Defining the Jefferson Family

Whether in the office, at home, or within the community, Jefferson knows what it means to be a family.
Today, with the uneven distribution of medical resources both at home and around the world and the increasingly bureaucratic nature of modern medicine, we are in danger of losing sight of healthcare’s primary focus — the individual patient. For many of us in medical education, revitalizing the physician-patient interaction in a collaborative and caring environment has become a major focus of our attention. In fact, it is exactly this personal relationship that drew most of us into the medical profession.

Building on Jefferson’s reputation for compassionate care, we are creating a new curriculum that will educate our students to work effectively in, and lead, the integrated healthcare delivery team that will be the mainstay of tomorrow’s medicine. The new Jefferson curriculum will serve as a benchmark in medical education. Much of this team-learning will take place in the Hamilton Building, but some will certainly occur in the new college green that will surround the building. Designed to create a person-friendly environment, a space where the individual feels in scale, the campus green will provide a setting where students, faculty, staff, and community members can interact informally. The result will be a place that encourages those one-on-one or small group contacts — the same kind of unscripted contacts that make a team, or a family, work effectively.

A central theme in our curriculum and in our physical spaces is a personal approach to medicine. But a personal approach also requires that each of us as practitioners be sensitive to the interpersonal as well as the factual aspects of medicine: among our colleagues working together as a team, with the staff supporting our teams, and with our patients. To lead tomorrow’s healthcare teams effectively, our graduates must understand how people work together.

In fact, many of the elements that make good doctors and team leaders in our professional lives are the same ones that make good spouses and parents at home. Our students must realize that they ignore one part of their lives only at the cost of another. A truly successful physician must balance the interpersonal needs of the patient and team with the equally important demands of the home and family.

Jefferson faculty and administrators are doing all they can to restore the art of human relations to the science of medicine, whether by offering specialties such as family practice and the Physician Shortage Area Program, or classes that teach doctors to build a healthy work-life balance. We will continue to provide avenues for those who wish to focus on humanistic medicine.

Our patients are people, people who have families who care about them the way we do about our own families. This vision of our patients helps us all keep in perspective what they expect of us — what we should expect of each other.

Sincerely,

Robert L. Barchi, MD, PhD
President
Thomas Jefferson University
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Concerning Professionalism

Those of us involved in the formation of future generations of physicians have been challenged in the evolution of our description of those characteristics among practitioners, which are both admirable as well as worthy of emulation. Two trends are worthy of comment in this regard—the first distracting from the issue, the second germane to the topic.

We are in the midst of the aggrandizement of what I have termed “excellence on the margin.” This is the promotion of, the popularization of, and the seeking of the individual who has unique experiences, insights, or techniques in the increasingly narrow dimension of a specialty. This extreme degree of subspecialization, coupled with its promotion as a celebrated educational and professional outcome, mirrors the events we have seen in research, where reductionism is carried to its extreme.

In the quest for answers to increasingly narrow questions at the molecular level, we have trained at least two generations of medical scientists who know little of the overall medical discipline. For example, it would be highly unusual to find a recent graduate of a physiology doctoral program who could tell you how human systems really work in an integrated fashion to sustain life, nevermind one who could teach medical students. A microbiologist graduate would not likely be able to give medical students an overview of the range of gram positive pathogens associated with human pneumonia. They will be able to eruditely explain the actions of particular protein kinases in the sequence of molecular trafficking and gene expression control. If they are capable of teaching medical students, it is usually in a very narrow area, one which they have mastered because of the need to teach, rather than as part of their daily activities.

This is also true in clinical medicine, at least in many of the environments in which medical students and residents are trained. We search out the individual with the greatest knowledge and experience in each area of patient care. Broad-based knowledge is less often celebrated. For example, the nephrologists with wonderful knowledge and experience in the treatment of a rare glomerular disease, may know little about the nuances of continuous dialysis or the consultation service for a catabolic postoperative patient with sepsis and renal failure. For that we must have a consultative nephrologist with a special interest in acute renal failure support in the surgical patient.

Please do not mistake these comments as criticisms of research or its translation into advances at the bedside. Research must go where it is led, with each question unfolding from the previous answer. In-depth expertise of difficult or unusual disorders is essential if we are to further push back the barriers of illness and morbidity each day.

There is, however, an aspect of this extreme degree of subspecialization that has the potential to have an adverse impact on professionalism, not only of the individual physician, but also on the students and residents who are their pupils. The risk lies in the evolution of the posture of the expert, the way they see their patients, and the manner in which they use their gifts of expertise, the byproduct of their commitment to excellence.

You see, as clinicians narrow their focus and become more reductionistic in their approach to their patients, the risk that the physician sees less and less of the whole patient increases. They lose the desire to deal with, as well as the practical working knowledge required to care for, those “other problems” outside their area of expertise with which the patient struggles. They naturally focus on the pathophysiologic entity they treat, rather than seeing the person afflicted with that malady. They run the risk of being unable to empathize with the patient, to see...
the forest that is the patient, rather than the tree that is the problem they are good at fixing. In its extreme manifestation, they are unaware of the context, having been reduced to focus solely on their area of expertise, regardless of what lies before them.

To the extent that our society, as well as our profession, is focused on—perhaps currently fixated on—clinicians with these narrow areas of expertise, we foster in our students and residents this reductionistic approach to clinical care. The results are the observed fragmentation, the lapses in continuity, and the dissatisfaction by the public as well as the physician.

You might ask, then, what does this have to do with professionalism and the inculcation of professional values in young students? I would put forth that we have just gone through a phase in medicine where we have done the same thing to professionalism that is being done to clinical care. In a typical reductionistic fashion, we have tried to describe professionalism, quantify dimensions of professionalism, evaluate precise dimensions of professionalism, and remediate areas of deficient performance in professionalism.

Certainly, no one would argue that agreement over the importance of professionalism and the scientific approach to the analysis of professional behaviors in order to understand, foster, and nurture these in all physicians, are both laudable and essential. However, we must guard against the unintended consequences of reductionistic analysis of professionalism parallel to that which I described earlier. We must not equate the “virtuous physician,” what some would call the “ultimate professional,” with individuals who can, during testing or observed practice, demonstrate respect, compassion, integrity, honesty, commitment to excellence, and other skills or behaviors consistent with professional behavior.

In an interesting and provocative series of articles in Academic Medicine in October 2005, the concept of motivation for professional behavior was raised as an essential component in the formation and practice of the professional. Thomas S. Huddle challenges us to understand how one lives a moral life as a physician, and explains how the outward manifestation of that life is exemplified by professional behaviors. Jack Coulehan, MD, MPH, reminds us that professionalism is fundamentally an act of the heart, not just of the mind. We can teach students how to express the fundamental moral motivations of the individual (how to demonstrate their feelings of concern in the setting of a life-threatening diagnosis, for example) but we cannot teach them to feel concern. We can teach them how to be honest by being candid about their lack of knowledge in a particular area on teaching rounds, but we cannot teach them how to be honest if they are not motivated to tell the truth. We can teach them how to be respectful to individuals of different social, economic, or cultural groups, but we cannot compel them to respect a person with a different skin color or from another part of the world if they possess fundamental biases.

Professionalism in medicine is a way of living out fundamental values and beliefs about the significance of human life, the worth of the individual, and the importance of societal commitment to the most vulnerable among us. Its outward manifestations are respect, compassion, integrity, honesty, commitment to excellence, and a life of learning. We are gaining understanding and attesting to the importance of professionalism as the central core of our lives as physicians. We must accept that it is our commitment to the values of professionalism and our aspiration to become virtuous physicians, which is our life’s work. We must recognize that professionalism is an expression of our fundamental morality, not just a set of learned behaviors that are tools to accomplish our “job.”

Perhaps Louis Dinon, MD, one of the anchors of Philadelphia medical education in the late 20th century, said it best. He described the “head light” of medicine, the quest for truth (veritas) in the form of knowledge and commitment to excellence, as the foundation for the practice of medicine. Upon that foundation were built the outward manifestations of the art, equanimity under duress to apply that knowledge and those skills in the care of the sick (equanimitas).
altruism, the innate desire to share those gifts with others, regardless of the secondary gain, or potential harm, to the giver.

While I may have modified or embellished his thoughts on this matter, I believe the synthesis is correct. Medicine is fundamentally a moral and intensely human endeavor. It must never be reduced to the sum of its parts. While embracing the benefits of reductionistic research, we must take the time to resynthesize, to create holistic pathophysiological schemas that encompass the uniqueness of each individual patient in their unique sociocultural setting, as we provide our component of their care. It is only then that the benefits of our research, the strengths of our unique contributions, can be fully brought to bear on the pain and infirmity of the individual, resulting in that intensely human, deeply personal, and fundamentally healing interaction called the doctor-patient relationship. Furthermore, we must never lose the core values, which are the expressions of our morality, in the course of the formation of young physicians.

I invite you to reflect on your personal linkages of morality, professional behaviors, professionalism, and the doctor-patient relationship. It is through these personal reflections that we each become more like the virtuous physicians we all aspire to be.

Sincerely,

Thomas J. Nasca, MD'75, MACP
Senior Vice President, Thomas Jefferson University
Dean, Jefferson Medical College
President, Jefferson University Physicians

I’m happy to enclose a check for your proposed One Hundred and One Fund, and I hope my fellow alums will do likewise. It’s a wonderful idea.

Arthur S. Tischler, MD’71
Newtown Highlands, MA

Speaking from experience, I too remember struggling — eating Philly soft pretzels, living loan check to loan check, becoming more financially unstable waiting for the day my paychecks would exceed my living expenses. ...I am doing well. Fulfilling my career ambition — working at a community health center in Wilmington, DE, taking care of the poor, underinsured, and uninsured.

Julie Prosseda, MD’99, FM’02
Newark, DE


I believe your idea for such a fund is outstanding and obviously much needed... It is unfortunate that people with your compassion are not more common in all of our lives. I am happy to be a part of the One Hundred and One Fund.

Bill Piatko, MD’82
St. Augustine, FL

Having been a student of yours in various medicine rotations and reading your articles, I am convinced that at least you have a heart. So as a former student my only word of advice to you is to treat all your students with respect while they are going through the system. Treating students poorly, I assure you, has a profound effect on donations. In closing, I will break my 13-year promise to myself and let go of the "persistent pain in my Jefferson heart.” Donation enclosed.

Richard McLaughlin, MD’96
Phoenixville, PA

I read [your] letter about the One Hundred and One Fund. It was heartwarming and urged me to review the many stages where I was helped. First, my parents. Then college where I could earn "board" in return for dishwashing. These were the Depression years. ...Then Jefferson. My family physician, Dr. Arthur S. McCallum of Barrington, NJ, knew of my interest in medicine. He offered to lend me the funds to enter Jefferson! And did so faithfully. Dr. McCallum was a graduate and on the outpatient staff. He arranged for me to work in the college laboratory year round... Thus you see how I was helped so many steps of the way. I’m enclosing a check for the One Hundred One Fund and trust many more will follow.

J. Arthur Steitz, MD’42
Medford, NJ

Send your letters to: Editor, Alumni Bulletin
Jefferson Medical College of Thomas Jefferson University
925 Chestnut Street, Suite 110, Philadelphia, PA 19107-4216
**Findings**

**A** Demyelination and Axonal Degeneration in Experimental Model of MS (EAE)

- Proteases degrade BBB basal membrane proteins.
- Immune cell invades the CNS.
- Proteases degrade myelin proteins through inhibition of proteases.
- Proteins in the vessel wall remains intact.
- BBI prevents proteases from degrading BBB basal membrane proteins.
- Immune cell secretes toxic molecules such as cytokines, reactive oxygen species, nitric oxide, and proteases, which directly and indirectly damage the myelin sheath and make neural conduction less efficient.
- Immune cells secrete toxic molecules which damage the BBB of small blood vessels and facilitate entry of cells into the central nervous system (CNS).

**B** Prevention of Demyelination and Axonal Degeneration in the CNS by Protease Inhibitor, BBI

- Blood Vessel
- Proteases
- Immune Cells
- Basal membrane of the blood-brain barrier (BBB)
- Blood
- Neurons
- Axon

**Soy-based Substance Might Help Fight MS**

A natural substance made from soy appears to have amazing restorative powers when given to animals with a multiple sclerosis-like disease. Using an animal model of multiple sclerosis, neurologists at Jefferson Medical College found that giving doses of a substance called Bowmann-Birk Inhibitor Concentrate (BBIC) dramatically improved the animals’ ability to move and walk. The scientists, led by A. M. Rostami, MD, PhD, professor and chair of the department of neurology at Jefferson and the Jefferson Hospital for Neuroscience, say the treatment’s effects may be useful in conjunction with more mainstream therapies such as beta-interferon in helping patients with multiple sclerosis. These findings were reported in the journal *Multiple Sclerosis.*

Multiple sclerosis, one of the most common neurological diseases affecting young adults, is thought to be an autoimmune disease affecting the central nervous system. In multiple sclerosis, the myelin coating of nerve fibers becomes inflamed and scarred. As a result, “messages” cannot be sent through the nervous system.

Rostami and his group used an animal model of experimental autoimmune encephalomyelitis (EAE), which mimics multiple sclerosis, to investigate BBIC’s potential immune system-suppressing properties. BBIC inhibits protease, an enzyme that plays an important role in the inflammation and demyelination processes that are at the heart of multiple sclerosis. It has been used for other conditions, notably precancerous conditions in the mouth.

He and his co-workers compared two groups of animals with EAE. One group received BBIC, while the other received only an inert substance. “Animals that received BBIC were able to walk while those that didn’t get the drug were not,” Rostami says. He notes that the animals are not cured but can walk with some limp or weakness. “The results are promising because this is a safe, natural compound from soybean and is given orally.”

Further analysis revealed that the central nervous systems of animals that received BBIC showed “significantly less inflamma-
tion and demyelination” than those that did not receive the therapy. “It’s the first time that BBIC has been used in an EAE model and has shown significant disease suppression. We hope it can eventually be used in humans,” says Rostami. The group’s next step is to design clinical trials in humans.

The scientists are not sure how BBIC works in multiple sclerosis, but they theorize that it suppresses the immune response to some extent, in addition to inhibiting protease. Rostami sees BBIC as being used as a single therapy or in conjunction with other drugs in treating multiple sclerosis. He notes that current therapies for multiple sclerosis involve injecting drugs such as interferon and copaxane. BBIC, however, could be developed as an oral agent and given by pill daily.

**Cardiologists Fix Broken Heart**

*Case Study Points to Rarely Diagnosed, Potentially Fatal Complication of a Heart Attack*

Unexplained chest pain after a heart attack might be more dangerous than many physicians originally thought.

In a case study published in the January issue of Clinical Cardiology, physicians at Thomas Jefferson University Hospital reported on a seemingly healthy, 55-year-old man who had a silent heart attack and subsequent unexplained chest pains.

Once he was admitted to the hospital, it was discovered that the man had a rarely diagnosed, potentially fatal complication called subepicardial aneurysm.

“The chest pain was a rupture of the heart wall about to happen—the most feared complication of a heart attack,” explains Michael Savage, MD, director of Jefferson’s cardiac catheterization laboratory. “The rupture occurs from a tear in the muscle that has already been damaged by a heart attack. The heart muscle breaks, and the wall bursts usually causing cataclysmic death soon after.”

Jefferson researchers recommend that when a patient experiences unexplained pain after a heart attack, physicians should consider the possibility of a subepicardial aneurysm.

“Diagnosis of a subepicardial aneurysm is extremely rare,” says Savage, who is also an associate professor of medicine at Jefferson. Only 20 cases have ever been reported, while many patients were diagnosed after death. It is highly likely that many more patients have died from this complication, but the cause of death was unrecognized.

According to lead researcher, Aaron Giltner, MD, a cardiology fellow at Jefferson, the man, who worked in construction, came to Thomas Jefferson University Hospital’s emergency room with chest pain. A heart attack was initially considered, and the emergency physicians called in the interventional cardiologists for a consultation.

The cardiologists also initially suspected a heart attack. The patient was admitted to the hospital and was readied for a cardiac catheterization to check for blocked arteries.

The cardiac catheterization indicated a subepicardial aneurysm, and the researchers arranged for a CT scan. This confirmed that the patient had a subepicardial aneurysm.

Once the problem was identified, surgeons promptly repaired the heart, saving the patient’s life.

“As our study shows,” Savage says, “CT imaging can be invaluable in establishing the diagnosis of a subepicardial aneurysm. Clinical recognition of this entity and the use of appropriate imaging modalities are imperative to facilitate life-saving surgical intervention.”

**RotaGlide Eases Insertion of Coronary Stents**

An emulsion of olive oil, egg yolk, and glycérine might be just the recipe to keep heart patients away from the operating room and cardiac bypass surgery. Such is the finding of a study published in Catheterization and Cardiovascular Interventions led by Michael Savage, MD, director of Jefferson’s cardiac catheterization laboratory. The mixture is not swallowed, Savage explains. Rather, it is used in the cardiac catheterization laboratory to bathe surgical stents before they are inserted into problem heart arteries.

Since being introduced in 1994, stents have worked in the majority of patients. Coated or drug-eluting stents, which prevent restenosis, were the next advance in this field.

“There are still a small number of patients with arteries that cannot be stented because of anatomic obstacles,” says Savage.

Tortuosity is one such obstacle. It occurs when there are extreme bends in the vessels leading to or from the heart artery, which taxes the limited flexibility of stainless steel stents. Savage likens attempting to place a
The lubrication used was RotaGlide, an emulsion originally designed to reduce catheter friction during other cardiovascular procedures. Composed primarily of olive oil, egg yolk phospholipids, glycerin, sodium hydroxide, and water, it is commercially available as a sterile solution. The only ingredients are egg yolk phospholipids, glycerin, sodium hydroxide, and water.

The cardiologists tested the emulsion in a group of 15 men and five women between the ages of 60 and 80. These patients had abnormal arteries that were oddly shaped or winding or had particularly tight blockages, and, therefore could not be stented. After failed conventional attempts to insert stents, the Jefferson physicians were able to place the lubricated stents successfully in 17 (85 percent) of these patients with no negative effects months after the procedure.

The lubrication used was RotaGlide, an emulsion originally designed to reduce catheter friction during other cardiovascular procedures. Composed primarily of olive oil, egg yolk phospholipids, glycerin, sodium hydroxide, and water, it is commercially available as a sterile solution. The only contraindication to use of the product is known allergies to any of the ingredients.

To address unresolved issues about biocompatibility with the often-used, drug-eluting stents, the researchers studied additional patients for a longer follow-up period. None of the patients who received the drug-eluting stents developed blood clots or restenosis. “We found that this emulsion is a safe, simple, and effective aid for stent delivery in the rare cases where stents could not previously be inserted,” Savage explains. “It would be a worthwhile addition to the interventionist’s bag of tricks.”

**Protein Shows Promise for Spinal Cord Injury Patients**

A recent study indicates a protein applied to the spinal cord of totally paralyzed patients during surgery may lead to some patients regaining partial movement.

A one-year clinical study of Cethrin®, performed by neurosurgeons at Thomas Jefferson University Hospital and other medical centers in the U.S. and Canada, indicates positive interim results for the treatment of acute spinal cord injuries (SCI). The study was designed to determine if the protein was safe and well tolerated by SCI patients.

In the trial, 31 percent of patients recovered some sensory and/or motor function below the level of their injury. In one case, a patient who participated in the study at Jefferson was able to regain movement in his previously paralyzed legs.

“It’s pretty exciting,” said the study’s primary investigator at Jefferson, James S. Harrop, MD, assistant professor of neurosurgery at Jefferson Medical College.

Harrop cautioned, however, that this is not a “panacea” and requires further study to determine if the protein can restore function.

“In a population that has seen no progress in the last decade in restoring spinal cord functions, this is a huge leap,” Harrop says.

There are currently no effective therapies for spinal cord injuries for nearly 12,000 new patients each year in North America alone. Despite significant scientific breakthroughs, existing clinical interventions remain limited to reducing local inflammation of the spinal cord.

The 12-month study evaluated 37 patients from nine centers who suffered a complete thoracic or cervical injury. Five of the participants were seen at Jefferson.

“A complete injury means no sensation or movement below the lesion, while an incomplete injury means the patient has some neurologic function, either sensation or motor,” Harrop explains. “This is important because if they have any sensation or movement the chances for recovery are much improved.”

Cethrin® is topically applied to the dural sac during decompression/stabilization surgery. Cethrin® is the first of a new class of protein that is specifically designed to penetrate cells and inhibit Rho, a signaling master switch whose activation triggers cell death and exacerbates spinal cord damage following injury.

The trial was not placebo controlled but has an efficacy component based on the American Spinal Injury Association’s scale, which is designed to assess sensory and motor functions in patients.
GI Researcher Awarded $1.6 Million to Study Disorders

Gastroenterology researcher Satish Rattan, DVM, professor of medicine at Jefferson, has been awarded $1.6 million from the National Institutes of Health to study the molecular mechanisms involved in maintaining smooth muscle tone of the internal anal sphincter (IAS), which is crucial for normal bowel functioning.

In research over the past 20 years, Rattan, who is in the division of gastroenterology and hepatology in the department of medicine, has found that IAS basal tone owes much to the distinct characteristics of smooth muscle in this region. He and his co-workers also found that nitric oxide is the major neurotransmitter for IAS relaxation, which is critical for normal bowel function. The work has had implications for therapies for a variety of gastrointestinal disorders.

The IAS is important for continence and is controlled autonomically, as opposed to the external sphincter, which as skeletal muscle, is voluntary. In contrast to the hypertensive condition, a hypotensive IAS results in incontinence. Consequently, IAS dysfunction cannot be easily controlled, and treating a hypertensive or hypotensive IAS can be difficult.

Last year, Rattan’s group reported in the journal Gastroenterology that drugs, which block the activity of an enzyme (Rho kinase), might hold a key to treating chronic and severe disorders such as certain forms of constipation, Hirschsprung’s disease, and other similar gastrointestinal problems.

New Technology for Evaluating and Treating Small Intestine Disorders

First, there was the swallowed camera, a device to take doctors on an incredible journey through a patient’s small intestine. Now, at Thomas Jefferson University Hospital, another innovation lets them make a stop along the way.

“Known as the double balloon endoscopy (DBE) system, this new technology enables physicians to evaluate and treat disorders of the small intestine that were previously inaccessible without invasive surgery,” explains Anthony Infantolino, MD, clinical director of endoscopic ultrasound and photodynamic therapy and co-director of the gastrointestinal bleeding center at Thomas Jefferson University Hospital. “It is an advance over the traditional endoscopy because it allows us to visualize the entire 12 to 15 feet of the small intestine.”

“Due to its extraordinary length and location in the body, the majority of the small intestine has been inaccessible when utilizing conventional endoscopic techniques and equipment,” says Mitchell Conn, MD, co-director of the gastrointestinal bleeding center and director of endoscopic training at Thomas Jefferson University Hospital. “The DBE system allows us to reach abnormalities found in the middle and distal small intestine for which we previously would have had to perform surgery for further investigation and possible treatment.”

“During the procedure, the patient is sedated and the physician inserts a scope through the mouth, which travels into the patient’s small intestine. The procedure is performed on an outpatient basis.

Previously, Jefferson physicians were able to diagnose but not treat unexplained bleeding, Crohn’s disease, polyps, arteriovenous malformations (AVMs) and other disorders of the small intestine by having patients swallow what is known as a small bowel camera, a device just slightly larger than a vitamin capsule. (The procedure is known as capsule endoscopy.) The device takes more than 50,000 color pictures of the digestive system while it travels through the stomach and the small intestine.

Jefferson Breast Care Center

The Jefferson Breast Care Center, located at 1100 Walnut Street, will consolidate breast imaging and treatment modalities into a patient-centered facility that is personalized and private, featuring state-of-the-art equipment and highly trained clinicians. The Jefferson-Honickman Breast Imaging Center, located on the newly renovated fourth floor, opened its doors to the public on January 23, 2007, marking the completion of the first phase of the renovations. Additional development of the center will include a dedicated lecture room for community information sessions, an educational center, a library, and a dedicated breast MRI — all supporting Jefferson’s team approach to the education and treatment of breast cancer.

If you would like to receive more information or to make a gift supporting the Jefferson Breast Care Center, please contact The Jefferson Foundation at 877-533-3443.
“Thomas Jefferson University Hospital was the first in the Delaware Valley to offer this innovative service six years ago,” Infantolino, who is also clinical assistant professor of medicine at Jefferson Medical College, says. “Today, Jefferson University Hospital is one of the top sites in the world for capsule endoscopy and the leading site in the United States.”

Koprowski Honored by NIH

In an environment of flat federal spending on science, virologist Hilary Koprowski, MD, professor of cancer biology at the Kimmel Cancer Center at Jefferson continues to amaze. Koprowski, the first scientist to develop the oral polio vaccine, was honored recently for over 50 years of continuous NIH funding. In his 40-plus years at the Wistar Institute and Jefferson, his research has spanned the spectrum of biomedical research from rabies to polio to cancer.

In the late 1940s, his research resulted in the first oral polio vaccine that was used extensively to immunize people on four continents. In the late 1970s, a passionate interest in rabies led Koprowski to develop a new tissue culture-based vaccine. He also pioneered the use of monoclonal antibodies to detect cancer antigens and cancer immunotherapy. His current research explores using plant-based vaccines against avian flu, smallpox, and rabies.

Koprowski is a member of the National Academy of Sciences. He currently is professor in the department of cancer biology at Jefferson Medical College and director of the Center for Neurovirology at Jefferson and the Biotechnology Foundation Laboratories, Inc.

The consummate Renaissance man, Koprowski is a concert pianist who writes music in his spare time—when he is not traveling to international conferences or being honored by foreign nations for his myriad scientific accomplishments.

Cheung Named Director of Nephrology

Joseph Cheung, MD, PhD, has been named director of the division of nephrology at Jefferson. He is also the Capizzi Professor of Medicine. An internationally recognized researcher, Cheung joins Jefferson from the Milton S. Hershey Medical Center and Pennsylvania State University College of Medicine where he was professor of medicine and cellular and molecular physiology.

In welcoming Cheung, Arthur Feldman, MD, PhD, Magee Professor and chair of the department of medicine at Jefferson, said he brings a strong and varied background in kidney research to Jefferson, which will both enhance and complement the current work in the division of nephrology. “He is well known for his research in signal transduction and calcium homeostasis,” says Feldman.

Cheung’s research has focused on exercise training in postinfarction hearts; cellular mechanisms of functional improvement; phospholemman and cardiac function; signal transduction mechanisms of erythropoietin; calcium and TRP channels; and calcium and congestive heart failure.

Principal investigator on two NIH grants and co-investigator on another NIH grant, Cheung has funding totaling close to $3 million. He is the author or co-author of more than 100 publications in numerous professional journals, including New England Journal of Medicine, Journal of Clinical Investigation, American Journal of Physiology, Journal of Biological Chemistry, and Journal of Applied Physiology.

Heffelfinger Joins Otolaryngology

Facial plastic surgeon Ryan N. Heffelfinger, MD’00, has joined the department of otolaryngology—head and neck surgery. Heffelfinger graduated from Jefferson and completed his residency at Thomas Jefferson University Hospital. He joins the staff here after a fellowship in facial plastic and reconstructive surgery at the University of California, Los Angeles, where he was a clinical instructor in the division of head and neck surgery. His research and clinical interests include cosmetic surgery of the brow, eyes, nose, face, and neck; microvascular reconstruction of the head and neck; and minimally invasive rejuvenation of the aging face.

Brent Receives Dean’s Medal

Robert L. Brent, MD, PhD, (center) distinguished professor of pediatrics, radiology, and pathology, was awarded the JMC Dean’s Medal on February 22, 2007. Brent has received numerous awards while at Jefferson including the Lindback Award for Distinguished Teaching; the Winged Ox for Outstanding Service to the University; and the Burlington Northern Foundation Award for Excellence in Teaching and Research.
Hubosky Joins Urology

Scott G. Hubosky, MD, has been appointed assistant professor of urology at Jefferson. He completed his medical training at Stritch School of Medicine, Loyola University of Chicago, and his general surgery training and urology residency at Thomas Jefferson University Hospital. He recently completed a clinical fellowship in urologic laparoscopy and endourology and has extensive training in robotic surgery, including radical prostatectomy. Hubosky will work primarily in the field of endourology with special interests in stone disease management, laparoscopic and minimally invasive surgery, upper tract transitional cell carcinoma management, and robotic surgery. He is a recipient of the Pfizer Scholars in Urology Award.

d’Amato Joins Surgery

Thoracic surgeon Thomas A. d’Amato, MD’90, PhD, has joined the department of surgery at Thomas Jefferson University Hospital and has been named assistant professor of surgery at Jefferson Medical College. He will focus his clinical practice on general thoracic and foregut surgery with a primary emphasis in thoracic oncology.

A board-certified general and thoracic surgeon, d’Amato has conducted extensive research on heart failure and minimally invasive thoracic surgery. d’Amato has served as a guest editor for the JSAIO Journal, American Society for Artificial Organs, and Annals of Thoracic Surgery. He holds a PhD in biology from the State University of New York in Binghamton.

Prior to joining Jefferson, d’Amato served as staff cardiothoracic surgeon in the department of surgery at Tri-City Medical Center in Oceanside, CA, from 2002 to 2005, and was staff cardiothoracic surgeon, U.S. Naval Medical Center, San Diego, from 1999 to 2002.

Brody Joins Surgery

Pancreatic cancer researcher, Jonathan R. Brody, PhD, has joined the department of surgery at Jefferson as assistant professor of surgery. Prior to joining Jefferson, Brody served as an instructor at Johns Hopkins University in advanced programs in biotechnology.

Brody’s research will focus on understanding the basic properties and defects of pancreatic cancer, so he can translate this understanding to optimize the use of chemotherapeutics. Currently, Brody is attempting to utilize the genetic understanding of pancreatic cancer to provide more rational drug treatments based on the individual characteristics of each patient’s tumor. These studies include optimizing the common chemotherapeutic 5-fluorouracil and other drugs that can take advantage of mutations found in the majority of pancreatic cancers.

Brody has received the Excellence in Basic Science Research honor from the pathology department for the fourth and fifth Annual Young Investigator’s Day and the Experimental-Pathologist-Trainee of the Year from the American Investigative Society for Pathology. He is the author of nearly two dozen peer-reviewed publications.

KCC Named Melanoma Center of Excellence

The Kimmel Cancer Center at Jefferson (KCC) has been recognized by the Melanoma Center of Excellence (MCE). KCC is one of the first 10 cancer centers to be designated as an MCE by the network. The organization has designated MCE’s across the U.S. to recognize both academic- and community-based melanoma treatment centers, as well as doctors who offer exceptional care, knowledge, and compassion to patients diagnosed with melanoma, the most dangerous form of skin cancer and the major cause of death in adult eye tumors.

"Jefferson physicians strive to define the diagnostic and treatment programs that best serve individual melanoma patient’s needs,” says Michael J. Mastrangelo, MD, director of the melanoma program in the department of medical oncology. “The focus is on immunobiology and immunotherapy.

“The honor that we received from MHN will facilitate the further expansion of the melanoma program at KCC,” says Takami Sato, MD, PhD, director of the metastatic uveal melanoma program in Jefferson’s department of medical oncology.

Melanoma accounts for about four percent of cancer cases, but it causes most deaths among patients with skin cancer as well as adult patients with eye cancer. The number of new cases of melanoma in the U.S. continues to rise. The American Cancer Society estimates that in 2007 there will be 62,190 new cases of melanoma in this country. About 7,910 people will die of this disease. Visit www.kimmelcancercenter.org.

Hamilton Building Update

Moderate weather conditions have helped the construction of the Dorrance H. Hamilton Building to significantly move forward. The structure is creating a true presence on Locust Street. Progress on the site now includes the beginning stages of the landscaping foundation for the plaza area. You can view the progress online at www.jefferson.edu.
Upcoming Events

**PARENTS DAY 2007**

Top Left: Student co-chairs for Parents Day 2007 Marylee Dilling (left) and Gilbert Kim join JMC Alumni Association President Lorraine C. King, MD, Ren’77.

Bottom Left: Pictured left to right are Benson Krieger, MD’45, his grandson, Isaac Whitman, Class of 2009, and Matthew DeCaro, MD’80.

Above: JMC is known for its legacies as the Class of 2009 pose with their alumni parents.

Please Note: A misprint in the winter 2007 issue of the Alumni Bulletin had Associate Dean Joseph Selzer, MD’71, listed as Associate Dean James Selzer, MD’71. We apologize for this error and regret any confusion it may have caused.

**MAY 16**
Scranton Regional Reception and Dinner
Summit, PA

**MAY 21**
Jefferson Reception at the American Urological Association Regional Meeting
Anaheim, CA

**MAY 31**
JMC Alumni/Senior Reception
Philadelphia, PA

**JUNE 1**
JMC Class of 2007 Commencement

**JUNE 23 – 27**
American Medical Association Annual Meeting of the Board of Delegates*
Chicago, IL

**AUG 3**
White Coat Ceremony

**SEPT 16 – 19**
American Academy of Otolaryngology – Head and Neck Surgery Specialty Meeting*
Washington, DC

**SEPT 28 – 29**
JMC Alumni Weekend
Philadelphia, PA

**OCT 7 – 11**
American College of Surgeons Meeting*
New Orleans, LA

**OCT 8 – 11**
American College of Emergency Physicians Meeting*
Seattle, WA

**OCT 11**
Jefferson Gala
Philadelphia, PA

**OCT 12 – 17**
American Society of Anesthesiologists Meeting*
San Francisco, CA

**NOV 2 – 7**
Association of American Medical Colleges Meeting*
Washington, DC

**NOV 25 – 30**
Radiology Society of North America Meeting*
Chicago, IL

* Exact dates for the Jefferson Reception to be held at this location will be listed in the summer 2007 issue of the Bulletin.

For more information on these listings, please visit [www.alumniconnections.com/oic/pub/JFDM/eventcal/eventcal.cgi](http://www.alumniconnections.com/oic/pub/JFDM/eventcal/eventcal.cgi)
Meet the Department of FAMILY AND COMMUNITY

Pictured left to right: Titilayo Alabi, MD (PGY-2), Adaliz Rivera, MD (PGY-2), Victor Diaz, MD, PGFPX '96, R. Patrick McManus Jr., MD, PGFPX '95, Richard C. Wender, MD, PGAFPX '82, Amber Stonehouse, MD (PGY-2), George Valko, MD '86, Joseph Picca, MD (PGY-3)
In 1971, just two years after the American Board of Family Practice (later the American Board of Family Medicine) was created, the department of family medicine at Jefferson was founded. In the past 35 years much has changed. As alumni professor and department chair, Richard C. Wender, MD, PGAFP'82, explains, “Training in family medicine gives doctors an appreciation of how to influence patient behavior, which, in addition to addressing the patient's acute care needs, is coupled with focus on both preventive care and chronic disease management.”

“Community” was added to the name of the department in 2005. Although that is a recent addition, engagement with communities is not. “By adding ‘community’ to the name, we weren’t changing course; we were recognizing how important and central working with the community is to our mission, and our belief that if we’re going to address the important public health needs with reduction of disparities this cannot be accomplished simply in doctors’ offices. We need to be in partnership with communities, particularly vulnerable communities,” says Wender.
The name change has altered the way others perceive the department. “When we created the division of geriatric medicine in the department, it brought a lot of attention to geriatrics at the institution,” Wender explains. “When people were working in any department in the area of geriatrics, they knew that there was a division they should work with. Community has kind of been the same. When you have a department of family and community medicine, it’s a lighthouse. It guides people to where they can come in the institution to a department that is really engaged in this kind of work, which can help in grant submissions, service projects, and education around the issue of the community.” Why not create a division of community medicine? “One of the ways we look at it — if you look at family medicine without community — there’s an educational agenda, a clinical agenda, a research agenda, and a community service agenda. In the community medicine part of our name there’s education, clinical, research, and service. So they are both comprehensive — that’s why we didn’t create a division of community medicine. It spans our entire mission,” notes Wender.

Some of the community programs Wender refers to include Youth Emergency Services (Y.E.S.). Project H.O.M.E., the Center of Excellence for Research on Obesity, Allies Against Asthma, and the Mazzoni Center. These programs are only a few in an “extensive litany.” Clinical assistant professor
and the department’s residency director, **R. Patrick McManus Jr., MD, PGFPX’95**, is the medical director at Y.E.S., which serves vulnerable — usually homeless or pregnant — teens. In this setting, Jefferson doctors, residents, and students service, teach, and provide “an intervention to improve health.” At Project H.O.M.E., Jefferson doctors provide services to the homeless in the St. Elizabeth community of Philadelphia. “We look at the environment and provide health-care services to this vulnerable population. We’re trying to expand on that service now,” Wender explains. **James Plumb, MD’74, MPH**, is the co-principal investigator in charge of the community outreach program of the Center of Excellence for Research on Obesity. That group is “identifying patients in certain zip codes who are obese, linking them up with lifestyle counselors and creating a community-based intervention (for example, looking at how they purchase food) to address obesity.” Allies Against Asthma, co-chaired by **Michael Rosenthal**, MD, PGFPX’84, is a community partnership for children with asthma; work has been done to reduce asthmatic children’s utilization of emergency room services. Jefferson also has a partnership with the Mazzoni Center, a healthcare center for lesbian, gay, bisexual, transgendered, and questioning individuals. **Robert Winn, MD**, a full-time member of the department, is the medical director of the center. Again, these are just a few of the many outreach programs the department undertakes.

The department has added several divisions over the years: primary care, sports medicine, geriatrics, and maternal/child health. Wender clarifies, “We don’t define family docs by what they do, but by how they think and relate to patients. It’s a family medicine approach to maternal/child health, for example.” A major change over the years has been research. Indeed, the department has been engaged in research for over 30 years, starting with the Greenfield Research Center. “Our research activity is much more extensive now. We’ve been co-investigators on major NIH-funded trials, and we have two individuals who are principal investigators on K grants and other R-level funding. We have new co-investigator trials.” The department ranks favorably with other institutions in NIH funding, “and we’re still growing,” Wender explains. “We have had great success in the area of geriatric medicine, working collaboratively with the Farber Institute for Neurosciences and with the Center for Applied Research on Aging and Healthcare. Together we’re investigating chronic disease and its management in elderly populations. The study of geriatric medicine, taking care of vulnerable elderly populations, has been an area of wonderful success. We participate in almost all the state-funded tobacco settlement initiatives. Currently, there’s a project on neurodegenerative diseases, which we participate in at the Center of Excellence for Research on Obesity, and there’s a submission under review right now by the state for the human papillomaviruses that **Christine Arenson, MD’90**, from our department is principal investigator on.” Research is a fundamental responsibility for all academic departments. The NIH roadmap recently recognized the importance of high-quality research that investigates the partnership between communities and primary care providers to improve health. Wender says, “We’re investing in ourselves to grow the research; it’s very, very challenging. The NIH-funding levels are decreasing, and the cut-lines for research are increasing. It’s getting harder and harder to get funding. But we’re doing that both as collaborators and on our own.”
National leadership is another major initiative for the department, with the faculty taking a community-based approach. Wender speaks with pride about the faculty: "Deb Witt, MD, is playing an important leadership role in the American Heart Association, working on their commitment to minority issues. Rosenthal was nominated for the presidency of our major academic organization, Society of Teachers of Family Medicine (STFM), leading a major strategic initiative for that group. McManus, our residency director, is involved as a representative of the residency group to STFM programming. Arenson is a national leader in geriatrics; Susan Parks, MD, PGFPG'99, our geriatrics fellowship director, is doing a lot nationally; Marc Harwood, MD, PGFPM'01, fellowship director in sports medicine, has been profiled nationally." And of course, Wender is leading the American Cancer Society (Alumni Bulletin, winter 2007 feature).

Patients have changed over the years as well. The most dramatic change, according to Wender, has been the scope of work. Even as recently as 2002, the department had 44,000 patient visits; "this year we’re going to see about 77,000 visits with 6,000 new patients every year." The department began with just one office; "now we essentially have three — with a little bit at Project H.O.M.E. We have a whole satellite: a large practice at the senior center which mainly houses our geriatric division; the big center at 833 Chestnut; and the Mazzoni Center. We also have the Jefferson satellites, which have been around for a while and are hospital owned. We’re not just in one location; it’s a much more extensive outreach than that."

When asked about how teaching has changed, Wender traces his roots in family and community medicine by addressing the topic of patient education. "The model of how we impact behavior as part of the community is very different today than it was 30 years ago. It’s a patient-focused, patient-centered, patient-empowered model as opposed to more of a benevolent paternalistic model. Patients are better informed, but they also face huge environmental challenges: the percentage of uninsured in America is going up not down. The disparities are widening, not lessening. I think at best doctors have not changed in terms of influence. What have changed are how we’re going to solve those problems and which methods to use."

Turning to student education, Wender discusses the expansion in this area. "We started as a 6/6/6 residency program. We’re now a 9/9/9. Twenty-seven [residents] are among the larger programs, certainly one of the most competitive and attractive residencies," says Wender. He continues, "We used to have just one faculty fellowship, now we have four geriatric medicine fellows, two sports medicine fellows, and up to two or three research fellows at any given time."

The increased size of the medical school class has put some pressure on the department. "Since we teach all of those students in the outpatient setting, which is educationally intense and takes a lot of time, it is a real challenge to find really good experiences for every medical student in their third and fourth years." Nevertheless, there has been much success. "We’ve been the highest-rated student clerkship in the third year for many years. We still are in the most recent data. We’re very proud."

But one of the most dramatic changes has been the approach to students, moving away...
from the paternalistic model of times past. “Increasingly, we treat the student as what they are — adult learners, who take a lot of responsibility for their own educations and their own experiences. We’ve been a part of that — the dean has really been the leader in that, but we’ve certainly played an important role.” Wender thinks he’d be remiss not to discuss the changes that continue to occur on campus. “There’s a whole new model in education emerging, which will probably be the most important trend in the next few years, and that is intra-professional education, with the goal of producing interdisciplinary care teams and systems of care. I think that’s another major change that should be mentioned in how we’re taking care of patients. I think the model of just having one doc that does it all is already proven to be inadequate. People have just accepted that it is a flawed model. Here’s an example: there are 27 different preventive measures for adults. With 15 minutes per visit, during which you have to address the patient’s acute concerns, chronic concerns, and 27 preventive items — that’s not going to happen. So you need systems of care that leverage the skill sets of different individuals. You leverage your medical assistants; you leverage the few nurses that you have. Everybody has their responsibility in providing care. What we need in moving toward systems of care are people who were trained in systems and then go on to provide systems of care. The deans are creating a center for professional education that’s going to be an interdisciplinary group responsible for planning how we teach in the future. Arenson is going to be the first director of that center. We’re excited about that, and I think that’s a major initiative for the department, and a reflection of how education is going to change as we move forward.”
We Are Family

Eight JMC alumni share their stories on marriage, family, and medicine — plus an update on an alumni couple 20 years later.
From Lab Partners to Life Partners
John and Elizabeth Bussard, MD’69

At a time when many women devoted themselves to managing the household and raising children, Elizabeth Schroeder had very strong support from her parents and a female biology professor to study medicine. At Jefferson, John Bussard and Elizabeth Schroeder were lab partners in microbiology during their second year. They married just before graduation.

The pair did not consider starting a family until the demands of residency were past. They had found positions as anesthesiologists — two of the three in their department — and bought the 250-year-old farmhouse of their dreams (the couple still resides there).

Elizabeth chose her specialty “partly because I felt that it would allow for more flexibility in arranging periods of leave than an office practice would.”

Daughter Anne was born in 1974. After a maternity leave of six months as arranged in Elizabeth’s contract, Anne spent the days with the young family of a physician’s assistant on the hospital staff. Because the couple worked at Hunterdon Medical Center in a “still rural area,” the OR caseload was light and John or Elizabeth was able to pick up their daughter at the end of the day. “Since this was a friendly as well as a business arrangement, there was little pressure to meet a closing-hour deadline,” Elizabeth explains. When Elizabeth’s parents moved nearby, evening and weekend baby-sitting became more readily available.

When son John was born, Elizabeth decided to take a leave of absence. “This stretched into seven years — an enjoyable time for me. There was always a background sense of frustration, having to juggle the demands of home and career.” When she was ready to resume her practice, she had to get “back up to speed,” so she completed a year of residency at Temple and returned to the Hunterdon Medical Center. At that time, John cut back his practice to help cover the family responsibilities. “This worked out well for us.”

Elizabeth was asked for advice by one colleague who found it very hard to leave her newborn to return to work. “I did not advise giving up medicine completely, as I had done — too stressful to get back. Instead, she cut back significantly on her office and call hours and was very happy with the arrangement; she returned easily to her full-time status as her children grew older. It isn’t easy, even in this age of the daycare industry, to feel that you’re giving your best to child nurturing.”

Does the couple have advice for other Jeffersonians? “The love and commitment of two people are the basis for a rich and fulfilling lifetime together; the challenge of managing family and careers is part of the fun!”

Asked about their children’s ambitions, the couple happily reveal, “We tried to stay neutral as our children thought about careers; it seemed that medicine was not a popular option for them early on. So, it was one of the happiest days of our lives when the acceptance letter from Jefferson arrived!” Anne Bussard, MD’01, has excelled, winning the Sarah Miller Prize for OB/GYN excellence, a specialty she has enthusiastically and successfully pursued.
Balancing Act
Gail (MD’72) and David Jacoby (MD’73)

Gail Tenikat and David Jacoby met at a frat party in October 1969. Gail was a sophomore, and David was a freshman. Three hours after Gail graduated from Jefferson on June 9, 1972, they were married. Gail’s internship was to begin just a little more than a week later; in order to have a honeymoon the couple “had to get things moving!” Gail explains that her parents did not want her to marry before she graduated. Because Gail is Catholic and David is Jewish, they wanted to have a ceremony officiated by both a priest and a rabbi. Since graduation was held on a Friday, that meant they needed to be married before the rabbi held services. “We were married at the Curtis Arboretum, and we made up the ceremony — trying to stress similarities and not differences between the two faiths. It looks like it worked!”

The couple had their first child, Nikki, in the fall of Gail’s third year of residency. Thinking back, Gail says, “David was very eager to have children. If it had been left solely up to me, I would have waited until we had been out of residency for at least two or three years.” She worked until the day her daughter was born, “I went into the hospital after morning conference — and returned to work five weeks later. I continued to breastfeed her for seven months. During my lunch break, I would go to the ICN and donate milk so that I wouldn’t have to transport it back and forth or discard it.” David promised to be “very helpful,” but Gail jokes that she has yet to see a man breastfeed.

The couple had a baby sitter come to their home. “We advertised in the San Francisco Chronicle for a baby sitter. Friends with children had told us it was best to interview prospective baby sitters in their homes in order to get a better perception of them. We found someone who was amazing. She is still our best and closest friend, even though she has moved and changed her professions many times.” Nikki started her life as contraband: “We lived in an apartment house in San Francisco that did not allow children. We spent many hours at night ‘bouncing’ our poor, colicky baby so that she didn’t cry too much. Fortunately, no one complained.” A month before their residencies ended, they moved into a house. At that time, the baby developed chickenpox. “What a way to greet friendly neighbors!” Gail remembers. “I was the only full-time, working mother with an infant in my neighborhood.”

Eventually, the Jacoby’s baby sitter got married and moved to southern California. “I tried the local daycare person who my neighbors used when they needed help; but by then I had a second child, our son, Alex, who was really accustomed to more personalized care. He was ‘kicked out’ of the daycare on his second day — at only five months of age! He cried too much, it seems. In reality, he had his first ear infection.” Life became more problematic. “We found a sweet, older patient of David’s that did daycare in her home in a neighboring town. We also found various high school students and junior college students who could help. Good drivers became a necessity as time progressed.”

Gail concludes, “I think that having (and raising) families is much more acceptable today for female physicians than it was in the past. Of course, there are many, many more female medical students, house staff, and practicing physicians today than there were in the past.”

It Takes A Village
Lori and Rudy DePersia, MD’81

Lori Siegel and Rudy DePersia met in college in 1974 and were classmates and friends. After graduation, they found themselves at Jefferson and maintained their friendship for four more years. They began dating at the Alumni Ball in 1981 and were married in February 1983.

The couple planned to have children while Lori was still a resident, but these things do not always go to plan. “We did not want to put off having children until our careers were established. It would have been easier if we had the children as residents or after our careers were established, but we were not getting any younger,” Lori explains. The couple’s son, Rob, was born in 1985 and their daughter, Kristen, in 1987.

What was the climate like for working mothers at that time? “Most of the working moms had jobs to make ends meet. Being a new mom and working was frowned upon by much of society,” Lori explains. “Most of the other mothers at the schools did not work. It is different now, but back then most professional women took a few years off or went...
super part time (one weekend a month or less) until their children were older."

When the children were infants, the DePersias had babysitters who came to their house. "In 1985, daycare was almost nonexistent. After school programs did not come into vogue until Rob was in 5th grade. When the children were old enough for school, we had a baby sitter come to the house in the morning to take them to school, and then a different baby sitter, or Lori, would pick them up and bring them home. We had several baby sitters, but two elderly women were with us for years; they had been Rudy’s patients. One of these ladies worked for us since Rob was two weeks old and still comes over a few days a week to straighten up and to visit the dog." Lori worked part time until Kristen was in 7th grade. At that time, Lori began to work full time as a radiologist. Once the children were older, the baby sitter would come to the house at 3:00 and be there when the children came home from school. She would stay until Lori came home.

Do you think it is easier for doctors starting out today? "There is no question that doctors and all professionals starting out today have advantages that did not exist 20 years ago. One question you did not ask was whether being a two-career couple with children negatively affected our careers. The answer for us would be yes, but for young doctors now starting families the answer is ‘just a little bit.’"

Does the couple have words of wisdom for students and young alumni? Lori responds, "I worked part time and put my career on the back burner so that the children and my marriage got all the attention it needed. It was stressful and required much scheduling and multitasking... I would advise all graduates to keep life in perspective as it can often be shorter than expected. Don’t put off personal goals in favor of your career. Always put family first. Make time for yourself.”

Rudy adds, "My father was Jefferson ‘48. That generation of doctors placed being a doctor over everything else. Those doctors were perhaps the best physicians of the modern era. The trade-off, however, was a lack of balance between professional and personal life. Lori and I have always made it a point to enjoy our family, our friends, and our leisure time. There is nothing more enjoyable than a weekend that includes golf, working out, hanging out with our kids and friends. We are physicians, but we are also everyday people who need to remember to enjoy the everyday pleasures of life.”

At a picnic on her first day of medical school, Lara Carson walked up to Michael Weinstein and asked what food was available for vegetarians. Because he too was a vegetarian, he knew some of the options. As her "big brother" — an upper classmate assigned to help first-year students navigate their way around — the two worked closely together. While at Jefferson, they helped develop Jeff HOPE, a student-run, service-learning program designed to provide volunteer medical services to local underserved communities. But it wasn’t until three years after their first meeting that they became a couple. They married in 1995.

Mike was a chief resident when their son was born. “There’s no perfect time, during medical school, residency, or being an attending to have children,” Mike says. Lara confides that the couple talked about having children in her second year [of residency]. “We started adding up the cost of daycare and our salaries and were shocked, so we decided to wait another year,” Lara reminds Mike. “That’s actually why I took the job [as an attending physician] rather than taking a fellowship.” Mike adds, “There was some financial planning involved with choosing when to have children. We wanted individu-
alized child care. We knew we’d be overnight from time to time, early hours, late hours. We have someone who comes early and can stay late. She’s been with us for eight years, since Zachary was born.” The couple now have two children: Zachary (8) and Zoë (5).

The Weinsteins’ answers diverge when they are asked to consider whether the idea of having a family influenced their choices when it came to choosing a specialty. “This is what I tell students and residents,” says Mike. “I don’t think you can choose, necessarily, the specialty based on what you want your family life to be. I think you need to find what you like in medicine and make them both work. Regardless of the specialty, plenty of people in all healthcare areas work extraordinarily long hours. Even within what people consider to be very demanding disciplines like surgery or neurosurgery, people can make it flexible, if they find the right people to work with. But you can make that work. Once the kids are a little bit older, everything changes.”

Lara, however, did choose her specialty with an eye to the future. “I picked family medicine to a certain extent for flexibility and toward the view of having a family. It did influence my career choice. It’s worked out well. You just have to put your family first and morph your career around it, regardless of the specialty. But family medicine had only a three-year residency. For me that was really important. I didn’t want to wait six years before starting a family, and I didn’t want to have a family during residency.”

When asked to compare her choices with the options that were available to the first female graduates of Jefferson, Lara responds, “There are so many women in medical school; the statistics have changed so much in the past 20 years. Those first women — especially in particular specialties — were such pioneers. Even if they started a family in their residency, they were really unusual people, really forging new ground. When I was first starting [people] weren’t as supportive. Now [women having children] in residency is accepted.” “My mom stayed home, so that’s very different. I feel like I was able to become an independent young woman and go to medical school because I had a stable home life.”

Mike’s favorite memory of being a parent and a physician is framed on the wall in his office: a school project created by his son. It reads: “My community helper is a trauma surgeon [his father’s specialty]. His job is to operate on people who get hurt. He operates on people who need things fixed inside their bodies. He operated on someone that got shot. The tools he uses are x-ray’s, cutting tools, and stitchis. My hero makes a difference because he saves people’s lives.” For Lara, no particular number stands out. “Every day I’m grateful that I can be a parent and a physician. I am happy to get on the train and be working then come home and be a mom.”

For those readers planning to start a family, Lara shares a secret she wished she had known. “It would have been easier to know that your kids are going to grow up, that they’re not going to be needy babies the whole time. I think as a woman, when you’re planning to have a child and a career, you’re only thinking of pregnancy, birth, and newborn. For me it’s been a transition in a good way. I went part time a year and a half ago to spend more time with my kids, so I could be available for them now that they’re more interactive humans. I never planned beyond ‘pregnancy/birth/baby.’ Your kids’ needs are going to change; their schedules are going to change.” This has enabled her to contribute academically. Lara’s research work is centered on community outreach and improving healthcare for members of vulnerable populations, specifically people whose lives are complicated by experiences of homelessness, addiction, poverty, mental illness, and violence.

Mike would have wanted to know about the emotional weight of both parenting and caring for patients at the outset. “What’s hard to cope with is the impact you have on people’s lives, both in medicine and family life. On the medical side it’s hard to get away from thinking about your patients, about what could be going wrong. As much as you go into medicine wanting to care and to help people, I don’t think you realize how powerful that is.”

The couple feels they have made the right choice marrying a fellow physician. “I think it’s a wonderful opportunity to have such an intimate life together. We can understand what the other person is doing, understand the challenges.” Mike adds, “Our lives just aren’t talking about medicine; it’s important to respect each other’s careers.”
In 1988, you were both working in the Philadelphia area. What path took you to North Dakota?

We had been slowly and casually looking at a variety of opportunities for several years. This one came up at the right time in our lives and had many of the elements we had prioritized: family life, good medical community, education, and access to a city.

How is working in North Dakota different from Philadelphia?

We have not worked in Philadelphia for over 12 years now, so it is difficult to say. The pace tends to be slower and more relaxed, and patients, especially those who are traveling in from more rural areas (or in Ron’s case when he travels out to the rural areas), tend to value medical care highly. Social services and support systems are well developed and relatively easy to work with (more important to Ellen in psychiatry); the system is small enough that many know each other. Managed care has been slow to make inroads.

How did you manage having children during residency?

Not sure! Biology helps... as does good (or poor) planning and flexible residency programs. There is really no ideal time to have a baby (or babies) in medicine or most professions.

We had our first child while Ellen was a PGY2. We moved into a rented house next to the hospital and arranged permission to take call from home. Ellen spent many days running back and forth. We also had a very good nanny who helped make this more do-able, but the intensity of nurturing a child, a marriage, and a career simultaneously is not to be underestimated.

After our second child was born, Ellen began a part-time fellowship and continued her pediatric fellowship in a similar manner after giving birth yet again. Ron worked full time throughout but often changed his schedule to accommodate Ellen’s and to be a hands-on parent.

At the time of the first interview, you had two children. Did you have any more children? What are your children doing now? Are any of them interested in medicine?

We now have four children: our daughter is 22 and heading out to the Middle East this semester to further her studies in Arabic; our oldest son is 20 and a college junior majoring in computer science; our middle son is a senior applying to colleges and very interested in the sciences and math; and our youngest son is 12 and in the 7th grade. Each of our children has very strong interests, but none have expressed a definite interest in medicine.

Did Dr. Feldman eventually begin full-time work?

Not really. I have had a variety of arrangements over the years. I now work 20 – 30 hours a week plus call (some weeks more and some weeks less).

There seemed to be a lot of give and take early on, Dr. Brockman staying in Philly while Dr. Feldman finished medical school; heading to Washington for Dr. Feldman’s internship; leaving Washington for Dr. Brockman’s fellowship. Did this pattern continue?

There is a daily give and take in any marriage so in that respect, yes, it did continue. Several years ago Ron decided to go back to school and get a master’s degree in healthcare administration, and that required some additional flexibility. We make sure one of us is always in town if the other has to travel.

As the family grew we had to shift priorities so the “give and take” felt like contributing to the marriage and family.

The original article ended, “Two-career households obviously do work. Flexibility and the willingness to compromise in favor of the highest objectives seem to be what makes them possible.” Although the wording seems quaint, the truth of the matter remains.
Robert S. Garber ’37 died December 5, 2006. He was a former medical director and president of the Carrier Clinic in Belle Mead, NJ. A psychiatrist, he was active in the APA and was elected speaker of the assembly in 1963; he became the first speaker to be elected president of that association in 1970.

Joseph W. Stayman Jr. ’42 died November 2, 2006. He was chief of surgery at Chestnut Hill Hospital in Philadelphia, PA, and held a teaching appointment in surgery at Jefferson. He was revered as an effective and compassionate teacher and surgeon. He is survived by two sons and two daughters. His son, Joseph W. III, is MD ’79.

Clifford C. Byrum ’43 died December 22, 2006. He served as chief of obstetrics-gynecology at Rex Hospital, Raleigh, NC. He is survived by his wife, Ruby; two daughters, and a son.

Frank J. Gilday Jr. ’44J died November 5, 2006. He served as chief of obstetrics-gynecology at St. Francis Hospital, Wilmington, DE. He was a volunteer teacher at Jefferson for several years. He is survived by his wife, Helen; two sons, and a daughter.

James B. Leonard ’44J died November 26, 2006. He served for 42 years as chief of pathology at the Morton Plant Hospital in Clearwater, FL. He is survived by his wife, Ruth; two sons, and a daughter.

W. Bosley Manes ’44S died July 29, 2006. The top student in his class, he had a surgical practice with Fred Wagner ’41 for years. He is survived by his wife, Helen Minerva, and cousin, John, MD ’36.

Francis A. Gress ’45 died December 8, 2006. He practiced pediatrics and had an appointment in pediatrics at St. Luke’s Hospital in Bethlehem, PA. He is survived by his wife, Virginia; two sons, and a daughter.

Gustav E. Rosenheim ’45 died May 26, 2006. Following his internship, he spent two years in the Air Force. Board certified in obstetrics-gynecology, he practiced at the Women’s Clinic in Boise, ID. He is survived by his wife, Alysce; two sons, and a daughter.

Robert E. Rowand ’45 died November 29, 2006. He served for 20 years as a naval surgeon with the rank of commander. Following his naval career, he practiced medicine in Little Creek, VA. He is survived by two daughters.

Charles W. Werley ’45 died October 29, 2006. He practiced in Bethlehem, PA, where he was on staff at St. Luke’s Hospital. In addition to his hospital obligations, he conducted a private radiology practice. He is survived by his wife, Betty; two sons, and a daughter.

Anthony Chmelewski ’46 died January 1, 2007. He graduated from Jefferson as a member of the Alpha Omega Alpha Medical Honor Society. He had a family practice in Millville, NJ, for 40 years and was widely admired for his medical skills. He is survived by four sons and a daughter.

John R. Bowen ’47 died November 5, 2006. He was a member of the medical staff at the Penn Mutual Insurance Company. He later became the county physician in Burlington County, NJ. He ended his medical career as the medical director of the AT&T facility in Richmond, VA. He is survived by his wife, Emily; two sons, and two daughters.

Thomas F. Blake ’48 died November 3, 2006. He practiced pediatrics and gynecology in Miami, FL. He is survived by his wife, Marcy; five sons, two daughters, a stepson, and a stepdaughter.

Edgar C. Sweeney ’49 died December 5, 2006. He was a fellow of the American Academy of Pediatrics. He practiced in Charlotte, NC, where he was on staff at Presbyterian Hospital. He is survived by his wife, Patricia; two sons, and a daughter.

William K. Carlile ’52 died October 3, 2006. He practiced pediatrics in Phoenix, AZ. He later served as administrative director for the newborn transport program of the Arizona Department of Health Services. He is survived by his wife, Jean.

Eugene Rightmyer ’55 died November 9, 2006. A recipient of both MD and PhD degrees, he was board certified in neurosurgery. His practice base was New Haven, CT, but he also did hospital administration in Egypt and Yemen and directed the Khola Hospital in Oman. He is survived by his wife, Elizabeth; three sons.

Richard A. Bedford Sr. ’57 died January 9, 2007. He had a family practice in the Holmesburg section of Philadelphia for more than 40 years. He also was the physician to two Catholic convents in North Philadelphia. He is survived by his wife, Rita; three sons, and a daughter.
We want to hear from you!

We care what readers think about the Bulletin. Won’t you take a minute to answer this brief survey? Just tear it off, fill it out, and mail to the address below. Your feedback will be very helpful. We want to hear from you! Thank you. — The Editors

Please rate the Bulletin in the following areas:

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Overall: ______
Writing: ______
Appearance: ______

How much of the Bulletin do you read?

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How much of the Bulletin do you read?

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Do you ever clip and save stories from the Bulletin or pass a story or a whole issue to family members, friends, or patients?

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How significant is the Bulletin compared to other sources of information you get, in making you feel connected to and knowledgeable about medicine at Jefferson?

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How enjoyable and interesting do you find the Bulletin compared to other alumni or organizational magazines that you receive?

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What magazines (paid or free) do you find most enjoyable and interesting?

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Do you find the level of scientific and medical detail in the Bulletin to be

☐ much too complex and technical
☐ sometimes a little beyond me, but I enjoy it
☐ just about right for me
☐ a little more superficial than I’d prefer
☐ much too simplistic scientifically and medically

What did you like MOST about the Bulletin?
(Continue on another sheet of paper if you’d like.)

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What do you like LEAST about the Bulletin?
(Continue on another sheet of paper if you’d like.)

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We would also appreciate knowing a little about you, so we can put your responses above in context.

I live in:
☐ Philadelphia
☐ elsewhere in Pennsylvania
☐ elsewhere in the United States
☐ abroad

My age is:
☐ under 30
☐ 30 – 49
☐ 50 – 69
☐ 70 or more

I work for TJU, TJUH, or Jefferson Health System
☐ I currently do
☐ I used to
☐ I never have

I work as a healthcare provider or a biomedical scientist:
☐ I currently do
☐ I used to
☐ I never have

Mail to: Editor, Alumni Bulletin, Jefferson Medical College, 925 Chestnut Street, Suite 110, Philadelphia, PA 19107-4216
Or fax to: 215-503-5084
Kenneth Dollinger reports that he is fully retired from his gynecology practice. Living in Boca Raton, FL, he enjoys playing golf.

Irvin Jacobs reports that he is fortunate enough to actively practice family medicine in a group, Dallas Family Practice, in Dallas, PA. He and his wife, Jewell, had an “amazing trek to Australia and New Zealand” in November 2006.

William H. Taylor still practices medicine four days a week after two heart valve replacements, a fractured cervical vertebrae, a hip replacement, and a pacemaker. He lives in Secaucus, NJ.

Alfred O. Heath has a surgical practice in St. Thomas, USVI. He is doing medical relief work in Haiti and Ecuador.

Donald Gordon-Dill is enjoying his 49th year as a practicing physician. After over 2000 deliveries, he has focused mostly on office and hospital work; he stopped doing obstetrics when the hospital he works in closed their obstetrics unit. He continues to maintain excellent health and fitness in Coronado, CA. “I thank ‘Jeff’ for the start.”

Joseph A. Besecker now works as a research analyst for a financial firm. He and his wife, Lynne, who live in Lancaster, PA, celebrated their 50th wedding anniversary with a private weekend around “our old neighborhoods around Jeff.”

Ronald Gilcher writes from Oklahoma City that he retired as the CEO of the Oklahoma Blood Institute in December 2006. He consults in transfusion medicine and spends more time at his Florida home.

Martin Dresner works as chief of the urology section at the Southern Arizona VA Healthcare System. He was recently selected as “teacher of the year” by the urology residents at the University of Arizona. He was re-elected as president of the Tucson Jazz Society. Dresner celebrated the arrival of his first grandchild (a boy) in December.

David A. Balling practices in the field of infectious diseases and works in medical education at Weis Memorial Hospital in Chicago, IL. He doesn’t see many Jeff grads in his area, so he was surprised when class agent Carl Stanitski showed up to review the hospital’s transitional residency program in October 2006. He also had a nice chat with former Spruce Street roommate and fellow Nu Sigma Nu member Charlie Meyer who was in town for a meeting.

Daniel N. Karch retired from the practice of urology in Tucson, AZ. He now volunteers for multiple non-profits, takes undergraduate courses at University of Arizona, and frequently visits Israel.

John B. Humphrey continues his internal medicine practice at North Canton Medical Foundation. He, daughter, Lisa, graduated from Case Western Medical School and is now chief resident in pediatrics at CHOP. His son-in-law, Prashant Malhotra, is an otolaryngology resident at Jefferson.

Mark Stein was selected “Man of the Year” by the National Jewish Medical and Research Center. He was honored at a luncheon in West Palm Beach, FL, on March 22, 2007.

Barbara Blofstein Berniker writes from El Cerrito, CA, to announce that her daughter is a freshman at Jefferson.

Michael (Steinberg) Rakoff has been president of a healthcare consulting firm serving both hospitals and physician practices for the past 25 years. He and his wife, Susan, have residences in Towson, MD, and Shepardsown, WV. They have seven children and two grandchildren. Rakoff is currently training as a volunteer family counselor at a local hospice. The couple travels annually to an ashram retreat in India.

Ronald Souder continues to practice general pediatrics with Penrigrade Pediatric Associates and serves as chairman of pediatrics at Grand View Hospital. His wife, Sue, is a senior biological safety officer at the University of Pennsylvania. The couple lives in Green Lane, PA. His oldest daughter, Jennifer, is a pediatric nurse practitioner in Bensalem. His middle daughter, Emily, is a first-year medical student at Jefferson, and his youngest daughter, Katie, is doing voluntary service in Washington, DC.

Raymond W. Merrell recently completed a three-year term as president of the medical staff at Memorial Hospital, WA. He continues as president of a five physician urology group in Yakima, WA. After coaching his youngest son’s U-19 Washington State premier soccer team, he looks forward to retiring from coaching soccer after 20 (mostly) fun years.

Joel Rosenfeld is the chief academic officer for St. Luke’s Hospital and Health Network. He lives in Bethlehem, PA.

Michael T. Brady ’77 was recently named chair of the department of pediatrics at the Ohio State University/Columbus Children’s Hospital. He is also physician-in-chief of Columbus Children’s Hospital and a member of the AAP Red Book Committee.
Ted Parris practices interventional cardiology as part of a 90+ person cardiology practice in Philadelphia. He is also director of the cardiac catheterization lab at Jeanes Hospital in Philadelphia. He and his wife, Wendy, recently celebrated their 32nd wedding anniversary.

’80
Mark Chilton serves the American Board of Orthopaedic Surgery as an examiner and is currently a member of the teaching staff at the University of Maryland School of Medicine. He resides in Frederick, MD.

’81
David G. Hershberger is still gainfully employed in the Cone area Health System in Johnstown, PA. He is in his 23rd year of emergency medicine, most recently at Miners Medical Center, Hastings, PA.

’83
Mitchell S. Whiteman reports that all is well in Weston, FL. He and his wife, Michelle, are both radiologists at the Cleveland Clinic, FL. They have two children, Erin and Scott.

’88
Richard Clark is a founding board member of the new Wheaton Franciscan Medical Group, a 220-physician, multi-specialty group in southeastern Wisconsin.

’89
Julie Pretell pursues her academic career as a hematopathologist at the Medical College of Wisconsin. She and her husband, Allen Rieland, enjoy their lakeside home and visiting their two sons, two daughters, and four grandchildren.

’91
Howard S. Pittle has a very busy practice in the suburbs of Pittsburgh specializing in adult and geriatric medicine. He and his wife, Naomi, enjoy their 18-month-old son Harrison.

Christopher A. Smith along with his wife, Lisa, welcomed their son, Daniel, on March 13, 2006. Daniel joins his sister, Alexandra (7), and brother, Patrick, on March 13, 2006. Daniel joins his sister, Alexandra (7), and brother, Patrick (5), at home in Ithaca, NY.

’92
Robert F. Dequevedo practices anesthesia and critical care at St. Luke’s in Bethlehem, PA. He and wife, Lisa, and son, Bobby, welcomed twins, Julia and Matthew, to the family on October 5, 2006.

Alumni Spotlight
Geno Merli, MD’75, FACP
Geno Merli, MD’75, FACP, began his duties as senior vice president and chief medical officer of the Thomas Jefferson University Hospital on February 1, 2007.

Thomas J. Lewis, president and chief executive officer of Thomas Jefferson University Hospital, enthused, “Dr. Merli is uniquely suited to fill this position. His proven leadership ability and boundless energy, together with his superior reputation as a clinician, will benefit all patients at Jefferson. I also believe that his integrity coupled with his innate inquisitiveness will serve us as well as we continue to pioneer new treatment methods that are supported by the advanced technology and clinical research in every area of our academic medical center.”

For over 35 years, Merli has been a member of the Jefferson community, first as a student, then as a teacher and member of Jefferson University Physicians. “This is an exciting opportunity and a great privilege,” Merli explains. “It is an honor to now play a key role in developing new patient care strategies that will continue Thomas Jefferson University Hospital’s tradition of providing excellent clinical care.”

Merli was most recently named the Ludwig A. Kind Professor of Medicine at Jefferson, and has served as the director of the division of internal medicine since 1987 and vice chair of clinical affairs since 2002.

A 1975 graduate of Jefferson, Merli completed his residency in rehabilitation medicine at Thomas Jefferson University Hospital in 1977. He was chief resident in the department in 1978 and completed a residency in internal medicine in 1980. In 1981, Merli was named clinical assistant professor in the departments of medicine and rehabilitation medicine. In 1994, he became clinical professor in the department of medicine of Jefferson and department of nursing in the Jefferson College of Health Professions. In 1997, he was also named vice chairman of primary care in the department of medicine.

The recipient of numerous teaching awards during his career, Merli received the Lindback Award for Distinguished Teaching in 1987 and the Dean’s Citation for significant contributions to the advancement of education in 2004. He has published 120 articles and edited 10 books and monographs. He is co-editor with Howard Weitz, MD’78, of the third edition of Medical Management of the Surgical Patient. He has also been active in clinical research on the prevention and treatment of deep vein thrombosis and pulmonary embolism. He has served as either a principle or a co-investigator in 38 trials.

He currently serves on the editorial board of Patient Care, Emergency Medicine, and Journal of Hospital Medicine. He is a reviewer for Journal of General Internal Medicine, Archives of Internal Medicine, Annals of Internal Medicine, Chest, and Journal of the American Medical Association. Merli is a member of the national DVT Coalition; he has worked with Senators Arlen Specter and Byron Dorgan and State Senators Robert Mellow and Joseph Kyrillos to have March designated “DVT Awareness Month” by the U.S. Senate and by the state legislatures in PA and NJ.
Stewart Slomowitz is an anesthesiologist for Sheridan Healthcare in Florida. While his primary practice is at Westside Regional Medical Center in Plantation, FL, he has contracts for his services in several other states, including Indiana, Maryland, West Virginia, and Vermont. He and his wife, Linda, have four children: Gabrielle (13), Jesse (11), Lily (9), and Jacob (6).

Richard Battista recently accepted a position at OAA Orthopaedic Specialists in Allentown, PA, as a hand/upper extremity surgeon. Previously, he served with distinction and achieved the rank of lieutenant commander in the U.S. Navy. His career was marked by numerous unit promotions and achievements. In January 2005, he was appointed a military advisor at the GlaxoSmithKline. He recently published several papers on the impact of medication adherence on clinical and economic outcomes. In the past year, he was appointed “senior scholar” in the department of health policy at Jefferson Medical College, was appointed to the Health Management Institute advisory board of the National Association of Managed Care Physicians, and was elected to a three-year term on the board of directors of the Greater Detroit Area Health Care Council. He resides in Montvale, NJ.

Manal Soliman Durgin and her husband, Tom, proudly announce the birth of their daughter, Olivia, on December 15, 2006. The family resides in Indian Harbour Beach, FL.

Emery Kim writes that he was honorably discharged from the Army in January 2005 at the rank of major (lieutenant colonel promotable). He has moved to Baltimore, MD, to join a large orthopaedic group as a hand surgeon. He and his wife celebrated the birth of their second daughter, Margaux Misso Kim, on March 7, 2006. Daughter Loren is now 2½ years old.

Michael C. Sokol serves as medical director of Health Management Innovations in the Managed Markets Division at GlaxoSmithKline. He recently published several papers on the impact of medication adherence on clinical and economic outcomes. In the past year, he was appointed “senior scholar” in the department of health policy at Jefferson Medical College, was appointed to the Health Management Institute advisory board of the National Association of Managed Care Physicians, and was elected to a three-year term on the board of directors of the Greater Detroit Area Health Care Council. He resides in Montvale, NJ.

Anand V. Germanwala completed his residency at the University of Pittsburgh Medical Center in June 2006 and will be finishing a cerebrovascular and skull base neurosurgery fellowship at Johns Hopkins Hospital in June 2007. In July 2007, he will become an assistant professor in the department of neurosurgery at the University of North Carolina in Chapel Hill.

Jennifer Thull-Freedman and husband, Steven, recently welcomed the arrival of their first child, Aviva Rebecca. They are currently sharing a year-long Canadian parental leave. She is the co-director of the clinical fellowship in pediatric emergency medicine at the Hospital for Sick Children, University of Toronto.

Erich Jr. Everts, MD ’79, and Deborah Everts Noll, MD ’90; Leslie Everts Noll, MD ’90; and Jennifer Thull-Freedman write that he was honorably discharged from the Army in January 2005 at the rank of major (lieutenant colonel promotable). He has moved to Baltimore, MD, to join a large orthopaedic group as a hand surgeon. He and his wife celebrated the birth of their second daughter, Margaux Misso Kim, on March 7, 2006. Daughter Loren is now 2½ years old.

Monica Crane and Luke Madigan are the proud parents of Cole Van Madigan, born on October 5, 2006. Crane is a geriatric medicine attending and Madigan is completing his orthopaedic spine fellowship at Ortho Carolina. They reside in Charlotte, NC.

Dawn Dunbar has been promoted to radiology manager for interventional radiology, MRL, ultrasound, and the vascular lab at Lehigh Valley Hospital, Muhlenberg campus, Bethlehem, PA. She is also working toward her MBA at Moravian College.

Vasudha A. Panday completed a residency in ophthalmology at the Wills Eye Hospital and a fellowship in cornea, external disease, and refractive surgery at the Wilmer Eye Institute. She is now a major in the U.S. Air Force, on active duty as a cornea and refractive surgeon at the Wilford Hall Medical Center in San Antonio, TX, where she lives with her husband Manoj M. Panday ’98.

Jake Rotman and Yaling Yang are happy to announce their marriage on May 12, 2005, on the island of Hawaii. They currently reside in Santa Monica, CA.

Aaron Cohn is an ophthalmology resident at Beaumont Hospital in Michigan. He lives in Huntington Woods, MI.

Carlos Oliveira, PGOBG’81, is pleased to announce that his son is Jefferson class of 2008. He lives in Palm Bay, FL.

Gregory N. Boger’s, PGOTO’01 son, Jacob, passed away due to SIDS on February 23, 2006. The Jacob Neil Boger Foundation raised $60,000 last year in support of pediatric medical research and treatment. Boger lives in Windermere, FL.

Jugash Cheema, PGUCM’02 is assistant professor of radiology at Yale University. He and wife, Amanpreet, have two children, Aeknoor and Rubina. They reside in Orange, CT.

It is the policy of the Alumni Bulletin to announce neither pregnancies nor engagements, only births and weddings.
By THE Numbers

It’s All Relative

Number of “JMC Couples” who have reported their marriages: 326

Number of Jefferson alumni who have one parent who is also an alumnus/a: 368*

Number for whom both parents are JMC graduates: 7

Number of babies delivered at Thomas Jefferson University Hospital in 2006: 2,154

1st father/son graduates: Samuel D. Gross (1828) and Samuel W. Gross (1857)

1st mother/daughter graduates: Jane S. Hughes ’66 and Jane Hughes ’93

Number of patient visits to Department of Family and Community Medicine projected for 2007: 77,000

1 family, over one hundred years:

Benjamin Kendig (1865); Jerome Kendig (1889); Harry Kendig (1930); Newton E. Kendig (1954); Newton E. Kendig II (1984)

Number of alumni with familial relationships to other Jefferson graduates:

Class of 1945: 35
Class of 1955: 55
Class of 1965: 37
Class of 1973: 34
Class of 1988: 54
Class of 1998: 61
Class of 2007: 21

Number of current faculty whose children are Jefferson alumni: 94

All numbers regarding alumni are based on self-reporting to The Jefferson Foundation.

* Does not include those who graduated before 1936.
Join the thousands of Jefferson Medical College alumni who contribute to the Annual Fund each year. Contact the JMC Annual Fund Office at 1-877-533-3443, or make a gift online at www.jefferson.edu/jeffgiving.

“For our family, giving is a way of showing our pride in being a Jeff alum and an opportunity to contribute to the education of future Jefferson physicians.”

Chris P. Lupold, MD'01, with his mother, Georgetta D. Lupold, MD'74