Retainer Medicine
Hands-On Care, With a Price Tag
formed U.S. medical education, Jefferson had the nation's first schools for nurses in 1891. In 1877, Jefferson subsequently opened one of as they treated patients was considered revolu-
tionary. The Jefferson School of Pharmacy in 2008, which currently has 336 students working toward a Doctor of Pharmacy degree. Jefferson is preparing these men and women for expanded roles that — in the future — may include prescribing medication in specific circumstances, as well as a broader scope in monitoring and coordi-
nating medical dispensing.

In 2009, we founded the Jefferson School of Population Health to educate leaders in health policy and delivery systems and to focus on the issues of health in large populations. Graduates emerge with the skills to shape care systems and to assess health outcomes and quality. The school currently has 230 master’s- and doctoral-level students. The Jefferson School of Health Professions, which has 820 students preparing for a range of therapeutic careers, recently introduced new doctoral programs in physical therapy and occupational therapy — preparing practitioners for a broader scope of responsibility and independence in the future that might potentially include prescribing treatment in addition to carrying out defined plans of care.

The Jefferson School of Nursing has grown rapidly, from 355 students eight years ago to 1,200 today. During this period of growth, the student body has shifted from primarily associate-level nurses toward individu-
als obtaining undergraduate, specialized master’s- and doctoral-level nursing degrees. The school first began offering the Doctor of Nursing Practice degree in 2007, training nurses for advanced-level direct care and for healthcare administration and policy. Now, nearly 50 students are working toward a DNP degree in preparation for new roles in triage and treatment that may address some of the shortages we face in primary care.

While turf issues are sure to arise as the roles of healthcare providers evolve in the coming years, Jefferson must be courageous enough to define new ways to address the nation’s healthcare needs and to reshape our curriculum accordingly. For instance, across all of our disciplines we are refining students’ team-
work skills through shared experiences with patient mentors, cross-disciplinary exchange and collaborative care exercises at Jefferson’s Clinical Skills and Simulation Center.

Team medicine requires mutual respect and an appreciation for what each profes-
sion brings to the table. It also reflects a new reality: healthcare professionals will collabora-
te in patient care — and potentially make rounds together — for the rest of their careers.

Team medicine isn’t just rhetoric. The approach expands the realm of expertise brought to bear on medical decisions, keeps costs in check and restores capacity to a health-
care system strained by increasing numbers of patients and looming physician shortages.

Just as our first 190 years required Jefferson to think differently and act boldly, so will the coming era. In fact, change is likely to acceleration. The new degrees and new schools are just the beginning.

Sincerely,

Robert L. Barchi, MD, PhD

President Thomas Jefferson University

Over the past seven years, Jefferson has reshaped itself, moving through a period of accelerated evolution in its scope and mission. Jefferson has now become a true health services university, committed to educating the entire healthcare team, developing the new tools and therapeutics that will need to care for patients and preparing our graduates to successfully navigate the rapidly changing landscape of U.S. medicine.

Our institutional agility reflects Jefferson’s historic record as an innovator in medical education. When Jefferson was founded in 1824, our approach of allowing medical students to work with experienced doctors as they treated patients was considered revolu-
tionary. Jefferson was among the first U.S. medical schools to open an affiliated hospital, in 1877. Jefferson subsequently opened one of the nation’s first schools for nurses in 1894. Well before the 1910 Flexner Report trans-
formed U.S. medical education, Jefferson had already pioneered its recommended changes by offering robust pre-clinical and clinical programs and training at the bedside.

Today, Jefferson has a far broader mission than its historic roots training doctors and nurses. Our institution has made a funda-
mental commitment toward cultivating the skills and teamwork needed among all the diverse professionals who will meet the nation’s future healthcare needs. This broader scope has led us to create dynamic new schools and introduce much-needed new degrees.

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Jefferson Medical College boasts more living alumni than any other medical school in the United States.

You clearly appreciate how important you are to each other’s career advancement and medical expertise. As I meet with alumni around the country, I often hear how interested you are in new ways to access this invaluable network of connections and friendships grounded in shared experiences at Jefferson.

When we surveyed alumni about ways to strengthen these connections, many of you expressed interest in a private, invitation-only professional and social network designed specifically for physicians. In response, we created connect.jefferson.edu for Jefferson alumni and former Jefferson residents, interns and fellows. Launched this fall, the site includes message boards geared to specific regions, medical specialties and graduating classes that will help you connect with colleagues in diverse ways.

For instance, a family physician in Austin who encounters a difficult case might post a query on a regional message board and find a Jefferson-trained physician nearby with the needed expertise – instead of referring the case to a regional academic medical center. Or, he might post a query on a specialty practice message board to obtain clinical guidance.

We hope you’ll also use the site to connect more easily and frequently with fellow alumni at medical conferences. For example, an anesthesiologist might post a message to invite Jefferson colleagues to her presentation at an American Society of Anesthesiologists meeting. And she might check to see which Jefferson friends plan to attend an alumni gathering at the meeting and persuade others to attend.

Message board dialogue may also yield employment opportunities. A physician looking to expand a surgical practice in Portland, Ore., may well find a talented surgical fellow currently at Jefferson who wants to move there.

The social media are great platforms for visual presentations that are entertaining as well as informative. With that in mind, we recently posted a video commemorating the 50th anniversary of Jefferson’s admission of women, “JMC: 50 Years of Women! ‘It Started with Nine.’” If you wonder how the Jefferson campus has changed over the years, check out our then-and-now photos. The website also includes news feeds about Jefferson that you can filter for your specific interests.

As you might expect, you can use the site to learn about upcoming alumni events and to post photos from alumni gatherings, such as a recent “Jefferson at the Shore” alumni reception and the 2011 Alumni Weekend. We anticipate more such gatherings in the future as new Jefferson alumni clubs spring up all over. A Hawaii club held its first reception in July to welcome newly accepted students. In September, alumni enjoyed a San Diego Padres game together, and a Sacramento club held its first event in October.

Additional features planned for the Jefferson alumni site will support physicians’ professional development. In the future, we hope to offer online access to on-campus events such as continuing medical education seminars, lectures and grand rounds speakers.

You’re at the heart of the Jefferson family, and we’re eager to continue to enrich your lives well beyond your years on campus.

Come join us online!

Mark L. Tykocinski, MD
Anthony F. and Gertrude M. DePalma Dean
Jefferson Medical College
Researchers at the Kimmel Cancer Center at Jefferson, along with an international team of collaborators, have discovered a biomarker in breast cancer that may help identify which women will respond to anti-estrogen therapy.

Anti-estrogen drugs, most notably tamoxifen, are widely used in patients diagnosed with estrogen receptor-positive breast cancer. However, as many as a third of the women given tamoxifen fail to respond.

The study, led by principal investigator Hallgerd Rui, MD, PhD, and published in the May 16 online issue of the Journal of Clinical Oncology, shows that women whose tumors retain the active form of the protein biomarker Stat5 have an increased likelihood of responding to tamoxifen so that they may be offered alternative and more aggressive treatments.

“Identification of predictive biomarkers present in breast cancer will lead to improved individualized therapies tailored specifically towards each woman’s cancer,” said Rui, professor in the Department of Cancer Biology at the Kimmel Cancer Center. “Absence of the active form of Stat5 could help identify a group of patients unlikely to respond to tamoxifen so that they may be offered alternative and more aggressive treatments.”

Stat5 protein is a DNA binding factor that regulates the expression of certain genes, many of which remain unknown. During pregnancy, Stat5 is activated by the hormone prolactin and stimulates milk production in the breast. Active Stat5 is also detectable at lower levels in healthy breast tissue of non-pregnant women. This study further shows that active Stat5 was lost in the majority of more aggressive tumors and in those tumors that metastasized to lymph nodes.

In 2004, Rui and colleagues reported that women with early stage breast cancer that may help identify which women will respond to anti-estrogen therapy, they further investigated the relationship between active Stat5 in the tumor and whether the patient had breast cancer recurrence or died of breast cancer within 30 years. The team found consistent favorable breast cancer outcomes when tumors retained active Stat5.

A benefit of optimizing a marker like Stat5 is that the assay for Stat5 is simple, inexpensive and easily adapted to routine analyses in pathology laboratories using standard procedures.

“More work remains to be done, but we are optimistic about the utility of Stat5 as a biomarker,” said Amy Peck, PhD, a lead author on the study. The team has plans for further investigation with a larger patient group in a randomized, prospective study to evaluate the use of Stat5 in managing and treating breast cancer.

**A. Loss of Active Stat5**

**B. Active Stat5**

Active Stat5 is a transcription factor capable of binding DNA when activated by Jak2, resulting in the expression of certain genes that regulate cell differentiation.

ER+, Stat5+ tumor. The loss of active Stat5 can lead to a more aggressive tumor and cell invasion, resulting in poor prognosis. Tumor cells lacking Stat5 are not responsive to tamoxifen and continue to survive.

ER-, Stat5+ tumor. Stat5 signaling confers a more differentiated and less aggressive tumor resulting in good prognosis. Active Stat5 contributes to responsiveness to tamoxifen.
RETAINER PHYSICIANS
Old-Fashioned Medicine or Destabilizing Trend?

Something was wrong. After three unanswered phone calls, Winslow Murdoch, MD ’86, drove to the group home where his patient, an alcoholic, lived. There he found the patient, “Joe,” lying in bed. Joe stood up, winced and said, “Oh – my leg!”

That house called saved Joe’s life, after diagnosing Joe with deep vein thrombosis. Murdoch drove him to an emergency room for treatment. Such is the unpredictable yet rewarding life of a retainer physician, whose retainer fee in this case was sponsored by his destitute patient’s parents.

Murdoch is among a growing group of physicians who have switched to a retainer practice model to escape insurance-mandated pressure to limit checkups to 10 minutes or less. “I had older patients with complicated chronic conditions. And the most important work I could do for patients in coordinating their care, typically about a third of my work, was not being compensated,” recalls Murdoch, who now runs a retainer practice affiliated with Total Access Medical LLC, of Bala Cynwyd, Pa.

Instead of Leaving Medicine
Murdoch’s decision came after 15 years in the trenches, building a solo practice into a group practice in East Goshen, Pa., that was sold to Main Line Health in 1995. He became an independent practitioner again in 2001. On the brink of leaving medicine altogether in 2004, he decided to convert to a “retainer fee direct practice.” Retainer physicians prefer terms like “retainer-based” or “direct-practice medicine” over “boutique” or “concierge” medicine, which they say evoke images of white-gloved servants.

Fees for retainer physicians vary widely – from basic plans costing $500 a year to the more prevalent range of $1,500 to $6,000 annually. While MD’, a firm with offices in six U.S. cities, offers a “Cadillac plan” that costs patients $20,000 a year (each physician has a caseload of 50 families), that’s not the norm. By comparison, MDVIP, a national firm representing 450 physicians whose practices are limited to 600 or fewer patients, charges annual patient membership fees of $1,500.

Patients who pay for retainer care usually keep their health insurance but use it for hospital, surgical and specialist visits. What they get for their retainer fees typically includes 24/7 access to a physician with a caseload of between 150 and 600 patients, which allows for what used to be the norm in medicine: unhurried physician visits (often 90 minutes long) and even house calls. Patients receive ongoing assistance from their retainer physician, for instance, for chronic or life-threatening diseases, medical emergencies, pre-and post-operative care and end-of-life consultation and guidance. Fees often cover nutrition and wellness programs as well as staff time devoted to helping patients navigate insurance reimbursement and pre-certification for other healthcare providers.

Sufficient Time

Patients who don’t get time with their physician often just don’t understand their diagnoses, medications or tests.”

Insurance-mandated constraints on time with patients stopped working decades ago for Bruce Sokoloff, MD ’86. “I always was an hour to two hours behind by the end of the day. But nobody minded waiting because I would give them all the time they needed,” he recalls. “However, with reimbursements dropping and overhead increasing, the only way to make ends meet was to see more people every day.”

According to the American Academy of Private Physicians, a national association, retainer practices first emerged in the mid 1990s; by 2005, there were 500 such practices, growing to 3,500 by 2011. Three percent of family physicians run retainer practices, according to a 2010 survey conducted by the American Academy of Family Physicians.

How insurance is aligned with retainer medicine varies and can be a sensitive and difficult-to-navigate issue: according to a study on retainer medicine commissioned for the Medicare Payment Advisory Commission in 2010, some state insurance commissioners have raised concerns about the risk of double billing and whether retainer medicine should be deemed another form of insurance subject to regulation. Medicaid policy about retainer practices, according to a 2010 survey conducted by the American Academy of Family Physicians.

Sufficient Time

Building Relationships
Accidentally, the benefits for patients are clear. Perkins recalls one patient in his late 50s whose obsessive-compulsive disorder threatened to prevent him from getting care for multiple conditions including diabetes, morbid obesity, hypertension and depression. “He took two months to gather the courage to make his first appointment,” says Perkins, whose practice is affiliated with Total Access Medical. “We spent two and a half hours during that first visit just getting him comfortable. Then we placed him on a treatment plan so he got the care he needed. Years later, I still get letters from him expressing his gratitude for his improved conditions. Under the old model, it would have been virtually impossible to give this patient the time he needed.”

Sokoloff, who shifted his Wilmington, Del., practice to the retainer model in 2004, recalls helping a patient get relief after he had experienced severe diarrhea for 17 years due to colitis. Sokoloff used new integrative medicine approaches for which he would not have been reimbursed by insurance. “We found out he was harboring bad bacteria in his bowel and put him on probiotics, prebiotics and botanical antibacterial,” says Sokoloff, whose practice is also affiliated with Total Access. Previous multiple specialists had been unable to get the patient’s symptoms under control.

Murdoch participates in family meetings to help cope with end-of-life or hospice-related decisions nearly every month. “I talk to family members all over the country and help them make sense out of a very complex healthcare world. I never had that kind of relationship with my patients before,” he says. He recalls one patient in his late 80s with end-stage renal failure. “Everyone wanted him on dialysis except the patient himself, who was getting bullied into doing things by his family and the health system. We stop the insanity of unwanted care, and that saves the healthcare system a tremendous amount of money.”

However, many physicians are wary of retainer medicine due to worries about where to draw the line with demanding patients, discomfort with winnowing a practice down typically to one-fourth their prior patient caseload and global concerns about contributing to the growing shortage of primary care physicians.

“One of the first questions I hear is, ‘Will I get the call at 2 a.m. from the patient with a hangnail who thinks she owns me?’” says Perkins. “That possibility exists. You’re on call constantly. However, abuse of after-hours calls has not been an issue with my patients.”

“Most people are reasonable,” says Matthew Kilsoon, MD ’93, of Kilsoon Medical Associates, an independent retainer medicine practice in Philadelphia. He makes around six house calls a year, limiting them to special circumstances such as a patient who’s a quadriplegic.

Difficult Goodbyes
Asking patients to switch to the retainer model or join another practice deters many physicians considering the retainer model. Sokoloff, who reduced his patient numbers from 1,800 to 300, says, “There absolutely was pain associated with that. I did a lot of freebies to make sure everybody was safely transferred to another doctor.”
Murdoch, who reduced his practice from 1,000 patients to 220, says, “The vast majority of my patients know our healthcare system is broken and saw the fragmentation in care. But they didn’t find the value proposition to continue. What was painful was the 15 to 20 patients who said, ‘I need you but don’t have the money.’ That was tough. But if it weren’t for this practice model, I wouldn’t be practicing clinical medicine today.”

Perkins resolved this issue by seeing 10 percent of his patients pro bono, “people with significant need who couldn’t afford this otherwise.” And Killion structured a hybrid practice – with 150 retainer patients plus 1,000 fee-for-service and Medicare patients. “I didn’t feel right about requiring everybody to pay a full annual fee,” says Killion. After seven years, though, he switched to a full retainer practice, grandfathering in patients who were unable to pay retainer fees.

Questions About Access

For critics who say retainer medicine contributes to the growing gulf between the wealthy and everyone else, Perkins says, “A caste system exists already in U.S. health care with all different levels of insurance out there, from the poorest HMO to the top-level premium care at premium prices. Retainer medicine levels the playing field. For a flat fee, you are guaranteed as much care as the next person.”

Murdoch adds, “I can’t fix the broken nature of our healthcare system that puts the poor at a disadvantage. Medicine requires a paradigm shift. What I’m saying is, ‘You guys take the next two decades figuring this out. I’m going to do it.’ If we can’t begin to make the primary care lifestyle more attractive, it’s going to be dead. One of the most important things that could happen to primary care is that doctors actively change the model. Otherwise, there won’t be anybody to take over.”

Richard Wender, MD, chair of Jefferson’s Department of Family and Community Medicine, believes that retainer medicine contributes to primary care physician shortages. “That’s self-evident,” he says. “While concierge medicine is one solution for individual clinicians who don’t want to provide high-volume care, it simply will not work to address the healthcare needs of the whole population. It’s not even up for debate. For patients who don’t have the resources, you would obviously dramatically reduce their access. If all doctors converted their practice to this model, even those with the resources to invest in their own health care might find it more difficult to find a physician.”

Primary care physicians have been functioning on the margin of financial and workload viability for years,” says Wender. “That’s a point on which Sokoloff concurs: ‘What’s really driving the shortage is the insurance companies that make life miserably for primary care doctors. There has to be some relief for physicians.’” However, Wender sees the solution in broader shifts in U.S. health care: “We need a fundamental realignment of incentives and a redesign of our delivery system to take care of everyone. The future of primary care doesn’t lie in meeting all of a patient’s needs and having more time to do it. The most exciting model is the patient-centered medical home: interdisciplinary teams of people who together meet the needs of their enrolled patient.”
Advancing New Therapeutics for Sickle Cell and Leukemia Patients

Samer Ballas, MD, witnessed suffering on an epic scale for nearly four decades in a career dedicated to patients with sickle cell anemia. “This is a group of people who are on the margins of life, often unable to work or start families,” says Ballas, describing how young adults with severe cases of this inherited blood disease experience increasingly acute bouts of pain by their early 20s. Recurrent strokes, chronic lung, heart and liver problems – even leg ulcers so deep that amputation may be the only recourse – complicate their suffering. Until recently, physicians had limited pain and prevention options for adult sickle cell patients, few of whom made it past their 40s. “A cure was the hope and holy grail of my career,” says Ballas, former director of the Jefferson Comprehensive Sickle Cell Program, who began practicing medicine in 1970. Now retired, he is honored to have an advisory role on the committee overseeing a promising clinical trial at Jefferson for adults with sickle cell disease. This trial involves a two-step stem cell transplant protocol using blood from donors who in some cases are only genetically half-matched to the patient. The first patient treated, a 29-year-old with severe sickle cell symptoms, is faring well two months post-transplant, and another five patients are in the queue for enrollment in the trial, which is open to patients with severe sickle cell symptoms. “So far, we have very encouraging news,” says Ballas. “But we have to be extremely careful in selecting patients for our clinical trial and counseling them and their families.”

Initially developed by Jefferson clinicians for patients with hematological malignancies, Jefferson’s new approach to half-matched donor transplants helps people who don’t have genetically matched donors, especially minorities and older patients, gain access to a vastly larger pool of donors for potentially life-saving treatment.

Prior to Jefferson’s new treatment approach, only one in three hematological malignancy patients could hope for a cure using a fully matched stem cell donor. For patients with severe sickle cell disease, the odds of finding a donor were still worse: the disease is more prevalent among minority patients for whom it’s difficult to find a match, and young adults with sickle cell disease are generally too frail to survive transplant.

Jefferson’s new two-step half-matched transplant protocol appears to overcome these barriers for patients with either sickle cell anemia or hematological malignancies, both of which involve abnormal cells being produced by the bone marrow. The new approach has also yielded positive outcomes with older leukemia patients even in their late 70s, a population that couldn’t tolerate prior stem cell transplant protocols.

Paradigm Shift

“Astounding” is the adjective that Neal Flomenberg, MD ’76, chair of Jefferson’s Department of Medical Oncology and clinical deputy director at the Kimmel Cancer Center, uses to describe the outcome of his group’s first clinical study using stem cell donors whose human leukocyte antigens (HLA) are only half-matched to the patient. That study included 27 patients who had hematologic malignancies. Of those who went to transplant with their leukemia in remission (controlled by a prior chemotherapy), 75 percent are alive and disease-free three years after transplant. Seventy-five percent survival is a big improvement. The vast majority would have relapsed and died otherwise,” Flomenberg says. Previously, he would have been happy to see 50 percent of high-risk patients disease-free three years post-transplant with a fully matched donor. Moreover, fewer than five percent of patients in this clinical trial developed severe acute graft-versus-host disease (GVHD). When GVHD occurred, the clinical manifestations were mild and easily managed in all but one case and did not trigger the potentially life-threatening infections often seen with the more serious forms of this condition.

Jefferson’s Bone Marrow Transplant Program is now a national leader in using half-matched donors and has conducted more than 135 transplants in its clinical trials. Data from these clinical trials – presented at national meetings, published in abstracts and currently pending publication in medical journals – may well point to a larger paradigm shift toward the use of half-matched stem cell donors, both for patients with hematological malignancies and those with sickle cell anemia.

Counter-Intuitive

“We’re now doing well enough that in our program we don’t differentiate anymore when you should be transplanted based on what kind of donor you have,” says Flomenberg. “We have eliminated the bias of transplanting later if you only have a half-matched donor. These patients are no longer second-class transplant citizens.”

In fact, says Flomenberg, results from two completed Phase II clinical trials at Jefferson, plus another seven related Phase II clinical trials currently under way, indicate that using a half-matched donor sometimes confers even greater efficacy to the transplant procedure. “We’ve learned how to use the donor immune system to help control the malignancy,” says Flomenberg. “One way in which transplant controls leukemia is by the donor immune system attacking the malignancy in a kind of graft-versus-tumor effect,” says Flomenberg. “Our data suggest that half-matched donors have a stronger anti-leukemia effect that hopefully would provide a lower relapse rate and better survival. While this hasn’t hit practice yet, we’re close to recommending half-matched donors over fully matched ones in high-risk situations. However, in our carefully regulated practice of medicine, we are still trying to come to grips with how to counsel patients in these high-risk situations.”

Jefferson’s findings build on counter-intuitive data from other studies. Relapse rates for patients with acute myelogenous leukemia transplanted from genetically matched sibling donors are around 10 to 15 percent. Yet for similar patients transplanted from an identical twin, the relapse rate jumps to 50 percent. “There’s a simple explanation,” says Flomenberg. “A twin’s cells, being a perfect copy of the patient’s, are often as blind to the leukemia as the
Patient Michelle DiVirgiliis, 31, received a half-matched stem cell transplant in March 2007 for treatment of acute lymphoblastic leukemia. Diagnosed with acute myeloid leukemia in March 2007 for treatment of acute lymphoblastic leukemia. Over the next three to five years, use of half-matched stem cell donors could become more widespread, according to Matthew Carabasi, MD ’80, associate director of clinical investigation at the Kimmel Cancer Center. “Prior to these findings, our major problem was that most patients didn’t have a matched donor,” says Carabasi. “If you have a sibling, the odds of a perfect match are only 25 percent. Unrelated donor registries are an important resource for patients without a sibling match. But the reality is that while some patients will find multiple fully matched donors, many patients won’t find a single match, especially minorities.”

Jefferson’s approach changes these odds. It expands the universe of possible donors for both diseases to now include parents, children or even siblings who aren’t a full match. Similarly, it opens new possibilities for finding an acceptable (though somewhat mismatched) donor in the unrelated donor registries; that’s important because fully matched sibling donors are scarce among older patients, non-existent among adoptees and impossible to obtain in families where siblings don’t share the same biological parents. A matched donor is especially difficult to find in minority populations and among people of mixed-race ancestry. African Americans are 10 times as diverse in their HLA patterns as Caucasians. So far, Jefferson is one of only two programs in the United States that offer half-matched stem cell transplants for sickle cell disease. Jefferson’s Sickle Cell Center cares for 250 adults, an estimated half of the adult sickle cell population with the disease in Philadelphia. Of those patients, approximately 60 have severe disease manifestations.

Joanne Filicko-O’Hara, MD, of Jefferson’s Blood and Bone Marrow Transplant Program, who wrote the protocol for the clinical trial for sickle cell patients, says, “We’re on the cusp of something that could be major. It would mean that people in their 20s who have presumed they have a life expectancy of maybe 20 more years – without an ability to be gainfully employed, raise a family or enjoy the normal things a healthy adult can enjoy – will now have these options. The public health cost savings would be enormous.” An estimated 70,000 people in the United States have sickle cell anemia. Each year 1,000 people are born with the disease, one in 500 African Americans is afflicted, as is one in 1,000 Hispanics.

“After decades of witnessing pain, it brings me great pleasure to see patients suffering all their lives suddenly be like you and me,” says Ballas. He was elected when the precursor of Jefferson’s clinical trial, a National Institutes of Health study, demonstrated that a cure for adults with sickle cell disease was even a possibility. In that breakthrough study published in the New England Journal of Medicine in 2009, nine of 10 patients (transplanted with stem cells from fully matched sibling donors) reversed the sickle cell disease. Stem cell transplants have been found to be curative in children with sickle cell disease. However, prior to 2009, unsuccessful attempts to use the therapy with young adults had created an assumption that the procedure had unacceptably high toxicity due to graft-versus-host disease. Flomenberg, who has been working on stem cell transplants for patients with hematological malignancies since the early 1980s, points to the important contributions of a team of clinicians at Jefferson and the influence of similar research currently under way at Johns Hopkins University. He notes, in particular, the contributions of Dolores Gross, RN, CRNP, who earned a doctoral degree in nursing practice in the course of the group’s research and whose insights were pivotal to the Jefferson group’s therapeutic protocols. “What we’ve achieved, collectively, is a game-changer that offers great promise for controlling malignancy and sickle cell,” he says.
Not long before the American Civil War, Jefferson Medical College was the most attended medical school in the world. But beginning in December 1859, a third of its 650 students left Philadelphia to return to the South. The students who remained, together with many Jefferson faculty members, became an indispensable army of ingenuity for the Union.

The battlefield became their brutal and unwanted – yet bountiful – proving ground for advances in pedagogy and training. Led by Samuel D. Gross, MD 1828, and Jonathan Letterman, MD 1849, they pioneered triage protocols and the first ambulance service; introduced medical supply lines, pharmaceuticals and early anesthetics; organized large-capacity hospitals; and literally wrote the book on new surgical techniques, including methods needed to treat more complex wounds made by new artillery.

Acting with urgency, these Jeffersonians transformed what had been considered experimental and theoretical into practical reality. They made breakthroughs in battlefield and trauma care that laid the foundation for emergency medicine as we know it today.

In four years that tested our nation, Jefferson graduates, students and faculty traversed ground in medicine that otherwise might have required decades. This year marks the 150th anniversary of the start of the Civil War, during which JMC played a unique role in advancing medical knowledge, sometimes blunting tragedy and saving thousands of lives.

This flag, made in Philadelphia, flew near the JMC campus and was never lowered throughout the 1,458 days of the Civil War.
Above
Jonathan Letterman, MD 1849 (with hands on his belt), served as medical director of the Army of the Potomac, but JMC connections ran much deeper than most people realize. The Army’s commander, General George Brinton McClellan (sixth from left), facing President Lincoln in this photograph, was the son of George McClellan, MD, the College’s founder.

Right
Since Alexander the Great, soldiers had been responsible for taking the wounded from the battlefield—until Jonathan Letterman, MD 1849, medical director of the Army of the Potomac, created the first American ambulance service in August 1862. Directed by medical staff, horse-drawn ambulances took wounded soldiers for immediate treatment before transfer to a local hospital.

Background
Numerous Jeffersonians joined the staff of the 3,500-bed Satterlee Hospital, constructed on 12 acres in West Philadelphia, roughly between 40th and 44th streets and between Baltimore Avenue and Spruce Street. Constructed in only 40 days, Satterlee treated some 50,000 patients during the Civil War, with a relatively low mortality and mortality rate. Jefferson physicians at nearby Turner’s Lane Hospital conducted some of the first modern, quantitative research there on nerve damage, including reflex sympathetic dystrophy syndrome, neurogia and phantom limb syndrome.

Opposite Right
Jeffersonians on the front lines of the Civil War sometimes spanned generations. Samuel W. Gross, MD 1857, pictured in dress uniform, saved lives using the modern techniques described in A Manual of Military Surgery, written by his father, Samuel D. Gross, MD 1828, the most renowned surgeon of his day. So esteemed was this publication, commissioned by the War Department, that the Confederate Army plagiarized the volume and reprinted it as its own. The younger Gross would go on to succeed his father as chair of surgery at JMC in 1882.

Reflecting the grim necessities of saving lives on the battlefield, Civil War surgical sets often included a full array of amputation saws. This one was retrieved from Fair Oaks, Va., where some 1,750 casualties were suffered in just two days of fighting. The Jeffersonian who found it, and subsequently used it, bequeathed it to the Thomas Jefferson University Archives and Special Collections.
Jefferson Faculty

William Kevin Kelly: Advancing Therapeutics for Urologic Malignancies

Palliative care and radiation were virtually the only treatments available to prostate cancer patients back when William Kevin Kelly, DO, began his clinical and research career 25 years ago. Fortunately, conversations with patients have long since shifted from “that’s all we have” to a nuanced dialogue about choices among many treatment options. That shift is due in part to Kelly’s pioneering research on urological malignancies and his expertise in drug design and development.

“One of our dilemmas now is how to choose the right treatment for the right patient at the right time,” says Kelly, who joined Jefferson in 2010 as director of the Division of Solid Tumor Oncology in the Department of Medical Oncology and associate director of translational research at the Kimmel Cancer Center. Kelly’s research linking elevated prostate-specific antigen levels to prostate cancer treatment outcomes remains a foundation for drug development in patients with advanced prostate cancer today. More recently, he has been instrumental in developing multiple compounds such as microparticle disrupting agents, histone deacetylase (HDAC) inhibitors and anti-angiogenesis therapies for urologic cancers. He has successfully developed several new drugs from bench through clinical trial and approval—most notably the HDAC-inhibitor vorinostat, marketed by Merck as Zolinza and approved for cutaneous T-cell lymphoma.

Prior to joining the Jefferson faculty, Kelly directed the solid tumor clinical investigative program at Yale University’s School of Medicine, where he also co-directed prostate and urological oncology. He spent the previous 15 years on the faculty at Memorial Sloan-Kettering Cancer Center. He currently serves on the editorial boards of *Clinical Prostate Cancer*, *Journal of Clinical Oncology*, and *Nature Clinical Practice Oncology*.

Kelly recently shared his views on his experiences at Jefferson.

Q. What attracted you to Jefferson?
A. The breadth and excellence of Jefferson’s translational research and clinical programs appealed to me, as did the high patient volume. As clinical researchers and physicians, we take concepts from the bench and apply them to the patients. Likewise, scientists apply clinical scenarios to their laboratory research. What’s unique about Jefferson is our truly multidisciplinary culture. There are great relationships among urologists, radiation oncologists and basic science people such as Karen Knudsen, who directs the Kimmel Cancer Center Prostate Cancer Working Group. We’re collaborative within our institution, and we also reach out to other institutions in the Philadelphia area and the world to understand the science and bring new technologies and treatments to our patients here. Team science is the only way forward, and we’re good at that.

Q. What’s your teaching philosophy?
A. I’m very practical in my approach to medicine. I try to take my years of experience and distill them into things residents and students can take home and implement as physicians.

Q. What inspired your interest in urologic cancers?
A. When I started in this field, very few people worked in urologic cancers. There was a wide open canvas that I could actually help define. In addition, I had some excellent and brilliant mentors during my fellowship at Sloan-Kettering Cancer Center. Since I started, the field has made tremendous progress—especially during the last few years, when so many new drugs were approved for prostate cancer. I am very pleased that I have had the opportunity to be involved with the development of many novel treatments that have recently been approved. I’m very hopeful that these new treatment options will improve the clinical outcomes of patients.

Q. What advances do you hope to see in the field over the next few years?
A. We hope to be able to personalize medicine for each individual patient and are looking at molecular diagnostics to guide us down this pathway. Our goal is to be able to have a patient come in, take a blood test and a tumor biopsy, analyze these for genomic and molecular characteristics, and based on these findings, we will be able to tailor the patient’s treatment for them. For instance, while a group of patients may all have prostate cancer, their cancer cells may have very different molecular abnormalities that will dictate which treatment options to choose for each patient. We’re several years away from that, although we are making progress every day. The research will require a highly methodical approach to identify disease patterns and signatures, which will allow us to sub-classify patients.

Q. Over the course of your career, what has given you the most satisfaction?
A. My interactions with people over the years have been most memorable and meaningful to me—from individual patients to Academy of Science members to the hundreds of people involved in patient care and clinical trials. The richness of biomedical science is all about what we can accomplish together.
Knudsen Receives Award for Cancer Research
Karen Knudsen, PhD, JMC professor of cancer biology, urology and radiation oncology and member of the Kimmel Cancer Center, received the Ron Ross Award at the Fifth Pacific Rim Breast and Prostate Cancer Meeting in Kingscliff, Australia. The award recognizes her contributions in the field of hormonal carcinogenesis.

Ballas Honored by Howard University
Samir K. Ballas, MD, former director of the Jefferson Comprehensive Sickle Cell Program, received a lifetime achievement award for service, research and education from Howard University in May for his groundbreaking work on sickle cell disease.

Levitan Named Brucker Professor
Irwin Levitan, PhD, founding chair of the Department of Neuroscience and director of the Farber Institute for Neurosciences at Jefferson, has been named the Paul C. Brucker, MD, Professor in Neuroscience Research. This professorship was created in support of a faculty member within the Farber Institute for Neurosciences who is engaged in Alzheimer’s disease, neurodegenerative diseases or other related neurodegenerative research fields.

Farrell Joins Department of Neurological Surgery
Christopher J. Farrell, MD, has joined the Department of Neurological Surgery as assistant professor. Farrell specializes in brain tumor surgery and research and has been published extensively in such journals as the Journal of Neurosurgery and the Journal of Neuro-Oncology.

Emergency Medicine Residency Program Celebrates the 25th Anniversary of Its First Graduating Class
The Department of Emergency Medicine celebrated the 25th anniversary of its first graduating class of residents Sept. 17 with a gala event on the Spirit of Philadelphia. More than 275 people attended. Joseph Zuccardi, MD, received the Grace Humanitarian Award for his many significant contributions as the inaugural director of the department. Pictured (front, left to right) are Zuccardi and department chair Theodore Christopher, MD along with graduates of the first four classes of the residency program. Proceeds from the event went to the M. Andrew Levitt Research Foundation, established in honor of the department’s first accomplished researcher.

People

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Headlines

Cancer Cells Accelerate Aging and Inflammation to Drive Tumor Growth
A new study led by Michael P. Lisanti, MD, PhD, a member of the Kimmel Cancer Center at Jefferson, shows cancer cells accelerate the aging of nearby connective tissue cells, causing inflammation, which then fuels tumor growth.

The research, published in Cell Cycle, found that lethal cancers show the same gene expression pattern associated with normal aging as well as Alzheimer’s disease and that oxidative stress is a common driver for both dementia and cancer cell spreading. “Lethal cancer is a disease of accelerated aging in the tumor’s connective tissue, then cancer patients may benefit from therapy with strong antioxidants and anti-inflammatory drugs,” said Lisanti, professor and chair of stem cell biology and regenerative medicine.

Radiation After Prostatectomy Cost-Effective but Under-Utilized
Two studies by Jefferson researchers show a disconnect when it comes to treating prostate cancer. One study, published online in Annals of Oncology, found that administering radiation therapy immediately after a radical prostatectomy is cost-effective compared to waiting to observe PSA levels. Despite evidence of benefits to overall survival, radiation is often not given immediately due to concerns about associated toxicities, overtreatment and cost. This study found the treatment to be a practical option for patients.

Robert L. Barchi, MD, PhD, to Step Down as University President
Robert L. Barchi, MD, PhD, president of Thomas Jefferson University since 2004, has announced his decision to step down at the end of his eight-year term in June.

Over the past seven years, Barchi has overseen a period of tremendous growth for the University. He designed and implemented an ambitious strategic plan that integrated the school’s clinical, research and education missions. During his term, two new schools – the Jefferson School of Pharmacy and Jefferson School of Population Health – were established, and overall student enrollment increased 51 percent. The Kimmel Cancer Center leapt 20 places in national rankings, and research revenues rose to nearly $150 million.

Barchi has also nurtured a physical transformation at Jefferson. The University’s 12-acre campus has evolved with the construction of the Dorrance H. Hamilton Building, the Sidney and Elhai Lubert Plaza and substantial landscaping. A new building at 901 Walnut Street is set to open in January and will provide a critical academic home for the Schools of Health Professions, Nursing, Pharmacy and Population Health. And despite a difficult economic downturn, the University has doubled the funds raised during the preceding eight-year period.

After completing a year-long sabbatical, Barchi will return to Jefferson as a full-time faculty member in September 2013. “Dr. Barchi has been a dynamic leader, and the Jefferson community and campus have greatly benefited from his extraordinary energy and vision. His gifts as a CEO and academician will be missed, but I am delighted that he will remain part of our faculty,” said David R. Binswanger, chair of the TJU Board of Trustees.

“I have greatly valued and appreciated my relationship with the University community here at Jefferson and look forward to continuing that interaction during the final months of my presidency,” Barchi said. “And I am eager to continue serving as an integral member of our community of scholars when I return from my sabbatical in the fall of 2013.”
Correction Regarding Presidential Papers of Peter A. Herbut, MD

A brief article on the presidential papers of Peter A. Herbut, MD, was published in the spring 2009 edition of the Alumni Bulletin. It stated that Dr. Herbut was president of Jefferson Medical College from 1959 to 1969. This was incorrect. He was president of the medical college and hospital from 1966 to 1969, when he obtained university status for Jefferson and Medical College to provide support for the professional development of female JMC faculty and students.

CONTRIBUTE TO JEFFERSON'S 1961 FUND TODAY


Medical Frontiers

Wills Vision Research Center Opens

Wills Eye Institute and Jefferson recently opened the Wills Vision Research Center, representing more than 15 scientific disciplines. The center’s multidisciplinary approach draws upon a team with extensive clinical expertise and fosters regional, national and global collaborations. Research already under way at the center is examining the genetics of congenital abnormalities; age-related macular degeneration; the impact of Parkinson’s on the visual system; retinoblastoma and uveal melanoma; low vision and depression; and diabetic retinopathy.

The center is co-directed by Julia A. Haller, MD, ophthalmologist-in-chief at Wills Eye Institute and professor and chair of the Department of Ophthalmology; and A. Sue Menko, PhD, professor of pathology, anatomy and cell biology.

The second study, published in the International Journal of Radiation Oncology • Biology • Physics, showed that urologists were less likely than radiation oncologists to recommend adjuvant radiation therapy or to believe it improves overall survival. “Despite being shown to be effective, less than 20 percent of qualifying patients receive it,” said Timothy Showalter, MD, assistant professor of radiation oncology, associate research member of the Kimmel Cancer Center and lead author of the study.

Jefferson Medical College’s yearlong celebration of the 50th anniversary of the admittance of female students culminated Oct. 28 and 29 with a series of presentations by notable women including Vivian Pinn, director of the NIH Office of Research on Women’s Health; Christine Cassel, MD, president and CEO of the American Board of Internal Medicine and the ABIM Foundation; Virginia Valian, PhD, author of Why So Slow?: The Advancement of Women; Christine Laine, MD, first female editor of the Annals of Internal Medicine and a Jefferson faculty member; and graduates from the first JMC class to include women. Approximately 250 people attended the weekend’s events, which ended with a reception at the Ritz Carlton Hotel.
50 Bernard V. Hyland has established the Mary Eileen McGurrin, RN, MSN, Department of Nursing at the University of Scranton, Pa. He undergraduate alma mater, in memory of Mary Eileen McGurrin, a Jefferson alumna who passed away from a malignant brain tumor in 1995 at the age of 39. McGurrin worked at Wills Eye Hospital until incapacitated by her illness. Her brother, Mark A. McGurrin, a vascular surgeon, graduated from JMC in 1982.

51 Victor F. Greco has been appointed professor of surgery at the Community Medical College of Pennsylvania in Scranton, Pa. He continues to lecture on cruise ships and lives in Drums, Pa.

52 H. Edward LaViolette retired in 1988 but still works part time doing New Jersey workers’ compensation evaluations. He lives in Haddon Township, N.J.

53 Keith R. Young retired from practice in 1989 and moved back to his college town, Oberlin, Ohio.

54 William J. Albright III lives in Highspire, Pa., and reports that he still active in his private practice and that his son, William J. Albright, MD ’85, is presently serving in Iraq.

55 David K. Stuhin continues to do consultative and surgical activities. He enjoys woodworking and lives in San Diego.

56 William V. Harrer serves as alumni trustee on the TJU board. Director of the laboratories at Lourdes Health System in Camden, N.J., Harrer lives in Haddonfield, N.J.

57 Stanley F. Peters still practices independently and is on call 24/7. Peters reports that he loves going to work for you”.

58 Robert M. Davis is president-elect of the York Rotary Club, the 40th-largest club in the world. He still does mission work in Ghana and India and resides in York, Pa.

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61 Robert B. Falk Jr. is an anesthesiologist at Lancaster General Hospital and lives in Lancaster, Pa.

62 Robert G. Timmons has retired as chief of orthopaedic surgery for more than 20 years and now works part time. He lives in La Quinta, Calif.

63 Charles Walters has been practicing emergency medicine for more than 20 years and now works part time. He lives in La Quinta, Calif.

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72 William H. McCoy III works as the chief medical information officer for MetLife Health Networks Inc. of Boca Raton, Fla.

73 Paul E. Goldberg lives in Yardley, Pa., and is proud to note that his son, Stephen Goldberg, is a member of the JMC Class of 2011.

74 David A. Goldberg is a member of the JMC Class of 2011.

75 James B. Turchik reports that he enjoyed a Phillies game with other alumni at Clearwater, Fla., last March. Turchik lives in Sarasota, Fla., with his wife of 42 years, Evelyn.

76 Manuel Morrow was recently named an honorary fellow of the Skin Cancer Foundation for his extensive contributions to the fields of Mohs micrographic and reconstructive surgery. He lives in North Caldwell, N.J.

77 Dean Winslow is currently deployed in Baguan Air Base, Afghanistan, and serving as a flight surgeon with the U.S. Air Force.

78 Francis A. Marro has retired from the practice of nephrology and is working as medical director of patient safety and IT liaison for Bay Health Medical Center. He lives in Dover, Del.

79 Neil H. Shusterman continues to pursue pharmaceutical medicine at Endo Pharmaceuticals in Chadds Ford, Pa. Smith reports the Penn State-Jefferson Primary Care Medical Program is still going strong. He lives in Wynnewood, Pa.

80 Sandra A. Willingmyre is enjoying working with the VA in Sierra Vista, Ariz.

81 Robert L. Witt practices at Christiana Care in Delaware and has an academic appointment as professor of otorhinolaryngology at Jefferson and as adjunct professor in biological sciences at the University of Delaware. He lives in Kennett Square, Pa.

82 Christopher M. Pezzi is the immediate past president of the Metropolitan Philadelphia Chapter of the American College of Surgeons and of the Philadelphia Academy of Surgery, founded by Samuel Gross, and director of the Clinical Advisory Committee of the “Delancey Street crew” and the Locust Bar after exams. He lives in Doylestown, Pa.

83 Jeffrey C. McConnell is an orthopedic surgeon living in Allentown, Pa. He and his wife, Christine, have three sons. McConnell heads Operation Straight Spine, a charitable mission project that provides spinal disease and deformity treatment for the poor and underserved in India.

84 Stephen A. Nurtkiewicz recently co-founded Alternatives, an Integrative Medicine Center, with his wife, Moira. They live in Sicklerville, N.J.

85 David M. Johnson is president of Visiocity, a health and wellness company engaging employers to create and sustain a culture of worksite health and wellness throughout the United States. Johnson lives in Spokane, Wash.

86 Mark Bezirski is director of the optical coherence tomography laboratory in the department of orthopaedic surgery at Brigham and Women’s Hospital and associate professor of orthopedic surgery at Harvard Medical School. He developed optical coherence tomography, an optical signal acquisition and processing method that has been approved by the FDA and is being used throughout the United States. He lives Madison, Mass.

87 Gregory E. Herman is the residency program director and chief of the clinical informatics office at Underwood Woodbury in Woodbury, N.J. He recently was the recipient of the Dean’s Award for Excellence in Education for the Jefferson Department of Family and Community Medicine. He lives in Skillahill, N.J.

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JMC CELEBRATES ANNUAL ALUMNI WEEKEND

Alumni Weekend kicked off Friday, Sept. 23, with a welcome reception at the Pennsylvania Academy of Fine Arts, where guests enjoyed a viewing of Thomas Eakins’ newly restored masterpiece, The Gross Clinic, and two distinguished alumni, Carol A. Miller and Amilu S. Stewart, received the JMC Alumni Achievement Award (see their profiles on pages 30 and 31).

The festivities continued Saturday with presentations by Miller and Stewart, the traditional “Taste of Philadelphia” luncheon with Dean Mark Tykocinski, campus tours and reunion dinners at the Loews Philadelphia Hotel for classes that graduated in years ending in 1 and 6. The weekend-long celebration ended Sunday with our first-ever alumni brunch and silent auction at the Fiz-Carlton Hotel, hosted by the “50 & Forward” committee in recognition of the 50th anniversary of the matriculation of female students at JMC.

Thanks to all who attended this year’s reunion – and to those who couldn’t make it, we hope to see you next time!

FRIDAY NIGHT AT PFAA

1. Timothy Michals, MD ‘96, and his wife, Anne, with JMC Alumni Association President George Valko presented Stanton Smullens, MD ‘91, with a Certificate of Excellence recognizing his classic contributions to the JMC Annual Fund. Smullens served as Class of 1981 reunion chair.
2. Margaret O’Dowd, MD ‘86, Dana Dolis Rand and Roger Rand, MD ‘81.
3. On Friday night, Dean Mark Tykocinski and JMC Alumni Association President George Valko presented Stanton Smullens, MD ‘91, with a Certificate of Excellence recognizing his classic contributions to the JMC Annual Fund. Smullens served as Class of 1981 reunion chair.
5. A viewing of Thomas Eakins’ newly restored masterpiece, The Gross Clinic.

SUNDAY MORNING ON CAMPUS

1. Joseph Mulligan, MD, assistant professor and director of professional development at the University Clinical Skills and Simulation Center; Phillip Marone, MD ‘57, MS ’72, associate dean for alumni relations and executive director of the JMC Alumni Association; and John Castello, MD ‘96.
2. Edward Podgorski, MD ‘54, with JMC students Phoebe Mellen and Roma Ahmadi.
3. Vincent Ammirati, MD ‘97, PhD ’79, president-elect of the JMC Alumni Association; with John Angstadt, MD ‘86, and his wife, Joanne.
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What Every Healthcare Professional Should Know: A General Medical Update

January 29 – February 3, 2012 • Viceroy Snowmass, Snowmass Village, Colorado

This year’s Annual Alumni Winter Meeting, What Every Healthcare Professional Should Know: A General Medical Update, will bring together renowned presenters from across several specialties. Spend the week together with our faculty who will provide the latest developments spanning a wide range of timely subjects.

Physicians who are in practice are expected to maintain their board certification within their specialties through ABMS processes. In addition, however, the public expects them to maintain an up-to-date fund of their general medical knowledge as they may be called upon in a variety of situations to provide advice or care outside of their normal practices. Besides physicians, the review of these important topics will also be relevant to other health care professionals including nurse anesthetists.

Medical Education
• JMC Medical Students: Now That They Are Admitted, What Do We Do with Them?
• The Impact of the Health Care Reform on Academic Medical Centers
• Incivility in Healthcare Settings
• Law and Medicine: Update in Regulatory Compliance and Healthcare

Cardiovascular Disease
• Advanced Congestive Heart Failure – What Are the Options?

The Interface of Art, History, Medicine
• Thomas Eakins’ Masterpiece: The Gross Clinic

When Medical Therapy Isn’t Enough
• Low Back Pain
• Integrating Integrative Medicine into Your Practice
• What to Do with the Patient with Unexplained Symptoms

Genetics
• Personalized Therapeutics

Geriatrics
• Geriatric Oncology
• Competence

Infectious Diseases
• Superbugs
• New Developments in the Treatment of Hepatitis B & C
• Irritable Bowel Syndrome

Management of GERD and Barrett’s Esophagus
• Medical Therapy
• Surgical Therapy
• Resect, Freeze, Burn or Call the Surgeon
• Minimally Invasive Surgery for Esophageal Cancer

Welcome to Colorado
• Acute Mountain Illness
• Basic Survival Skills
• Acute Cold Exposure and Hypothermia

Breast Cancer
• Radiology
• Surgery
• Oncology
• Plastic Surgery

Prostate Cancer Raft Debate: Join in a lively Raft Debate on the topic of Prostate Cancer Care. Examine the issues from the perspectives of the surgeon, radiation oncologist, medical oncologist and the always present devil’s advocate.

Hotel Room Rates
• Studio Room: $309/night or $326/night
• One Bedroom Residence: $425/night or $362/night
• Two Bedroom Residence: $782/night or $572/night

Room Reservation Information
To book guest rooms, please contact the hotel directly at 866-326-9765 or reservations@viceroysnowmass.com. Ask for the “Thomas Jefferson Alumni Group” rate. While booking, ask about the special lift ticket rates available with this package.

Register Online: jeffline.jefferson.edu/jeffcme

For more information, or to register online contact the JMC Office of CME at 1-888-JEFF-CME. Other questions, call Sharon D’Hurieux in the Jefferson Foundation at 215-955-8387.

$500 Registration Fee covers
• All education sessions and CME Fees
• Welcome Reception on Sunday, January 29
• Breakfast each morning
• Afternoon snacks
• Group dinner for two (additional guests may attend the dinner for $80 per person)

SUNDAY MORNING BRUNCH
1. Jefferson faculty and “50 & Forward” steering committee members Vivian Chung, MD, MPH, Elizabeth Van Bockstaele, PhD, Karen Novelli, MD ’86, and Elizabeth Kunsel, MD, stand with Dean Mahoney and Holly Johnson of the Class of 1986.
2. Members of all the reunion classes danced the night away to the sounds of the Mahoney Brothers.
3. Angela Smith; Nicholas Ruggiero, MD ’01, director of Structural Heart Disease and Non-Coronary Interventions at Jefferson; and Joshua Eisenberg, MD ‘99, chief of the Division of Vascular and Endovascular Interventions at Jefferson; and Stanton Smullens, MD ’61, and his wife, Sara Kay.
4. Members of all the reunion classes danced the night away to the sounds of the Mahoney Brothers.
5. Members of all the reunion classes danced the night away to the sounds of the Mahoney Brothers.

SUNDAY NIGHT AT LOEWS HOTEL
1. Dean Mark Tylicki and JMC Alumni Association Associate Director Philip Moore, MD ’71, and wife, Sara Kay.
2. Angela Smith; Nicholas Ruggiero, MD ’01, director of Structural Heart Disease and Non-Coronary Interventions at Jefferson; and Joshua Eisenberg, MD ’99, chief of the Division of Vascular and Endovascular Interventions at Methodist Hospital.
4. James Barone and Michael Pryor of the Class of 1987; and Elisabeth Kunkel, MD, stand with Dean Mahoney and Holly Johnson of the Class of 1986.
5. Members of all the reunion classes danced the night away to the sounds of the Mahoney Brothers.

THOMAS JEFFERSON UNIVERSITY

Register Online: jeffline.jefferson.edu/jeffcme

For more information, or to register online contact the JMC Office of CME at 1-888-JEFF-CME. Other questions, call Sharon D’Hurieux in the Jefferson Foundation at 215-955-8387.
Amilu S. Stewart, MD '65: Surgeon, Mother, Pioneer

Amilu Stewart, MD '65, is not afraid of firsts. She was in the first class at Jefferson Medical College that accepted women and became the first mother to receive a medical degree from Jefferson. She was also the first in her family to become a doctor at a medical school. Amilu S. Stewart – both from the Class of 1965, the first graduating class that included women.
This list includes alumni, faculty who contributed to Jefferson from July 1, 2010, to July 15, 2011. In parentheses denote members of our 1824 Society, who recognizes donors who give $2,500 or more to Jefferson. The club is divided into five primary levels:

<table>
<thead>
<tr>
<th>Key to Giving Levels</th>
<th>Contributions</th>
<th>Members</th>
</tr>
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<tbody>
<tr>
<td>Partner</td>
<td>$25,000 and above</td>
<td>25 donors totaling $36,780</td>
</tr>
<tr>
<td>President</td>
<td>$2,500–$4,999</td>
<td>44% total class participation</td>
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<tr>
<td>President</td>
<td>$500</td>
<td>33% total class participation</td>
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<tr>
<td>Young Donor</td>
<td>$25 or more</td>
<td>11% total class participation</td>
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Class Agent: Joseph E. Malfick

Alumni Giving
30% total class participation
3 donors totaling $2,525

CONTRIBUTORS

Joseph N. Marino (26)

CONTRIBUTORS

33% total class participation
1 donor totaling $1,250

1944

CONTRIBUTORS

Total class giving:
25 donors totaling $5,430

41% total class participation
10 donors totaling $4,950

1 donor totaling $1,250

Herbert A. Yantes

Robert Poole and

Friends

E. Milton Witthoff Jr.

Class Agent: Robert C. Bashore Jr. (5)

Class Agent: Charles Scott (7)

Class Agent: Howard L. Field (30)

Class Agent: Perth C. Shonkwiler (25)

Class Agent: Harry Boretsky (28)

Class Agent: Stanley N. Levick (30)

Class Agent: Edward I. Cooper (8)

Class Agent: Bertram D. Hurowitz (22)

Class Agent: Richard J. Hanratty (30)

Class Agent: Joseph J. Glorioso

Class Agent: John K. Kreider

Class Agent: Robert J. Maro Sr. (22)

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1960 Class Agent: Robert G. Somers (24) 42 donors totaling $17,185
Class Agent: Joel L. Seres 30 donors totaling $17,185
Class Agent: Marvin Z. Rotman (30)
Class Agent: Paul M. Roediger
Class Agent: Daniel T. Pompey
Class Agent: John D. Lane (6)
Class Agent: James M. LaBraico
45 donors totaling $34,959
46 donors totaling $49,959
Class Agent:
1959 Class Agent: Lawrence A. Sullivan Jr.
Class Agent: William J. Stromen
Friends
Patrick V. Catellino
Frank A. Malini
CONTRIBUTORS
L. R. Ahearn
Peter J. Andrews (28)
Nahum M. Balotin
Peter J. Andrews (28)
John T. Murray
Class Agent:
1961
Class Agent: Robert G. Somers (24)
Class Agent: Joel L. Seres
Class Agent: Marvin Z. Rotman (30)
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Class Agent: James M. LaBraico
45 donors totaling $34,959
46 donors totaling $49,959
Class Agent:
1960
1971

Class Agents: James E. Barone and Terrence S. Carden Jr.

Total giving: 63 donors totaling $39,370
37% total participation
Annual fund giving: 63 donors totaling $39,370

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

25 donors totaling $17,500
26% total class participation

Members

1972

Class Agents: Craig T. Hyatt

Harry W. Craker Jr.

Total giving: 54 donors totaling $34,500
21% total class participation
Annual fund giving: 53 donors totaling $33,120

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

21 donors totaling $13,920
27% total class participation

Members

1973

Class Agents: Richard P. Altreuter

Edwin P. Doig Jr. (30)

Total giving: 45 donors totaling $28,200
23% total class participation
Annual fund giving: 43 donors totaling $28,358

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

25 donors totaling $16,900
26% total class participation

Members

1974

Class Agents: Robert P. Good

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

28 donors totaling $18,650
27% total class participation

Members

1975

Class Agents: Robert F. Jr.

Friends

Louis A. Caesar

30 donors totaling $23,200
19% total class participation

Members

1976

Class Agents: Larry G. Glazerman

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

25 donors totaling $16,700
23% total class participation

Members

1977

Class Agents: William E. Carnes

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

31 donors totaling $21,400
19% total class participation

Members

1978

Class Agents: Thomas M. Williams

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

26 donors totaling $17,700
18% total class participation

Members

1979

Class Agents: Alan H. Goldberg

PRESIDENTS’ CLUB

Friends

Louis A. Caesar

25 donors totaling $16,700
19% total class participation

Members
FALL 2011

39

PRESIDENTS’ CLUB

Members

Ralph J. Marino (22)
David P. Maguire (9)
R. Bruce Lutz III (20)
Alex V. Levin
Charles B. Krespan
Denise M. Kenna
Robert M. Gorsen (20)
Larry M. Gersten (29)
David S. Estock (5)
Albert DiGerolamo
Franklin J. Chinn Jr.
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In Memoriam

Abd H. Fotouhi, 94, of Binghamton, N.Y., died Aug. 18, 2010. Fotouhi was born in Maragheh, Iran, and educated at the American School in Tehran. After receiving his medical degree from JMC, he completed his surgical training at the University of Pennsylvania. Fotouhi retired in 1992. He is survived by his wife, Eftraou.

Louis F. LaNoce, 89, of Lafayette Hill, Pa., died Jan. 19. LaNoce was honorably discharged as captain from the U.S. Army Medical Corps in 1949. In 1950 he opened his family practice in Rohnsborough, Pa. He retired in 1996 and is survived by his wife, Gloria, three children and five grandchildren.

William E. Sheely, 86, of Alexandria, Va., died April 16. Sheely had a radiology practice in Northern Virginia for nearly 40 years and was a former president of the D.C. Medical Society’s radiological section. He is survived by two daughters and two grandchildren.

Louis Isuzi, 89, of Springfield, Pa., died Sept. 9, 2010. Isuzi was class president for the Class of 1949 and served as chief of urology at Crozer Chester Medical Center, Taylor Hospital and Sacred Heart Hospital. He also was a past president of the Philadelphia Urologic Society. He is survived by his wife of 61 years, Gloria, one son, one daughter and four grandchildren.

Vincent P. DeAugustine, 91, of Garnet Valley, Pa., died Apr. 26. DeAugustine served in the U.S. Army. After his discharge, he attended JMC and went on to practice obstetrics and gynecology as well as minor surgery. He was also a coroner’s physician for Delaware County, Pa. He is survived by his wife, Dolores, and five children.

Jack Fink, 82, of Blue Bell, Pa., died April 23. Fink was an assistant professor of obstetrics and gynecology at JMC and was an active member of the JMC Executive Alumni Committee. Fink is survived by his wife, Janet; three children, Marc Fink, David Fink, MD ’84, and Julie Wolfe; and five grandchildren.

Edward T. Carden, 70, of Insaquah, Wash., died May 13 at home. Carden completed his residency in otolaryngology in 1970 at Jefferson and went on to serve in the U.S. Army, where he received the Army Commendation Medal in 1972. After his discharge, Carden opened a medical and surgical practice in Moorestown, N.J., and served as clinical professor of otolaryngology at Jefferson. He is survived by his wife, Ann, two children and one granddaughter.

Francie J. Viozzi, 70, of Harrisburg, Pa., died suddenly May 2 at home. Viozzi began his career at Geisinger Medical Center in Danville, Pa., in 1972 as an associate in rheumatology and was ultimately appointed chief of rheumatology. He also served as the assistant medical director and interim chief of medicine at Geisinger. He moved in 1988 to become medical director of St. Agnes Hospital in Baltimore until his retirement in 2000, when he and his wife, RoseAnn, moved back to Pennsylvania. In addition to RoseAnn, Viozzi is survived by two sons, two daughters and nine grandchildren.

By the Numbers

Class of 2015: At a Glance

Average MCATs: 32 (26/31)
Average GPA: 3.7
Age range: 19–30
Number enrolled through the DIMER (Delaware) program: 21
Number in the Penn State BS/MD program: 22

Students from the tri-state area:
Pennsylvania: 102
New Jersey: 20
Delaware: 21

Students Applied: 10,010
Students Accepted: 260
Students Enrolled: 368

Gender breakdown: 50/50

Countries outside U.S. represented: 5
(Bahamas, Canada, Korea, Nigeria, Malaysia)

U.S. states represented: 28

Robert Irby Wise, MD, PhD, Former Chair of Internal Medicine

Robert Irby Wise, 96, former chair of the Department of Internal Medicine at Jefferson, died June 15 in Williamsburg, Va. A 1950 graduate of the University of Texas Medical Branch, Wise was appointed assistant professor of medicine at Jefferson Medical College in 1955 and was promoted to associate professor within a year. He was named the Magee Professor and Chairman of the Department of Medicine in 1959.

After retiring from Jefferson in 1975, Wise became associate chief of staff for education at the Veterans Medical Center at Togus, Maine. He soon became chief of staff, a position he held until his second retirement in 1984. During his tenure, he made significant improvements in the quality of care offered to U.S. military veterans in Maine.

In 1986, Wise and his wife, Mary Catherine, moved to Williamsburg Landing, a retirement community in Williamsburg, Va. In Williamsburg, Wise was instrumental in designing the water of James City County by chlorination for the first time.

Wise is survived by three children, six grandchildren and four great-grandchildren.
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