

Alumni Today

FALL 2014

Alumni Association of the College of Medicine ■ State University of New York Downstate Medical Center



**REUNION
ISSUE
2014**

WHAT'S NEW?

Visit the
Updated Web Site
of the
**Alumni Association-College
of Medicine, Downstate**
<http://www.downstate.edu/alumni>

- Join us for the Alumni Reunion festivities **5.15.15 - 5.18.15**
- See the Alumni Reunion Weekend schedule
- Read the latest Alumni Today magazine
- Learn about the activities and programs we sponsor for our medical students and alumni
- Support our activities- pay your dues or make a gift on-line
- Update your contact information and help locate alumni
- See who serves on our Boards
- Provide us with your feedback



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2014 Reunion Photos



Editor's Greeting

Each reunion I attend seems to outshine those before. Our scientific sessions had presentations which were not only outstanding but very current in the research, applicability and educational content. The reception at our awards ceremony showcased the enormous contribution to science and medicine made by our alumni.

The evening reunion dinner dance was exciting and fun accompanied by fabulous food. The hum in the room from classmates greeting each other was a joyous cacophony of sound.

We alumni can be proud of our school and our peers. We are recognized nationally as a school providing one of the best clinical training programs and we remain the top ten of faculty in medical schools across the country.

As a former President of the organization and an ongoing member of the Board of Trustees and Board of Mangers as well as Editor of *Alumni Today*, I have been very active in fundraising for students scholarships. It is vital that each of us "give back" to the school which provided us with a phenomenal education. Right now most students graduate with loans in excess of 100,000 and tuition at Downstate keeps rising, now over 30,000/year.

We provide scholarships each year to programs which enhance student life. Mentoring, the Brooklyn Free Clinic, Health Care in Developing Countries, Research Fellowships, Graduate programs and many other student activities.

Finally, I want to recognize two individuals who have worked for the organization. LeAnn Alexander who was our Finance Assistant has left for a position as a member of the Donor Services Team at Rockefeller Philanthropy Advisors. We thank her for over 5 years of devoted service to the Alumni Association, College of Medicine.

Jill Ditchik who has been our Executive Director for over 19 years has retired. She was always our advocate for our organization with the Medical School administration, students, donors and all alumni. She helped us move forward in fundraising, student programs, admissions and numerous other member programs to help enhance alumni communications and student life. Thanks Jill. We appreciate all that you have done for us.

Constance Shames, M.D. '63

Editor, Alumni Today

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Constance Shames, M.D. '63
Editor, Alumni Today

“We alumni can be proud of our school and our peers.”

SUNY Downstate President's Greeting



John F. Williams,
MD, EdD, MPH, FCCM
President, SUNY Downstate
Medical Center

Dear Alumni,

I am pleased to share with you that the SUNY Board of Trustees voted to confer permanency on my appointment as President of SUNY Downstate Medical Center. I am honored and humbled by the opportunity to provide leadership for this prestigious institution, and I take great pride in our teaching, research, and clinical care mission and in the unique and diverse population that we represent and serve.

Although our mission is multifaceted, our overarching reason for existence is training future generations of physicians, nurses, therapists, scientists, and public health practitioners that will serve Brooklyn, the State of New York, and beyond. Our student body is among the most diverse in the nation, and many of our graduates choose to stay in Brooklyn to pursue their professional careers.

This is especially true for the College of Medicine. According to the *Journal of Medical Regulation*, Downstate ranks fourth in the nation in the number of graduates holding an active license to practice medicine in the USA. We enhanced this number this past spring, when 218 students graduated from the College of Medicine. In addition, 323 physicians graduated from our Residency Program. (Downstate is the training center for one of the largest residency programs in the country, offering 46 primary care and subspecialty programs at 34 affiliated institutions in Brooklyn, Queens, Staten Island, and Manhattan.)

I think it is fair to say that not only is Downstate the largest educator of physicians for Brooklyn and New York City, but we are a key resource for the nation.

In addition to Downstate's important role in the physician supply chain, we are recognized for our efforts to provide Brooklyn students with early exposure to healthcare career options through a variety of pipeline and mentorship programs. This includes 1) the Undergraduate Summer Research, the Pipeline Access to Health-Careers, and the Exploring Health Careers programs, which are geared to high school and college students; 2) a collaboration between Downstate, SUNY, and the New York Academy of Sciences to mentor middle school students in STEM subjects through an afterschool program funded by the National Science Foundation; and 3) our collaboration with the Arthur Ashe Institute for Urban Health on the Health Science Academy, which brings local high school students to Downstate's campus for science enrichment programs.

Downstate is deeply committed to reducing health disparities and healthcare inequities. The population we serve in Brooklyn is among the most diverse in the world, but it is also a community with disturbing health inequities. Urban health disparities present complex challenges, and they require multi-dimensional, multi-disciplinary, and multi-stakeholder solutions. This is why I have challenged our faculty and staff to collectively leverage our expertise on initiatives that address the health divide through the launch of the President's Health Disparities Research Fund. The goal is to maximize Downstate's diverse

**“ Urban health
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life science and population-based research strengths and facilitate partnerships between our clinical, basic, and public health faculty with industry and the community. More than 40 initiatives were submitted for consideration and are currently under review.

Recent new appointments have strengthened our academic processes. Dr. Pamela Sass, senior associate dean for academic affairs and a member of the faculty since 1989, has agreed to serve as Acting Dean of the College of Medicine as we conduct a nationwide search to replace Dr. Ian Taylor, who stepped down from the COM deanship in September 2014. Dr. Sass led the restructuring of the College of Medicine's new curriculum, and has a strong understanding of how medical education needs to advance in order to prepare students for the changing healthcare landscape. Dr. Susan Phillips, an education expert with extensive knowledge of SUNY and its education structures, has joined Downstate as Senior Vice President for Academic Affairs. Dr. Joseph P. Merlino has been appointed Vice President for Faculty Affairs and Professional Development. Melanie Gehen, formerly vice president for academic fiscal affairs, has been appointed Interim Vice President for Finance and Chief Financial Officer.

We lost two of Downstate's greats in 2014: Dr. Alan R. Shalita and Dr. Gerald Schiffman. Dr. Shalita, distinguished teaching professor emeritus and longtime chair of the Department of Dermatology, passed away in February. He was a giant in the field, a pioneer and internationally known expert in the treatment of acne. Dr. Schiffman, distinguished service professor emeritus of microbiology and immunology, passed away in January. Dr. Schiffman created a unique legacy at Downstate by developing and introducing the first widely used vaccine to prevent a lethal variety of bacterial pneumonia. We will miss both of them.

As Downstate looks forward to the future, we will launch an institution-wide strategic plan to examine all aspects of Downstate's mission, with the goal of setting a course for the future. Our Department of Policy and Planning will be working with each of our colleges, our research division, and University Hospital of Brooklyn to review where we stand and where judicious change might best serve our interests.

I enlist your support as we navigate through the challenging and rewarding work ahead. We have an unprecedented opportunity to better understand and clarify the priorities and challenges of the population we serve, to unify our stakeholders, and to plan the future course together.

Sincerely,



John F. Williams
President

Report from Dean Taylor on His Retirement



FROM: Dr. Ian L. Taylor

Senior Vice President for Biomedical Education and Research
Dean, College of Medicine

DATE: August 12, 2014

I wanted to express my gratitude to you all for your hard work and dedication to the College of Medicine and Downstate Medical Center during my eight year tenure as Senior Vice President and Dean. We have come a long way together. The new Integrated Pathways Curriculum (IPC) has been rolled out and has been well received by both faculty and students.

During a recent visit, one of the LCME secretaries indicated he wanted to showcase the IPC nationally as it represents one of only a handful of curricula that are truly competency based. The new academic building, which is well on its way to completion, will provide new teaching facilities, new laboratories, and a home for our School of Public Health. It should be completed in fall of 2015 and no debt will accrue to the Medical Center and its schools.

We have also experienced a phenomenal growth in our NIH funding thanks to the hard work of our research faculty. The AAMC data demonstrates that between 2009 and 2012 the College of Medicine experienced a 390% greater growth in NIH funding compared to the mean of all other State Medical Schools. This is an amazing statistic. We moved from last to second amongst SUNY's medical schools.

You are well aware of how diverse and how talented our student body is. We experienced a remarkable 73% increase in completed applications to the school between 2005 and 2012. The average MCAT of entering students increased from 30.1 to 32.3 over that time period. In 2013, we ranked in the 81 st percentile (out of 141 medical schools) in terms of graduates practicing in underserved areas. We were in the 96 th percentile in terms of African-American graduates and the 93 rd percentile in terms of under-represented faculty. We also ranked in the 93 rd percentile in terms of graduates becoming faculty in Academic Medical Centers. In 2012 the Journal of Medical Regulation (published by the Federation of State Medical Boards) listed our school as fourth in the nation in terms of the number of our graduates holding an active license to practice medicine in the USA in 2012. As such, we are not only the largest producer of physicians for Brooklyn and New York City but a key resource for the Nation.

In the 2013 AAMC graduation survey, our students rated the quality of their educational experience as exceeding national norms in six out of 9 areas and equal to national norms in the other 3. I was particularly touched by what one student wrote in the students' most recent LCME self-study. He or she wrote "I feel prepared for whatever lies ahead. I also think that I am a kinder and more open-minded person for having come here." To me that sums up what medical education is all about and why I am so proud of what we have all achieved here.

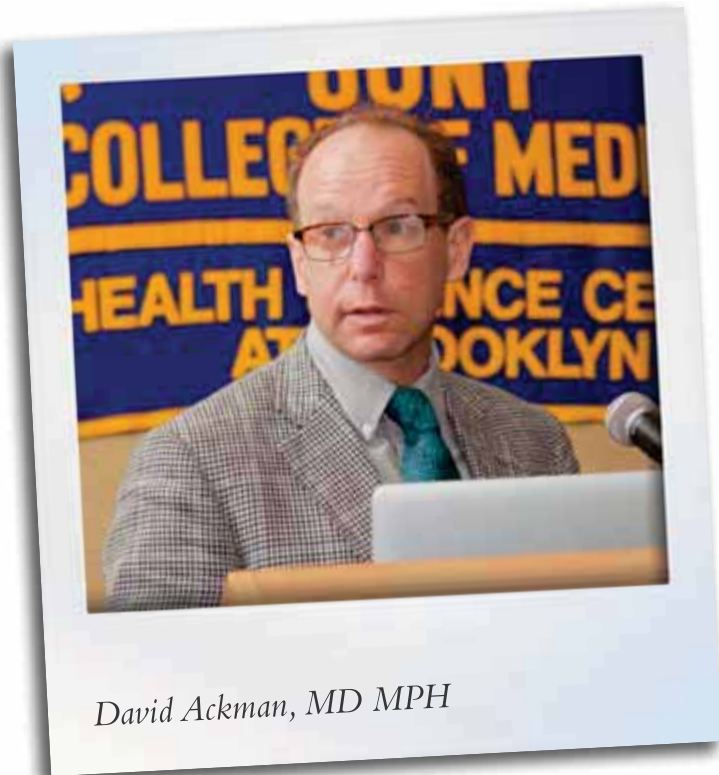
Grants Distributed by the Alumni Fund Alumni Association-College of Medicine Grants for the 2013-2014 Academic Year

\$185,000	Tuition Scholarships – 51 students*
\$80,000	Summer Research Scholarships – 25 students
\$38,250	Health Care in Developing Countries – 17 students
\$28,000	Full Year Research Scholarship
\$17,952	MD/PhD Program – Summer Research Fellowships – 5 students
\$22,200	Conferences for students to present research at national meetings**
\$10,000	White Coat Ceremony for first year students
\$9,000	Mentoring Programs for 250 students and faculty
\$7,000	Match Day and Graduation Activities for Class of 2014
\$5,000	Partial funding for second Full Year Research Scholarship**
\$3,000	The Brooklyn Free Clinic
\$3,500	AOA Alpha Omega Activities
\$2,500	Student Poetry Booklet
\$2,500	Commencement Dinner
\$2,500	Student and Resident Service Awards
\$1,000	Student Yearbook
\$5,000	Other Programs
\$428,202	Total

* This includes a distribution from the Engle Trust to the HSCB Foundation

** Funding being requested at 6.26.14 Board of Trustees meeting

Scientific Presentation



David Ackman, MD MPH

The Affordable Care Act at Six Months: An Insurance Industry Perspective.

PRESENTATION BY:

David M. Ackman, MD '89, MPH

Medical Director, Medicare Programs
Wellpoint

The Affordable Care Act (ACA) is the most far-reaching piece of legislation affecting the health care industry since the creation of the Medicare and Medicaid programs. While it touches almost every piece of health care, from how doctors practice, to how information is created and shared, to how alternative treatments will be evaluated, it is primarily about health insurance – how it is priced and regulated, how it is sold and marketed, and what insurers can do in relation to patients and providers. This assessment is an early one but already there are significant changes to the industry.

The politics and policies that led up to the ACA can be traced to the failure of the Clinton Health plan, and are beyond the bounds of this talk. Starting at the bill's signing in March 2010, there was substantial regulatory reform at the federal level, much of which was to set the stage for Medicaid expansion and the establishment of the private exchanges for uninsured individuals. For insurers, most of the work involved preparing products for the exchanges (a large and to some extent unknown market) and preparing for Medicaid expansion. As many of you recall, the opening of the exchanges was a technical disaster, due to major problems with the CMS enrollment web site, and a policy mine field, as the federal government had to reverse or delay several aspects of the law in response to political or public pressure.

Commercial: Implementation Planning with Backdrop of Uncertainty

Activity on federal regulations implementing the health care reform law:

- The health care sector has digested over 2M words worth of federal regulations
- The close of the 2014 open enrollment period is a "soft" close
- Filing deadlines for 2015 coverage begin in May despite having limited data on 2014.



David Ackman, MD MPH

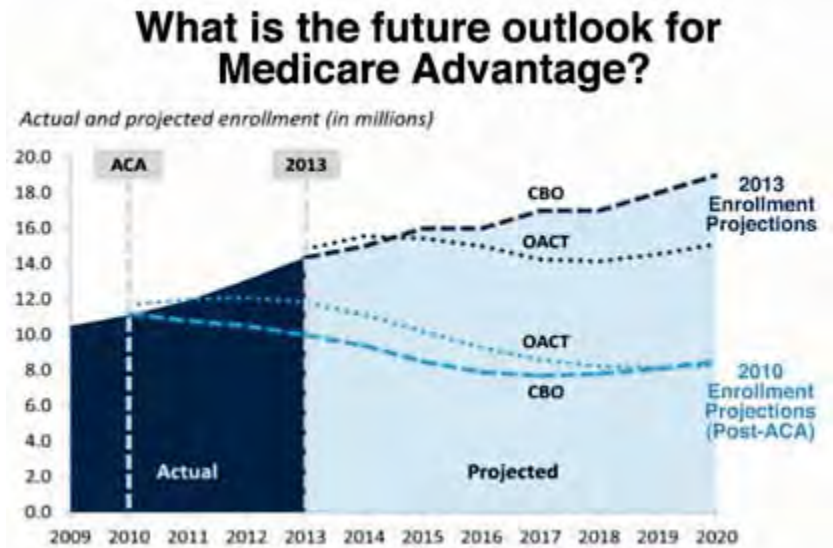
Nevertheless, by June of 2014 enrollment in the exchanges had exceeded projections, Medicaid expansion had occurred smoothly in the 27 states that had elected to do so, and insurers had been able to absorb members and provide services.

Still, there have been significant delays. The Employer mandate was pushed back to 2015 in early February, as there have been technical difficulties with enrollment site and delays in publication of rules as to what constitutes adequate coverage. Looking ahead to the rest of 2014 and 2015, there will be continued uncertainty about rates in the exchanges. Insurers will be filing plans based on only 3 months experience, which increase risk to insurers and consequently may result in large swings in premium prices and products offered.

In the Medicare program, the primary effect of the ACA was to reduce premiums to Medicare Advantage Plans. MA plans now cover 15 million members, or 29% of the program. The ACA was projected to sharply reduce membership in MA plans, as insurers would have to take steps to reduce what had been an enhanced benefit package and/or increase member costs. Surprisingly this has not happened, and MA membership is now projected to grow further under the ACA. This may reflect the fact that many Medicare beneficiaries are comfortable with the restrictions placed upon them by plans due to prior experience as employees. The ACA, however, is not finished with MA plans, and has placed new and stringent quality targets on these plans. Under these conditions, small plans and those that cannot reach quality goals may exit some or all markets.

Finally, a few words about the Medicaid expansion. This is the most immediate and significant impact of the ACA. The ACA raised the income threshold and made millions of persons newly eligible. Many states, however, including Texas and Florida, have not accepted Federal funds for expansion. Whether this continues, or whether these states will find politically palatable ways to expand, is at this point unknown.

It is hard to summarize what the ACA has wrought in only five minutes, even if I am talking only about the insurance industry, and not the doctors, patients, or other entities that have had to respond to the new law and regulations. I thank you for your indulgence and hope this at least puts some of the changes in context. ■



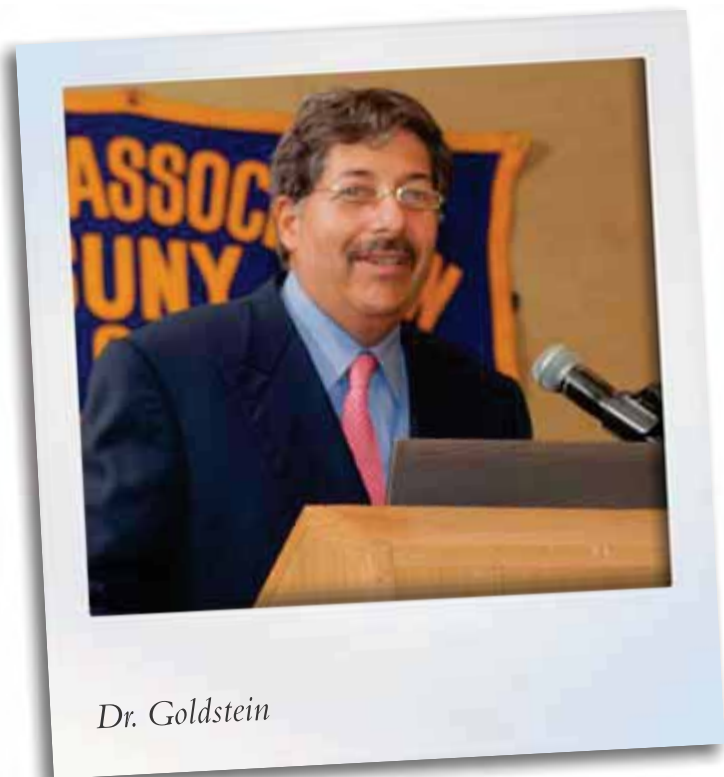
Status of State Action on Medicaid Expansion

Decisions to Expand Medicaid to 133 Percent of Poverty

- Expanding Medicaid through Managed Care Model (22 plus D.C.)
- Not Expanding Medicaid (23)
- Implementing/Seeking Approval of Expansion through an Alternative Model (5)



Scientific Presentation



Dr. Goldstein

Physician Cooperatives Using the Agriculture Model

Legal and Structural Analysis

PRESENTATION BY:

Michael T. Goldstein, MD '74, JD

The delivery of healthcare in the United States is undergoing a rapid transformation. Medicine is shifting from the private practice model to hospital-based employment and large group practices. Hospital mergers have created large vertically integrated institutions with huge market shares. Physicians who want to remain independent are seeking entities which enable them to compete in the evolving healthcare marketplace. These include Independent Practice Associations (“IPAs”), Accountable Care Organizations (“ACOs”) and quasi group practices.

Rather than try to invent new entities, this article proposes the adoption of a business model, the agricultural cooperative, which has been in existence since the early days of the American Republic. This article will discuss the history and structure of an agricultural cooperative, a proposed structure of a medical cooperative and legal issues involved in the formation of a medical cooperative.

HISTORY

The history of cooperatives in the United States dates back to colonial times. Benjamin Franklin was involved in the founding of the first known cooperative in the colonies a mutual insurance company called “the Philadelphia Contributionship for the Insurances of Houses from Loss by Fire, a mutual fire insurance company established in 1752”. Soon after a cheese production cooperative formed in the early 1800s in Goshen, Conn. Cooperatives expanded with the onset of

“Cooperatives play an important role in the modern economy.”

the Grange movement in 1867. Cooperatives sold goods, including farm supplies, to their members in cooperative owned stores, operated grain elevators and tobacco warehouses, exported wheat and marketed agricultural products and wool. By 1920 there were “as many as 14,000 farmer cooperatives”.

Cooperatives play an important role in the modern economy. “Cooperatives handle, process, and market farmers’ products; negotiate with processors and other buyers on their behalf; enable them to purchase inputs at a discount; and provide them credit and other financial services.” “There



are over 3,000 farmer cooperatives across the United States, whose members include a majority of our nations two million farmers". According to the National Cooperative Business Association, there are more than 29,000 U.S. cooperatives with approximately 73,000 places of business, owning more than \$3 trillion dollars in assets, generating \$654 billion dollars in revenue , \$75 billion dollars in wages and benefits and employing over 2 million people.

"Marketing and supply cooperatives account for a third of both total farm sector revenue and input purchases". However, cooperatives involve other sectors of the economy, including credit unions, cooperative housing, and multiple other business entities, "Franchisees, governmental units, hardware and grocery stores, florists and numerous other businesses use cooperatives to market their products and secure the supplies they need at competitive prices".

COOPERATIVE PRINCIPALS

A cooperative is collaboration of individuals, who would otherwise be competitors, for their mutual benefit. By acting together cooperatives take advantage of the economy of scale, market clout, bargaining power and efficiency. A cooperative is collaboration of individuals, who would otherwise be competitors, for their mutual benefit. By acting together cooperatives take advantage of the economy of scale, market clout, bargaining power and efficiency. Capital comes from the direct contribution of the members, including sale of stock, membership fees, withholding of shareholder income, and retention of profits. The liability of each shareholder is limited to his/her contributions to the cooperative. Coopera-

tives operate under a user owner principal where the stakeholders benefit from the profits and are obligated to maintain its economic viability. The cooperative is controlled by the shareholders with each shareholder having only one vote. In some cooperatives high volume users will have additional votes. What is unique to cooperatives is the patronage refund system. Under that system cooperatives provide services and pay for goods at market prices with non retained earnings distributed at the end of the fiscal year to the patrons as cash or equity based on their proportion of total use. Cooperatives do not pay federal income tax as a business entity. Instead a cooperative receives a pass through designation , with the taxes paid by the individual or business who receives the funds in accordance with IRS Subchapter T Cooperatives tax code.

PHYSICIAN MEDICAL COOPERATIVE RATIONALE

The proposed physician cooperative, to succeed, must adapt to the realities of the healthcare marketplace. Regardless of the payment model, physician cooperatives need to provide cost effective, quality healthcare at a competitive price while affording its physician members income and quality of life conditions that are competitive or superior to other alternatives. Patient satisfaction and quality metrics must be competitive. The purpose of the cooperative is not to generate a profit for the cooperative corporation but instead to enable its members to compete against larger entities in the healthcare marketplace.

This concept has worked in many other businesses but has never been attempted by physicians. Historically medicine, has until recently, been thought of as primarily a profes-

Scientific Presentation



“Individual physicians lack the economy of scale, efficiencies and the collective bargaining power of joint ventures.”

sion. Cooperatives have generally been businesses. Now that medicine has evolved to a business model, organizations that have worked in other businesses need to be considered. The cooperative is one such example of an innovative healthcare delivery system.

Healthcare delivery is restructuring. Larger group practices and vertically integrated healthcare systems with physician employees are replacing both private practice and small group physician practice. Physicians in private practice have declined from 57 percent in 2000 to 39 percent in 2012 and are declining at a rate of 2 percent per year. Just like the family farm that faced extinction from consolidation and powerful processors, physicians in private practice are facing extinction.

Individual physicians lack the economy of scale, efficiencies and the collective bargaining power of joint ventures. The preservation of cost effective private practice physicians is necessary to maintain both diversity and maintain competition in the marketplace.

There is a huge parallel between farming in 1922 and medical practice today. The private practice and small group physicians are selling their professional services, instead of agricultural products, to a small number of health insurance company purchasers. These purchasers are paying physicians, inflation adjusted, declining fees while at the same time increasing the price consumers pay for health insurance. As a result profits for health insurance companies have increased dramatically. Reducing the spread in the case of healthcare

means reducing the percent of the premiums paid by consumers and employers that is retained by the insurance companies. The parallel situation between the farmers of 1922 and the physicians of today suggests that rather than reinventing the wheel with new business entities physicians should copy with industry specific modifications the successful model of the agricultural cooperative.

Senator Arthur Capper, the principal sponsor of the Capper Volstead Act in the Senate was concerned that, with regard to farming there was too big a spread between the payment to the farmer and the cost to the consumer. The Capper Volstead Act that provided antitrust protection for cooperatives came into existence to give the farmers bargaining power to deal with the middleman. “According to the Act’s proponents, these entities then paid farmers unjustifiably low prices while, in turn, charging the consumer high prices. This meant these large firms were ‘collecting their tribute from both the farmer and the consumer’”. The same situation exists in medicine. The middleman in healthcare is the insurance company. The spread between the payment to the physician and other providers and the costs to consumers is the loss ratio. When a higher percentage of premiums are retained, above costs, the profits increase. For example, from 2001-2007 there was a 466 percent increase in health insurance company profits. Despite the rising insurance premiums, physician income has declined, suggesting that the increase in premiums has not been used to compensate physicians but

Michael T. Goldstein, M.D., J.D

has instead been retained by the insurance companies as increased profits. The Capper Volstead Act was supposed to enable the farmers to remain in business and protect the food supply. Here too the situation is analogous to modern medical practice. At the same time that there is a projected growing shortage of physicians in the United States, which will jeopardize the availability of healthcare. Private practitioners are being driven out of business at a rate of 2 percent per year by their inability to compete with larger entities. Many of these physicians will join larger entities but older physicians who constitute a significant percentage of active physicians will in large numbers retire. This will further exacerbate the impending physician shortage. Physician cooperatives could enable physicians to preserve private practice, enable them to be more competitive and efficient, provide better care and enable them to be fairly compensated while controlling costs.

PHYSICIAN COOPERATIVE LEGAL STRUCTURE

A physician cooperative would have same legal structure and purpose of a farming cooperative. Each physician would contribute capital and become shareholders in the cooperative. The cooperative would be incorporated in the state where the physicians are practicing. The cooperative would be governed by a board of directors elected by the physicians in a democratic fashion with each physician having one vote. The purpose of the cooperative would not be to make a profit but instead to mutually benefit all of the physician stockholders. The cooperative if permitted by law will distribute patronage to the physician stockholders based on proportionate use. Patronage distribution by a physicians cooperative is an untested area of the law. It is possible that it may be violation of the Stark Law. This will be discussed in Stark Law analysis section.

OPERATIONAL MODEL

The physician cooperative model would be designed to financially integrate independent practitioners. Joint volume purchasing would lower costs of supplies. Employee benefits including health insurance could be jointly purchased at a discount. The cooperative physicians could provide a preferred provider network for their employees. Billing for professional services and credentialing could be centralized reducing in-

dividual office overhead. Claims adjudication, quality assurance and follow up on denied claims could be centralized. Marketing for the cooperative would be a joint venture. The members would be required to adhere to certain standards to maintain the quality of the cooperative name branding. The cooperative could bargain collectively for professional fees, terms and conditions. There is the possibility for both risk sharing contracts and capitation contracts.

The cooperative would enable physicians to enhance the care provided to patients of cooperative members. Equipment sharing would enhance cooperative members ability to provide more comprehensive services at a lower cost. Access to on site medical devices, would eliminate institutional referrals and facilitate treatment. Cooperatives could jointly own radiology services with radiologist being members of the cooperative. Ambulatory surgery centers could also be owned by the cooperative.

“The physician cooperative model would be designed to financially integrate independent practitioners.”

All specialties would benefit in different ways. Primary care specialists would benefit most from laboratory and radiology services. Other specialties would benefit from other diagnostic testing and medical device usage. Surgical specialties would benefit from the ambulatory surgery. Radiologists would benefit from the radiology center. The cooperative would develop income streams from these ancillary services enabling them to compete with hospitals and large group practices that currently have these income streams.

If healthcare changes from a fee for service to outcome based model the cooperative and their members would have the infrastructure and operational capacity to compete and provide services in that environment. The cooperative model enables to physicians to maintain their private practices, con-

Scientific Presentation

control their own hours, patient volume and overall productivity while still reaping the benefits of a joint venture. The cooperative model would enable physician members to compete on a level playing field with large group practices and vertically integrated healthcare systems. The preservation of private practice would preserve diversity and competition in the marketplace. Costs will be kept lower due to competition.

DISADVANTAGES

This model has limitations. Cooperative physicians would still have to manage all of the expenses and headaches of operating their own business. An employed physician does not have these responsibilities. In a group practice only the managing partners have to deal with the management of the practice. In the group practice setting as physicians become partners they acquire equity in the group practice. In contrast the physician who is a stockholder in a cooperative should not expect to acquire equity beyond their original investment.

ALTERNATIVES

A cooperative is distinguished from an IPA because it is more encompassing. In a clinically integrated IPA model, there would be collective bargaining, but in the IPA model there would not be shared facilities, nor secondary income streams from these shared facilities. They would be similar in that they could jointly market, share information, work together for increased efficiency, reduce overhead through group purchasing and share management. Both cooperatives and IPAs can incorporate medical homes into their model. They can both be structured for capitated and risk sharing contracts.

A group practice is totally integrated. There is a single entity, with the group managing all of the overhead costs and operating shared facilities.

The cooperative structure is designed to have all of the integration features of an IPA combined with the joint ownership of facilities and equipment common to group practice while preserving the physicians ownership of their own practices.

DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION GUIDELINES

The Federal Trade Commission ("FTC") and Department of Justice (DOJ) have created guidelines and safe harbors, under

the antitrust laws, for physician organizations that are either clinically or financially integrated. The goal of the guidelines as stated in these guidelines is "to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition".

Cooperatives can be structured to comply with these guidelines through financial or clinical integration or both. The guidelines apply to physician joint ventures.

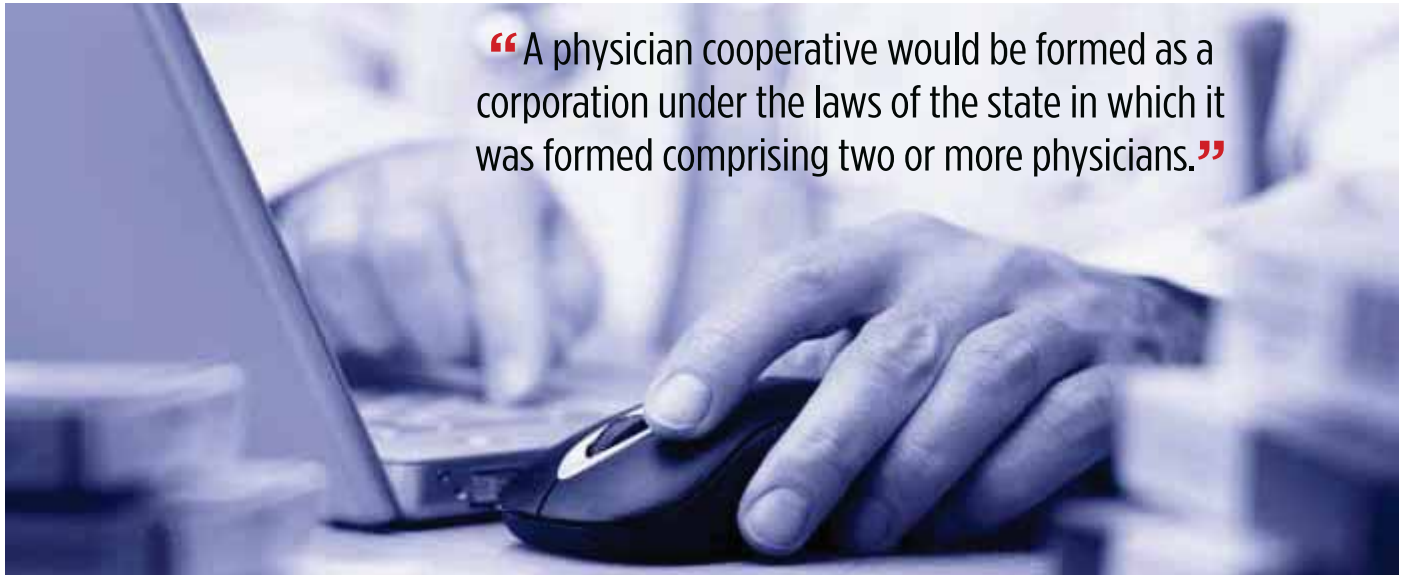
Physician networks that qualify for antitrust protection "must share substantial financial risk in providing all the services that are jointly priced through the network". The FTC offers the following rationale for using risk sharing as determining factor of financial integration "Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians. The FTC gives examples of risk sharing that would fall into the safe harbor. These include capitation, services for a percentage of the premium, incentives to physicians to achieve cost containment goals, through withholding a percentage of the fees and or establishing cost utilization targets, coordination of care among specialists for a fixed fee.

RULE OF REASON ANALYSIS

(FOR COOPS THAT DO NOT MEET SAFE HARBOR REQUIREMENTS)

The principal behind the rule of reason is that "physician network joint ventures that fall outside the antitrust safety zones also may have the potential to create significant efficiencies, and do not necessarily raise substantial antitrust concerns." The FTC further states that "The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."

In theory a physician cooperative which is modeled after the tried and true agricultural cooperative model, an accept-



“A physician cooperative would be formed as a corporation under the laws of the state in which it was formed comprising two or more physicians.”

able joint venture model, should be an acceptable organizational structure under the rule of reason test. However the rule of reason is a three part test that must be passed in order for a joint venture to be approved by the FTC.

STARK ANALYSIS

The Stark Law and its regulations Stark I, Stark II and Stark III make it illegal for physicians to refer patients for Designated Health Services (DHS) to other entities in which they or their family members have a financial interest.

For a cooperative to offer the most benefits to its members it would need to meet the group practice safe harbor protection under Stark. Under the statute the group practice requirements are defined. Structuring a group practice in the following manner should conform to the group practice definition.

A physician cooperative would be formed as a corporation under the laws of the state in which it was formed comprising two or more physicians. Physicians would supply the same full range of services that they had provided before the formation of the cooperative. Billing would have to be done with an authorization to bill in the name of the cooperative with the funds being passed through to the members, after deducting overhead expenses based on a pre-arranged agreement. The cooperative would have to function as a unified business under the regulations. Additional compensation cannot be given based on the value of referrals to the coopera-

tive. However it does not mean that if too much money were taken out for overhead expenses that the excess could not be refunded to the members on a proportional basis. This refund of excess withholding is consistent with the Profits and productivity bonus exception, provided that the refund is related to services personally performed. If there are Stark Issues with regard to the patronage refund component of a physician cooperative then patronage refunds may be saved by 15 USC § 13b which states that “ Nothing in this Act shall prevent a cooperative association from returning to its members, producers, or consumers the whole, or any part of, the net earnings or surplus resulting from its trading operations, in proportion to their purchases or sales from, to, or through the association”. To determine which law would control, if there is a conflict, would require a judicial determination based on extensive conflict of law analysis

Profits based on referrals would have to be shared. It is unclear if sharing of expenses based on proportional use is permissible. There is a risk that it would be interpreted as a pay for click under the Stark Laws as opposed to an overhead sharing arrangement for jointly owned equipment. Overhead sharing of equipment can be structured to comply with the Stark laws and regulations. Physicians in the cooperative on the aggregate would have to devote at least 75% of their physician professional encounters within the cooperative structure.

A cooperative structured in this manner could be designed

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to qualify for the group practice safe harbor. The cooperative could also petition the Secretary to modify the regulations to fit the cooperative model.

ANTI-KICKBACK CONCERNS

The Anti-Kickback Laws are criminal laws which make it a felony to knowingly and willfully receive of pay anything of value to influence the referral of federal healthcare program business. Violation of the law can result in up to five years in prison, criminal fines up to \$25,000 and administrative civil penalties up to \$50,000.

The Office of Inspector General (OIG) has created safe harbors and failure of fall into a safe harbor, is not per se illegal but must be analyzed on a case by case basis.

One of the safe harbors is the Investments in Group Practices. If the group practice meets the Stark Definition of a group practice then it falls into this safe harbor.

The second safe harbor that could apply is the Shared Risk Safe Harbor.

“The cooperative model is longstanding method by which independent business owners who would otherwise be competitors join forces for their mutual benefit.”

CONCLUSION

The cooperative model is longstanding method by which independent business owners who would otherwise be competitors join forces for their mutual benefit. Agricultural cooperatives, who do not engage in anticompetitive activity, have long been regarded as a procompetitive market force. In fact one third of our agricultural production is from cooperatives. With 39 percent of physicians in independent practice it is likely that medical coops could emulate, in healthcare the important role agricultural cooperatives play in preserving a competitively priced food supply.

Physician cooperatives differ from agricultural cooperatives because they do not have the specific antitrust protection of the Capper Volstead Act. Instead they must comply with the FTC guidelines for healthcare, the Stark laws and regulations and Antikickback statutes. Some cooperatives could be designed to fall within the FTC safe harbors but most will have to pass the three part rule of reason test. The patronage refund system, used in cooperatives, where excess profits are returned to members in proportion to use, can only relate to services personally performed otherwise it could raise anti-kickback and Stark issues.

We are in an era where healthcare costs are too high and innovative and cost effective solutions are necessary. Physician cooperatives should be allowed to enter the marketplace. Once formed, only economically viable cooperatives that serve their members and society by providing quality healthcare at a competitive price will survive. ■

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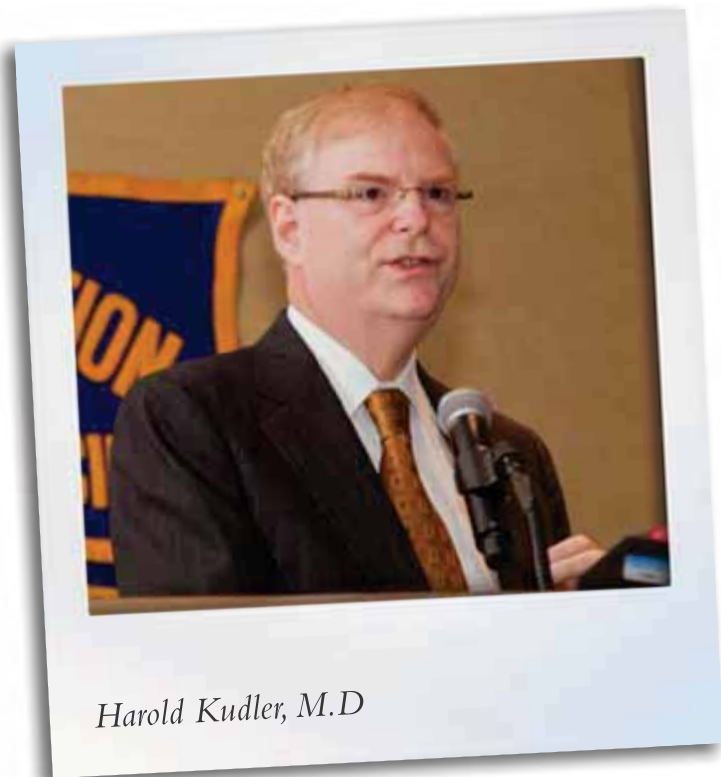
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Scientific Presentation



Preparing for the Mental Health Burden of War:

Lessons Learned from Past Wars and Need for Action Today

PRESENTATION BY:

Harold S. Kudler, MD '79

Associate Director

VA Mid-Atlantic Mental Illness Research,
Education and Clinical Center

Associate Professor

Department of Psychiatry and Behavioral Sciences

How does the nation train and retain a high capacity, highly experienced professional workforce to support the deployment-related mental health (MH) needs of Service Members, Veterans, and their families before, during after war?

My question stems from experience as a VA psychiatrist who, for thirty years, has worked locally, regionally and nationally on the diagnosis, treatment and, when possible, prevention of Posttraumatic Stress Disorder (PTSD). I'm also motivated as the namesake for my grandfather, Harold M. Sachs, M.D., Long Island College of Medicine Class of 1929, and my grandmother's kid brother, Sumner Brandstein. Both were from Brooklyn, both volunteered after Pearl Harbor, both served in the Army Medical Corps and both died in World War II. My grandfather served in the invasion and occupation of North Africa until a series of heart attacks brought him home to Brooklyn where he died on his way to treat military casualties on Governor's Island. My great-uncle was a medic who died when his ambulance ran over a landmine in Germany shortly before the war's end. He was on his way to help bring a German baby into the world. Neither of them were professional soldiers. Then, as now, they and the majority of their colleagues entered military medical service without specialized training on deployment stress or deployment mental

health. As a child who made frequent visits to my grandmother's apartment, I often wondered why the only medical books on the shelf were psychiatric texts (including the Penguin edition of the Works of Sigmund Freud). What would a G.P. be doing with these and why were they the last books he kept at home?

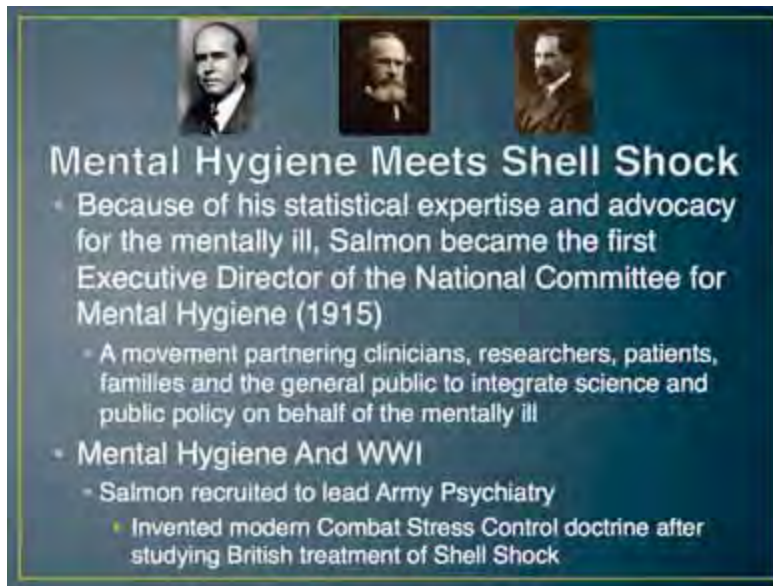
I started at Downstate in 1975 just a few months after the end of the Vietnam War. America has seen many new wars since I became a doctor including the invasions of Grenada (in part, to rescue American medical students) and Panama, the first Gulf War, Somalia, the Balkans, Haiti, Operation Enduring Freedom in Afghanistan (OEF) and Operation Iraqi Freedom. Looking back on my own medical training, I can't remember a single mention of military medicine as a field unto itself. The only comment I can recall having been made about military mental health is that psychological disorders may be severe at first but generally get better over time (an interesting parallel to what we were later taught about mild traumatic brain injury- remember that PTSD was not defined until 1980). Where

Scientific Presentation

is military medicine in the medical curriculum now and how are we, as a nation preparing for the mental health burden of war now that we know that its effects can be lasting and resonate through every American community, within families and across generations? Given that one in every five Americans is either a Service Member, a Veteran or one of their dependents, these are questions which need to be asked!

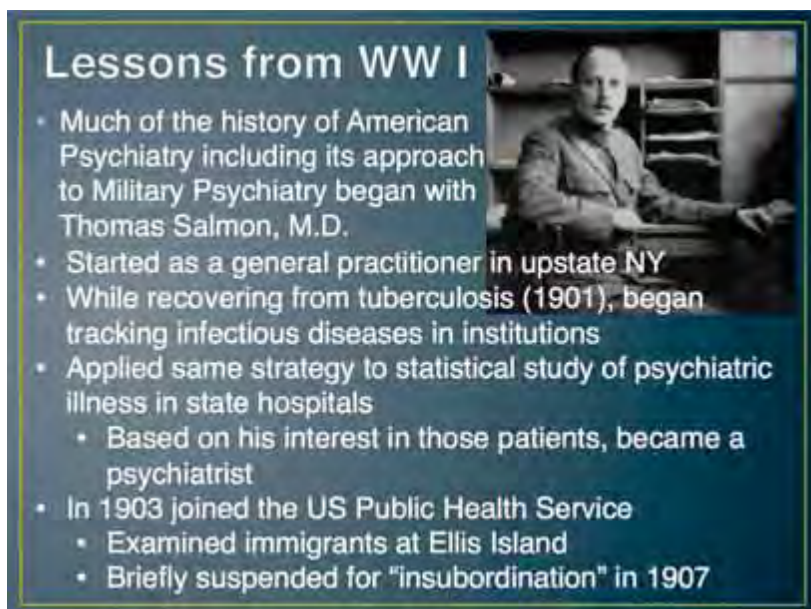
OEF, now in its 14th year, is the longest war in American history. OEF and OIF have been fought by an all-volunteer force of over 2.6 million Americans. Their military medical providers are mostly volunteers too. During these wars, VA's budget has more than tripled to \$151 billion in fiscal year 2014. As the war winds down, many look forward to a "peace dividend" but it is important to remember that there is likely to be another war somewhere, sometime and that it makes sense to prepare for it. And, as we've learned over the past century, it is particularly important to prepare for the mental health burden of war - a cost to individuals, families, the military and the nation which may only become apparent months or years after peace is declared.

in Brewster, New York. While recovering from tuberculosis (1901), he began tracking infectious diseases in healthcare institutions. Later, he applied the same strategy to the sta-



Mental Hygiene Meets Shell Shock

- Because of his statistical expertise and advocacy for the mentally ill, Salmon became the first Executive Director of the National Committee for Mental Hygiene (1915)
 - A movement partnering clinicians, researchers, patients, families and the general public to integrate science and public policy on behalf of the mentally ill
- Mental Hygiene And WWI
 - Salmon recruited to lead Army Psychiatry
 - Invented modern Combat Stress Control doctrine after studying British treatment of Shell Shock



Lessons from WW I

- Much of the history of American Psychiatry including its approach to Military Psychiatry began with Thomas Salmon, M.D.
- Started as a general practitioner in upstate NY
- While recovering from tuberculosis (1901), began tracking infectious diseases in institutions
- Applied same strategy to statistical study of psychiatric illness in state hospitals
 - Based on his interest in those patients, became a psychiatrist
- In 1903 joined the US Public Health Service
 - Examined immigrants at Ellis Island
 - Briefly suspended for "insubordination" in 1907

tistical study of mental illness in state psychiatric hospitals as part of an effort to better understand and meet the needs of the mentally ill. Based on his interest in those patients, Salmon became a psychiatrist. In 1903, he joined the US

Public Health Service and was assigned to examine immigrants at Ellis Island (where a young Fiorello LaGuardia served as his translator).

Because of his statistical expertise and advocacy for the mentally ill, Salmon became the first Executive Director of the National Committee for Mental Hygiene (1915), a movement partnering clinicians, researchers, patients, families and the general public to integrate science, public policy and compassion on behalf of the mentally ill. When America entered WWI, Salmon was recruited by a member of his National Committee, the Surgeon General of the Army, and asked to lead Army Psychiatry. Based on his proactive study of the British treatment of shell shock, Salmon developed the core elements of Army Combat Stress Control doctrine

Much of the history of American Psychiatry including its approach to military issues began with Thomas Salmon, M.D. (1876-1927) Salmon started out as a general practitioner

which are still applied today in Afghanistan with a 97% return to duty rate.

At the end of WWI, Salmon was responsible for thousands

Harold Kudler, M.D.

of psychiatrically hospitalized American troops in France and the US. At that time, there were still a few Soldiers' Homes left over from the Civil War but there were no modern military or VA hospitals available to treat these Veterans. The US Public Health Service Hospitals refused to take them. Salmon then developed a plan to retain WWI Army psychiatrists and assign them and their patients to selected state psychiatric hospitals strategically distributed across the US but the patient's parents refused to allow this (in large part, because Salmon's Committee on Mental Hygiene had done such a good job of publicizing the significant flaws of those hospitals). Ultimately, Salmon petitioned Congress to create a new VA hospital system to receive these Veterans. By the time these hospitals opened as part of the Veterans Bureau, the number of American Veterans of WWI requiring psychiatric hospitalization had increased from 3,200 to 8,000.

As WW II began, a rash of books by mental health professionals who had served in WW I were released just in time to offer advice for the next generation of military providers yet

“There was . . . considerable preparation for the understanding and therapy of war neuroses, yet actual experience with such cases in a theatre of operations disclosed that our clinical knowledge was meagre, our interpretations often erroneous and our therapy inadequate.”

the situation, as described by newly minted military psychiatrists, Lt. COL Roy R. Grinker and Captain John P. Spiegel from their post in North Africa seemed bleak. (quote)

The original plan for WW II was to minimize MH casualties by screening out those likely to “break” rather than re-institute Salmon's combat stress control principles. The high rate of rejection, the pressing need for more troops and the fact that even screened troops broke down at an alarming rate led

to abandonment of screening. The Salmon principles were applied (with excellent results). Many who had originally been



declined enlistment performed well under fire. Salmon's combat stress control strategy has been a vital component of US military operations ever since. In the wake of WW II, Grinker and Spiegel's success with cathartic treatments (hypnosis and amylal interviews) brought new prestige to American Psychiatry and American Psychoanalysis.

Sixteen million Americans served in WW II of a total US population of 140 million. Many returned with deployment-related MH issues ranging from subclinical problems with sleep, anxiety, depression and irritability to what would today be diagnosable disorders including PTSD, Major Depression and Substance Dependence among others. Unfortunately, as noted in the preface to DSM-I (1952), the American psychiatric nomenclature of the time had been developed to describe the problems of institutionalized mental patients and “90%” of mental disorders encountered among those who served in WW II could not be adequately described in those terms.

One in four American psychiatrists served in WW II and had become acculturated to the thinking (and the leadership) of Brigadier General Will Menninger. When they came home, they worked together under Menninger's leadership to push the American Psychiatric Association to create its first Diagnostic and Statistical Manual of Mental Disorders: the DSM. During the war, Menninger had encouraged all Army Medical Corps staff to study psychiatric principles; this may explain my grandfather's edition of Freud. I can't help but wonder

Scientific Presentation

if he was studying it to help in his ongoing work with war casualties, many of whom were likely dealing with MH issues co-morbid with their other wounds.

As current combat operations come to an end, large numbers of Service Members will again return from deployment. A draw-down in military size will soon produce thousands of new Veterans, many of them with significant combat experience. As part of the same process, an entire generation of military MH professionals will re-enter the civilian workforce. As Veterans, their families and their military MH providers diffuse back into the civilian world, will they be recognized for their service and will the lessons of past wars be put to good use?

“Our illusions about military members, Veterans and their families often interfere with our ability to identify and meet their needs.”

Our illusions about military members, Veterans and their families often interfere with our ability to identify and meet their needs. Many Americans, including many health care professionals, assume that service members and Veterans almost always live on or near military bases. In actuality, most Active Duty service members and their families now live off base, virtually all Reserve Component troops (40% of the fighting force in OEF/OIF) and their families are scattered across the entire nation and Veterans of Afghanistan and Iraq live in virtually every community in the US.

It is therefore important to ask whether service members, Veterans and their families are reliably identified and appropriately triaged in community health care settings. Unfortunately, this doesn't seem to be the case. A recent web-based survey found that 56% of community providers don't routinely ask their patients about being a current or former member of the Armed Forces or a family member. Further, only 29% of providers agreed with the statement: "I am knowledgeable about how to refer a Veteran for medical or mental health care services at the VA".

Lessons Learned in WWI and WWII

1. Even when a war is finally over, its effects continue at home
 - When you go to war, prepare for its long term psychiatric impact
2. While it might work some day in the future, pre-screening for those who are going to break down in combat has never been effective
 - The primary lesson of WW II is that, given enough stress, everybody breaks
3. You have to pave the road all the way home
 - Service Members/Veterans and their families live virtually everywhere in the nation
 - One in five Americans is either a Service Member, a Veteran or a family member
 - Take military histories of every patient and document it
 - Ask "Have you or someone close to you served in the military?"
 - Build this into the electronic medical record on the basis of meaningful use
 - Build it into the training of health professionals across disciplines
4. Build on the common language, experience and bonds of military mental health professionals as they return to civilian roles and spread back across the nation
 - Recognize them for their service and recruit them as mentors to VA and community clinicians
 - In particular, professional societies such as the American Psychiatric Association and the AMA should find ways to identify, honor and involve military clinicians both during their years of service and in the years following service in order to improve the care of Veterans and their families and to maintain readiness for future wars
5. Preserve institutional memory of deployment mental health in DoD, VA, Professional Organizations and in Community Mental Health Systems
 - Build on VA's Community Mental Health Summit process
 - Disaster preparedness will help the national system keep its edge between wars
6. Keep thinking through underlying theories, diagnostic systems and clinical practice with each new war

Harold Kudler, M.D.

Now is the time for a revolution in the way America thinks about deployment mental health. Salmon and Menninger understood the importance of a common theory, common language and institutional memory. The following lessons, learned in WWI and WWII, apply just as strongly today and provide the platform for future action on the national front and in every clinical setting:

The war was never just (as the George M. Cohan's song put it) Over There: it has been here at home in every community across America since the start of operations and it will continue to resonate across the nation and across generations. The impact of war needs to be recognized, understood and dealt with in every home, clinical practice, professional training curriculum and community. War is a national mission which extends beyond the 60 million Service Members, Veterans and their dependents into every workplace, school, clinic, courthouse, social program and branch of government. Every American is a part of this mission and has a role to play. While VA's role is critical and irreplaceable, the mission cannot be accomplished by any single organization; it is an essential duty of every health professional and every citizen.

As long as the future health of Veterans and their families is "someone else's responsibility", they will never receive the care or respect they deserve and we, as a nation, will have failed in our mission. ■

VA's Unique and Essential Mission: Build on its Institutional Memory and Special Expertise in Veterans Health Care

- Salmon and Menninger understood the need for a common theory, common language and institutional memory
- VA is distinguished by its institutional memory and unique mission of care and research on behalf of Veterans
- No one else owns this mission or could own it
- Even if DoD/VA/Community Partnerships are optimally successful, the Nation will still depend on VA to preserve a common theory, a common language and the institutional memory required as the crucial link in a national system and culture in the service of Veterans and their families

¹Grinker RR, Spiegel J: War Neuroses in North Africa. New York: Macy Foundation, 1943.

²Kilpatrick, D.G., Best, C.L., Smith, D.W., Kudler, H., Cornelison-Grant, V. Serving those who have served: Educational needs of health care providers working with military members, veterans, and their families. Charleston, SC. Medical University of South Carolina Department of Psychiatry, National Crime Victims Research & Treatment Center, 2011.

Scientific Presentation

Metallosis, Hip Replacement Recall and Trunionosis

PRESENTATION BY:

Raymond Scalettar, MD '54, DSC

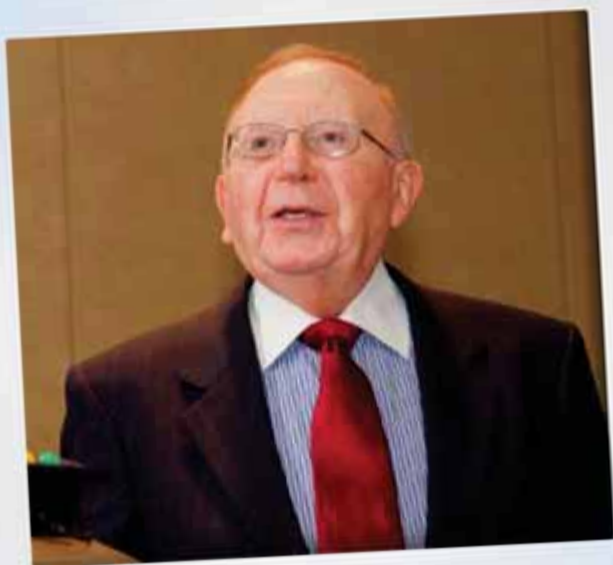
Clinical Professor of Medicine,
George Washington University Medical Center, Master,
American College of Rheumatology, Fellow, American
College of Physicians, SUNY Downstate Medical Center, '54.

The purpose of this presentation is to alert the public and the profession to the significance of cobalt toxicity in association with total hip arthroplasty: where and how it occurs, its signs and symptoms, and how to diagnose and treat patients for cobalt toxicity.

The problem of cobalt toxicity received dramatic attention with two recent publications in *Lancet*¹ and the *New England Journal of Medicine*². In the former case report, "Cobalt Intoxication Diagnosed With the help of Dr. House is an example of art imitating life and science. Here the author described how he was able to make this diagnosis after recalling a TV episode of Dr. House, a snippet of which was played in my presentation.

“There have been more than 1,000,000 metal-on-metal hip implants performed worldwide.”

There have been more than 1,000,000 metal-on-metal hip implants performed worldwide. This means that the femoral head and the metallic cup in the acetabulum are made of metal. This is usually vitallium, an alloy of cobalt, chromium and other metals. These are at risk for breakdown causing "Adverse Reactions from Metal Debris" (ARMD). In addition



Raymond Scalettar, M.D., D. Sc

to the local deterioration of the hip joint requiring total hip revision, this results in the systemic release of metals such as cobalt and chromium.

Metal-on-metal hip implants have received all the attention, and there has been a significant amount of ongoing litigation relating to these devices. However, there has been a growing recognition that breakdown and the associated reactions also occur with metal-on-polyethylene. (See Figure 1. Hip Prosthesis Corrosion Sources). In that instance, the problem arises because there is corrosion at the metal femoral head and the modular stem (modular corrosion), resulting in the release of these metallic ions³. This is what has been called Trunionosis. The result is deterioration at the head and modular neck, with associated pain, synovial effusion, pseudotumors and osteolysis. The presentation is like septic arthritis, which has to be ruled out.

Cobalt toxicity is an emerging clinical problem⁴ and is of global concern.⁵ The referenced reports emphasize that the problem is not only metal-on-metal but metal-on-polyethylene. There is corrosion occurring at the head-neck modular juncture and at the neck-stem taper, as in the Stryker-recalled hip prosthesis. The Stryker prosthesis is not a metal-on-metal device, but fretting and corrosion occur at the neck-stem



junction and can result in the signs and symptoms of Metallosis. The DePuy ASR system is a metal-on-metal system that also has been recently recalled because of fretting and corrosion and subsequent cobalt toxicity.

Cobalt toxicity can have numerous manifestations. Not only may there be local signs of inflammation, with pain, swelling and limitation of motion at the hip, but there also may be numerous systemic developments. These include myopathy, neuropathy, dermatitis, hypothyroidism and, of the greatest severity, cardiomyopathy, extensively written about in the Clinical Problem Solving section of the New England J of Med.²

The case reported at the medical school reunion was that of an octogenarian male who had a DePuy Pinnacle hip arthroplasty in 2006. This device is metal-on-polyethylene, and has not been recalled. His symptoms were that of progressive localized pain, spasm, limitation of motion and, subsequently, dermatologic manifestations of systemic disease. The latter presented as acne vulgaris and erythema nodosum. Later, he developed myopathy and severe fatigue. Arthrocenteses showed no bacterial growth but did show yellow turbid fluid with metallic particles. His cobalt and chromium levels were elevated. A hip revision, with irrigation of the surrounding area, was performed. His metallic ions gradually returned to normal as did his local hip symptoms of pain and decreased range of motion. At the present time he is asymptomatic for Metallosis and has good range of motion at the affected hip with very little discomfort. Intensive physiotherapy in the form of aquatics has been very helpful.

In summary, one must be aware that the problem of Metallosis can occur in hip arthroplastic joints that are non-metal-on-metal. It can occur in metal-on-polyethylene. No alloy is safe from corrosion. Metallosis can occur at the modular head-neck juncture, as it did in our current case report, as well as at the neck-stem junction, as occurred in the Stryker-recalled hip replacement systems. Just as exists in the UK, the United States needs registries of all hip replacement hardware so we can know what products are unsafe. (See Figure 2. Summary and Recommendations). ■

1. Dahms, K., Sharkova, Y, Heitland, P, et al. Cobalt intoxication diagnosed with the help of Dr. House. Lancet 2014; 383: 574
2. Allen, Larry A, Ambardekar, A., et al. Missing Element of the History. N Engl J Med 2014;370:559-66
3. FDA website on Metal-on-Metal Hip Implants. [http://www.fda.gov/MedicalDevices/Products and Medical Procedures/Implants and Prosthetics/Metal on Metal Hip Implants/ucm241604.htm](http://www.fda.gov/MedicalDevices/Products%20and%20Medical%20Procedures/Implants%20and%20Prosthetics/Metal%20on%20Metal%20Hip%20Implants/ucm241604.htm)
4. Cooper, H., et al. Corrosion at the Head-Neck Taper as Cause for Adverse Local Tissue Reactions After Total Hip Arthroplasty. J Bone Joint Surg Am. 2012 Sep 19;94 (18): 1655-1661
5. Beaver, R.J. et al. Corrosion at the neck-stem junction as a cause of metal ion release and pseudotumor formation. J Bone Joint Surg. 2012; 94-B(7):895-900

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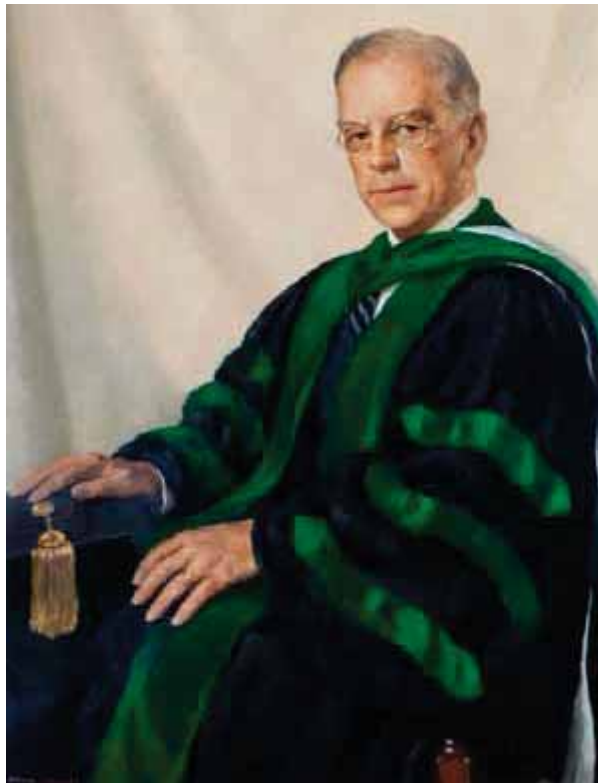
To Julie Ellen Mangino '89

The Babbott Award Remarks

Edited by Constance Shames, M.D. '63

Frank L. Babbott served as Pediatrician, Assistant Dean, President, and Chairman of the Board of Trustees of the Long Island College of Medicine. He played a key role in the College during its separation from the Long Island College Hospital, and in the decision to purchase land to relocate the College to Clarkson Avenue. In his honor, the College of Medicine Alumni Association annually bestows the Dr. Frank L. Babbott Memorial Award to an alumnus in recognition of distinguished service to both the medical profession and the medical community.

Born in Brooklyn in 1891, Babbott received his medical degree from Columbia's College of Physicians and Surgeons, and then briefly spent time on the pediatric staffs of the John's Hopkins and Yale University medical schools and Bellevue Hospital. The greater part of his career was devoted to LICM. He joined the College in 1925 as an associate in pediatrics, served as Assistant Dean from 1927 to 1931, and then as Presi-



by Dr. Frank I. Babbott, MD
Grandson of Dr. Frank L. Babbott
at the Downstate Awards Ceremony
May 17, 2014

Frank Babbott's uprightness of character, his friendliness, his delightful sense of humor and most important of all the trust and affection of his col-

Babbott had a philosophical outlook which was:

How can we prepare this type of position – this doctor whose interest is as much in the man as the microbe? In the first place great care must be exercised in the selecting of the individual medical student. Not only should there be a thorough study of his intellectual attainments, as exemplified in past scholastic endeavor, but also all possible light must be brought to bear on his character and personality.

The faculty member...needs to have an inquiring mind, to be constant and a thoughtful student - who, by his patient example, can "e-du-cate" or "lead out" his pupils into the fields of learning.

Such a school should be clinically top-heavy. It needs what Osler called the 'leaven of science' without which it would never rise above a doughy mass of sentimental mediocrity...but the purpose of the science laboratories of such a College are not those of a medi-

“The faculty member...needs to have an inquiring mind, to be constant and a thoughtful student-”

dent for 10 years. Following his retirement in 1941, Babbott became a member and then Chairman of the College Board of Trustees.

leagues that made it possible for him to fulfill his commitment to medical education in Brooklyn.

cal research institute where all effort is bent solely to the solving of scientific riddles, but rather to the illumination of the path immediately facing the student

and the practitioner.

Such a college must do all within his power to formulate an integrated curriculum. Good organization pre-supposes departmental autonomy-but care and patience must be exercised to breakdown the inter-departmental barriers - for after all, each division of teaching is but a part of a grander scheme.

Close cooperation is particularly important between the major clinical divisions and two rapidly developing branches of medical education, namely preventive medicine and psychiatry.

The duty of a medical school does not cease with the presentation of a diploma.

"I believe in the totality of the individual.

I believe his needs must be served by the profession of Medicine.

I believe in the education of men and women to that end.

I believe we have loyal trustees and friends, who will support, and an able faculty which will conduct, this education.

I revered the memory of the great men of this College.

I gratefully but humbly accept the honored position you have offered me and I pledge to it all that I have to give."

Thus began his term as President of the Long Island College of Medicine.

After his retirement in 1941 he became and remained the Chairman of the Board of Trustees until 1950. You are well aware of his many accomplishments before, during and after his presidency. These include the growth of the medical school, development of the Clarkson Avenue Campus, research facilities and the creation of Downstate Medical Center.



Frank L. Babbott, Jr., MD, 1972H;
1891 to 1970

As reported in the Columbia University P&S Quarterly, Fall, 1970, "to preside over the destinies of a medical school in its transition from a hospital-controlled institution with the standards and traditions of 50 years ago until it became a university medical center with no mean task. To those who knew him best it was their echoes emanating from their accomplished careers, which reflect so well on the legacies of Downstate Medical Center. ■

Portrait of a Donor — Florence Kavalier, MD, MS, MPH

FLORENCE KAVALER, '61 MD, MS, MPH

Health care administrator, scholar, educator and advocate for quality health care.

By Constance Shames, MD '63

In medicine and public health, there is almost no area that escaped the interest and involvement by Dr. Kavalier. Her long and successful career was undoubtedly stimulated early on by her father Samuel Kavalier, M.D. a 1922 graduate of LICH(forerunner of Downstate Medical Center). He practiced as a GP in Brooklyn for many years.

As a pre-med and mathematics major at Barnard College, Dr. Kavalier received a B.A. and subsequently a masters of science in biostatistics and masters of public health at Columbia University School of Public Health. This experience launched her into an extraordinary lifelong devotion to many areas of health care.

In addition to research and extensive publications in the quality of health care, she wrote books including DRG and cost containment , and three editions of Risk Management in Health Care institutions.

She served in such positions as Assistant Commissioner of Health in the NYC Health Department Medical Director and administrator in an HMO nursing home, and created an Institute of Medical Law, Inc. to train hospital and health care risk managers. She also was a commissioned officer in the US Public Health Service as an assistant surgeon general (2 star rear admiral), and was Director of the USPHS hospital on Staten Island. As a Professor at Downstate College of Medicine she gave seminars in administrative medicine and community health, ambulatory care and geriatrics and also taught in the University of North Carolina, Duke and NYU.

In the new Downstate school of Public Health she was Associate Dean and Chair of the Department of Health Policy and Management until her recent retirement.

Over the years, many professional groups and societies have recognized her for her outstanding contributions to health care. At Downstate she was elected to AOA in the



College of Medicine, and Delta Omega in the school of Public Health.

Dr. Kavalier has been a leader in many areas. She has served as President of numerous organizations including The Public Health Association of New York City, the Commissioned Officers Association of the US Public Health Service, the Downstate Alumni Association, and the Downstate Centerwide Faculty and Professional Staff. The SUNY Board of Trustees awarded her a Doctor of Science in 2014.

In her personal life, Dr. Kavalier enjoys the friendship of many and supports the theater arts.

She created an endowment in the Alumni Association which supports the scholarship program for students at Downstate and feels that by helping young medical students she is giving back to the school which provided her with the ability to enjoy a wonderful career in medicine and a purposeful life. ■

Portrait of a Donor – Tah W. Kwan, MD, FAHA, FACP, FACC, FSCAI

TAH W. KWAN, '85 MD, FAHA, FACP, FACC, FSCAI

By Constance Shames, MD '63

Dr. Kwan and his family emigrated from Hong Kong to the NYC in 1975 when he almost 18 years old. His father worked as a cook in a Chinese restaurant and his mother worked in a factory. He worked as a waiter in a restaurant. He felt “inside his heart” that he wanted to help people who were ill.

Dr. Kwan was the first in this family to attend college. After graduating from Brooklyn College, he attended Downstate and was fascinated by the field of cardiology.

From 1992-1996 he taught cardiology as a member of the faculty at Downstate and then began a private practice in Chinatown treating a wide variety of patients. More than 99% of his patients spoke only Chinese.

He was co-director of the Cardiac Cath Lab at University Hospital from 1994-1998 and Director of the Cardiac Cath Lab and Interventional Cardiology at the Brooklyn Hospital Center.

From 1995-2010 he was adjunct Professor of Clinical Medicine at N.Y. Medical College and from 1996 – 2010 served as an attending in the Division of Cardiology at St. Vincent's Hospital and also served at Albert Einstein 2007-2012 as an associate Clinical Professor of Medicine. In 1998 and 2008 he served as a consultant to Guang Han General Hospital in China. At the present time he is Professor of Medicine at Albert Einstein College of Medicine, Co-director of Asian cardiovascular center at Beth Israel Hospital and adjunct clinical Professor of Medicine at NYU School of Medicine.

Dr. Kwan is a Fellow of numerous heart and cardiology associations and his honors and award range from the cancer societies, the Ellis Island medal of honor, and many relating to special recognition in cardiology.

He has served on multiple Board of Directors, edited or peer reviewed many articles in cardiology. done research in cardiology, presented at regional national and international conferences and has published over 100 articles, book chapters, review articles and invited editorials



Dr. Kwan still finds time to travel, run for fun and for activities with his family.

His daughter Jo Anne is currently a second-year student at Downstate. She was inspired by her father's stories about medicine and his studies at Downstate

She graduated valedictorian at St. Michael's high school in Staten Island and majored in Biology at NYU graduating in 2010. She completed a two year Masters in Medical Sciences

at Boston University and her father encouraged her to attend Downstate. She is currently interested in Pediatrics and is President of Peds 'R' Us. She enjoys arts and crafts, fencing, running, and gym activities.



Dr. Tak Kwan stated that he felt the Downstate gave him a wonderful education. He believes that he received the best clinical education and he “owes so much” to Downstate for the wonderful career he enjoys.

His goal is to continue to be a donor to help future Downstate students have the opportunity to fulfill their dreams of a career in medicine. ■

2014 Alumni Reunion





2014 Alumni Reunion





Elective PUBH 4540: Global Health in Developing Countries

School of Public Health, State University of New York, Downstate Medical Center

This elective for medical students at SUNY Downstate has been supported for many years by the Alumni Association of the College of Medicine.

BANGKOK

by Logan Jardine, Class of 2014

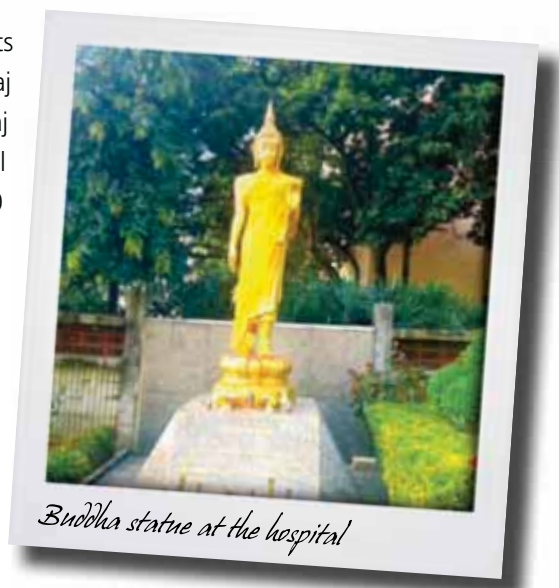
Because of generous funding provided by the Alumni Fund of the College of Medicine, I was fortunate to have the opportunity to rotate at Siriraj Hospital in Bangkok, Thailand for six weeks. I am very grateful for the financial support by the Alumni Fund of SUNY Downstate. The experience allowed me to observe not only a different culture but also to participate and engage in a medical system that is different than the medical system in the United States. It was a very valuable learning experience.

Siriraj Hospital is a large public hospital in Bangkok that serves patients with public health insurance plans. There is also a private hospital called Siriraj Private Hospital which is also affiliated with Mahidol Medical School. Siriraj Hospital is well known in the region for providing specialty care for critically ill patients and patients with rare diseases. The public health hospital has 2,000 beds and has more than 1 million outpatient visits per year. It is located in Bangkok on the west bank of the Chao Phraya River. The hospital was founded in 1888 by King Chulalongkorn and is affiliated with the Mahidol Medical School which was founded in 1889. Prince Mahidol who is now the school's namesake studied public health at Harvard University and is credited with bringing Western medicine to Thailand. There is even a large statue of Prince Mahidol in a courtyard in the center of the hospital complex. If you walk past the statue you can see people paying respect to Prince Mahidol's statue by laying jasmine wreaths at his feet and lighting incense.

I rotated on the respiratory, gastrointestinal and infectious disease services at the public hospital. I spent two weeks on each service. My schedule changed daily for each rotation but always included rounding on the ward with the residents and the attending, journal club and grand rounds, some procedural observations and seeing patients in the outpatient department. The rotation was purely observational except for the occasional physical exam of the patient with interesting findings.

At times it was challenging because lectures, rounds, and conversation in general was often in Thai. Some residence and often the attending would make an effort to speak in English or these translate when the presentations were and Thai. The medicine itself was very up-to-date, current guidelines are followed very closely. Often though insurance issues, especially issues with the public health insurance limits of treatment for some patients. Medications and treatments were either unaffordable and or not on the public health insurance formulary list. I could see that this was challenging and frustrating for the medical providers. They often had to treat patients the best way they could with what they could.

During my first two weeks I rotated with a student from Japan named Shun. We rotated



on the respiratory and tuberculosis service together. He was a 6th year student, which is the equivalent of being a 4th year medical student in the United States. Not only did I learn a lot about the Thai medical and medical education system but I also learned a lot about how medical school works in other countries because of my interactions with the other international students rotating in Siriraj. In Japan, Shun explained to me that students go to medical school straight from high school. Medical school is six years long with the last two years being observational medicine. He said that in Japan students are not allowed to see their own patients, do not draw blood or please IDs on patients or do any procedures. After the six years they then go and practice as a general practitioner for two years and during that time they decide if they want to specialize. All specialties are two years. In Thailand there's a similar system. Medical school is also six years with the last two years being clinical. Medical school is highly subsidized by the government if not free. Because of this upon graduation from medical school doctors must practice for two years as a general practitioner in an underserved area of the country before they can start their residency in their chosen field. The number of years of training is roughly equivalent for United States physicians and physicians from Thailand or Japan. It was interesting for me to learn about how physicians are trained in other countries and to hear about how Thailand has dealt with physician shortages in rural and underserved communities.

My first two weeks at Siriraj hospital, I was assigned to the division of respiratory and tuberculosis medicine. I was nervous at first to be put on this service because of contact with tuberculosis patients. Universal precautions are not used in the hospital. Simple surgical masks are used on the units, patients with tuberculosis are not held in negative pressure isolation. The hospital doesn't have isolation rooms, the wards are all open with patients lying in close proximity to each other. The wards are also very hot with simple ceiling fans oscillating and windows open to provide circulation. The attending said that finances are the reason that there are no isolation rooms in the public hospital. She said that in the private hospital every room is a private single room. I was told by the attending that 40% of the patients in the hospital have TB, either latent or active disease.

TB is endemic in Thailand affecting a large percentage of the population. Every child in Thailand receives the BCG vaccine. The BCG vaccine has only been proven to be effective for adults pulmonary TB. On my rotation my time was divided between observing procedures, spending time in the outpatient department and attending journal club and evening rounds. The outpatient experience was very different from the US. The outpatient department is packed with people. I asked the attending how many people came to the outpatient clinic and she said 1000 come to the clinic but they can't see them all. I also observed procedures such as a bronchoscopy for bronchial alveolar lavage. BAL was commonly used to identify the insulting pathogens for patients on the ward. I saw unusual presentations of TB such as military TB, Pott's disease, and also observe the complications of TB such as complete lung atelectasis from bronchial strictures. Aside from TBI also saw COPD and reactive airway disease. In the hospi-



View of the hospital from Chao Praya River



Elective PUBH 4540: Global Health in Developing Countries

School of Public Health, State University of New York, Downstate Medical Center

tal, I observed a very high rate of ventilator associated with pneumonia especially caused by *Acinetobacter baumannii*. The *Acinetobacter baumannii* strain found in the hospital was also commonly multidrug resistant. One patient had a very resistant strain of *A. bom* and could not afford the drug, that expensive drug that could treat the infection, he died within a few days.

I spent the next two weeks rotating with the gastrointestinal division at Siriraj Hospital. This was a very interesting rotation but it was shortened because there were many national holidays during this two-week period. On my gastrointestinal rotation, I was happy to be rotating with Jane, the other SUNY Downstate medical student so that we could discuss cases together. The G.I. rotation was organized similarly to the respiratory rotation with the procedure component, and outpatient component and lecture and rounds component.

Hepatitis B was very prevalent in the Thai population. We saw many patients in the outpatient department who had hepatocellular carcinoma due to Hepatitis B. All babies are now vaccinated against Hep. B in Thailand but there is a significant percent of the population that was born before the vaccine was used and they are unvaccinated with high rates of infection. We saw some interesting cases on the wards. One case was a man who had a disease I had never heard of before call distinctive disease. Distinctive disease is when a patient has a liver abscess which has been seated to another distant site in the body.

In this case an elderly man had a liver abscess due to *Klebsiella* that had homogeneously spread to infect the posterior chamber of his eye. He presented with four days of blurry vision and fever and the liver abscess was discovered when on physical exam he had an enlarged liver span. We also saw a lot of immunocompromised patients on the wards with AIDS who had diarrhea caused by CMV, isospora or TB infection. I had never seen diarrhea caused by TB before.

For the last two weeks of the rotation Jane and I rotated through the infectious disease department. I think that this was the most interesting experience of all the rotations. Our time was divided between the outpatient HIV clinic, evening consult rounds, microscopy laboratory, journal club and grand rounds. Microscopy lab was very interesting. A case was presented and we would all look at a specimen and try to figure out what the specimen was based on if it was a gram-positive or gram-negative, the shape of the bacteria, whether it was a lactose fermenters or what type of agar the specimen grew on. Observing the outpatient HIV clinic was also an interesting experience. We found out that the Thai public health insurance only covers some HIV medications and this greatly limits the patient's ability to get optimum treatment especially if they have a resistant strain. The attending also said that sex tourism from Western countries has greatly increased the number of very highly resistant HIV strains in Thailand. Every day we would go to evening rounds with the attending, the fellows



Echocardiography room

and the residents. We would see about seven to ten consults cases per day. The cases vary greatly but mostly had to do with the resistant hospital acquired bacterial strains. It was very similar to the infectious disease consult service at Downstate and Kings County Hospital.

I learned a lot about Thai culture from rotating in the hospital and also from living in Thailand for six weeks. Respect of elders and superiors is very important in Thai culture. The doctors were very well respected by their patients and it was not uncommon for patients to bring food and gifts to their doctor's appointments. This was different from my experience in the United States where it is not uncommon for patients to be disrespectful. I very much enjoyed this rotation and I would recommend the experience to other medical students.

For medical students who are assigned to this site in the future I suggest that they stay at the PSB apartments, which is very close to the hospital, the Wang Lang food market and also to the ferry boats. I started at the Ruen Indra apartments and quickly moved to PSB because of its location and proximity to food. It would have also been nice to have more Downstate students on the rotation but I understand that there are limitations to how many students can be sent to this site. Overall the experience was invaluable.

Student Name	Overseas Site
Advolodkina, Polina	India
Ahsan, Lusana	Bangladesh
Brehm, Robin L.	India
Drapala, Drew-Anne	Dominican Republic
Golub, Eugeniya	Thailand
Isovski, Arton	Taiwan
Jardine, Logan C.	Thailand
Mangan, James W.	Mozambique
Ness, Craig R.	Dominican Republic
Ngo, Christian	Guatamala
Parikh, Deep U.	India
Reddy, Sushmitha	India
Selby, Maurice	Taiwan
Thrun-Nowicki, Matthew C.	India



PHOTOS BY: EUGENIYA GOLUB – CLASS OF 2014

Class Notes 2014

1940s

NORMAN M. MANN, MD '45 is still a Clinical Assistant Professor in the Department of Medicine at the University of Connecticut Health Center. He gives periodic lectures but no longer sees patients.

PHILIP R. ARONSON, MD '48 is active with the Emeritus faculty of Wake Forrest University School of Medicine. He still thinks of Dr. William Dock as his hero.

MARVIN MOSER, MD '47 was recently awarded an Honorary Doctorate degree at the commencement ceremony of SUNY Downstate Medical Center for his outstanding treatment of hypertension and prevention of cardiovascular disease. He has also been honored with awards from the National Heart, Lung and Blood Institute and the International Society of Hypertension.



1950s

CAROLINE G. BAUMAN, MD '50 continues to practice Pediatrics and Allergy Medicine. She has two sons, one who is a dentist and the other who is an endocrinologist. The American Thyroid Association established the Arthur Bauman Clinical Symposium, in honor of her husband, **ARTHUR BAUMAN, MD '50**, in 1999. She attends the symposium yearly with her son Andrew Bauman, a professor at Dartmouth Medical School. Her son, William Bau-

man, MD heads a research laboratory at the James J. Peter VA Medical Center where he conducts his world-renowned research on treating spinal injuries.

BENJAMIN A. ROSENBERG, MD '50 is a Professor of Medicine at the State University of New York Downstate Medical Center. He was celebrated by the Rotary Club of Jersey City for his talk on "Helpful Health Hints," offering remedies for lower back pain and headaches. Dr. Rosenberg also served as the master conductor during the 2013 commencement ceremony for the College of Medicine at SUNY Downstate Medical Center, which was hosted at Carnegie Hall.



JEROME S. MALINER, MD '53 is happy to write that he practices charity medicine exclusively.

PHILIP WARREN, MD '53 is proud to report that his grandson Jay Levin, who is also the son of **SONDRA WARREN LEVIN, MD '81**, graduated from Brown Medical School and is currently a resident of Neurology at Brown University Medical School.

RAYMOND SCALETTAR, MD '54 still practices medicine in downtown Washington, DC. He is a Clinical Professor of Medicine at George Washington University Medical Center. He is a Master of the American College of Rheumatology and enjoys deep water running in his spare time.

ELLIOT I. MORRISON, MD '57 retired at the end of 2011.

ELIZABETH KING MACDONALD, MD '54 is please to update that her daughter Nancy is an Assistant Professor of Pediatric Nephrology at Harvard Medical School and is also on staff at Boston Children's Hospital.

SEYMOUR J. EISNER, MD '55 continues to practice Gynecology.

LEONARD LEVINE, MD '55 retired but is currently volunteering at clinics.

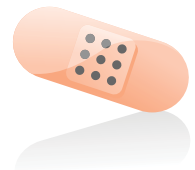
MARTIN ZELUCK, MD '57 retired from his practice in 2004. He seasonally lives between New Jersey and Florida. He enjoys traveling, playing tennis, bridge and going to the movies. He is happy to be in good health.



PERRY HOOKMAN, MD '58 has written a new book entitled "Diagnostic Gastroenterology."

HENRY J. MAGLIATO, MD '58 remains active in orthopedic peer reviewed work. He is on various New York County boards.

RICHARD BLOOMENSTEIN, '59 has retired but still helps out part time doing consulting work at Wound Care Center Englewood Hospital. He also



Class Notes 2014

helps out with medical legal plastic surgery cases.

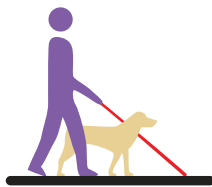
NORMAN GOLDSTEIN, MD '59 is an adjunct professor of Dermatology at SUNY Downstate Medical Center and a Clinical Professor of Dermatology at Mount Sinai Medical Center.

ABBY J. GREENBERG, MD '59 was the President of Nassau Pediatric Society for the 2013-2014 year. She continues to serve as a Board Member of Nassau County Board of Health. She also works part time as a pediatric medical expert for Social Security Disability hearings. Her husband **GERALD M. GREENBERG, MD '59** is "fully retired and enjoying it!"

JOSEPH HARTOG, MD '59 is a Clinical Professor at the University of California, San Francisco. He still has a part time private practice and is the editor of "Anatomy of Loneliness." He is happily married with three daughters and 5 grandchildren.

HAROLD MOSKOWITZ, MD '59 is still working at the University of Connecticut Health Center, mainly teaching 4th year students and residents.

ROY E. EHRLICH, MD '57 has been named Psychiatric Consultant to the MIRA Foundation. He has also been named for the Board of the MIRA Foundation. The MIRA Foundation is the only organization in the United States that



provides guide dogs to blind children ages 11-17. If you would like more information contact Roy at roy@mirausa.org

1960s

CONSTANCE LENORE GLASGOW, MD '60 excitedly announced the birth of her first grandchild, Steven Glasgow Styles, born August 3rd, 2013 in Shanghai China.

HERBERT PARDES, MD '60 is now the Executive Vice Chair of New York Presbyterian Hospital.

PHILIP R. LIEBSON, MD '60 wrote a one-act play called "A Touch of Vermont," it is listed in the Chicago Literary Club.

SANDRA A. GILMORE, MD '60 is thoroughly enjoying her return to New York after her retirement. She has 3 children, 4 grandchildren; the youngest is 2 years old. She rejoices that New York's terrible snowy winter is now over and sends her regards and love to all her fellow graduates.



COL. HOWARD H. SHERMAN, MD '60 served on the United States Air Force for 28 years. He is now retired but still works as a contractor for the government, examining applicants for the military. He is a proud grandfather of 12 and enjoys playing doubles in tennis. Dr. Sherman was also one of the original owners of the National Basketball Association team the Phoenix Suns.

HARRIET HARRIS, MD '61 still works part time as a volunteer at the New York University School of Medicine, Department of Dermatology.

JOHN H. HOERTZ, MD '61 has retired earlier this year after 10 years of practicing Obstetrics-Gynecology in the Navy. He also practiced for 43 years in Sarasota, Florida.



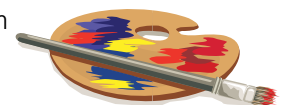
GERALD W. DEAS, MD, MPH, MA, DSc '62 was honored by the Medical Society of the County of Queens with a Lifetime Community Service Award.

STANLEY SHAPIRO, MD '62 enjoys a full time career in Psychiatry as well as playing the baritone saxophone.



MICHAEL BLUMENFIELD, MD '64 lives in Los Angeles, California with his wife, Susan. His three children and grandchildren also live in the same city. He still has a part time private practice and is currently President of the American Academy of Psychoanalysis and Dynamic Psychiatry. He writes a blog "PsychiatryTalk.com", while Mrs. Blumenfield reviews movies on "FilmRap.net". Dr. Blumenfield enjoyed attending his 50th Reunion celebration earlier this year.

DAVID W. KINNE, MD '64 enjoys retirement as a Tour Guide for the Metropolitan Museum of Art.



Class Notes 2014

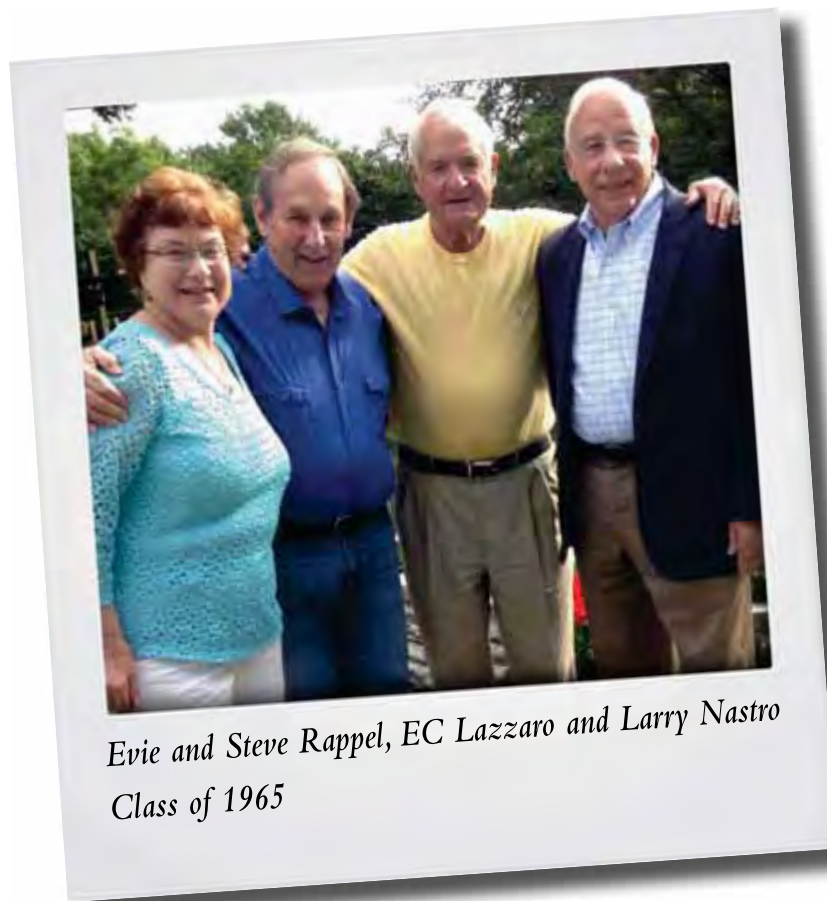
ALLAN L. NAARDEN, MD '64 was named Chairman of the Institutional Review Board for the North Texas Division of HCA Healthcare Medical Center in Dallas.

DIANE G. TENENBAUM, MD '64 remains in the practice of Dermatology, which she enjoys, on Manhattan's Upper East Side.

BARBARA DELANO, MD '65 MPH, FACH serves at the Chair of the Department of Community Health Sciences for the School of Public Health at SUNY Downstate Medical Center.

CLIFFORD LAZZARO and **LARRY NASTRO** of the class of 1965 enjoyed a pre dinner libation on the terrace of Villa Lazzaro in Deal, NJ. Nickie Lazzaro not in the picture as she is the designated photographer. We had a three star dinner on the boardwalk in Long Branch, N.J. At Sirena restaurant. If you are in the neighborhood, try the veal at Sirena's. It is the best in the city. At any rate, we hope to see all the members of the class of 1965 at the 50, the reunion in May of 2015. E.C. Lazzaro, M.D

ANTHONY BOTTONE, MD '66 practices as a Child and Adolescent Psychiatrist. He joined the Amen Clinic Northwest in 2006 and lives in Washington State with his wife and son. He was awarded the Governor's Humanities Award for Teaching Human Values, in 2001, for discovering an unrecognized suicide epidemic and establishing a successful prevention program to address it.



*Evie and Steve Rappel, EC Lazzaro and Larry Nastro
Class of 1965*

HOWARD PARNES, MD '66 reports that he "is still vertical and taking nourishment!"

DEBORAH TOLCHIN, MD '66 has been retired from her Pediatric practice for 2 years. She now teaches Introduction to Clinical Medicine at Albert Einstein College of Medicine. Dr. Tolchin also volunteers at White Plains Hospital and Burke Rehabilitation Center. She enjoys family life with her husband, Richard, children and 7 grandchildren.

RONALD HALWEIL, MD '67 is pleased to update that he has 4 young grandchildren, ages 2-7, who keep him and his wife very busy.

BARRY M. SCHWARTZ, MD '67 proudly hooded his daughter on May 29, 2013 at the SUNY Downstate Medical Center, College of Medicine commencement ceremony. He adds that's "it was a beautiful graduation!"



JOHN SINGER, MD '67 has 2 children and 3 grandchildren.

JOHN J. OBRIEN, MD '68 retired from his active orthopedic practice at St. Francis Hospital and Medical Center in Connecticut in January 2013.

Class Notes 2014

GEOFFREY M. POSNER, MD '68 writes that his son, Jonathan, works for the State Department and presently lives in Riga, Latvia with his wife, Jone, and 3 children. They have all learned Russian, since living there for the past 2 years.

JOFFREY SOROKIN, MD '68 reports that he is now retired and enjoying life with his wife, children and grandchildren.

EDWARD KATZ, MD '69 is a happy grandfather of 3. He spends his spare time playing golf and traveling. Dr. Katz works 3 half days a week.

RICHARD AKANIE, MD '69 retired to Boca Raton where he plays golf, tennis and enjoys reading. He loves spending time with his grandchildren.



1970s

BURT DIBBLE, MD '70 still works full time at the Manchester, New Hampshire VA and is pleased to practice medicine there.

NORMAN MEYOR, MD '70 updates that he is now retired, enjoying time spent with his grandchildren and great grandchildren. He is a member of the Lions Club and Masonic Lodge.

TERRY M. SILVER, MD '70 is a Professor Emeritus of Radiology at the University of Michigan and is happily retired. His youngest daughter, Michelle, is a

recent graduate of the University of Wisconsin, currently enrolled in a Master's Degree program at The University of Michigan's School of Public Health, in Ann Arbor.

SUSAN E. KROWN, MD '71 works on developing clinical trials for AIDS associated cancers in Africa. She recently became a grandmother. The two events have proven to be "interesting adventures."



MICHAEL F. CANE, MD '71 retired after 34 years as a General Surgeon in Rockledge, Florida. He will spend his time traveling, playing duplicate bridge and golf.



PAUL QUENTZEL, MD '71 retired from his Gastroenterology practice and now volunteers regularly in his local clinic to treat indigent patients. He finds this to be "very rewarding."

ESTELLE I. YOUNG, MD '71 is a proud volunteer for the New York City Medical Reserve Corps and feels blessed to have the power to heal as a physician.

STANLEY POLANSKY, MD '71 ran the 2014 Boston Marathon to raise funds for the Leukemia and Lymphoma Society. This is his 68th marathon to date. He is retired from his practice and now works as Chief of Staff elect for Mercy San Juan Medical Center in

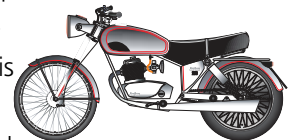
California. Dr. Polansky has 3 "great" kids, a "great" wife, and 2 "terrific" grandchildren. He "feels blessed."

ANDREW ADLER, MD '72 retired from the Brooklyn VA after 37 years of service. He is presently working at SUNY Downstate Medical Center facilitating the curriculum for the foundation years and facilitating small groups.

IRWIN H. BERKOWITZ, MD '72 was listed along with **DAVID FERNANDES, MD '72** in New York Magazine's "Top Docs" in the New York Metro Area. Dr. Berkowitz notes, "It is a distinct honor to be chosen by his peers."

STEVEN BROZINSKY, '72 reports that his daughter, Amanda, is the Managing Director of Mount Sinai's BioMe Biobank. His son Noah is a public defender in Miami, Florida.

HARVEY MANES, MD '72 was recently celebrated for his 40 years of practicing medicine. He is a pioneer in joint replacement surgery and was the youngest Orthopedic Surgeon ever to be board certified in the United States. He spent over 20 years teaching resident physicians at Nassau County University Hospital and still has his office in Lindenhurst, NY. He is the author of



several medical journals, the most recent being, "The Prevalence of Carpal Tunnel Syndrome in Motorcyclists" published in "Orthopedics" and a recent graduate of Hofstra University, School of Law.

Class Notes 2014

ANTHONY M. POLICASTRO, MD '72 welcomed his 9th grandchild on October 1, 2013.

ERIC J. RUBY, MD '72 will retire from practicing medicine in Massachusetts once Electronic Medical Records become mandatory for licensure.

CHRISTOPHER P. ZAZAKOS, Jr. MD '72 retired and is living with his wife, Connie, and 14 year old daughter, Elle, adopted from Guatemala in 1999, in Charlottesville, Virginia.

REEDE E. PHILLIPS, MD '73 works part time as a Palliative Care Specialist at North Shore-Long Island Jewish Health Systems Glen Cove Hospital in Glen Cove, New York. He is also a part time physicist at SUNY Stony Brook Teaching Hospital, working on Ocean wave Electrical Energy Generation.

HOWARD GRILL, MD '74 announces the birth of his first 2 grandchildren. He still practices Interim Medicine with his brother DAVID GRILL, MD '80 in Freeport, New York.

HOWARD LEWIS, MD '74 retired as an Associate Professor of Radiology at Temple University and as Director of Radiology at Episcopal Hospital in Philadelphia,

Pennsylvania. He has been married for the past 38 years to Mary H. Lewis, a graduate from SUNY Downstate Medical Center-College of Nursing. He traveled to Israel in October, 2013.



RONALD E. HELLMAN, MD '75 was honored with the American Psychiatric Foundation Award for Advancing Minority mental Health.

JAMES H. LEWIS, MD '75 is excited to celebrate 35 years in academic medicine in Washington, DC.

HILARY BRYNILDGEN, MD '76 and PETER BRYNILDGEN, MD '76 report that their daughter, Tracy, started Veterinary School. They have 7 grandchildren; their last three, Emi, Benjamin and Lucy born in 2013. Both are also happily retired.



MILLICENT COMRIE, MD '76 is now Director of Maimonides Hospital Center for Women's Health.

LEONARD GIOIA, MD '76 proudly announces the birth of his grandson.

ELIZABETH M. LEGAT, MD continues to practice Gynecology and enjoys it. She enjoys the "over 40 crowd" as well as teens and young adults. She has a "beautiful office" in Rye, New York and is part of the large specialty medical group in Lower Westchester, New York.

ROBERT J. SPATZ, MD '77 shares 2 children, Harrison and Paula, with his wife, Bilha Spatz, a graduate of SUNY Downstate Medical Center-College of Health Related Professions. Harrison attends the School of Dental



Medicine at the University of Connecticut. Paula graduated from Roslyn High School, a member of Nassau County Basketball Team and now attends Adelphi University.

CHRISTOPHER LOFTUS, MD '78 is Chair of the Department of Neurosurgery at Loyola University, Chicago, Stritch School of Medicine in Maywood, IL. He was also recently appointed Treasurer of the World Federation of Neurological Societies.

BRENDA NURSE, MD '79 is the author of two articles on management of Intravenous Access Devices in long term active care hospitals in "Rehabilitation Nursing" and "Journal of Vascular Access".

1980s

DAVID S. KATZ, MD '80 happily updates that his son graduated from Indiana University with a Bachelor of Arts Degree in Economics. His daughter, married, is an Assistant Vice President in Business Banking for PNC Bank in Columbus, Ohio.

VICTOR R. KLEIN, MD '80 received a Master of Business Administration from Hofstra University. He is also the Vice Chairman for Quality and Patient Safety at the Department of Obstetrics-Gynecology at North Shore-Long Island Jewish Health System.

PAUL B. ROSS, MD '81 is active in a program at Hofstra University for retired individuals. He leads classes in Poetry and Literature.

Class Notes 2014

BARRY J. KUTTNER, MD, PhD '82 will be collaborating with Earth Science Tech, Inc. to bring innovative and economically accessible healing products to the United States Natural Health and Wellness Markets. He practices Dermatology in West Palm Beach, Florida and has published several peer reviewed articles.

ELLIS TOBIN, MD '82 wrote the lead chapter in the first Clinical Nanomedicine Handbook, published by CRC Press, titled "Nanotechnology Applications for Infectious Disease". He is a Clinical Professor of Medicine at Albany Medical College and a Lecturer at SUNY College of Nanoscale Science and Engineering.

THOMAS FISCHER, MD '84 currently works for Urgent Care in Port Jefferson Station, NY.



MIRIAM T. VINCENT, MD, PhD '85 JD was recently honored with a Women Celebrating Women Award at a gala ceremony hosted by the Progressive Democrats Political Association for her practice of medicine in underserved Brooklyn communities. Dr. Vincent was also admitted to the New York State Bar with Special Certification in Health Law and announces the birth of her new grandson, Brandon Kinzer.



SALVATORE VOLPE, MD '86, FAAP, FACP, CHCQM writes that his sons continue to refine their acting chops by

participating in their school's dramatic and musical productions. His Chief Medical Officer position at Physicians' Desk Reference continues to be interesting as the company develops products and services, many of which integrate with Electronic Health Records.

MICHAEL HARRIS, MD '87 is the Outpatient Medical Director for the Department of Physical Medicine and Rehabilitation at MetroHealth Medical Center in Cleveland, Ohio. He is also an Assistant Professor at Case Western Reserve.

MICHAEL D. AMMAZZALORSO, MD '87 became a Master of the American College of Physicians in 2011 and is now Chief Medical Officer at Winthrop University Hospital.

JANET PISCITELLI-BOSSO, MD '87 currently works as the Eastern Region Medical Director for Quest Diagnostics.

EMILY A. NOLFO, MD, FACP '87 is the President Elect of New Haven County Medical Association and Preceptor for First Class of Quinnipiac Frank H. Netter Medical School.

HOWARD D. KLEIN, MD '87 updates that his son, Max, graduated Cum Laude from The University of Florida Honors Program.



CHARLES ROSENBERG, MD '89 was sorry to miss his 25th year reunion but hopes to see some smiling photos

on the alumni webpage. He has been practicing Dermatology and Dermatology Surgery in Huntington Beach, California for more than 20 years and lives in Newport Coast, California with his wife and two children.

1990s

ICILMA V. FERGUS, MD '92 was inducted as the new President of the Association of Black Cardiologists. She serves as the Director of Cardiovascular Disparities at Mount Sinai Hospital.

SHERYL FEINGOLD, MD '93 is happily married to Ronald Feingold with three children, Harper, 18, Marshall, 15, and Jules, 12.

CATHRYN CUNNINGHAM, MD '93 practices Adult, Child and Adolescent Psychiatry. She also practices Psychoanalysis. She is a recent graduate of New York Psychoanalytic Institute. She enjoys being a grandmother and gardening. Dr. Cunningham is grateful to have a fulfilling career and family life.

JENNY LIBIEN, MD, PhD '96 has been appointed the Interim Chair of the Department of Pathology at SUNY Downstate Medical Center.

SUSIE B. BALDWIN, MD, MPH '96 has taken a long break from her busy career in Public Health to recover from a double lung transplant, performed at the University of California, Los Angeles.

Class Notes 2014

HASSAN TETTEH, MD '98, MPA, MBA, FACS remains an

active commander in the United States Navy and is also a Cardiothoracic Surgeon at INOVA Fairfax Hospital. Dr. Tetteh also works at Howard University as an Assistant Professor of Surgery and the Uniformed Services University in Bethesda, Maryland. He lives in Washington, DC with his wife and two children and recently wrote the novel "Gifts of the Heart."



2000s

SAM GAO, MD '02 and FENNEY

KWAN, MD '02 are enjoying life with their new baby boy, Blake Cooper Gao born earlier this year.



ANDREI DOKUKIN, MD '06 is President and Founder of Proprius Health Medical Group in Southern, California. He is also Medical Director of Rehabilitation Services at St. Mary Medical Center in Long Beach, California.

STEPHANIE M. MELKA, MD '08 is the new Director of Ultrasound Medicine at Eos Medical Group in Fishkill, New York.

NICHOLAS SANTAVICCA, MD '11 is doing a dual residency in Baltimore, Maryland in Internal Medicine and Emergency Room Medicine.



More 2014 Reunion Photos



Remembrances

EDITED BY CONTANCE SHAMES, M.D. '63

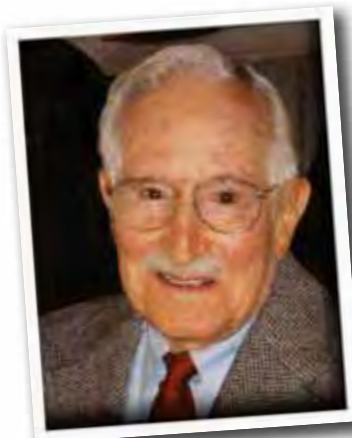
IRIS F. NORSTRAND '41

November 21, 1915 – November 18, 2013

Dr. Norstrand was a distinguished neurologist, psychiatrist, and PhD in biochemistry. She made frequent contributions to medical and scholarly publications. She was a member of Who's Who in American Women. She was born Iris Marie Fletcher to Violet Marie Anderson and Mathew Emerson Fletcher and the sister of the distinguished mystery writer Lucille Fletcher.

Dr. Norstrand graduated from Brooklyn College (class of 1937) and Long Island College of Medicine (1941). She was one of only 3 female students in her graduating class.

JAMES L. KRIEGER, M.D. '49



James L. Krieger M.D. (87) of Smokeshire Valley in Chester, Vermont died December 29th 2012 at his home surrounded by his family. Jim was born in New York City to Irwin and Celia who predeceased him, as did his brother Arthur.

He graduated from St. Lawrence University with the Naval V-12 program, and from the Long Island College of Medicine. He served in the US Navy during WWII and the Korean conflict. He was a board certified radiologist. In 1963 with three other radiologists he founded the Jefferson X-Ray Group in Hartford CT, now the largest Radiological group in the state. He maintained life-long interests in golf and photography and has been an avid skier.

Randall Dudley Bloomfield '53

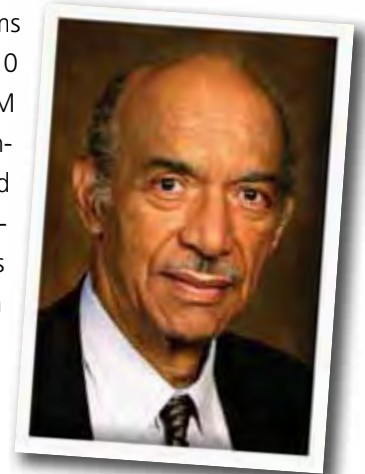
Physician and Advocate for Disadvantaged Communities

by Pascal James Imperato MD '62, MPH and TM, MACP

Dean and Distinguished Service Professor, School of Public Health, SUNY Downstate Medical Center

Dr. Randall D. Bloomfield was a leading African-American figure to medicine and public health. He was nationally

known for his efforts to create opportunities for minority youth and to facilitate their entry into the health professions. He and his late wife, Edris Adams Bloomfield (5 June 1922 - 10 July 2013), established PRISM for youth a not-for-profit foundation, to identify, select, and mentor pre-medical minority students at Medgar Evers College Preparatory School in Brooklyn, New York. In the area of public health, he was vice president and corporate secretary of the Friends of the Congressional Glaucoma Caucus Foundation. The group supported free glaucoma screenings for disadvantaged communities.



Dr. Bloomfield, or Randy, as he was known to his friends and colleagues, was born in Harlem in New York City on 3rd August 1923. At the age of three years, his father died, and his mother, who had immigrated to New York City from Jamaica, raised him alone. She supported her family by working as a laundress. As a teenager, Dr. Bloomfield reached a height in excess of 6 1/2 feet and for the remainder of his life physically towered over those at any gathering. However, it was not only physically that he rose above most others, but also through his remarkable achievements.

While working as a stevedore during the day he attended the City College of New York at night. He was greatly encouraged in his studies by his cousin, Lola Vassall, who was a physician. During World War II, he served in the Army in France as a military policeman. In 1949, Dr. Bloomfield entered the Long Island College of Medicine now the State University of New York Downstate Medical Center, College of Medicine. An early mentor was Dr. Richard Augustus Taylor, and orphan from the island of St. Kitts, who graduated from the medical school in 1903. On his first day medical school, Dr. Bloomfield was told by one of the white faculty members that a black student was admitted to the school only every other year, but that they really graduated he proved him wrong, and graduated at the top of his class.

Remembrances

Randall Dudley Bloomfield '53 (cont.)

Dr. Bloomfield completed his residency in Obstetrics and Gynecology at Kings County Hospital in Brooklyn, New York, and then did a Fellowship and Gynecological Oncology at Memorial Sloan-Kettering Medical Center in New York City. He later became board-certified in both specialties, and became associate professor of clinical Obstetrics and Gynecology at the State University of New York Downstate Medical Center.

Encouraged by his wife Edris and his mentors, he established a private practice in Brooklyn. Maintaining his connection to Kings County Hospital, he eventually became Director Obstetrics and Gynecology there, as well as an attending physician at several of the hospitals. As his career evolved, he became a leader in organized medicine, and eventually served as President of the Medical Society of the County of Kings, a Trustee of the Medical Society of the State of New York, a delegate to the American Medical Association House of Delegates, and a consultant to the Director of the National Institute of Child Health and Development. He served on many national, state, and local boards, committees and councils, and was the author of numerous scientific medical articles. In addition, Dr. Bloomfield served in several leadership positions in the Alumni Association of the College of Medicine at the State University of New York Downstate Medical Center and its Alumni Fund. He also served for many years as the Editor of the organization's magazine, *Alumni Today*.

As a leader in the Alumni Association, he was an early strong advocate for its financial support of the global health in developing countries elective for fourth-year medical students, then organized by the College of Medicine Department of Preventative Medicine and Community Health. To date, this elective, now offered by the School of Public Health, has enable some 375 Downstate medical students to render both medical and public health services to people in resource poor countries.

Under Dr. Bloomfield's guidance and with the financial support of his classmate, Frank Moya a scholarship fund was also established in the alumni fund to aid minority graduates to practice in underserved communities. Dr. Bloomfield cultivated valuable relationships with local elected officials, and through them was able to foster programs of great value to disadvantaged communities in Brooklyn. Through these rela-

tionships, he also obtained their continuing support for the mission and goals of the Downstate Medical Center.

Dr. Bloomfield was the recipient of numerous awards and honors in recognition of his commitment to patients and to the community. Among these were the Dr. Frank L. Babbott Memorial Award for Service to Medicine and the community, the Louis M. Hellman, MD Master Teacher Award in Obstetrics and Gynecology, and the Distinguished Alumni Achievement Award, all from the Alumni Association of the State University of New York, Downstate Medical Center, College of Medicine. He was also the recipient of the President's Citizenship Award of the Medical Society of the State of New York, the Beacon of Hope Award from Congressman Major R. Owens, and the Outstanding Leader in Community Health Award from New York State Assemblywoman Rhoda Jacobs.

Dr. Randall Dudley Bloomfield passed away peacefully in his ninety-first year on 30th July 2014. He and his late wife, Edris, had a great sense of the rightness of things in the conduct of human affairs. Together, they dedicated their lives in the service of promoting the well-being of others, especially the disadvantaged.



Paul Gans, M.D. '54

Dr. Paul Gans was a family physician in Queens and died at the age of 84. He practiced on 35th Street in Astoria for more than 50 years. He retired in 2010.

An iconic figure in the neighborhood, he treated generation of families as well as many patients who were unable to pay.

Dr. Gans graduated form SUNY Downstate medical school in 1954 and served his residency in the Army at the U.S. Army Hospital as a captain in 1957. He was an ardent fisherman, a hobby which he enjoyed throughout his life.



Daniel Ochs '54

Daniel Ochs, MD of Demarest, New Jersey passed away peacefully at his home on October 4th surrounded by loved ones. He was born in Cologne, Germany and immigrated with his family to the US during World War II. Dan graduated from the Bronx High School of Science, CCNY, where he was elected to Phi Beta Kappa, and Downstate Medical Center. He was board certified in Radiology and was in the first cohort

of physicians to be board certified in Nuclear Medicine. He served as Chief of Nuclear Medicine at Bronx Lebanon Hospital and is Clinical Assistant Professor of Radiology at the Albert Einstein College of Medicine. He also served as a Lieutenant in the U.S. Navy.

Known for his intellect, wit and insatiable curiosity, Dan was a teacher and a poly-math devoted to science, classical music, art, and all technology - from his slide rule collection to apples. He love to entertain children and adults by sculpting animals from aluminum foil; Dan called the animals his bestiary. One of his favorites was Alice in Wonderland's perennial late rabbit. Dan was dedicated to family both here and abroad.

Martin H. Blum '58

Martin H. Blum, MD an extraordinary and dedicated teacher who influenced the lives and careers of hundreds of psychiatric residents during his long career at the Zucker Hillside Hospital died on December 4th, 2013.

Teaching the art and science of psychotherapy is a daunting task. To do so with extraordinary patience and erudition, while pushing the trainee to recognize the complex interplay of the numerous factors that influence our perceptions, beliefs and behavior was a characteristic of Marty as he uniquely intoned 'hmmm' which followed his comments. His ability to link diverse areas and aspects of history, the arts and human experience in the context of his teaching and supervision was a characteristic which made him one of the most consistently sought after and admired teachers, year after year.

He taught us how to think and reflect, not only about our patients, but ourselves as well. Dr. Blum was on the staff of the Zucker Hillside Hospital for 46 years. He was always willing to help meet any clinical and teaching need that arose. He embraced new technology with greater ease than many of his younger colleagues, and was open to new systems, if they made sense, even into his 80's. He was voted teacher of the year on multiple occasions. His patients were enormously grateful to him for his ability to hone in on their particular problems, to make them feel special and understood, no matter what their condition. He was a true gentleman. Martin Blum was born on October 20th, 1932. He received his BA from Columbia University and his M.D. from the State

University of New York College of Medicine in Brooklyn. He completed both a psychiatric residency and psychoanalytic training at SUNY Downstate Medical Center.

Leonard Glass '58

The Leonard Glass MD Scholarship Fund

Leonard Glass, M.D., Class of 1958, passed away on January 22nd, 2014. Leonard was a Past President of the Downstate Alumni Association and devoted most of his professional life to Downstate. Throughout his life, Leonard was admired for his compassion, his sense of humor, his ability to treat everyone fairly, and for his dedication to Downstate medical students, residents and fellows.

To honor his memory and contribution to Pediatric medicine and Downstate, his family has establish "The Leonard Glass, M.D. Scholarship Fund" for a Downstate medical student with limited financial means. It was his wish that a medical student would have the opportunity to pursue a successful medical education and career.

When Brooklyn-born Leonard graduated from Downstate, he completed his internship in pediatrics at Brooklyn Jewish Hospital. He then served as Captain in the Army for two years. As he often laughingly told his colleagues, "join the Army and see the world, and I was Chief of Pediatrics at Fort Hamilton Army base in Brooklyn!"

After the Army, he completed his residency in Pediatrics at New York Hospital. He then opened his own private practice, but the call of academic medicine beckoned him. Over the next years, he worked as a Neonatologist at Harlem Hospital, Brooklyn Jewish Hospital, and Westchester County Medical Center where his goal was to improve the teaching of perinatal and neonatal care.

Leonard returned to Downstate and Kings County Hospital as Chief of Neonatology in 1978. Over the next 20 years, he was responsible for establishing excellent clinical neonatal



Remembrances

Leonard Glass '58 (cont)

services, developing a strong neonatal training program, and initiating critical interdisciplinary clinical projects to improve perinatal a neonatal outcomes. Under his leadership and guidance, the first infant apnea program at Downstate was established to provide evaluation and follow-up for infants who were identified as at risk for SIDS.

From 1994 to 1998, Leonard was Acting Chairman of the Downstate department of Pediatrics while continuing to guide the neonatal division as Chief. He then left to what he called his "retirement job", becoming Chairman of the department of Pediatrics at Methodist Hospital. He finally retired in 2004 having spent 50 years in the medical field. He considered saving the lives of hundreds of babies to be his greatest professional reward in his career. Parents appreciated his knowledge and kind help and advice.

Dr. Glass authored over 40 scientific articles. In 1976, he and his classmate Hugh E. Evans co-authored the "Perinatal Medicine" textbook. Dr. Glass received many awards in his lifetime. The awards given to him from the alumni Association had special meaning for him. He received the Frank L. Babbott Memorial Award in 1993, The Richard L. Day Award in 1998, the Alumni Service Award in 2003, and the Clarence and Mary Dennis Dedicated Award in 2013.

It is hoped that all Downstate alumni will support this important scholarship fund, gifts are tax-deductible you can contribute online on the website at: www.Downstate.edu/alumni. All gifts to The Leonard Glass MD Scholarship Fund are welcome and appreciated.



Ruth H. Singer '68

Dr. Ruth H. Singer, a retired physician who was a state health administrator and leader worked in AIDS and HIV treatment at Chase Brexton Health Services, died of pancreatic cancer on May 27 at her North Baltimore home. She was 69.

"What one loved about Ruth is that she never held back," said Dr. Alfred "Al" Summer, Dean Emeritus of the Johns Hopkins Bloomberg School of Public Health. "If something was too soft and dreamy, she insisted on facing the practical nature of the course of action and hoped for an outcome."

Born Ruth Harris in the Bronx, New York, she was the daughter of Irving Harris, a certified public accountant, and

Anne Harris, a homemaker. She was a graduate of the Bronx High School of Science and earned a Bachelor's degree in Biology at the University of Pennsylvania and a medical degree from the State University of New York at its Downstate campus. Dr. Singer also had a Master's degree from the Hopkins Bloomberg School of Public Health.

Family members said that as a first year medical student, she met John Alan Singer, who was then a second-year student, while she was dissecting a cadaver in an anatomy class. The couple married in 1966, they moved to Boston, where she interned at the US Public Health Services Hospital. In 1970, they settled in Baltimore, where she completed her residency in public health at the Maryland Department of Health and Mental Hygiene. She worked in preventive medicine.

"My mother accumulated friends the same way she accumulated eyeglasses, scarves and chunky colorful necklaces - there were some older ones that she cherished, but there were always room for a new and special one," said her son, Dr. Daniel Adams singer of Malawi, Africa in a eulogy. "Because she was a role model and a willing mentor, many of these friends were much younger than she."

From 1975 to 1980 she was the Carroll County Help Officer. Dr. Singer then became the director of local health administration for the state and worked at its W. Preston St. headquarters. After being diagnosed with multiple sclerosis, she stepped down from the state job because of the travel involved. She wished to remain active in healthcare and in 1990 she joined Chase Brexton Health Services and work several days a week. She was Director of its sexually transmitted disease clinic. Her lab coat read "Dr. Ruth".

"It was a very challenging public health job. AIDS was arguably the third-largest public health crisis in the 20th century," said a public health colleague, Andrew L. Solberg, a Columbia resident. "She was working at the predominant AIDS clinic in Baltimore."

She also sang in the Beth Am congregation choir and hosted rehearsals.

"I met her at her house at a rehearsal. I was a young physician, and she pushed me and encourage me to join Chase Brexton," said Dr. Judy Davidoff a family physician now on the staff of Chase Brexton. "She said that I could do the work and, more important, that I should do the work." Dr. Davidoff,

who lives in Mount Washington, we called her colleague: "She had something to say about everything. She could be sarcastic, but not in a nasty way. She had a way with words."

After retiring in 2000 from Chase Brexton, Dr. Singer became a Baltimore Museum of Art Docent and often lead school children on tours. In 2006, Dr. Singer became one of the organizers of the group that led annual humanitarian medical missions to Cali, Columbia. She traveled on seven of the missions providing medical services to the indigent population of Cali.



William Allan Ross '74

Dr. William Allan Ross, a Long Island Internist, died at his home on December 30th, 2013. He was 65. Dr. Ross was born on November 8th, 1948 to Shirley and Daniel Ross in New York. He attended Bayside High School, where he helped earn Bayside the city swimming championship. He went on to compete nationally for Colgate University, and later on the master's swimmers circuit. Dr. Ross attended medical school at SUNY Downstate, was Chief resident at Long Island Jewish, a Fellow in Gastroenterology at Mount Sinai, and practiced for more than 25 years. By all accounts, Dr. Ross was a skilled and beloved physician, and unparalleled diagnostician with a caring bedside manner - a doctor's doctor. In 1972, Dr. Ross met his wife Cheryl. Together they raised four boys at their Great Neck home. This year, Bill and Cheryl celebrated their 40th anniversary.



Alan Spinowitz '81

I wish to make a donation to the Alumni Association Fund in memory of my classmate, Alan Spinowitz, M.D.

Alan was a prince of a man, a distinguished cancer dermatologist and a devoted husband, father and friend.

— Lawrence M. Kamhi, M.D. '81



Fariborz Nobandegani '90

Fariborz Nobandegani, the Iranian American community mourns the loss of its prodigal son Dr. Fariborz Nobandegani, known professionally as Fred Noban, who passed away at the ultimately age of 49, on November 29th from complications following bone marrow and liver transplants. He was the youngest Director of Neurosurgery at Lenox Hill Hospital,

and was touted as the "Doctor's Doctor" by many of his colleagues. Dr. Nobandegani, was a diplomat of the American Board of Neurological Surgery as well as the American Board of Pain Medicine. He was a member of the prestigious Alpha Omega Alpha National Medical Honor Society and an Assistant Professor at NYU School of Medicine. Fariborz emigrated with his family from Iran in December 1978, in the midst of the Islamic Revolution. He began his first day of classes as a 9th grader just 12 hours after his arrival in the United States. Working late into the night and often with the dictionary by his side, he quickly rose to the top and consistently graduated first in his class. He received his electrical engineering degree from the State University of New York at Stony Brook, only to realize that his passionate lay in medicine. While working for Symbol Technologies as a researcher, he studied for his MCAT and was accepted to Downstate Medical School what he also completed his residency training. He found his calling in neurosurgery while treating many police officers with gunshot wounds in the crime spree of 1980s Brooklyn. He went on to become a highly successful and respected neurosurgeon, practicing both at the Lenox Hill Hospital and the NYU Medical Center. He and his partners founded Neuroaxis in Manhattan in an upper eastside historical brownstone, which he meticulously restored and refitted to serve the needs of his patients. Neuroaxis became a pioneer approaching patient care from pain management to post-operative rehab, nutrition counseling, and holistic care.

An avid sportsman who loved nature and "beautiful America", he often traveled to faraway places to find the perfect fly-fishing spots. He loved his adopted country so deeply that he routinely dedicated his first Thanksgiving prayer to the "blessings of this wonderful country". His heartfelt speeches and unique humor would move everyone to tears, only to be followed by exploding laughter. His larger-than-life personality, his passion for life and huge smile was contagious. His love for his wife, Jennifer, and their two daughters, Alexa and Ava was unmatched. His dedication to his mom, for whom he planted a rose garden in the backyard of his Ridgefield, Connecticut home was unconditional. His relationship with his adoring sisters was magical. He had unwavering commitment to the state of Israel and Jewish charities.



IN MEMORIAM LIST FOR 2013-2014

INCLUDED BELOW ARE ALL THE REPORTED DEATHS RECEIVED BY THE ALUMNI ASSOCIATION IN 2014

CLASS OF	NAME	DATE	CLASS OF	NAME	DATE
'41	Iris F. Norstrand	11/18/13	'58	Martin H. Blum	12/4/13
'44	Leonard L. Madison	3/27/14	'58	Lawrence Dalglish	4/20/14
'44	Albert G. Thomas	3/10/14	'58	Leonard Glass	1/22/14
'45	Bertram A. Slaff	10/11/13	'58	Arthur Karanas	10/17/13
'46	Charles A. Fager	4/8/14	'58	Victor Weinstein	3/19/14
'46	Anthony Pappas	2/11/14	'59	Ronald Schreier	4/12/13
'47	Brian F. Hoffman	2/11/13	'60	Edward Beatty	5/29/14
'48	Albert W. Stahman	6/10/14	'60	Stephen R. Shapiro	3/20/13
'48	David S. Wax	2/1/13	'62	Michael Suhl	3/6/14
'49	Joseph H. Davis	3/27/13	'63	Don M. Sloan	9/30/13
'49	Leonard Rubin	12/31/13	'64	Ernest Levenson	6/23/14
'50	Howard A. Levy	4/7/14	'64	Barry N. Nocks	6/23/14
'51	Jack Hasson	5/31/13	'66	Robert J. Klimek	8/13/13
'51	David Spielsinger	6/4/13	'67	Cyrus M. Cioffi	1/31/14
'52	Eugene A. Brody	5/2/14	'68	Ruth Singer	5/27/13
'53	Randall D. Bloomfield	8/4/14	'68	Bernard Suster	6/25/14
'53	Ronald A. Weintraub	9/14/13	'68	Robert M. Wolfert	6/25/14
'54	Paul Gans	9/11/13	'70	Joseph Racine	6/2/14
'54	Franklin Horowitz	1/29/14	'70	Christinia Ukrainski	6/2/14
'54	A. Daniel Ochs	10/4/13	'74	William A. Ross	12/30/13
'54	Sheldon Weiner	10/23/13	'75	Geary E. Ahern	4/23/14
'55	William Liebesman	10/21/13	'75	Daniel C. DuCoffe	6/2/14
'55	Lawrence Savetsky	2/2/14	'78	Douglas M. Briggs	6/16/14
'55	Joseph D. Schattner	5/29/14	'81	Alan L. Spinowitz	12/30/13
'55	Nathaniel P. Selleck	12/11/13	'89	Bram Riegel	3/21/14
'56	Pierre J. Putter	6/17/14	'90	Fariborz Nobandegani	11/29/13
'57	Howard W. Gershon	5/31/13	'98	Demesvar A. Jean-Baptiste	3/23/13

DATES 9/6/2013 9/9/2014

Alumni Today

FALL 2014

Alumni Association of the College of Medicine ■ State University of New York Downstate Medical Center

SUPPLEMENTAL ISSUE

“The Big Debate”



**NUTRITION
YOU ARE
WHAT
YOU EAT**

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Reunion Issue
2014

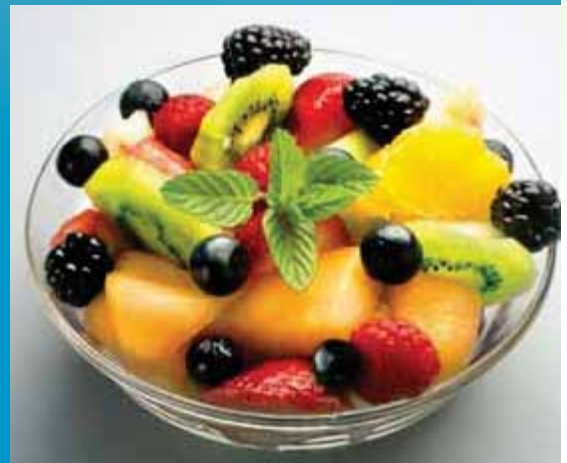


Feature Articles

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by Constance Shames, M.D.
- 57** Benchmark for the Nutrition Thread
Nutrition and the Downstate Integrated
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America
by John V. Forrest, M.D.
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Carbohydrates on the Body
An Interview with Dr. Richard D. Feinman, PhD.
by Constance Shames, M.D.

“The field of Nutrition is still evolving and no final conclusion on “BEST Diet” has been promulgated. But at least scientists and researchers are talking and keeping this very important subject in the forefront and overall encouraging diets which are healthy and may ultimately reduce some of the side effects in chronic diseases.”

– Constance Shames, M.D.



You Are What You Eat

By Constance Shames, M.D. '63

While attending medical school at Downstate, nutrition was not ever a specific subject. We learned something about sugar and diabetes and Vit B12, and the effect of alcohol on cirrhosis of the liver but the emphasis was never just on food and its effects on health and disease.

In the past few years there has been a slow but steady evolving interest in food, especially in light of the ever increasing obesity "epidemic".

Medical schools have begun to revitalize their curriculums and in the following article there is discussion of the new curriculum at Downstate and the inclusion of courses emphasizing nutrition and its relation to health and disease.

Several years ago, Neal D. Barnard, M.D. contributed a supply of books for the library at Downstate entitled "Nutrition Guide for Clinicians" which was published in 2009 by The Physicians Committee for Responsible Medicine. The books were distributed to all four classes at that time. I also received a copy and must admit that I was a bit skeptical about many of the claims about the relation of food to disease. For example, it was noted that many patients with rheumatoid arthritis showed marked improvements in their symptoms by eating a diet mainly of vegetables and fruits with olive oil and omega 6 fattyacids.

In the past few years there seemed to be emerge a plethora of TV programs on food and health and the press also began more frequent references to this area. Programs featured such advocates as Depak Chopra, Dr. Oz, etc. The main message given was that a "healthy diet" could lead to a longer life and fewer symptoms of chronic aging and diseases.

To date there does not appear to be a consensus as to the ideal diet. Could it be vegetarian, low carb, no sugar, vegan, low calorie, etc.?

“To date there does not appear to be a consensus as to the ideal diet.”

Fast food restaurants must now list calorie contents in their meals; In New York City there was a campaign to limit

large sodas full of sugar, and school lunches are under attack for their fat and sugar and sodium contents.

The first lady, Michelle Obama appeared in the press championing school lunches devoid of unhealthy items. It was noted that children were dumping their lunches because they were not tasty...ie whole grains were grainy and the veggies were not filling. The kids cried "hunger".



Organic foods, gluten free foods and non GMO (genetically modified origin) are becoming more popular and more expensive. The explosion of vitamins of all types, probiotics, enzyme supplements, herbal supplements, fish oils, etc. scream out to the consumer to use them for their health and vitality. However, it is often noted that a healthy diet is all one needs..ie the right combination of foods, will provide one with good health. It has been said that consuming at least 5 helpings of fruits and vegetables each day is essential. Portion sizes are also important in the fight against obesity. Beyond that, there is no absolute formula to follow.

There are a number of advocates for specific diets and these will be presented in some of the following articles. Dr. Feinman argues for a low carbohydrate diet and Dr. Forrest

You Are What You Eat



“On the other hand, some researchers advocate for a low carbohydrate diet as a way to stay healthy.”

presents his views on a vegan-vegetarian style diet.

The summer edition of *Arrive*, an Amtrak magazine, features “GOING VEG”. The article notes “before the word vegetarian was coined in the 19th century, the practice of eating only plants was known as the Pythagorean diet, which takes its name from the Greek philosopher’s writings in the sixth century, B.C. The article further states “Vegetarians and vegans...have been popping up in some new places recently:... People from Bill Clinton to Jay-Z have adopted or at least tried the lifestyle. Dropping meat from one’s plate has become the latest thing.”

On the other hand, some researchers advocate for a low carbohydrate diet as a way to stay healthy.

Dr. Eugene Fine, a Professor at the Albert Einstein College of Medicine in NY relates that a low carb diet is effective in fighting degenerative illnesses, including epilepsy, obesity, diabetes, and heart disease and cancer.

Starving cancer cells can cause oxygen deficiency and cancer cells thrive on sugar. By limiting carbohydrates which turn into glucose in the body, a ketogenic state exists and cancer cells cannot survive. Dr. Fine notes it is premature to suggest that a ketogenic diet can cure cancer until further studies are done. (Examiner.com Nov. 13, 2013).

Finally, a recent article in *The New York Times*, September 2, 2014 titled : A CALL FOR A LOW CARB DIET: A Major study promotes dietary conclusions that health authorities have long favored. It notes that a new study by NIH showed that you can lose weight by cutting carbs without focusing on calories. People in the low carb group saw markers of inflammation and triglycerides plunge, and HDL rose. Also, LDL particles became larger and less likely to clog arteries. One of the conclusions was that health authorities...should pivot away from fat restrictions and encourage people to eat fewer processed foods, particularly those with refined carbohydrates.

The field of Nutrition is still evolving and no final conclusion on “BEST Diet” has been promulgated. But at least scientists and researchers are talking and keeping this very important subject in the forefront and overall encouraging diets which are healthy and may ultimately reduce some of the side effects in chronic diseases. ■

Benchmark for the Nutrition Thread

Nutrition and the Downstate Integrated Pathways Curriculum 2014

A New Approach

by **Mariana Markell, M.D.**

Nutrition Thread Director, Associate Professor
of Medicine SUNY Downstate Medical Center

The Six Domains of Competence

The design of the integrated pathways curriculum and assessment of the students is driven by the six domains of competence and their underlying curriculum goals. These competencies and goals define that the six domains of competency are Patient Care Medical Knowledge, Professionalism, Interpersonal and Communication Skills, Practice-Based Learning and Improvement, Systems-Based-Practice mirror those used by the ACGME in residency training students to be able to demonstrate that in order to graduate.

Overall Goal:

At the end of four years of medical school, the student will be knowledgeable regarding the general recommendations for nutritional intake during health and disease, and will understand the biochemical and physiological basis for these recommendations. The student will be able to perform and assess a diet history across all age groups, from neonatal through geriatric, including special circumstances such as pregnancy and lactation, acute and chronic illnesses, and pre- and post-surgical procedures. Finally, the student will be able to formulate a culturally sensitive nutrition plan appropriate to the patient's condition, assess the patient's readiness to accept dietary changes, and give basic counseling regarding these changes.

Benchmark #1:

By **Gateway #1**, the student will have analyzed his or her dietary patterns, using the newly "healthy plate" approach, and will be able to take a diet history in a culturally appropriate manner. The student will be able to describe the inter-

action between nutrition including vitamins minerals amino acids and fatty acids and basic biochemical functions including energy metabolism enzymatic inflammation and other cellular functions. The student will understand the interaction of nutrition and immunology and be able to explain the consequences of nutritional deficiencies regarding host defenses



and food allergies. The student will also be able to explain the dietary recommendations for diseases of the gastrointestinal and endocrine systems, including celiac disease and gluten sensitivity, obesity, metabolic syndrome, including uric acid metabolism, and diabetes, and the genesis of these recommendations and will be able to recognize the controversies regarding these recommendations. The student will be able to explain the interaction of nutrition with issues regarding reproduction, fertility and pregnancy, including the effects of nutrient deficiencies.

Benchmark #2:

By **Gateway #2**, the student will be able to explain the interaction between nutrition and diseases of the cardiovascular, respiratory, and renal systems. The student will be able to assess the evidence for dietary recommendations includ-



Benchmark for the Nutrition Thread

ing for prevention of cardiovascular disease and hypertension and progression of kidney disease. The student will be able to explain the reasoning behind the dietary recommendations for patients with established cardiac, respiratory or kidney diseases. In addition, the student will be able to describe the interaction of nutrients and behavior, including theories regarding depression and autism, and will be able to recognize signs and symptoms of eating disorders and other behavioral issues regarding food intake.



Benchmark #3:

By **Gateway #3**, the student will be able to take a prenatal diet history recognize the effects of nutritional deficiencies on the developing fetus, and develop a nutrition plan for the mother. The student will learn to recognize and address nutritional issues in the failure to thrive child, the child with autistic spectrum disorder or autism and the child with genetic disorders including inborn errors of metabolism and sickle cell disease. The student will understand and be able to counsel the mother of a child with food allergies. The student will be able to recognize pediatric and adolescent eating disorders including anorexia, bulimia and obesity, and devise a basic nutritional intervention. The student will be able to take a simple three day diet history and identify nutritional issues that should be addressed in a patient with chronic medical illness, including diabetes, hypertension, pulmonary, kidney disease, cancer or HIV/AIDS. The student will also be able to describe the nutritional issues that may be present on inpatient ad-

mission to the medicine service and prescribe an appropriate diet. The student will recognized interaction between and anesthetic agents and various dietary supplements and will be able to take an appropriate history during the pre-op visit. In addition, the student will be able to explain the changing nutritional needs that occur following surgical procedures, and how wound healing can be affected by nutrient intake.

Benchmark #4:

The student will be able to describe the nutrient content of basic TPN solutions and will be able to construct a simple TPN prescription. The student will be able to explain the changing nutritional needs that occur with ageing, and will be able to make an appropriate dietary recommendation for the elderly patient with failure to thrive, including the edentulous patient, the patient with a PEG tube, and the patient who requires basic caloric supplementation.

What we have accomplished so far includes:

Foundations Years:

Unit 1: Two lectures introducing the students to general principals of nutrition including DRI's and caloric expenditures, as well as epigenetic impact of nutritional interventions and



basic recommendations. Students were also asked to analyze their own diet using the US Governments "Rate My Plate" website.

Unit 2: Interactions between vitamins and biochemical

Benchmark for the Nutrition Thread



processes – including the effects of vitamin deficiencies (Vitamins A, E, B complex and C). Anti-oxidants and redox reactions.

Unit 3: Nutrient absorption and malabsorption, celiac disease, physiology of feeding behavior (ghrelin, leptin). Students were asked to follow a gluten free diet for two to three days. Liver disease and Vitamin K. Effects of weight loss surgery and short gut syndrome on nutrition. Vitamin D. Also nutritional recommendations and controversies regarding the treatment of Type 2 diabetes, students will be asked to follow the ADA recommended diet for Type 2 diabetics for two to three days. Impact of nutrient deficiencies on fertility.

Unit 4 (planned activities): Dietary recommendations for the treatment of hypertension, cardiovascular and kidney disease (including kidney stones). Students will be asked to follow AHA and KDIGO recommended diets. Impact of diet on respiratory quotient. Vitamin D and kidney disease.

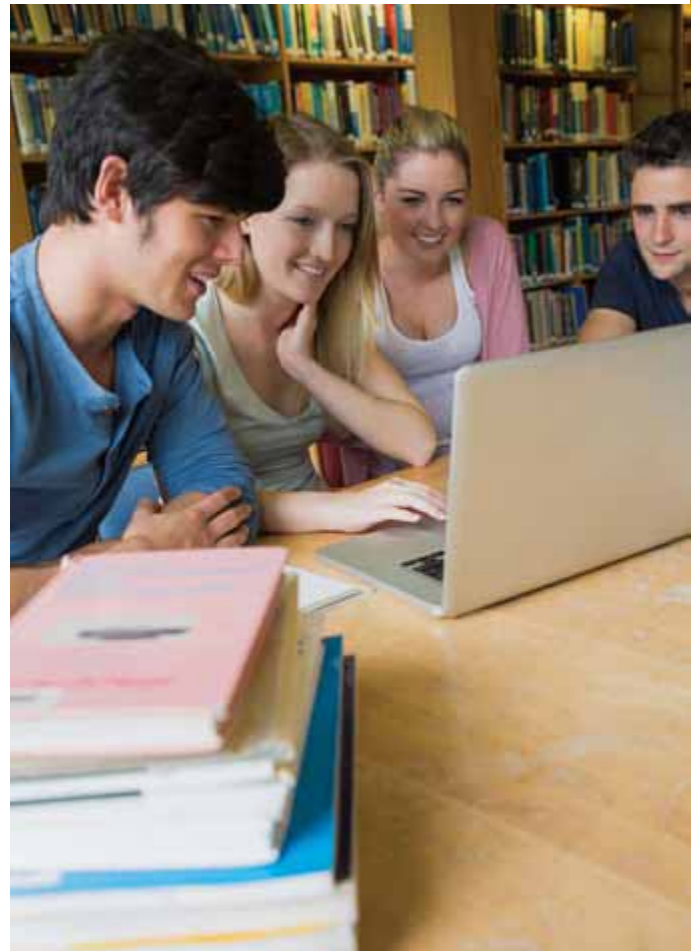
Unit 5 (planned activities): Recognition and treatment of eating disorders (anorexia, bulimia and obesity). Possibly dietary treatment of seizure disorders and autism (not definite).

Third Year (planning stages): May be accomplished through Journal Clubs, small group sessions or lectures by clinical nutritionists.

Fourth Year: Nutrition Intensive elective – possibly using

the University of Maryland on-line nutrition course as a jumping off point, a student will elect to write an in-depth paper looking at one aspect of nutrition. ■

“ At the end of four years of medical school, the student will be knowledgeable regarding the general recommendations for nutritional intake during health and disease, and will understand the biochemical and physiological basis for these recommendations.”



LOST & FOUND

Nutritional Medicine in the 21st Century America

By John V. Forrest, M.D. '66

This article is a distillation of various talks and seminars given at SUNY Downstate (October 2013) and other health care facilities and hospitals.

Edited by Constance Shames, M.D.

Dr. Forrest notes that after retiring from academic diagnostic radiology, my professional life was lost until I came across the big debate between low carb and low fat advocates and found a fascinating field of study which has helped me with my own health and the health of many friends and acquaintances. I found that I had time to study nutrition and diet; my career and income were not affected and I had no problem learning and accepting a better way of practicing medicine.

The discoveries of brilliant men have been lost as medical science raced to new drugs and procedures in the past 50 years. We are now using expensive therapies that are often much less effective and more harmful because medical professionals are not taught what effect diet has on the prevention and treatment of chronic disease. I will explain why medications and procedures are often promoted over nutrition, the various groups who have an investment in this and the research showing how important nutrition is to overall health and the prevention of illness.



Overall, when it comes to diet: This is what really matters:

Diet is the basis for the prevention and treatment of chronic disease

Optimal diet is whole food plant based

It is very difficult to incorporate this into American medical practice

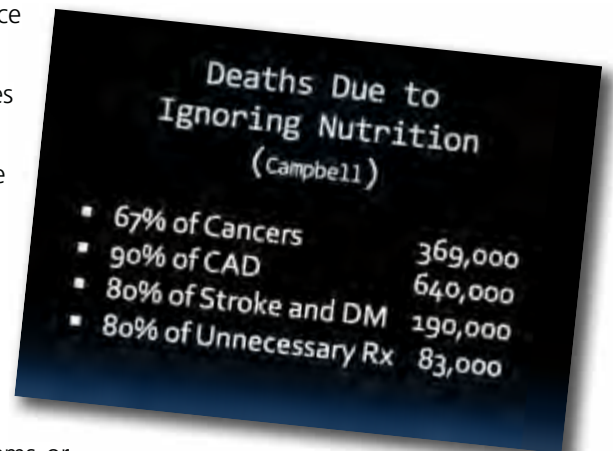
Using this in your own life and for patients is work but worth it

Taste and habits change...it is not that difficult.

YOU might hate this information; your education is challenged; future income is threatened; but YOU and Not I or Professors can change medical practice and help patients.

I would like to mention a few researchers who began studies in the thirties and forties on the effect of diet on disease.

William Chandler, a brilliant lab scientist from Germany left there in the early thirties as he was Jewish and was fired from his job. He went to Duke Medical Center and worked with patients with severe hypertension and chronic renal disease. He utilized a diet of rice and sugar and fruit and his patients, as well as those with diabetes improved. At about the same time, Dr. Snapper in Amsterdam was contacted by the Rockefeller Institute in NY and became Chief of Medicine in Peking (no Beijing). He worked with diabetic patients and found none had cardiovascular disease or eye problems or



neuropathy and found it was because they were on a rice diet.

Burkitt, another extraordinary researcher working in Africa noted that the African diet, low in animal products and high in fiber and vegetables had an extremely low incidence of cancer, no heart disease and low to no incidence of other diseases.

Nathan Pritikin, another outstanding thinker began to study diets which were plant based and also found many diseases were cured or helped.

Michael DeBakey, a world renowned cardiac surgeon, followed Pritikin's work and prescribed diet and he lived to be almost 100 years old. He noted that his longevity and good health was attributed to that diet.

There are many other studies which confirm the role of diet in disease (references on request) and that patients do best on a basic intake of fruits and vegetables.



Chinese Lessons to Western Medicine • A Contribution to

Geographical Medicine from the Clinics of Peiping
Union Medical College by I. SNAPPER

Professor and Head of the Dept. of Medicine, Peiping Union Medical
College, Peiping, China. • With a Foreword by GEORGE R. MINOT,
Professor of Medicine, Harvard University.

What diseases are cured or helped?

- CAD and peripheral vascular disease
- Diabetes, Hypertension, Rheumatologic diseases,
- Chronic bowel diseases, multiple sclerosis, peptic disease and reflux
- Chronic renal disease, "female diseases" including PMS
- Stones, gall and kidney: Osteoporosis, macular degeneration and cataract, addiction, ADHD, and behavioral disorders

Why is this not recognized?

- Physician's knowledge, preferences and self interest
- Custom and tradition
- Business interests
- Agribusiness
- Food manufacturers
- Restaurants – fast food
- Medical businesses...especially drugs

Physician's Reasons

- Knowledge
- Can't ask for what I won't do
- My patients won't comply
- Not enough time or support
- Financial conflicts

LOST & FOUND Nutritional Medicine in the 21st Century America

“It is also not a huge exaggeration to say that health care, more than any other non-governmental sector, has made itself impervious to disruptive innovation. Medical training discourages entrepreneurship, embedded practice patterns marginalize it, bureaucratic in medical organizations and insurance companies recoil from it. And, would-be disruptors are generally disconnected from patients, their ultimate consumers: they have to take the innovations to physicians, who are notoriously change averse, and then they must get the government and Medicare, first and foremost to approve and pay for them.”

— Jonathan Rauch, The Atlantic, May 2013

In a recent email Dr. Forrest notes, “Recently I have been re-studying low carb diets spurred on by an extensive email dialogue with Dr. Richard Feinman, Prof. of Cell Biology At Downstate (my alma mater). Dr. Feinman is a highly regarded scientist who has done research on metabolism in low carb diets and I have learned a lot from him. He advocates a very low carb diet...20% of total calories from carbs with no fat restriction).....Low carb programs have convincingly shown excellent control of weight and metabolic syndrome in diabetes and high blood pressure.

....The question is are some people better off with low carb and others with low fat. I am confident that you will thrive on a plant based whole food diet which avoids processed oils. I withhold an opinion on a long term low carb diet. ■

Starting a Healthy Diet

- Make a list of vegan unprocessed foods
- Try different foods from this list
- Create menus of foods you like
- Follow these menus for 3 weeks.

BELIEVE IN GROWING OLD GRACEFULLY
AND WITHOUT CHRONIC DISEASE.



Let food be thy medicine
and medicine
be thy food.

– Hippocrates



No disease that can
be treated by diet
should be treated
with any other means.

Maimonides



Metabolism and the Effects of Carbohydrates on the Body

Interview with **Dr. Richard D. Feinman, PhD.**
Professor of Biochemistry,
and Cell Biology, SUNY Downstate Medical School

By **Constance Shames, '63 Editor**



Dr. Feinman has always had a great interest in chemistry. He states he had to “fight fat” for his entire life. He notes he was always heavy as a child, or very overweight, or thought he was.

His interest in metabolism led to his studies on the effects of carbohydrates on the body and based on his research and personal experiences, he concluded that carbohydrates are a major factor in obesity and diabetes.

Dr. Feinman has written a number of articles in conjunction with other researchers on the relation of carbohydrates to disease states.

In a review entitled “Dietary carbohydrate restriction induces a unique metabolic state positively affecting atherogenic dyslipidemia, fatty acid partitioning and metabolic syndrome” published in *Progress in Lipid Research* 47, 2008, 307-318, they conclude that carbohydrate restriction is the preferred dietary strategy for cardiovascular health beyond weight regulation.

Through a number of elaborate studies at the cellular level they provide evidence that carbohydrate restricted diets proved many beneficial health results. For Example: They state that the best predictor of microvascular and, to a lesser extent macrovascular complications in patients with type 2 diabetes is glycemic control (HbA1c). The United Kingdom Pro-

spective Diabetes Study looked at the incidence of the vascular complications in a population of over 5000 patients with newly diagnosed type 2 diabetes. They found that the major control variable was the HbA1c. As this value increased, there was an exact relation to the increase in fatal and non-fatal myocardial infarcts. They also found that the HbA1c is definitely reduced by low carbohydrate diets.

Dr. Feinman et.al also conclude by their studies and studies done by others that dietary carbohydrate restriction is also the most effective way of reducing serum triglycerides and increasing HDL. Another finding was that patients with type 2 diabetes on carbohydrate restricted diets frequently can reduce or even eliminate medication. Those with type 1 usually require lower insulin. This is a very significant finding as medications often cause adverse effects. There is no adverse finding to patients on low carbohydrate diets.

“Carbohydrate restriction is the preferred dietary strategy for cardiovascular health beyond weight regulation.”

DEFINITIONS OF LOW CARBOHYDRATE DIETS:

Very low carbohydrate ketogenic diet: Carbohydrate, 20-50 g/d or less than 10% of the 2000kcal/d diet, whether or not ketosis occurs. Derived from levels of carbohydrate required to induce ketosis in most people. Recommended early phase (“induction”) of popular diets such as Atkins Diet or Protein Power.

Low carbohydrate diet: Less than 130g/d or less than 26% total energy. The American Diabetes Association (ADA) definition of 130g/d as its recommended minimum.

Metabolism and the Effects of Carbohydrates on the Body

Moderate carbohydrate diet: 26-45% Upper limit, approximate carbohydrate intake before the obesity epidemic (43%).

High carbohydrate diet: Greater than 45%. Recommended target on ADA websites. The 2010 Dietary Guidelines for Americans recommends 45-65% carbohydrate. The average American diet is estimated to be about 49%. This may be an underlying reason for the obesity epidemic which has swept through our nation. This is why carbohydrate restriction may play an important role in weight reduction along with exercise and overall good eating habits.

Carbohydrate restriction results in a unique metabolic state: "the increase in the oxidation of lipid substrates is associated with an increase in sympathoadrenal activity, enhanced lipolysis, elevated levels of fatty acids and synthesis and utilization of ketone bodies. The hormonal changes that accompany carbohydrate restriction, fasting or physical activity lead to inhibition of glycogen syntheses and inactivation of acetyl-CoA carboxylase and a fall in malonyl-CoA levels which, in turn, relieves inhibition of carnitine transport and thereby stimulates fatty acid oxidation.



The authors include a table labeled: Metabolic and enzymatic adaptations to low carbohydrate diets....

TABLE

Fat metabolism

Fat oxidation

Muscle utilization during exercise

VLDL catabolism during exercise

Fatty acid binding protein and fatty acid translocase

Ketone body production and utilization

Muscle lipoprotein lipase

B-hydroxyacyl-CoA dehydrogenase

Carnitine acyltransferase

3Oxoacid CoA thiolase

Carbohydrate metabolism

Carbohydrate oxidation

Muscle glycogen storage

Muscle glycogen rate of utilization during exercise

Gluconeogenesis

Phosphoenolpyruvate carboxykinase

Hexokinase

Pyruvate dehydrogenase

All of these areas are discussed in great detail in the body of the published articles.

Throughout his articles, Dr. Feinman and co-authors do note that diabetics who adhere to a low carbohydrate diet (encouraged by their health care providers) demonstrate a lower HbA1C, lower cardiac risk factors and often significant weight loss. Dr. Feinman also notes that the literature has little in the way of discussion of carbohydrate restriction in the treatment of diabetes and atherogenic dyslipidemia. He makes a very strong argument for further integration of nutritional outcomes with underlying biochemical and cell biological processes.

His work in this area continues and he hopes that future studies by him and other scientists will find a "cure" for diabetes and perhaps even....cancer. ■

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2015 Alumni Reunion

May 15 – 18, 2015

Event Schedule

FRIDAY MAY 15, 2015

1:00 PM – 3:00 PM
**Tour Downstate Medical Center
and Kings County Hospital**

5:00 PM – 7:00 PM
**Cocktail Reception NY Marriott
at the Brooklyn Bridge
(All Classes)**

**Cocktail Reception for
5 and 10 Year Classes:
(2005 and 2010) and
Graduating Class of 2015**

DINNER DANCE

Price: \$250/person.
A special price of \$100/person
for Class of 2005 and 2010
Special Diets available – fish,
kosher, etc.; Seating requests
accommodated.

TRANSPORTATION

Free transportation will be pro-
vided on Friday afternoon taking
people to and from the Medical
School and Marriott NY at the
Brooklyn Bridge.

SATURDAY MAY 16, 2015*

8:00 AM – 8:45 PM
**Annual Alumni
Business Meeting**

8:45 AM – 10:45 AM
**Scientific Program
(CME Credit)**

11:00 AM – 11:30 AM
**Address to Alumni
John F. Williams, MD, EdD, MPH,
FCCM (Downstate president)**

11:30 AM – 1:00 PM
Awards Ceremony

1:00 PM – 2:30 PM
Complimentary Luncheon

7:30 PM – 8:30 PM
Cocktail Hour

8:30 PM – 12:30 AM
DINNER DANCE

SUNDAY MAY 17, 2015*

8:00 AM – 10:00 AM
Complimentary Breakfast

HOTEL ACCOMODATIONS

1. Blocks of rooms are reserved
until 5/6/15 at the Marriott NY
at the Brooklyn Bridge.
Call 718.246.7000 or 1-888-
436-3759 and mention the
“Alumni Association” to get
the special low rate.
2. Singles and doubles are
\$199.00 plus tax per night.
3. Valet parking is available for
a fee at the hotel.

*All activities Saturday and Sunday will be held at the Marriott NY at the Brooklyn Bridge, 33 Adams Street, Brooklyn.

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