poverty than many of the health-care initiatives that have been priorities in the developing world, such as hydration," Javitt says. "Ending blindness is less expensive than paying for it."

Javitt's research, which continued through his studies at Weill Cornell and the Harvard School of Public Health, landed him positions first at Johns Hopkins and later at Georgetown, where he turned his attention to the economic impact of blindness in this country. In the early 1990s, his articles on the cost-effectiveness of preventive eye care for patients with diabetes resulted in major reforms in how both HMOs and the federal government manage the disease. The work also led to the World Bank's first large-scale health investment—not surprisingly, a program to increase cataract surgery in India.

At the same time, Javitt was growing increasingly interested in how the health-care system could improve its efficiency by changing how it handles information. "Medical error accounts for 25 cents of every health-care dollar," says Javitt. "The problem isn't that doctors and nurses need remedial education—even the best-trained human beings are always going to make mistakes. We need systems in place to help them at the moment when they are making a decision that can impact a patient's health."

Back in medical school, when Javitt was crunching the numbers from his India study, he'd been among the first researchers to use Cornell's new mainframe computer system. In 1986, he published *Computers in Medicine: Applications and Possibilities*, one of the earliest books in the field. Over the years, he has helped found and run several health IT companies; he also spent a year as a senior executive at a health insurance firm, an experience that inspired him to write his first novel, an unpublished thriller in which an insurer puts out hits on its sickest patients. He says he had no intention of writing a second, but the plot for *Capitol Reflections* "reached out and grabbed me by the throat." Javitt started writing it when he was being considered for the post of commissioner of the FDA. "I was going to interview after interview in which people were asking me about genetically modified foods, and I realized that there was a real lack of understanding of the issues. There were things I could say in fiction that one could never say in a non-fiction context."

Javitt is still mulling the next chapter in his own career. He may end up in another government role—but in the meantime he's returning to his roots. His father approached him two years ago with a hypothesis about the etiology of macular degeneration. The pair has been conducting research together and recently submitted their first joint research paper on the initial findings. Now another member of the family has joined the project: this summer, Javitt's sixteen-year-old son was granted a student fellowship by the National Institutes of Health to work alongside his grandfather in the lab. "Three generations, trying to solve a problem together," Javitt says. "It's almost literary."

— C. A. Carlson



PROVIDED

Ping Pong,
the wonder dog

Creature Comforts

Caring canines help kids heal

a PEDIATRIC THERAPIST WITH A WRINKLED BROW wears his yellow vest and ID badge, ready for work. His responsibilities: high-five young patients, run in circles on command, and snuggle in bed with an ill child.

The therapist is Ping Pong, a four-year-old Shar-Pei and one of three dogs who (along with their owners) spend an hour each week at the Komansky Center for Children's Health at NewYork-Presbyterian/Weill Cornell, interacting with patients in the playroom or at bedside. "They offer a friendly visit and some normalcy," says Maura Connelly, coordinator of the Center's Child Life Program.

To become certified therapy dogs, the canines must pass a basic obedience class. Then they undergo rigorous specialized training to refrain from jumping and barking—even in hospital hallways crowded with patients, wheelchairs, and beeping IV poles. Most of the kids are thrilled to play with Ping Pong or one of his co-workers: Uno, a Yorkshire terrier, and Obie, a golden retriever. Parents, siblings, and even staff members say they feel less stressed after a few minutes with the dogs. One fifteen-year-old patient says the pet-therapy sessions give him something to look forward to. "Especially," he says, "if the dog can do tricks."

— Susan Kelley

On Top of the World

A neonatologist braves the elements to scale Mount Kilimanjaro

WHEN THE WORLD STOPS spinning and the nausea relents, I attempt to catch my breath. I peer down at my feet and realize that if they'd moved a few inches to the left, I would have slid down a thousand-foot sheet of ice and died on the negative-twenty-degree rocks below. My mind, starved of oxygen and not working well, has lost all track of time. After eight days of hiking, climbing, rain, snow, dry heaves, vomiting, endless diarrhea, and bloody-chapped lips swollen to Angelina Jolie proportions, I shed tears on Uhuru Peak.

Roughly 10,000 people attempt to climb Tanzania's Mount Kilimanjaro each year, with about half reaching the top. However, because of the rainy season and colder temperatures at the summit (elevation: 19,340 feet), only about 150 souls are naïve enough to climb in April. And since each attempt requires the expense of a house down payment, they tend to be a gambling and spirited group.

I had started my climb on April 10th; the unrelenting rain began about three hours into our first day. Kilimanjaro is an ecological wonder, with temperature zones from steamy savannah to glacial ice. So we began our climb in lush rain forest where the air is thick enough to support wide-bore tree trunks, flowering plants, and Tarzan-thick vines. Simon, our local guide, told us as the rain started that "climbing the mountain is a privilege, not a punishment." But as the mileage increased, it would become harder to tell the difference.

Vomiting and nausea are the first signs of altitude sickness, which is epidemic on Kilimanjaro as climbers ascend as much as 3,000 feet per day. Sixty percent of people will experience some form of the sickness above 10,000 feet. To prevent this, guides constantly scream "Pole, Pole!"—Swahili for "slowly"—to remind climbers that slower ascents allow for more acclimatiza-



PHOTOS PROVIDED BY DR. SHETAL SHAH

Summit: Shetal Shah, MD '00, reached the top of Mt. Kilimanjaro after an eight-day ascent.

tion. Statistically, altitude isn't the most dangerous element of the climb; you're more likely to sprain an ankle or dehydrate, making the chance of dying on Kilimanjaro less than 0.1 percent. But the danger was always in a corner of our minds. Less than three months before, an engineer from Colorado had been crushed to death in a rockslide—during otherwise ideal climbing conditions.

Our expedition included four climbers (an executive, a journalist, a nurse, and myself, a neonatologist at NYU Medical Center), plus two guides and almost twenty porters. You'd think you'd emerge with a bond, an unspoken fellowship that comes from sharing meals, tents, and a lifestyle where not changing clothes for forty-eight hours is socially acceptable. But it's remarkable how lonely a Kilimanjaro climb is. With nothing but the roar of rain on your hood filling your ears and lungs too deflated to sustain conversation, each day provided ten hours of solitude.

We are at 18,500 feet now, and the sun reflecting off the packed glacial ice is blinding. We're ascending the sixty-degree ice sheet from Glacier Camp to the summit. The forty-mile-per-hour wind has polished the ice smooth, and we need ice axes to cut steps out of the glacier.

The previous night, at roughly 18,000 feet, the temperature had fallen to negative-thirty. Our drinking water froze, and we sucked on ice to stay hydrated. We filled bottles with freshly boiled water, raced to our tents, and packed them by our feet and crotches—anything to stay warm. The sweat from my brow had frozen my metal glasses to my face. My heart rate was roughly 130 at rest and my oxygen level had plummeted to the seventies. The constant nausea overwhelmed hunger, and I didn't eat enough to maintain my strength. I would arrive back in the U.S. fifteen pounds lighter than when I'd left.

Once you arrive at the top of the ice ridge, straddling the glacial expanse of the



mountain on one side and the ravine you'd just climbed on the other, all protection is gone. It's sunny, but the wind is now fifty to sixty miles per hour. Less than fifteen minutes later the summit marker welcomes us to Uhuru Peak, "Africa's highest point" and the "world's highest free-standing mountain," 5,895 meters straight up.

The summit marker looks no different than it does in photos. It's mildly disappointing, as your ego expects more fanfare to commemorate the event—something along the lines of fireworks. Photos are taken. Hugs exchanged. Guides smile, as tips will surely go up.

Thirty-six hours later, the trees rise again on the path, telling us the rain forest has returned. Eight hours after that, we're on our way home.

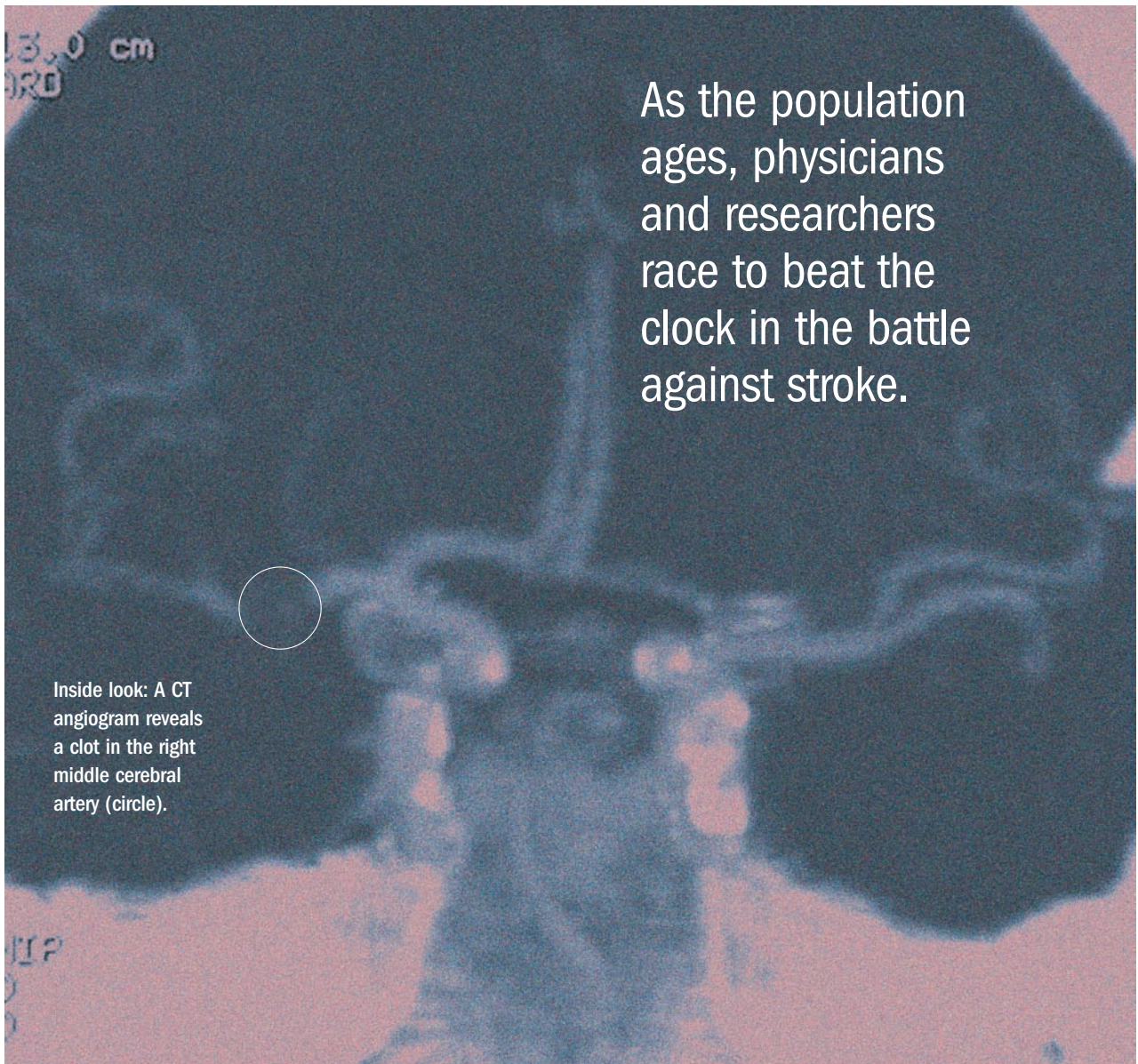
— *Shetal Shah, MD '00*

Thin air: The summit of Mt. Kilimanjaro is 19,340 feet above sea level—and most climbers feel the effect of altitude sickness above 10,000 feet.

time = brain

by beth saulnier

photographs by john abbott



As the population ages, physicians and researchers race to beat the clock in the battle against stroke.

Inside look: A CT angiogram reveals a clot in the right middle cerebral artery (circle).

there's a truism in real estate that property values boil down to three things: location, location, and location. If you have a stroke, the same could be said of your chances of survival—and especially of resuming life as you knew it before.

Stroke is the third-leading cause of death in America, after heart disease and cancer. But of that Big Three, stroke stands out in its demand for technically advanced treatment in those few golden hours following its onset. Cancer, generally speaking, is a slow killer, and even the smallest community hospital is likely to be well equipped to treat a heart attack. But for stroke patients, where the attack happens—whether it's in close proximity to a major medical center whose staff is trained and equipped for stroke care—can mean the difference between emerging relatively unscathed or a lifetime of disability.

"The care for stroke has come to recapitulate the care for heart attack thirty or forty years ago, in terms of the urgency to intervene and treat patients very, very quickly," says neurologist Dr. Alan Segal. "There's a mantra that developed for the heart, that 'time is muscle.' We've adapted that to say that 'time is brain.' Stroke and heart attack are essentially the same in the sense that an artery that's supplying vital tissue is blocked, and you want to get blood flow back as quickly as possible."

Segal is co-director of Weill Cornell's Stroke Center, which brings together physicians and support staff from neurology, neurosurgery, neuroradiology, cardiology, rehabilitation, and emergency medicine—not to mention lab and radiology technicians and telecommunications staff. Their aim is to work together closely—and quickly—to give stroke patients the best chance for a full recovery. "It requires a multidisciplinary effort on the part of a lot of different people," Segal says. "One of the beauties of the development of the Stroke Center at Weill Cornell has been that we've been able to pull in so many different subspecialties."

A decade ago, a thrombolytic drug called recombinant tissue plasminogen activator (rtPA) revolutionized the treatment of stroke; if given in time, this so-called "clot-buster" can stop a stroke in its tracks, before neurons have succumbed to free-radicals and other cellular killers. But like many magic bullets, it comes with a catch: to be given rtPA intravenously, patients must be treated within three hours of the onset of a stroke. The drug can have a longer window of about six hours, but only if it's given intra-arterially at the site of the clot, via a catheter threaded into the brain. "The treatments that work for acute stroke are very technically sophisticated," says Dr. Matthew Fink, director of the Division of Stroke and Critical Care. "They cannot be done at many hospitals."

Just pinpointing when a stroke occurred can be devilish; the patient may live alone, or have had the stroke while sleeping. To avoid giving the drug too late and potentially causing dangerous bleeding, says Dr. Dana Leifer, director of the Stroke Unit and Neurovascular Ultrasound Lab, "we take the time the stroke occurred as the last time the patient was seen to be normal." As a result, according to the American Stroke Association, only 3 to 5 percent of patients get to the hospital in time to be considered for treatment with rtPA.

In August 2005, NewYork-Presbyterian/Weill Cornell was officially certified a Stroke Center by the New York State Department of Health; ambulances carrying stroke patients divert to the hospital rather than a closer facility without stroke specialists. Since the certification, Segal says, the Center's rate of treating patients with rtPA has doubled. "A lot of hospitals are being dedicated as stroke centers throughout





New York State," he says. "What makes our program unique is that we're really state of the art in being able to offer comprehensive services, such as intra-arterial or endovascular therapies." Segal's co-director, Dr. John Caronna, points out that the Center follows a tradition of stroke care and research at Weill Cornell, going back to the 1960s and the work of anti-coagulant pioneers Irving Wright, MD '26, and William Foley, MD '37. Says Caronna: "Not all hospitals, even in New York City, are able to give the emergent stroke care that we can."

To mobilize staff as quickly as possible, the Stroke Center has devised a stroke code system: When a suspected stroke case is en route to the hospital, the telecommunications department pages the entire team, including the emergency attending, stroke attending, interventional neuroradiologist, stroke coordinator nurse, and head laboratory and radiology techni-

Dr. John Caronna

'Not all hospitals, even in New York City, are able to give the emergent stroke care that we can,' says Dr. John Caronna.

cians. The neurology resident is expected to be at the patient's bedside within fifteen minutes, no matter where he or she is in the hospital. "We expect that we're going to advance this field dramatically," Fink says. "We have put together an interdisciplinary team that works in a collaborative model, which is critical to have the best outcomes."

When someone comes into the Weill Cornell emergency department with a suspected stroke, labs are drawn and the patient is sent for a CT scan of the brain. If no hemorrhage is found—indicating that the patient suffered an ischemic stroke, as is the case 85 percent of the time—and it's within the three-hour window, they're given intravenous rtPA; if it's beyond three hours but within six, they can be given the drug via a catheter into the brain. If the drug fails, the interventional neuroradiologist can attempt to remove the clot manually using a corkscrew-like device called the MERCI Retriever, developed in the 1990s by Weill Cornell radiologist Dr. Pierre Gobin. "There's a window of opportunity," says Caronna, "where cells that are in danger of dying still can be resuscitated and rescued."

Beyond that window, the damage is done; procedures such as a decompressive craniotomy—in which half the skull is removed to allow the brain to swell—could be performed to save a patient's life. But at least for now, medical science's ability to save the patient's brain is exquisitely time-dependent. "The big problem we have in New York is that patients will go to an outside hospital first and there is a delay in getting them to us in time to intervene," says neurosurgeon/interventional radiologist Dr. Howard Riina. "By the time patients reach us they're outside the eight- to ten-hour window, and it limits our ability to do what we need to do."

But when today's senior neurologists were doing their residencies, even these time-limited interventions were the stuff of fantasy. Over the past decade, developments such as rtPA and the MERCI Retriever have revolutionized stroke care to the extent that some medical veterans barely recognize their specialty. "When I started out in this field thirty years ago, there was no treatment for any sort of stroke," Fink recalls. "When patients were admitted, they were shoved in a back corner of the ER and left there, and that was basically it. Nothing was done for them, because nothing could be done."

Caronna, who earned his MD from Cornell in 1965, is only half-joking when he recalls that neurologists were once tagged as "the person



Dr. Dana Leifer

who knew everything but couldn't do anything." "There was a nihilism that the doctor could give a German name to the person's language problem, and the patient would be lying there in the bed, and the erudite neurologist would be explaining how the brain was damaged and the patient was ignored. Now it's a proactive approach, both in prevention and acute intervention."

Some of the risk factors for stroke are beyond one's control: age, family history, race, gender (there are three female stroke patients for every two males), history of prior stroke or heart attack. But other factors can be controlled or treated. They include high blood pressure, smoking, diabetes, obesity, carotid artery disease, atrial fibrillation, sickle cell disease, certain blood disorders, high cholesterol, the use of illegal drugs such as cocaine and amphetamines (thought to account for half of strokes in people under fifty), lack of exercise, excessive alcohol consumption, and a history of transient ischemic attacks, or "warning strokes."

An important part of prevention, physicians say, is educating the public about what they can do to reduce their risk. And if a stroke should occur, they need to know how to recognize the symptoms. "When people have chest pain, they immediately come to the hospital," says Caronna. "But when people have weakness or paralysis, the first thing they do is go to bed." Signs of a stroke include the sudden onset of numbness or weakness of the face, arm, or leg; confusion; difficulty speaking, seeing, or walking; dizziness; loss of balance or coordination; and severe headache with no known cause. "There's a misconception that it will just go away by itself," says Leifer. "It's not crushing sub-sternal chest pain that seems as ominous as a heart attack does, so it doesn't drive people to the emergency room as quickly as it should."

Leifer points out that inherent in some strokes is a denial or neglect syndrome, a lack of awareness that anything's wrong. "You'll ask them to raise their arm and they won't, and they'll either say, 'I'm raising it' or 'I just don't feel like it,' or in some more extreme forms, 'It's not even my arm.'" Many people, he adds, mistakenly believe that strokes can't afflict the young. "Stroke can happen at any age, from neonates on," he says. "About two-thirds occur over age sixty-five, but that means that the other third occur in younger people."

At Weill Cornell, researchers are working toward the future of stroke care. Leifer—who has been on New York State Department of Health and American Heart Association panels developing guidelines for stroke center certification—is Weill Cornell's principal investigator on several current multi-center studies. They include a clinical trial on using transcranial Doppler ultrasound, both to visualize blood flow in the brain and to use sound waves to break up clots; a study of the effectiveness of the MERCI Retriever and the use of MRI to identify appropriate candidates for the procedure; and an investigation of an alternative thrombolytic drug called Viprinex (so named because it's derived from the venom of the Malayan pit viper). Leifer is also conducting an NIH-sponsored trial, in collaboration with Columbia's stroke center, on using high doses of a statin drug, following up on animal studies showing that it may protect against damage in acute ischemic strokes. Another study, with Weill Cornell hematologists, is looking at platelet function in stroke patients. Stem cell research into the potential for regrowing nerve cells in the brain is ongoing; Fink, who calls it "a completely new approach" to stroke treatment, hopes it will be ready for testing in patients within three to five years.

the holy grail of stroke care, many physicians say, is a neuroprotectant that could make brain cells more robust—saving them from damage and promoting better healing. But such a therapy has been elusive, Segal says, because "there are a lot of different pathways by which a nerve cell dies"—and a neuroprotectant (or a cocktail of several) would have to cover them all. "Many drugs have been tested for that purpose," he says, "and none have been shown to work." Caronna notes that the



Dr. Howard Riina



PROVIDED BY DR. ROBERT D. ZIMMERMAN

Have MERCI: A patient who came in six hours after a stroke—too late for IV rtPA—was successfully treated with the MERCI Retriever. The clot was removed, and blood flow into the middle cerebral artery branches restored.

Rehab: The Robot

New technologies help patients recover their mobility

“Rehab,” says neurologist Dr. Alan Segal, “starts on day one after a stroke has occurred.” At Weill Cornell, rehabilitation of stroke patients has gone high-tech with the advent of several new devices. They include:

- SaeboFlex, a spring-loaded device that helps patients regain their ability to grasp and release objects by supporting their wrist and hands, including the individual fingers;
- The NESS H200, produced by the Bioness company, which fits around the forearm and wrist, providing electrical stimulation to help the hand open and close, increase range of motion and strength, and improve circulation;
- InMotion, a robotic rehab system in which the patient’s arm, shoulder, and wrist are supported while he or she performs repetitive exercises guided by computer video images.

“Patients have been waiting for this,” says occupational therapy manager Kerri Morris, noting that Weill Cornell is the only rehab facility in the New York City area to offer all three devices. “It provides stroke patients with something tangible and objective. Whether it’s with some assistance or not, they’re able to see their hand working. For them, in terms of hope and motivation for therapy, it has definitely enhanced what we can offer in addition to the traditional neurodevelopment treatment



COURTESY OF BIONESS

Helping hand: The Ness H200 speeds recovery with electrical stimulation.

techniques we utilize. Think about what hand function does for a person’s independence. Just being able to put on their shirt or brush their teeth in the morning is a major accomplishment for them.”

Rehabilitation after an injury is never easy, but stroke patients face particular challenges: their deficits may be cognitive as well as physical. Morris and her colleagues evaluate each patient’s memory, cognition, range of motion, balance, strength, muscle tone, and more. “We approach it from a functional level,” she says. “Occupational therapists assess and treat patients with deficits in activities of daily living. For example, are they able to

get out of bed, walk to the dresser, pick out their clothes, and put them on correctly? If not, what aspects of the task do they need assistance with and why? Is it a decline in functional mobility, thinking and problem-solving skills, visual balance problems or more? Are they able to grasp a toothbrush and sequence the proper steps necessary to brush their teeth?”

The therapist must be equal parts instructor and motivator. “They’ve experienced this devastating change in their lives, and you need to empower them, to continually drive their rehabilitation focus and potential,” Morris says. “There are many aspects of the person you need to address. It is gratifying to observe patients progress from such a devastating event to potentially being able to walk out the door, functioning as independently as possible.”

Neurologist Dr. Matthew Fink stresses that the recovery process following a stroke is often painfully slow—a difficult reality that both patients and their families must understand. “This is a long-haul problem,” he says. “The brain gets sick very quickly and recovers very slowly. The patient who has a major stroke, as a rule, will take at least six months to a year to recover. Families have to be prepared to deal with that, recognizing that they can’t lose hope or give up. Everybody has to keep looking forward and being optimistic—seeing how things will be a year or two from now, and not worrying about what’s going to happen from one day to the next.”



Kerri Morris

ideal treatment would be one that could be given by an emergency medicine technician, in the field, as soon as a stroke is suspected—but is otherwise innocuous, akin to the administration of glucose. “If you’re right, you save them,” he says, “and if you’re wrong, you don’t do any harm.”

although today’s stroke treatments are light-years beyond those of a generation ago, the disorder remains a major killer. According to the American Stroke Association, about 700,000 Americans each year suffer a new or recurrent stroke. Stroke kills nearly 157,000 people annually, accounting for about one of every fifteen deaths. And beyond the mortality rate, Fink notes that stroke is the primary medical cause of permanent disability in the U.S. “It is the number-one cause for a person ending up in a nursing home—and for most people, that fate is worse than dying. Many patients come to see me and say, ‘Doctor, help me prevent having a stroke, because if I end up in a wheelchair and I can’t talk or I end up in a nursing home, I’d rather be dead.’ Most people actually express that quite openly.”

Beyond the toll in terms of human suffering, stroke has a major effect on the nation’s bottom line: it eats up a significant portion of the American health-care budget. “It’s a huge public health problem,” Fink says. “The latest numbers I’ve seen put the medical cost of stroke in the U.S. at around \$60 billion per year—and climbing, because the population is aging. The Baby Boomers turned sixty this year, and they’re entering the age group where the risk of stroke goes up dramatically.” By the year 2050, he says, society’s bill for stroke care could rise to \$2.2 trillion. “Our best chance to reduce that is to prevent strokes. I spent a good part of my career treating patients who’ve had major strokes, and over the years came to be of the opinion that we should put far more into prevention, because the money spent treating one patient can probably prevent strokes in one hundred.”

In stroke care, the advances and the challenges are running neck-and-neck: although revolutionary treatments have been developed, and the advent of drugs to treat high blood pressure have pushed back the onset of stroke in the average patient by a decade or more, the aging population means that more and more people are at risk. Fink notes that although stroke may be the third-leading cause of death in the U.S., worldwide it’s more like the second—because people in developing countries often don’t have access to preventive care. And even in this country, he says, only about 60 percent of people with high blood pressure are aware of it, and of those only about half are being adequately treated. “One of the reasons I went into neurology was that I believed then, and I believe now, that the brain is the most important organ in our body,” Fink says. “It makes us who we are. A stroke essentially removes someone’s personality. To reverse it to the degree that we’re now able to—that to me is one of the most gratifying things I could do as a physician.”

But treating stroke patients isn’t for everyone, Fink says; it’s a particular calling, one that requires a high degree of empathy on the part of medical staff. “You have to be extremely sensitive to the needs of the patient, who often is unable to communicate,” he says. “In many ways, you need to imagine what it would be like to be in that situation. We understand that you need a high level of compassion to get people through a devastating illness like this.” ■

‘A stroke essentially removes someone’s personality. To reverse it to the degree that we’re now able to—that is one of the most gratifying things I could do as a physician.’

— Dr. Matthew Fink



Dr. Matthew Fink

in the company of men

by c.a. carlson

illustrations by robert neubecker
photographs by john abbott

More and more, physicians are realizing that men and women have different ways of navigating the medical system—and that men need to take health care more seriously.

frank Osborn knows about risk. “As an entrepreneur, I’m used to problem solving,” says the fifty-nine-year-old, who is CEO of his own broadcasting company in Stamford, Connecticut. “Every single day, I do probability functions and deal with statistics. I know that nothing is perfect, and at a certain point you have to make decisions based on the information you’ve got. Whether I’m dealing with my business or my health, though, I want to make sure that I have the best information I can.”

For at least fifteen years, Osborn has been getting an annual physical exam, including a prostate-specific antigen (PSA) test. An increased level of PSA in the blood can be one early sign of prostate cancer—so when Osborn’s PSA shot from 2.3 to 3.6 in a single year, his doctor was concerned. A biopsy three years ago came back negative. But Osborn’s PSA went up dramatically again last fall, and this time the biopsy was positive for prostate cancer.

Osborn tackled the problem the way he would a business deal. He read the leading books on prostate cancer, interviewed experts, looked up the latest data online. Within a couple of weeks, he’d made two decisions: he wanted to have his prostate surgically removed, and he wanted Dr. Peter Schlegel to do it.

For Schlegel, chairman of Weill Cornell’s Department of Urology and a leading

expert on prostate cancer and male infertility, Osborn was a dream patient. Not many men, he says, are so willing to confront problems with their health. "Men put off medical care because they're in denial that anything could be wrong with them," says Schlegel. "And they don't realize that if something is wrong, we're able to do much more than we could in the past. We can cure prostate cancer. Of course, men's health is still a developing field, and we're learning more all the time, but if we can get men to take advantage of routine care and screenings, we can improve not only their health but their quality of life."

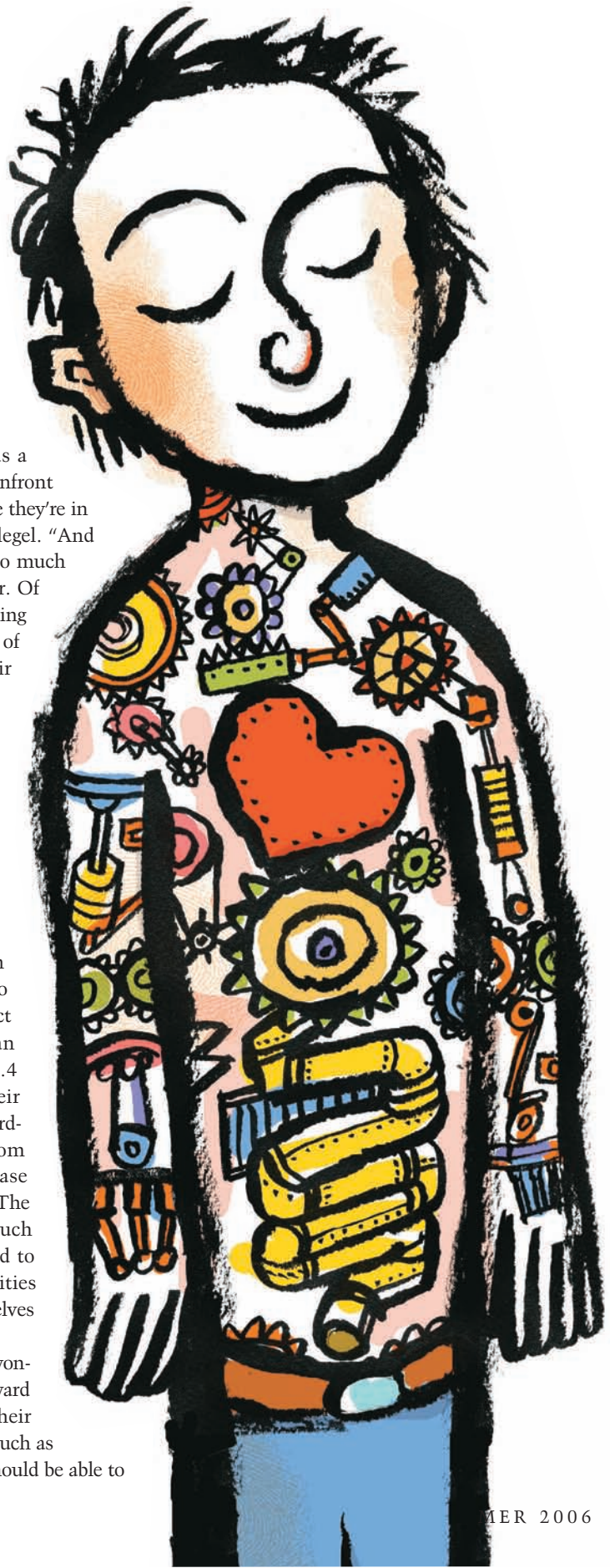
Schlegel is one of a growing number of experts who are calling for men's health to be taken more seriously—not just by patients but by the medical community. A June 17 op-ed in the *New York Times* pointed out that the National Institutes of Health spends twice as much on studies done only on women as on those done only on men. While many have applauded increased attention to women's health issues as a corrective to longtime neglect, the fact remains that American men die an average of 5.4 years sooner than their female counterparts, according to 2002 numbers from the Centers for Disease Control and Prevention. The

reasons for this gap in life expectancy are the subject of much debate; some say they simply reflect the fact that men tend to choose more dangerous occupations and recreational activities than women do, and that cardiac problems manifest themselves earlier in male patients.

In recent years, however, some physicians have begun to wonder if the greatest risk factor for men may be their attitude toward health care. Most men take better care of their cars than their bodies, but with new screenings and treatments for concerns such as heart disease, prostate cancer, and sexual dysfunction, they should be able to



Dr. Peter Schlegel





Dr. Linda Applegarth

stay in good health longer. “Men think of themselves as too busy to make their health a priority,” says Dr. Linda Applegarth, who directs psychological services at Weill Cornell’s Center for Reproductive Medicine and Infertility, led by Dr. Zev Rosenwaks. “The irony is that if they don’t spend the time up front to take care of themselves, they may find themselves spending massive amounts of time later to take care of a problem that could have been easily addressed in the early stages.”

It’s long been known that Mars and Venus have different expe-

riences in the bedroom and the workplace, but it’s becoming increasingly clear that they also have different experiences in the health-care system. Even if women don’t get regular checkups from a family physician, most get an annual exam from their ob-gyn. “The gynecologist often becomes a primary care doctor for women,” says Dr. Antonio Gotto Jr., dean of the Medical College and an authority on cardiovascular disease. “Female patients tend to get their advice on health and wellness from that source, and they may also rely on their gynecologist to do screenings for things like cholesterol and blood pressure.”

Men are less likely to have an ongoing relationship with a physician, and they may visit the doctor’s office only when something goes wrong. “Men often think that they are going to live forever,” says Gotto. “It takes a crisis to make them come to terms with their own mortality, whether it’s a relative or friend having a heart attack, dealing with a serious illness in the family, or discovering an abnormality, like high blood pressure or an elevated glucose level, while going through a screening program. Then they start to think about taking care of themselves.”

At the Cardiac Prevention and Intervention Center, Dr. Bassem Masri meets many male patients for the first time after they’ve ended up in the emergency room with chest pains. Masri, who directs the Center, sees an interesting paradox in how men and women approach their health: while women are better about

Cybersurgeon

A robot named da Vinci is in the vanguard of prostatectomy

no one is better acquainted with the options for treating prostate cancer than a urologist. So when Ohio specialist Dr. Mark Seal got back the results of his own biopsy, he knew he had to make a decision. “The total disease in my prostate was roughly that of a lead on a No. 2 pencil,” he says. “It might never have progressed to the point that I would have had any problems. But with an option like robotic prostatectomy available, I didn’t see any reason to wait.”

Seal also knew whom he wanted to perform the surgery: Dr. Ashutosh Tewari, director of robotic prostatectomy and prostate cancer-urologic oncology outcomes at the Brady Urology Foundation, part of Weill Cornell’s Department of Urology. The two doctors had met in the Phoenix airport after a professional conference, just a few weeks before Seal got his diagnosis. For the last seven years, Tewari has been researching and using minimally invasive approaches to prostate surgery. He has helped to pioneer the use of the da Vinci Surgical System, manufactured by Intuitive Surgical, to remove prostates from patients with a cancer diagnosis.

Minimally invasive approaches have been a hot trend across surgical disciplines in recent years, but the robotic technique offers special advantages in the field of prostate surgery. “The prostate is a hidden organ,” says Tewari, who has been involved with more than 1,300 robotic prostatectomies over the last six years. “The delicate structures and blood vessels in the area make this operation challenging to execute, even for trained hands.” With the da Vinci Surgical System, the surgeon controls instruments from a console while a magnified 3-D view of the surgical site shows nerves and mus-



INTUITIVE SURGICAL

routine care, men respond more quickly when they're having a crisis. "Women tend to downplay their physical pain," says Masri. "Men perceive themselves as physically stronger, so when they experience pain they assume that something is really wrong."

The goal, says Masri, is to get men out of the emergency room and into their doctors' offices for preventive care and screenings. Regular checkups are a physician's best opportunity to encourage and monitor lifestyle changes, such as a healthier diet and a sensible exercise regimen. More men can also benefit from taking the class of cholesterol-lowering drugs known as statins, according to Gotto. "When it comes to bad cholesterol in particular," he says, "we're finding that lower is better. We shouldn't wait until after a man has had a cardiac event to get those levels under control."

Early intervention can also make a big difference with prostate cancer. While more men are opting for regular PSA tests and digital rectal exams, they may not be aware of how dramatically the options for treatment of the disease have changed in recent years. Until about twenty years ago, surgeons were like explorers in an uncharted jungle, trying to find their way through the intertwined nerves and blood vessels packed densely in the narrow space of the urogenital system. "Although surgeons have been removing prostates for eighty years, a basic understanding of relevant anatomy wasn't available until

cles in greater detail than is possible during traditional surgery. The system's instruments, which enter the body through small incisions, can be manipulated into positions not possible with the human hand.

"The robotic surgery is just fabulous in terms of allowing the surgeon to see the anatomy to preserve and reconstruct the neck of the bladder for continence and to preserve the nerves for potency," says Seal, who performs the procedure in his own practice. While studies are still being conducted on the advantages of robotic prostatectomy, anecdotal reports and early evidence suggest that the procedure minimizes blood loss during surgery and complications afterwards. Many patients are thrilled with the short recovery time—Seal was back in his office a week after surgery—and the quick return to baseline normal levels, including complete continence, with no urinary leakage, and total sexual functioning.

Some insurance companies are still reluctant to cover the new procedure, but the popularity of robotic prostatectomy is growing rapidly, especially among physicians. On the day that Seal had his surgery, Tewari also performed the procedure on two other doctors. The Weill Cornell surgeon says that the procedure is not so much revolutionary as evolutionary. "Nothing I'm doing is totally new—this is just building on the work of surgeons who have spent their lives refining and understanding the issues of male anatomy and prostate cancer surgery," says Tewari. "This little robot is following in the footsteps of giants."



Dr. Marc Goldstein

the 1980s," says Schlegel. "It was thought that if you removed the prostate, you had to damage nerves and muscles near it, knocking out a man's ability to have erections and control his own urine."

Schlegel was among the scientists who helped to map those nerves and muscles, and his work has served as the foundation for new surgical and radiological approaches to treating prostate cancer. Today, nearly all patients can expect a full return to continence after prostate surgery, and Schlegel can tell otherwise healthy patients like Frank Osborn that there's an 85 percent chance of regaining normal erectile function. While studies are still ongoing, anecdotal evidence suggests that minimally invasive techniques like robotic prostatectomy and innovative radiation-delivery systems like interstitial therapy, in which tiny radioactive "seeds" are planted directly in the prostate, are reducing side effects and recovery time while allowing physicians to target cancer more precisely.

While public awareness of prostate cancer is growing, misconceptions about other aspects of men's health still linger. Public understanding of male infertility may have advanced beyond the Middle Ages, but it hasn't gotten much further than the Renaissance. "Most men still make the assumption that Henry the Eighth did: infertility has to be the woman's fault," says Schlegel. "Men think that if they are able to function sexually, they must be fertile."

In fact, only a third to a half of all couples are infertile solely because of the female partner. Many of the other cases are due to problems with sperm production and viability—and for men an infertility diagnosis can be devastating. "Women tend not to understand the shame that a man may feel," says Dr. Elizabeth Grill, assistant professor of psychology, who works with Dr. Applegarth and Dr. Laura Josephs to provide counseling at the Center for Reproductive Medicine and Infertility. "And while women have outlets for talking about their feelings—friends, support groups, chat rooms—men sometimes suffer silently."

The psychological services team helps couples understand each other's experience of infertility and make decisions about their options. Dr. Marc Goldstein, director of the Men's Center in the Institute for Reproductive Medicine at Weill Cornell, has pioneered many of the approaches that are available today to help men with even the most severe sperm-production problems. In addition to creating microsurgical techniques for repairing varicoceles (varicose veins) and blockages in the testicles, he has worked with Schlegel to refine ways to extract sperm from men who thought they'd be unable to father a child. Goldstein has also suc-



Dr. Bassem Masri

cessfully reversed vasectomies in hundreds of patients, using sutures that are one-sixth the diameter of a human hair. “When men come back after that surgery, I love to show them their own sperm swimming under the microscope,” says Goldstein. “And when they call to tell me that their wives are pregnant, I want to open a bottle of champagne. People ask me how many kids I have, and I tell them 1,500.”

But even though male infertility has become more treatable, it’s still a challenge to get men to view it as a medical problem instead of a personal failure. “A lot of men seem to bind up their sense of masculinity with being fertile,” Goldstein says. “They’re reluctant even to find out if they might be the reason their wives aren’t pregnant. We can’t help them until they open their minds to that possibility.”

The only subject that may be harder for men to discuss than infertility is erectile dys-



Checkup Checklist

Some guidelines for men’s health screenings

If you can take in your car for an oil change every 5,000 miles, you should be able to get yourself to the doctor at least once a year. A number of organizations offer guidelines for the tests that men should request at different times in their lives; here are some recommendations from Weill Cornell’s experts:

Ages 15–17 Before signing up for high school athletics, most adolescent males are required to have a physical. Weill Cornell urologists Dr. Darius Paduch and Dr. Marc Goldstein think that this should include teaching young men how to do a monthly testicular self-exam for signs of cancer and other problems. “They should learn that if they see something resembling a bag of worms, especially on the left testicle, that’s probably a varicocele,” says Goldstein. “We can repair that when someone is a teenager and prevent a lot of problems, including infertility and testosterone deficiency, later on.”

Ages 18–39 These are the years when men may have the fewest health issues, but it’s still important to see a doctor on a regular basis. “Guys in this age group may not be aware of their risk for STDs,” says Paduch. “Erectile dysfunction is a possibility, too, especially if someone is using drugs like marijuana.” For members of high-risk groups, such as African Americans and men with a family history, it may be a good idea to start screenings for prostate cancer in their thirties. Physicians should also discuss diet and exercise. “It’s much harder for someone to start making healthy lifestyle decisions later in life,” says Medical College dean and heart disease prevention expert Dr. Antonio Gotto Jr. “And physicians should urge their young male patients to quit smoking as soon as possible.”

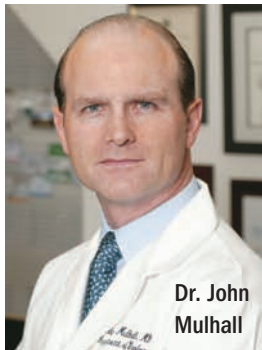
Age 40 The greeting card industry may treat “the big 4-0” as a joke, but this is a good moment for men to get serious about their health if they haven’t already. At the Cardiac Prevention and Intervention Center, Dr. Bassem Masri screens men with much more than the standard tests for cholesterol and blood

pressure. Complex lipid profiles that distinguish among different types of bad cholesterol and protein levels that indicate vascular inflammation can help give physicians more precise information about their patients’ cardiovascular risk than ever before. Men may also want to schedule their first PSA test when they’re forty. “There is still some controversy about the value of the test, and we’re waiting for proof that PSAs are lowering the death rate from the disease,” says Schlegel. “I think that the currently available information is more than sufficient, though, for doctors to urge their male patients to have a blood test and an exam at least every two years.”

Age 50 and onward Early screenings are valuable not just because they can catch emerging problems, but also because they establish a baseline for future test results. For example, one PSA in isolation is not as valuable as a history of tests that tracks changes over the course of years. As men age, they should return to their doctor for annual examinations. “Men need to establish a relationship with a physician, just as women have ongoing relationships with their gynecologists,” says Gotto. “And physicians need to establish a basis of trust with their patients.”

function. In commercials sandwiched between ads for pickup trucks and pro wrestling, Viagra has brought "ED" into the male lexicon, but most men remain reluctant to talk about it with their doctors. "We're still seeing only about 15 percent of the men who have erectile dysfunction," says Dr. John Mulhall, associate professor of urology and director of the Sexual Medicine Program. "It's not just embarrassment among patients. There are some data to suggest that the reason patients don't bring up sexual dysfunction to their physicians is that a large number think their doctor is going to be embarrassed." Mulhall says that most discussions of erectile dysfunction take place during the so-called "doorknob consult." "The primary care physician and the patient have had the diabetes talk and the smoking talk and the cholesterol talk, and as the doctor is walking out, with a hand on the doorknob, the patient says, 'By the way, doc, what about Viagra?'"

despite the fact that many men are walking out with a prescription in hand, about a third of them stop using the ED medication after one prescription. Sometimes, if the problem was psychological, they've regained their sexual confidence and don't need the drug, says Mulhall, but there may also be a lack of follow-up by the physician. As a result, doctors could be missing an opportunity to assess health problems related to erectile dysfunction. Mulhall and SUNY-Downstate Medical Center physician Richard Sadovsky recently completed a paper on the value of more closely monitoring ED patients. According to the researchers, the penis is a kind of canary in the coal mine of men's health. Because the blood vessels in the penis are one-quarter the diameter of those in the heart, they can start to clog years before the first signs of coronary artery disease show up. An inability to achieve and maintain an erection can also be an indicator of diabetes, hypertension, or depression. "If we don't ask our patients about their penises," says Mulhall, "we're missing



Dr. John Mulhall

an opportunity to learn more about their overall health."

By overcoming their own inhibitions about discussing sexual health, physicians can act to prevent other problems for their patients—and it's best to start the conversation as early as possible, says Dr. Darius Paduch, assistant professor of urology. In addition to treating adult men for infertility, ED, and other concerns, Paduch also works with many adolescents. He's especially interested in two conditions that can cause problems later in life. One is Klinefelter syndrome, which causes low testosterone levels in one out of 500 men. It is the most common chromosomal aberration in humans; patients with the syndrome usually have underdeveloped testicles, a body that is taller than average but feminine in build, and a lack of pubic and facial hair. Left untreated, it can result in infertility. The other condition is varicoceles, which manifests itself as early as adolescence and has the potential to affect sperm production.

"Pediatricians need to examine young men more closely," says Paduch. "It's best to diagnose and fix problems like Klinefelter syn-

drome and varicoceles early, well before you're concerned about questions of infertility." Paduch is developing an inexpensive genetic test for Klinefelter syndrome, and he hopes that physicians will use it to determine whether testosterone treatment is appropriate for such patients; replacing the hormone early can allow adolescents to develop normally and prevent later problems caused by a lack of testosterone, including infertility and osteoporosis. Varicoceles, which may also impair the testicles' ability to produce testosterone, can be repaired through microsurgical techniques that Goldstein and others have developed.

Paduch urges physicians to teach adolescents how to examine their own testicles for varicoceles and warning signs of testicular



Dr. Darius Paduch

cancer, the most common cancer among men ages fifteen to forty-five. While Lance Armstrong's fight against the disease raised public awareness, not every man wearing a yellow Live Strong bracelet is doing a regular self-exam. "In adolescence, we have an opportunity to get young men actively involved in their own health," says Paduch. "If we can make them comfortable in dealing with these issues early in life, they are not going to hesitate to get help with medical problems later on." Changing the way that young men think about their health is also an opportunity to start changing the culture. "I don't have a problem asking my mom about her Pap smear and breast exam—there's just not a big taboo about those issues anymore," says Paduch. "I hope that in the next ten years, we'll be able to think in the same way about men's health and development."

Just as he prides himself on being a forward thinker in the business world, Frank Osborn is glad to be ahead of the curve in his attitude toward health care. At the end of March, Schlegel removed his prostate, and he was back at work a few days later. Although his research had made him confident about a full recovery, Osborn was "utterly stunned" by how quickly he returned to normal functioning. All indicators suggest that the cancer is gone for good, but he will continue to get exams on a regular basis to make sure. "It boggles my mind that someone wouldn't get an annual physical and a simple blood test," says Osborn. "There are certain body parts that have a higher probability of going wrong, and I do what I can to make sure they're OK. It's not a big deal. It's just common sense." ■

ladies of the lamp

A look back at the early days of nursing education
by beth saulnier

few professions can trace their roots to the efforts of a single person. Nursing can: its founder and patron saint is, of course, Florence Nightingale—the daughter of a prominent British family who rejected a titled suitor and braved her parents’ ire to become the “Lady of the Lamp.” Born in 1820 and trained at a nursing school in Germany, Nightingale famously brought a team of thirty-eight nurses to the Crimea, where she battled unsanitary conditions and medical condescension to improve the lot of wounded soldiers. In 1860, she founded London’s Nightingale Training School—and worked tirelessly to make nursing a respectable profession for British women. That same year, she published *Notes on Nursing*, which laid out the principles of the profession: careful observation and sensitivity to the patient’s needs. (A century and a half later, the book is still in print—and May 12, Nightingale’s birthday, is celebrated as International Nurses Day.)





IMAGES PROVIDED BY THE WEILL CORNELL MEDICAL COLLEGE ARCHIVES

Women in uniform: Early nursing garb reflected the profession's combined military and religious heritage.



Beyond the bedside: As health care advanced in the last part of the nineteenth century, nursing began to take on a more scientific bent, requiring proficiency beyond the traditional role of “comforter.”



New York Hospital, ca. 1825

On the other side of the Atlantic, New York Hospital had begun training nurses two decades before Nightingale’s birth. In 1799, Dr. Valentine Seaman founded a nurse-training course that continued until his death in 1817. In 1877, shortly after New York Hospital moved to West 15th Street, it established the Training School for Nurses (which preceded the founding of Cornell University Medical College by twenty-one years). For decades, the Training School stood out as one of the few institutions to offer comprehensive preparation for the profession. “The state of nursing education is dismal,” nursing pioneer M. Adelaide Nutting said in a 1908 address to the New York State Nurses Association. “For example, as to classrooms and equipment, in certain schools there is one classroom and some equipment, in hundreds of schools there is not even a pretense of either.”

The Training School was founded during an era of dramatic change for the nursing profession: reformers sought both to protect the public from untrained women passing themselves off as nurses and the nurses themselves from brutal hours, lack of respect, and often deplorable working conditions. As Isabel Hampton, the first president of what would become the American Nurses



Wartime: During World War I, Red Cross Base Hospital Unit Number 9 (left) was organized in 1916 at New York Hospital. The nurses in Mobile Hospital No. 2 (right) served from their base in France, working under exhausting and primitive conditions.

A Nurse's Story

Second Career in Caring

how does someone go from being a Ralph Lauren model to a registered nurse? For Bill Steeves, an RN at NewYork-Presbyterian/Weill Cornell Medical Center, it was all a matter of timing.

"I knew nothing about nursing," he says, "but I was staying with a friend who is a nurse's aide and whose mother had been a nurse and, after listening to them talk about their work, I was hooked."

Later, when his friend's mother died, Bill was moved by the fact that so many of her former patients attended the funeral. "I couldn't believe how many lives this one woman had affected."

Now an RN specializing in oncology, Bill says what he loves most about nursing is the impact he can have on other people's lives. "It's all about the human equation," he says. "And from a career point of view, a nurse's schedule offers a lot of flexibility, and there are many areas of nursing from which to choose. That also attracted me to this profession."

Although he has his diploma from the Bridgeport School of Nursing, Bill is planning to go back to school to study for his bachelor's degree in nursing, with a goal of making senior staff nurse in two years. "Being a nurse at NewYork-Presbyterian is great because it provides what I call a 'career ladder,'" he says. "The more schooling you get, the more rewards come with it, as well as professional growth."

Bill currently works three days a week from 7:30 a.m. to 8 p.m. Ultimately, he would prefer a night shift. "I'm a night person," he says. "There aren't many careers where you can do that, but it suits me well."

— Michael Sellers



AMELIA PANICO

Normally a person's memory of a childhood tonsillectomy is not an altogether pleasant one. That certainly was not the case for Annabelle De Jesus, a registered nurse at NewYork-Presbyterian/Weill Cornell Medical Center. "I was fourteen or fifteen years old, and it was the nurses that I remember most," she says. "I recall getting very good care from the nurses and decided there and then that I wanted to be a nurse, too."

Why a nurse, when a young person has so many other career possibilities? "It's simple—nurses make a difference in patients' lives and their families' lives," she says. "It's rewarding to hear a patient say, 'thank you.'"

A former phlebotomist and nurse's tech at another local hospital, Annabelle works on the renal transplant floor. She wants to do her part to provide even better patient care. "There's something special about kidney transplant patients," she says. "I want to do what I can to make their lives better."

Annabelle has set her sights on making senior staff nurse in two years. "I want to be a bedside nurse, but I'm also considering going for a nurse practitioner degree." In the meantime, she works the night shift from 7:30 p.m. until 8 a.m. "You definitely have to be a team player to work a night shift," she laughs. "On the job you make your own schedule—I work three days on, four days off—so I can spend time with my husband, who just returned from Iraq as an Army medic."

"Nursing is great. I can have a career and still have time to pursue personal interests and have a family life," Annabelle says. "I never thought I would enjoy it this much, but I wouldn't have it any other way."

— Michael Sellers



AMELIA PANICO



Graduation day: For many years, the nurse's cap was the symbol of the profession, much like the doctor's white coat.



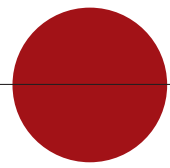
Lending a hand: In this photograph from 1953, a nurse is assisting in the emergency room during hand surgery.

Association, wrote in *Nursing of the Sick* (1893): “‘Trained Nurse’ meant anything, everything, or next to nothing.” The *American Journal of Nursing* was founded in 1900; the following year, New Zealand became the first country to regulate nurses nationally. Two years later, New York and three other states passed nursing licensure laws.

When the Training School for Nurses joined New York Hospital-Cornell Medical Center in 1932, its name was changed to New York Hospital School of Nursing; it became Cornell University-New York Hospital School of Nursing in 1942. Over the years, many graduates became national leaders in their field. They include Lillian Wald, founder of the Visiting Nurse Service; Clara Weeks, who wrote the first textbook by an American nurse; Anne Goodrich, the first dean of the Army School of Nursing and of Yale University School of Nursing; Julia Stimson, Director of the Nursing Service of the American Expeditionary Force in World War I; Irene Sutcliffe, who played the leading role in making New York Hospital School of Nursing a major force in American nursing; and Eleanor Lambertsen, who served in the Veteran’s Administration and the Department of Defense. But in 1979, a withdrawal of New York State funding and inadequate financial support forced the nursing school to close. ■







NOTEBOOK



JOHN ABBOTT

Dear fellow alumni:

Reunion 2006 is fast approaching and your Alumni Association, along with the Office of Alumni Affairs, has been busy developing an exciting and celebratory two-day program for you. It is filled with informative presentations by distinguished alumni and guests from around the world. There will be formal and informal reminiscences by classmates and colleagues. The physical and intellectual growth of the medical center will be updated for you by the dean of the medical school and the president of the hospital. There will be ample time for individual socializing as well as a splendid evening together at Chelsea Piers.



Reunion 2004 was the most well-attended in recent memory, and we have preliminary data to indicate Reunion 2006 will exceed its predecessor in attendance. Of note, this will be the 100th year of reunion for the Alumni Association. Special Classes include those whose graduation years ended in 0, 1, 5, or 6. Special recognition will be given to those with fifty or more years as alumni: the newly formed 50th Anniversary Society. Whether or not any of these years applies to you, we urge you to join us in celebration of our medical heritage.

Remember the words of Sir William Osler: "The pre-eminence of an institution of higher learning is measured first and foremost by the success of its graduates." So many have been so successful, there should be an opportunity to share each other's stories. That's what reunions are for—and that's why we "try harder" to make your reunion a success. Join us in October; you'll be glad you did.

Best Wishes,

Kenneth Swan, MD '60

President, CUWMC

Alumni Association

1930s **Norman D. Thetford '34, MD '38:** "Forty-nine years in the same home and 67 years with the same wife."

Hamilton M. McCroskery, MD '39: "I am 94 years of age now—doing well. I have been retired for many years from emergency room medicine in South Florida: Boca Raton and Ft. Lauderdale. Taking it easy. Trying to get back on our feet from Hurricane Wilma."

1940s **Richard B. Stark, MD '41,** sent a catalog of "Memoirs by Hand," a retrospective of his drawings and watercolors, which the Wally Findlay Galleries presented in March 2006. This is Dr. Stark's 25th exhibit.

Daniel M. Hays, MD '44: "I received the William E. Ladd Medal for lifelong contributions to pediatric surgery from the Surgical Section of the American Academy of Pediatrics."

Robert Lundberg, MD '44: In February, Addison Gilbert Hospital named the new Lundberg Medical Arts Floor in honor of Dr. Lundberg, who spent 36 years in Gloucester, MA, serving as one of the hospital's general surgeons. The new development supports four primary care practices.

David S. Brown, MD '45, and **Charlotte Rush Brown, MD '45:** "We wrote a book detailing the idyllic life of medical practice that we attributed in great measure to our Cornell years. We're helping **Rudy Jones, MD '45,** expand attendance at our coming reunion by sending a copy to each surviving member of our class."

Edward K. Du Vivier, MD '45: "I graduated from medical school during the war and was sent to Alabama by the Army for two years. This was when I married my lovely wife, and we eventually had seven brilliant children. I became a certified pediatrician who practiced in Alton, IL, from 1950 to 1988. I was chief of staff at all three of Alton's general hospitals: St. Anthony, Alton Memorial, and St. Joseph. I volunteer in AARP, Leisure Friends, the Hayner Library, and the Lewis and Clark Interpretive Center. It's been a great life. I have been many times blessed and lucky, and nothing could have been done without the constant help of friends and a wonderful wife."

Herbert McCoy, MD '45, was the subject of an article about his exercise regimen in the *San Diego Union-Tribune*. A one-mile swim is the core of his program. He also travels as a ship's doctor and serves as a physician on trips with fellow scuba divers.

Carol Brach Hyman, MD '47: "My answer to those who told us in 1944 that they did not like to admit women to the Medical College, as their education would be wasted by dropping out for family obligations: I was married for more than 50 years (until my husband's death). I have three daughters and two granddaughters. I am continuing to practice pediatric hematology part-time 59 years after graduation, and am enjoying a full life of family, friends, and travel."

Jacob Robbins '44, MD '47: "I am at the NIH in Bethesda, MD, where I am now scientist emeritus and a volunteer worker in NIDDK. My office is still in Building 10, the old Clinical Center, where I arrived the year after the hospital opened for patients, and adjacent to the new Clinical Research Center that opened a year ago. After closing my laboratory about 15 years ago, I changed my focus to thyroid cancer research and have been a consultant with NCI in a cohort study of thyroid cancer resulting from the Chernobyl nuclear plant accident. I served as president of the American Thyroid Association and editor-in-chief of *Endocrinology*. I live in Bethesda, MD, with my wife, Jean, a retired cellist who was

working summers at Cornell for George Papanicolaou when we met. Two of our children are professional musicians and one is a weaver, so the arts have claimed the next generation, and our grandchildren are just beginning to find their way in the world."

Edwin M. Knights, MD '48: "Ruth and I moved from Michigan to New England after I retired. We had met in 1961 in the Outer Islands of Indonesia on Project HOPE, where she was a registered nurse. Also served Project HOPE in Vietnam, Peru, and Ecuador. My pathology career was divided between hospitals and private labs; sold the labs to Dow Chemical Co. and directed a branch of Bio-Science Labs for more than 15 years. I also was a volunteer ringside physician for Golden Gloves in Michigan, eventually working at professional bouts, including some world championship fights. Met some interesting people: Tommy Hearn, Howard Cosell, Don King, and Jackie Kallen. Founded GeneSaver in 1996 with Dr. George Fischer and have had fun dabbling in genetic genealogy ever since. Volunteer in the USS *Constitution* Museum's Curatorial Dept."

Joseph A. Worrall Jr., MD '48: "I will be 82 years old in August 2006. I am still working, mostly ob/gyn ultrasound and a few Pap smears in Fairbanks, AK. I have good health and things are going well."

Harold W. Evans, MD '49, was an internist at the Grand Forks Clinic in Grand Forks, ND, and on the faculty of the University of North Dakota School of Medicine and Health Sciences from 1958 to 1997. He and his wife, Jacque, who live in Grand Forks, have five children, four grandchildren, and two great-grandchildren. "Since retiring in 1997, I've been busy with infrequent traveling, genealogical research, reading, computing, and golf. I also walk or ride my bicycle around the block—well, a little farther than that. Jacque enjoys the traveling, as well as reading, jigsaw puzzles, shopping, and, especially, the casinos. We've had no desire to move to Florida, California, or Arizona."

Samuel M. Schlyen, MD '49: "I retired from private practice three years ago at age 80. We moved to South Florida and are combating with equal success the hurricanes and multiple myeloma. I am in contact with classmates **Abe Blumer** and **Ledford Gregory** via e-mail."

James Toole, MD '49, is the Walter C. Teagle Professor of Neurology and serves as director of the Stroke Research Center at Wake Forest University Baptist Medical Center. He was a leader in research in cerebrovascular disease research, particularly on carotid stenosis and vitamin intervention for stroke prevention. His book, *Cerebrovascular Disorders*, has been translated into seven languages; the sixth edition is due to be published in 2007 under the title *Toole's Cerebrovascular Disorders*. He and his wife, Pat, participate in various community theaters in and around the North Carolina Triad and enjoy time spent with their children and grandchildren.

1950s **Stanley Birnbaum, MD '51:** "I'm living in NYC with my wife, Michele, and expecting a grandson in a day or two. I am in practice at NYP Hospital and enjoy the transition from the full-time staff to the clinical staff at Cornell. I look forward to seeing everyone at our reunion."

James H. Pert, MD '51: "After 11 years at CUMC and Bellevue, I got away from academic politics by going to Washington, DC, as research director of the American National Red Cross Blood Program. I was able to get a line-item into the federal budget to change the Heart and Lung Institute to the Heart, Lung, and Blood

Institute, viewing blood as a national resource. We developed a central laboratory in Washington-Bethesda. Working with the National Cancer Institute, we developed the first practical method of preparing platelet concentrates for clinical use, improving the treatment of leukemia. By the time I left, the R&D budget was well into seven figures and a training program for technologists was proving effective."

Charles Parton, MD '52: "I practiced pediatric surgery in Hartford, CT, until I was designated full-time chief of Emergency Services at Hartford Hospital. After a two-year part-time stint at the Yale School of Public Health, I was named chief of the Dept. of Ambulatory and Community Medicine at the Mt. Sinai Hospital in Hartford and clinical associate professor of medicine in the UConn Dept. of Community Health. I am particularly proud that, working with a community worker and an insurance company executive, we started, without federal support, community health services in the urban north end of Hartford in a one-floor storefront clinic that is now, 38 years later, a three-story health center."

Kenneth C. Archibald, MD '53: On August 17, California Pacific Medical Center Foundation held a groundbreaking ceremony for the Archibald-Ehrenberg Rehabilitation Terrain Park in San Francisco.

Kenneth A. Hubel, MD '54: "Eight years ago, I retired after 36 years of teaching internal medicine and physiological research at the University of Iowa. Jan and I are well and active: she in swimming, band (French horn), sewing, and quilting; me in Iowa City Free Medical Clinic, band (alto sax), and shepherding international visitors around our small academic city. Last fall on the way to my 60th Rye (NY) High School reunion, we bicycled along the Erie Canal from Rochester to Amsterdam and rode with some sense of

and their families live close by. The memoir I wrote for my family recounts the gradual subversion of the academic mission by 'third party payers,' whose marketplace jargon changed our name from doctors to health care providers. Despite the most recent years, our 50th Reunion led me to believe that the Class of 1954 lived during an extraordinarily fine time." (khubel@southslope.net).

Charles Frey, MD '55: "After graduation I completed my general surgery residency training at the New York Hospital in 1962, interrupted by a two-year stint in the Air Force. Jane Tower and I were married July 20, 1957, and after 49 years are still together. In the interim we had five children (two boys and three girls) and eight grandchildren."

Peter T. Knoepfler, MD '55: "I am finally retired after retiring gradually over three years. I spend a good deal of time teaching Introduction to Clinical Medicine to first-year students at the University of Washington, and English as a second language to recent arrivals in the U.S. Time with my wife, five grandchildren, three sons, and our King Charles spaniel fills up my life. I am also studying the relationship between medicine and yoga. It has been and is a good life in the Pacific Northwest."

John Ross Jr., MD '55, was a section head at the NIH before joining the University of California, San Diego, School of Medicine in 1968 as professor of medicine and head of the cardiology division. His initial research concerned development of transseptal left heart catheterization, and myocardial mechanics and left ventricular function. At UCSD he directed a series of NIH Center grants on acute myocardial infarction, ischemic heart disease, and heart failure. Recent research has included development

methods for studying cardiac function in the mouse, and high-efficiency cardiac gene transfer in rodents. He is distinguished professor of medicine emeritus at UCSD.

Forrest T. Tutor, MD '55: "Lochinvar, my home in Pontotoc, MS, was almost totally destroyed by a tornado in February 2001 with my wife Janis, son Gordon, and me inside, but we got out without a scratch. We decided to try to rebuild Lochinvar. It took two full-time carpenters and ourselves four years, but Lochinvar is back and open for visitors and tours. Rick and Jan Richmond recently visited us. We welcome other classmates."

Stanley J. Landau '53, MD '56: "I retired six years ago after 34 years practicing adult and pediatric urology. Since then, I spend time as an expert in reviewing urology medical malpractice cases for doctors and lawyers. Maxine and I enjoy good health and



Reunion: Charles Parton sent this photo of a Class of '52 get-together on Martha's Vineyard. The members of the distinguished group are (L-R) Russ Hoxsie, Parton, Sid Werkman, and Dick Lennihan.

nostalgic delight and disbelief through hilly Syracuse, where we had lived during residency 50 years before. This summer we'll bike in southern Montana and visit our son in Missoula. Two daughters

have been busy traveling yearly (China and Thailand in '02, Russian River Cruise in '03, Galapagos in '04, Antarctica in '05, and planning India this year). I play golf, create digital photographs, play duplicate bridge, and write short stories. We enjoy weekends in NYC at museums, theater, and concerts. Have been taking classical piano lessons. We spend a month in the winter in Sarasota, FL, electively frustrating ourselves on the golf course. Our greatest joy is our five children and nine grandchildren. Life has been good."

Mitchell Mills, MD '56, married Betty Benton right after Princeton graduation. Their marriage lasted 50 years and produced four children. After medical school, Mitch was drafted and elected a 20-year career as a Navy surgeon. He trained in general and thoracic surgery, serving aboard an aircraft carrier and a hospital ship. Then he became chief of thoracic and cardiovascular surgery at the Bethesda Naval Hospital, where he was director of the residency training program in his specialty for 10 years. After retiring from the Navy, he was appointed clinical professor of surgery at George Washington University Medical College and practiced there for 15 years, retiring as emeritus professor. Betty died of Parkinson's in 2002. Mitch moved to Greenspring, an Erickson's retirement community in northern Virginia. He remarried in 2005 and lives there with his second wife, who was also a Parkinson's caregiver to her spouse.

Mildred D. Rust, MD '56: "I practice psychiatry, both private and community, in Rochester, NY, and retired in 1998. In 1982, I divorced. I have two grown daughters: Lynn is married, has a PhD in microbiology, works for NIH (her husband, Eric, also a microbiologist, works for FDA); they have no children, but two wonderful dogs. Paula, PhD sociologist, has a partner and four children, and lives in East Brunswick, NJ. Two years after retirement, I moved with Paula and her family to New Jersey, where I had grown up. I am now living in a good assisted living place near her. In the past four years I have written and published my autobiography. Writing it was a grand and therapeutic experience."

Kathryn H. Ehlers, MD '57: "On a trip to Santa Fe, NM, last fall we saw **Bill, MD '57**, and **Bobby Plauth**, who have retired there to be near their doctor son and his family. They were wonderful tour guides for us and we had a great time visiting with them and seeing their lovely adobe-type home."

John S. Madaras, MD '57: "I just returned from a trip to the North Pole in July. Less than 18,000 people have been there."

Alan B. Retik '53, MD '57: "This will be my 30th year as chair of the Dept. of Urology at Children's Hospital in Boston. I am also surgeon-in-chief. My wife, Lynn, and I live in Weston, MA, with a summer home on Martha's Vineyard. When not working or traveling, we try to spend as much time with our nine grandchildren as possible."

Bernard S. Siegel, MD '57: "This fall my ninth book comes out, *Love, Magic, and Mud Pies*, from Rodale Press. It is related to healthy parenting. I think parenting is our number one health issue in the way a lack of love leads to self-destructive behavior. I see this in the cancer support groups I have been leading for more than 30 years, as people struggle with the destructive messages of their childhood. I continue to lecture and coach patients interested in self-improvement and survival behavior."

Irwin R. Merkatz '55, MD '58, professor and university chair of the Dept. of Obstetrics & Gynecology and Women's Health at Albert Einstein College of Medicine, will be honored for his 25-year career

at an evening event at the United Nations on November 9, 2006.

George Shambaugh, MD '58: "Two years following the loss of my second wife in 1996, I met my current wife, who lived and worked in Atlanta. The loss of two wives was devastating to me, and I needed to begin life again. I closed my lab, retired from Northwestern University Medical School, and moved to Atlanta in the fall of 1999. Having spent my life in teaching, becoming a professor emeritus and actually retiring seemed untimely for me at my age. Accordingly, I have joined the volunteer faculty as a professor of medicine emeritus, now at Emory University. I have assembled a course, *Molecular Endocrinology: An Introduction*, designed to bridge the gap between clinicians and basic researchers. I precept in endocrine clinic, participate in journal clubs and clinical conferences two or three times a week. We have moved to a large house where everything is out of storage, and the stage is set for downsizing. Do come to see us. We have plenty of space. Our new address is 7655 Blandford Place, Atlanta, GA 30350."

Michael H. Stone '54, MD '58, was recently the host of an eight-part series on the Discovery Channel devoted to his work on the extremes of personality, based on his profiling research and interviews with serial killers from around the country. He has also lec-



Iceman: In July, John S. Madaras, MD '57, traveled to the North Pole aboard the Russian icebreaker *Yamal*.

tured over the past year on severe personality disorders in Copenhagen, Stockholm, Prague, and Munich. His latest book, *Personality Disorders, Treatable and Untreatable*, was published in February by the American Psychiatric Press. On the personal side, two more grandchildren have been added to the family.

James Amlicke, MD '59: "Recently appointed to the faculty at the Medical University of South Carolina, Charleston, as clinical assistant professor in orthopaedics. We are due to have our twelfth grandchild in September 2006. Enjoying the aging process here in South Carolina. Recently shot my age in golf (73)."

1960s Elizabeth Barrett-Connor, MD '60: "My husband retired in July, giving me some incentive to follow suit. Seems most CUMC classmates are no longer in practice, and leading interesting different lives, another incentive. Nevertheless, I have no plans to retire. I still love the excitement of students and science. The downside is the difficulty of getting grants funded, and the disproportionate part of academic life spent just getting permission to do clinical research. Our most exciting news is eagerly awaiting a fifth grandchild."

David B. Robbins, MD '60: "Enjoying the practice of psychiatry in Chappaqua, NY. All three children are in health care: Jonathan, psychology; Chris, nursing; and Jennifer, physical therapy."

Julian T. Hoff, MD '62: "I moved to the University of Michigan as the head of the Section of Neurosurgery in 1981. The Section eventually became an independent department. I retired as chair a year and a half ago and remain on the faculty, now nearing the emeritus level. The laboratory has flourished here and now employs about 25 people with excellent support from NIH. The focus remains on cerebral vascular diseases, particularly intracerebral hemorrhage, where the basic mechanisms of that catastrophic illness are under study. Diane and I have been married since 1962. Our children are all grown. Two are married, and we have four grandchildren. Life in Ann Arbor has been good to us."

Nola Rosanoff Marx '59, MD '64: "I spent the last 12 years in private practice in San Antonio, TX, where I was listed in *The Best Physicians in America: Central Region* in 1996 and 1997. In 2002, I retired from private practice and currently collaborate with my husband, Alvin Marx, an inventor and retired pathologist, in the development of medical devices. While I miss my patients and their families, I'm happy learning and doing new things. Some of my greatest joys are visits with my three children, their spouses, and four grandchildren in New York City, Shaker Heights, OH, and Taipei, Taiwan."

Jeremy J. Kaye, MD '65, was recently appointed interim chairman of the Dept. of Radiology and Radiological Sciences at Vanderbilt University Medical Center, where he is professor of radiology and radiological sciences and professor of emergency medicine.

Peter Tsairis, MD '65, retired as director of neurology at the Hospital for Special Surgery and from the practice of neurology. "I spend most of my time golfing, doing landscape architecture, and running the Alexia Foundation for World Peace with my wife, Aphrodite. We sponsor photojournalism competitions and raise money to promote global understanding through photojournalism (www.AlexiaFoundation.org)."

Robert C. Young, MD '65, is president of Fox Chase Cancer Center in Philadelphia. He is an expert in the treatment of lym-

phoma and ovarian cancer. Young received the American Society of Clinical Oncology's Distinguished Service Award for scientific leadership in 2004.

Richard A. Borrison, MD '66: "After 25 years as the radiation oncologist at El Camino, a community hospital in Mountain View, CA, I retired in June 2001. My wife, Lynda, and I made the break from working complete by moving to New York City for one year. We lived on 72nd St. near York and were there for 9/11, which we viewed from afar on a morning walk at 5th and 60th. It was a great year otherwise. Activities now are varied, from San Jose Sharks to San Francisco Ballet as leisure activity; skiing several weeks locally or in the Rockies, running, or biking as more vigorous activity; and we intermittently spend about four months per year at a townhouse in Maui for semi-vigorous activity like snorkeling and reading (biographies and history are my passion). Our five children have produced ten grandchildren, with one on the way. All but one live nearby, so we are likely to stay in the San Jose area. We have been fortunate in having good health and in having raised a family that enjoys many of the same activities."

Arnold Postlethwaite, MD '66: "I am director of the Division of Connective Tissue Diseases (Rheumatology) at the University of Tennessee Health Science Center. I have done NIH-funded research on scleroderma and rheumatoid arthritis dealing with oral tolerance to collagen types I and II, respectively, mechanisms of transdifferentiation of monocytes into fibroblasts, and the effects of sleep restriction on autoimmune arthritis in mice. Research is still exciting to me—although someday I want to retire to Postlethwaite Ridge in Wetzel County, WV."

Mark M. Sherman, MD '66, is a trustee of the Massachusetts Medical Society and served as president of the Hampden District Medical Society of the MMS. Son Brian is completing a master's and starting a PhD program in clinical psychology; son Keith is in a master's program in political science at Northern Arizona University in Flagstaff.

Steve Muller, B Chem E '63, MD '67: "I entered the Navy intending to serve my two years as a Berry Planner. During the next 21 years, I served on the East Coast, in Japan, and in Europe. My assignments included everything from staff orthopaedic surgeon to hospital commander. My final assignment before retiring was as the Fleet Medical Officer for U.S. Naval Forces in Europe. Along the way, my family lived in Washington, DC, Japan, and England. After retiring from the Navy in 1993, I was the chief medical officer for hospitals and health systems until I retired again in 2004. Since then I have done a bit of health-care consulting. My wife, Gerri, who has sustained me for over 30 years, and I live in Atlanta, GA. My oldest daughter, Laura, is a chemistry professor. Daughter Abby teaches elementary school; she is the mother of our three grandchildren. Our youngest, David, who lives just north of Tel Aviv, works as a writer and English teacher in Israel and Australia. We would welcome getting reacquainted with fellow Cornellians who live or pass through the Atlanta area."

Alfred L. Horowitz, MD '68: "In June 2002, I resigned from a full-time community hospital radiology position in Chicago, and my wife, Paula, and I moved to the mountains of Asheville, NC to retire. I work about 12 weeks a year providing radiology coverage in my area and in California. I still play the piano seriously and have taught piano music appreciation courses in Asheville. I love com-

puters and spend a lot of time with flight and train simulation. We have a 35-year-old son who is a mathematician working for a software company in San Francisco, and a 29-year-old daughter who is an attorney living in Berkeley."

Steven G. Gabbe, MD '69: "I have just celebrated five years of service as the dean at the Vanderbilt University School of Medicine. During this past year, I served as chair for the Assn. of American Medical Colleges Task Force on Clinical Research and, in the coming year, I will co-chair the Liaison Committee on Medical Education as a representative for the AAMC. In addition to investigating diabetes mellitus complicating pregnancy, my research interests have focused on burnout in the leaders of academic medicine. My wife, Dr. Patricia Temple Gabbe, a professor of pediatrics here, serves as medical director of Nurses for Newborns, a program that supports at-risk new mothers by providing them with home visits from pediatric nurses. In the coming year, Pat and I will study the impact of such visits on preventing subsequent pre-term births."

1970s **William W. Goodhue Jr., MD '70**, recently returned from a two-and-a-half-week vacation to Australia during which he visited Sydney, Uluru (Ayers Rock), and Melbourne. He practices forensic pathology as first deputy medical examiner of the City of Honolulu.

Michael B. MacQuarrie, MD '70, was featured in an article in the *Sierra Sun*. He has worked 26 years as an emergency room doctor at Tahoe Forest Hospital in the middle of North America's highest concentration of ski resorts, an area informally known as the "bro-

ken bone capital of the world."

Francis V. Adams, MD '71: "The third edition of my book *The Asthma Sourcebook* will be published by McGraw-Hill in February 2007."

Arnold W. Cohen, MD '71: "Having a great time being chairman of ob/gyn at Albert Einstein Medical Center in Philadelphia. Marcia still loves teaching. We are proud grandparents of two new baby boys and have one more on the way."

Larry Reese, MD '73: "It is hard to believe that more than 30 years have passed since we left CUMC. I have increasingly appreciated the Cornell education, realizing how fortunate I was to study there. I have spent the last few years working with CAAAN in Broward County, FL; this is a diverse group of Cornellians who meet with high school seniors applying to Cornell. I encourage everyone to look into this, as it has been a rewarding experience. I continue to practice in Aventura and Ft. Lauderdale under the title of Retinal and Macular Consultants, P.A. If anyone is in the area, don't hesitate to get in touch."

V. Paul Addonizio, MD '74, is chief of cardiac surgery at Abington Memorial Hospital in Abington, PA. He was recently named the surgical director of the Porter Institute. His cardiac surgical specialties include complex mitral and aortic repairs and left ventricular remodeling of the heart. He has performed several "world's first" cardiac procedures, including replacement of half of a 40-year-old man's diseased mitral valve and his entire aortic valve using donated human valves.

Carlyle H. Miller, MD '75: "After graduation I trained at the New York Hospital in internal medicine and at Memorial Sloan Cancer

Center in digestive diseases. Shortly after training, I set up practice in NYC, became heavily involved with teaching at the medical school, and served on several committees. In 1995 I served as president of the Cancer Prevention Research Institute. In 2002 I became the chair of biomedical sciences at Pacific College of Oriental Medicine; in 2003 I was named academic dean. I left my position in July 2006 to become the associate dean of students and equal opportunity programs at Weill Cornell. I'm looking forward to continuing my relationship with all aspects of medical student life. It's good to be back home."

Joshua Nagin '71, MD '75, MBA '88: "For the last three years I have been semi-retired. Although I am still working one or two days a week in a community hospital emergency department, I have developed a passion for golf while still enjoying tennis, traveling, and eating/drinking too much. Ronna and I are most excited to become grandparents in



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August; we intend to take our role as spoiling grandparents seriously. Our daughters now live in New Jersey and Washington, DC, so we are planning to move in that direction in the next year or so. Best wishes and regards to all."

Walter F. Schleich, MD '76, an internist and infectious diseases specialist in Halifax, Nova Scotia, is governor of the Atlantic Provinces Chapter of the American College of Physicians. He is professor of medicine at Dalhousie University Faculty of Medicine, where he is also an assistant professor of microbiology and immunology. He has worked as a trainer in HIV medicine with the Academic Alliance on AIDS Care and Prevention in Africa and taught at the Infectious Disease Inst. of Makerere University in Uganda.

Jane Ballowitz '72, MD '76: "I moved to California the day after our CUMC graduation and have never looked back. I completed my internship in 1977, paid three years back to the U.S. Public Health Service, and then finished my internal medicine residency in 1982. A year at UC Berkeley to get my MPH in 1986 completed the requirements to pursue the career in public health that I had always wanted. I'm now the director of a large public clinic in San Francisco. We provide primary care and public health without regard to ability to pay. My faculty appointment as associate professor in the UCSF Dept. of Medicine allows me to teach students and house staff at the clinic and during my annual inpatient attending month at San Francisco General. I live in Berkeley with my partner, dog, and a garage full of bicycles."

Robert Friedman, MD '76: "I do pain medicine in New Jersey. Our daughters continue to surprise us. Jena does consulting for Booz Allen Hamilton and improvisational comedy. Dara has one more year at Wharton for her MBA and is currently a summer intern with Morgan Stanley in San Francisco."

Lynda Rosenfeld, MD '76: "I remain at Yale (hard to believe it's 27 years) where I am an associate professor of medicine and pediatrics. I do cardiac electrophysiology and am the director of the Clinical Cardiac Electrophysiology Fellowship Program. I live in Hamden, CT, with my husband, Richard Weiss, who is an executive in the wine and spirits industry. In our spare time, we travel and try to stay physically active (we plan to run in a 5K race this weekend)."

Joan E. Flender '74, MD '78: "**Ann Willoughby, Elen Shulman Baker, Francine Halberg**, and I (all **MD '78**) meet regularly in San Francisco to paint toenails, get massages, and enjoy each other's company."

Jeffrey P. Gold '74, MD '78: "New position—dean of the Medical University of Ohio and vice president for medical affairs, Toledo, OH."

Linda H. Ripstein, MD '78: "My sister Ellen is featured in *Wordplay*, a documentary about the world of crossword puzzles. She was the national crossword puzzle champion in 2001. I am semi-retired and working part time as a radiologist at Mount Sinai in Miami Beach. I work closely with the residents, which is a lot of fun."

Paul A. Skudder Jr., MD '79: "I am sad to report the loss of my father, **Paul A. Skudder, MD '53**, on June 24. Many of the class knew him as a member of the surgery department at NYH-CUMC during our years at the Medical College. Fortunately, he remained generally well until the last weeks of his life. I and my family are doing well otherwise, and enjoying the fruits of family and career."

1980s **Alice Bendix Gottlieb, MD '80**, is Tufts-New England Medical Center's new dermatologist-in-chief. She is professor of dermatology and chairs the Dept. of Dermatology at Tufts University School of Medicine. She is an expert in psoriasis and psoriatic arthritis, and was one of the first scientists to demonstrate that psoriasis is a T-cell mediated disease. Her current research includes the study of apoptosis and inflammation-related protein and gene expression in patients responding to novel psoriasis treatments.

Rochelle L. Peck, MD '80: "I continue to practice general ophthalmology at Montefiore Family Care Center in the Bronx, where I have been for 20 years. I'm also working in a group private practice (Northern New Jersey Eye Institute) in West Caldwell, NJ. I have two wonderful daughters, Dana, 26, and Margot, 23. Dana will be attending law school in the fall, and Margot is working in marketing at L'Oreal. I would love to connect with classmates who work in New Jersey, particularly in the West Caldwell area." [RPeckMD@aol.com]

Bauer Sumpio, MD '80, PhD '81, is a tenured professor of surgery at Yale University and is the head of vascular surgery. He was recently chosen by *New York* magazine as one its Best Doctors in 2006. He is happily married to Catherine Zappolo Sumpio, BNurs '76, and has three children. His oldest, Christina, is Class of 2008 at Cornell University.

Melissa Larsen, MD '81: "I have been involved in organized medicine both in Virginia and California. In 2004–05, I was president of the Monterey County Medical Society, and I have continued to serve on its board. I am also a delegate to the California Medical Society. While I was at Natividad Medical Center, the obstetrics/gynecology service was expanded, and I taught UCSF family medicine residents and students obstetrics/gynecology. My current practice is focused on Ob-Gyn Associates of the Central Coast (Salinas, CA), where I am a founding partner and medical director."

Nina Schor, MD '81, will begin her new duties as chair of pediatrics at the University of Rochester Medical Center on September 1.

Walter E. Donnelly Jr., MD '82: "Greetings from the Midwest. My group of 10 family medicine doctors is now the largest single-specialty group in Cincinnati. We are well into our complete conversion to electronic medical records (look for us at www.thefamilymedicalgroup.com) and striving to be full-service providers for our patients. We now do in-office DEXA scans, echocardiograms, and nuclear stress tests. We have a full-time diabetes educator, a large number of insulin pump patients, and a busy physical therapist. Cincinnati isn't Manhattan, but there is life."

Mace Beckson, MD '85: "The past 20 years have gone by quickly. Los Angeles has been my home since 1986, and things have gone well. I was recently promoted to clinical professor of psychiatry at UCLA. I have a successful clinical and forensic psychiatry practice. My wife, Ann, and I have been married 17 years and have three children who show us both the sacrifices and the pleasures of raising children. Unfortunately, the cost of living here is steep, the work hours are longer than I like, and I'm more than a bit perturbed about getting older so quickly. We have had our various trials and tribulations, and life has thrown us some unexpected curveballs, but we have stuck together and that has been the key to survival. Depending on the day, I might complain, but I'm also well aware of how good I have it. I maintain some contacts from medical school, and I feel connected to my experiences at Cornell,

as they occurred during a formative period. In some ways I am the same, and in others I am different from that younger and more naïve medical student in the early '80s. Overall, I think I've become more comfortable with my identity, both professionally and personally. I hope that life's journey has been a challenging and fulfilling one for everyone with whom I shared med school."

Steven T. Berger, MD '85: "I am in private ophthalmology practice at the Baystate Eye Care Group in Springfield, MA, where I specialize in cataract and corneal surgery and laser vision correction. I also wear the hat of medical director of the Pioneer Valley Eye Surgery and Laser Center. We recently completed construction of our new home in nearby Somers, CT. My wife, Linda, and our three children, Matt, Alex, and Jillian, are enjoying the new area. I look forward to our 20th reunion this fall and am eager to reunite with such good friends from the Class of '85 as **Roger Blumenthal, John Papa, Troy Elander**, and many others."

Roger S. Blumenthal, MD '85: "My son Ross turns 7 in September 2006. He is an avid lacrosse player. Basketball is his second favorite sport. Wendy and I look forward to seeing many of the Class of '85 at our reunion."

Richard J. Maraia, MD '85, heads the Section of Molecular and Cell Biology at NIH in Bethesda, MD. "I direct basic research in genetics and biochemistry. Research and the training of young MD, PhD, and MD-PhD candidates associated with my program are fascinating and rewarding. I live with my wonderful wife of 33 years in nearby Kensington, MD. Our son Eric is pleased with his career as a team leader vascular ultrasound technologist at a nearby medical center, and our younger son Neal is beginning training to become the same. I sail a Hunter 33 on the Chesapeake Bay as often as possible and visit the Cornell Alumni Club of Washington about once a year."

1990s **Daniel B. Jones '86, MD '90,** is chief of minimally invasive surgical services, Beth Israel Deaconess Medical Center, and associate professor of surgery, Harvard Medical School. He founded the Simulations & Skills Center (www.BIDMC.Harvard.edu/SASC) and co-directs the Center for Minimally Invasive Surgery at Harvard teaching hospitals. A leader in the fields of bariatric surgery, minimally invasive surgery, and skills training, he is the author of more than 150 publications. Recent textbooks include the *Atlas for Minimally Invasive Surgery* (Cine-med, 2006) and *Laparoscopic Surgery: Principles & Procedures* (Marcel Dekker, 2004). His book with co-authors **John Zebala, MD '93,** and Stephanie Jones, *Medical School Admissions: The Insiders Guide* (Mustang Publishing), is in its fifth edition. His wife, Stephanie, is an anesthesiologist and program director at BIDMC. Their children are Ryan, 11, and twin girls Leah and Cara, 7.

S. Robert Rozbruch, MD '90: "I recently celebrated my 40th birthday. I live in Westchester with my wife, Yonina, and my kids, Jason, 12, and Libby, 9. I practice orthopaedic surgery and specialize in limb lengthening and deformity surgery at the Hospital for Special Surgery, where we take care of post-traumatic deformities and bone loss in adults and leg-length discrepancies and deformities in children. I am the director of the Limb Lengthening and Reconstruction Fellowship; we offer advanced training to graduates of residency in orthopaedic surgery."

Michael P. Lisanti, PhD '91, MD '92, is professor of cancer biol-

ogy at Jefferson Medical College of Thomas Jefferson University. His research at the Kimmel Cancer Center uncovered the role of caveolin-1 as a tumor suppressor in mammalian cells. Before his appointment at JMC, Dr. Lisanti was professor of molecular pharmacology and medicine at Albert Einstein College of Medicine.

David B. Rosenberg '89, MD '93: "Son Zachary was born April 6, 2006. He is our third child."

Curtis L. Cole, MD '94: "Still at Weill Cornell. Recently appointed associate dean of medicine and public health."

Philip A. Goldberg '92, MD '96, joined Endocrine Associates of Connecticut, 6 Business Park Dr., Suite 304, Branford, CT 06405. Son Kevin Jay Goldberg was born April 6, 2005. "Big sisters Shayla and Casey are thrilled."

Sheila Partride, MD '97, is in general surgery private practice at Newton-Wellesley Hospital in Newton, MA, specializing in laparoscopic bypass and breast cancer surgery. "I am the medical director of the Newtown-Wellesley Hospital Bariatric Surgery Center and assistant clinical professor of surgery at Tufts University Medical School. In addition, I am busy with two wonderful children, Timmy, 3, and Ellie Grehan, 1."

2000s **Jennifer Cho, MD '02:** "I am in my third year of residency in obstetrics and gynecology at Johns Hopkins Hospital and working toward my fellowship in gynecology oncology next year. In November I'm returning to NYC for my elective rotation at Memorial Sloan-Kettering for about a month. Looking forward to keeping in touch with everyone."

Lisa A. Mills, MD '02, is a fellow in infectious diseases at Johns Hopkins and is living in Uganda, East Africa, working on HIV/AIDS and associated infections.

Francine Samuels, MD '02: "I finished my general pediatric residency at Yale and am currently completing my first year as a post-doctorate fellow in pediatric gastroenterology/hepatology/nutrition at Morgan Stanley Children's Hospital of NewYork-Presbyterian Hospital."

Henry Wei, MD '02: "**Mitul Vakharia, MD '02,** and Jennifer Neitzer (S. Illinois Med '02) married on May 28 in Chicago. In attendance were '02 classmates **Ryan Romeiser, Naomi Hayashi, Rupa Krishnamurthy, Dorothy Wang, Lena Kuo,** and class president **Ameet Singh,** who taught everyone how to dance *bhangra*."

Elisabeth Winterkorn, MD '02: "Fellowship is over, and I am finally ensconced in primary care pediatrics in North Andover (just north of Boston). I love every minute. Dave is in his second year of medical school, so I'm learning bugs and drugs again, too. Life with children is incredible. I can't believe that Sam turns three this September, and Ben is almost one. Hope to see some of you this year."

Kimble Poon, MD '04: "I am completing my third year of internal medicine residency at UCLA. Next summer I will start my cardiology fellowship at Harbor-UCLA. Though UCLA has been good to me, I do miss the extraordinary camaraderie we had at Cornell. Fortunately, Cornell alumni fill the ranks of several departments at UCLA, including medicine, pediatrics, urology, and radiology. I wish everyone the best, and I look forward to learning more about the good fortunes of my classmates."

Zandraetta Tims-Cook, MD '05: "Riha Meadow Tims-Cook was born July 7, 2005 (first week of internship, on day off), at 8 lbs. 13 oz."



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IN MEMORIAM

'37 MD—**Dorothea D. Vann** of Durham, NC, April 3, 2006; retired pediatrician; practiced at Englewood Hospital and Bergen County Children's Home; painter.

'39 MD—**Edward Charles Kunkle** of South Freeport, ME, July 9, 2005; neurologist.

'36 BA, '39 MD—**Harold S. Wright** of Cape Porpoise, ME, April 23, 2006; psychiatrist, Greenwich Hospital; taught at Cornell Medical College; active in civic, professional, and religious affairs. Pi Kappa Phi. Wife, Ruth Barclay Wright '35.

'38 BS Ag, '42 MD—**Robert C. Hickey** of Madison, WI, May 17, 2006; retired physician; active in alumni affairs.

'46 MD—**Howard J. Kessler** of Palm Beach, FL, July 19, 2006; former attending surgeon, Lenox Hill Hospital; veteran; clinical professor of surgery, New York University and New York Medical College; active in civic, community, and professional affairs.

'46 MD—**Harold Murphree** of Napa, CA, March 9, 2006; neurosurgeon; chief of staff, Queen of the Valley Hospital; veteran; active in community and professional affairs.

'48 MD—**James M. Colville** of Bingham Farms, MI, July 17, 2006; head of infectious diseases and director, microbiology dept., William Beaumont Hospital; former staff physician, Henry Ford Hospital; veteran. Wife, Josephine Jurusik Colville, BS Nurs '48.

'50 MD—**Charles H. Bippart** of Norwich, VT, August 24, 2004; obstetrician, Morristown Memorial Hospital.

'46 BA, '50 MD—**Carolyn Diehl** of Englewood, NJ, June 14, 2006; director of development, Rogosin Institute; first woman to

be top-ranked in her graduating class; attending physician, NewYork-Presbyterian Hospital; former faculty member, Weill Cornell. Delta Gamma. Husband, **Albert L. Rubin, MD '50**.

'53 MD—**Paul A. Skudder** of Rye, NY, June 24, 2006; attending surgeon and faculty member, CUMC and NewYork-Presbyterian Hospital; director of the fracture service; helped to introduce bariatric surgery; worked at the cancer research unit of New York Hospital Dept. of Surgery until 2005; veteran; active in community and professional affairs.

'49 BA, MD '53—**Florence A. Wilson** of Newton Upper Falls, MA, June 4, 2006; retired physician; co-author, *Health Services in the United States*; taught at Harvard School of Public Health and CUMC; practiced at Anthony Jordan Health Center, Carney Hospital, Geiger-Gibson Health Center, Fenway Community Health Center, and others; active in community and professional affairs.

'58 MD—**Raymond McCaffrey** of Old Tappan, NJ, July 24, 2006; professor, Columbia University College of Physicians & Surgeons; leader in obstetrics and gynecologic care and education, NewYork-Presbyterian Hospital.

'60 MD—**Richard J. Lynch** of Pittsfield, MA, January 1, 2006; physician, Berkshire Health Systems.

'59 BA, MD '66—**David Kearing** of Brackney, PA, September 9, 2005; physician; active in alumni affairs. Delta Kappa Epsilon.

'71 MD—**Russell Vergress** of Westlake Village, CA, March 22, 2006; orthopaedist, Providence St. Joseph's Hospital.

Beautiful Music

TRI-INSTITUTIONAL RECITALS OFFER A MIDDAY BREAK, AND SOME TUNEFUL INSPIRATION



JOHN ABBOTT

eVERY FRIDAY FROM SEPTEMBER TO JUNE, SCIENCE makes way for art. Since 1986, the Tri-Institutional Noon Recitals have been giving members of the Weill Cornell, Memorial Sloan-Kettering, and Rockefeller University communities a lunchtime respite filled with glorious sound. “Not only do they provide a place where people can hear excellent music, it allows them to get their minds off their work,” says Medical College dean Dr. Antonio Gotto, who attends the concerts as often as possible. “It’s a nice amenity, and a great addition to the Tri-Institutional community.”

The recitals, held in Rockefeller’s acoustically blessed, 450-seat Caspary Auditorium, are often filled to capacity. The artists are world class, their performances often booked to coincide with trips to New York to appear at such venues as Lincoln Center or Carnegie Hall. Past performers have included the Moscow Chamber Orchestra, the Stonewall Chorale, and “throat singers” from Tuva, Mongolia; Allen Ginsberg once recited “Howl” while the Kronos Quartet performed a composition inspired by the poem. “It’s an astonishing opportunity to be just a few feet from some of these performers,” says Dr. Donald Fischman, the Klein Professor of Biomedical Sciences and a former dean of the Graduate School, one of the series’ originators, “and it’s a time for

the three institutions to gather in a way that’s more low key.”

The task of booking each year’s forty recitals falls to John Gerlach, a longtime researcher in neuroendocrinology, now the series’ full-time director. What began with an audience of some three dozen (in a room in Sloan-Kettering’s Nurses’ Residence) has grown to a major event, with top-flight artists and managers clamoring for a slot in the schedule. Although most of the music is from the Western classical canon, Gerlach tries to craft a season complete with jazz, world music, and special programs geared to various holidays. “The concerts have an incredible reputation,” he says. “At this point, the series has become rather broadly known, and not just in New York or the United States. It’s a real jigsaw puzzle to fit everybody in to the Fridays that are available.”

The concerts receive modest financial support from the three institutions, but most of its costs are covered by voluntary contributions from regular attendees. The artists receive an honorarium, and something less tangible: the chance to perform for an appreciative New York audience without the pressure of a more formal concert venue. “There are no reviewers,” Gerlach notes. “If something doesn’t work, it’s not going to be reported—so they can really go for it.”

Different drummer: On June 2nd, Indian tabla master Badal Roy joined forces with jazz pianist Michael Wolff for some inspired improvisation.

Summer of Discovery

A Cooperative Exchange Program with WCMC-Qatar



Dr. Ronald Crystal, chairman of the Department of Genetic Medicine and the Bruce Webster Professor of Internal Medicine at Weill Cornell, discusses the role that Zeinab Ammous, a WCMC-Qatar student, played in his lab's research this summer on the role of the environment in genetic expressions associated with major lung disorders. Ammous spent two months working in Dr. Crystal's lab as part of Weill Cornell's "Summer of Discovery," a cooperative student exchange program that provides WCMC-Qatar students with research and clinical experience at Weill Cornell's New York City campus. Ammous's recently acquired RNA extraction and Snopes genotyping skills are being used to develop protocols that will allow the campuses to collaborate on the project, which will ultimately be used to compare the two populations.

For more information about this program and other news, visit www.med.cornell.edu/publications/

Reunion 2006

Friday, October 13, and Saturday, October 14, 2006

Reunion at Weill Cornell Medical College is a time to renew old friendships, take a stroll down memory lane, enjoy fine cuisine, and hear first-hand about the exciting work that's taking place at your alma mater. You'll hear from Dean Antonio Gotto and New York-Presbyterian CEO Dr. Herbert Pardes, and also have the opportunity to attend special keynote addresses and social events.

All alumni of the Medical College, Graduate School of Medical Sciences, and the Center Alumni Council are welcome to attend Reunion 2006!

To view the full Reunion 2006 schedule, please visit:
www.med.cornell.edu/about/reunion.html

FRIDAY, OCTOBER 13

7:30 – 8:00 AM	Registration in Uris Auditorium
8:30 – 9:00 AM	Welcome & Opening Remarks Presentation of the CUWMC Alumni Association 2005 and 2006 Honorary Fellowship Awards
9:00 – 10:00 AM	DEAN GOTTO'S STATE OF THE MEDICAL COLLEGE ADDRESS
10:30 – 12:00 PM	Keynote addresses by some of Weill Cornell's most distinguished alumni
12:15 – 1:45 PM	Dean's Luncheon and Biennial Business Meeting & Election of Officers
2:00 – 3:30 PM	Panel discussions and keynote address
4:00 PM	OPENING OF THE 16th MEDICAL COMPLEX ART SHOW
5:00 – 6:30 PM	Performance & Cocktail Reception

SATURDAY, OCTOBER 14

9:00 – 10:15 AM	CEO's Breakfast & State of the Hospital address
10:30 – 12:40 PM	"Beyond Borders" sessions
12:40 – 1:10 PM	PRESENTATION OF THE DISTINGUISHED ACHIEVEMENT AWARD AND DISTINGUISHED HOUSESTAFF AWARDS
7:00 PM	REUNION GALA AT CHELSEA PIERS

Special anniversaries

5th	10th	15th	20th	25th
2000	1995	1990	1985	1980
2001	1996	1991	1986	1981
30th	35th	40th	45th	
1975	1970	1965	1960	
1976	1971	1966	1961	

Induction of the 50th & Golden Anniversary Classes 1945, 1946, 1950, 1951, 1955 & 1956

We have been able to keep the cost of this year's reunion the same as the last reunion. Registration for the day events is \$85 per person or couple (you may bring your spouse or guest at no extra charge) and \$170 per person for the Gala. For more information about Reunion 2006, please call the Alumni Office at (212) 746-6546 or e-mail alumni@med.cornell.edu.

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