Building for the Future

The transformative leadership of
Dean Antonio Gotto
Research Leads to Cures

The Inside Story—
What Our Scientists are Learning about The Healing Power of Genes

Ronald G. Crystal, MD
Bruce Webster Professor of Internal Medicine
Professor of Genetic Medicine
Chairman of the Department of Genetic Medicine

Focus: Genetic Medicine/Personalized Treatments for Diseases

Our Parents and Our Health

“We can’t choose our parents, but if we know what our genes are and how they vary, we can be advised on what we should be doing in our lifestyle to minimize the risk of health problems, including personalized therapies to protect against diseases like cardiovascular disease, diabetes, and cancer.

“We now know, for example, in collaborative research with our colleagues at Weill Cornell Medical College-Qatar, that there are genetic variations in some of the proteins that carry lipids in our blood. Up to 1% of the patients with cardiovascular disease who we see at Weill Cornell might have this variation. This means that they are among those people who might be more susceptible to having high lipids – and so they are at more risk when they eat a steak, or have a Big Mac, than someone who doesn’t have this variation.

“We also know that, depending on your genes, when you do have a disease you may metabolize or respond to treatments in different ways. By knowing what kind and level of drugs and other treatments work best for you, we may choose to treat you with one approach and someone else with a different one – all for the same disease.”

The Healing Power of Genes

“One of the most exciting developments is in identifying ways in which we can correct abnormalities caused by genes that are dysfunctional or missing. In cardiovascular disease, for example, we see patients for whom standard therapies are no longer effective. One strategy we now use is to put a gene into the heart to tell the heart to make new blood vessels – sort of a ‘bio-bypass’ – to get around the obstruction.

“Another gene therapy approach is being used to address childhood disorders. Some children have problems metabolizing proteins within the neurons of their brain cells, which can cause disorders that are sometimes fatal. By putting genes directly into the brain, we can correct that abnormality.

“This is a fantastic time to be doing genetic research.”

For video interviews with Dr. Crystal and other Weill Cornell physician-scientists go to
WEILL.CORNELL.EDU/CAMPAIGN/RESEARCH

Weill Cornell Medical College
22 PASSING THE TORCH

BETH SAULNIER

At the end of December, Dean Antonio Gotto steps down after a decade and a half of service. They’ve been transformative years for Weill Cornell—physically, financially, academically, and scientifically. During Gotto’s tenure, the Medical College has seen an overhaul of its curriculum; record-setting fundraising campaigns; a renaming in honor of foremost benefactors Joan and Sanford Weill; the establishment of the Qatar campus; and much more. This fall, Gotto sat down for a conversation with Weill Cornell Medicine, offering thoughts on topics from his professional legacy to his fondness for spy novels. “I would like to think that I have helped make Weill Cornell a gentler, more collaborative place,” he says, “but also one that was transformed in its academic endeavors.”

30 DISCOVERY CENTER

BETH SAULNIER

On an unseasonably warm and sunny day in early November, Weill Cornell celebrated the dedication of its $650 million medical sciences facility and unveiled its name: the Belfer Research Building. Named in honor of Robert and Renée Belfer in recognition of their $100 million gift, the building is the centerpiece of Weill Cornell’s $1.3 billion Discoveries that Make a Difference Campaign and its Research Leads to Cures Initiative. The 480,000-square-foot facility, which has been under construction since spring 2010, is scheduled to open in spring 2014. “Coupled with the brilliant scientists already on staff and with additional ones being recruited,” Robert Belfer said at the event, “the building is certain to house discoveries that will benefit my family, New Yorkers, and all mankind.”

34 CREATIVE SOLUTIONS

SHARON TREGASKIS

Microbiologist Carl Nathan, MD, has been fascinated by scientific discovery since he was a young teenager working in the lab of an NYU pathologist. Now, he’s marshaling a myriad of weapons—including novel partnerships with industry—in the ongoing battle against tuberculosis. It’s no easy fight: Mycobacterium tuberculosis resides in one in three people worldwide and causes another infection every second. The disease costs 1.8 million lives per year—making it the third leading cause of premature death and the leading cause of death from a curable infection.
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Food, fitness, fun
It is very difficult to write just a few words about how much Tony Gotto means to my wife Joan and me. Most importantly, Tony would be the first to say that he would not be the person he is if it were not for the support of his beautiful wife, Anita, and his terrific family. I wholeheartedly agree. It has been a pleasure getting to know them over the last fifteen years. The Gotto family truly epitomizes class.

Weill Cornell has soared to new heights under Tony’s leadership. He and our great team have worked tirelessly to position Weill Cornell as a world-renowned institution for medical education, medical research, and clinical care. As a result of Tony’s vision and passion, Weill Cornell has raised more than $2 billion; developed key partnerships around the globe in Qatar, Tanzania, Turkey, Haiti, and Houston; strengthened ties with Ithaca to enhance research, education, and patient care; and forged a strong bond with NewYork-Presbyterian. I have enjoyed each and every day working with Tony, and there is no question he is one of the smartest people I have ever met. I always like to tell people that they have the luxury of turning to Google for answers to tough questions, while I just need to turn to Gotto.

My partnership with Tony has been one of the special highlights of my life and something I will cherish forever. We have traveled the world together, and I have seen firsthand the respect and admiration that world leaders, as well as ordinary people from all walks of life, have for him. I will never forget a trip we took to visit our doctors at Weill Bugando Medical Centre in Tanzania, and seeing Tony perform rounds before the sun came up one morning. He examined a young girl who had malaria, HIV, and tuberculosis—and to this day I still cannot believe all of that could exist in one person’s body. Tony had the ability to make this young girl smile, and he reminded those of us with him that people become doctors to improve lives. Tony has certainly followed this credo for the last fifty-five years of his life.

The mark of a good leader is to leave something better off than it was found. Tony has certainly done this and much more. We all owe him and his family a deep debt of gratitude, and we look forward with much anticipation to the exciting days ahead for Weill Cornell.

Sandy Weill
Chairman, Board of Overseers

Tributes to Dean Gotto by other distinguished members of the Weill Cornell community begin on page 24.
Thank You, Dean Gotto!

Alumni Gratitude Reaches

This year – at events in New Orleans, San Diego, Boston, Houston, and Denver – **Weill Cornell alumni** had a chance to enjoy one another’s company and to celebrate Dr. Gotto’s leadership and achievements as he wraps up 15 successful years as Dean of Weill Cornell Medical College. (See page 22.) On January 1st, 2012, Dr. Gotto assumes his new responsibilities: as Co-Chairman, with Sanford I. Weill, of the Board of Overseers; and as a Vice President of Cornell University – in addition to maintaining his clinical practice and research activities. Here are snapshots from some of the gatherings, and thoughts from a few alumni.

“Tony Gotto is a wonderful advocate for Weill Cornell and an inspiration to alumni. His presence at Weill Cornell in the last 15 years has transformed the face of the medical college. As an alumna, it has been thrilling to witness and be part of this transformation.”

Carol Storey-Johnson, MD ’77

“Our Alumni Association is a success because of Dr. and Mrs. Gotto’s active participation in our organization and their engagement with alumni. We owe them both a debt of gratitude.”

Michael M. Alexiades, MD ’83

Anita N. Gotto; Tammy Thramann; and Jeffrey J. Thramann, MD ’94 in Denver

Mary Day, MD; Daniel J. Friedman, MD ’10; and Brian Y. Changlai, MD ’80 in New Orleans
Coast to Coast

“We are thrilled by the amount of interaction alumni now have with Weill Cornell students, thanks to Dean Gotto and his administration. It is meaningful to us, and appreciated by the students who benefit from our stories and experience.”

James H. Reichheld, MD ’90

Laila Aganovich, MD; David J. Najafi, MD ’95; and W. Christopher Fang, MD ’97 in San Diego

Stuart B. Mushlin, MD ’73 and Richard F. Tosi, MD ’73 in Boston

Mae C. Jemison, MD ’81; Paul DeMarsh; Susan Soletsky, MD ’89; and Anne Robbins in Houston

Charles W. Flowers, MD ’89 and Norman A. Johanson, MD ’78 in San Diego

“We, as alumni, are extremely thankful that Tony Gotto’s vision and leadership over the last 15 years has helped strengthen Weill Cornell’s reputation as a world class institution.”

Ronald A. Arky, MD ’55

For more information and a detailed list of gift opportunities, please contact Lucille Ferraro, Campaign Director, at 646-962-8721 or luf2003@med.cornell.edu

Please visit our Website at: weill.cornell.edu/campaign

Weill Cornell Medical College
It has been a profound honor to serve as dean of Weill Cornell Medical College over the past fifteen years and to lead our institution into the twenty-first century. When we moved to New York at the end of 1996, my wife, Anita, expected that we would return to Houston to retire after I had completed a five-year term. We could not have imagined that I would end up continuing as dean for an additional ten years. It has been an adventure that we have enjoyed every step of the way, and we are happy to have made a home in New York.

This has been a period of dramatic transformation for the Medical College, and I am extremely proud of all that we have accomplished together. I have been very fortunate and blessed to have the friendship and support of countless individuals from within the Weill Cornell community, at Cornell University in Ithaca, and from our partnering institutions. These relationships have greatly enriched my time as dean.

I am especially thankful to Joan and Sandy Weill, who allowed us to rename the Medical College in their honor; to Hank and Corinne Greenberg and the Starr Foundation; to Bob Appel, who is chairing our current campaign; and to our Board of Overseers. At Ithaca, I deeply appreciate the support of our University Board of Trustees, under the successive leadership of Stephen Weiss, Harold Tanner, and Pete Meinig, and of Cornell presidents Rawlings, Lehman, and Skorton. It has been a true pleasure to work with Herb Pardes, former president and CEO of NewYork-Presbyterian Hospital, to strengthen the Medical Center in keeping with our shared values. In addition, our senior administration and department chairs at Weill Cornell, our faculty and staff, our students and alumni, and our many other generous donors and friends have all contributed on multiple levels to the successes of the past decade and a half. For that I am very grateful.

Together we have improved student education by continually modernizing our curriculum. Weill Cornell remains a national leader in the recruitment of students underrepresented in medicine, and increasing faculty diversity is a high priority. We have expanded our clinical services by opening our first ambulatory care facility, the beautiful Weill Greenberg Center. We entered into a period of great collaboration between the Medical College and NewYork-Presbyterian, with our Medical Center ranking as a preeminent site for patient care in New York and in the nation. Numerous advances in basic, clinical, and translational research have been made, and top investigators have joined our faculty to launch new programs. I am confident that the opening of the Belfer Research Building, named in honor of our generous benefactors Renée and Bob, will lead to even greater discoveries. Finally, Weill Cornell has vastly expanded its reach, with new affiliations in New York City, Houston, and Tanzania and a branch campus in Qatar. Our commitment to improving health around the world represents an investment in our shared future.

Today’s medical students are able to help patients in ways that we never dreamed about when I first entered medical school in the Sixties. The past fifteen years have been an exciting time of growth and transformation for Weill Cornell and for modern medicine, but I believe the best is yet to come. After all is said and done, when we sum up our careers and our lives, the things that really matter most are our faith, our family, our friends, and our good name.
The Power of Research Partnerships

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

In recent years, pharmaceutical companies have begun to re-examine their model for drug research and development, including their relationships with universities. As the cost of developing drugs continues to rise and the flow of new products in the pipeline slows, the biomedical industry is under pressure to find more effective and efficient ways to bring promising therapeutic compounds and diagnostic methods to market. In this new landscape, pharmaceutical and biotech companies, as well as medical device manufacturers, have turned to academic medical centers in search of new ways to collaborate. These partnerships are creating new opportunities for us in the Graduate School to advance health care through science.

Until recently, the traditional model for pharmaceutical companies was to acquire potential drugs only in the late stages of development, once chemical compounds had been shown in an early clinical trial to be safe and effective. Today, academic researchers and industry experts are collaborating at earlier stages. As our faculty members validate targets, they can partner with industry experts. For example, there are new interactions at Pfizer’s Centers for Therapeutic Innovation, an initiative the Medical College joined earlier this year. Pfizer has agreed to sponsor the research of two of our leading scientists: Barbara Hempstead, MD, PhD, the O. Wayne Isom Professor of Medicine, who is researching a novel target with implications for the treatment of acute coronary disease, and Katherine Hajjar, MD, the Brine Family Professor of Cell and Developmental Biology, who will be studying new cellular targets to manage diabetic retinopathies. Their work will be done in tandem with Pfizer scientists who bring experience in the use of therapeutic biologics, pharmacokinetics, and toxicology to the table.

Other more recent collaborations extend across our Tri-Institutional stem cell research efforts with Memorial Sloan-Kettering and Rockefeller University. And this issue of Weill Cornell Medicine details the work of Carl Nathan, MD, the R. A. Rees Pritchett Professor of Microbiology, who has pioneered models of collaboration with nonprofit organizations and industry, including pilot programs with GlaxoSmithKline, Lilly, and Sanofi-Aventis, to bring to market drugs to treat tuberculosis and other infectious diseases that, under the old model, were sometimes neglected. There are many other existing relationships with our professors and industrial partners.

Caren Heller, MD, who oversees the development of new industry initiatives at the medical school, recently attended an open house hosted by a global biopharmaceutical company. At the event, representatives emphasized that this particular company is open to collaborations with academic researchers at any stage. As understanding of human biology has deepened, they said, academic researchers offer industry much greater scope. The firm cannot cover every area of medical research—but if it collaborates with academic medical centers, it can put smaller bets in a wider range of areas.

Those bets could pay off with enormous advances in the diagnosis and treatment of disease. Our research scientists welcome new and creative collaborations, as we continue our efforts to translate basic science into clinical outcomes that improve health care for all.
After an extensive search that yielded dozens of highly qualified candidates, Weill Cornell has chosen a nationally renowned immunologist and translational medicine pioneer as its next dean. As of January 1, physician-scientist Laurie Glimcher, MD, will serve as Cornell University provost for medical affairs and the Stephen and Suzanne Weiss Dean of the Medical College.

In announcing Glimcher’s hiring in early September, Cornell President David Skorton, MD, called her the ideal choice to lead the institution as it expands its biomedical research enterprise—citing the construction of the new Belfer Research Building and the near-completion of the $1.3 billion Discoveries that Make a Difference Campaign. “I am honored and delighted that Dr. Glimcher has accepted the challenge of guiding our great institution,” Skorton said. “Her passion for accomplishment and her many research and clinical strengths make her ideally suited to build on Tony Gotto’s strong foundation and lead Weill Cornell’s bright future in clinical care, education, and translational research as well as participate at the highest level of Cornell University in fostering excellence in the life sciences.”

Glimcher graduated magna cum laude from Harvard in 1972 and earned her MD cum laude from Harvard Medical School. She went on to join the Harvard faculty, becoming the Irene Heinz Given Professor of Immunology at the Harvard School of Public Health, where she directed the Division of Biological Sciences, and professor of medicine at Harvard Medical School, where she headed one of the world’s leading immunology programs. Her research lab is credited with myriad discoveries including the T-bet transcription factor, which regulates immune functions, and the Schnurri-3 adapter protein, which controls adult bone mass. Board certified in internal medicine and rheumatology, Glimcher is known as a pioneer in partnering with the private sector; she is the longest-standing member of the board of directors of the biopharmaceutical company Bristol-Myers Squibb.

“This is great news for the medical school and for the city,” said Board of Overseers Chairman Sanford Weill. “With her thorough appreciation of the management and financial challenges of complex organizations, I am confident she will lead the college with the same creativity and acumen she demonstrated when she pioneered the establishment of Bristol-Myers’s science and technology committee, which is widely credited for transforming its stake in research.”

Glimcher is a fellow of the American Academy of Arts and Sciences and a member of the Institute of Medicine of the National Academy of Sciences. A past president of the American Association of Immunologists, she has been elected to numerous professional societies including the American Association for the Advancement of Science. She has authored more than 350 scientific articles and chapters, publishing in leading journals such as Science and Nature. At Harvard, her lab used biochemical and genetic approaches to elucidate the molecular pathways that regulate lymphocyte development and activation in the immune system—work that could lead to treatment of autoimmune, infectious, allergic, and malignant diseases. One of her publications, a landmark paper in Cell on the T-bet transcription factor, has been cited more than 1,100 times.

Glimcher has pledged to continue Weill Cornell’s efforts to increase faculty excellence and strengthen research ties to the Ithaca campus, while tapping her experience in working with the private sector to foster partnerships with industry. “I am convinced that Weill Cornell Medical College is perfectly positioned, thanks to the great work of Tony Gotto, Sandy Weill, and the Board of Overseers, to be a leader in academic medicine in this country,” Glimcher said. “I have a clear vision for how that can happen, but I also am excited that the president of Cornell—David Skorton, who is a physician-scientist—the Board of Overseers and the WCMC faculty will work with me to shape that vision. I also look forward to leveraging the enormous strengths in life sciences, the physical sciences, and engineering at Cornell University’s Ithaca campus to raise the bar even higher across the university.”
Dean Gotto Gives Final State of the College Address

Speaking to a standing-room-only audience in Uris Auditorium in late November, outgoing dean Antonio Gotto used his final State of the Medical College address to reflect on his fifteen years in office. Gotto went on to detail Weill Cornell’s growth and progress in a number of arenas, including student admissions, clinical care, biomedical research, and fundraising. He noted that Weill Cornell’s endowment has quadrupled to $1.1 billion, including $45 million endowed for scholarships, and that the Medical College created 122 new faculty endowments, including commitments for sixty-four professorships and forty-six clinical, education, and research scholars. He also outlined positive trends in student recruitment—the mean science GPA for the Class of 2015 is 3.77, tied for highest in Medical College history—and in the number of faculty and staff, which has grown from some 3,000 in 1997 to more than 5,600 today.

At the event, Graduate School Dean David Hajjar presented Gotto with a plaque in his honor; it included the line, “No greater devotion has been exemplified by any provost or dean in the history of this institution.”

Student iPad Tablets Mark Shift to Digital

As of fall semester, instead of receiving printed course notes and texts, all first- and second-year students have been given an iPad 2—making Weill Cornell one of the first medical colleges to make the leap from paper to digital. In addition to sparing students the burden of hauling heavy texts, the tablets will allow them to download course materials, submit electronic course evaluations, access their grades, collaborate with other students, and save their notes and coursework. Jason Korenkiewicz, director of educational computing, noted that “the iPad is also a green alternative, saving about 2 million pages and copies without being any more expensive.”

On the iPad, students can view 3-D molecular models rather than flat photos on a page; images being discussed during training, such as views through a scope, can be transmitted wirelessly to all the tablets in the room. In the future, they could be synched with electronic medical record systems during student clerkships. According to Vinay Patel ’14, who was part of a pilot group that tested the device last spring, some students were initially apprehensive about shifting away from paper—but overall, he says, “the response has been extremely positive.” The iPad initiative echoes the current trend toward electronic record-keeping, which will be the standard in students’ future practice. Says Patel, “With an iPad, it will be easy to keep personal and patient records updated in real-time as you’re meeting with the patient, checking reference information, and even looking up body-scan images on the fly, while making rounds.”

Chervenak Elected to Institute of Medicine

Frank Chervenak, MD, the Given Foundation Professor and chairman of the Department of Obstetrics and Gynecology, has been elected to the Institute of Medicine of the National Academies—one of the highest honors in health and medicine. Chervenak has published more than 260 peer-reviewed papers and co-authored or co-edited twenty-eight textbooks on topics including ultrasound and ethics in ob/gyn. He currently serves as president of the International Society of the Fetus as a Patient and of the World Association of Perinatal Medicine, among other leadership positions.

TIP OF THE CAP TO...

Phyllis August, MD, the Ralph A. Baer Professor of Medical Research, and ob/gyn professor Daniel Skupski, MD, named Outstanding Physicians for Hypertensive Disorders of Pregnancy by the Preeclampsia Foundation.

Charles Bardes, MD, associate dean of admissions and professor of clinical medicine, winner of the Siegel Family Faculty Award, which recognizes a Weill Cornell professor who demonstrates excellence in teaching and research.

Andrew Dannenberg, MD, director of the Weill Cornell Cancer Center and the Henry R. Erle, MD–Roberts Family Professor of Medicine, winner of an award for excellence in cancer prevention research from the American Association for Cancer Research.

Joseph Fins, MD ’86, the E. William Davis Jr., MD, Professor of Medical Ethics, installed as president of the American Society for Bioethics and Humanities.

Incoming Medical College dean Laurie Glimcher, MD, given honorary lifetime membership in the International Cytokine Society, the group’s highest honor.

Dermatologist Marie Jhin, MD ’94, winner of the Entrepreneurial Leadership Award from Asian Women in Business.

Michael Stewart, MD, chairman of the Department of Otolaryngology–Head and Neck Surgery and the E. Darracott Vaughan Jr., MD, Senior Associate Dean for Clinical Affairs, appointed editor-in-chief of the *Laryngoscope.*
Panel Touts Intercampus Collaborations

In October, biomedical sciences professor Robin Davisson, PhD—who holds appointments at both Weill Cornell and Ithaca—moderated a panel discussion on the benefits of collaborations between the two campuses. Speakers at the event, held in Ithaca during the Trustee-Council Annual Meeting, included two Veterinary College professors—Paula Cohen, PhD, associate professor of biomedical sciences and director of Cornell’s intercampus Center for Reproductive Genetics, and molecular microbiologist David Russell, PhD—as well as Weill Cornell’s Anne Moscona, MD, professor of pediatrics and of microbiology and immunology and vice chair for research of pediatrics. The panelists discussed their collaborative efforts, including Moscona’s work with veterinary researchers to study viral infections in dogs and cats—which could shed light on how an animal virus can adapt to infect humans. Efforts to promote cooperation between the two campuses have been stepped up in recent years, with initiatives including startup grant funding for collaborative projects and the establishment of a direct bus service offering work space, Wi-Fi, and power for electronic devices.

FROM THE BENCH

$5.5 million NIH Grant for Spina Bifida Research

Weill Cornell researchers have received a five-year, $5.5 million Transformative Research Project (T-R01) Award from the NIH to fund investigations into risk factors for spina bifida and related congenital defects in which an area of a baby’s spine or brain is not fully enclosed. The project will be led by Margaret Ross, MD ’79, PhD ’82, director of the Laboratory of Neurogenetics and Development and professor and vice chair for research in the Department of Neurology and Neuroscience, and Christopher Mason, PhD, an assistant professor of computational genomics in the Department of Physiology and Biophysics. In collaboration with a colleague at the University of Texas, Austin, they aim to identify which genes are modified by folic acid levels and how those patterns can be used to assess risk for having a child with spina bifida or other serious neural tube defects.

Varicoceles Linked to Lower Testosterone

In the journal BJU International, Weill Cornell physician-scientists report that varicoceles, masses of enlarged and dilated veins in the testicles long known to cause infertility, also interfere with testosterone production. Along with low energy, decreased muscle strength, and sexual problems, says urologist Marc Goldstein, MD, the Matthew P. Hardy Distinguished Professor of Reproductive Medicine, low testosterone is a major risk factor for osteoporosis and can cause cognitive and psychological issues such as depression. However, the researchers found that microsurgery can increase testosterone levels in 70 percent of patients.

Lessons from COURAGE Trial Rarely Applied

In a review of nearly 500,000 cardiac cases nationwide, researchers at NYP/Weill Cornell found that the lessons learned from a major, widely publicized study are not being well implemented. Despite the findings of the Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) trial—that patients should receive a combination of common cardiac drugs such as aspirin and a beta blocker before and after stenting—the researchers reported in JAMA that the number of patients receiving the optimal therapy had increased by less than 3 percent. Says cardiologist William Borden, MD, the Nanette Laitman Clinical Scholar in Public Health: “This snapshot of what is happening in the real world should be a call for physicians, as well as policymakers, to look at how patient care can be improved.”

HIV Emerging in Middle East

Researchers have developed a fluorescent tool that can track the ways in which RNA both sustains human life and contributes to disease. The tool, a green fluorescent protein dubbed “Spinach,” tags cellular RNA, allowing researchers to track it—and gain a deeper understanding of its still-mysterious role. “Scientists used to think that RNA’s function was limited to making proteins and that these proteins alone dictated everything that happened in cells,” says Samie Jaffrey, MD, PhD, an associate professor of pharmacology and the study’s senior author. “But now we are understanding that cells contain many different forms of RNA—and some RNAs influence cell signaling and gene expression without ever being used for synthesizing proteins.”

Protein Plays a Vital Role in Lung Regeneration

A protein known as MMP14 may be crucial for the production of new lung alveoli, the tiny sacs where oxygen exchange takes place. In a study published in Cell, researchers led by Shahin Rafii, MD, the Arthur B. Belfer Professor of Genetic Medicine and co-director of the Ansary Stem Cell Institute, have identified endothelial cells that trigger lung regeneration in mice. The findings may eventually point to a way to induce regeneration in patients with chronic obstructive pulmonary disease (COPD), which currently has no effective therapy.
A Leg Up

Orthopaedic surgeon S. Robert Rozbruch, MD ’90, is a leader in a burgeoning field devoted to lengthening stunted limbs and repairing old injuries.

Nancy Napurski was twenty-five and on a climbing date in the Connecticut Traprocks when the accident happened. Though a novice, she was leading the climb; during the hardest part of the ascent, she somehow lost her grip. “I learned much later that when you fall, you’re supposed to be like Spider-Man and hang onto the cliff as tight as you can, but I jumped away from it,” recalls Napurski, now fifty. “I swung back, and the impact was taken by my left ankle. It dislocated and I was hanging by my rope, terrified and screaming.”

Luckily, two teenagers were being trained in mountain rescue nearby; their instructor came to Napurski’s aid and supervised her removal via litter, since there was nowhere to land a helicopter. She was eventually moved to a hospital in Westchester, where she had surgery. “The next morning, my surgeon said I had a 50 percent chance of walking normally,” she says. “At the time I was playing competitive volleyball, I had been a gymnast, I skied. I was so active, and the news was frightening.”

Napurski eventually resumed normal walking. But over the next two decades she developed painful bone spurs and other complications—including an equinus deformity that required walking on the ball of her foot. Ankle surgery didn’t solve her problems; she was forced to wear either an orthotic insert or high heels. She made the best of it by throwing herself into competitive swing dancing. She earned a bachelor’s degree, began a career in public relations, and eventually moved to Upstate New York to be with her fiancé. By her late forties, she
Talk of the Gown

Attitude adjustment: Napurski’s artist husband decorated her fixator so strangers would be less frightened of the device.

was facing the daunting prospect of having the joint fused when she heard about a program at Hospital for Special Surgery that might offer hope.

Enter S. Robert Rozbruch, MD ’90, an associate professor of clinical orthopaedic surgery at Weill Cornell. Rozbruch is a pioneer in the nascent specialty of limb lengthening and complex reconstruction. Based on techniques developed in Russia after World War II, the field aims to correct the lingering effects of orthopaedic trauma, from shortened limbs due to childhood growth-plate injury to the complications of poorly healed fractures or postsurgical infection. Using external fixators—scaffolds that surround the limb and require tiny daily adjustments to pins inserted through the skin—Rozbruch and his colleagues are able to replace bone, add inches to arms and legs, and restore function almost to pre-injury levels. “This is life-changing for people—that’s part of what’s so exciting for me,” says Rozbruch, president-elect of the hundred-member Limb Lengthening and Reconstruction Society. “You see an adult who had had a fracture as a child; they’re walking around with a leg that’s crooked and short, and they’ve been told by doctors over the years that there’s nothing that can be done, they just have to live with it. And then they find out that it can be repaired; we can straighten the leg, lengthen it, and make it normal. The emotion that people display is fabulous.”

The field’s progenitor was Gavriil Ilizarov, MD, an orthopaedic surgeon in the Siberian city of Kurgan who developed fixators—which the patients could adjust themselves—to treat poorly healed war wounds, using the basic physiological principle that compression facilitates bone healing. “The story goes that he went away for two weeks and left instructions on how to adjust the frame, but the patient turned it the wrong way,” explains Rozbruch. “When he came back two weeks later and took an X-ray, he found the bone was pulled apart—was ‘distracted’—yet there was new bone growing in the gap. That was the beginning of the thought that you could regenerate bone with distraction—and that led to the whole idea of limb lengthening.”

During the Cold War, Ilizarov’s technique didn’t get much exposure in the West; it made its way to Italy in the Eighties, and the first such procedure was performed in the U.S. in 1988. Rozbruch became interested in the field after completing his orthopaedic training in the mid-Nineties; he took a sabbatical from HSS in 1999 to study the technique at the only facility, at the time, with a dedicated limb lengthening service: Sinai Hospital in Baltimore. HSS launched its own program in 2000; it became a dedicated service in 2005, with Rozbruch as chief. In addition to post-trauma repair, he and his team treat patients with conditions such as dwarfism and children with limb discrepancies and deformities related to birth defects and trauma. They also conduct research on a variety of topics, including the development of internal fixators and the basic science of bone healing. “We’re a dynamic group,” he says “We’re asking questions and doing research. We’re training fellows, med students, and residents. It’s an exciting field and this is an exciting time.”

Napurski had her surgery in July 2009—timing it, in part, so she could avoid the slippery sidewalks of a Rochester winter while sporting the fixator. During the procedure, Rozbruch used a technique called ankle distraction, separating the joint and injecting stem cells taken from her hip to promote re-growth of cartilage. “The day after, the pain was terrible,” she recalls. “I had a morphine drip, and it was appropriate. When I had to unlock the fixator and move my joints, I made sure that I was on codeine, but otherwise I was able to manage my pain with Tylenol. Some days were better than others.”

She wore the fixator for twelve weeks, cleaning the pin sites and making adjustments several times daily. “One interesting thing I found is that the fixator scared people,” she recalls. “It’s not that scary when you have it on. But when strangers saw it, it made them afraid.” Her husband is an artist, and he decorated the fixator with whimsical trappings like colorful pipe-cleaners and a clown head. “Suddenly people were attracted to it—they would smile at it and compliment me on my mobile sculpture,” she says. “It was a completely different experience.”

For Napurski, the procedure was a resounding success. As Rozbruch promised, she was “shoe to shoe” in nine months—walking in normal footwear by the following March. While she occasionally gets stiff if she’s been on her feet all day, it’s nothing that can’t be handled with ibuprofen. “I’ve had such a miraculous recovery,” says Napurski, whose testimonial is one of many on the service’s website. “I can stand flat-footed—I hadn’t been able to do that for twenty years. I can balance on one foot at a time. I can walk in heels, flip-flops, and sneakers without any problem. When people see my story online, they often ask, ‘Is it really painful to have the fixator on?’ I tell them, ‘It’s not any more painful than when you broke your leg in the first place.’”

— Beth Saulnier
Bearing Witness

An ethics fellowship brings a student to Auschwitz to confront medicine’s role in the Holocaust

In the research room of Berlin’s House of the Wannsee Conference, fourth-year medical student Stephanie Purisch felt a sense of dread creeping over her as she read documents detailing the crimes of Nazi doctors complicit in the Final Solution. She felt it again, profoundly, on a strangely cold and overcast day in July as she toured the grounds and buildings of Auschwitz-Birkenau, where those atrocities were carried out. The unseasonable weather seemed part of the place, she says, as if that vast campus of death were forever under an evil pall.

Purisch was one of fifty students chosen by the Fellowships at Auschwitz for the Study of Professional Ethics (FASPE) for a two-week program of profound instruction. Founded in 2010, the fellowship uses the Holocaust as a framework for exploring the responsibilities of professionals to maintain ethical standards even in the face of war, social unrest, and personal risk. About a dozen students are chosen from each of four fields: medicine, law, journalism, and religion. This past summer, the 2011 FASPE fellows attended workshops, lectures, and seminars in New York, Berlin, and Poland. “As physicians we’re in a powerful position; people put their lives in our hands and depend on what we say and do,” she says. “The fellowship has definitely helped solidify my commitment to treating my patients as individuals, to making every effort to learn about who they are.”

FASPE is designed to use the history of the Holocaust—when doctors, lawyers, journalists, and even religious leaders collaborated with Nazi authorities to commit systematic crimes against humanity—as a framework for an exploration of contemporary ethics. Purisch studied such issues as the complicity of physicians in establishing and carrying out Nazi policies; the relationship between state authority and medicine; and the role and limits of contemporary bioethics, including physician-assisted suicide. The fellowship’s ultimate goal is to make students aware of the ethical challenges that they will confront in their working lives.

That possibility seems remote to Purisch, a Maryland native and frequent volunteer at Weill Cornell’s Community Clinic who plans to specialize in obstetrics and gynecology. But she is well aware that ethics are a vital part of medicine—and that she may face hurdles she can scarcely imagine. “Ob/gyn is an emotionally and ethically charged field,” she says. “As a doctor I will have obligations to a pregnant mother, a fetus—life itself. I know there will be difficult cases that will test my ability to do the right thing for my patients in life-and-death situations.”

Purisch lauds the medical training she has had so far and says she’s gratified that advocating for patients seems to come naturally to her. But nothing could have prepared her for what she learned about Nazi doctors who performed brutal experiments on prisoners and ushered helpless victims to the gas chamber, lying to them all the way. “I’m Jewish and have extended family who survived the camps, and I thought I knew a lot about the Holocaust,” she says. “But the idea that doctors were so deeply involved in conceiving and orchestrating the Final Solution was new to me.”

It is estimated that at least 350 German physicians—and probably hundreds more—participated in the killing of millions of people under the concept of lebensunwertes Leben, “life unworthy of life.” The genocide began with the idea of purifying the Aryan race through coercive sterilization. It was followed by the killing of “impaired” children, then adults in mental hospitals. In Auschwitz-Birkenau alone, an estimated 1.1 million people perished, 90 percent of them Jews.

Purisch was sickened to learn how doctors—people sworn to do no harm—steril-
Dietary Detectives

Researchers in Doha and Ithaca team up to study food-borne illness in Qatar

Qatar is seeing an era of remarkable growth. Between the 2004 and 2010 censuses, its population rose from about 775,000 to 1.7 million, mainly due to an influx of expatriate workers from around the globe. The nation is taking an increasing role on the world stage, is hosting the FIFA World Cup soccer competition in 2022, and is in the running to host the 2020 Summer Olympics.

Under a three-year, $1 million grant from the Qatar Foundation, two researchers are tackling a little-heralded subject—food safety—that is becoming increasingly vital as the nation grows. The project brings together a pair of Cornell scientists working on opposite sides of the globe: Ali Sultan, PhD, an associate professor of microbiology and immunology at WCMC-Q, and Hussni Mohammed, PhD, an epidemiologist in the College of Veterinary Medicine on the Ithaca campus. "The idea is to look at the food chain from farm to fork," says Sultan. "This is the first study in Qatar to look in such a meticulous, scientifically detailed way at the food chain, define any sources of contamination, and come up with a risk-assessment model."

According to figures from Qatar’s Department of Public Health, incidents of food-borne illness are on the rise; about 1,600 cases were reported in 2007, Sultan says, compared with fewer than 200 in 2004. "The increase could probably be attributed to many factors," he says. "It might be because of the rapid rise in population, the increased practice of reporting incidents, or the opening of new food outlets." In any given case of food poisoning, the researchers note, it can be hard to track down the source, due to such factors as the ease of cross-contamination. "If you bring home contaminated meat and cut it up, you can contaminate the kitchen," Mohammed says. "So after you cook it, although you killed the pathogen in the meat, it is still living in the surrounding environment."

The researchers are focusing on four of the most common pathogens implicated in food-borne illness: E. coli, Salmonella, Campylobacter, and Listeria monocytogenes. They’re taking samples from such sites as dairy operations, milk processing plants, abattoirs, restaurants, and food suppliers, as well as analyzing strains isolated from food poisoning cases at Hamad Medical Corporation, the medical center affiliated with WCMC-Q. Other collaborators in Qatar include the Department of Public Health Supreme Council of Health and the Department of Animal Resources. "Our preliminary studies show that these four pathogens are prevalent in the food animal sources and among human cases with gastroenteritis," Mohammed reports. "On completion of the investigations, we hope to shed light on how these patients contracted the infections in the hope of making recommendations to mitigate risk."

The researchers note that although food-borne illness was once seen as a localized issue, nowadays—with people and products becoming increasingly mobile—it is a matter of international concern. "Our goal is to help the public, to preserve health in general," Mohammed says. "Although we’re working in Qatar, the world is getting smaller and smaller—so the issues become global."

— Beth Saulnier
Music Men
Longtime pals pen and perform a parody on modern medicine

The song is sung to the tune of “Be Our Guest” from Beauty and the Beast. But it has a new title: “Have a Test.”

You’ll feel lots more healthy
We’ll be lots more wealthy
Be our guest! Have a test! Have a test!

In their cabaret show Damaged Care, Greg LaGana, MD ’71, and Barry Levy, MD ’71, offer a witty musical take on the modern health-care system—from the promise and pitfalls of technology to the role of business in medicine. The satirical “Spare Parts Blues,” with original music by Brad Ross, contemplates the promise of cloned pig organs sold on eBay; “Send in the Dogs” (complete with Levy in canine costume) spoofs the rise of pet therapy. One of the most popular parodies is the heartfelt “No Time”; sung to “Somewhere” from West Side Story, it laments the harried life of the physician:

A chocolate bar and fries
No lunch, no exercise
There’s no time left to heal myself…
Someday, when we are retired,
Maybe then we’ll be inspired…
to take time

“I’ve had physicians tell me they cried after they heard that song,” says LaGana. “It’s a modern dilemma in health care.”

Damaged Care evolved from the class shows that LaGana and Levy produced as students; after meeting on the second day of med school, says Levy, “we realized we were kindred spirits.” Both went on to train in internal medicine; the New Jersey-based LaGana shifted to volunteer teaching after retiring from active practice, while Levy is a Boston-area specialist in occupational and environmental medicine and public health. After taking musical theater courses at the New School in the mid-Nineties, the pair pledged to write a class show for their 25th Reunion. Facing a deadline, they holed up for the weekend with pizza and a laptop—and quickly realized a large-scale production would be impossible to rehearse. “I said, ‘I think this is a two-man show,’” LaGana recalls. “And Barry said, ‘But I don’t sing.’ And I said, ‘Well, you do now.’ ”

They structured the show around two contrasting characters: LaGana plays an old-school workaholic who cares deeply for his patients but neglects himself, while Levy is comically fixated on technology as a boon not only to human health but his own bottom line. In the end, the characters embrace a middle ground. “The ideal physician,” Levy concludes, “might be someone who is entrepreneurial but retains the human touch in the face of the technology and time limitations.” Both share anecdotes from real life: LaGana recalls a caring doctor who made a house call to treat his childhood asthma attack, while Levy describes a story that he grew up with: “When my Uncle Lou delivered me, he turned to my mother and said, ‘It’s a doctor.’ ”

LaGana and Levy have performed the forty-five-minute show more than 120 times nationwide—not only at their 25th Reunion but their 35th as well. They have mounted Damaged Care for Weill Cornell students, medical societies, health systems, hospital associations, and numerous other audiences; it has been featured in such media as the New York Times, CNN Headline News, and ABC’s “Nightline.”

While the two have contemplated licensing the show so it can be performed more widely, LaGana says that “it seems to have a lot more credibility, impact, and resonance when it’s performed by physicians.” They’ve recorded a CD and DVD and—in the tradition of satirical productions like Forbidden Broadway—regularly update the show with new material. “The problem is trying to stay ahead of the rapid changes in medicine,” LaGana says. Adds Levy: “Some years ago we wrote songs about medical tourism and about writing prescriptions over the Internet. These have become mainstream. Now, we have parodies about the health-care policy that covers nothing and hospitals telling low-income patients, ‘Go away, you’re sick!’ ”

— Beth Saulnier

Let’s put on a show: Barry Levy, MD ’71 (left), and Greg LaGana, MD ’71, created and star in the musical revue Damaged Care.
The man had survived testicular cancer in his twenties, but a decade later he was facing a different kind of crisis: infertility. “Having children was critically important to him and his wife,” recalls Peter Schlegel, MD, professor and chairman of urology and professor of reproductive medicine at Weill Cornell. Because of his cancer’s advanced state, the patient had been rushed into chemotherapy without being offered the option of banking his sperm; now he’d been diagnosed as infertile. But thanks to a technique developed and refined at Weill Cornell, there was hope that he—as well as others who lack sperm in their semen for a variety of reasons—could conceive with their own DNA. “Until fifteen years ago, this was an untreatable medical problem,” Schlegel says. “This is a completely new avenue of treatment that most people didn’t think was feasible.”

The success of microTESE depends on the cause of a man’s azoospermia, the medical term for absence of sperm in the ejaculate. Overall, Schlegel and his team are able to retrieve sperm from 60 percent of men. Those retrievals lead to pregnancies nearly half the time, usually resulting in live births; random biopsies allow sperm to be found only half to two-thirds as often as microTESE does.

Schlegel stresses that the technique is sorely needed. About 1 percent of men have no sperm in their ejaculate, and the problem affects two-thirds of those who are treated for cancer. Despite awareness of the side effects of chemotherapy on fertility, only about a third of men bank their sperm before treatment, Schlegel says. And while prepubescent boys who are treated for cancer may ultimately be able to produce sperm and conceive naturally, sperm-preservation techniques for that age group are still experimental, involving removing testicular tissue and freezing it for future grafting. Other causes of azoospermia include undescended testicles, hormonal problems, and genetic conditions such as Klinefelter’s syndrome (in which men have an extra X chromosome) or deletions of certain areas on the Y chromosome. “Some of those men, depending on the location or type of deletion, will have sperm, and some will have zero chance of sperm,” Schlegel says. “We can quantify the chance of retrieval based on the cause.”

The first published report of the microdissection procedure was in 1999. Schlegel and his colleagues published the results of microTESE among seventeen male cancer survivors in 2001, finding it successful in 43 percent of them. After trying microTESE among fifty-six more survivors, they updated their findings in March 2011 in the Journal of Clinical Oncology. Retrieval rates ranged from 85 percent among men treated for testicular
Making Accommodations

A Muslim doctor explores how medicine can honor faith-based requirements for physical modesty

Tim Padela, MD ’05, was a fourth-year medical student when the legal battle over Terri Schiavo’s life made national headlines. Schiavo had been in a persistent vegetative state since 1990; her husband was seeking to respect her prior wishes by having her feeding tube removed. As the case sparked ethical debates around the country, Padela found himself called upon to provide a unique perspective. “Because I was a Muslim medical student, all of a sudden people expected me to know what the guidelines of my faith would be,” Padela recalls. “I was supposed to be an expert in Muslim health-care behavior: ‘What does Islam say about feeding tubes at the end of life?’ Having my feet in both cultures—not only being a medical practitioner, but being of the Muslim faith—I should be able to speak to both communities.”

Today, such questions are at the center of Padela’s professional life. In addition to being board-certified in emergency medicine, Padela has done extensive research at the intersection of medicine and Islam. As a Robert Wood Johnson Clinical Scholar at the University of Michigan, Padela studied health-care disparities in Muslim and Arab-American populations and ways in which hospitals and physicians can accommodate the cultural needs of such patients; he has also served as a fellow with the Institute for Social Policy & Understanding, an American Muslim think-tank, working to reduce cultural barriers to clinical care for Muslim patients. This summer, he joined the faculty at the University of Chicago’s MacLean Center for Clinical Medical Ethics as well as its newly established Program in Medicine and Religion. "My interest is in how patients are treated by physicians and the health-care system," says Padela. "Using the Muslim patient experience as a lens to look at these larger issues around health-care disparities and cultural accommodation seemed like a natural fit."

Born in New York to Pakistani parents, Padela spent part of his childhood in Pakistan; he has also lived in Egypt, where he studied Arabic and Islamic law. A double major in biomedical engineering and Arabic language and literature at the University of Rochester,
are not just a matter of discomfort or personal Muslim of the same gender. The third prefer-
is not possible, the second best is a non-
woman,” Rodriguez del Pozo notes. “If that
sex—a man by a man or a woman by a
male relative, she’s wearing a Muslim
headscarf and refuses to remove her clothes or don an
exam gown. When the male
physician tries to introduce himself, she asks, “Are there
any woman doctors around?”
The paper goes on to
explore the various Islamic
rules surrounding modesty and
gender interaction that can
affect medical treatment; they
include the prohibition against
an unrelated woman and man
being alone together, physical
contact between the genders, or
uncovering certain body parts,
such as a woman’s hair. “There
is a preference that, ideally, a
patient should be treated by a
Muslim physician of the same
sex—a man by a man or a woman by a
woman,” Rodriguez del Pozo notes. “If that
is not possible, the second best is a non-
Muslim of the same gender. The third prefer-
ence is by religion again. And in last place, a
non-Muslim of the opposite sex.” He notes
that among observant Muslims, such issues
aren’t just a matter of discomfort or personal preference. “In Islamic traditions,” he says,
“these are commands.”
As Padela has found in his research,
including focus groups he has conducted
with Muslim Americans, lack of accomi-
dation for modesty rules can have marked
effects on health outcomes. “Studies have
shown that Muslim women in Michigan
change their health-care-seeking habits
based on accommodations of these sorts of things,” he says. “Many women might delay
seeing an ob/gyn because they’re trying to
find a female doctor. There are low rates of
screening for breast, cervical, and colorectal
cancer in South Asian Americans, because of
feeling uncomfortable uncovering their gen-
italia in front of someone else.”

While all health-care institutions operate
under resource constraints—and it isn’t
always possible to offer a same-gender
provider—the researchers say that such
issues can often be ameliorated through
communication and minor adjustments.
For example, a patient can be allowed to
wear his or her own clothes, or a more
modest robe, rather than a revealing hospi-
tal gown, and uncover only those body
parts that are clinically necessary for exam-
ation. “Here in Doha, a male doctor or
student does not go in to see a female
patient unless he has first asked a female
nurse, doctor, or classmate to inquire if the
patient minds being seen by a male,”
Rodriguez del Pozo notes. “It’s not the law,
but it’s the custom of the place. My stu-
dents have to learn it very early on: you
don’t go into a room without asking.”

To avoid breaking the prohibition
against being fully alone with a member of
the opposite sex, physicians can use a pri-
vacy curtain instead of closing the exam
room door. As in the resolution to the
paper’s theoretical case, strictures against
touching can be satisfied if the physical
exam is conducted by a female nurse prac-
titioner while the male physician observes,
or even if he simply dons gloves to avoid
skin-to-skin contact. “The recommenda-
tions are common sense, and they’re very
simple,” says Rodriguez del Pozo, who
notes that such guidelines can also apply
to treatment of observant Jews and mem-
bers of other faiths that require modesty.
“As in every doctor-patient interaction, it’s
all about fostering trust. A simple gesture
can go a long way.”

And conversely, Padela stresses, negative
interactions can have lasting consequences.
“Patients will talk to me about being in a
nursing home after a stroke, and what they
remember most was being bathed by a per-
son of the opposite sex—for them, that was
d a daily humiliation,” he says. “Or a Muslim
female who comes to the ED with vaginal
bleeding, and all she’s told is, ‘We can’t assign a wo-
man to take care of you.’ That can have lasting
effects on whether they go to a health-care provider
next time—and the real issue is how they felt they
were treated. People may
not mind that they couldn’t
find an accommodation so much as the way it
was delivered.”

Instead of dismissing a patient’s concerns for the
sake of expediting treat-
ment, Padela says, pro-
viders can often bridge the
gap by assuring patients
that they respect their cus-
"Sabbath elevators for observant Jews. “In
modesty. As in many other instances, that’s
simply good medicine.” Padela points out
that medicine has a long tradition of
accommodating religious requirements—
from the development of bloodless surgery
for Jehovah’s Witnesses to the use of
Sabbath elevators for observant Jews. “In
our medical encounters, we’re playing the
role of doctor, no matter where we come
from,” he says. “Whatever I can do to make
the patient experience better, as long as it
doesn’t compromise my own values, I will
try to do.”

— Beth Saulnier
Karen Gonta has a vision of medical information without borders. “Once we’re able to share electronic data across the entire system and put an end to the fragmentation of information, we’ll transform health care as we know it,” says Gonta, a caseworker at an Ithaca-based mental health clinic. “We stand to learn a lot about what’s working and what isn’t, and to compare newer treatments with standard ones.”

Now in its second year, the Weill Cornell Health Information Technology Certificate Program is training professionals like Gonta for careers at the nexus of health care and IT. The six-month program is a collaboration between the Weill Cornell Graduate School of Medical Sciences and Columbia University’s Department of Biomedical Informatics. Faculty on the two campuses collaborate to develop shared educational materials, but admit and train separate classes of students. In early 2010, it was one of nine programs nationwide to receive a federal health IT stimulus grant to establish one of these advanced training programs.

“Electronic health records offer much more than just the electronic storage of patient data,” says Rainu Kaushal, MD, MPH, the program co-director and the director of the Center for Healthcare Informatics and Policy at Weill Cornell. “They have the ability to potentially transform care by making sure the right thing is done for the right patient at the right time in more efficient ways.”

To accelerate the conversion from paper to electronic records, the federal government is offering monetary incentives to health-care providers and hospitals that can demonstrate that they have purchased EHR software and are using it effectively and appropriately. At the same time, Ancker says, EHRs must be designed to match the needs of real-world clinical care—needs that vary with specialty, geography, and patient population, among other factors. “When you consider the many components of patient care—hospitals, pharmacies, insurance plans, public health departments, and thousands of private medical practices scattered across the country—you begin to get a sense of the complexity of our health-care system,” Ancker says. “Without rigorous training in the specific needs and parameters of health care, even the most sophisticated IT specialist could get lost in the labyrinth.”

The Weill Cornell program offers a rigorous curriculum with a mix of health informatics theory, pragmatic application...
of that theory, and team-based collaboration on multidisciplinary projects. Students become versed in the legal and financial dimensions of EHR technology, along with the policy implications of the national push to connect all the elements of the health-care system through technology. Online lectures cover topics as diverse as the culture and politics of health care, data-sharing and security, reporting requirements, and project management.

The program also includes facilitated teamwork with experts in academia and industry; one Saturday per month, students convene in either New York City or Ithaca for intensive collaboration on a project, with the two groups teleconferenced together. “For example, we might present them with an EHR that has weaknesses and challenge them to think through a variety of solutions to the problem,” Ancker says. “In a small-group environment, they’ll decide whether the system needs to be modified, overhauled entirely, or replaced with another type of software. They also learn to enter data, requiring them to get down to the granular level around the codes pertaining to particular medical conditions, and retrieve data that might be useful for quality reporting or public health.”

The Weill Cornell program graduated twenty-six students last summer, with a new class set to finish in March 2012. They include physicians, nurses, other health professionals, and administrators, along with IT specialists seeking new careers in health care—one of the fastest growing fields even in this sluggish economy, according to the Bureau of Labor Statistics. An estimated 55,000 new health IT jobs are expected to be created in the next five years, industry analysts say, spanning such diverse positions as quality assurance engineer, EHR software trainer, and clinical analyst.

Ancker stresses that students don’t need to be tech wizards to do well in the program and gain the necessary skills to succeed on the job. Recent graduate Mary Koval, a registered nurse who manages the clinical quality program for the Weill Cornell physician organization, confesses that she used to find computers intimidating. “I’ve been involved in quality management for more than fifteen years,” she says. “When I started, we used manual chart reviews to assess quality of care. I didn’t know whether I’d take to the technology when I entered the program—but it quickly became second nature for me.”

— Margaret Crane

Blind Faith

With a radical new prosthetic retina, Sheila Nirenberg, PhD, aims to help millions with degenerative eye disease

Some ten million Americans have degenerative retinal disease; of those, 1.9 million suffer from advanced-stage blindness. Historically, there has been little that doctors can do. Medications help only a small subset of patients—and then just slightly improve vision or slow the disease’s progress. So far, prosthetic retinas

Sheila Nirenberg, PhD
have had limited appeal: they reveal high-contrast edges and spots of light, allowing people to orient themselves within spaces they already know but hardly approximating normal vision. But now an experimental, next-generation artificial retina developed by Sheila Nirenberg, PhD—associate professor of computational neuroscience in the HRH Prince Alwaleed Bin Talal Bin Abdulaziz Alsaud Institute for Computational Biomedicine and in the Department of Physiology and Biophysics—is currently in the animal testing phase and showing great promise, producing images so sharp and subtle that they closely resemble what a fully sighted person would see.

In healthy eyes, the retina serves as the entryway for visual information to travel to the brain. At its front end, photoreceptors pick up patterns of light and dark. In the middle, complicated circuitry extracts information from those patterns, “converting it into a code the brain can read,” Nirenberg explains. From there, the retina’s ganglion cells send that neural code to the brain in the form of electrical signals called spikes. Any image can be converted into its own corresponding code, or pattern of spikes, using a set of mathematical equations.

Existing artificial retinas, which have been around for about two decades, have tried to replicate the work of the photoreceptors with surgically implanted, light-receiving electrodes. But without incorporating the neural code to decipher what’s in front of the eye, Nirenberg says, “they’re very limited—it’s nothing close to normal vision.” She and postdoc Chethan Pandarinath, who earned a PhD in Nirenberg’s lab, have taken a different, two-pronged tack: a device that processes the code plus gene therapy that activates the ganglion cells.

Surgically implanted electrodes are not the main focus of Nirenberg’s design. Instead, a patient would receive gene therapy that makes the ganglion cells—which are typically spared by retinal diseases—express a light-sensitive protein called channelrhodopsin. “Surgery won’t need to be involved,” Nirenberg says, “just a quick injection into the eye.” About three weeks later, after the therapy has taken hold, a patient would don glasses containing a camera and a chip (similar to the microprocessors inside cellphones) that processes the code. The camera “sees” the images and sends them to the chip, which converts them to light pulses. Those pulses are actually image-specific neural code, and they activate the light-sensitive channelrhodopsin in the ganglion cells. In so doing, the cells can fire the right code to the brain so the patient can see. “Other people have also used this light-sensitive gene, but they don’t have the retina’s code, which is our key ingredient,” Nirenberg notes. “We’ve brought it back to life so it can fire like a normal retina.”

Until she began testing the artificial retina, Nirenberg’s focus was largely on basic science, focusing on two fundamental conceptual challenges in neuroscience: understanding the neural code and determining how populations of retinal neurons work together to encode scenes such as faces and landscapes. In 2009, one of her students mentioned improvements in channelrhodopsin technology—and Nirenberg had a eureka moment. “I thought, Wow, now we can put our knowledge of the code with channelrhodopsin and this will work,” she remembers. “I almost fell off my chair. I realized I knew exactly how to make a prosthetic.”

When Nirenberg and Pandarinath tested the concept in mice later that year, it worked as anticipated. In findings she presented at last year’s Society for Neuroscience meeting, Nirenberg showed that the retinas of completely blind mice were able to produce normal firing patterns and animals treated with the technology could discern moving images. The results led to a $250,000 prize from the BioAccelerate NYC contest to develop the technology for commercial use. Nirenberg plans to collaborate with scientists from Harvard, the University of Florida, and a German company to develop it for monkeys—and, ultimately, people. “It’s exciting to know that what you’ve been working on suddenly has human value,” Nirenberg says of her shift from basic science to clinical applications, “especially as the years go by and you realize you need to do something for people, not just because it’s intellectually interesting.” Tests of the retina in monkeys have begun, and if all goes well, it could be on the market within five years, Nirenberg says. The coding aspect of the technology could also be used to drive the electrodes in patients with older prosthetic retinas.

If the device sounds like science fiction, Nirenberg says, its results would be unmistakably real to the people who receive it. She admits that patients wearing the glasses might “look sort of dorky.” But the ultimate hope, she says, is that “they’d be able to see—see patterned images, see faces, walk through the supermarket and pick out a box of cereal, recognize their children.”

— Jordan Lite
At the end of December, Antonio M. Gotto Jr., MD, DPhil, steps down after fifteen years as dean of the Medical College. The decade and a half since Dean Gotto took office have been transformative years for Weill Cornell—physically, financially, academically, and scientifically. During his tenure, the Medical College has seen an overhaul of its curriculum; record-setting fundraising campaigns; a renaming in honor of foremost benefactors Joan and Sanford Weill; the establishment of the Qatar campus and of a medical school in Tanzania; affiliation with the Methodist Hospital in Houston; and the development of state-of-the-art facilities including the Weill Greenberg Center and the Belfer Research Building, which will double the institution’s lab space when it’s completed in 2014.

Gotto was born in Nashville, the son of a schoolteacher and a publishing company employee. He earned his undergraduate degree in chemistry from Vanderbilt University with minors in English and math. As a Rhodes Scholar, he earned a doctorate in biochemistry from Oxford under Sir Hans Kornberg, PhD, and Nobel laureate Sir Hans Krebs, MD, before returning to Vanderbilt for his MD. An expert in lipid science whose work helped establish statins as a standard of cardiac care, Gotto came to Weill Cornell from Houston’s Baylor College of Medicine and Methodist Hospital, where he served as chairman of medicine for two decades. He and his wife, Anita, have been married for fifty-two years; they have three daughters and five grandchildren. After retiring as dean, Gotto will remain on the faculty, continue his research, and serve as a Cornell University vice president and as co-chairman of the Weill Cornell Medical College Board of Overseers.

This fall, Dean Gotto sat down for a conversation with Weill Cornell Medicine, offering thoughts on such varied topics as his legacy, the landmark Weill gift, the relationship between the Medical College and the Ithaca campus, his yen for spy novels—and what he hopes the New York Times will leave out of his obituary.
As dean and provost for medical affairs, Tony Gatto has advanced clinical care, research, education, and outreach, including major global health initiatives. He has helped bring significant new resources to the College, recruited outstanding new faculty, and developed and renovated clinical and research space. He was a driving force behind the construction of our new Belfer Research Building. And he expanded the College’s mission globally, with the establishment of Weill Cornell Medical College in Qatar.

He is also a superb role model for our students. A world leader in atherosclerosis research, he has shown enormous dedication to the public good, disseminating information about cardiovascular disease to the general public as well as to the medical profession. And he has led Weill Cornell to greater contributions in global health, advancing our efforts in Doha, at Weill Bugando Medical Centre in Tanzania, and in Haiti, Brazil, and elsewhere.

I’m delighted that Tony has agreed to stay on for three years as University vice president and co-chair of the Board of Overseers. His leadership will be invaluable.

David Skorton, MD
President, Cornell University

Although Dr. Gatto and I were in Houston at the same time, we did not know each other then. However, before coming to Weill Cornell, I heard a great deal about him—all positive—and it has all proven true. What I have learned since is that he has a remarkable knack for pushing things forward, even though people don’t always realize they are being (gently) pushed. He was missed a great deal when he left Baylor and Methodist, and he will be missed here as well.

Michael Stewart, MD
Professor and chairman, Department of Otolaryngology–Head & Neck Surgery
E. Darracott Vaughan, MD, Senior Associate Dean for Clinical Affairs

Weill Cornell Medicine: What do you find most gratifying about academic medicine?

Antonio Gatto: There’s excitement in discovery, but also in passing on knowledge to the next generation—seeing them stimulated in intellectual curiosity, which they will apply whether they’re doing research or practicing medicine. It’s our intention that our students have inquiring minds, and in practice they will continue the process of learning; by being curious they’ll find things that help their patients.

WCM: How was your medical school experience different from that of today’s students?

How have you seen medical education evolve?

AG: It was based very much on a large lecture approach, and there are fewer lectures today. Our new curriculum, when it was introduced fifteen years ago, moved away from that and toward small-group, problem-based learning. Now we’re in the process of changing again, toward competency training—letting people move at different paces. Another difference is that for residents and students there are limited hours. There weren’t any regulations like that; you could be on as long as you had to be on. This has obvious disadvantages of fatigue, but there’s an advantage in the continuity and the experience that you get. When I was a student at Vanderbilt, the only way an intern could get a vacation was to get a medical student to fill in. It was good clinical experience for students, but you can’t do that today without breaking some regulations.

WCM: Why is medicine still a gratifying career for young people to go into? One hears about physicians telling their kids, “Don’t go into medicine, it’s managed care, it’s not the same.”

AG: Medicine enables you to help people, and at the same time you’re learning new things, which goes on throughout your career. You have curiosity about discovery—whether it’s in the laboratory, in the clinic, or just observing your patients. I think that combination will continue to stimulate the best and the brightest to go into medicine, even with all of the restrictions and various negative things that you may hear about it.

WCM: Is it true that you originally wanted to be a lawyer?

AG: It’s true. I was on the debating and forensics teams in school and at Vanderbilt, so I thought the legal profession and politics would naturally follow. My father did not have a high regard for lawyers, so after discussions with him, I decided I would pursue medicine instead. I thought about engineering and other possibilities, but I felt that medicine would be more interesting and challenging. Growing up, I was a great fan of Sherlock Holmes; I read all of his stories and got interested in using chemistry and other techniques to solve crimes—which is not that different from using chemistry to solve medical mysteries.

WCM: At Oxford, you worked under the legendary biochemist Hans Krebs, who won the Nobel Prize for discovering the citric acid cycle known as the Krebs Cycle. What was that like?

AG: My direct supervisor was [the eminent biochemist] Sir Hans Kornberg; Sir Hans Krebs was the professor and my internal examiner. Professor Krebs was very Germanic. Every morning he would come by and say, “Vat are you doing?” and I would explain to him what I was doing. During the course of my research, which was to determine how microorganisms grew on a particular two-carbon compound, I discovered a new enzyme and managed to crystallize it. After convincing myself these were real crystals by repeating it several times, I got up in the middle of the night and made fresh preparation, which were beautiful structures, and set up a phase-contrast microscope. So when Professor Krebs came in sharply at eight, he asked me the usual question and I said, “I have something I’d like to show you.” He looked it at and said, “Satisfactory, quite satisfactory.” Kornberg, who was my tutor, asked, “What did the professor say?” I said, “I don’t think he was too impressed. He said, ‘Quite satisfactory.’ ” Kornberg said, “When I discovered the glyoxylate cycle, he only said ‘Satisfactory’—so that’s the highest praise you’ll ever get.”

WCM: What excited you about lipid science? Why did you devote your research career to that field?

AG: One reason is it offered the opportunity to study a disease at a basic science level and also at a clinical level, to treat patients. Number two, lipids play a central role in cardiovascular disease, which is our major killer. It’s been gratifying to see the development of statin drugs, which
White coat to black tie: Gotto accepts the Greenberg Award in May 2010.

have been so effective not only in reducing cholesterol and modifying lipids, but also in treating and preventing disease.

WCM: Because you were involved in some of the major trials that demonstrated that efficacy, you have helped prolong millions of lives, which is something that your average physician can’t say. How does that feel?

AG: I believe I’ve made some contribution to the field, but there are a lot of others also. It feels good to be working on something that has turned out to be so beneficial. It’s not as if after ten years they found out the drugs cause cancer or cause people to go blind—both of which were feared at the time.

WCM: So in the early days, it was feared that statins could be dangerous?

AG: It was thought that if you interfered with cholesterol or metabolism you were likely to cause some bad effects. In 1989, an investigative reporter named Thomas Moore wrote an article in the Atlantic called “The Cholesterol Myth” that said lowering your cholesterol won’t make you live any longer and may cause you harm. Much of what he claimed turned out to be incorrect. Lowering cholesterol doesn’t cause cancer, can be treated with drugs, and does prolong life. He claimed the “cholesterol myth” was part of a giant conspiracy concocted by scientists in NIH who wanted more government funding, as well as by pharmaceutical companies, the American Heart Association, and the American College of Cardiology—and that this whole conspiracy was masterminded by a small group of academics that he called the Cholesterol Mafia. My name was Antonio Gotto, so I was not surprised to be included.

WCM: Have you been able to keep up with your research, with the demands of your job as dean?

AG: To a limited extent. I had a large specialized center of research for atherosclerosis the entire time I was in Houston. I maintain some research collaboration and involvement in

What is the secret to Tony Gotto’s uncanny ability to recruit so effectively and to surround himself with such remarkable talent? It’s quite simple. (His absolute integrity, fairness, and values go without saying.) Once Tony develops confidence in a faculty member, he lets him or her “fly.” He guides, mentors, and remedies by nudging, not brow-beating. He frees his faculty to blossom and meet their potential. Micromanagement is not in his vocabulary.

So, in my opinion, Tony Gotto’s most important contribution to our Medical College has been not so much the magnificent clinical and research buildings that have revitalized an aging campus, not his infusion of a Texas-style “can do” attitude toward fundraising, nor his ability to bring meaningful stability to this academic medical center during a period of external turbulence. Of course, those are all important and they will be remembered. But his most important contribution to WCMC has been his legacy of academic and clinical excellence in an environment that nurtures individual creativity within a vibrant community of collective scholarship.

Andrew Schafer, MD
Chairman, Department of Medicine
E. Hugh Luckey Distinguished Professor

I have always been amazed at how Tony can not just master arcane, but can turn around and use this information effectively. Here is but one example: At one time, to construct the Belfer Research Building, the Medical College was going to amend the ZLDA by going through ULURP to extend the LSCFP. In the end, we decided to go directly to BSA to get the required FAR.

Now, Dr. Gotto, being a busy guy, could not possibly have heard these arcane real estate terms more than once. Nonetheless, he stood up in front of a group of donors (many of whom were in the real estate business) and, in response to a question about zoning, delivered a completely cogent and amazingly accurate summary of the college’s process, using every term with precision!

Stephen Cohen
Executive Vice Provost
I met Dean Gotto many years ago when he presented his “State of the Medical College” address to the Alumni Association board. I was impressed that the dean took the time out of his busy schedule to address a group of alumni with a detailed and well-thought-out presentation. I cannot overstate the goodwill it created. It made alumni in general, and the board in particular, feel relevant to the Medical College and the students. Many programs have been started and expanded under his watch, including the Stethoscope Initiative, Alumni to Student Knowledge program, and the Dean’s Circle, which now boasts more than 162 members. Dean Gotto is affable and self-effacing, exemplified by his recounting of the newspaper report of his hiring as, “Famous cookbook author hired as dean of Cornell Medical College.”

Michael Alexiades, MD ’83
President, WCMC Alumni Association

Dr. Gotto and I have worked closely together on fundraising for Weill Cornell. We have had some tremendous successes, a few surprises, and some disappointments. Human nature being what it is, we have also had some laughs. He has been a superb fundraiser for several reasons: he has been dean at the right time, at the right institution, and with the right leadership. Weill Cornell’s mission and its location in New York City have been catalysts for support, and the leadership of our Medical College is outstanding. He has built thoughtful and productive collaborations with Cornell University and with NewYork-Presbyterian Hospital. He has encouraged, and put his trust in, a skilled development team.

I believe, however, that the real key to his success lies in his character. I’m no expert, but I spend a lot of time around powerful and successful people. Among august types such as these, Dr. Gotto stands out. He is a man of great integrity, passion, and grace. He also has natural kindness and humility, attributes that cannot be taught. He approaches donors as valued friends—and when gifts come in, he is as happy for the donor as he is for Weill Cornell, because he knows that a special bond has been created.

Larry Schafer
Vice Provost for Development

Global vision: Gotto with Tanzanian President Jakaya Kikwete in April 2010

clinical trials, but to a much lesser degree. I do think that it’s a good idea for administrators to maintain contact with their roots.

WCM: Have you been able to keep a hand in patient care?
AG: Yes, I still see consultations.

WCM: How has that informed your work as dean?
AG: You see the move from paper records to the electronic medical record, you see more regulations, reporting requirements, and red tape. This allows you to experience the problems the practicing physician is facing.

WCM: How did you come to be recruited to Weill Cornell in the first place?
AG: After I’d been at NIH for about three years, I started getting offers from medical schools and universities. In 1970, I received an offer from Cornell for an endowed professorship in cardiology. After several visits, I ended up going to Texas. At that time, we had three young children and thought Houston would be a good place to rear them; our oldest daughter had been diagnosed with juvenile diabetes, which requires a lot of attention. While Cornell had a long and excellent history, Baylor was a newer medical college; it had a frontier spirit and seemed to offer opportunities to build programs. Seven or eight years later, I was invited back to look at the chairmanship of medicine, but I wound up staying in Texas. Then when Dr. Gordon Douglas retired as chairman, I came for another visit. So that was the third attempt to recruit me. And finally the fourth time…

WCM: So we had to woo you four times before you said yes?
AG: Four times before I left Texas, yes.

WCM: Was it hard for a Southern gentleman to move to New York?
AG: I had been chair of medicine for twenty years at Baylor and Methodist Hospital, and
hand. We’ve been joined at the hip since 1927, after Payne Whitney bought this property.

WCM: In a nutshell, what’s special about Weill Cornell?
AG: The collegiality of the faculty. It’s small enough that people get to know their peers quite well. It has a nurturing atmosphere toward students, faculty, staff, and patients. It has a reputation as a good place to work and a good place to be. It has an enthusiastic board that has been enormously generous, and a supportive university board and president in Ithaca.

WCM: What did the Weills’ landmark gift mean to the institution?
AG: It had a transforming effect, because it triggered a series of successful philanthropic campaigns, including one of the largest fundraising campaigns any medical school has ever carried off.

WCM: How has the college evolved during your tenure?
AG: When I came, it had a reputation for high-quality clinical work and education, but it had a small research platform and not much research space. It was financially strapped. We had not had a large fundraising campaign in some time. Our activities were restricted here in Manhattan; we’d had an affiliation with North Shore University Hospital, but that had been terminated. And so we had to develop a series of teaching sites in the NewYork-Presbyterian/Weill Cornell network, at affiliated hospitals that hadn’t been used much for teaching. We’ve moved to a much greater extent on the international scene, as well as nationally with an affiliation with the Methodist Hospital in Houston. We also started a series of fundraising campaigns, each targeted toward specific projects—scientific and clinical objectives or capital projects, such as the Weill Greenberg Center and currently the Belfer Research Building.

WCM: How is the experience of the average Weill Cornell student different now compared to when you arrived?
AG: Almost half of our students now take an overseas elective. A lot of them do research; there’s more research going on at the Medical College and more of the MD-PhD students are working in labs here. The MCATs and GPAs of entering students are higher than they were then. The average age of entering students is 23.7 years; most have done volunteer work, worked in a laboratory, or served in the Peace Corps. It’s a highly qualified group. It’s a different profile than before; as physicians, I hope they will be equally successful as our distinguished alumni.

WCM: The Qatar branch was established during your deanship. Why is the campus important to Weill Cornell?
AG: It represents a partnership with the Qatar Foundation with the aim of establishing an academic medical center in an Arab country in the Middle East, and I think it was a wonderful opportunity. It has enabled us to test our curriculum, which at that time had been in effect only five years, in a different cultural environment but with the same academic standards. It has allowed our doctors, students, and scientists to do research in a population we had not had access to before. And I think that if anything can create better relationships among different cultures and different parts of the world, it’s medicine. Medicine knows no boundaries.

WCM: How has the relationship between Weill Cornell and the Ithaca campus evolved?
AG: I like to think that the relationship and interactions with Cornell in Ithaca have grown and increased during my tenure. This has been a high priority. We will have space in the new building dedicated to joint projects. We’ve given a number of seed grants to stimulate research between investigators on the two campuses, and they have paid off; they have usually led to large follow-up funding from NIH or foundations.

WCM: What about the relationship between Weill Cornell and NewYork-Presbyterian?
AG: To have a great medical center, a hospital and a medical college have to work hand in hand. We’ve been joined at the hip since 1927, after Payne Whitney bought this property.

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t is a huge honor to follow in the distinguished footsteps of Dean Antonio Gotto. Thanks to the great work of Dean Gotto, WCMC is poised to be one of the leaders in academic medicine in this country. With the new Belfer Research Building under construction because of Tony’s immense success in attracting resources, this institution is ready to achieve the preeminence in the biomedical sciences that it has already achieved in clinical medicine. Thanks to Dean Gotto, WCMC is also unique among academic medical centers in having forged meaningful partnerships here and abroad. Every one of these partnerships has been groundbreaking. WCMC has benefited from Dr. Gotto’s superb leadership, and I will have the tremendous advantage of his continued engagement, advice, and wisdom over the next several years. If I can be half as effective as he has been over the last fifteen years, I will count my tenure as dean a success.

Laurie Glimcher, MD
Incoming Dean

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tony Gotto was responsible for quantum qualitative and quantitative growth in research, clinical care, and the educational experience at Weill Cornell. He accomplished this by garnering great philanthropy and directing it to support a multiplicity of research, clinical, educational, and even lifestyle programs. He oversaw the recruitment of numerous gifted scientists and developed the infrastructure necessary to facilitate a marked increase in NIH and other extramural funding. He recruited several clinical chairs and significantly grew the full-time faculty. He led the Medical College through two successful LCME accreditation reviews and oversaw curriculum reform. With his great success in attracting philanthropy to build the Belfer Research Building, he has positioned us to become one of the ten leading medical schools in the U.S.

Daniel Knowles, MD
David D. Thompson Professor and Chairman, Department of Pathology and Laboratory Medicine
CMO, Weill Cornell Physician Organization
Tony is remarkable; he is dynamic with enormous energy and leadership ability. He has fostered an environment of collegiality and collaboration within the Medical College and with its partners in the Tri-Institutional area on York Avenue and around the world. He is able to engage with a wide variety of individuals, bringing out the best in them to enlist their support. This is not a skill that can be easily learned; I believe that it distinguishes leaders who will leave a lasting legacy from those who will not. A hundred years from now, Tony Gotto will be remembered for leading Weill Cornell into the twenty-first century and helping to forge a new model for academic medical centers in the world.

David Hajjar, PhD
Dean, Graduate School of Medical Sciences

I have been impressed with Dean Gotto’s deep appreciation and respect for our students and how he made them feel supported and welcomed. Each year he attended the annual boat ride for matriculating students, an opportunity to welcome them to the Medical College. The next day, he always presided over opening ceremonies—something the students really appreciated. Dean Gotto and his wife, Anita, hosted a reception for the first-year class at their home, purposefully arranging it without a lot of administrators present so that he had a chance to meet the students.

The teaching faculty also grew to respect and admire Dean Gotto. They appreciated the fact that he carved out time every year to attend the annual education retreat. Dean Gotto regularly supported the Excellence in Teaching Awards, another reason why the faculty respected his engagement at WCMC.

There are so many things that Dean Gotto championed to make WCMC a better place for our students and faculty. He made WCMC a special place and promoted extraordinary growth in all of its missions. We must also thank Anita for lending him to us for these many years.

Carol Storey-Johnson, MD ’77
Senior Associate Dean for Education
Associate Professor of Clinical Medicine

WCM: Why is the Belfer Research Building so vital to Weill Cornell?

AG: Research not only generates new knowledge, it attracts students. It also attracts patients, who want to go where new things are being done and where, in some cases, they can get into clinical protocols that aren’t available elsewhere. The reputation of an institution depends not only on its clinical prowess, but also on the new knowledge that comes out of it. So it’s important for the future of this institution that we build on research and not just be an education and clinical service organization.

WCM: What will retirement look like for you? Will you be able to pursue interests, both professional and otherwise, that you haven’t had time for?

AG: Well, I’m retiring as dean, but I’m not retiring. There’s a transition period of three years when I’ll continue working with the new dean and President Skorton, however I can be helpful to them—but particularly, I imagine, in philanthropy and in some of the affiliations I’ve helped establish, as well as with interactions with life sciences in Ithaca.
WCM: What words of advice might you have for your successor?
AG: The advice I would give is not to forget that we have a tripartite mission, and we have to pursue it on all fronts.

WCM: What are your interests and passions outside of work?
AG: My wife, children, and grandchildren. From a recreational standpoint, I enjoy tennis and water sports. I like to play golf, but I haven’t had the opportunity to play much, and I’m a very poor golfer. I do like to fish, and I keep a sailboat in Maine. We have a house in Wayne, a little village about an hour and a half north of Portland, where we go in August. Maybe we’ll spend more time there. Also, my wife and I enjoy travel. We’re interested in history, including the history of medicine, and various other things like spy stories.

WCM: Who’s your favorite spy novelist?
AG: Daniel Silva. He writes about a Mossad operative who is an art restorer.

WCM: And Mrs. Gotto? What are her interests?
AG: She was an elementary school teacher; she taught school in England when we were there. But with two of our three daughters with juvenile diabetes and my career having such time demands, she has devoted her life to the family. She has been a vital part of my career; her interactions with faculty, staff, students, overseers, and potential donors have been indispensable. She has also supported the various organizations that I’ve been involved with, and she has been active with the Juvenile Diabetes Foundation. She also worked with the American Heart Association, has always had an interest in libraries, and has been an elder at Fifth Avenue Presbyterian Church. Most of all, she has been my life partner, main confidante, critic, and friend.

WCM: Did any of your daughters follow you into medicine?
AG: My eldest is a liaison psychiatrist with cancer patients at City of Hope outside Los Angeles. She went to Baylor, and she didn’t want to be treated differently because her father was head of medicine, so she’d wear her name tag inverted. My second daughter, who has been incapacitated since 2003 due to a stroke, was a medical social worker before she was disabled. So two of the three went into some aspect of medicine. My third daughter is an investment banker with Goldman Sachs. She was in Hong Kong for three years, and she’s just moved back, so she and four of our grandchildren are living a few blocks from us.

WCM: One day, hopefully decades from now, the New York Times will run your obituary. What would you like it to say about your legacy to Weill Cornell?
AG: I don’t want to be remembered for what they wrote when I came, which was: “Cornell selects cookbook author.” That’s what they pulled out of my bibliography. So you never know with the New York Times.

WCM: You’re a cookbook author?
AG: Dr. Michael DeBakey and I wrote several books for the general public on the Living Heart Diet.

WCM: And as to your legacy?
AG: It’s hard to do this without seeming immodest. I would like to think that I have helped make Weill Cornell a gentler, more collaborative place, but also one that was transformed in its academic endeavors. The legacy, to some extent, will depend on what happens to these things—if the Belfer Research Building recruits superb medical scientists and there’s great work coming out of that. I hope that we’ll see an academic medical center in the Middle East. I hope we’ll see stronger relations with Ithaca, Tanzania, and the Methodist Hospital in Houston—that these things will continue to flourish. I hope that this is a place where students will want to come, where doctors will want to practice and do research, and where patients will want to be treated.

WCM: And as to your legacy?
AG: Dr. Gotto’s commitment and dedication to Weill Cornell will last many lifetimes. He was instrumental in my appointment as dean for student affairs and equal opportunity programs and, at the same time, was an important figure in ensuring that the Medical College remain diverse. From the moment he mentioned diversity at my interview—with pride in his eyes—I knew that he was special and that he felt Weill Cornell was special as well. I was always supported in initiatives that my office undertook to ensure that students were considered across every committee that would help shape the college.

Carlyle Miller, MD ’75
Associate Dean for Student Affairs and Equal Opportunity Programs
Assistant Professor of Medicine
Discovery Center
At a festive ceremony, Weill Cornell dedicates the Belfer Research Building

Namesake: Robert Belfer speaks at the dedication ceremony as Congresswoman Carolyn Maloney (on the dais) and his family (seen on the video monitor) look on. Right: The construction site after the unveiling of a banner with the building’s official name.
On a surprisingly warm and sunny day in early November, several hundred guests gathered in a tent decorated with festive red banners. The dignitaries, donors, faculty, staff, and students had come to East 69th Street to celebrate the latest milestone in the $650 million project: the recognition of Robert and Renée Belfer’s $100 million gift and the dedication of the research building that will bear their family’s name.

“The new medical research building will not only double the amount of research space available [at Weill Cornell],” Robert Belfer said in his remarks. “More importantly, as a state-of-the-art medical research facility, it will house the newest cutting-edge equipment needed to fully utilize breakthroughs in medical technology. We can now see more, see more deeply, and focus and analyze data on a scale that boggles the mind. Coupled with the brilliant scientists already on staff and with additional ones being recruited, the building is certain to house discoveries that will benefit my family, New Yorkers, and all mankind.”

Under construction since spring 2010, the Belfer Research Building is the centerpiece of Weill Cornell’s $1.3 billion Discoveries that Make a Difference Campaign and its Research Leads to Cures Initiative. At the dedication, campaign chair Robert Appel noted that Discoveries is nearing the finish line, with more than $1.1 billion raised thus far. “When we launched our campaign five years ago with a goal of $1.3 billion, we thought that might be a little far-reaching, particularly in the beginning of a recession,” said Appel, vice chair of the Board of Overseers. “But we knew that if we were successful we would make a major transformation in this institution, and more importantly bring about some major breakthroughs in medical science. Well, the dream has become a reality.”

Located on the north side of East 69th Street between First and York avenues, the 480,000-square-foot building will rise eighteen stories and include such features as an indoor terrace, an airy two-story lobby, and an innovative double-paned glass curtain wall. The building, which will have thirteen floors of research laboratories, is scheduled to open in spring 2014. “It will be one of the hallmarks of the twenty-first century for this medical college,” Dean Antonio Gotto said at the ceremony. “This will be home to thirty new researchers who will carry out discoveries that we hope will lead to new and improved ways of diagnosing, treating, and curing disease. These new researchers will work with the clinicians in the hospital...
across the street; they will be mentors and tutors to our medical students, fellows, and residents. So they’ll have a big impact on this campus over the succeeding generations.”

In addition to marking the building’s dedication, the ceremony served as an opportunity to honor Gotto, who steps down from the deanship at the end of 2011 after fifteen years of service. “Somehow or other we got lucky, and Tony decided to come up here from Houston and from the chair of medicine at Baylor,” foremost benefactor and Board of Overseers chairman Sanford Weill said in his remarks, “and we’ve had one heck of a fifteen years.” He went on to laud Gotto—who will remain on the Weill Cornell faculty, be co-chair of the Board of Overseers, and serve as a Cornell University vice president—for his many accomplishments. They include supporting three successful campaigns raising a combined total of well over $2 billion, attracting top students and faculty, and establishing medical education programs in Qatar and Tanzania. Said Weill: “Tony has taken this school from being something just on 68th Street to really an international institution.”

The new building will feature design touches rarely seen in academic research facilities, such as a limestone lobby, workbenches made of American cherry, and an urban garden with plantings, seating, and fountains. Like the nearby Weill Greenberg Center, its curtain wall will be made of “water white” glass (whose low iron content keeps it from having a greenish hue) covered in a white ceramic coating known as a frit. The building has many environmentally friendly features—from incorporating locally sourced materials to collecting rainwater for irrigation to offering bicycle storage on site—making it eligible for Leadership in Energy and Environmental Design (LEED) certification at the silver or gold level.

While the building will be primarily devoted to research, it will also enhance Weill Cornell’s educational mission, with several areas of student space such as lounges and seminar rooms—and since clinical research will also be conducted there, it will further the clinical mission as well. “This state-of-the-art facility will help to speed the rate at which discoveries may be translated into advanced treatments to help people in New York, across the country, and across the globe,” President David Skorton, MD, said at the dedication, calling the project “a crucial milestone in the growth and development of this college of medicine, and also a milestone for Cornell University as a whole.”

The ceremony also featured remarks from New York Congresswoman Carolyn Maloney, who called the building “a powerful catalyst for scientific discoveries that address some of today’s biggest health challenges” and touted its benefits to the city and state. “We are already one of the leading research centers in our country,” she said. “It will help us cement that standing and build on it. I believe we will be the research, high-tech, medical science center not only for our country, but for the world.”

A graduate of Columbia College and Harvard Law School, Robert Belfer is the former chairman of Belco Petroleum Corporation, a company that later merged with InterNorth, Inc. In 1992, Belfer founded Belco Oil & Gas Corporation; he is currently chairman of Belfer
Management, LLC, a private investment firm specializing in the energy, real estate, and financial services sectors. Renée Belfer, a Vassar College alumna, is an avid philanthropist whose activities include serving as a trustee of the Metropolitan Museum of Art and as a member of the NewYork Weill Cornell Council. The Robert A. and Renée E. Belfer Family Foundation supports such institutions as the Harvard Kennedy School, Lincoln Center for the Performing Arts, and the Dana-Farber Cancer Institute. The couple has three children—Rachelle, Laurence, and Elizabeth—and five grandchildren. “They’ve been involved with the Medical Center for many years, going back to Bob’s first visit to [professor of clinical medicine] Rees Pritchett as a physician,” Dean Gotto said in announcing the building’s name, “and the Belfers have supported many different aspects of our Medical College, from professorships to gene therapy.”

In his remarks, Belfer recalled his first visit to the Medical College and its teaching hospital. “A little over fifty years ago, I entered Weill Cornell and NewYork-Presbyterian as a patient whose parents thought I was in mortal danger—but then again, I had very loving parents,” he said, garnering a laugh. “Happily, through the good medical skills of Dr. R. A. Rees Pritchett, I came out of this in good shape. I was fortunate enough a month or so later to meet my loving Renée, with whom I’ve celebrated fifty wonderful years of marriage. Over that period of time my family’s involvement with Weill Cornell grew and grew. My parents, my spouse, my children and their spouses, my grandchildren, and many of my nieces and nephews have all been patients of the doctors of Weill Cornell. So in many ways what I’m celebrating here is recogni-

Honored guests: The audience was surrounded by bright red banners celebrating the building’s vital role in campus research.

“BACK TO THE FUTURE
Time capsule offers a taste of 2011

In the year 2098, a future generation of Weill Cornelia ns will open a container full of history. As part of the dedication for the Belfer Research Building, the Medical College created a time capsule—a metal box, roughly the size of a footlocker, containing artifacts from 2011. The capsule includes such items as common medical instruments (stethoscope, tuning fork, pulse oximeter); a can of Tab (Dean Antonio Gotto’s favorite beverage); copies of the New York Times and Wall Street Journal dated 11/9/11; lab standards like gloves and a white coat; and the Ithaca-to-New York intercampus bus schedule. The objects were chosen by a committee chaired by Helen Appel; members included Robert Belfer, Joan Weill, Anita Gotto, Graduate School Dean David Hajjar, PhD, and student overseer Jeffrey Russ. “It’s quite an eclectic accumulation of things, and some of it may not be recognized by 2098,” said Gotto, noting that the year was chosen because it will mark both the bicentennial of the founding of the Medical College and the centennial of its renaming in honor of Joan and Sanford Weill.

Toward the end of the November 9 dedication ceremony, Gotto and Appel sealed the capsule with rubber mallets—and the dean pointed out that organizers had taken pains to insure that it will be accessible eighty-seven years in the future. “There have been instances where people or institutions put away sealed time capsules and then can’t find them,” he said. “But we’ll surely be able to find it, because there will be a plaque on the wall to mark where it is.”
Creative Solutions

By Sharon Tregaskis
n the summer of 1959, seven years after Selman Waksman won a Nobel Prize for his discovery of streptomycin to treat tuberculosis, thirteen-year-old Carl Nathan started a summer job as an assistant animal hand- 

er in the NYU lab of pathologist Lester Grant, MD, DPhil. While Grant investigated how inflammatory signals trigger white blood cells to adhere to the endothelial cells lining blood vessels, the teenager cleaned rabbit cages and cultivated a passion for scientific inquiry. Even as he com-
muted to Grant’s lab in lower Manhattan, Nathan fueled his curiosity by reading biographies of such nineteenth-
century scientists as Robert Koch, who won the 1905 Nobel for revealing *Mycobacterium tuberculosis* as the infec-
tious agent behind tuberculosis, and Louis Pasteur, whose food-sterilizing treatment prevents transmission of a form of the disease that once sickened those who drank raw milk from *Mycobacterium bovis*-infected cattle.

“I was fascinated by the history of medicine,” recalls Nathan, the R. A. Rees Pritchett Professor of Microbiology and chairman of Weill Cornell’s Department of Microbiology and Immunology. “I was impressed with how these giants created the experimental structure that defines modern medicine. For them, TB was an overwhelming concern.” More than half a century later, Nathan’s lab investigates the molecular machinery of the bacterium behind the disease in search of new strategies to foil its infective power. In the last seven years, he has also begun promoting new models of collaboration among scientists, nonprofits, and pharmaceutical companies—including pilot programs with GlaxoSmithKline, Lilly, and Sanofi-Aventis—to bring drugs to market that combat neglected infectious diseases like TB.

Even in the years immediately following Waksman’s streptomycin discovery, tuberculosis remained an over-
whelming force both in society and in medical practice. Everyone knew someone who had been touched by the disease. Grant—just one generation older than his apprentice—had lost both his mother and the aunt who subsequently raised him to the disease; during World War II, he was excused from military service because his own bout with TB destroyed one of his knees. Yet by the time Nathan was in high school, public health experts were confident that, armed with Waksman’s new antibiotic, physicians would fast vanquish a disease that had been a cultural touchstone and the cause of one in four deaths in the U.S. and Western Europe during the nineteenth century—including those of Frédéric Chopin, Henry David Thoreau, and Elizabeth Barrett Browning. “The final chapter of the battle against tuberculo-
sis appears to be at hand,” Waksman declared in his 1964 memoir, *The Conquest of Tuberculosis*.

By then Nathan was an undergraduate at Harvard, studying East Asian history. When his mother was diagnosed with cancer, he resolved to expand upon his earlier training in immunology with Grant to find a cure for the disease. He received notice of his admission to Harvard Medical School on the day she died, cementing his course. “I was incredibly impressed with the power of the immune system to protect us,” he recalls. “I wanted to bring that to bear on metastatic cancer.” Nathan would go on to earn board certification in oncology, ascend to the chairmanship of the National Cancer Institute’s Tumor Immunology Committee at age thirty-three, and then direct his focus to the mechanisms by which host defense cells like macrophages battle cancer.

In the process, Nathan became increasingly discouraged by the broad destruction wrought by chemotherapy and the lack of biochemical underpinnings to inform the develop-
ment of more effective, less toxic treatments. “I was frustrat-
ed with the underdeveloped state of immunology in terms of our understanding of when cells kill, how they kill, and how their power to kill is regulated,” he says. Answering those
questions demanded a shift to even more basic research. “I became fascinated by host protective cells and their seek-and-destroy ability. To train them on combating cancer, I had to understand the rules and the tools of engagement.”

But cancer—especially in humans—involves complex processes. So in the mid-Seventies, Nathan took an evolutionary step back, parsing instead the settings in which our immune function evolved: defense against infectious agents. After a decade of toggling between the worlds of oncology and infectious disease, Nathan had detailed some of the fundamental pathways that regulate the ability of white blood cells like macrophages to kill pathogens, such as release of interferon-gamma from antigen-stimulated lymphocytes, and the molecular machinery they deploy in the process, such as production of nitric oxide. “That,” he says, “led me to the mechanisms organisms use to protect themselves.”

‘There are layers of problems that have led major pharmaceutical companies to retreat from antibiotic development—but meanwhile the ability of microbes to build resistance has been picking up steam.’

By then it was 1986 and Nathan had moved from Rockefeller University to join the Weill Cornell faculty as the Stanton Griffis Distinguished Professor of Medicine. HIV—a catastrophic viral assault on the immune system—was roiling New York City hospitals. The aftermath—bacterial tuberculosis—hit just a few years later. Its resurgence owed to a perfect storm 24). “How much will the twenty-first century resemble the nineteenth in our relationship with TB?”

Nathan credits Lee Riley, MD, then a Weill Cornell assistant professor investigating the molecular pathways that Mtb uses to infect its host, with re-igniting his interest in the disease. It was 1990, and every weekday morning Riley took his young children to the bus stop. As the family waited at the corner of First Avenue and 63rd Street, Nathan would walk by en route from Grand Central Station to the Medical College. Riley made the most of their morning pleasantries. “I casually said maybe we could put together a grant proposal to work on TB and the role of nitric oxide,” says Riley, now a professor in the Division of Infectious Disease and Vaccinology at the University of California, Berkeley, School of Public Health. “The macrophages make nitric oxide, and I had this feeling there was some relationship in how TB interacts with these macrophages and the release of nitric oxide.” Riley’s suggestion prompted a series of conversations in Nathan’s office. “Lee would drop by with his micrographs and bar graphs and show me what he was working on,” Nathan recalls. “He convinced me that TB is a fascinating disease.”

Think of Mtb as the tortoise of the bacterial world—slow and steady. When it’s dividing, it reproduces at a rate of about one division per day and, once resident in a human host, can remain latent for decades—encapsulated within the macrophages meant to evict pathogens from our bodies—before sparking an active infection and resuming its geometric spread to new hosts. Once active, the disease exacts its toll at a leisurely pace, with a constellation of easily misdiagnosed symptoms including weight loss, diminished energy, poor appetite, and a productive cough. Over the course of many months, the patient wastes away. In the era preceding the Industrial Revolution, the bacterium’s handshake was often credited to vampirism; even today, definitive diagnosis can take weeks because of the bacterium’s plodding growth in a test tube and the insensitivity of the microscopy methods used to analyze sputum samples.

Humans are Mtb’s only natural host; we transfer it via aerosolized droplets of saliva propelled into the air when an infected person coughs or sneezes. While relatively rare in the United States, the disease is rampant throughout Asia, Africa, and Eastern Europe. Worldwide, it strikes disproportionately among the poor, for whom the extended and expensive treatment...
regimen—a cocktail of complementary drugs that must be taken for six to twenty-four months—can be impossible to sustain. Incomplete or inconsistent treatment only bolsters Mtb’s virulence, speeding the evolution of drug-resistant strains and increasing the imperative for new antibiotics.

By 1990, when he and Riley started talking, Nathan had published more than seventy-five articles on the genes and molecular signals that govern the immune response. In the intervening two decades, he has deployed those insights in a quest for clues to the biochemical processes Mtb uses to set up housekeeping within the macrophages, the tactics these cells use to combat active infection, and the enzymes the bacterium uses to resist our defenses.

He has also grown increasingly concerned about the economic, legal, and scientific conditions that have converged to shift pharmaceutical research and development away from antibacterial agents, and not just those used to treat neglected diseases like tuberculosis that afflict vast numbers of people in developing countries. “There are layers of problems that have led major pharmaceutical companies to retreat from antibiotic development—but meanwhile the ability of microbes to build resistance has been picking up steam,” he says, “We’ve been emptying our anti-infective medicine chest and not refilling it.”

To restock the cabinet, Nathan has become convinced that scientists, policymakers, non-profits, and pharmaceutical companies have to work collaboratively to combat infectious diseases. It can take decades to progress from the basic biochemical insights gleaned by academic scientists through the layers of clinical trials sponsored by a drug company and regulated by federal law to yield a marketable drug that produces returns high enough to satisfy stockholders. It is not patent law itself but the application of patent protection that shapes the incentives that reward progress. To speed the development of new weapons against TB, Nathan advocates a more integrated approach that commends not only an optional alternative incentive system, but also new relationships between academics and pharmaceutical companies, as well as changes to the FDA’s clinical trial regulations. He promotes the creation of public-private partnerships and open-access sectors within pharmaceutical companies to facilitate the development of treatments with high social value but low commercial appeal. Nature published his first thoughts on the topic in 2004. In 2007, his commentary “Aligning Pharmaceutical Innovation with Medical Need” appeared in Nature Medicine, and in 2009, Cell Host & Microbe published his analysis of the par-
ticular challenges TB poses for pharmaceutical companies.

In May 2011, Nathan laid out his vision for new collaborative approaches in another commentary in *Cell Host & Microbe* that described the array of emerging partnerships formed to seek promising compounds in the fight against pathogens, while urging readers to imagine further innovations. “Campaigns to discover anti-infectives were launched only if they could forecast a return on investment comparable to what could be expected from selling a product under monopoly prices to very large numbers of affluent or well-insured people with chronic diseases who, being helped but not cured, would use it indefinitely,” he writes in the article’s conclusion. “It is no surprise that anti-infective drug discovery nearly came to a halt. Given that a prolonged halt will prove catastrophic, every aspect of this depiction needs to be rethought.”

Nathan doesn’t just call for change from the bully pulpit of peer-reviewed journals—he’s been actively involved in multiple pilot programs launched by firms that share his concerns. “Pharmaceutical companies,” he says, “are using this neglected disease as the point of the spear to experiment with new ways of working with academics, other pharmaceutical companies, and the nonprofit sector.” Under a grant from the Bill & Melinda Gates Foundation, Nathan has partnered with GlaxoSmithKline’s Open Laboratory at Tres Cantos, Spain, a research and

Sabine Ehrt, PhD
Mycobacterial geneticist Sabine Ehrt, PhD, was a postdoctoral fellow in Riley’s lab at Weill Cornell in the mid-Nineties and worked with him and Nathan to isolate a novel antioxidant gene from Mtb. On the Weill Cornell faculty since 1999, Ehrt has continued collaborating with Nathan, co-authoring more than a dozen papers on the metabolic processes that sustain Mtb. Currently, the two have a five-year grant from the NIH to investigate how intrabacterial pH influences Mtb’s persistence in the macrophages. With her additional collaborator Dirk Schnappinger, PhD, she has funding from the Bill & Melinda Gates Foundation to collaborate with pharmaceutical companies in the search for new TB drugs. “Dr. Nathan sets an example that collaborations between academia and industry can be productive and fruitful,” she says.

Nathan also encourages the synergies that can emerge when academics come together. His team meets weekly with those of Ehrt, Schnappinger, and fellow Weill Cornell TB investigator Kyu Rhee, MD, PhD, as well as biochemist Aihao Ding, PhD, to form a forty-member consortium comprising specialists in immunology, microbiology, genetics, metabolomics, and biochemistry, among other fields. “A collaborative project is one thing, but joint lab meetings really propel the work forward,” says Ehrt. “Often you are stuck in your own little world and the more you’re willing to step out of it, the more fun and productive research becomes. Dr. Nathan is not shy about suggesting ideas and coming up with experiments that might be high risk, but he proposes solutions, has very broad knowledge, and knows the literature. He’s not restricted to tuberculosis or nitric oxide, and he applies that broad knowledge to his own research and to our group meetings.”

With funding from a second Bill & Melinda Gates Foundation grant, Nathan’s lab is screening a library of tens of thousands of compounds supplied by a combination of academic and industrial collaborators, including GlaxoSmithKline, Sanofi-Aventis, Lilly, Beijing University, the Broad Institute, the University of Kansas, Boston University, and the Lankenau Institute. Instead of providing the ideal conditions to promote TB’s growth in a test tube, they’ve used insights from research by Nathan, Ehrt, Schnappinger, and others to create conditions that mimic the hostile environment of the human immune system. “It isn’t reasonable to target a bacterium only when it’s in the test tube under conditions where it doesn’t have a care in the world, with all the oxygen, sugar, nitrogen, vitamins, and minerals it wants,” he explains. “It’s not like that when a pathogen is competing in the body—that’s a tough place. The host is already doing quite a bit to fight the infection, and the pathogens that are most effective are the ones that can defend themselves.”

Nathan says that his work offers multiple non-financial rewards. In addition to the joy he gets from solving intellectually engaging problems, his research has the potential to forge new methods for finding anti-infective compounds, generate insights into the basic biology of the competition between host and pathogen—and, most important, help the millions afflicted by TB. Ultimately, he hopes, “we should put TB on the list, with smallpox and polio, of diseases that can be eradicated by modern medicine.”

‘It isn’t reasonable to target a bacterium only when it’s in the test tube under conditions where it doesn’t have a care in the world, with all the oxygen, sugar, nitrogen, vitamins, and minerals it wants.’
Dear fellow alumni:

As the summer of 2011 drew to a close, the weather vacillated between extreme heat and torrential rain—but even a hurricane could not prevent your Alumni Association from welcoming the Class of 2015 at the White Coat Ceremony on August 23. All entering students were presented with coats and stethoscopes, generously provided by the Buster Foundation and several alumni donors. This annual event marks a rite of passage for the incoming medical students, whose interests, accomplishments, and talents will contribute significantly to the Weill Cornell community.

We have also received word from many of our newest alumni about their adventures in the medical world. Their days have been punctuated by hard work and long hours in their internships and residencies, demonstrating their commitment to medicine. The Alumni Association has planned some new and innovative ways to keep our newest graduates engaged as they progress through their training.

This year is a time of transition for the Medical College. As I’m sure you know, Laurie Glimcher, MD, has been appointed the new Stephen and Suzanne Weiss Dean of Weill Cornell Medical College and Provost for Medical Affairs at Cornell University. The search committee evaluated more than fifty excellent candidates before choosing Dr. Glimcher, the Irene Heinz Given Professor of Immunology at the Harvard School of Public Health and professor of medicine at Harvard Medical School. The Alumni Association is delighted to welcome her to the Cornell family, and we look forward to working with her in supporting the mission of the Medical College.

We thank outgoing Dean Antonio Gotto, MD, wholeheartedly for his guidance, enthusiastic engagement of our alumni, and steadfast support of the Alumni Association. His fifteen years in office have ensured that Weill Cornell is able to compete with the finest institutions in the world. He will remain active as a vice president of Cornell University and co-chair of the Weill Cornell Board of Overseers.

This fall was busy as we traveled to Boston, Houston, and Denver, visiting alumni and friends. These events are a wonderful chance to reconnect with fellow alumni and discuss all things Weill Cornell. Looking ahead, we are planning another regional event in San Francisco in early February and will keep you updated as the date and venue are established. Furthermore, planning for Reunion 2012 (October 19 and 20) is well under way. It promises to be a wonderful weekend filled with celebrations and stimulating lectures. I look forward to seeing the extended Weill Cornell family get together next fall.

Finally, I would like to thank you, the alumni of Weill Cornell, for your constant support of the institution and its students. In particular, your generous support of scholarships has made a medical career possible for many students who otherwise could not afford it.

Best and warmest wishes,

Michael Alexiades, MD ’83
President, WCMC Alumni Association
alexiadesm@hss.edu
1940s

Emanuel Wolinsky ’38, MD ’41: “I’m almost 94 and retired from Metro Health Hospital and Case Western Reserve Medical School in Cleveland, where I spent 44 years in infectious diseases. My wife, Marjorie, and I would love to hear from anyone in the Class of ’41.”

Francis Greenspan ’40, MD ’43: “I finally retired after 60 years of teaching clinical research and clinical practice of thyroidology. It was great. I’ve moved into an excellent retirement center with my wife, Bonnie (married 65 years), and am very happy.”

Herbert I. McCoy, MD ’45: “I’m hanging in there at 90-plus and engaged to be trip doctor for a scuba group in Fiji and the Solomon Islands next April.”

Bob Frankenfeld ’45, MD ’47: “I finally retired two years ago after practicing internal medicine in Long Beach, CA, for 53 years. I was associate clinical professor of medicine at both UCLA and UC Irvine. Four of us attended our 60th Reunion in 2008: Ernie Gosline ’45, MD ’47, with wife Whit; Nelson Niles, MD ’47, with wife Sofie; Carol Brach Hyman ’44, MD ’47; and me. We were the oldest class there.”

Ernest Gosline ’45, MD ’47: “The field of psychiatry still holds my attention, but health may soon force full retirement. I recently published a rather bold paper called ‘Algorithm of the Mind’ based on various psychoanalytic schools of theory. I stay in contact with Bob Harwick ’45, MD ’47, Bob Frankenfeld ’45, MD ’47, and John Clements ’45, MD ’47. The ‘Greatest Generation’ sails onward, but in a leaky ship.”

Ludwig G. Laufer, MD ’48: “I retired from the practice of psychiatry, after 55 years, in November 2008 and now spend most of every day outside working around our property that is on a cliff on Long Island. On a clear day I can see downtown New Haven, CT. Lots of medical problems under control. My wife, Patricia, and I love the location—no street lights and deer on the property.”

Rees Pritchett, MD ’48: “I gave up patient care in June 2010, but remain on the Medical College’s full-time staff. I do development work and serve on several committees.”

Edmund T. Welch, MD ’49: “Not much has changed since my last note. I just passed my 86th birthday and am getting along well with a cardiac pacemaker. My life now is much more sedentary, with no more tennis. I still correspond by e-mail with Harold Evans, MD ’49, and would welcome hearing from other classmates, although our number now is greatly decreased. My e-mail address is etwjdw@yahoo.com.”

1950s

Robert C. Hafford, MD ’50: “My wife, Audrey, passed away last April.”

Carol Remmer Angle, MD ’51: “I’m retired—riding horses and enjoying life in Charlottesville, VA. I live next door to my son, Fritz, an interventional radiologist at UVA.”

Roy W. Menninger, MD ’51: “I’m still in private practice of psychiatry in Topeka, KS.”

Anne Johnson Minkoff ’48, MD ’51: “I’m ‘aging in place’ in Great Neck, NY, with my husband of 53 years. We still enjoy visiting our Lake Winnipesaukee island spot in New Hampshire, which is now owned by our children, Ellen and Paul. And our two grandchildren (one just graduated from Pitzer College and the other will next May) are doing great. Their mother, our daughter, Ellen Pashall, is practicing psychiatry in Newton, MA. Our son, Paul, is an X-ray tech at a
Queens hospital.”

Patrick J. Mulrow, MD ’51: “What a wonderful life: 60 years a physician. What fond memories of those four exciting years as a medical student culminating in graduation and the diaspora. Our class pursued many different disciplines. I chose an academic career and enjoyed teaching, patient care, research, administration (20 years as chairman of medicine), and world travel lecturing and presenting papers at international conferences. When young students ask my advice, I urge them to become a physician. It’s worth the effort and expense. What a wonderful life.”

Edward Swain, MD ’51: “I’ve been retired since 1999 from the private practice of psychiatry. Still physically and mentally active in my 85th year—at least on an age-appropriate level.”

Robert Boyer, MD ’52: “I’m enjoying retirement, including gardening, golf, and painting. Recently had a visit from Charlie Malone, MD ’53. I also see Allan Levy, MD ’51, and Ron Allen, MD ’54, periodically. Looking forward to our 60th Reunion next year.”

Robert Wagner, MD ’52: “Sue and I are still holding forth at the foot of the Bighorn Mountains in Buffalo, WY. We sure could use a visit from classmates.”

Ginger Weeks, MD ’52: “I’m coping with the Golden Age problems: AF, lymphedema, venous stasis ulcers, mild CHF, hypertension, hyperuricemia, and having been overweight. In the last three months I’ve lost 40 pounds with diuresis (oral) and dietary control. All my clothes have had to be altered. I’m working six hours a week in addiction outpatient clinics and enjoying my friends, grandchildren, and bridge.”

Richard H. James, MD ’53: “Ginny and I are fine for 84 and 85 years. Golf and tennis are going OK. We have four children, nine grandchildren, and two great-grandchildren. Still living in Keene, NH, in our own house.”

Peter R. Mahrer, MD ’53: “I cannot get myself to completely retire. Still doing teaching rounds at LAC/USC Medical Center and tertiary care at Kaiser Foundation Hospital in L.A.”

Allen W. Mead, MD ’53: “I survived multiple neck fractures following a fall at home and am married again, to Mary Dean from McLean, VA, a 32-year employee of the CIA.”

Bernard A. Yablun ’48, MD ’53: “Proto magazine has asked permission to print part of my letter on discontinuing the practice of wearing stethoscopes around the neck and placing them in the uniform pocket instead.”

William H. Gordon Jr., MD ’54: “I retired after 44 years with Kaiser Permanente in Fontana and Riverside, CA; started nuclear medicine at both hospitals. I live in Upland, CA, with wife Jean. I have four children: Stephen, a federal defense lawyer; William, a broker; Valerie, a nurse at L.A. Children’s Hospital; and Michele, a cosmetologist. I’m active in the Episcopal Church and Claremont University Club.”

Ken Herd, MD ’54: “Last February, while presenting a poster at a Gordon Research Conference in Ventura, CA, supporting our hypothesis that a deficiency of Gunter Blobel’s signal peptidase accounted for the primary pathology in cystic fibrosis (more aptly called mucoviscidosis), I ran into the distinguished son of one of our classmates. I had studied this disease in 1956 with the pathologist Dorothy Andersen, who first described her findings in 1938. She was also the first to describe the elevated sweat chloride levels, in 1948, later tests for which became the diagnostic hallmark clinical finding for this condition. Dorothy cautioned that elevated sweat chloride did not readily explain the pathology and urged our attention to the cellular process of protein secretion then being worked out by George Palade at the Rockefeller Institute and later clinched by Gunter Blobel’s publication of the signal peptide hypothesis in the 1970s. Then working in the general field of pediatric rheumatology, I did not become aware of the importance of the existence of hydrophobic signal peptides at the amino terminus of all secreted proteins until the late 1980s and was at once drawn back to the problems of sticky secretions in mucoviscidosis. Back to Ventura: Dr. David Erle was listed as a speaker on something to do with respiratory mucins, great big proteins secreted into the...”

We want to hear from you!
Keep in touch with your classmates.

Send your news to Chris Furst: cf33@cornell.edu
or by mail:
Weill Cornell Medicine
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Ithaca, NY 14850
pulmonary passages. He was at UCSF. I recalled that our classmate with the same last name (Henry Erle ’50, MD ’54) had two sons, both MDs, one named David and one named Steven (Steven Erle, MD ’86). Indeed it was the same David Erle. We planned to meet at the Ventura GRC, but circumstances prevented his attendance. Upon return from the West Coast, I charged off to NYC hoping to have a visit with Gunter regarding our hypothesis about the role of his enzyme in the cause of cystic fibrosis, but his recent convalescence from major chest surgery prevented it, so I had dinner with Henry and Joan in their home in Bellaire Towers and looked down on the old familiar East River and NYC. What a delightful evening. If you want to recall what Henry looked like when we all studied together, Google David Erle from UCSF and you will see that the photo is an incredible likeness. Incidentally, David’s work is now getting published in PNAS. He has already given me some helpful pointers on mucins and very likely could well advise about the isolation of respiratory mucins from patients with mucoviscidosis. But first I’ve got to get some support. Wish me luck. I tried to stay retired, but no success there. Regards to all."

Robert J. Hubsmith ’52, MD ’56: “At the hospital I continue to advise for insurance on adverse determinations re: admissions, length of stay, and payments. I’ve had an active role in the Cornell Alumni Association of Northern New Jersey as treasurer since the mid-1960s. I visit with classmates and attend reunions less frequently.”

Robert P. Goldstein, MD ’57: “I’m still working part-time for the Dept. of Surgery at Stony Brook University Hospital, doing quality and safety work. New e-mail address: cedric.priebe@sbumed.org.”

Sidney Goldstein ’52, MD ’56: “I still have an office at Henry Ford Hospital and show fellows and residents how to examine the heart. I’m medical editor of Cardiology News and am involved with numerous clinical trials.”

Ramon R. Joseph, MD ’56, is happily retired in Sun City West, AZ. He married Karen Moran in February 2009. He has given up clinical practice and is now doing pro bono work helping senior and disabled citizens negotiate the difficulties they encounter with Social Security and Medicare. He also enjoys his three children and six grandchildren.

Donald P. Goldstein, MD ’57: “I’m still involved with clinical practice and am now doing pro bono work helping senior and disabled citizens negotiate the difficulties they encounter with Social Security and Medicare. He also enjoys his three children and six grandchildren.”

William H. Plauth Jr., MD ’57: “I’m very happy in Santa Fe. Pretty much staying right there and enjoying gardening, tennis, dog walks, and friends—in no particular order. Would love to see my classmates.”

Robert A. Levine ’54, MD ’58: “I left SUNY Upstate Medical University to join Boston Medical Center as professor of medicine, Boston University School of Medicine, in the Section of Gastroenterology. I’m working in the Liver Clinic and participating in academic activities. Barbara and I moved to Needham, MA, where we have two sons and four grandchildren in the same town and are closer to my son in New York City with two granddaughters. We have a condo in Ogunquit, ME, for summer weekends and vacations. I am publishing my 105th paper, in Hepatology. I play lots of tennis and bike ride, too.”

Robert G. Merin, MD ’58: “We have just moved to a continuing care community: 3500 West Chester Pike, F103, Dunwoody Village, in Newtown Square, PA 19073. So far we are enjoying it, but it’s quite a change.”

Edward E. Wallach, MD ’58: “Hello. I’m still working, but at a reduced pace. Clinical responsibilities and mentoring of students, house officers, junior faculty, and fellows consume a lot of time. I’m also busy with clinical research and committee work. Johns Hopkins has been a fantastic part of my professional life; since leaving Penn I’ve been here for 27 years. Joanne and I have gotten together with John Queenan, MD ’58, and also spent a day at Albert Einstein with Irwin Merkatz ’55, MD ’58. Cornell was a wonderful start to my medical life and a memorable experience.”

L. Davis Arbuckle, MD ’59: “My wife, Julie, died in September 2010 after a long illness.”

Bruce H. Drukker, MD ’59, and his wife, Esther, have moved from Salem, SC, to Spring Lake, MI. All is well and now they’re much closer to family and old friends. They’re also getting ready to reacquaint themselves with “big snow.”

James E. Shepard, MD ’59: “It was great to see former classmates at reunion last year. It has been interesting to read and see the various advances at the Medical Center. One delightful surprise was discovering the little Italian restaurant at York and 71st that has the best linguine con vongole I have ever tasted.”

**1960s**

Kenneth R. Barasch, MD ’60: “I’m still practicing ophthalmology in New York City. No plans to retire. The 50th Reunion was wonderful. When we all get together, it seems as though we had seen everyone the day before.”

Gene Sanders ’56, MD ’60: “I’ve retired to Florida and spend time writing for a variety of non-medical journals and magazines, especially philatelic. I was recently voted outstanding alumnus of Frederick (MD) High School, bringing back a multitude of fond memories.”

Carl G. Becker, MD ’61: “We are well, still sailing on Lake Michigan, and enjoying Door County, WI. Our local politics are insane, but nature is quite grand here. Best to all.”

Andy Hedberg, MD ’61: “We’re looking forward to seeing our classmates at our 50th Reunion celebration in October 2012.”

Bill Chaffee, MD ’62, will be back for the 50th Reunion.

William R. Hazzard ’58, MD ’62: “I’m retired at last. But what does that mean? For me, so far, it’s a matter of philosophy and choice. So that means refilling my plate with things that are most likely to be fulfilling..."
Antonio address. I sincerely desire to main-
you from sending news and mail to my San
it up to Aspen, but I hope this will not deter
degrees. It takes a while for my mail to make
enough when the temperature is 100
CO. I love San Antonio, but not nearly
ing my summers in retirement near Aspen,
ning in Weston, FL—lots of celebrations.”
Alfred Parisi, MD ‘63: “I’m consulting for Unum on cardiac
disability claims and teaching at Miriam Hospital, Brown
University.”
Robert S. Ennis, MD ‘67: “I’m retired
from my orthopaedic surgery practice,
but I continue to teach and do part-time
consulting. Lorelie, my wife of 47 years,
and I are active in a number of philan-
thropic organizations. There are currently
four generations of the Ennis family liv-
ing in Weston, Fl—lots of celebrations.”
John L. Marquardt, MD ‘67, and his
wife, Betty, are living at the Ocean Reef
Club in Key Largo, FL, and enjoying the
beautiful weather in South Florida. “Our
six children are all married, and we are
expecting our fifteenth grandchild. We
hope to see you all at the 45th Reunion
in 2012.”
George G. Telesh ‘62, MD ‘67: “We’re
moving right along in Daytona Beach—
getting older and developing old age
issues, but still working full time. Keep
plugging.”
Burton C. West, MD ‘67: “Katherine
and I continue to enjoy our family in
Nashville and Birmingham. I’m enjoying
seeing hospital patients about every other
week, despite hassles. Aren’t contract medi-
cine and government medicine wonderful!”
Lois J. Copeland ‘64, MD ‘68: “I attended
the Ludwig Von Mises Institute meeting
in Vienna in mid-September, hoping it
would reach the heights of its meeting in
Spain two years ago. Important information
for these difficult times in historic places.”
Jeffrey S. Borer, MD ‘69: With the
acquisition of Long Island College Hospital,
its original home in 1860, SUNY Downstate
Medical Center has enlarged its health-care
system and with it, the responsibilities of
Dr. Borer, professor and chairman of the
Dept. of Medicine and chief of the Division
of Cardiovascular Medicine. He views the
merger with LIC as a great opportunity,
both for enhanced clinical service and
heightened academic activity.
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Paterson, with emphasis on resident educa-
tion and research at the latter. My daughter,
Aimee, son-in-law, Rob, and two grandchil-
dren, Lily and Michael, are living close by.
We’re grateful. Jo and I are considering taking
up Can-Am riding (three-wheel motor-
ized bikes) if we don’t lose our nerve.”
Steve Rosenblatt, MD ‘71: “I’m in full-
time practice of nephrology and active in
the transplant program in San Antonio, TX.
In the summertime my wife and I enjoy
hiking in Colorado. I play golf and enjoy
skiing. I’d like to have more time for travel
to family, touring, and just free time. I have
three children: Josh lives in Rockville, MD,
and is a pilot and airplane broker for busi-
ess jets. He’s married to Kelley and has two
children. David lives in Austin, where he
works as a film editor; he and his wife,
Michelle, have one child and one on the
way. Lauren is a graduate engineer from
Georgia Tech and works in New York City
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ally be the case). And so far it’s all going well
and as planned: teaching and mentoring as I
wish while steadfastly resisting administra-
tive re-engagement. Let’s touch base at our
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system and with it, the responsibilities of
Dr. Borer, professor and chairman of the
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tive re-engagement. Let’s touch base at our
50th next fall for updates.”
Anthony Saidy, MD ‘62: “In July I spoke
at the San Francisco Jewish Film Festival
after a screening of Bobby Fischer Against the
World, in which I appear. I’ve been
wrestling with Dr. M. Angell’s articles in
the New York Review casting grave doubts
on psychopharmacologic practice (see
www.nybooks.com).”
Thomas H. Snider, MD ‘62: “I’m spend-
ing my summers in retirement near Aspen,
CO. I love San Antonio, but not nearly
enough when the temperature is 100
degrees. It takes a while for my mail to make
it up to Aspen, but I hope this will not deter
you from sending news and mail to my San
Antonio address. I sincerely desire to main-
tain my membership in the WCMC Alumni
Association. Thanks very much, and my best
to all.”
Muriel King Taylor ‘58, MD ‘62, is hap-
pily and completely retired, painting water-
colors and sumi-e for fun. In summer, she’s
in Lakewood, WA, managing
the produce from the garden,
and in winter enjoys a small
house atop the hill overlooking
Banderas Bay near Puerto
Vallarta. Her 90-year-old hus-
bond, Jack, is hard at work in
Washington constructing a
cruising boat in a 16-foot
Poultsbo hull, while in Mexico
he continues to refine his self-
built sailing trimaran. These
boats are the fourth and fifth
in his series of bluewater-sailboats-
constructed-by-Jack. “We are
both fortunate in being well,
ambulatory, and able to travel a
bit, so we are planning a trip up
the west coast of Vancouver
Island in the fall and a cruise on
the Mekong River with Uni-
versity of Washington alumni
next February. We recently
stopped by and enjoyed a visit
in La Jolla, CA, with Libby
Barrett Connors, MD ‘60, my
roommate for two years in Olin
Hall. Best wishes to all.”
John L. Marquardt, MD ‘67, and his
wife, Betty, are living at the Ocean Reef
Club in Key Largo, FL, and enjoying the
beautiful weather in South Florida. “Our
six children are all married, and we are
expecting our fifteenth grandchild. We
hope to see you all at the 45th Reunion
in 2012.”
George G. Telesh ‘62, MD ‘67: “We’re
moving right along in Daytona Beach—
getting older and developing old age
issues, but still working full time. Keep
plugging.”
Burton C. West, MD ‘67: “Katherine
and I continue to enjoy our family in
Knoxville (three adult children and their
families) and visits from and to the other
two adult children and their families in
Nashville and Birmingham. I’m enjoying
seeing hospital patients about every other
week, despite hassles. Aren’t contract medi-
cine and government medicine wonderful!”
Lois J. Copeland ‘64, MD ‘68: “I attended
the Ludwig Von Mises Institute meeting
in Vienna in mid-September, hoping it
would reach the heights of its meeting in
Spain two years ago. Important information
for these difficult times in historic places.”
Jeffrey S. Borer, MD ‘69: With the
acquisition of Long Island College Hospital,
its original home in 1860, SUNY Downstate
Medical Center has enlarged its health-care
system and with it, the responsibilities of
Dr. Borer, professor and chairman of the
Dept. of Medicine and chief of the Division
of Cardiovascular Medicine. He views the
merger with LIC as a great opportunity,
both for enhanced clinical service and
heightened academic activity.
Steve Shaul, MD ‘69: “I’m still practic-
ing rheumatology in Yakima, WA.”
as a research coordinator; she’s applying to medical school. The things I remember most are some pretty rough basketball games in the gym during exam time and the end-of-year skits.

Albert H. Mangold, MD ’73: “My daughter, Karen, just became a pediatric emergency attending at Children’s Memorial in Chicago. Jean and I became grandparents for the first time when my son, Kurt, and his wife gave us a grandson, Charlie, in March.”

Stuart Mushlin, MD ’73, has been named the master clinician in the Dept. of Medicine at Brigham and Women’s Hospital. He is the second master clinician in all departments. Dr. Mushlin practices internal medicine and is director of preliminary residency for the Dept. of Medicine.

Richard Tosi, MD ’73: “Based on how I used to work, one could say I was semi-retired right now. I can practice like this forever, as my internal medicine/pulmonary career still holds great interest and professional enjoyment. Life is now less pressured since we have paid off the college bills for the three aliens who claim to be our children. They hit us up for Cornell once, Penn once, and Columbia twice. Contact me at azt200@gmail.com.”

Jeffrey S. Wasser, MD ’73: “I retired from the private practice of hematology and medical oncology in 2008 and spent the next two years establishing a new cancer program at a local community hospital. In May 2011 I joined the division of hematology and medical oncology at the University of Connecticut as an assistant professor and medical director of the clinical trials office.”

Roger W. Geiss, MD ’75: “I’m professor and chair of pathology at the University of Illinois College of Medicine at Peoria. For the academic year 2010–11, I received the student award for Best Instructor in the Cardiovascular Course, as well as the Faculty Outstanding Service Award.”

James Newman ’71, MD ’75, a specialist in rheumatology, was named the first senior vice president and executive director of the Christiana Care Value Institute and appointed as Christiana Care’s chief academic officer. He previously served as Christiana Care’s chief medical officer and chief patient safety officer. Dr. Newman received his residency training in internal medicine at the Hospital of the University of Pennsylvania from 1975 to 1978 and completed a postdoctoral fellowship in rheumatology at Yale University Medical Center in 1980. He joined Christiana Care’s medical staff that year. His faculty appointments include lecturer in internal medicine at Yale University Medical Center, 1979–80, and clinical associate in medicine, 1984–89, at the University of Pennsylvania School of Medicine. Since 1982, he has been clinical associate professor of medicine at Jefferson Medical College.

Karen Toskos Robertson, MD ’75: “I’m still working and loving it after all these years.”

Jeffrey Gold ’74, MD ’78: “My daughter Steph graduated summa from NYU. I was named chair of the Liaison Committee on Medical Education for a two-year term and re-elected to the AMA Council on Medical Education and then to the executive committee, broadly serving American medical education. I continue in my role as chancellor and executive vice president at the University of Toledo.”

1980s

Carolyn Grosvenor, MD ’80: “I am still a staff physician at the Albany VA. I’m also on the faculty at the SUNY Albany School of Public Health, where I teach Social and Behavioral Aspects of Public Health. I work with a local rescue mission and am developing a health education curriculum. My husband, Wayne (we’ve been married 35 years), took early retirement and is pursuing a music career in acoustic bass with a jazz quartet.”

Sharon A. Strong, MD ’81: “I love working in home hospice. My husband, Phil Bossart, MD ’81, continues at the ER at the University of Utah. Our oldest son, Chris, 24, started medical school this fall at the University of Utah. Abby, 21, has been studying in Spain for her junior semester abroad; she traveled to Portugal, Italy, Croatia, Switzerland, and Ghana, and finishes up at Occidental College in 2012. Matt, 19, finished his first year at Dartmouth.”

Douglas F. Buxton, MD ’82, is clinical professor of ophthalmology at New York Medical College and president of the Jorge N. Buxton Micosurgical Education Foundation.

Walter “Ted” Donnelly, MD ’82: “Life is busy in the Midwest. Our oldest son, Kevin, who would have made a brilliant engineer, is applying to medical school. Now I need to convince his mother that the Upper East Side is not rampant with muggers. Middle son Ryan is a sophomore at Ohio State in biomedical engineer, and daughter Erin still wants to be a vet. Karen and I celebrated our 25th anniversary last fall. Tempus fugit.”

Peter H. Judson, MD ’82, and his wife, Grace Makari-Judson, MD ’82, have a son, Timothy, entering Weill Cornell in the Class of 2015.

Barnaby Starr, MD ’82: “I continue to run a general pediatric practice in Baltimore. Not a day goes by that I don’t think back fondly on my Medical College experience. The clinical skills and confidence gained there are useful every day.”

Mary Nolan Hall, MD ’83: “I have been promoted to deputy chief academic officer and designated institutional officer at Carolinas Healthcare System. I am busy in the Midwest. Our oldest son, Matt, entered Weill Cornell in 2010. He is working in home hospice. My husband, Wayne (we’ve been married 35 years), is no longer with us. My two kids—Matt and Katie—are now out of college. Give me a call if you’re in town.”

Maureen Tierney, MD ’83, and her husband, John Brennan, moved with their sons from Massachusetts to the D.C. area nine years ago, where Maureen worked for the FDA in the Office of Infectious Diseases and John was a Congressional lawyer specializing in railroads. John’s knowledge got him recruited for a terrific position with Union Pacific Railroad. “So here we are in the true heartland—Omaha, NE—and the boys, John, 15, and Jim, 13, are at Creighton Prep. I am doing some consulting and also becoming more involved in the support and advocacy for those with Asperger’s syndrome. Visitors most welcome.”

Scott Hayworth, MD ’84: “I’m busy in my role as CEO of the Mount Kisco Medical Group. We have 270 physicians in 22 locations. Finishing my stint as chair of the American Medical Group Association and on the ACOG board. My wife, Nan Hayworth, MD ’85, is busy commuting between Washington and the district. She is enjoying the challenges of being a member of Congress. The long hours of practicing medicine have prepared her well for her new job.”

Larry Robinson, MD ’84: “I completed my MBA this May—a tremendous amount of work but overall a great experience. I’ve used this degree to become the managing director for the research unit in our practice, but am also attempting to create a senior executive position of surgical services.
since we left the Medical College!”

Matthew J. Kates, MD ’86: “I just reached 20 years in practice and am a partner in ENT and Allergy Associates, a 125-doctor specialty practice. My oldest starts high school this fall. A lot has changed since we left the Medical College!”

Randy Jacobs, MD ’87: “I’ve been a staff physician with Kaiser of Colorado in the St. Joseph Hospital Emergency Dept. for 16 years. We are affiliated with the Denver Health Emergency Medicine Residency. I enjoy the challenge of teaching residents in our busy ED. Aside from work, I’ve really gotten into the Colorado lifestyle; I mountain bike all summer and ski all winter. Right after returning to Colorado, I got married to Jill. We have three boys—Zak, Reed, and Max—who keep us very busy. If anyone from the class is ever in Colorado, give me a shout.”

Karl A. Illig, MD ’88: “After 23 years at the University of Rochester, I have relocated to the University of South Florida, in Tampa, as professor of surgery and director of the Division of Vascular Surgery; my e-mail (and all are welcome to contact me there) is killig @ health.usf.com. I’ll miss Paul Rubery, MD ’88 (spine surgery in Rochester), who I operated with on a weekly basis. Professionally my career continues to be a lot of fun. I was elected to the Vascular Surgery Board of the ABS, and as Jeff Gershenwald ’84, MD ’90, is also on the Surgical Oncology Board, we have two members of our class helping to run the show. I’m editing a 120-chapter textbook on thoracic outlet syndrome and run a yearly national meeting for medical students and surgical residents interested in vascular surgery. I’m past president of the Peripheral Vascular Surgery Society and serve on several SVS committees, so life is fun and busy. Personally, Juliet and I just celebrated our 20th wedding anniversary. Andrew, 15, is looking forward to being able to drive, and Melissa, 13, enjoyed surf camp last year. Andrew loves computers and cars (and likes golf a bit), while Melissa is an amazing artist, having won several competitions. Everyone is doing well. Hope all are well. Please visit if you’re in Tampa.”

Theresa Rohr-Kirchgraber, MD ’88, was named executive director of the Indiana University National Center of Excellence in Women’s Health. She is associate professor of clinical medicine and pediatrics and a faculty member in the Indiana University School of Medicine’s Division of Adolescent Medicine.

Dora Weinstein, MD ’89: “My best wishes to all my friends and colleagues.”

1990s

Julio Lopez-Andujar, MD ’91: “I’m a primary care internist and medical director of a private geriatric multi-specialty clinic of CAC Florida Medical Centers in the great weather of South Florida, where we provide comprehensive and holistic care. I have a great wife, Amelia, and two great children, Sofia, 11, and Julio, 15. I enjoy traveling, spending time with my family, and my small private practice science lab and library of more than 3,000 books. I study every subject you can imagine, from astronomy and particle physics to sociology, literature, and economics. That broad perspective has really helped me better understand and deal with the multiple dimensions of my patients’ sense of well-being. I like working with a great, motivated team of staff and physicians. I remember Dr. Daniel Alonso’s sincere dedication and support for us students. I hope to hear from Alfonso Torres ’86, MD ’90, Byron Simmons, MD ’92, and Daniel Jones ’86, MD ’90. Life is great and Weill Cornell was a good starting experience.”

Thomas W. Shields, MD ’96: “I’m an attending emergency department physician at Forsyth Medical Center in Winston-Salem, NC.”

2000s

Katie Hisert, MD-PhD ’06: “I’m in the second year of my pulmonary and critical care medicine fellowship at the University of Washington. In February I will return to the lab full time to study the interactions between the innate immune system in the lung with bacterial pathogens.”
In Memoriam

'41, '44 MD—Morton A. Beer of Morristown, NJ, August 12, 2011; ob/gyn; chairman, Dept. of Ob/Gyn, Morristown Memorial Hospital; clinical assistant professor of ob/gyn, Robert Wood Johnson Medical School; veteran; active in civic, community, and professional affairs.

'46 MD—Thomas C. Hill of Salisbury, MD, June 4, 2011; practiced internal medicine; chief of staff, Peninsular Regional Medical Center; veteran; worked on medical research that led to the safe use of pilot ejection seats; active in community, professional, and religious affairs.

'48, '50 MD—Leon I. Charash of Plainview, NY, September 14, 2011; pediatric neurologist; associate clinical professor of pediatrics, Weill Cornell Medical College; consultant in child neurology; veteran; chairman, medical advisory committee, Muscular Dystrophy Association; founded a cerebral palsy center in São Paulo, Brazil; appeared yearly on the Jerry Lewis Labor Day Telethon; veteran; active in professional and alumni affairs.

'44, '50 MD—Robert H. Dickson of La Crescenta, CA, September 10, 2011; general family practitioner; physician at the maximum security Tehachapi State Prison; veteran; active in community and professional affairs. Phi Delta Theta.

'50 MD—Heinz F. Eichenwald of Dallas, TX, September 8, 2011; expert in pediatric infectious diseases; professor emeritus and department chairman, UT Southwestern; chief of staff, Children's Medical Center Dallas; chief of pediatrics, Parkland Memorial Hospital; helped improve pediatric hospitals in Chile, Colombia, Haiti, and Vietnam; active in professional affairs.

'51 MD—Lyle R. Smith of Kingsport, TN, September 3, 2011; president of medical staff and executive committee member, Holston Valley Medical Center; taught medieval English history at East Tennessee State University's Kingsport Allandale Center for Continuing Education; held a degree in theology from the University of the South; veteran; active in community, professional, and religious affairs.

'47, '51 MD—James O. Wynn Jr. of Carrboro, NC, February 10, 2011; chief, Division of Endocrinology, University of Arkansas Medical Center; taught at Duke University Medical Center; in private practice in Durham, NC; chairman, Dept. of Medicine, Durham Regional Hospital. Sigma Phi. Wife, Patricia Stroup Wynn '50.

'52 MD—Leston L. Havens of Cambridge, MA, July 29, 2011; professor emeritus of psychiatry, Harvard Medical School; principal psychiatrist and co-director of education, the Cambridge Hospital; author; editor; active in professional affairs.

'52 MD—Russell S. Hoxsie of Wilbraham, MA, July 30, 2011; private family physician; medical director, Martha's Vineyard Hospital's Windermere long-term health delivery services; medical examiner; emergency room physician; set up the first cardiac care unit on Martha's Vineyard; pioneer in the diagnosis and treatment of Lyme disease; author; newspaper columnist; active in community and professional affairs.

'52 MD—Herbert S. Sacks of New Haven, CT, August 30, 2011; clinical professor of child and adolescent psychiatry, Yale School of Medicine; international medical consultant; past president, American Psychiatric Association; volunteer faculty member, Child Study Center; proponent of confidentiality of medical records; campaigned for group insurance coverage for outpatient psychiatric treatment and mental health parity in insurance coverage; supported the “Goldwater Rule,” barring psychiatrists from offering professional opinions about anyone they have not personally examined; author, Hurdles: The Admissions Dilemma in American Higher Education; veteran; active in civic, community, professional, and alumni affairs.

'53 MD—Kenneth C. Archibald of San Francisco, CA, August 24, 2011; specialist in rehabilitation, California Pacific Medical Center; professor, UCSF Medical Center and Temple University; helped create the Archibald/Ehrenberg Rehabilitation Terrain Park; veteran; ski patrol member.


'57 MD—Helen Carter Abel of Elizabethtown, NJ, June 25, 2011; gynecologist; active in community affairs. Husband, Robert R. Abel, MD '56.

'55, '59 MD—G. Billie Lerner of Washington, PA, August 4, 2011; first woman to be chief resident at the Veterans Hospital in New York City. Husband, William C. Lerner '55.

'60 MD—James W. Innes of Stamford, CT, formerly of Greenwich, CT, August 29, 2011; practiced gastroenterology and internal medicine; taught interns and residents at Greenwich Hospital and Yale New Haven; veteran; active in civic, community, and professional affairs.

'64 MD—John B. Morrison of Dix Hills, NY, September 19, 2011; co-chief, Division of Cardiology, North Shore University Hospital; associate professor of medicine, Weill Cornell and NYU; served on four NIH study sections; veteran; author; active in professional affairs.

'65 MD—Robert P. LaFiandra of Middlebury, VT, September 3, 2011; physician; served in the Public Health Service in Chile; master gardener; active in community affairs.
Get Moving

Weill Cornell student group teaches disadvantaged kids the pleasures of exercise and good nutrition

Inner-city kids face a host of hurdles in adopting a healthy lifestyle. There’s the ubiquity of fast-food outlets; the dearth of markets selling fresh fruits and vegetables at affordable prices; the lack of safe, open spaces to play. Those and other factors are fueling what Maura Frank, MD ’88, calls a crisis in childhood obesity. “We know that obesity is likely to continue into adolescence and adulthood unless there are interventions,” says Frank, an assistant professor of pediatrics and the director of pediatric ambulatory care at Weill Cornell. “Because of its severe effects, this may be the first generation of children who live shorter lives than their parents.”

Frank is a faculty adviser to one such intervention: MAChO, a Weill Cornell student group that aims to instill healthy habits in kids from disadvantaged neighborhoods. Founded in 2009 by Ghanaian-born medical student Nii Koney ’12, the group—whose acronym stands for Motivating Action through Community Health Outreach—offers year-long programs for kids aged eight through thirteen. “Younger kids may not know things that are second nature to us, like calories or what lean meat is,” says Diana Mosquera ’14, a Colombia native whose Spanish fluency has been handy in communicating with immigrant parents. “What I find gratifying is knowing that I’m helping kids learn these things early on. And it’s fun spending time with them—they’re really adorable.”

Each session begins with the “MAChO Super Set”: a fast-paced series of jumping jacks, push-ups, crunches, and other calisthenics. Then there are lessons in healthy cooking—from veggie-topped mini-pizzas to whole-wheat pasta with broccoli and pesto—as well as ample chances to run and play. Sometimes, the kids take field trips to places like an Upstate New York farm, an urban greenmarket, the Sony Wonder Technology Lab, or the Tribeca Film Festival. The program’s message is positive: the pleasures of healthy living can rival the temptations of junk food and video games. “We don’t say, ‘You must never eat candy,’” Koney says. “It’s, ‘If you’re going to have candy, eat it in moderation; check the nutrition label, know how much you’re taking in and what that means for your body.’” We don’t say, ‘Never go to McDonald’s’; instead, it’s, ‘When you go to McDonalds, you don’t have to have the hamburger—choose the salad.’ We try to empower them to make good choices.”

Originally, the group—first named Movement Against Childhood Obesity—recruited kids who were already overweight or obese, with BMIs above the 90th percentile. “But we moved away from that,” Koney says, “to keep the program from being stigmatized as the ‘fat-kids’ camp.” Besides, he says, “Our vision is to have our participants help change things at home, in their schools, and in their communities—and any kid can do that.”

Koney notes that MAChO is a true community effort, with backing from a veritable village of supporters. It was started with the help of Warria Esmond ’80, MD ’84, medical director of East Harlem’s Settlement Health, a key venue for participant recruitment; it has been funded by such sources as the Weill Cornell Alumni Association, the Student National Medical Association, and the Aetna Foundation; student volunteers have come not only from Weill Cornell but also Hunter College, Columbia, NYU, and Cornell University’s urban semester program; and it is currently expanding through partnership with the Boys Clubs of New York. And, says Koney, they hope to eventually expand to other medical schools.

Involving parents is also essential to the program’s success, Frank stresses. “You can see tremendous change if you affect even small pieces of behavior—for example, decreasing the sugary beverages that children consume—but you have to get the whole family on board, or it’s tough to make it work,” she says. “Younger kids are still growing—so if you can slow the weight gain, you’ve pretty much solved the problem.”

— Beth Saulnier
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Patricia Gutter
Executive Director of Development
Phone: (646) 317-7351
Email: pag2002@med.cornell.edu

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