

BROWN MEDICINE

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A magazine for alumni and friends of The Warren Alpert Medical School of Brown University

HOMEWARD BOUND

VA clinic offers homeless vets
more than just health care.

PLUS:

Baby Fat Battle
Resident Life of Yore



LETTER

FROM THE DEAN



Ahead of the Curve

There is excitement in BioMed. Presuming approval by the Brown Corporation, the new medical school building at 222 Richmond Street is on target for ground breaking in April 2010. We are about to select a construction manager and will immediately begin detailed plans for the restoration. We plan to finish in August 2011 in time for the entering class of 2015.

This issue of *Brown Medicine* highlights one of the important programs at the Providence VA Medical Center and my wife, Rena's, work in obesity. The VA medical system, which one can call "socialized," is being held up as an example of low-cost, high-quality care. Dr. Tom O'Toole, associate professor of medicine, is spearheading new programs for our veterans, including the one described in these pages. Incidentally, Tom was one of my residents at the University of Pittsburgh, where he singlehandedly developed a series of free clinics for the homeless. Rena's work speaks for itself. Many say there is no greater health problem in the U.S. than obesity, and her work has been at the forefront of behavioral treatment of this problem for many years.

Edward J. Wing



“It’s one thing to be aware. It’s another thing to figure out what to do about it.” —*Thomas O’Toole*

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Primary Consideration

BY EILEEN O’GARA-KURTIS

At the Providence VA, housing—and all the other basic needs—is health care for homeless vets.

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BY SHARON TREGASKIS

American children are becoming obese just like adults. Here’s what Brown faculty are doing about it.

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BY KRIS CAMBRA

Think you had it rough? Check out what medical residents in 1942 had to put up with.

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Jim Pannoni by Kathleen Doohar

SCOTT KINGSLEY; JESSICA DEANE ROSNER; KAREN PHILIPPI

Worlds Collide



As I write this, my eyes are still sticky from a 2 a.m. return from Comayagua, Honduras, where I had gone to

continue construction work on a daycare center. Located in an impoverished neighborhood of unpaved streets and dirt-floor shanties, the center's mission is to serve the poorest of the poor.

While the organization running the daycare service awaits its license, its members serve nutritious meals to local children three times a week. I'm no doctor, but I'd wager that the majority of the kids suffer from some degree of malnutrition. When you guess their age it's best to tack on three or four years. Now, back at my desk, I have just proofread this issue's feature on the amazing work being done at Brown to understand and address childhood obesity in the United States. It's a strange sensation indeed to read about kids who need to eat less, having days ago been with kids who just need to eat.

Our feature on the VA clinic for homeless veterans is as moving as it is informative, I think. I for one had never considered the need for organization and punctuality in a homeless person's day, or the fact that suddenly no longer being homeless can be seriously disorienting. The approach of Dr. O'Toole and his colleagues—treating not just patients' homelessness but integrating all their challenges into their care—is so logical as to seem self-evident, but really bears witness to their innovation and dedication.

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INBOX

NICU OF THE FUTURE

Kris Cambra's cover story, "Room to Grow" (Fall 2009) reminds all of us who are NICU-affected of the value and importance of those caring for our very young preemies, and that the outcomes our premature children face can and should be measured, and improved. I myself gave birth to extremely premature twins, weighing a pound at birth, in 2000. Our daughter suffered a serious setback shortly after birth, and died when we removed her from life support four days later. Our son survived for eight



years to be multiply-disabled, before succumbing to complications that dated back to that same premature delivery.

The life of an extremely premature infant can be a complicated one. As the story so gracefully articulates, not all these babies go on to be "miracles" or "success stories." For a parent, the road can be equally difficult as one learns to navigate the world of illness and challenging conditions, like chronic lung disease and cerebral palsy. While bioethicists continue to debate the pros and cons of resuscitating very premature infants, it's profoundly reassuring to know that the doctors at Women & Infants have recognized the array of lifelong complications an ex-preemie can face, and have dedicated themselves, through their research, studies, and implementations, to limiting those adverse outcomes.

PAUL BROBEN/ISTOCK PHOTO

YAY, US!

Brown Medicine has received two Council for Advancement and Support of Education District 1 Communication Awards: bronze in the Best Overall Magazine category and honorable mention for Best Writing.

The Providence model surely ought to be that of the future, and I have no doubt ex-preemies and their parents will benefit remarkably from it.

Vicki Forman

Author, *This Lovely Life: A Memoir of Premature Motherhood* (Houghton Mifflin Harcourt/Mariner Books, 2009)

dents have the same opportunity I had to rub John Hay's nose on the way in to encounter the classics of medicine.

Jason Rosenstock '89 MD'92

Assistant Professor of Psychiatry and Director, Medical Student Education University of Pittsburgh School of Medicine

THANKS FOR THE MEMORIES

I enjoyed reading the "From The Collections" piece by Steven Moss and Tovah Reis (Fall 2009), describing the Rhode Island Medical Society (RIMS) collection at the John Hay Library.

I remember the RIMS collection fondly: after Brown acquired it in 1987, I helped create an annotated catalogue of the material under the tutelage of Professor of the History of Medicine Naomi Rogers—and with the help of a UTRA summer research grant. Spending two months nestled amid the dusty stacks of the Hay, picking up each new tome to see what lay inside, and creating notes for scholars to use to understand the collection—well, it was inspiring and thrilling to be part of it all. As a PLME student concentrating in history of medicine, the RIMS resources were invaluable. I'm thrilled that the collection still exists, and that Brown stu-

MISTAKEN IDENTITY

I enjoyed the fall 2009 edition of *Brown Medicine*, and the "Bird's Eye View" (Big Shot) is a great picture and a nice story. Unfortunately, the bird is not a falcon but rather is *Buteo jamaicensis*, a red-tailed hawk. It certainly did have a watchful eye on graduation, however.

Steve Davis MD'80

Clinical Associate Professor of Family Medicine, Alpert Medical School

SOMETHING TO SAY?

Please send letters, which may be edited for length and clarity, to:

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- Brownmedicinejournal.org

THE BEAT

WHAT'S NEW IN THE CLASSROOMS, ON THE WARDS, AND IN THE LABS

MILESTONE

Finding Nemo

The future medical school has a rich past.

At its meeting last October, the Corporation of Brown University endorsed design schematics for a new medical education building—the Medical School's first dedicated home in its four-decade history.

After the meeting, Dean Edward Wing said that approval of the plans marked “the beginning of a new era in medical education” at Brown. The project is seen as a major step toward fully realizing the potential of the \$100 million gift made in 2007 by The Warren Alpert Foundation.

The new state-of-the-art facility, located at 222 Richmond St. in Providence's Jewelry District, was among the properties purchased by the University in October 2006. A \$45-million renovation is scheduled to begin this spring, and the opening is slated for August 2011.

Designs for the approximately 137,000 gross-square-foot project include a central atrium, an anatomy lab, case study rooms, and a realistic outpatient care facility for student interactions with standardized patients. The facility will enable the School to expand class size in response to the nation's physician shortage. It will also accommodate the Academy system, in which students from all



four years are organized in subgroups for teaching and mentoring.

The 1928 building is the former home of Brier Manufacturing Company. Founded in 1913 by Benjamin Brier, the company produced Little Nemo brand costume jewelry and, in the 1950s, was the second-largest costume jewelry manufacturer in Providence. Brier, former president of the company, was the third chair of the board of The Miriam Hospital. His son, Milton '50, was cap-

tain of Brown's swim team and president of the company from 1972 to 1978. His grandson Jeffrey worked there in the 1970s and is currently chair of the board of The Miriam Hospital Foundation.

A PLAN FOR THE JEWELRY DISTRICT

According to an independent analysis by Appleseed Inc. of New York, the renovation will directly create nearly 350 temporary jobs in the construc-

A view of the building's planned Richmond Street facade.



KLIMENT HALSBAND ARCHITECTS

tion trades and related industries and, through a multiplier effect, will support an additional 200 jobs and generate \$26.2 million of economic output throughout the state. The plans have generated considerable media coverage, including in the *New York Times*, and locally have been received positively. According to Daniel Baudouin, executive director of the Providence Foundation, a private nonprofit focused on downtown development, the building will

create the “critical mass” needed to establish a knowledge-based economy.

Also last October, the Corporation received a report from planning architect Frances Halsband, who led a study for areas of the Jewelry District in which the University owns property. The planning principles and design concepts she presented would establish a pattern for development that would integrate the University with the neighborhood, contribute to a more vibrant community,

and support ongoing efforts to spur economic growth.

A coherent, well-crafted plan for developing Brown’s properties in the Jewelry District—particularly the new medical school and the Laboratories for Molecular Medicine, at 70 Ship St., will contribute to the revitalization of an important Providence neighborhood and will help transform it into a bona fide Knowledge District.

—Adapted from an article by Mark Holmer

THE BEAT

The supercomputer is big, but it's six times more energy efficient than what had been available at Brown.



COOL TOOL

That's Fast New computer leaves others in the dust.

Last November, Brown and IBM announced the opening of a multimillion-dollar supercomputer at Brown's Center for Computation and Visualization. The size of six refrigerators, the supercomputer is the most powerful computing system in Rhode Island and will be used by researchers statewide to tackle "grand challenges" in climate change, education, energy, and health.

The supercomputer can perform more than 14 trillion calculations per

they could address just a few short years ago," says Nick Bowen, vice president of technology for IBM, "from mapping the human genome to helping figure out how to cut down on carbon emissions to helping ensure our waters and food are safe and sustainable."

Examples of the research that will take advantage of the increased horsepower include advances in genomics that could lead to drugs for treating diseases such as cancer; investigation of the mechanics of human and animal movement; exploration of the web of animal life and ocean ecosystems; and studies of the terrain of planetary bodies, such as Mars.

"We live in an era where computer-enabled research cuts across all research

The supercomputer can perform more than 14 trillion calculations per second.

second—nearly 50 times faster than what had been available at Brown. The system operates at a peak performance speed of more than 14 teraflops and holds 4.5 terabytes of memory, about 70 times more than what was previously available.

"This new system will also help scientists make our world smarter through the ability to address problems that are orders of magnitude larger than what

and opens entirely new pursuits and innovations," says Jan Hesthaven, professor of applied mathematics and director of the Center for Computation and Visualization. "We now have a computing system for these times." —Richard Lewis

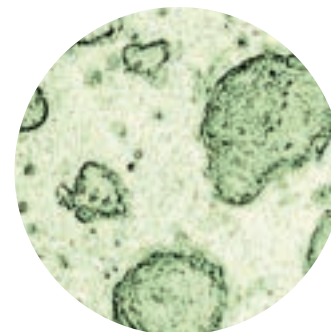
Visit www.brown.edu/Departments/CCV/ for more information on how researchers will put the supercomputer to use.

BIG MONEY

Transformers

NIH grant jump-starts stem cell research at Rhode Island Hospital.

Rhode Island Hospital has received an \$11 million grant to fund research that will lead to a general understanding of stem cell biology and identify unique approaches to tissue regeneration in lung and marrow dis-



eases. The grant will enable Dr. Peter Quesenberry, director of hematology/oncology at Rhode Island Hospital, to research the true phenotype of marrow stem cells and their fate as tissue. The goal is to translate basic stem cell studies into clinical trials on tissue restoration or correction in patients with chronic obstructive lung disease and malignant blood diseases.

The five-year Center of Biomedical Research Excellence (COBRE) grant from the National Center for Research Resources of the National Institutes of Health also provides funding for the development of a major stem cell research center at Rhode Island Hospital. Work in the center will also include general stem cell biology. According to Quesenberry, who is also the Paul Calabresi, MD, Professor of Oncology at Alpert Medical School, "This grant holds real promise for expanding our understanding of stem cell biology."

—Rebecca Kaufman '11

RYAN CONATY; ISTOCK/DRA_SCHWARTZ

Check Yourself

What to do about cancer screening.

Last fall, the U.S. Preventive Services Task Force issued some surprising and controversial new guidelines for mammography. Dr. Robert Legare, associate professor of obstetrics and gynecology (clinical) and director of the Breast Health Center at Women & Infants Hospital of Rhode Island, offers his perspective.

What are you advising your patients in light of the government advisory panel guidelines?

Acknowledging the limitations of mammography, we continue to recommend screening beginning at age 40 because this remains our best tool for early detection and successful treatment of breast cancer. In fact, screening

mammography is a principal reason the U.S. breast cancer mortality rate has steadily declined since 1990.

Annual mammographic screening realizes maximum effect in women aged 50 to 74, but most research indicates at least a 15 percent reduction in mortality in women aged 40 to 49. Women with personal risk factors or family history should begin screening at least at 40. If women delay mammography to age 50, there will definitely be delays in diagnosis which will impact survival.

Mammography's risk in younger women is "false positive" results that lead to additional imaging, needle biopsy, and more frequent follow up. This may add to some women's anxiety, but may reassure others. We hope the recommendations continue to increase dialogue on the benefits and limitations of screening and acknowledge a great need for more effective screening approaches.

Have a medical question? Send it to Brown_Medicine@brown.edu and we'll ask an expert for you.

FINDINGS

Cellular Abuse

Damage from childhood trauma is not only psychological.

Children who suffer physical or emotional abuse may be faced with accelerated cellular aging as adults, according to new research from Butler Hospital and Brown University.

The findings draw a direct connection between childhood psychological

shorten with age, decreased in length more rapidly in subjects who reported suffering maltreatment as children, compared to study participants who did not. Maltreatment included moderate to severe emotional abuse, emotional neglect, physical neglect, physical abuse, and sexual abuse.

"It tells us something. It gives us a hint that early developmental experiences may have profound effects on biology that can influence cellular mechanisms at a very basic level," says Dr. Audrey Tyrka, the study's lead author and an assistant professor of psychiatry and human behavior. She is



Audrey Tyrka has linked abuse with faster aging.

"Early developmental **experiences** may have **profound effects** on biology."

trauma and accelerated reduction in the size of telomeres, the "caps" on the end of chromosomes that promote cellular stability. Telomeres, which typically

also associate chief of the mood disorders program at Butler Hospital.

Shorter telomere lengths have been linked to a variety of aging-related

medical conditions including cardiovascular disease and cancer. Tyrka says, "It is possible that this is a mechanism of risk for illness following childhood abuse. But the precise role of telomeres in this process remains to be determined."

This may be the first attempt to look at telomere length in relation to childhood mistreatment. The research is published online in the journal *Biological Psychiatry*.
—M.H.

THE BEAT

ELEVATOR PITCH

Heavy Hitter

New center treats sports-related concussions.

Have you ever heard the crack of helmets while watching a football game? Mounting evidence shows that football players—from the peewee leagues to the NFL—suffer frequent concussions that sometimes result in life-long brain damage.

Brown Medicine recently spoke with Assistant Professor of Neurology (Clinical) Mason Gasper, DO, MPH, F'05 about the Sports-Concussion Management Program he started at Memorial Hospital of Rhode Island.

How did your interest in concussion research begin?

Besides an interest in neurorehabilitation and keeping up-to-date on an expanding scientific understanding of

mild traumatic brain injury, a personal experience of a concussion during a high school football game drove my interest. During the concussion, I clearly recall not being able to communicate at all with coaches or other players, even though I recall them speaking to me and saying “welcome to the NFL” in jest. The curious thing about the experience was that I must have outwardly appeared OK, as I was sent back out on the field, but inwardly I really had no

clue where to stand or what play was being called. This is a story shared by many after a mild head injury, and many concussed athletes remain in the game, seemingly normal yet with no ability to understand and react quickly to events around them—a set-up for another injury.

What is the Sports-Concussion Management Program?

Janet Grace, PhD, a neuropsychologist at Memorial, and I began talking about a sports concussion program two years ago. At the time, sports-concussion management was a growing concern in the media. While much of the focus of public discussion in sports-concussion care is on professional athletes, we felt we could make an impact on the local high school and college levels, especially since there are few options for concus-

Our goal is to **evaluate student athletes** at any age as **quickly as possible**.



Mason Gasper helps athletes keep their heads in the game.

KAREN PHILLIPS

sion care in Rhode Island. Additionally, we are fortunate at Memorial to have a group experienced in concussion care and sports medicine.

Our goals are to evaluate student athletes at any age as quickly as possible (we are prepared to see athletes the next day in most cases) and set a return to play and school plan (with graded exercise protocols when symptomatically and cognitively appropriate, and cognitive rest as appropriate), and follow up for postconcussive syndrome (persistent memory problems, vertigo, headache, fatigue).

What is your reaction to recent legislative involvement in NFL policies regarding concussions?

The NFL has come a long way (with prodding from the media, players, and Congress, of course) in recognizing the importance of addressing concussion. The decision to have independent neurological evaluations will be important to remove any conflict of interest in highly competitive situations.

However, it is important to realize that players ultimately are responsible for reporting concussions. An interesting idea is to allow the on-field referees to disqualify players for suspected concussion, as in rugby, thereby removing some of the dependence on player reports.

Brown football alum Sean Morey '99 of the Arizona Cardinals has agreed to donate his brain to the Boston University CSTE study. What do you think the significance of this study will be?

Neuropathology studies were a key part of making sports concussion an important health concern. Dr. Bennet Omalu performed autopsies on multiple NFL football players who had died at relatively young ages. At the time, it was surprising that these young players' brains showed changes seen usually with Alzheimer's disease. The question now is, Do some cases of mild head injury where there are less frequent head impacts result in neuropathological abnormalities? **R.K.**

ISTOCK/BOCAMINUS

EATS

Tray Bien

Who knew hospital food could be so good?

Patients at The Miriam Hospital are in for a surprise when mealtime rolls around, thanks to the launch of an innovative program that offers the kind of dining experience usually associated with a restaurant. The new Personal Choice Dining program assigns each patient to a host or hostess. As the patient's "food ambassador," the host or hostess helps patients select meals according to dietary restrictions or doctor recommendations during the hospital stay. The host or hostess is also responsible for the preparation and delivery of the patient tray.

"Because each host or hostess is assigned between 30 and 40 patients, they are able to build relationships with these patients, and in turn, patients are more

Choices include sole, salads, and even comfort foods like macaroni and cheese.



comfortable asking questions or expressing any concerns," says Margarida McFarland, manager of the hospital's Personal Choice Dining program.

Patients now have their choice of featured entrees, which range from lemon dill sole to a Waldorf salad. They also have the option of selecting items from the hospital's "All Time Favorites" list, featuring such comfort food staples as macaroni and cheese, chicken noodle soup, and grilled cheese, which are available all day. Kosher meals include such varied dishes as baked polenta with fresh homemade tomato sauce and mozzarella, chicken paprikash, eggplant parmesan, and grilled chicken and kasha.

—**R.K.**

Over Heard

"The right to procreate, no matter what heinous offense one has committed, is set against the right of a child to grow up without being abused."

GREGORY K. FRITZ, MD, professor of psychiatry and human behavior, in a November 13, 2009, commentary in the Providence Journal, in which he advocates the involuntary sterilization of convicted child abusers.

THE BEAT

GOOD NEWS

You Stay. We'll Pay.

Primary care loan repayment program aims to bring docs in state.

With 400 miles of coastline, it's hard to imagine anyone would need coaxing to move to Rhode Island, but thanks to a new loan repayment program, primary care physicians are getting some incentive.

A coalition of local organizations—The Rhode Island Foundation, Blue Cross & Blue Shield of Rhode Island, and the Rhode Island Medical Society—have joined forces to create a \$1.1 million loan forgiveness pool for primary care physicians. The goals are to lower health care costs and address the state's shortage of these clinicians.

Robert M. Trachtenberg, associate director of the Rhode Island Area Health Education Center (RI AHEC) and president of the National AHEC Association, is tasked, in part, with building the primary care workforce in the state. He is a member of the committee reviewing the loan for-

“We hope to attract some residency graduates who want to stay in Rhode Island but can't afford to, and to improve recruitment of new physicians to the state.”

giveness applications. “We hope to attract some residency graduates who want to stay in Rhode Island but can't afford to, and to improve recruitment of new physicians to the state,” he says.

Those who are selected will receive up to \$20,000 annually for a maximum of four years. The first round of applications

SIGHTSEER

Dazzled by the Jewelry District

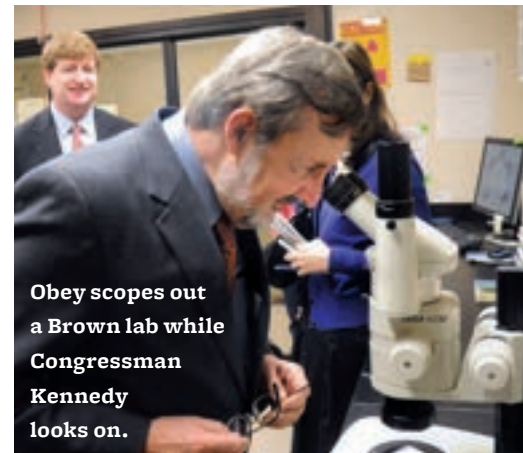
Brown laboratories host Congressman David Obey.

Brown's Laboratories for Molecular Medicine at 70 Ship Street were visited on November 13 by Rep. David Obey (D-WI), chairman of the U.S. House Appropriations Committee, and several Rhode Island elected officials.

Obey toured Providence's Jewelry District at the invitation of Rep. Patrick Kennedy (D-RI) to see the state's economic needs firsthand. A visit to Brown laboratories demonstrated the increasing presence of Brown research and development in the Jewelry District that has the potential to boost the state's economy.

Brown Vice President for Research Clyde Briant greeted the officials and took Obey on a tour of the crystallography lab of Rebecca Page, an assistant professor of biology, and the nuclear magnetic resonance lab of Wolfgang Peti, an assistant professor of medical science. These labs employ basic life-sciences research that can be translated into drugs aimed at treating diseases such as Parkinson's disease, Alzheimer's disease, and drug addiction.

This potential for product development and business growth emphasizes the importance of Brown's collaborations with the state and the necessity of obtaining federal funding for such efforts. —Today at Brown staff



Obey scopes out a Brown lab while Congressman Kennedy looks on.

were due in late 2009, and awards will be announced in February 2010. Currently the program is open to physicians in family medicine, internal medicine, and pediatrics. Eligible physicians must provide an average of 32 hours of direct patient care per week during each year of service. To meet its mission of reaching the underserved, the program requires that recipients must provide care regardless of a patient's ability to pay and accept patients with Medicare, Medicaid, or other state-funded health care benefit program.

The Rhode Island Student Loan Authority will administer the program.

“This is a natural extension of our college planning and education financing activities. Given our 25-plus years experience in administering education loans, we can implement a new program like this quickly and efficiently,” says Charles P. Kelley, executive director of the agency. —Kris Cambra

ISTOCK/RISAMAY; FRANK MULLIN



David Washington, Jennifer Gao, and Naida Cole are easy on the ears.

HARMONY

A Patient Audience

Music that tugs at the heart strings.

Dozens of medical students pass through the halls of East Bay Manor and Tamarisk Assisted Living Residence every two months to visit their Doctoring longitudinal patients. But even after moving on to rotations at The Miriam Hospital, Bradley Hospital, or Rhode Island Hospital, a group of 50 students will trade the stethoscopes for sheet music and return to the assisted living residences, this time as musicians.

The group Chordae Tendinae (composed of students as well as two physicians, Kenneth Korr and Ray Welch) comes together once a semester to play music at a different residential facility. They perform genres ranging from classical to jazz, R&B to folk.

Performing for the elderly residents

provides a perspective on patients beyond that offered by the typical Doctoring interaction. “It’s an extension of the doctor-patient relationship,” says Naida Cole MD’11. “The environment is very personal.”

Cole, David Washington ’07 MD’11, and Jennifer Gao MD’11 founded the group in their second year as a way of giving back to patients and doctors at the facilities. *Chordae tendinae* is Latin for heart strings, the fibrous threads that anchor the heart valves to the papillary muscles.

“The main thing about being a resident in an assisted living facility is that it can be really lonely,” explains Gao. “This is something we can do to not only give something back to the residents we have come to know so well through the

Doctoring program, but also to provide some fun and help alleviate the sense of loneliness, if only for a few hours.”

The experience is as much about the facility residents as it is about a passion for music. It can be challenging to find time to play, given the demands of medical training. Performing with Chordae Tendinae gives the students a chance to take time to do what they enjoy.

“Scheduling across different levels of training can be difficult, but the love of music makes it happen. It’s very therapeutic,” says Washington. “You’re playing and it’s good for you, they’re listening and it’s good for them. The healing goes both ways.”

But even when the white coat is off, the students never lay their medical instincts completely to rest. “During the second concert, a patient started coding next door,” says Cole, who played music professionally before entering medical school. “We all wanted to reach for our stethoscopes.”

—R.K.

THEBEAT

NICE JOB

Got a Match?

Med student-run marrow registry drive saves a life.



As a freshman in fall 2008, Tyler Rogers '12 was looking forward to doing all the things 18-year-olds are allowed to do, like vote. When he saw a sign for a marrow registry drive on the Main Green, he discovered another thing a newly minted adult can do: submit a sample to the National Marrow Registry.

Rogers thought the call he received a couple of months later from the Registry asking him to go for further testing was just part of the routine. Then he found out he was a match for a man with Hodgkin lymphoma. Would he be willing to donate bone marrow to this stranger?

Rogers was a **match for a man with Hodgkin lymphoma.**

That a Brown student would actually match with a patient seemed like a remote possibility to Jenna Kahn '08 MD'12 and Geolani Dy '08 MD'12 when they began working on the drives with the Program in Liberal Medical Education Senate four years ago. They just wanted to raise awareness about the registry and improve enrollment rates in the U.S.

With the guidance of the program's faculty adviser, Professor of Medicine Edward Feller, Kahn and Dy run at least two drives each school year and try to educate potential donors about the process.

"There are a lot of myths and misconceptions," Kahn says. "I was scared at first, too. I thought it might hurt."

Joining the registry just takes a simple cheek swab, which is done during the

drives and is overseen by a nurse. For the actual donation, most people are more familiar with the bone marrow extraction process that involves taking liquid marrow from the donor's pelvic bone, but peripheral blood stem cell donation is now done 80 percent of the time. Rogers chose to do this non-surgical procedure in May 2009.

He was given an injection of the drug filgrastim every day for five days, to encourage his bone marrow to produce more stem cells. On the fifth day, Rogers went to the Rhode Island Blood Center, where an IV was put in each hand. One needle withdrew blood and through a process called apheresis, extracted the stem cells that would be given to the patient. The other needle returned the remaining blood products to his body.

"It wasn't painful. You just relax and lie back," Rogers says of the five-hour procedure. He returned to campus immediately after and gave a 45-minute presentation for a class final.

"The effort is minimal and the impact it can have is huge," he says.

Four months later, Rogers learned that the patient was in remission. In the first year after the transplant, a donor and recipient may communicate through the transplant center if they so choose.

Kahn and Dy see the registry drives as another way to address health disparities among minority groups. "A Caucasian has an 80-85 percent chance of finding a match, whereas minority patients have a 35 percent chance of a match," Kahn explains.

It's particularly difficult if you are biracial, says Dy. "We can take advantage of the rich diversity on the Brown campus. There is a big emphasis on changing the 35 to 80 percent."

—K.C.

FRANK MULLIN



TECHNOLOGY

It's All There

New system replaces students' paper files with one web-based portfolio.

Students, faculty, and administrators at Alpert Medical School reached another technological milestone last fall when they began using the School's new Electronic Medical Student Record (EMSR).

The system is being phased in, starting with the class of 2013. When complete, busy third- and fourth-year students immersed in clerkships will be able to review their evaluations, while hospital-based advisers will be able to follow their students' progress much more easily.

The system—which replaces the old paper files formerly stored in Arnold Lab—provides a complete record of a student's academic history, from the time he or she applies until graduation. This includes grades, clerkship evaluations, and any academic honors (or warnings). With students and faculty spread out across campus and throughout seven hospitals, an electronic record with secure remote access offers considerable advantages.

One of the most innovative features is students' ability to build their own online academic portfolio. They can upload papers they have written, information on their research projects, and news of any honors or awards they have received. "When it's time to begin applying to residency programs, the application will practically write itself," says Director of Medical Student Affairs Alex Morang. In

addition, the system will greatly streamline the process of preparing Dean's Letters.

EMSR is a follow-on to the Medical School's successful Supplemental Medical School Admissions System (SMSA). SMSA consolidates an applicant's data—primary and secondary applications, recommendation letters, and so on—into a unified web page. This enables Admissions Committee members to review applications at their convenience—and from the location of their choice. Given that Admissions Committee meetings sometimes take place on Sunday mornings, that's nothing to sneeze at.

—**Clifford Hirschman,**
director of Biomed IT

FASHION DON'T

What Not to Wear

Students move to ban microbe-carrying neckties.

Though it's a staple for most male physicians, the necktie is one of many threats to patients in critical and intensive care units across the country. Ties are rarely washed, even after coming in contact with many patients over the course of a day. As research emerged implicating the necktie and other physician apparel as culprits in rising rates of nosocomial (that is, acquired in a hospital) transmission of disease, Alina Markova MD'12 and John Shuck MD'11 took action.

"In recognition of the burden of disease by nosocomial transmission, we decided to create a resolution to advocate for the modification of hospital attire to create a safer environment for the critically ill," says Markova. "As American Medical Association [AMA] members, our resolution aims to address this problem."

Markova and Shuck presented Resolution 720 to the AMA House of Delegates in June 2009. Consideration of the proposal will depend on the AMA's findings regarding disease transmission and physician dress, to be presented this June. A similar policy, outlawing jewelry and sleeves below the elbows, has already been adopted by the National British Health Service.

"Prior to our involvement in this issue, we were unaware of the role medical students can play in health care on the national level," says Shuck. "We're excited by the attention our resolution received within the AMA and among the general population. It is rewarding to find that even as students, we have a voice."

—**R.K.**

Book SHELF

Making Rounds With Oscar:

The Extraordinary Gift



of an Ordinary Cat

By **David Dosa, MD,**
Assistant Professor of
Medicine

and Community Health, Hyperion,
2010, www.hyperionbooks.com

THE BEAT

NETWORK

Paging Dr. Mom

MomDocFamily helps physician-mothers have it all, whatever that is.

Assistant Professor of Medicine Lynn E. Taylor remembers vividly the first time she realized there might be a need for MomDocFamily, the organization she co-founded.

“I was very pregnant, and [Assistant Professor of Medicine and Obstetrics and Gynecology (Clinical)] Amy Gottlieb asked me what I would do if the baby was born right now. ‘What do you mean?’ I said. I was 100 percent in medicine mode—I hadn’t thought about child care at all.”

Gottlieb hooked her up with another physician with whom Taylor was able to share a nanny. Taylor and Carolyn Blackman ’88 MD’97 realized that more women should have access to this informal network of mother-doctors helping other mother-doctors, and in 2003

MomDocFamily was born. Today the organization boasts 170 members from all specialties and career tracks, from academic to community physicians, part-timers to researchers.

Taylor and Gottlieb are the co-directors. “I love this organization because it is a model of change that starts at the grassroots level with a bunch of women who are committed to being successful in their profession of medicine but also want to be successful as mothers and to enjoy both, which is also very hard,” Gottlieb says.

Their main mode of communication is an email listserv, “a functional, easy way to get both personal and professional referrals and advice fast,” according to Associate Professor of Family Medicine Julie Taylor, a mother of four. An early member

of the organization, she is now on its Advisory Board. Members also meet quarterly for brunch, and a babysitter is provided so members may bring their children.

MomDocFamily partners with the Medical School’s Office of Women in Medicine, which hosts the organization’s website and offers opportunities to connect with women faculty and students.

Advisory board member and pediatrician Beatrice Lechner, with co-authors Gottlieb and Lynn E. Taylor, recently published a letter to the editor in *Academic Medicine*. The letter calls for mentoring that addresses the particular challenges of combining a medical career with motherhood, not just the typical faculty development topics. The letter is one step toward the goal of establishing MomDocFamily affiliates across the country in order to encourage systemic change.

In addition to supporting its members, MomDocFamily “puts parenthood on the agenda,” says Gottlieb, advocating for better parental leave policies and options that promote work-life balance. These, she says, not only benefit women but also their male colleagues.

Second-year medical student Marina MacNamara became a MomDocFamily member when her daughter was born last spring. MacNamara led a needs assessment study of members and has presented her findings at professional meetings. Her study is the basis for her scholarly concentration in medical education.

MomDocFamily’s leadership sees much of its purpose to be about making it easier for the mother-doctors coming up through the ranks, like MacNamara.

“I remember pumping breastmilk in dirty bathrooms or perched on a counter in the stockroom in the ICU,” Lynn E. Taylor says. “As I did it I said, ‘I’m too junior right now, and too strung out between two babies and call to figure this out, but I don’t ever want another physician to do this.’ Every challenging thing that I went through, in my mind I was saying, I want this to be better for the next physician.”

—K.C. ■

SCOTT KINGSLEY



From left to right: Drs. Ann Wold (Ob-Gyn), Lynn Taylor (Internal Medicine), Julie Taylor (Family Medicine), Amy Gottlieb (Internal Medicine and Ob-Gyn), Beatrice Lechner (Pediatrics), Neha Raukar (Emergency Medicine). Missing from photo: Carolyn Blackman ’88 MD’97.

RESIDENT EXPERT

BY JOANNA D'AFFLITTI, MD, MPH



Here With Me

You can hold on and still let go.

Some events change your life forever. On February 5, 2006, my 24-year-old cousin was killed in a snowboarding accident. We had grown up like sisters, and her death left me with an irresolvable sadness. Not a day passes without her entering my mind. My son is named after her; I carry her wallet in my white coat pocket; her number remains, un-erased, in my cell phone. She is with me as I round on my patients. I channel her perseverance and sense of adventure as I embark upon a challenging procedure or a marathon call shift. More often than not, however, she is with me as I treat patients facing critical illness and death.


Whether it is sudden and unexpected or gradual and well anticipated, the death of a loved one is always devastating. As a physician, my challenge has been to support families through the process of dying while explaining the underlying patho-

physiology and helping them to make important end-of-life decisions. Over the past two years I have had the privilege of taking care of a young woman with systemic sclerosis. She was diagnosed after the birth of her daughter, now 5, when her kidneys began to fail and she was hospitalized with scleroderma renal crisis. Her life from then on was punctuated by frequent hospitalizations and dialysis treatments. Several months ago she was admitted

again, this time with an infection at the site of her dialysis catheter. In spite of broad-spectrum antibiotics, she became septic. I had to explain to her family that her condition was critical and that this time, she might not survive. Prior to my cousin's death I would have been terrified of this situation—afraid to be honest and direct, afraid to be in the room with the grief that would inevitably follow. But I was able to stay with the patient's family, to tell them how hard I knew this must be, and to walk with them as their loved one was wheeled to the intensive care unit, where the following morning she died.

I had another patient, a woman in her 40s, who had reached the end of a long struggle with breast cancer, now metastatic to her lungs and brain. She had failed several trials of chemotherapy, she was in pain, and she struggled to breathe.

Her sister, however, was not ready to stop fighting. She wanted to transfer the patient to another hospital, where she could be enrolled in a trial of a new chemotherapy agent. The patient did not want this for herself but was willing to do it if it would help her sister. I had many talks with the sister, all long and circuitous, all coming back to her saying, "I just can't give up yet." She wanted to know why this had happened, why the chemotherapy hadn't worked. I had no good answer for her. I did my best to be caring yet direct, telling her that she was not giving up but rather accepting the end. She did finally make the difficult decision to let her sister go, as she had wanted—comfortably and peacefully with family around her.

As I carry the memory of my cousin with me from room to room, I know she has taught me that death happens, often without any reasonable explanation. More importantly, she has taught me that people can live with the weight of the ensuing sadness. We can carry loss and still go on with our lives. Enduring her death has made me better able to listen to families and be present with them as they face the death of a loved one, to absorb some of their grief without being undone by it. I will probably carry my cousin's wallet in my pocket until it falls apart, and I may never erase her number from my cell phone. In other ways, she has taught me to let go of the notion that every tragedy has an explanation, and to free myself of the fear that the weight of grief will drown us. 

Joanna D'Afflitti is in her third year of Brown's general internal medicine residency training program.

**The cold and
darkness of
winter don't keep
Shelley Cyr
off the road.**

Running with the Boys

How Shelley Cyr stays at the front of the pack.

If you ask Michele Cyr how she's successfully navigated the "old boys' club" of medicine, she'll tell you it's a skill she learned back in high school: she was the only girl on the boys' track team.

A Rhode Island native, Cyr (known as Shelley to friends and colleagues) went to Bowdoin College as a member of what was only the second class to include women at the formerly all-male school. There, too, she and the other women in her class were greatly outnumbered by the men.

It was a male mentor at Bowdoin who encouraged Cyr to apply to medical school. A double major in biochemistry and art, she was thinking about graduate school, or maybe finding a way to blend her love of drawing with her passion for

science after college graduation. Though she came to the decision "sort of late compared to other students," Cyr did apply to medical schools and chose to go to Dartmouth. "It felt like it wasn't such a drastic transition coming from a small, northern New England liberal arts college," she says.

She completed residency at Maine Medical Center, nurturing what has become a lifelong love of Maine. Her husband, Assistant Professor of Surgery (Clinical) Gregory Towne, did his residency at Rhode Island Hospital and had a three-year commitment to the public health service. He took a placement in East Providence, and Cyr says she came somewhat reluctantly. "I did not want to fulfill the cliché of Rhode Islanders

never leaving." The deal was they'd stay for the three years of his commitment and then move to Maine.

"That was 28 years ago," she says.

Today Cyr is an associate dean at Alpert Medical School, overseeing academic affairs, which includes faculty affairs, graduate medical education, and women in medicine. Cyr became involved in clinical teaching and resident education during her first full-time job at Rhode Island Hospital. She was hired to be a "teaching attending" in general internal medicine. "Three of us were hired to be the attending doctors of record for patients who had been admitted to the medical service and had no primary care physicians," she explains.

That work led to an opportunity to go to Stanford to study with the guru of clinical teaching, Dr. Kelly Skeff, who led a month-long faculty development program. After intensive training in

clinical teaching techniques, attendees were sent back to their home institutions to teach others to be more skilled clinical teachers at the faculty and resident levels. Cyr was nominated, and attended the program in 1988.

“That was a terrific opportunity for me—to have this particular area of expertise, to be the only one here who had been involved in that program, and to bring it back to Brown,” she says.

Cyr later became director of the general internal residency program, and in 2000 she became the associate dean for graduate medical education. Soon after that, her life took an unexpected—and ironic—turn.

THE OTHER SIDE OF THE STETHOSCOPE

Having developed an interest in women’s health, Cyr helped Associate Professor of Medicine Anne Moulton and Clinical Professor of Psychiatry and Human Behavior Carol Landau start a women’s health practice in 1987. She also wrote a book on menopause with Landau and Moulton. They later updated the book, publishing *The New Truth About Menopause*.

In 2002, Cyr says, “I was literally en route to the American College of Physicians meeting, where I was going to be giving a talk on menopause and women’s health in general, when I discovered what turned out to be breast cancer.”

“It was a stressful time, knowing that I was going back to Rhode Island to have a biopsy. I was pretty certain it was going to be breast cancer,” she continues. “I remember the first question someone asked me after I gave the talk ... it was really a statement. This individual

thought that I had overstated the link between hormone therapy and breast cancer. This was before the Women’s Health Initiative results were released, so the link between hormone therapy and breast cancer was speculative, based on observational studies, not the randomized, controlled trial that was the Women’s Health Initiative. She made the point that the number of excess breast cancers, even if there was this linkage, wasn’t that big a deal. ‘We’re talking about relatively few women who would have breast cancer based on hormone therapy versus the number of women who would be benefited by the effects on heart disease.’ Of course, that turned out not to be true—there was no benefit.

“I’m listening to this individual talk about ‘What was the big deal about a few extra cases of breast cancer?’ and I’m thinking, *My God, she should only be in the situation of looking down the barrel of having this diagnosis!* It just

brought it home. It was an interesting collision of my personal life with my professional life.”

Cyr had the breast biopsy, and as she predicted, it was cancer. Thus began the strange journey of going from physician to patient.

“The people who gave me the diagnosis were my colleagues and my friends,” she recalls. “It was such an out-of-body experience. You go from one minute being ‘Shelley Cyr-Shelley Cyr,’

to the next being ‘Shelley Cyr, with breast cancer.’ It was just very bizarre.”

She quickly moved from absorbing the diagnosis to wanting to begin treatment, to “just take care of it.”

“Being on the other side of the stethoscope was an interesting experience,” Cyr says. “Sometimes physicians interacted with me as I suspect they interact with all their patients, and sometimes they interacted with me much more as a colleague. I’m not being critical of either approach, but for me I so much wanted to be treated as a patient. I wanted them to tell me based on *their* expertise what they thought I should do.”

Her physicians knew all of the data and any question she asked could be answered easily by giving her references to the literature, “but it was that physician who sat with me and said, ‘You know, you’re going to be OK’—that was the thing I needed to hear.”

The experience taught her valuable

“You go from being ‘**Shelley Cyr**’ one minute to ‘**Shelley Cyr with breast cancer**’ the next.”

lessons about being a doctor, too. “You really hang on every word [your physician says]. I remember vividly, when I was waiting for results and the physician would call and start making small talk, I just wanted them to cut to the chase. So now that is something that I absolutely do with all my patients. Even if it’s just results from a urine culture that’s not going to be life altering, I still start with ‘Everything’s OK.’ It’s just so important to get it out there, because people are

ZOOM

anxious. Until you are in that position of waiting you don't realize how patients are reacting to your words," she says.

JUST DO IT

Cyr says that during this time when so much was happening that was beyond her control, it became important to take charge whenever she could.

"One of the things I did was continue my running program," she says. "I just

miles. I'm pretty sure that I won in my category of 'women in the 45 to 50 age group, on chemo, with no hair,'" she says in good humor.

Cyr found support from her good friend Joan Benoit Samuelson, the first woman to win the Olympic women's marathon, whom she met when they both served on the Bowdoin Board of Trustees. (Although they overlapped as undergraduates at Bowdoin, they didn't

they are going to feel. Colleagues too, who have known what I went through, have felt comfortable consulting with me about their issues. That's been an incredible opportunity to give back."

In her professional role as associate dean Cyr is well known and respected as an adviser and advocate. A few years ago she won the Outstanding Faculty Mentor award from the Brown University/Women & Infants Hospital National Center of Excellence in Women's Health. There were several letters nominating her, including one from Assistant Professor of Medicine (Clinical) Michael J. Maher, who wrote: "[Dr. Cyr's] advice and support have been invaluable to me during my career in academic medicine. In fact I can state with all honesty that I would not be where I am today without having had her support and guidance."

Last year Cyr added a new appointment, as associate dean for academic affairs, to her portfolio. She says her three roles overlap, as they are all focused on the development of a diverse, successful BioMed faculty. She oversees appointments and promotions of faculty in the Division of Biology and Medicine and has even more opportunity to mentor faculty around promotions.

"That's one part of the job I'd like to do more of," Cyr says. "It's rewarding ... to help faculty navigate the promotions process. I certainly learned a lot based on my own mistakes. It's the classic model ... to impart experiential wisdom to others."

And it's fortunate that she enjoys that part of the job. Whether it's helping a faculty member move ahead or someone with cancer navigate and survive the illness, Shelley Cyr has a lot of wisdom to share.

"I think I'm a lot better now at **helping patients navigate the decisions** they have to make..."

decided that I had to absolutely make time to run no matter how I felt, and if I didn't feel up to running I would still do my best to do it. That became very defining for me."

As she began chemotherapy, Cyr committed to do a 5-mile race with her husband in Mattapoisett, MA. "It was actually the Fourth of July—my birthday. And I was bald ... It was one of the hottest days ever, it hit 105 degrees. Everybody in Mattapoisett was out on the race course hosing us down. But I ran that race I had to do it and show it was possible."

Cyr set another goal for herself: to get to the end of chemotherapy and run the 10-mile Blessing of the Fleet Race in Narragansett. "That race was very important to me because my father, who was a native of Block Island and a charter boat captain, used to have his boats blessed on this occasion. So my husband and I ran the 10-mile race, and again I was bald—my brother said that it made it easy to spot me among the other runners even with my cap on.

"I did it in 80 minutes, ran 8-minute

know each other and Cyr is quick to point out that "this was the one time that I finished ahead of Joan.") "She has been one of my great cheerleaders and supporters in all of this, and she remains an inspiration," Cyr says. Since then she and Joan have had many conversations about people getting through major illnesses, particularly cancer, by continuing to stay active in whatever way they can.

"I really think it's that whole notion of taking charge, being in control. You're experiencing side effects and symptoms and there are so many things you can't control, but if you can control that, it's so meaningful. It gives a sense of self esteem."

STAY THE COURSE

Surviving cancer has given Cyr the chance to do something she loves: help make things easier for others. "I don't think I'm a perfect doctor by any means, but I think I'm a lot better now at helping individual patients navigate the decisions they have to make and anticipate how

FROM THE COLLECTIONS

BY SARAH BALDWIN-BENEICH
PHOTOGRAPH BY KAREN PHILIPPI

A Pox on Both Your Arms

A pioneer in infectious diseases and immunology tests his hypothesis.

Fans of early medical history in the Brown community are a lucky bunch. The History of Science Collection, housed in the John Hay Library, contains books and manuscripts dating from the late 15th to the mid-20th century. For more than three decades, the collection has been strengthened by ongoing gifts from George Bray '53, an internationally recognized medical researcher in diabetes and obesity.

One especially important and pleasing volume is the 1798 work *An inquiry into the Causes and Effects of the Variolae Vaccinae, A Disease discovered in the western counties of England, particularly Gloucestershire, and known by the name of cow-pox*, by Edward Jenner, MD. In it

“I shall continue ... this inquiry, encouraged by the hope of its becoming ... beneficial to mankind.”

Jenner describes his now famous process of inoculating the young James Phipps with cowpox virus taken from the sores of a dairymaid, Sarah Nelms, and inserted in his arm, causing mild symptoms but effectively protecting the boy against the far more virulent disease of smallpox. He



A color plate showing an open sore caused by cowpox.

understood that “what renders the Cowpox virus so extremely singular is, that the person who has been thus affected is for ever after secure from the infection of the Small Pox; neither exposure to the variolous effluvia, nor the insertion of the matter into the skin, producing this distemper.”

Jenner’s writing is as elegant as the delicately tinted drawings of open sores. He begins: “The deviation of Man from

which may not originally have been intended for his associates. The Wolf [the dog in a degenerated state], disarmed of ferocity, is now pillowed in the lady’s lap. The Cat, the little Tyger of our island, whose natural home is the forest, is equally domesticated and caressed, the Cow, the Hog, the Sheep, and the Horse, are all, for a variety of purposes, brought under his care and dominion.”

After detailing his experiments, he concludes: “Thus far I have proceeded in an inquiry, founded as it must appear, on the basis of experiment; in which, however, conjecture has been occasionally admitted in order to present to persons well situated for such discussions, objects for a more minute investigation. In the mean time I shall myself continue to prosecute this inquiry, encouraged by the hope of its becoming essentially beneficial to mankind.”

Jenner is widely credited with the ultimate eradication of the smallpox virus.

FIELDNOTES

BY LESLIE MORRIS MD'10



Haus Calls

A ride through Germany's urgent care system.

Knock, knock, knock. It was 7:45 in the evening as Dr. Anne Meister and I stood in a darkened hallway, waiting. In one hand I carried an unwieldy metal suitcase containing Dr. Meister's medical supplies. In the other I grasped a pocket-sized German-English dictionary. At length, the door opened, revealing Mrs. F, an asthmatic woman of 70 who was wheezing audibly.

"Hello," Dr. Meister chimed brightly, "I'm the doctor. I understand you are having trouble breathing."

Mrs. F led us a few steps into a tiny living room and motioned for us to sit.

Her breaths were coming so quickly that she could speak no more than a few words at a time. Observing the woman's distress, Dr. Meister focused on the situation. I unclasped the suitcase, splaying it open. Inside lay bottles of medication, disposable syringes, bandages, a blood pressure cuff, and numerous other supplies. We quickly removed our winter coats, and Dr. Meister began to auscultate Mrs. F's chest. Several minutes after an albuterol treatment, her respiratory rate began to normalize and she was able to speak in full sentences. Dr. Meister wrote instructions for Mrs. F to

take a tapered course of oral steroid and gave her a referral slip to see her own internist the following day. We then chatted with Mrs. F until Dr. Meister was convinced that it was safe to leave her.

Earlier that evening, Dr. Meister and I had sat at a small table in her kitchen, becoming acquainted over coffee and ginger cookies. I had come to Hamburg, Germany, for a month with my fiancé to study the language and explore a unique aspect of the German national health system. I am particularly interested in primary care and issues of access to care. My fiancé, an emergency physician and a German national, and I had filled many hours discussing ER use and overcrowding in the United States. When he told me of the traveling urgent care physician network in Germany, I was intrigued.

GERMAN ENGINEERING

Since 1969, primary care physicians in Germany have been making house calls to patients on an after-hours, urgent-care basis as part of a broader municipal urgent care service that also includes two adult urgent care clinics, four pediatric urgent care clinics, and a psychiatric call service. The *Kassenaerztliche Vereinigung* (KV) is an organization that represents doctors participating in the national health care system. It requires outpatient physicians to take about one urgent care shift per month. The KV for Hamburg has divided the city into eight districts. Physicians travel in KV cars driven by EMTs and equipped with GPS navigation. Unless the volume is unusually high, each physician takes calls only from within his or her district, to maximize efficiency. In the compact neighborhoods of Hamburg, it rarely takes

more than 15 minutes to travel from one address to the next.

Hamburg residents can call one of two numbers: one, like “911,” contacts the local emergency medical service. The other reaches a KV call center, where triage staff determine the best level of care for the caller. The first level is a telephone consult with the on-call physician. The next is a house call. For emergencies, the triage service notifies EMS directly. Each house call is subsequently assigned a level of urgency: very urgent cases require that the physician reach the patient within 20 minutes; urgent cases, within 30 minutes; and regular, within 2 hours. Mrs. F had been assigned “very urgent” status.

At each visit, Dr. Meister quickly assesses whether the patient is in need of emergency care. She takes a brief history, assesses vital signs, and performs a focused physical exam. In most cases, she is able to dispense medication that will get the patient through the night until seeing his or her primary care doctor the following day. She might give a shot of

fee for a visit is 10 euros (\$14) per patient per annual quarter. Dr. Meister’s practice pays for the medications and supplies used; there is no additional charge to the patient. The doctors are not reimbursed in any other way for their time.


IN THE BEDROOM

Throughout the evening, we zipped through narrow city streets, saw 20 patients in their homes and took phone calls from an additional three. Among these were a family of four, each sick with an upper respiratory infection (URI); a 19-year-old blind diabetic with a URI and elevated blood glucose; several patients with stomach complaints; and a handful of children with low-grade fever. In a typical evening, Dr. Meister sends one or two patients by ambulance to the hospital and pronounces the death of at least one other.

“I think I have been in every bedroom in Hamburg,” laughed Dr. Meister as we left one apartment building in the early hours of the morning. I had said how interesting it was for me, as a

see the two-dozen kitschy wooden placards engraved with proverbs and racy jokes about women. From the 30-something couple living in a modern, Ikea-furnished space to the retirees peering between faded lace-curtained windows, Hamburgers manage to live fully within pint-sized spaces.

More importantly, within these intimate spaces were husbands, wives, mothers and fathers, their faces drawn with exhaustion and worry. They ushered us in to their loved ones’ bedrooms in bathrobes and slippers and helped me understand the family experience of illness. Some were caring for chronically ill parents, but most were the “worried well.” Often all that was needed was the laying on of hands and gentle reassurance. For some, the very presence of a doctor in the home seemed therapeutic. The hospitality we received in exchange for this service was overwhelming. In nearly every home, we were offered a place to sit, conversation, coffee or tea, and sincere expressions of thanks for our visit.

House calls, the dominant means of providing primary care in the United States until the mid-20th century, dropped from 40 percent of physician encounters in 1930 to 10 percent in 1950, and less than 1 percent in 1980. Though the house call is enjoying a modest resurgence in this country, most services are concentrated on the homebound chronically ill and elderly. The *Kassenaerztliche Vereinigung*, by continuing the tradition of house calls for after-hours urgent care, has managed to bridge the gap between primary care and emergency services in a creative and cost-effective way. 

For some, the very presence of a doctor in the home seemed therapeutic.

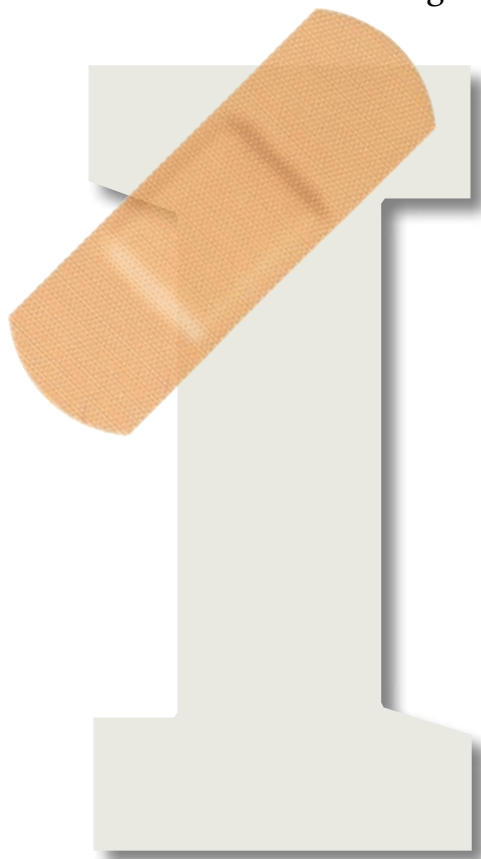
metoclopramide to a patient with intractable nausea and vomiting, or leave a mother with several doses of children’s acetaminophen for a feverish toddler.

She keeps a black leather-bound notebook containing receipt pads and a small electronic card reader for recording state insurance numbers. The

foreigner, to get such an intimate look at everyday life in a German city. Indeed, months later, it is our patients’ faces and their kitchens, living rooms, bedrooms, and front stoops that I remember most vividly. In the cramped kitchen of one elderly gentleman, above a Bavarian-style wooden table and bench, I can still

A Matter of Principle

All health care systems should guarantee universal basic coverage.



In 1994, the conservative government in Taiwan decided to implement a health care system for its citizens. One of the “new Asian Tigers” enjoying economic growth and prosperity, Taiwan decided to make a major investment in health. Because the country felt indebted to the United States and admired our economy and culture, it looked to us first for a health care system model. And after careful consideration, they decided not to follow us. Why? Because our system does not provide care to all citizens. This principle, which is the starting point for almost all systems in the developed world, can be simply stated: All people should be provided health care regardless of their ability to pay.

In the U.S., we have not accepted this principle. My own beliefs on the issue are based on T.R. Reid’s seminal book, *The Healing of America*. To me, it is a matter of principle, of ethics, a moral question. Should those who don’t have the resources to pay be denied penicillin for a sore throat to prevent rheumatic fever? Should a child with asthma not receive appropriate care and medications? Should a woman not receive a Pap smear? Our system provides emergency care, not routine, chronic or preventable care for everyone. Most developed countries have decided that they have enough resources to ensure that everyone has access to at least basic medical care without concern for costs. We still debate the issue. We should decide, firmly and without equivocation, to guarantee health care to all our citizens.

Cost and accessibility have been major subjects of debate during our health care battles. In other countries, these problems were solved when universal coverage was the guiding principle. It is also true that each country solved them according to its individual culture and outlook. One solution is for providers to be private, but for the government to control prices directly. For example, France (by many measures ranked first in the world in terms of health), has private physicians, private hospitals, and private, not for profit insurance companies. Everyone is covered.

ISTOCK/ROUZES

Patients pay the provider but are compensated within five days. The government sets prices. Cost is one half what it is in this country, and quality measures are significantly better. Providers negotiate with the government instead of the insurance companies. While the French complain about their system, they are intensely proud of it and feel it is far superior to that of the U.S.

Japan offers a similar solution, but differs in delivery. Access is universal and prices are dictated by the government. Every doctor's office has a very large book with the prices for every conceivable service. All providers and insurance companies are private. Interestingly fee for service, widely blamed for excessive costs in the U.S., is the reimbursement system. Japan's costs are one half of ours, and some quality indices are the highest in the world, including longevity. Most remarkably, the Japanese use approximately twice the services that we do. They visit doctors three times as often, have twice as many CT scans, and have an average length of stay in the hospital of 36 days (as opposed to 6 in the U.S.). The downside is that providers—doctors, nurses, and hospitals—are paid less. Although medical education and malpractice costs are extremely low, compensation levels would not be acceptable in the U.S.

Rationing—i.e., denying certain procedures and drugs—has been used by the

UK to control costs. Access is universal, with no co-pays. Even though private insurance is permissible, 97 percent of the population uses only the National Health Care system. Primary and preventive care is not rationed, and primary care providers are incentivized to make house calls. There are enough general practitioners (60 percent of the physician workforce) because they earn more


solved the problem with half the cost and higher quality than we have. Furthermore, they have not been afraid to learn from each other. By examining other systems, they have picked the best elements for their country and then implemented it through government action. Universal coverage has also allowed cost savings, a focus on preventive care, and an emphasis on primary care.

Most developed countries have decided that they have **enough resources to ensure that everyone has access to at least basic medical care** without concern for costs.

than specialists. Another approach using rationing to control costs exists in Canada. Care is limited by long waiting lines, a solution that is acceptable to most Canadians. Citizens don't mind as long as everyone has to wait.

WHAT'S RIGHT FOR US?

None of these solutions would be completely appropriate for the U.S. Nonetheless, these countries have started from a fundamental principle of universal health care, and then fit their system to achieve that goal, addressing cost, accessibility, and quality next. Each has its own solution, but in most cases has

The U.S., on the other hand, is in denial. Our health care system has some outstanding qualities, but costs are high, quality is inconsistent, the system is unfair, and there are parts of the health care industry making unseemly profits. We have refused to face the problems and learn from other countries' experiences. But most importantly, we refuse to accept the first principle, the imperative that we provide health care for all our citizens. 

Edward Wing is dean of medicine and biological sciences and the Frank L. Day Professor of Biology at Brown University.





BIG SHOT

ASSISTANT PROFESSOR OF
BIOLOGY CASEY DUNN

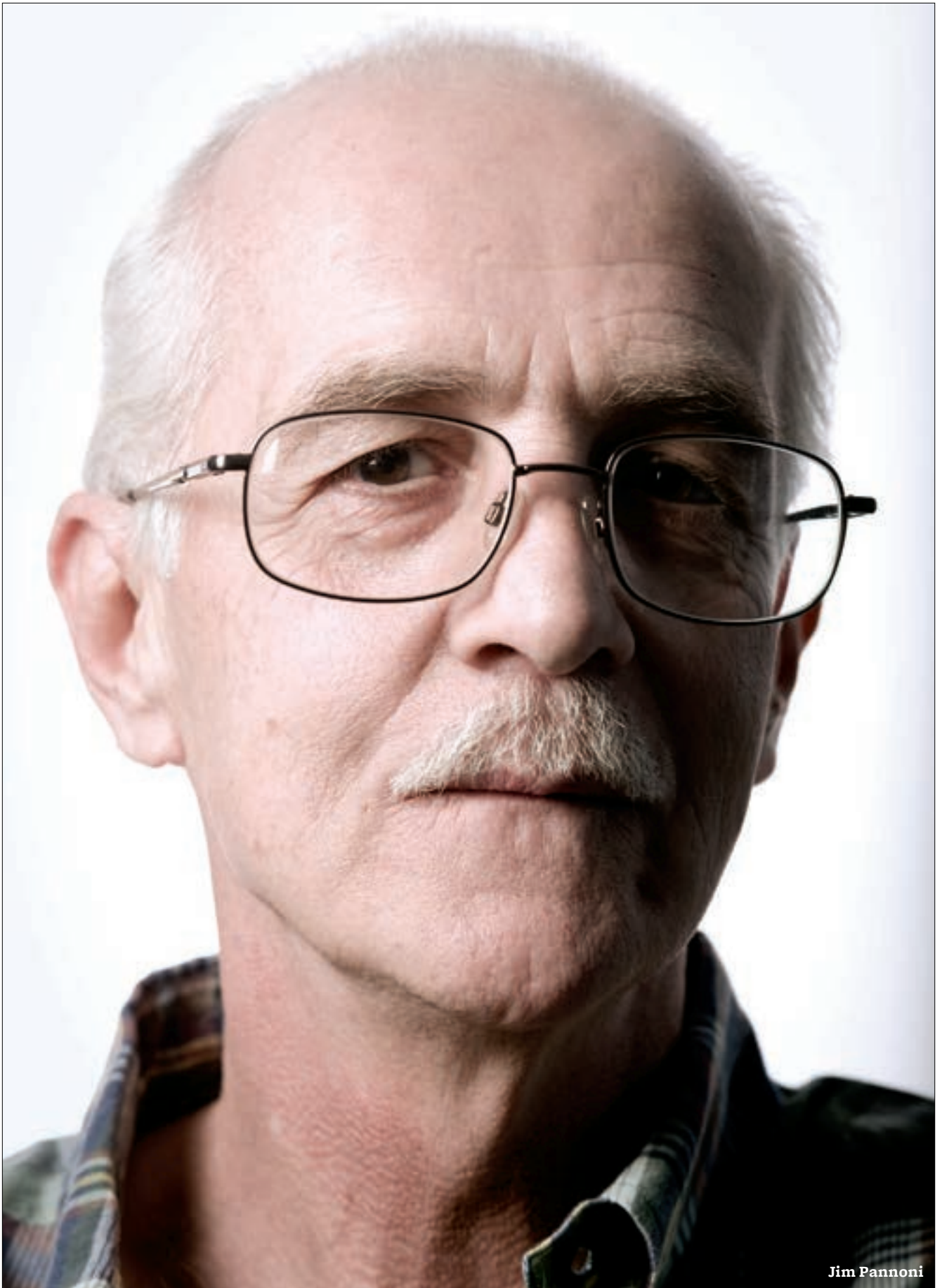
Nature's Pincushion

Not all relatives have a family resemblance.

This photograph of *Leucospermum erubescens* was taken in South Africa. *Leucospermum* belongs to Proteaceae, a group of plants that are mostly found in the Southern Hemisphere and include many species with large beautiful flowers. Oddly enough, recent work has shown that the closest relatives of Proteaceae are the groups that include sycamores and the lotus flower. This relationship was not anticipated based on studies of plant structure, but has been strongly borne out by DNA analyses.



Give us your best shot. Go to brownmedicinemagazine.org/view/photos.php and follow the instructions for submitting a photo. Don't forget to include details about the image!



Jim Pannoni

PR1MARY CONSIDERATION

The Providence VA Medical Center's primary care clinic is a medical home for homeless veterans.

BY EILEEN O'GARA-KURTIS
PHOTOGRAPHY BY KATHLEEN DOOHER

Jim Pannoni has weathered his share of squalls.

He was once a commercial fisherman out of Provincetown. He was a lobsterman on Nantucket. Sun on the water. Sudden storms that came and went. Heady days of healthy catches.

Long before that, in the waning years of the Vietnam War, Pannoni was a scared teenager awaiting deployment while stationed with a U.S. Air Force civil engineering team in the California desert. "I never went over, but it was stressful knowing that word could come any day," he remembers. "There were 80 guys in my graduating class, and I think 25 came home."

Pannoni had volunteered for duty, in part for job training. After discharge, he looked for work as an HVAC technician. But civilian training and certification requirements proved daunting, so he took to the sea.

Life was good. Then hard times came.

“I lost the vision in one eye, and then I had two heart attacks,” he says. “I was homeless for a while. I was living in a kind of a one-room shack for a while. I had nowhere to turn. No money.”

Today, Pannoni is living in his family home, bequeathed to him and his 13 siblings by his parents. He struggles to maintain the place while coping with a spectrum of chronic conditions. He comes to the Providence VA Medical Center to see his physician, Thomas O’Toole.

Along the way, he passes block after block of foreclosed homes. “I look at all

VA Medical Center, has dedicated the past two decades to researching and providing health services for the homeless. He launched the clinic for homeless vets three years ago upon his arrival from Georgetown University, where he had been associate dean for curriculum development in addition to his clinical appointment.

“It’s an open-access system and a wrap-around service model,” O’Toole says. “Our goal is not just to make a homeless person healthier, but to address the quality of life issues that affect health status—one of which is homelessness—and help each person to realize his potential.”

O’Toole’s group recently started patient recruitment on a four-year, \$710,000 VA-funded research project aimed at improving outreach and primary care engagement among homeless veterans.

“I LOOK AT ALL THAT [VACANT PROPERTY] AND I WONDER HOW YOU CAN JUSTIFY ANYONE BEING HOMELESS.”

that [vacant property] and I wonder how you can justify anyone being homeless.”

BUILDING RELATIONSHIPS

Pannoni is one of 250 patients treated annually in O’Toole’s primary care clinic for homeless veterans, which logs about 1,500 visits each year.

O’Toole, an associate professor of medicine at Alpert Medical School and chief of primary care at the Providence

For O’Toole, addressing acute and chronic health conditions is an entry point for addressing broader problems, thereby fulfilling the promise of primary care at its best. “We encourage [our patients] to come as often as they want. By meeting regularly, talking about their hypertension, their diabetes, or other needs, we’re able to strengthen the connection and build the relationship to tackle more complex issues.”

“Every new patient goes through a comprehensive intake process, including a mental health assessment, blood work, and physical exam—and that first visit also covers housing, employment, and benefits,” O’Toole explains. “It’s all geared to answer the question *How do we get you to a better place in your life?*”

“We encourage our patients not to be defined by their homelessness,” he continues. “We embrace their strengths. Most of us define ourselves by our strengths, not our needs; for instance, you wouldn’t find someone saying ‘I’m a cardiovascular patient.’ Homelessness is just one element of our patients’ overall condition, and we believe it’s a condition that can change.”

NO VET LEFT BEHIND

The clinic has logged a 100 percent increase in utilization over the past year.

“When the economy goes bad, the people on the edge are the first to go,” says O’Toole, noting that victims of the recession are now taking their places in the clinic alongside the longer-term homeless. “We see people who don’t have a cushion when bad times hit, people who have been struggling for a long time to make ends meet and have been one paycheck away from homelessness.”

In its first two years, patients came to the clinic primarily through professional referrals from elsewhere in the VA or the outside health care system. Today, it’s mostly word of mouth. Veterans refer each other; often, a patient will bring a buddy with him. Vets tend to take care of each other on the street, just as they did during active duty. “Nobody gets left behind,” O’Toole says.

The VA is the largest provider of



Thomas O'Toole



Claire Bourgault

transitional and subsidized permanent housing in the nation, and in fact Secretary of Veterans Affairs Eric Shinseki last year announced a major national initiative designed to expand that capacity—with the ultimate goal of ending homelessness among veterans. The number of homeless veterans has reportedly decreased over the past two years. Still, there is an average five-month wait for housing. People are struggling.

According to the U.S. Department of Veterans Affairs, approximately 131,000 veterans are homeless across the United States on any given night. The Veterans Administration estimates that approximately 2,000 veterans from the Iraq and Afghanistan wars have already become homeless—and a 2008 Rand study found that an estimated 31 percent of returning war veterans suffer from mental health challenges, with only about half seeking treatment. The National Coalition for the Homeless estimates that, although veterans comprise only 34 percent of the general adult male population, approximately 40 percent of all homeless men are veterans.

In Rhode Island, as in the rest of the United States, a disproportionate percentage of homeless people are veterans.

BUILDING A MEDICAL HOME

The Providence VA Medical Center provides health services for about 30,000 veterans—12,000 in three community-based clinics in Middletown, Rhode Island, and New Bedford and Hyannis, Massachusetts, and the rest in Providence.

In 2006, the VA developed a special populations unit for high risk/high needs patients who struggle to get the care they need in a traditional model of primary care. A series of clinics, each geared to the needs of a specific population, operate throughout the week. All

of the clinics, says O'Toole, are based on a philosophy of tailored care and case management—on building a medical home for all patients.

High-risk geriatrics patients are seen on Wednesdays and Fridays. Patients with serious, persistent mental illness are seen on Tuesdays. A women's clinic operates on Wednesdays and Friday mornings. And, on Tuesdays and Thursdays, the clinic becomes a medical home for homeless veterans. A mission-driven, interdisciplinary team—including a benefits expert, a housing consultant, and a nurse—convenes in the clinic to channel its collective expertise on behalf of patients.

"We're very fortunate to have the resources of the VA to address this critical need," O'Toole says. "But resources are finite, so we've built this model by making do with what we have—by reassigning staff and reallocating resources, rather than adding expense."

Shelters require their clients to be up

and out early in the morning. So the clinic opens at 7 a.m., enabling patients to make it their first stop of the day. They're usually waiting when the doors open, with 15 individuals seen on an average morning. One by one, they are summoned from a packed waiting area

THE VETERANS ADMINISTRATION
ESTIMATES THAT APPROXIMATELY
2,000 VETERANS FROM THE IRAQ AND
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ALREADY BECOME HOMELESS.

to see O'Toole, who works in the clinic on Thursdays, or physician Thomas Doyle MD'03 HS or nurse practitioner Paul Simkowski, who work on Tuesdays.

The clinic exudes a sense of calm, order, and efficiency. The goal is to finish by noon, leaving patients time to take care of the day's business before the daily late-afternoon ritual of finding shelter for the night. But, because there are no appointments and volume is unpredictable, the staff just keeps going until every patient has been seen. If that process extends past lunch time, each person still waiting is given a voucher for the cafeteria.

"In three years, we've never had a problem, and I have never heard a person complain that we've kept him waiting," says clinic nurse Claire Bourgault, RN.

COME IN FROM THE COLD

On a recent Thursday, a full knapsack sat on a chair in Bourgault's office—a welcome present for a veteran who had

called to say he'd be coming, but had not arrived. ("About half of our guys have cell phones," O'Toole says.) Each veteran who becomes a patient of the clinic gets a knapsack filled with donated clothing, shaving supplies, and other essentials.

Bourgault is a 35-year VA nurse with kind eyes and the tough love demeanor that characterizes great nurses and great mothers. ("I hear that I'm a mother figure a lot," she says with a smile, "but I think *How can that be? Some of these guys are only four or five years younger than me!*")

She was on the cusp of retirement three years ago, before this program gave her a renewed sense of mission. In addition to running the primary care clinic five days a week—including the two dedicated days for homeless patients—she rides in the clinic's outreach van a couple of nights a week with a colleague, homeless outreach social worker Sean Lonergan, LCSW. They stop at churches, soup kitchens, the VA's Gateway Transitional Housing facility, and Harrington Hall, a Cranston shelter where veterans gather.

Veterans tend to find each other on the street, she says. They have a kind of radar. They know each other by their demeanor, their tattoos, their slang. They find comfort in shared experiences. And they tend to watch each other's backs.

"We look for them on the streets, in drop-in centers, in shelters," she says. "We screen for mental health and substance abuse and talk to them about their needs. Ultimately, we try to get them to come to the clinic."

Walking the halls of the clinic, Bourgault is approached by patients who

need bus vouchers, patients who need an eye exam to replace lost glasses, patients who need guidance in navigating the VA system or the world outside. She is notified whenever a clinic patient is admitted to the VA emergency department. She is called when there is crisis in patients' lives, and when there is good news. And she knows that there is a fine line between those two states.

Homelessness arises from a variety of causes—including unemployment, disability, substance abuse, post-traumatic stress disorder (PTSD) and other mental illness, and the broken relationships that result from all of the above. Those root causes do not disappear with the procurement of housing.

That is why soon after the clinic's debut, it was decided to allow veterans to continue to consider it their medical home even after they have secured

when they find themselves living alone in an apartment."

UNCONDITIONAL CARE

Sean Lonergan, the clinic's homeless outreach social worker, agrees.

Lonergan has worked with homeless populations in London, Liverpool, Boston, and Providence, and says that some truths transcend culture and geography.

"Housing is just the beginning," he says. "When you're homeless, you have your own clock. If you're in a shelter, you have to be out early in the morning and back late in the afternoon to get a place to sleep. If you're sleeping out, you have to find a safe spot and protect it—you don't want to give it away. Then there are the hidden homeless, who might spend seven nights on seven different friends' couches. A lot of homeless people get only two or three hours'

THE SUDDEN STATE OF NOT BEING HOMELESS CAN BE A CRITICAL STRESSOR THAT LEAVES [THESE INDIVIDUALS] IN NEED OF SUPPORT.

shelter. The staff discovered that the patients wanted to continue the relationship. And, says Bourgault, the sudden state of *not* being homeless can be a critical stressor that leaves them in need of support.

"Newly housed patients who have underlying mental health or substance abuse issues can relapse," she says. "There can be an overwhelming sense of isolation, or loneliness, or boredom

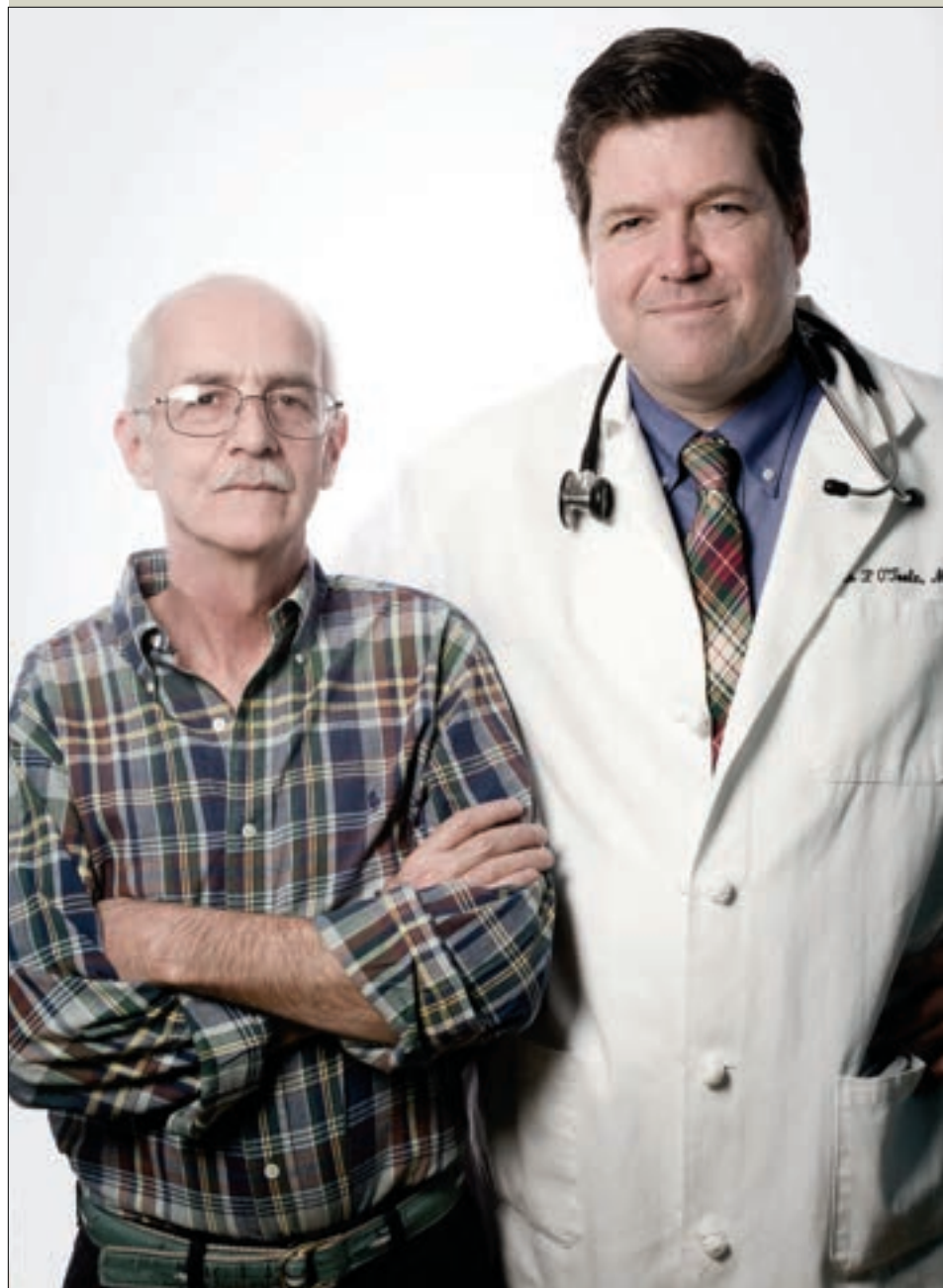
sleep. When they wake up in the morning, their long-term goal is finding a safe place to sleep that night. And they never get a day off from that routine."

"If you do that for five or ten years, if you're used to surviving day to day, and then suddenly you've got four walls and a ceiling and bills coming in, it can be hard. It gets harder with every year that you've been homeless."

The VA clinic is there for its patients

AWARENESS + ACTION = CHANGE

One physician's journey toward activism through clinical practice.



Tom O'Toole has spent the past two decades as a researcher and provider of primary care services for homeless people—at the University of Pittsburgh, at Johns Hopkins Medical Center, at Georgetown University, and now at the Providence VA Medical Center. But his epiphany came long before all that—before residency, and even before medical school.

As a newly minted graduate of UC-Berkeley, O'Toole was a legislative aide to Senator Joseph Biden. It was the 1980s, and a soft economy, deregulation of the mental health system, and other factors were forcing America to confront the full impact of widespread, visible homelessness for the first time in a generation.

One day, O'Toole met with the legendary advocate for the homeless Mitch Snyder, and wrote a brief on the issue for Senator Biden. On the way home that night, O'Toole passed people sleeping on the street—people suddenly visible and vividly real.

Policy met reality. “It was a humbling experience—it hit me like a two-by-four across the head,” he remembers. “It took six or seven years for me to act on it, but as a second-year resident at the University of Pittsburgh [Medical School], I helped set up the first [homeless medicine] clinic in the city. And then it became my life's work.”

“It's one thing to be aware,” he says. “It's another thing to figure out what to do about it.”



Sean Lonergan

during that transition, and operates on the principle of meeting its patients wherever they happen to be in life. O'Toole remembers a man who came in for several consecutive weeks and simply slept in the waiting area until, one day, he was ready to accept treatment. "We took him on his own terms," he says. "This is about unconditional care."

"We offer our patients a therapeutic relationship," says Lonergan. "When you're homeless, you've usually burned bridges with your friends and family and run the gamut of social services. This is a population that often feels shunned. We not only accept them, but we try to help—not just medically, but also by connecting them with benefits, housing, employment, and substance abuse and mental health services."

"That's the beauty of medicine," says O'Toole. "On the individual patient level, a person can feel respected in a lifestyle that usually causes them to be disregarded by society."

LESSONS LEARNED

O'Toole readily acknowledges that his clinic model depends on the interdisciplinary services that are available under one roof at the VA Medical Center and on its virtual liberation from the economic pressures that challenge private-sector providers. But he says that there are lessons to be learned across platforms—in terms of outcomes and in terms of redefining the role of primary care in contemporary society.

Several metrics reveal the efficacy of the clinic over its three years of operation. Emergency department visits among clinic patients are down 49.5 percent

since last year, and a 48.5 percent reduction in ED visits per clinic patient has also been reported. O'Toole says that compliance and follow-up rates among clinic

patients hover at 80 percent—an achievement that he credits to the culture of mutual respect that connects caregivers and patients. And approximately half of the clinic's patients have "graduated," securing employment and housing.

On a philosophical level, O'Toole believes that the kind of care provided in the clinic represents the power and the distilled essence of primary care at a time when the specialty has been battered by low reimbursements, recruitment challenges, and a kind of identity crisis.

"What is primary care?" he asks. "Are we gatekeepers? Country doctors? How do we define our profession? By procedure or organ system? By billable diagnosis? What's our role in society? What's our social responsibility?"

"I believe we have responsibility in three basic areas: the management of chronic disease; the closing of health disparities; and providing leadership at the crossroads of public health and chronic care. Primary care needs to be part of the solution."

Solving the multidimensional problems of homeless patients—with an

integrated approach to addressing physical, psychosocial, and health status challenges—is a role uniquely suited to physicians trained in primary care,

"HOW WE DEAL WITH THIS POPULATION IS A BAROMETER OF WHO WE ARE AS A SOCIETY."


O'Toole says. And it speaks to the broader role of physicians as community leaders and social change agents.

"How we deal with this population," he says, "is a barometer of who we are as a society."

"The one resounding theme that runs through this work is the resilience of the human spirit. You don't see a lot of people taking it on the chin," he says. "You see a glimmer of hope, and you want more of that, and it keeps you going."

"This work also embodies the fundamental challenge and opportunity of our profession," he continues, "learning from our patients and enhancing our listening skills."

And, in every patient's eyes, there is a reflection of the human condition.

"You see yourself in so many of them." 

Eileen O'Gara-Kurtis is the founder and president of Silver Branch Communications, a strategic communication consultancy dedicated to partnering with individuals and organizations effecting positive change in health care, technology, education, the arts, and other arenas.

Super



When President Barack Obama nominated 53-year-old Regina Benjamin to the post of U.S. Surgeon General last summer, her size-18 silhouette garnered almost as much press as her credentials. In 2008, the family physician was awarded a MacArthur genius grant for her work with impoverished, rural patients in Alabama. An MD with an MBA, she launched a clinic in a bayou fishing village in 1990 and has rebuilt it three times in the wake of hurricanes and fire. After a natural disaster that destroyed the local economy, she had the pharmacy run a tab under her own name to ensure that patients didn't go without vital prescriptions—and made house calls until her clinic was back in operation. In 1995, Benjamin was elected the first black woman trustee of the American Medical Association, becoming the first physician under 40 named to that board.

Like two-thirds of the Americans she serves, Benjamin has a plus-size figure—but she's no stranger to the health hazards of a high body mass index (BMI). Obesity has hit minority and low-income Americans especially hard, and when Benjamin accepted the president's nomination in a Rose Garden ceremony, her speech resonated with the heartache of a family cleaved by chronic, preventable illnesses. Her mother died of lung cancer; her brother died of AIDS. Diabetes and hypertension—frequent sequelae of obesity—killed her father. "I cannot change my family's past," Benjamin said as she mourned their absence on that historic day, "but I can be a voice to improve our nation's health for the future."

The nation's health educator in chief has her work cut out for her. Over the past 25 years, ever-greater percentages of the population have topped 30—the BMI that defines obesity—and excess weight now plagues even the pre-school set. As with their adult counterparts, burgeoning rates of overweight and obesity among school-age children and teens owe to a toxic brew of ever-cheaper, calorie-dense fast foods, super-sweet soft drinks, and increasingly sedentary lifestyles. More than 12.5 million Americans under the age of 19 now exceed the 85th percentile for healthy weight for their height, age, and gender. This past

Brown scientists tackle the bulging waistline of America's youth.

BY SHARON TREGASKIS

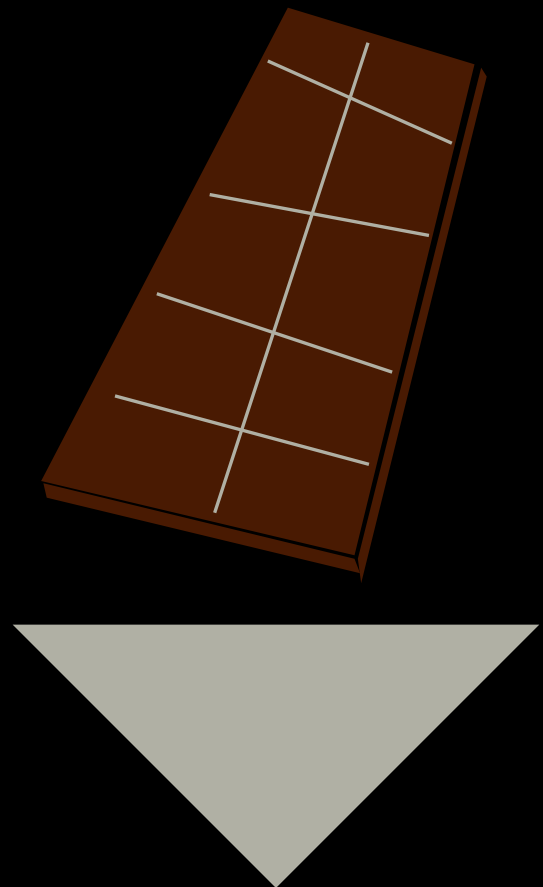
Sized

January the Centers for Disease Control and Prevention released a report suggesting obesity rates have peaked, but although they are no longer increasing, they are still too high. And so are the costs.

The nation currently spends about \$80 billion annually on direct health care costs associated with obesity. Rhode Island's portion of the tab amounts to about \$227 million—roughly \$300 per person for the 22 percent of residents with a 30-plus BMI (that's 203 pounds or more on a 5'9" frame, for example). While the percentage of obese Ocean Staters has doubled since 1990, most other states have gained even faster and Rhode Island now ranks among the nation's five slimmest.

WALK WITH ME

Twenty-six-year-old Rajiv Kumar '05 MD'11 can take some pride in that ranking. As a first-year student, he attended a lecture by Professor of Psychiatry and Human Behavior Rena Wing, a PhD scientist who directs The Miriam Hospital Weight Control and Diabetes Research Center. Alarmed by Wing's state-by-state maps of the increasing percentage of overweight and obese Americans and inspired to avert the tremendous health toll those excess pounds could exact, Kumar launched Shape Up RI in 2005. The annual worksite-based campaign deploys healthy competition among pedometer-equipped adults to boost physical activity. In the intervening four years, more than 35,000 Rhode Island residents have sweated their way through upwards of 1.1 million hours of exercise. In January 2009, *Obesity* published an analysis by Wing, Kumar, and two co-authors of the 2007 results. Their conclusion: the collective approach was a cost-effective strategy to promote weight loss. Among participants with a BMI over 30



Community Medicine

Most Americans bathe daily. It's hard to get away with poor personal hygiene, so we make time to wash up, no matter how busy our schedules. Assistant Professor of Pediatrics (Clinical) Marjorie Nasin '94 MD'98 urges her patients to apply the same mindset to regular exercise. In May 2009, the one-time Navy pediatrician of the year launched YouthFit, a medically supervised weight management program. "To some extent, we all prioritize our activities depending on what society expects from us," says Nasin, who admits that she, too, struggles to maintain her ideal weight.

Black girls and Hispanic kids of both genders have been especially hard hit in the obesity epidemic. To increase the program's appeal for the low-income and minority children in her practice at Memorial Hospital of Rhode Island's Pediatric Primary Care Center, Nasin has forged a partnership with the Boys and Girls Club of Pawtucket. The YouthFit program pays the annual memberships at the club. "I bond with my patients on whatever level I can," says the pediatrician.

She also tailors her nutrition advice to family preferences and eating habits, as well as what's actually available at local grocery stores, fast food joints, and a subsidized farmer's market in the neighborhood. (Professor of Community Health Kim Gans, co-director of Brown's Institute for Community Health Promotion, has multiple studies under way to enhance accessibility of affordable fruits and vegetables, increase their consumption among low-income and minority populations, and promote lifestyle changes to avert childhood obesity.)

Over the course of nine visits spanning six months, Nasin covers a series of talking points featuring fitness and nutrition, from sleep and puberty to hunger and fullness. The curriculum—intended to engage the whole family—combines education and action between sessions: a module on fitness highlights the benefits of walking and comes with a pedometer so kids can monitor their progress toward a 5-mile-a-day target. Other lessons address the nutritional density of food, a home health makeover, and mindless eating. The module on physical activity often proves most difficult, given that many children spend up to 10 hours after school in sedentary pursuits. "It's one thing to suggest that they do a high-paced activity for an hour," says Nasin. "It's quite another for them to restructure that large bulk of time in a way that gets them moving intermittently."

With teens, the pediatrician puts personal responsibility for exercise and nutrition on par with brushing their teeth, wearing a seatbelt, and safe sex. "It's not about nagging them," she says, "it's about kids growing into young adults who are taking care of themselves." With younger children, she addresses parents. "It's not fair to expect a 5-year-old to make 'healthy choices,'" she says. Instead, they need adults to model a healthy lifestyle. "You can't tell them to eat vegetables and then take them to eat fast food every day."

at the start of the program, nearly one quarter reduced their weight to below the obesity threshold before it ended.

Last fall, Kumar turned his attention to Rhode Island's children. In a six-week pilot program, three fifth-grade classes competed for prizes as digital pedometers tracked their steps. By the time the program ended, those 64 kids had logged more than 1 million steps. A "Walk the World" curriculum developed for the pilot incorporated lessons on geography, nutrition, and physical fitness to highlight the healthy habits that can stave off obesity. Unlike the adult program, which features a strong weight loss component, the kids' version eschewed all mention of weight.

"If we can change children's habits now we can set them up with the kinds of healthy practices that will serve them for a lifetime," says Kumar. "We treated the entire classroom as one large team, working together to achieve progress. It wasn't about singling out those who didn't do as well, but how the class did together."

To insure a collaborative ethos, each child received two pedometers and encouragement to get moving with an adult family member. At the end of each week, the teachers—serving as team leaders—tabulated the cumulative steps for their students and announced only the totals. As a reward for participation, each child received a small prize for handing in his or her activity logs: an apple, a hacky-sack, a Shape Up RI T-shirt. "Kids are forced to compete in so many different aspects of their lives—athletics, test scores," says Kumar. "We didn't want to add to the stress; we wanted to bring them together."

Over the next few months Kumar and Wing will analyze results of a survey the professor designed with Shape Up RI staff to tease out the effect of a child's participation in the pilot on other family members and summarize the program's efficacy. If Kumar sees cause for optimism in the battle of the bulge, it's due both to the momentum of the program and to evidence from the fight against smoking. "Over the last 18 years, Rhode Island went from third highest to eighth lowest in terms of prevalence of smoking," he says. "The rate plummeted." Kumar credits that campaign's success to the synergy of simultaneously tackling social norms, increasing education, and changing policy. "Those are the same three ways we'll be able to confront obesity and encourage healthy living and healthy eating," says the aspiring primary care doc. "I think we'll hit the same tipping point with obesity. We have real, historic examples to hang our hat on."

FAMILY MATTERS

Assistant Professor of Pediatrics (Clinical) Kyung "Kay" Rhee has focused on how the home environment affects a child's weight gain. "There are so many social and environmental factors that influence why someone becomes overweight and what makes it difficult for them to lose weight," says Rhee, a pediatric hospitalist at Hasbro Children's Hospital who studies childhood weight gain and obesity. Last fall, she and Wing launched two studies under the auspices

of the Weight Control and Diabetes Research Center exploring the parenting styles of families with 8- to 12-year-olds. "The traditional family-based behavioral interventions are the gold standard of treatment for childhood obesity," says

they write. "Permissive and neglectful parenting styles also increased childhood overweight risk, relative to the authoritative style."

In March 2009, *Obesity* published Rhee's analysis of the causal relationship between restrictive maternal feeding practice and weight gain among elementary school children. While early increases in supervision actually helped to hold boys' weight steady over time, the researchers found that a child's weight gain—especially among girls—precipitated greater maternal control. "There has been some concern about the negative impact of restrictive feeding practices and that we should be more lax and let the child determine how much, when, and what

to eat," says the scientist. "However, some degree of control may not be harmful and may actually help certain children, particularly those children at risk for obesity, maintain or control their weight."

In her collaborations with Wing, which are currently enrolling subjects, Rhee plans to assess the meal-time dynamics of families with overweight children and analyze the efficacy of the diet advice they receive in the intervention. "With this study, the goal is to do a traditional, family-based intervention," she says, "and measure the parenting variables to see if they're related to the success of the child's weight loss." They also plan to enroll families with healthy weight children to determine if there



Rhee, "but they tend to be more *behaviorally* oriented, focusing less on how you parent or interact with your child."


In a retrospective analysis published in *Pediatrics* in 2006, Rhee and her collaborators analyzed the relationship between maternal parenting style and children's weight as they approached their sixth birthday. (Authoritarian parents focus on a no-nonsense "do as I say" style, while the more democratic, authoritative approach takes a more nurturing tone and cultivates a child's capacity for decision making.) "Mothers with an authoritarian parenting style were significantly more likely to have children who were overweight two years later, in first grade, compared with mothers with an authoritative style,"

are baseline differences in parenting style between these families and families with overweight children.

In an ideal world, children would confront only healthy choices as they develop, says Rhee. But in the real world, greater autonomy means increased opportunities for kids to choose soda over milk and TV or video games over more physically demanding play. “The parenting factors can be one aspect of obesity and how we treat it,” she says, “but I believe that the environment still shapes a lot of our choices.” With the current study, she hopes to further reveal the trajectory of parental influence as children mature. Says Rhee: “I wonder whether the impact is more salient in the younger age period, when kids are learning to eat fruits and vegetables.”

“ARE YOU SURE YOU WANT TO EAT THAT?”

Teens have seen perhaps the greatest spike in rates of obesity over the last quarter century. Associate Professor of Psychiatry and Human Behavior Elissa Jelalian has taken a comprehensive approach to combating the epidemic. While her research with Wing at the Center investigates strategies to support individual adolescents as they shed pounds, the clinical psychologist also makes time for community service to promote healthy patterns. “Over time, I’ve come to better appreciate the broader context, the policy issues,” says Jelalian, whose early career focused on individual and family-based interventions. She currently serves on the Rhode Island Healthy



“Sometimes too much responsibility is put on teens for having created the situation.”

Schools Coalition’s steering committee, which promotes access to healthy foods and increased physical activity in the public schools, and on the scientific advisory board of the for-profit Wellspring Retreats, which offers after-school interventions, family weight loss camps, and residential programs for teens. “I think of this as multi-layered and multi-leveled,” she says, “both in terms of causes and in terms of treatment and intervention.”

Much work remains to tease apart the relative effects of genetic predisposition, family environment and values around food, cultural and school setting, and access to healthy food options. And yet, says Jelalian, some policy interventions clearly make sense now. Rhode Island schools have removed sugar-sweetened beverages from vending machines, for example. “It’s hard to argue why that wouldn’t be a good step,” she says.

In earlier collaborations with Wing, Jelalian explored peer-based, adventure therapy, and Internet interventions for 13- to 16-year-olds, with an emphasis on leveraging such normative adolescent concerns as appearance, enhanced athletic performance, and peer acceptance. “Kids are motivated by their peers and they care a lot about what their peers think,” she says. “We need to be mindful of that in designing and delivering interventions.”

Jelalian’s current work considers the grown-up side of the equation. “With

adolescents, it’s much more ambiguous what role parents should be playing,” says the psychologist, herself the mother of a teen daughter. To address the question head-on, she matched a control group of high school students

charged with taking full responsibility for their weight loss with an experimental group in which parents also attend the weekly sessions and even set a personal target weight of their own. The experimental sessions also include a module adapted from materials originally designed to help parents talk with their kids about sex. “Communication related to weight, diet, and activity is incredibly tough for some of these families,” says Jelalian. “The kids can feel criticized even when the parental intent is to support and encourage.”

Jelalian says her own efforts to maintain healthy eating and activity habits over time have added nuance to her work. Most research promotes an overhaul of menu and mindset for the entire family of a dieting teen. At times, however, in subtle and overt ways, parents or siblings can take a critical tone and even undermine efforts to create an environment that promotes healthy eating and physical activity levels. “It’s definitely given me empathy for teens whose families may not recognize the challenge they’re going through,” she says. “Sometimes too much responsibility is put on teens for having created the situation that they’ve ended up in.”

PROOF POSITIVE

Last fall, Jelalian and Wing began recruiting teens for a database modeled on

By the Numbers

The National Weight Control Registry (NWCR) compiles data on more than 5,000 adults whose collective weight loss over the past 50 years tops 165 tons. Professor of Psychiatry and Human Behavior Rena Wing established the database with co-investigator James Hill, a University of Colorado Health Sciences Center pediatrician, to track adults who have lost at least 30 pounds and maintained their new weight for 12 months or more. Their successes have informed a wealth of scholarly analyses as well as some easy-to-digest tips for those of us with a personal stake in America's expanding waistline.

Do what works. While formal weight-loss programs are a central feature in the quest to slim down for 55 percent of registry participants, the remaining 45 percent take a solo approach. Experiment, and go with the approach that fits your personality and circumstances.

Get moving. Everyone knows that weight loss boils down to a very simple equation: burn more energy than you ingest. More than 90 percent of NWCR participants used regular workouts to turn their calorie count upside down. Most exercise at least an hour every day to maintain their new figures.

Beware holidays. Taking a break for weekends or festive occasions can wreak havoc, according to a 2004 study published in the *International Journal of Obesity*. NWCR participants who take a consistent approach across the week and throughout the year were 1.5 times more likely to gain 5 pounds or less over the course of a year than their counterparts who take diet "vacations."

Eat breakfast. The most important meal of the day kick-starts the morning of more than three quarters of NWCR participants. Only 4 percent skip straight to lunch. *Obesity* published details in 2002.


Step on the scale. Three quarters of NWCR participants take a strict approach to monitoring their progress—they weigh in at least once a week. Frequent monitoring correlates to sustained success, according to a 2007 *Obesity* article.

Feel good. Despite rumors to the contrary, those who shed pounds and keep them off exhibit no more distress or depression than the average American, according to a 1998 *Health Psychology* report.

Take the long view. Over time, it gets easier to stick to a low-fat diet and regular exercise practice. Even better, as weight maintenance persists, the likelihood of regaining falls. *Obesity* published the findings in 2000.

the National Weight Control Registry (NWCR) established by Wing and a collaborator at the University of Colorado Health Sciences Center in 1994. The NWCR tracks adults who have lost at least 30 pounds and maintained their new weight for 12 months or more. It now contains the stories of more than 5,000 adults who lost between 30 and 300 pounds each in the years spanning 1943 to 2008. More than 30 scholarly papers based on the registry have investigated everything from psychological traits that distinguish the cohort to the relationship between television viewing and weight re-gain.

The Adolescent Weight Control Registry will highlight the successes of 14- to 20-year-olds who've dropped at least 10 pounds and kept it off for a year or more. "We want to understand ... what role they played in the change and what role their parents took," says Wing, who in 2009 garnered more than \$12 million in federal funding for studies at the Center. "Should the parent be actively involved or just play a supportive role and let the child take the lead? Is it different for boys and for girls?"

Though the pace of weight gain may have plateaued, Wing says the battle to promote healthy habits has only just begun. "The obesity epidemic has now affected everybody in the population and the treatments one needs for a 3- or 5-year-old are different from what you'd want for an adolescent or for an adult," she says. "The problem is moving fast and we haven't solved it, yet." 

Ithaca, NY-based writer Sharon Tregaskis reports on health care, the environment, and higher education.

ALL THOSE YEARS AGO

*A glimpse of
medical training
in the 1940s
through a resident's
handbook.*

✚ A rocky economy, a nation at war, an impending shift in the demographics of the country that would change the practice of medicine—these were the realities confronting medical trainees in 1942. Perhaps life wasn't so different from our modern times.

Reproduced here are excerpts from the handbook issued to interns and residents at Rhode Island Hospital in 1942. In 100 or so pages, house officers were briefed on administrative practicalities as well as given detailed instructions for patient care, organized by specialty area. A foreword from the hospital's superintendent, Dr. Dennett L. Richardson (a noted infectious disease specialist in his day), contained the admonition: "These procedures have been carefully prepared, and by following them closely both the hospital and the Intern will be benefited."

According to *To Meet These Wants: The Story of Rhode Island Hospital 1863-1988*, at the time interns and residents lived on the hospital campus in Peters House (hence the term "resident"). The hospital was experiencing shortages of staff and personnel, since nearly half of its 251 physicians and hundreds of employees were serving in World War II. Most of the educational efforts focused on the training of interns for general practice. There were only two full residency programs at the time, in cardiology and pathology.

The first half of the handbook, from which the following selections were taken, provides a broad introduction to hospital rules and regulations. The second half is divided by service, from Anesthesia to Urology, and gives textbook-like instructions on procedures as varied as performing lumbar punctures, removing foreign bodies from the eye, and treating pulmonary hemorrhage ("Step 1. Reassurance of the patient").



A surgical intern in his call room is summoned to the wards.



The residents' dining room, set for dinner here, did not admit unannounced latecomers.



RESIDENT HANDBOOK 1942

+ THE JOHN M. PETERS HOUSE

This building is designed to provide in the two lower floors facilities for use of the Visiting Staff, Residents and Interns. The two upper floors are the living quarters of Residents and Interns. Rules for use of this building will be found posted there. Please follow them.

+ UNIFORMS

The Hospital supplies uniforms to the Interns as follows:

1ST YEAR

- 4 coats
- 4 pants
- Jackets-6 issued 1st year.
- Replaced when necessary.

2ND YEAR

- 2 coats
- 4 pants
- Replace 2 pants if necessary.

Since the Hospital has provided you with white uniforms, it is required that you wear them at all times while on duty in the Hospital. Coats are provided, and it is expected that they will be worn except in very warm weather or when doing clinical procedures on the ward. Neat, personal appearance is as important within the Hospital as outside.

+ HOURS FOR MEALS

- Breakfast 7:30 - 8:30 A.M.
- Lunch 12:30 - 1:30 P.M.
- Dinner 5:30 - 6:15 P.M.

The doors will be closed and no one will be admitted after these hours, unless the Dining Room is called before closing time and notified of those who will be late. This privilege for breakfast is limited to those unavoidably delayed by pressing hospital duties.

Smoking is permitted in the Dining Room, but there shall be no smoking in the corridors, wards or nurses stations.

+ GUESTS

Residents and Interns may have male guests in Peters House with permission from the Superintendent or one of his Assistants.



***Time off duty is limited
to one afternoon a week and
every other week-end.***

They may also have guests in the Dining Room with similar permission. Members of the Visiting Staff and employees of the Hospital are not eligible as guests in the Dining Room.

+ TIME OFF DUTY

Such “time off” is not a right, but a privilege which must be relinquished whenever the proper administration of the Service makes this necessary.

Before going off duty, the Intern must give notice to, and receive permission from his House Physician or House Surgeon or Senior Intern. No Intern shall at any time go off duty until his work is finished. In his absence the Intern next below in rank will attend only to his senior’s emergency work and not to his routine.

When leaving the Hospital after proper permission is obtained, the Intern shall designate his absence by calling the Telephone Operator—giving her the length of time he intends to be absent, and the name of his substitute. Upon his return he will again call the Telephone Operator, and inform her that he is ready to take his calls.

No Intern shall leave the Hospital before 2:30 P.M. for his afternoon except with special permission from the Superintendent or one of his Assistants. This afternoon and evening period may extend to 7:00 A.M. of the following day.

Time off duty is limited to one afternoon a week and every other week-end.

Exception to the rule will be made only by special permission of the Superintendent or one of his Assistants.

+ SALARY AND BONUS

Each Resident is paid a salary of \$50.00 per month, in addition to his living. Interns are paid no salary, but each, at the end of his term of service, is usually given a gift costing \$25.00.

* * *

+ DISCHARGES

Interns shall be sure that each patient has a suitable place to go when discharged and a suitable means of transportation to that place. If there is evidence that the patient has no such place, this information shall be given on a “disposal blank” to the House Social Worker so that she may arrange for the future care of the patient. No patient may be discharged who has not someone to accompany him, except with the permission of the Assistant Superintendent.

... It is very important for the welfare of patients that they receive detailed instruction about what they are to do after leaving the Hospital. Interns shall be sure that all necessary treatment, such as recommendations of consultants, dental work, and medicine to take out, has been completed, in so far as possible, before the patient leaves the ward.

Interns shall make sure also that patients are given the information they desire in so far as it is wise. Questions

about diagnosis and prognosis shall be answered as fully as the patient’s best interest seems to warrant. Precisely what to say at this time to any given patient requires the Intern’s nicest judgment. In incurable conditions such as cancer, if the patient has not been told the diagnosis, some responsible relative should be informed. Prognosis should be very well guarded in any case in which there is any question of compensation or lawsuit.

+ REPORTABLE DISEASES

Cases and carriers of the diseases listed in the table below *must be reported* to the First Assistant Superintendent. Cases of chancroid, gonorrhoea and syphilis are reportable by name or number only to the Division of Venereal Diseases of the Rhode Island Public Health Commission and not to the local health officers. Diseases listed in CAPITALS must be reported to both the local health officer and to the Public Health Commission, the others to the local health officer only.

ANTHRAX.

BOTULISM.

Chancroid.

Chickenpox—when smallpox is nearby or when requested by the health officer, and all questionable cases.

CHOLERA, ASIATIC.

Diphtheria.

Dog Bites.

Dysentery, amebic and bacillary.

Encephalitis, epidemic (lethargic).

German measles—questionable cases only.

Glanders.

Gonorrhoea.— all forms.

LEPROSY.

Malaria.

Measles.
 Meningococcus Meningitis.
 Ophthalmia Neonatorum.
 PLAGUE.
 POLIOMYELITIS, ACUTE EPI-
 DEMIC.
 PSITTACOSIS.
 RABIES.
 Scarlet Fever.
 Septic Sore Throat—epidemic or
 streptococcic.
 SMALLPOX.
 Syphilis.
 Tetanus.
 Trachoma.
 Trichinosis.
 TUBERCULOSIS—all forms.
 TULAREMIA.
 TYPHOID AND PARA-TYPHOID
 FEVER.
 TYPHUS FEVER.
 UNDULANT FEVER.
 Whooping Cough.
 YELLOW FEVER.

✦ DANGER LIST

When it seems probable that any illness or injury may end fatally, it is the duty of the Intern to place the name of the patient on the Danger List. This is done by filling out a slip, to be found at the Head Nurse's Desk.

The Senior Intern is responsible for keeping relatives informed of the condition of patients on the danger list. It is important that he should keep in close touch with these relatives and take the initiative in notifying them of changes in the patient's condition. He shall make every effort to get them to the Hospital before the death of the patient in order that they may be present when the patient dies. To this end Interns must see

the relatives of these patients when they come to the Hospital and they are not only entitled but expected to telephone to the relatives as often as may be necessary. This may be done without permission in each case of a patient on the danger list for calls in Rhode Island; the permission of the Assistant Superintendent shall be obtained for calls outside of the state.

✦ RELATIVES AND FRIENDS OF PATIENTS

Interns shall be in the waiting room daily at 2:15 P.M. to interview relatives of patients. Statements to them must be tactful and in strict accordance with the facts. Persons other than relatives seeking information regarding patients must be referred to the Assistant Superintendent.

The conversation between an Intern and the friends of a patient should be guarded. The Intern must remember that ill-advised remarks to patients or their friends concerning the diagnosis and treatment of the family physician

pronounce the patient dead. He will naturally render any service possible to relatives and friends.

✦ POST-MORTEM EXAMINATIONS

The importance of obtaining a high percentage of autopsies on the bodies of patients who die in hospitals needs no emphasis. At the Rhode Island Hospital it is necessary to obtain permission from the nearest relative of the patient; that is, husband or wife, father or mother, son or daughter, siblings and then the more distant relatives.

When an older person has been cared for by a sister her authority precedes that of brothers or other sisters.

In cases in which family controversies may arise it is well to obtain permission from both sides of the controversy.

The remains of a patient are held at the Hospital for five hours and autopsy permission must be obtained within that time. ... The Intern should see the relatives as soon after death as possible

At the time of death emotionally unstable individuals should be shown every courtesy—a stimulative sip of whiskey can be dispensed ...

often lead to unpleasant results for the family physician, the Hospital and the Intern.

✦ DEATH OF PATIENT

It is the Intern's duty to be present at the death of a patient in order to render every possible service and to

and should see to it that the ward nurses or the Information Desk keep the relatives in the hospital until he is able to interview them.

At the time of death emotionally unstable individuals should be shown every courtesy—a dose of sodium bromide or phenobarbital or a stimulative sip of



Tennis courts on the grounds of Peters House provided recreation for interns and nurses.



Minor Surgery in the New Accident Room . . .
Using a local anesthetic, the doctor is about to remove a bit of metal from this young man's forearm—a type of injury common among industrial workers.

whiskey can be dispensed ... It is usually best for two Interns to be present at the interview because this way one doctor may be thinking of new approaches while the other is talking.

+ TYPES OF PATIENTS NOT ADMITTED TO THE HOSPITAL

No cases of purely mental type, no narcotic addicts or cases of acute or chronic alcohol poisoning shall be admitted to the Hospital.

Patients with acute contagious diseases are not admitted to this Hospital. Such patients who come to the Accident Room or cases developing on the wards, shall be referred to the Admitting Office at once for disposal.

Obstetrical patients are not admitted. Before the period of viability of the foetus, they may be admitted if the

pregnancy seems in danger of termination; after that period they are sent to the Providence Lying-In Hospital.

+ ORDERS

Every new patient is to be seen by an Intern before any order is written and the initial orders for such patient's care and treatment are to be written as soon as possible after admission. All orders concerning patients must be in writing.

Nurses are not permitted to take verbal orders from Interns except in cases of emergency, and then the verbal order must be ratified in writing within twelve hours of the time the order is given.

Each afternoon by 4 P.M., the "Cipher List" of patients whose bowels have not moved is posted in the order book. Interns should leave cathartic orders on these patients before 6 P.M., in order that the medicines may be given as a part of the six o'clock medications.

+ AMBULANCE SERVICE

By arrangement with the Providence Police Department, the Hospital sends an ambulance with an Ambulance Surgeon when called for any street accident, sudden illness away from home e.g., on the street, in public buildings, at place of employment, etc., also to the scene of all two-alarm fires.

The Intern in charge of the ambulance, shall, when on duty have full and complete control of and be responsible for the condition of the ambulance.

Ambulance surgeons must restrict their surgical treatment to such emergency measures as secure the patient's safety or promote his comfort while in transit. All patients suffering from partial or complete loss of consciousness, including those whose condition is apparently due to alcoholism must be brought to the hospital. Extreme caution must be exercised by the ambulance surgeon in deciding that a case does not need a more thorough examination in the hospital. Error in diagnosis is less likely to occur at a hospital, because of better conditions and more complete facilities. Ambulance surgeons must bring to the hospital all patients with injuries involving the cavities of the body.

In responding to a call, the ambulance should always be driven at a rapid, but never at a dangerous rate of speed. In returning, the rate of speed should always be moderate, except when with cases which must be brought to the Hospital without delay. The Intern in charge shall always instruct the driver in this respect.

Compiled and edited by **Kris Cambra**, *with research assistance from* **John N. Pliakas**, *teaching associate in emergency medicine. Photos and pages from Rhode Island Hospital's annual reports from 1942 and 1943 courtesy* **Mary Ann Slocomb**, *director, Library Services for Lifespan and Women & Infants; RIH Archives and Peters Health Sciences Library.*

MOMENTUM

CAMPAIGN FOR ACADEMIC ENRICHMENT

A Living Legacy

Alumnus endows new medical scholarship.

Majid Mohiuddin '97 MD'01 spent a lot of time thinking about the kind of impact he wished to make with his gift to Brown, and he decided that he wanted to do more than leave a legacy—he wanted to watch one grow. This winter, he endowed the Dr. Mohammed Mohiuddin P'97 MD'01 Medical Scholarship.

The younger Mohiuddin grew up in Cherry Hill, NJ, and in high school, won a Brown University Book Award, sponsored by Brown alum Richard Schomp '70. The prize—a dictionary with the Brown seal on the cover—is awarded to “those who use words effectively to be leaders in their generation.” This award made Mohiuddin think seriously about attending Brown, and as it sits on his bookcase, it makes him realize how

even a small gift from an unrelated alumnus could have a lasting impression on a promising student.

Mohiuddin did his undergraduate work at Brown in biology and, with the flexibility of the Program in Liberal Medical Education (PLME), was able to participate in the Rose Writing Fellows

Program. The PLME also enabled him to pursue a new passion for Islamic art and architecture.

Currently, Mohiuddin lives in Houston, TX, where he practices radiation oncology. He spent three years as an assistant professor in Baltimore, MD, after doing his residency at Harvard. Since leaving Brown, he has given lectures about Islamic art and has published on topics ranging from medicine and religion to creative writing. He is grateful that his interests in the arts were not only

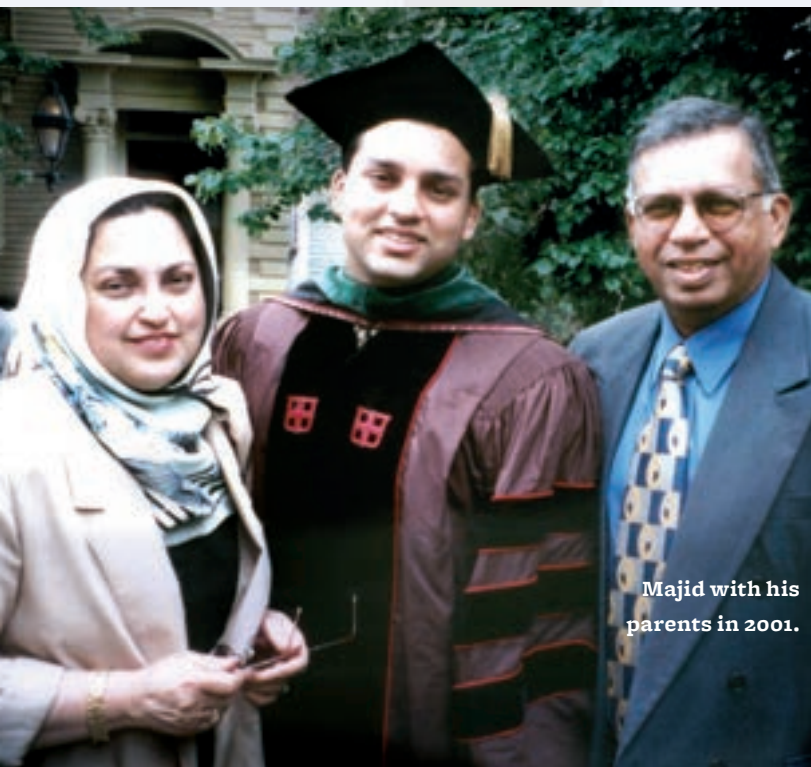
encouraged at Brown, but expanded into life-long pursuits.

It is easy to see the influence Mohiuddin's family had on his career path and interests. His mother, Mubeen, taught English literature and his father, Mohammed, is a physician-scientist in the field of oncology. Mohiuddin chose to honor his father by naming this new scholarship after him. “Aside from being a physician,” Mohiuddin says, “my father is an educator who is passionate about making intellectual contributions that

“I want to see the **impact of this gift** in my parents' lifetime.”

benefit humanity. He told me that the real contribution one makes in academic medicine is teaching the next generation. So, the timing is apropos: I am a father now, and I have a new appreciation for the role a father plays as a mentor.”

This scholarship will have a lasting effect on Alpert medical students, and Mohiuddin is looking forward to hearing all about it. “Right now, I am feeling excited about the school, how it has grown, and the momentum it has gained over the years. Though I am just starting out, I wanted to make a substantial gift now, while I am still young. I want to see the impact of this gift in my parents' lifetime. I want to hear stories from scholarship recipients 20 years from now about what paths their careers and lives have taken, and I hope their stories change my life, too. And I hope that one day, if they are able, they will consider a gift to the next generation.” —**Amy R. Umstadter**



Majid with his parents in 2001.

ALUMNI ALBUM

CHECKING IN WITH BROWN MEDICAL ALUMNI

Hope these MD'85 guys bring their costumes to the 25th Reunion in May.



CLASSNOTES

1976

Joseph Perlman is currently working in a private practice in Spring, TX. He is

TALK TO US

Career news, weddings, births, reunions...it's all good. Go to med.brown.edu/alumni and click on "Fill us in."

working to develop an affiliation with a United Arab Emirates hospital to establish a cosmetic and reconstructive surgery center for patients from the Middle East and East Africa.

1977

Joel Shalowitz '74 is at Northwestern University, where he is a professor of health enterprise management at the Kellogg School of Management and a professor of medicine and preventive medicine at the Feinberg School of Medicine. He is a co-editor and author

of a new book, *Medical Innovation and Government Intervention*.

1978

Linda Semlitz '75 says, "I just had a chance to catch up with Alan Muney and his wife, Karen, in Providence while visiting our daughter Liz '09, who just started the first year of the medical school program, and my son, Cameron, starting the second half of a combined program with Colgate and Columbia University in physics and engineering. I have also been participating in a Healthy

ALUMNIALBUM

1982

Health Care series that examines medical and mental health treatment in Japan. After five years in the pharmaceutical industry, I decided to join the non-profit world. I'm now the clinical director of the Tokyo English Life Line, a non-profit organization that provides

a lifeline and face-to-face professional counseling to the international and multicultural families in Japan.”

Robert Weinberg '74 has become a grandfather with the birth of his granddaughter, Natalie.

Michael Migliori '79, P'11, '12 has been appointed chief of ophthalmology at Rhode Island Hospital. Migliori previously served as physician and surgeon as well as director of ophthalmic plastic and reconstructive surgery at Rhode Island Hospital since 1989. He serves on the faculty as a clinical associate profes-

EYE
ON ALUMNI

All in the Family Three psychiatrists, all Brunonians.

The tradition in medicine of handing down experience and wisdom from one generation to the next has taken on new meaning in the Alexander family, where three generations of psychiatrists have been passing along their knowledge of and love for their specialty since the 1950s.

Both Brown University and psychiatry are a family affair for Paul Alexander '67 MMS'69, a passion he learned from his father, Daniel '35, and passed on to his son, Zev '97 MD'03 MMS'05 (currently the assistant director of an inpatient psychiatric unit at Cornell's New York Presbyterian Hospital).

Growing up on the grounds of the Gardner (MA) State Psychiatric Hospital, where his father worked as a psychiatrist, Paul knew he wanted to be a doctor.

“I was raised to be comfortable around people who are mentally ill,” he says. “[Living at the hospital] had a profound impact about learning tolerance for those with unusual behaviors.”

Certain of his career goals, he applied early decision to Brown's new six-year medical program. The small and innovative program consisted of four years of undergraduate classes with an intensive science focus and two years of medical school, as well as research for a master's degree. Not only did the rigorous science background appeal to Paul, but “I also loved going to Brown football games with my father!” he recalls.

“We called ourselves ‘the guinea pig class,’” says Paul. “We started with 40 students and only 12 finished. The program was modified for later classes based partly

on our feedback.” Professor Emeritus of Medical Science Milton Hamolsky was his strongest influence during that time, and remains his role model for the doctor-patient relationship.

In 1971, after earning his medical degree from Mt. Sinai, Paul went on to residency at Yale, and from there to a research fellowship at the National Institute of Mental Health. In 1977 he returned to Rhode Island and became the first alumnus to serve as a full-time faculty member of Brown's medical school. On the faculty ever since, he is currently a clinical associate professor. He supervises medical students and residents, treats patients, and lectures to practicing physicians nationally on psychopharmacology.

In 1984, Paul and his father enjoyed their sole collaboration at the American Psychiatric Association's (APA) national meeting, where they presented the second peer-reviewed paper on the use of Xanax for panic disorder. In 2008, Paul spoke on an APA panel again as part of a father-son team. This time, though, the father was Paul and the son was Zev. —*Nancy Kirsch*



Can you spot the three Alexanders?

ADAM MASTOON

Gut Feeling

This GI's mission is alimentary.

Kenneth Chang '81 MD'85 is director of the H.H. Chao Comprehensive Digestive Disease Center (CDDC) at University of California, Irvine (UCI). A pioneer in the world of endoscopic ultrasound, he's also a renowned champion of the comprehensive care model. And last summer he appeared on the television show *The Doctors* to demonstrate radiofrequency ablation, a life-saving procedure he developed for ridding the esophagus of cancerous Barrett's cells. It's a rather high-profile position for someone who always planned to do quiet missionary work in the poorer regions of the world.

At Brown, Chang was very involved in religious and spiritual groups on campus. In 1981, he took time off to work at a missionary hospital in Taiwan. "That year changed my whole perspective and got me into the mode of inventing equipment that didn't exist," he says. "Here in the States the thinking was, 'If we don't have it, we don't have it.' Over there it was, 'If we don't have it, let's make it.' [The missionary doctors] were my heroes. I thought, 'This is what I want to do.'"

With his sights set on a career in medical missionary work in Asia, Chang applied for a GI/Liver fellowship at UCI and revealed his penchant for new technologies early on. "There was this piece of equipment stuck in a corner with a shroud over it," he recalls. "It was a new ultrasound endoscope, but nobody knew how to use it. So I taught myself. Soon, I was able to see things that no one had seen before."

Upon completing his fellowship, Chang and his



"Everything is **driven by my desire** to help a patient who is at the end of their rope...."

wife, Christy, considered going overseas. But with their second child on the way, he instead took a faculty position at UCI and spent the next decade leading the GI Oncology department at UCI's Comprehensive Cancer Center. In 2003, he received a \$2 million grant to establish the CDDC, one of only a handful of truly integrated comprehensive centers in the U.S. that focus on digestive diseases. Currently, the CDDC has 23 faculty and 100 staff. Last year, they saw 20,000 patients.

"My first passion is still—to go back to that little hospital at the southern tip of Taiwan—the patient," says Chang. "Everything is driven by my desire to help a patient who is at the end of their rope.... That sparks the innovation, the desire to provide good service, to have an efficient, comprehensive approach."

—Susan Hsia Lew '97

sor of ophthalmology at Alpert Medical School.

1983

John Van Deren '80 writes that he works at Kings Daughters Medical Center, Ashland, KY, in administration and IT applications.

Lewis Satloff works at a pediatric dental surgery center in Fresno, CA, with immigrant Hmong and Hispanic children who have suffered severe dental neglect.

1984

Michael Rossi '81 is currently the physician executive director at Lehigh

Valley Physician Group in Allentown, PA, a 500+ physician multispecialty practice of Lehigh Valley Hospital. He was recently named the Walter and Hazel May Endowed Chair in Cardiology as well as clinical professor of medicine at Penn State University College of Medicine. He and his wife, Barbara, have four children.

Read All About It



BROWN
Alpert Medical School

The Brown Medical Alumni Association (BMAA) is currently accepting board member nominations for the term beginning May 2010. The BMAA meets once in the fall, during Family Weekend, and once in the spring, during Reunion Weekend. In recent years, this group has been responsible for conceiving new initiatives and supporting time-honored traditions, such as the White Coat Ceremony, the HOST (Help Our Students Travel) Program, and other regional and local events.

Interested alumni are asked to contact Bethany Solomon, director of alumni programs, at 401 863-1635 or Bethany_Solomon@brown.edu. She will be happy to answer any questions and take your nominations.

[HTTP://MED.BROWN.EDU/ALUMNI/BOARD](http://med.brown.edu/alumni/board)

OUR MISSION

The Brown Medical Alumni Association (BMAA) serves as the central organization and primary resource for connecting medical alumni to Brown's medical school, the University, and the extended medical community.

STATEMENT OF PURPOSE

The BMAA promotes loyalty and pride in the strength and vitality of The Warren Alpert Medical School of Brown University and its mission. Specifically, the BMAA:

- **Develops communications**, programs, and community outreach to strengthen the relationship between alumni and Brown.
- **Represents the formal voice of medical alumni** as advisers to the University and Dean of Medicine and Biological Sciences.
- **Serves as a forum** for the exchange of alumni ideas and views.
- **Enhances medical education** through the promotion of enduring relationships between alumni, students, residents, parents, and the medical community.
- **Increases the impact of alumni** on the Medical School's future through alumni involvement, volunteerism, and participation in fundraising initiatives, including the Brown Medical Annual Fund.
- **Strengthens the reputation of Brown's medical school** by promoting the accomplishments and achievements of its graduates to applicants, medical organizations and the general public, and recognizing outstanding contributions to the advancement of medicine.



The BMAA
Board

1985

Rich Parker says: “I remain an internist at Beth Israel Deaconess Medical Center in Boston. I still see my own in-patients! I am the medical director for our 1,700-doctor organization and I frequently serve as an expert witness in malpractice cases. Happily married with four children.”

ALUMNIALBUM

1993

Paulo Pacheco writes: “My partner, Paul Brennan ’90, and I have a 3-and-a-half-year-old daughter named Isabel. She is incredibly funny and has brought incredible joy to our lives. We love walking

her to her school every day in the West Village.” He is currently in private practice in gastroenterology in Manhattan and is co-directing a GI course for fourth-years at NYU Medical Center. He is also on the publications committee of the American College of Gastroenterology.

EYE
ON ALUMNI

Supporting Role She was meant to mentor.

Emma Simmons MD’91 MPH’04 believes in the power of support.

Assistant dean for minority medical affairs since last October, she dreams of someday endowing a Levi C. Adams Scholarship Fund to honor the former associate vice president of external affairs, whom she applauds for his role as a champion of medical students, especially underrepresented minorities. “You could walk into his office and always feel welcomed,” Simmons says. “He connected with us—medical students, graduate students and faculty—on a personal and professional level. He pushed us, too.” Adams helped launch so many careers, she says, that many doctors credit him with their success.

Following Adams’s lead, Simmons recently launched a student-alum mentoring program. Personal support, information about specialties, the dos and don’ts of residency—alumni have many insights to offer their future colleagues. Still in its infancy, the program is receiving positive reviews from mentors and mentees alike. Simmons also directs a local minority medical mentoring program she started last April.

Simmons learned much from her mentors. “Doctors like to be autonomous and independent,” she says, “but medical school teaches you to work in teams. It pushes you to move beyond your limits of knowledge—and beyond what’s familiar.”

Describing her primary role as “supporting students academically, emotionally, and professionally to become the best medical students and doctors they can be,” Simmons maintains a laser-like focus on those



Emma Simmons
kicks off
Reunion Weekend
2009.

future physicians’ attributes: “Consummate good doctors have a great bedside manner, are extremely knowledgeable, on top of their research and teaching games, and respected leaders in their fields.”

In addition to her new role, Simmons continues to work as a physician and to pursue her research on health disparities in minority populations, with a focus on HIV/AIDS prevention and eliminating testing barriers. Her long list of awards includes Preceptor of the Year from the family medicine residency program, a Dean’s Teaching Excellence Award, a Fleet Community Fellowship, and a World AIDS Foundation Grant for HIV research in Manila.

With husband Scott Allen MD’91, Simmons also derives balance from raising their two children: Miles, 15 (born with a severe congenital abnormality) and Kari, 8. Her parenting skills—giving them undivided and fully present attention—are equally applicable to her students, whom she calls “amazing, passionate and energetic. They teach me so much, and that’s a powerful deterrent to burnout.”

—**N.K.**

ADAM MASTOON

ALUMNIALBUM

1995

Sara Fazio '91 is currently living in Boston and running the internal medicine clerkship for Harvard medical students at the BIDMC. She is an Associate Master of the Holmes Society at Harvard Medical School and in 2009 received the Society for General Internal Medicine Na-

tional Award for Scholarship in Medical Education. She says: “Recently **Jayson Carr '91 MD'95** moved to Boston and joined an affiliated practice. I have been sending many medical students his way, and they absolutely love working with him, which is no surprise. I am fortunate to keep in regular touch with (I’m using their maiden names) **Triste Coulombe**

MD'95, **Preetha Basaviah '91 MD'95**, **Renu Sharaf '91 MD'95**, and **Srilata Naidu MD'95**.”

1997

Margriet van Achterberg '93 lives with her husband, Ariel Sabar '93, and their two children in Washington, DC.

Phyllidia Ku-Ruth '93 says, “I am practicing part-time internal medicine in a

EYE ONALUMNI

Yin and Yang Mixing eastern and western medicine in just the right measure.

When David W. Miller MD'96 began practicing as a pediatric hospitalist a decade ago, he felt he “didn’t have sufficient tools” to treat many of the illnesses afflicting his young patients. And so, having studied and practiced Reiki during his residency in the late 1990s at the University of Chicago, he turned to complementary and alternative medicine. Miller began taking classes at Chicago’s newly opened Pacific College of Oriental Medicine—and then enrolled in its four-year program.

“It was a big commitment, but definitely the right one,” says Miller, who today is one of the few U.S. physicians board certified in both pediatrics and traditional Chinese medicine. Since finishing his education in 2005 he’s been building his private practice, East-West Integrated Medicine, in Chicago, where he offers holistic medical care to children—and often to adults.

“Everybody I see has been to a traditional pediatrician,” says Miller. Some “have tried everything else.” Others—a small but growing number of adults—have tried Chinese medicine themselves and want to integrate it with more traditional primary care and treatments for their children.

Miller stresses that aspects of both western and Chinese medicine are valuable. Western medicine is prefer-



David Miller offers patients the best of both worlds.

able in cases such as emergency care, “but isn’t always the best place to start with primary care treatment. Many patients—for example, those with ADHD—will see excellent results with diet and lifestyle modifications, acupuncture, herbal medicine, and Chinese massage. If these are not sufficient, we look into western medicine. Drugs like Ritalin should be reserved for really recalcitrant cases,” he says.

People often don’t realize that Chinese medicine is not just acupuncture, he adds. “It’s much broader than that: it’s diet, lifestyle, herbal medicine. It’s a philosophy and an outlook—treating a whole person.”

The way western medicine is currently practiced doesn’t allow for a holistic approach, says Miller, who spends two hours in an initial visit with a family and another hour on follow-up in treating disorders such as asthma, ADHD, eczema and other skin diseases, and Crohn’s disease.

“Building a therapeutic relationship with patients is in itself a key therapy,” he says. “We should foster a system that supports this well proven pearl of medicine.”

Miller also teaches at the Pacific College of Oriental Medicine and is the director of the Illinois Acupuncture Federation, a coalition acting to set safety standards, make Chinese medicine more accessible, and raise public awareness that holistic modalities can improve health care and cut costs.

“As we work to reform health care, we should strive to integrate these invaluable systems,” says Miller.

—**Mary Jo Curtis**

physician-owned multispecialty group in Portland, ME, and was recently elected to the Board of Directors. We successfully recruited Bill (**William Ruth** MD'97) from his previous position to join me at InterMed and start up an Urgent Care for our group. Emilia is 9 and our son, GW, is 6. We recently moved to Littlejohn Island in Yarmouth, ME, and would love to see old friends and classmates."

Srihari Naidu '93 and his wife, Nina, a plastic surgeon, have launched Anokha Skin Care, a line of all-natural products crafted from South Asian plants and botanicals for sensitive skin. Visit anokhaskincare.com for more information. They celebrated the birth of their son, Kiran, in 2009.

1999

Melisa W. Lai Becker '94 published a letter to the editor in the October 12, 2009, edition of the *Boston Globe* on health care payment reform, arguing that different types of care require distinct modes of payment as opposed to a one-size-fits-all health care payment model.

2000

Sarasa Kimata of San Francisco, CA, and Jacob A. Korn were married on November 14, 2009.

Danielle Walker '92 has moved to California to work with the Prima Medical Group in their Sausalito office.

Serena S. Wu '93 has joined Doylestown Hospital. She completed her ob/gyn residency training at the University of Chicago, as well as fellowship training in maternal-fetal medicine. She is currently board eligible.

2002

Debra Hillier is living in Boston, MA, and working at Children's Hospital

Boston in the Intermediate Care Program as a hospitalist and in the emergency department at Beverly Hospital, seeing pediatric emergency patients. She and her husband, Timothy, had their second child last June.

2003

Patricia Brunker '94 is currently finishing her clinical fellowship in transfusion medicine at Johns Hopkins Hospital and began post-doctorate research at the NIH in November 2008. She and her partner, Tim, "have a 2-year-old daughter, Anastasia, whom we call Anna, who is talking up a storm!"

Ethelind Cheng '98 says, "I finished residency in 2007 from Harbor UCLA. I have been working with a great group of doctors at Kaiser Permanente in Baldwin Park. I recently got 'promoted' to assistant chief of the ob/gyn department and, no surprise, enjoy doing the administrative work." She is living in Altadena, CA, and looks forward to meeting up with any Brown alumni in the area.

2005

Arlene The '01 and husband **Albert Kwon** '01 MD'05 write: "[We] are happy to announce the birth of our daughter, Aubrey Kwon, on July 24, 2009."

2006

Leah Scherzer '02 completed a pediatrics residency at St. Christopher's Hospital for Children in Philadelphia last June. In July, she joined the Pediatric AIDS Corps (PAC), a program run by Baylor College of Medicine. She says: "I would love to keep in touch with everyone and have started a blog: www.botdoc.blogspot.com. I would love to hear from all, especially anyone who is in southern Africa." She will spend a year in Botswana. Contact Leah at leah.scherzer@gmail.com.

2009


Sonia Aneja '04 says: "**Rajeev Chaudhry** MD'09 and I were married in Pittsburgh on June 6, 2009, two weeks after graduation. We had a big traditional Indian wedding and several members of MD'09 were present. We currently live in Durham, NC, where we are both interns (I'm an ob/gyn intern at Duke and Rajeev is in the urology program at Duke)."

Amy McIntyre is currently a resident at the Family Medicine Residency of Idaho in Boise, ID.

John Rommel '05 is currently a resident at University of North Carolina Hospitals.

Neel Shah '04 writes: "While completing joint degrees in medicine and policy this past spring, Ariana Green '04 and I launched a nonprofit social venture aimed at preventing medical bankruptcy called Costs of Care (www.costsofcare.org). You can support our efforts on the Web, Facebook, or Twitter." Neel and his wife, Jule (MIT '04), live in Cambridge, MA, where they are resident tutors at MIT. Neel started residency training in obstetrics and gynecology at Mass. General and Brigham and Women's Hospital last summer.

HOUSESTAFF 2003

David R. Cloutier, a general surgeon at The Miriam Hospital since 2003 and a clinical assistant professor of surgery at Alpert Medical School, is this year's recipient of the Riesman Family Excellence in Teaching Award. The award recognizes excellence in teaching by a Miriam Hospital physician who is actively involved in medical education. Cloutier has won other Alpert Medical School teaching honors, including the 2005 and 2009 Outstanding Teaching Faculty Award, the 2008 Teaching Recognition Award, and the 2001 Dean's Teaching Excellence Award. 

ALUMNIALBUM

OBITUARIES

EDWARD N. BEISER

Professor Emeritus of Political Science Edward N. Beiser passed away on Friday, September 4, 2009, at Tamarisk Assisted Living Facility in Warwick, RI, of Parkinson's disease at the age of 65.

Beiser grew up in the Bronx and graduated cum laude from City College of



New York in 1962. He received his MA and PhD in political science from Princeton and, in 1965, began teaching at Williams College. He joined Brown's Department of Political Science in 1968, where he became known for his use of the Socratic method. His course "Hard Choices" became popular among students, who voted him "best teacher" many years in a row. He was made parliamentarian of the faculty upon arrival at Brown.

"He had the ability to transform a classroom and bring to life the material he was teaching," recalls former student Daniel Neff '74. "His remarkable wit—funny but never biting—was always present, and his openness to students was legendary. There was always a crowd outside his door during office hours."

Says former student and colleague Tom Bledsoe MD'88, associate professor of medicine: "Coming from such a rich background in political science

and law, [he] had a remarkable capability to get the group to stop and think about what, culturally, had become a matter of routine. His thought-provoking questions instilled a lifelong ethos of questioning the values, both personal and professional, both patient- and physician-related, that are the true drivers behind medical decisions."

In 1977, Beiser received his JD from Harvard Law School and, in the 1980s, then-Dean of Medicine David S. Greer recruited Beiser to develop the Program in Liberal Medical Education. Beiser was appointed associate dean of biomedical ethics. In this capacity, he helped develop a third-year clerkship program in applied clinical ethics with Dan W. Brock, professor emeritus of philosophy and founder of Brown's Center for Biomedical Ethics.

Beyond Brown, Beiser was considered an expert witness in medical ethics by the Rhode Island Supreme Court. After 35 years of teaching political science, law, and medical ethics at Brown, Beiser retired in 2003.

Beiser is survived by three sons and three daughters-in-law: Reuben '91 and Tehila, Joshua and Suellen, and Benjamin and Felicia. He is also survived by 10 grandchildren and by his brother and sister-in-law.

MICHAEL LYSAGHT

Professor (Research) of Molecular Pharmacology, Physiology and Biotechnology Michael Lysaght passed away on October 24, 2009, at his home in East Greenwich with his wife, Carmen, and family by his side.

Lysaght received an AB from Georgetown University, a BS and MS in chemical engineering from MIT, and a PhD in biomedical engineering from University of New South Wales. Lysaght's work in the biotechnology industry brought him to Providence in 1989 to start CytoTherapeutics,

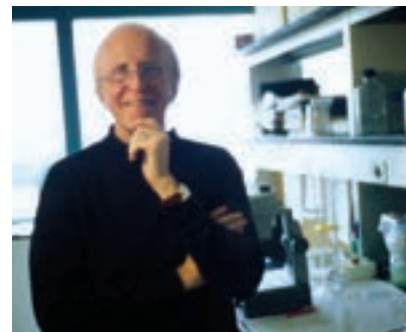
where he served as vice president and chief technical executive until 1994.

In 1995 Lysaght joined the faculty of Brown University, where his research focused on therapies for end-stage renal disease, tissue engineering to relieve diabetes and deteriorating cartilage, and social and economic implications of organ and tissue replacement.

Lysaght oversaw the creation of the Rhode Island Center for Cellular Medicine, which supported the development of university research into private sector technology. He served as the organization's president until 1999 and on its board until 2003. He was the recipient of two gubernatorial citations for his contribution to the State's economy.

Lysaght was the founder and director emeritus of Brown University's Center for Biomedical Engineering, which he helped form in 2000 and which established an undergraduate concentration and a graduate program in the field.

"Part of Michael's desire to pass on information about biotechnology came from his own experience and success in the field," says Barrett W. Bready '99



MD'03. "His depth of knowledge and his clarity of presentation were inspiring. He prompted a legion of Brown grads to enter careers in biotechnology."

Lysaght contributed more than 200 papers to the scientific literature and held more than 25 U.S. patents. He received Brown's Elizabeth H. Leduc Award for Excellence in Teaching in the Life Sciences and the Class of 2003 Barrett Hazeltine Citation, also for excellence in teaching.

MEET ALEEMA PATEL '08 MD'12.

A gift to the BMAF will help her pay for medical school.

Aleema came to Brown from Austin, Texas. She plays the violin and enjoys Ghanaian drumming and the Javanese gamelan. As an undergraduate anthropology concentrator in the Program in Liberal Medical Education, Aleema spent semesters at the University of Seville, Spain, and the American University in Cairo, Egypt. She volunteers at Rhode Island Free Clinic, and plans to become a dermatologist.

GIFTS TO THE BROWN MEDICAL ANNUAL FUND HELP ALEEMA'S DREAM OF BECOMING A DOCTOR A REALITY.



Fifty-five percent of the Brown Medical Annual Fund is dedicated to providing scholarships to deserving students like Aleema. Last year 25 medical students received a Brown Medical Society Scholarship, made possible by donors to the BMAF.

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Visit <http://bmaf.brown.edu> for more information.

Questions? Contact Bethany Solomon, director of the Brown Medical Annual Fund, by email at Bethany_Solomon@brown.edu or phone at 401 863-1635.



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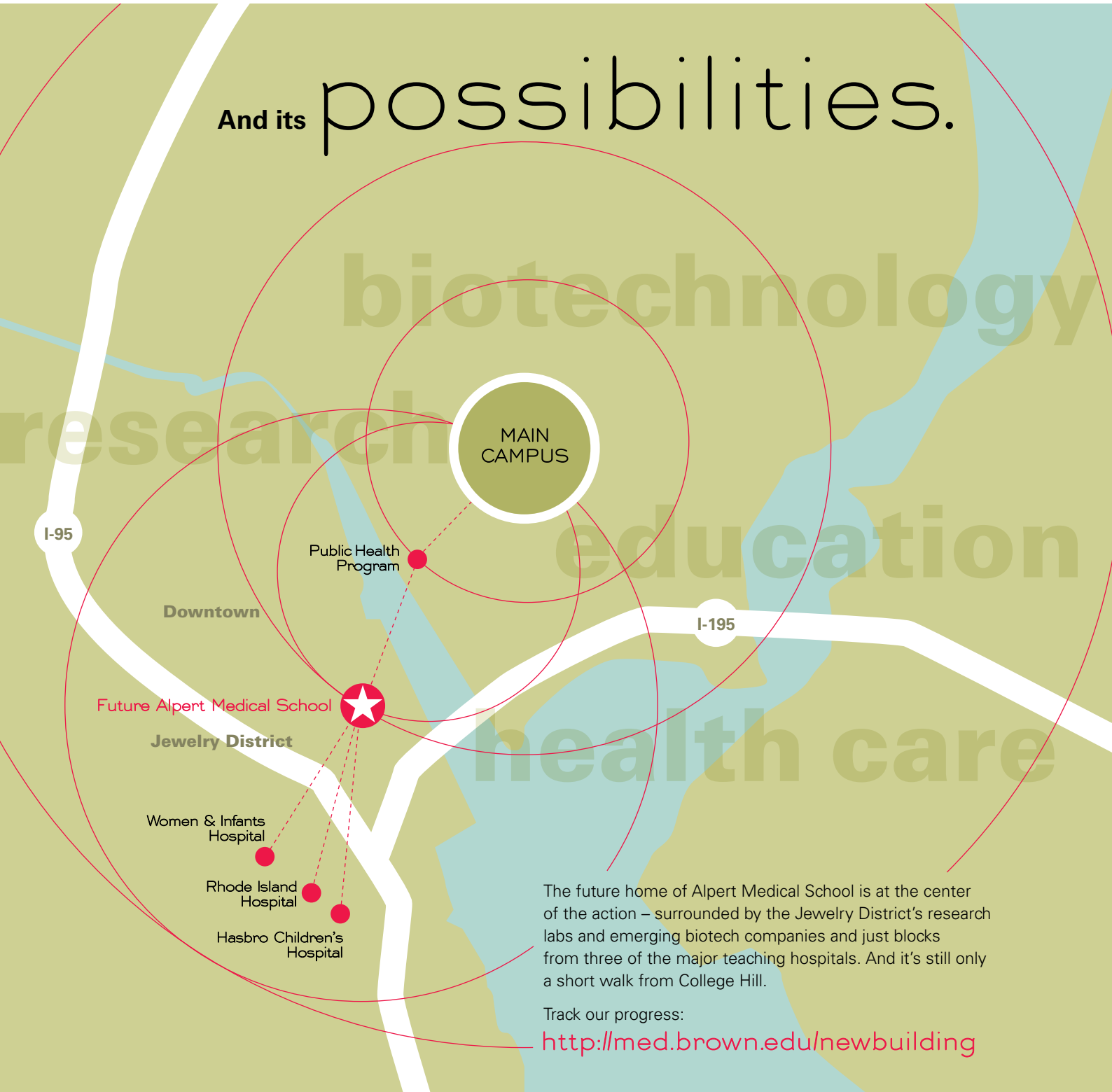
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