2 LETTERS

4 FACULTY REMEMBERED: FRANKLIN MCCUE HANGER, 1894-1971

6 RESEARCH REPORTS
- Mutation causes chromosome instability and immune deficiency
- Punching holes in heart helps angina sufferers
- Effects of “Chasing the Dragon” heroin use
- Melatonin for jet lag? Maybe not
- Curtailing blood supply to fight cancer
- Non-toxic chemotherapy
- Where did I see that?
- “Molecular clutch” shifts cells from idle to drive
- Transplanted follicle cells induce new hair growth
- Stimulating kidney development

9 CLINICAL ADVANCES
- Vasopressin: new weapon against deadly hypotension
- Giving women more control during delivery

13 PRIDE AND PREJUDICE
Although P&S dates its first African-American graduate to 1908, research by a Georgia State University professor found evidence that African-Americans attended P&S as early as the 1830s.

17 BASSETT HEALTHCARE
When P&S students think of Cooperstown, N.Y., not all thoughts turn to baseball. This profile of Bassett Healthcare, a P&S affiliate since 1947, is the first of a series of profiles of affiliated hospitals.

22 CLOWNING AROUND
Members of the Clown Care Unit of Babies & Children’s Hospital take their work seriously.

25 A NIGHT IN A REAL ER: NO LIGHTS, NO CAMERAS, BUT PLENTY OF ACTION
Arguably the most hectic area of any medical center is the emergency room. Columbia-Presbyterian’s ER is no exception, especially at night.

29 P&S STUDENTS
Medical school has several transition points, one of which is the movement from the preclinical years to the clinical years. Now P&S has a ceremony to commemorate the beginning of the third year.

30 P&S NEWS

31 IN MEMORIAM
Faculty and alumni who have died

37 ALUMNI SECTION
Profile: Martha M. MacGuffie’49

ON THE COVER: Laughter is good medicine, as the adage goes. Quantifying that statement is a goal of research that uses scientific methods to measure the impact of the Clown Care Unit on the smallest of patients. Story, page 22. Photo by Jonathan Smith
Dear Editor,

Dr. Christy’s wonderful article about Dr. Grokoest [Faculty Remembered, Fall 1999 issue] reminded me instantly of my first encounter with him. One of the first orientation rituals for P&S students, at least during the late 1970s, was the showing of “Bloodfinger,” a black and white low budget film made by Robin Cook during his own student years here. Dr. Cook, readers of a certain age will recall, went on to write medical thriller novels such as “Coma.” “Bloodfinger” was a send-up of James Bond movies, in this case documenting a day in the life of a third-year clinical clerk tracking down a mysterious patient to take a blood sample. A memorable scene caught Al Grokoest teaching a group of students when the bad guy comes caroming down the hall, knocking them all over like bowling pins. Al was the last to fall, tottering on his feet for a few theatrical moments. Amateur musicians like myself soon got to know him through the Bard Hall Orchestra, which he conducted. His film persona was totally predictive of his delightful, self-deprecating manner.

David A. Kahn’79
P&S associate clinical professor of psychiatry

Dear Editor,

I would like to add a Shorty tale to your collection. A group of us who graduated from P&S in 1954 bonded during our internship and residency at Presbyterian Hospital. Shorty was a particular favorite of our group and he joined us at one of our periodic gatherings. Always the raconteur, he related the following experience.

He was striding down the hallway of Presbyterian Hospital when he was accosted by a statuesque female medical student who, looking him eye-to-eye, said “This is the dumbest medical school.” “Why?” asked Shorty. “Because the guys are all so short.” He tested this observation on visits to medical schools at Harvard and Case Western Reserve and determined that their students were all “normal height (62”-63”).” He concluded that the stature of the student body at P&S was determined by the dean of admissions, “whose feet don’t reach the floor when he sits down.”

Of our group, Earl may have approached 6 feet. The rest of us (Marv, Fred, Vince, and me) were in the 5’6”-5’8” range. But though we looked at each other, silently thanking Aura Severinghaus for our good fortune, we laughed heartily at Shorty’s astute anthropologic research.

Tom Bradley’54
Boerne, Texas

To Nick Christy’s profile of “Shorty” Grokoest and the “... stories that do not fit smoothly into an orderly narrative,” I have one to add:

In 1971, I returned from a sabbatical in Germany and brought back with me a 2002 BMW, with which I was exceptionally satisfied. One day Grokoest spied me in the parking lot and asked how I liked the car and I responded that it was super. Well, he said, this was not his experience with the same model and would I be willing to test drive it and compare it with mine. I agreed and off we went on a trial run. Admittedly, Riverside Drive bore no resemblance to an autobahn on which I had only recently driven at 100 mph, and our drive was not a real test of what a BMW could do, but I put the car through its paces and concluded that it was just fine. After a couple of weeks we ran into each other again and he was still dissatisfied. I then advised him to take the car to the service place that cared for my car. (It was excellent and its salient feature was its foreman, a German trained in Munich by BMW, who was a superb diagnostician.) “Shorty” followed my advice and later, when I brought my own car for a scheduled service, the foreman told me in his thick German accent, “I saw your friend. There was nothing wrong with his car. It is all psychological with him.”

Grokoest was a wonderful person and his death saddened me greatly.

Michael Katz, M.D.
Vice President for Research, March of Dimes
P&S Carpentier Professor Emeritus of Pediatrics

Dear Editor,

Nick Christy is a wonderful writer whose remembrances about former faculty I always enjoy reading. I was particularly delighted by his recent one about Al Grokoest which highlighted Al’s talents in medicine, psychology, and music. What really made Shorty so special, however, among other great resident and faculty teachers at Columbia in the 40s and 50s, was his compassion and concern for his patients and how he communicated this to his students. Shorty loved people, tolerated their shortcomings with gentle and polite amusement, and never seemed impatient.

Milford Fulop’49
Gertrude and Feinson Professor and Vice Chairman of Medicine
Albert Einstein College of Medicine
Dear Editor,

Thank you so much for printing the article about Al (Shorty) Grokoest. Nick Christy did a commendable job writing about a wonderful physician, teacher, and, most of all, a wonderful human being. I was a medical student from 1955-59 at P&S. It was a time when the school was represented by some of the giants of medicine: Robert Loeb, David Seegal, Dr. Hanger, Drs. Cournand and Richards, Mike Lepore, and numerous others, but of all my teachers Al Grokoest will remain my ideal. I was not a particularly outstanding student in my first two years. I chose medicine for my first rotation that summer of 1957, and I was fortunate to get Dr. Grokoest as my attending. My first history and physical I handed in was, to be generous, awful. Dr. Grokoest called me in and with a gentleness not known to many attendings at that time tried to find out something about me and pointed out that he knew I could do better. With his guidance my H and Ps improved and I did well in my last two years. When Al Grokoest's attending time was over he made a point of keeping in touch with me during my last two years, and he and I would meet and talk about a great variety of things every few weeks. I never had a teacher in any school I attended from grammar school through my residency in medicine who ever took as much time and seemed so genuinely interested in me not only as a future physician but as a thinking, feeling human being. I know there have been many other students who received the same attention from him.

After I left P&S and moved into my residency program at UCSF and later when I became a practicing internist and gastroenterologist, I often thought about Al Grokoest, and I thought about dropping him a line but never did. I once called him when I was offered a fellowship in Boston, and I couldn't decide whether I should take it or not, and he gave me his usual thoughtful and wise opinion.

I didn't know he had died until I read Dr. Christy's profile in P&S, and I realized that my letter to him now would be in vain, but I felt compelled to write to the editor about this special man. I retired last year, and I sometimes wonder how good a doctor I was. One thing I am certain of and that is because of Al (Shorty) Grokoest I was better than I would have been. I know P&S is sent to places all over the world, and possibly out of this world, so, Al, if you happen to see my letter to the editor, a belated thank you.

Fred A. London’59
San Rafael, Calif.

---

Dear Editor,

You can't imagine how pleased I was to read my obituary in the 1956 Class Notes, Spring 1999. To the best of my knowledge I am alive and well, but prognostic caution is always wise.

You will also appreciate the mirth my family and friends have enjoyed over this premature obituary. Especially Celia, my dear wife of more than a generation, who wondered if the Jean you referred to made me a bigamist. I assured her and our children it did not.

Since accuracy is the soul of scholarship, I am sending my c.v. and bib. by postal mail for your writers in the hoped-for distant future. At that time—when I have really crossed the bar—my distinguished career, quiet modesty, subtle charm, good looks, buoyant humor and slightly overweight habitus will be appropriately and accurately remembered.

Don't be discouraged. You've made a good start!

William V. Healey’56
San Antonio, Texas
The career of Franklin Hanger, distinguished hepatologist and clinical teacher of internal medicine, illustrates sharply the difference in atmosphere between P&S then (from 1920 to 1960) and today. For those of us who graduated half a century ago, more or less, those changes surpass belief. Looking back, we moderns may think of the Faculty of the Wilson-Harding-Coolidge-Hoover-FDR era as anachronistic. Not so. The teachers of that time were medically advanced, "cutting edge" investigators, viewed as "way out" by clinicians; they were quite in keeping with the science of their times, though in memory they may now seem to us almost primitive.

Dr. Hanger, one of the few authentic Old Southerners at P&S, was born in Staunton (rhymes with "Anton"), Va., a small city in the Shenandoah Valley: center of a farming region, home of several schools and colleges, graced by "many fine old brick houses," the birthplace of Woodrow Wilson. Graduating from the University of Virginia in 1916 and from Johns Hopkins School of Medicine four years later Hanger came to Presbyterian Hospital in 1920. His move to New York from Baltimore coincided with that of Palmer, Loeb, Atchley, and Dochez. Like them, he wished to venture out onto new pathways, having wearied somewhat of the Hopkins milieu, which seemed to them overmastered by the past, perhaps resting too much on the laurels of William Osler. Finishing his PH internship and residency in medicine, Hanger joined the P&S faculty immediately, moving from assistant to professor of medicine (1926 to 1960), becoming emeritus professor in 1960.

His first research interests comprised infectious diseases: the common cold (in collaboration with A.R. Dochez and on his own), topics in allergy and immunology, and cat-scratch fever. After the mid-1930s his most notable scientific contribution was his development of the "flocculation of cephalin-cholesterol emulsions by pathological sera" (1938-39), known locally as the "ceph. flocc." This blood test (some critics thought it excessively dependent on a particular technician), though qualitative only, measured simply as + to +++, became a national and international index of hepatic disease. Working with his colleague Alexander B. Gutman, who was then refining the serum alkaline phosphatase test (1940 and later), Hanger, using both tests in tandem, could often differentiate between parenchymal and obstructive jaundice, an important distinction when liver biopsy had not yet been introduced. Keeping abreast of the times, Hanger became adept at this technique, teaching it to residents, fellows, and selected members of the medical staff.

Dr. Hanger's major impact on the college came from his great skill as a clinician. For many years, as predecessor of Yale Kneeland, he managed the "Physical Diagnosis" course. For decades he made memorable rounds on the medical service...
and later was chief of service rounds. There is little doubt that his bedside teaching was the most colorful and the most entertaining to be found anywhere in the medical center. An astute clinical observer, he was—like all other roundsmen—not always right.

His teaching found expression also in his writings. Apart from his 50 or more research articles, he produced clear and gracefully written didactic pieces—mostly on liver diseases—for medical textbooks, notably for Cecil's.

Hanger at the bedside deserves description. Tall, robust, radiating enthusiasm and love for what he was doing, with a booming voice, he unfailingly exuded concern and sympathy. He was never harsh with those in training. Some thought him a little too candid, sometimes, in bedside discussions, but most of the remarks he made—some of them hilarious—were delivered not on the ward but in the solarium or the hallway.

Examples are innumerable; here are a few. Around 1950, Hanger was making rounds, teamed with the brilliant assertive cardiologist Réné Wéria, an expert on salt and water metabolism. After one of Hanger's especially lofty flights of clinical speculative philosophy, rather remote from the subject at hand, Wéria remarked, “Dr. Hanger, you sound like a cosmic physiologist.” Without hesitation Hanger answered back, “That's better than being a BUCKET physiologist.”

In the mid-1950s, a young woman was admitted with an influenza-like illness which, luckily, subsided overnight. The house staff, addressing Dr. Hanger at the bedside the next morning, made light of the matter. Dr. Hanger, taking the group outside, lectured them earnestly on the seriousness of flu, recalling the enormous mortality rate of the 1918 epidemic in the United States. To emphasize the point, Hanger, dipping into his past, produced this: “Why, I remember, back in 1918, in Baltimore, I'd asked a young lady out to a dance. When I went to pick her up on Saturday night there was crepe on the door.”

In talking of the LE test he defined it as “those crazy globulins and the cannibal cells.” Another colloquy in the solarium yielded this: The residents had presented a man with cirrhosis and gross ascites. Hanger tried to find out what the total body sodium was but could not get across the import of his question. Finally, exasperated, he asked, “No, no. What I mean is this: If you took this man and incinerated him totally, how much sodium would you find?” There are gentler stories. A fourth-year P&S student was undergoing the ordeal of the PH medicine intern interview, in a small room, tightly closeted with all the senior members of the department. The young man had fared badly with several questions. Now it was Dr. Hanger's turn. He gave a simple, even simplistic account of a person with obvious tuberculosis; with easy question after easy question he could not get an answer. Finally, he offered this hint: “Sometimes it affects the region right around the heart” (pericarditis). Again in the 1950s, Dr. Hanger, with a private patient of his own, showed a group of Harkness residents how to do a rectal examination on a debilitated patient: You simply roll him toward you. Today, it is still possible to see seasoned doctors almost on their knees, crouching, aiming their right index finger at the relevant orifice, in the most awkward position imaginable.

Sometimes a little flamboyant, perhaps, as a bedside instructor, Hanger was modest and self-effacing. He was always willing to tell stories about his own clinical failures. When he left CPMC in 1960 he slipped away with so little fuss and fanfare that most people did not know he had departed. A measure of his deep commitment to teaching is preserved—simply, and only—in the words of the PH parking lot attendant who recalled that on Dr. Hanger's last day at work “he looked as if his life had come to an end.” It had not. Two years later, at age 68, he became president of the American College of Physicians.

He died at Staunton in 1971.

Author's Note: To clarify the change in the P&S climate from Dr. Hanger's era to now, it is pleasant to recall that in his day, senior members of the Department of Medicine used to gather after lunch in his small office on 8 Stem, then called “G stem.” They discussed everything from medicine through baseball to the war, politics, and the stock market. There was leisure then for that kind of amenity—not like today's frantic pace. Such details become harder to recover as the past recedes from us. The P&S Archives can supply much but not everything and many departments have only sparse records of departed staff members. Heavy reliance has to be laid on sketchy anecdotal memories of surviving contemporaries and students. These articles cannot be taken as definitive histories of the college.—N.C.
Mutation Causes Chromosome Instability and Immune Deficiency

Lead Researcher: Timothy Bestor

Several researchers led an international team that identified the first human genetic syndrome caused by defective DNA methylation. The failure to add methyl groups (CH$_3$) to specific sections of DNA produces unstable chromosomes that break apart and rearrange abnormally, resulting in the Immunodeficiency, Centromere instability, and Facial anomalies syndrome (ICF). Dr. Timothy Bestor, associate professor of genetics and development, and his colleagues identified the gene responsible for this syndrome in the Nov. 11, 1999, issue of Nature.

The findings show that methylation plays an essential role in the organization and stability of at least one compartment of the human genome. They also suggest that classical satellite DNA, an abundant and repetitive class of DNA of previously unknown function, silences selected genes when methylated by forming small gene “prisons” within the nucleus.

“Because DNA methylation increases the information content of the genome, it can in principle have many functions. But the real functions have been difficult to identify and the subject of much controversy,” says Dr. Bestor. “DNA methylation is known to be involved in genomic imprinting and inactivation of one X chromosome in females. This is the first time it has been associated with human disease.”

Other researchers who made major contributions to this paper were Drs. Evani Viegas-Péquignot and Déborah Bourc’his from Hôpital Necker-Enfants Malades in Paris and Drs. James Russo and Xiaoyan Qu of the Columbia Genome Center. The research was supported by grants from the National Institute of Child Health and Human Development and the Leukemia Society of America.

Punching Holes in Heart Helps Angina Sufferers

Lead Researcher: Daniel Burkhoff

Using a laser to punch holes in the wall of the heart can help relieve angina in patients for whom no other treatments are available, according to a study published in the Sept. 11, 1999, issue of the Lancet. Although it remains a mystery why the technique works, the study is the most scientifically convincing demonstration yet of its benefits, says Dr. Daniel Burkhoff, associate professor of medicine and lead author of the study.

“We believe that we have conducted the most rigorous trial possible of a surgical procedure of this kind,” says Dr. Burkhoff. “The results of the study suggest that this therapy is a reasonable option for patients who are really suffering and who have no other option.”

Dr. Burkhoff estimates that about 75,000 patients per year in the United States might benefit from the procedure, known as transmyocardial revascularization or TMR. For patients who do not respond to medications, angioplasty and coronary artery bypass are commonly used to eliminate or get around constrictions in the vessels supplying blood to the heart. But angioplasty and coronary artery bypass do not work for patients whose blood vessels are constricted in many places. The new study confirms that TMR can help these patients.

The Lancet paper reports results from a multicenter trial, known as the Angina Treatments—Lasers and Normal Therapies in Comparison Study in which 182 patients with severe angina and poor response to other therapies were randomly assigned to treatment with either TMR and medication or medication alone. Twelve months later, mortality among the TMR patients was 5.4 percent compared with 10 percent in the medication-only control group. TMR patients were able to exercise an average of 65 seconds longer than before the procedure, while control group patients exercised 46 seconds less. Angina, as reported by patients, had improved significantly in 61 percent of the TMR patients and only 11 percent in the control group. TMR patients also reported an improved quality of life.

It remains unclear why TMR works. Dr. Burkhoff believes the inflammation and subsequent healing that occurs after the holes are burned into the heart may promote the growth of additional blood vessels.

The study was funded by the CardioGenesis Corporation.

Effects of “Chasing the Dragon” Heroin Use

Lead researcher: Arnold Kriegstein

“Chasing the dragon,” a form of heroin use in which the drug is heated and the resulting vapor is inhaled, can produce a progressive and permanent brain disorder and even death, according to a study published by Dr. Arnold Kriegstein, professor of neurology, in the Nov. 10, 1999, issue of Neurology.

“Chasing the dragon” has become a more common technique for using heroin because it avoids the risks, such as HIV and hepatitis infection, associated with direct injection of the drug. However, users run the risk of developing spongiiform leukoencephalopathy, in which the brain’s white matter becomes covered with microscopic fluid-filled spaces, creating a sponge-like appearance. The disease targets specific cells, causing them to block nerve impulses in the brain. Because the cerebellum and motor pathways are the most severely affected brain regions,
patients become uncoordinated and have difficulty moving and talking.

"The illness is extremely grave, with no known treatment and progression to inability to move or speak and death in approximately 20 percent of reported cases," says Dr. Kriegstein. "Most patients who survive have permanent deficits. The symptoms usually progress rapidly over days to weeks, even after the drug is no longer present in the body. They may improve gradually over months to years, but most patients do not return to normal."

Numerous cases related to “chasing the dragon” have been documented in Europe and other regions of the world. Dr. Kriegstein’s study reports the first three known cases in the United States. “We suspect that there may be many more cases that are being misdiagnosed,” he says.

Melatonin for Jet Lag?
Maybe Not

Lead researcher: Robert Spitzer

Melatonin has been widely promoted as a cure for jet lag. But most of the studies supporting melatonin’s beneficial effects have lacked scientific rigor. Columbia researchers, led by Dr. Robert Spitzer, professor of psychiatry, developed the Columbia Jet Lag Scale and used it in a randomized, double-blind, placebo-controlled trial of melatonin with 257 Norwegian physicians who traveled from New York to Norway, six hours eastward. The physicians were divided into three groups taking either five milligrams of melatonin at bedtime, a half milligram at bedtime, or a half milligram on a shifting schedule. Jet lag ratings were made on the day of travel and for the next six days in Norway.

There was a marked increase in total jet lag score in all four treatment groups on the first day at home, followed by progressive improvement over the next five days. However, researchers saw no difference among the groups. The study was published in the September 1999 issue of the American Journal of Psychiatry.

Curtailing Blood Supply to Fight Cancer

Lead researcher: David Stern

S tarving cancerous tumors of their blood supply, known as anti-angiogenesis, has become a promising strategy against cancer. Dr. David Stern has isolated a novel anti-angiogenic molecule, termed EMAP II. Dr. Stern’s laboratory has been studying an experimental tumor, known as methylcholanthrene A-induced fibrosarcoma.

The tumors spontaneously undergo regression due, in part, to dysfunction of their blood vessels, which display blood clots and hemorrhage. By analyzing factors produced by these tumor cells, Dr. Stern, professor of physiology and cellular biophysics, and his colleagues were able to isolate an EMAP II.

In mice models, EMAP II suppressed the growth of primary tumors and the development of metastases by inducing programmed cell death in dividing endothelial cells within tumors. At the same time, it did not interfere with normal wound repair. Dr. Stern and his colleagues published their findings in the Aug. 2, 1999, issue of the Journal of Experimental Medicine.

The research was supported by the U.S. Public Health Service, the T.J. Martell Foundation, and the National Foundation for Cancer Research.

Where Did I See That?

Lead researcher: Domonick Wegesin

W hen most people think of memory they usually think of the ability to remember the content of information. But it is also important to remember where or when that information was encountered, which is called “source memory.” Researchers at P&S, led by Dr. Domonick Wegesin, assistant professor of neurology, have learned that source memory declines nearly twice as much as content memory as a person ages. More importantly, they have learned that taking estrogen after menopause helps reduce the loss in source memory associated with aging. Dr. Wegesin presented his findings at the annual meeting of the Society for Neuroscience.
For the study, researchers recruited healthy postmenopausal women between the ages of 60 and 80 and a group of younger women between the ages of 18 and 30. Half of the postmenopausal women used estrogen while the others did not. None of the younger women used hormones, including any type of birth control.

The women studied two separate sets of sentences. They then looked at a list of words, some of which had appeared in the sentences and some of which had not. They were asked first if they had seen the word in any of the sentences, a test of content memory. If so, they were then asked which set of sentences the word had appeared, a test of source memory.

The young women were better than the older women at both content and source memory tasks. But older women taking estrogen did better than the older women not taking estrogen, especially on the source memory test.

The research was supported by grants from the National Institute of Aging.

"Molecular Clutch" Shifts Cells from Idle to Drive

Lead researchers: Eugene Marcantonio and Gregg Gunderson

Scientists have known for decades that focal adhesions, collections of thousands of proteins embedded in the cell membrane, are the "cleats" of cell movement. They had thought that stationary cells remained so because these cleats were stuck down, loosening themselves just before a cell begins moving. But now Columbia researchers, led by Drs. Gregg Gunderson and Eugene Marcantonio, have shown in stationary cells the focal adhesions are, in fact, sliding along the bottom surface grabbing nothing—a cellular version of idle.

Images they took of stationary and mobile cells reveal that when the cell is stimulated to move, the focal adhesions lock in place as the cell rolls forward over them. They suspect that some sort of "molecular clutch" controls the shift from neutral to drive. The findings have significant implications in many fields, ranging from embryonic development to wound repair and tumor metastasis. The Nov. 5, 1999, issue of Science, in which their report appeared, also featured on the cover their dramatic images of focal adhesions and attached microfilaments in stationary fibroblast cells.

The research was supported by NIH grants.

Transplanted Follicle Cells Induce New Hair Growth

P&S researcher: Angela Christiano

Researchers have induced new hair follicles—and actual hairs—to grow in a person's skin for the first time. Dr. Colin Jahoda, working with his wife Dr. Amanda Reynolds, both from Durham University, performed the experiment using themselves as donor and recipient test subjects. The hair follicles grown in Dr. Reynolds' arm were "seeded" using "dermal sheath cells" transplanted from Dr. Jahoda's scalp. The new hairs were thick terminal hairs, similar to those growing on the donor's scalp. Remarkably, the two people were immunologically incompatible, a condition that causes rejection in most organ transplants.

The molecular analysis was performed by Dr. Angela M. Christiano, Irving Associate Professor of Dermatology, whose laboratory has worked extensively in the genetics of the hair follicle. Using a procedure called laser capture microdissection followed by gender-specific PCR, the researchers demonstrated that the newly generated hair contained a dermal papilla containing an XY chromosome complement, indicating that it originated from Dr. Jahoda, and that the remainder of the follicle was in fact XX, confirming that it originated from Dr. Reynolds. This result confirmed that the structural elements of the newly generated hair follicle were actually chimeric, containing cells of both the male donor and the female recipient.

This technology may be useful in tissue transplantation, in particular, for the induction of new hair follicles in the scalp. Current hair restoration surgery simply redistributes the finite number of follicles on the scalp, while this technology may allow the induction of large numbers of new follicles beginning dermal sheath cells. Details of this research appeared in the Nov. 4, 1999, issue of Nature.

Stimulating Kidney Development

Lead researcher: Jonathan Barasch

Dr. Jonathan Barasch, assistant professor of medicine, and his colleagues have isolated two factors that can induce precursor kidney cells to develop into nephrons, the basic functional unit in kidneys. These factors have been sought since 1927. Dr. Barasch and his colleagues were able to isolate the inductive factors from a line of ureteric bud cells they developed. Columbia has submitted a patent application for the process, which may one day be used to improve kidney transplants, treat damaged kidneys, and possibly even grow new kidneys. Dr. Barasch's findings were published in the Nov. 12, 1999, issue of Cell.

The research was supported by the National Institute of Diabetes and Digestive and Kidney Diseases, the American Society of Nephrology, the American Heart Association, and the Zambetti Foundation.
Vasopressin: New Weapon Against Deadly Hypotension

Medical science rarely has the “Eureka!” moments that signal dramatic breakthroughs. Medical knowledge more commonly grows through the steady accumulation of incremental advances. And increasingly sophisticated technology has made clinical observations an even rarer source of medical breakthroughs. But a fortuitous clinical observation by Dr. Donald Landry, associate professor of medicine, led to the development of the hormone vasopressin as a “uniquely effective” treatment for life-threatening low blood pressure.

“Vasopressin is a very significant treatment for patients for whom we previously had no treatment options,” says Dr. Myron Weisfeldt, Bard Professor and Chairman of Medicine.

In 1994, Dr. Landry was called into the intensive care unit to examine a woman in septic shock, low blood pressure resulting from bacterial infection of the blood. Septic shock is notoriously difficult to treat, with mortality rates ranging between 50 percent and 60 percent. Although the woman had received large doses of the vasoconstrictor norepinephrine, her blood pressure remained dangerously low. As a result, her kidneys had failed. Dr. Landry, a nephrologist serving as the consult attending physician for the month, was called in for a dialysis to cleanse her blood. When he looked at the woman’s chart, he noticed that her blood pressure had dropped abruptly a day earlier, at about the same time that doctors had stopped giving her vasopressin.

Vasopressin is a hormone synthesized in the hypothalamus and stored in the pituitary gland. Although scientists did not completely understand its natural role in the body, it had been used clinically for more than 50 years, primarily as an antidiuretic and to treat esophageal varices, dangerously dilated blood vessels in the esophagus. Despite its name, vasopressin was well known not to raise blood pressure.

When the woman’s doctors had seen that the vasopressin apparently stopped the bleeding in her esophageal blood vessels, they discontinued treatment. They believed that her subsequent drop in blood pressure was unrelated to the vasopressin and nothing more than a coincidence. But Dr. Landry was suspicious.

“I thought it was too much of a coincidence. I thought it was causal,” says Dr. Landry. So he tried an impromptu experiment and turned the vasopressin drip.
back on. “When I did, the blood pressure shot up.”

Eureka! Dr. Landry hypothesized that vasopressin may play a crucial role maintaining systemic blood pressure. Although it has no effect on healthy patients, it may have raised the blood pressure of the woman in septic shock because she had depleted her own stores of the hormone and increased her sensitivity to it.

In spite of the dramatic effects on that patient, Dr. Landry did not have an opportunity to try this off-label use of vasopressin again until about six months later. A colleague in the intensive care unit asked Dr. Landry for advice on another septic shock patient whose blood pressure remained dangerously low in spite of large doses of both epinephrine and norepinephrine. Dr. Landry suggested trying vasopressin, but at only one-tenth the dose normally given to patients. Again, the blood pressure rose dramatically. Soon, a resident turned off the vasopressin because the woman’s blood pressure was too high. The blood pressure dropped. When the attending physician turned the vasopressin back on, the blood pressure rose once again. The role of vasopressin was established.

“We had stumbled on a syndrome of hormone deficiency and hypersensitivity,” says Dr. Landry.

Work done in collaboration with Dr. Juan Oliver, associate professor of clinical medicine, and Dr. Mehmet Oz, assistant professor of surgery, has established vasopressin as standard treatment at Columbia for patients in septic shock. It is more effective than the catecholamines norepinephrine and epinephrine at raising blood pressure in these patients; it also causes fewer of the harmful side effects associated with them. It has become so well established at Columbia-Presbyterian that clinical trials to definitively prove its efficacy could not be conducted here because withholding vasopressin in control patients would be considered an ethical violation. The trials will be conducted at other hospitals where vasopressin has not yet been so enthusiastically adopted.

Dr. Landry and colleagues in the Department of Surgery have extended the uses of vasopressin to cardiogenic shock. Heart surgery often requires patients to go on cardiopulmonary bypass, which can cause a systemic inflammatory response that brings on shock. Vasopressin is effective at treating this form of shock, and cardiac surgeons around the country have been quick to adopt its use. Recently, Columbia surgeons have begun using vasopressin before the heart surgery even begins.

“It’s the ideal prophylactic,” says Dr. Landry. “If you give it to normal people, it doesn’t raise blood pressure. It works only when you need it.”

Most recently Dr. Landry and his colleagues have shown in animals that vasopressin will likely be an effective treatment for patients who have lost so much blood that they have gone into irreversible shock. Clearly, that first “Eureka” continues to echo.
Giving Women More Control During Delivery

By Jill Max

Patients who deliver babies at Columbia-Presbyterian and at St. Luke's-Roosevelt Hospital Center are now able to have more control during labor, thanks to recent advances in epidural anesthesia. Columbia faculty have been leaders in offering self-administered epidurals and “walking” epidurals, which give women the ability to control the delivery of pain medication and to move around during labor.

The advances have come about as a result of changes in both philosophy and technology, says Dr. David Birnbach, associate professor of clinical anesthesiology and director of obstetric anesthesiology at St. Luke's. Physicians want to make labor as natural a process as possible, according to Dr. Laxmi Baxi, professor of clinical obstetrics and gynecology and vice chair of obstetrics and gynecology at P&S.

Until about 20 years ago, most women received spinal anesthesia, in which a numbing local anesthetic is delivered directly to the cerebrospinal fluid that surrounds the spinal cord and nerves. But to do that, anesthesiologists have to puncture the dura, a tough membrane enclosing the spinal cord and central nervous system. Cerebrospinal fluid often leaked out of the hole in the dura, leaving women with a raging headache later. In addition, spinal anesthesia was useful only very late in labor, for the actual delivery.

In an epidural, a needle is inserted into the epidural space inside the spinal column but does not puncture the dura. A catheter typically delivers pain medication, which diffuses through the dura. However, epidurals traditionally require high drug doses to relieve pain, which means that women often suffer motor block and are unable to move or even push.

But a couple of changes allowed doctors to rethink their approach. One was the development of synthetic spinal narcotics, which are needed in only tiny doses and therefore have minimal to no effect on the baby. Another was a change in the design of the spinal needle so that it spreads the fibers of the dura instead of puncturing them, reducing leakage of spinal fluid and the excruciating headache that followed. At the same time, anesthesiologists began experimenting with lower doses of epidural anesthetics.

“Before there was no in-between,” says Dr. Birnbach. “Now we found you could provide almost total pain relief while allowing the patient to retain motor control.”

These advances paved the way for the combined spinal epidural or “walking epidural.” After the epidural needle is inserted, a spinal needle inside the epidural needle pushes through the dura into the spinal space to deliver a spinal narcotic that quickly relieves pain but doesn’t rob the patient of motor control. The spinal needle is removed, and an epidural catheter is inserted through an epidural needle, which is then removed. Local anesthetic and

“Walking” epidurals have become possible in part due to the recent development of this needle-within-a-needle. The smaller needle penetrates the spinal space to deliver narcotic directly to the spinal nerves while the larger needle allows passage of an epidural catheter that delivers local anesthetic to the epidural space. This technique, known as combined spinal epidural, allows a patient to retain motor control of her lower extremities while being pain-free during labor and delivery.
usually an additional narcotic can be continuously administered through the catheter. By carefully controlling the amount of anesthetic delivered, anesthesiologists can maintain the patient’s motor control.

As a result patients can not only push, they can sit up and move about during the first stage of labor. “Our goal is to give you the least amount of motor block so you can participate more,” says Dr. Birnbach. He is enthusiastic about patients being able to walk around because it breaks the monotony of a long labor, creates a situation that more closely approximates natural childbirth, and helps patients feel more self-empowered. About half the patients who receive the walking epidural at St. Luke’s get out of bed and move about.

“Women love it,” says Dr. Birnbach. “It’s absolutely incredible how many women rave about this.” He says that patients are now coming in and asking for the technique by name.

One of the first proponents of the “walking” epidural in the country, Dr. Birnbach says he was nearly laughed off the stage when he first presented the technique at a meeting of the Society for Obstetrics Anesthesia and Perinatology in the early 1990s. Critics thought it would take too long to perform and was too complicated and expensive. But as Dr. Birnbach and his colleagues proved that the procedure worked, and physicians increasingly appreciated patient participation, the walking epidural became more widely accepted. Today 90 percent of patients delivering at St. Luke’s get epidurals, and 95 percent of those get the walking epidural.

At Columbia-Presbyterian, anesthesiologists have taken the philosophy of patient participation a step further. They often allow patients to administer the epidural medication themselves. Usually, a very low “background” dose of medication is delivered through a pump attached to the epidural catheter. The patient controls delivery of additional medication by pressing a small button on the pump. Although the patient can press the button as often as she likes, the pump will dispense no more than a small dose (usually four or five milliliters) about every 12 minutes or so. The timing and dosage can be adjusted according to each patient’s needs.

Dr. Richard Smiley, associate professor of clinical anesthesiology and director of obstetric anesthesia at Columbia-Presbyterian, is convinced of the benefits of patient-controlled epidural anesthesia (PCEA). “Our experience has been almost uniformly positive,” he says. “Patients really felt like they were much more in control.”

One of the advantages of PCEA is that patients generally use less medication than with a standard epidural, Dr. Smiley says. “Once they know they can get something, they’re much less likely to need it. They tend to wait more,” says Dr. Susan Kim-Lo, assistant professor of anesthesiology, who has administered PCEA many times. Often, they are also willing to continue labor longer, rather than requesting cesarean section, says Dr. Baxi.

Mandy Erlich, who delivered her daughter in May, says she activated the pump only once during her labor and was relieved at not having to worry about asking for pain medication. “It was helpful for me to know I could take care of myself,” she says.

Marcia Melendez, who delivered in April, pressed the button every 10 minutes for only a short time during her labor; otherwise she used it about once every half hour. “It’s a convenient way of tailoring the medication to any patient,” says Dr. Kim-Lo.

The procedure is now routinely offered at Columbia-Presbyterian, one of the few metropolitan area hospitals that have developed expertise in this type of epidural.
Travis J.A. Johnson, a member of the Class of 1908, is widely hailed as the first black graduate of P&S, yet long-neglected records indicate that at least four black students matriculated at the medical school starting 75 years before Johnson. Research suggests that at least one of the students completed requirements for a diploma from P&S, but school administrators were unwilling to formally recognize the accomplishment with a degree.

The P&S attendance of these four pioneers—John Brown, Washington Walter Davis, David Kearney McDonogh, and James Parker Barnett—spanned the years 1830 through 1850, establishing P&S as one of the first medical schools in America to offer courses of study in medicine to men of African heritage. Yet the progress of the four was severely hindered by the racism of their time, including a reluctance among some P&S officials to treat them on an equal footing with their classmates.

Although scant information has been uncovered regarding Barnett (who studied at P&S between 1848 and 1850 under the aegis of the abolitionist Anti-Slavery Society and received a medical degree from Dartmouth’s medical school in 1854) more is known about Brown, McDonogh, and Davis, the latter of whom attended P&S under the sponsorship of the American Colonization Society, or the ACS. The ACS, founded in 1817, directly or indirectly affected the education of all three and maintained records of their educational histories even when P&S did not.

Color and colonization

The ACS held that differences in color, culture, history, and temperament would forever prevent whites and free blacks from living harmoniously within the same political structure. While the Anti-Slavery Society, a rival organization, championed education for blacks to help them advance in America, the ACS did not have an abolitionist motive but rather saw education for blacks as a necessary step in deporting them to Liberia, a colony in Africa.
To that end, the ACS sought to train black specialists who would establish "civilization" in Liberia, even while the students regarded the training as a way to better themselves. In addition to medical personnel, these specialists included missionaries, school masters, clergymen, businessmen, and engineers.

At first, the training of black clergy and teachers was the highest priority of the ACS. But over time, the group came to realize that medical personnel were of paramount importance in view of such health issues as immunity, differences in local pathogens, the ill effects of dietary change, accidents, and the stress associated with migration.

Because blacks were not trained in medicine before 1830, white physicians constituted the medical corps for several years after the formation of Liberia in 1822. A turning point came in 1830, when Dr. Thomas Henderson, the ACS board manager and physician, recommended that whites not be encouraged to settle in Liberia because its climate seemed hazardous to their health.

In seeking medical schools that would allow ACS-endorsed black men to receive the appropriate training, the ACS found sympathizers at P&S, where John Brown studied—under restrictive conditions—in the early 1830s.

**A thwarted pioneer**

Born in Hartford, Conn., on Feb. 20, 1803, John Brown went to New Haven to apprentice as a shoemaker but instead became a house servant in the residence of Sarah and Nathaniel Patten. Under the tutelage of the Rev. M.P. Wells, Brown cultivated a deep interest in reading and other intellectual pursuits, earning his reputation as a discerning and well-rounded gentleman with a gift for conversation.

In 1824, Brown moved to New York City with a letter of recommendation from Nathaniel Patten. Within two years he started the study of medicine in the office of Dr. Joseph Hansen, an 1814 P&S graduate. After Hansen's death in 1828, Brown continued his medical studies under Dr. G. Van Doren, whom P&S records list as Brown's preceptor.

Brown, who is said to have attended P&S lectures during the winters of 1828 and 1829, was formally admitted under the presidency of Dr. John Watts and was present during the sessions 1830-1831 and 1831-32 with the aid of Dr. Nicoll Dering, P&S registrar. But in 1832, when Brown declared his intent to stand for his examination for the M.D. degree, Dr. John Augustine Smith, who had recently assumed the P&S presidency, refused. As reported in an 1840 issue of the black newspaper, the Colored American, Smith's position was that "no diploma should be granted to a colored man, whatever might be his pretensions, unless he would sign a pledge that he would not avail himself of its benefit in any place but Liberia."

Brown, who would not sign the pledge, never obtained his medical degree from P&S. But letters attesting to his qualifications as a physician and his good moral character were written on his behalf by Dr. Van Doren and Dr. William Collard Hickok, a P&S graduate. The New York free black community also honored Brown by giving him the title "Doctor." It was a common practice at that time for individuals to attend medical school courses without graduating but function as doctors.

Dr. Brown began a medical practice that lasted no longer than a year. The difficulty of sustaining a full-time practice in a poverty-stricken free black community seems to have been the primary reason he left medicine for work as a school teacher. Nevertheless, John Brown was the first professionally trained black physician in the city of New York, a credit often given to Dr. James McCune Smith.

An 1838 editorial by the Rev. Samuel E. Cornish, editor of the Colored American, lauded Dr. Brown as a crucial influence on educational achievement in the city's black community, calling him "our best mind and better calculated to be at the head of our public school education than any other individual among us. There is no man of color who possesses the confidence and respect of so large and intelligent a portion of our colored population. . . ." But even as an educator, Dr. Brown was a victim of discrimination: In his editorial, Cornish charged that although Dr. Brown effectively acted as the de facto principal of School No. 1, his salary was nearly half that of the less competent white principal.

Sensing no further advancement, Dr. Brown left the public school system in the spring of 1839 and opened a proprietary school in the basement of St. Philip's Episcopal Church. That fall, he also began traveling throughout the state, presenting science lectures under the auspices of the Phoenix Society, an anti-slavery educational organization to which he belonged. But
after his return to New York City in October, Dr. Brown ruptured a blood vessel. He died Feb. 16, 1840.

**Torn between two continents**

Following Dr. Brown at P & S was Washington W. Davis. Born in Virginia in 1810, Davis was the eldest child of Allen and Elsey Davis, who emigrated to Liberia with their children in 1825. In Liberia, Washington’s precocity soon came to the attention of the settlement’s colonial agent, Jehudi Ashmun, who recommended to the ACS board of managers that Davis be sent to America to be trained as a teacher.

Arriving in New York City in 1827, the young Davis was placed under the care of Charles C. Andrews, principal of the New York African Free School. Davis left the school after three years, then briefly worked as an agent for the ACS and the African Mission Society of Connecticut, a pro-colonization school founded by the Episcopal Diocese of Connecticut to train black specialists for life in Liberia. Davis’ agency involved persuading blacks—particularly those in the states of Virginia and Maryland—of the desirability of emigration to Liberia.

In May 1832, the ACS board resolved “that a letter be addressed to Dr. J.A. Smith of New York inquiring whether Washington Davis could enjoy the benefit of lectures at the College of Physicians and if so that Mr. C.C. Andrews be requested to obtain for him a situation in which he can most advantageously pursue his medical studies...” Dr. Smith’s prompt decision led the board to resolve two weeks later “that the thanks of this board be presented to the president and other members of the College of Physicians in New York for their liberality in consenting to afford the benefit of the lectures of the institution gratuitous to Washington Davis.”

Davis appears to have regularly attended P & S in 1832 before a decision was made for his education to continue at the Columbian Medical College (now George Washington University’s medical school) in Washington, D.C. Why the society wanted Davis’ affiliation with P & S terminated by March 1833 is unclear, but it is known that at the time Davis attended P & S, the ACS was already supporting the medical education of three other black students at Columbian.

The ACS’ decision to have Davis complete his studies in Washington came at a time when the three students at Columbian were concerned about the quality of their medical education and their subsequent ability to perform medical procedures in Liberia. Two of the students threatened not to emigrate if they were not better prepared.

To avoid dragging another student into the controversy, the ACS instructed Davis to remain in New York. No longer connected with P & S, Davis resumed his studies under Dr. Edward G. Ludlow, an 1823 P & S graduate. Ludlow was doubtless paid by the ACS board, but Davis himself was no longer directly supported by the organization.

In a letter to the board dated May 12, 1835, Davis negotiated the final salary terms he would accept for returning to Liberia as an ACS physician. He made it a point to state that his goal in returning to Africa “was not for the sake of money alone; but to be useful to the people— as I have their interest at heart.” While nothing in the subsequent records of the ACS indicates when Davis returned to Liberia, or where he resided there, the Liberian census of 1843 lists Washington W. Davis as a physician with a wife and a 3-year-old son. Davis also served as a Liberian legislator before his death in 1853.

**From slavery to science**

David Kearney McDonogh was born in New Orleans in August 1821. Because he was born a slave—the property of John McDonogh, who had amassed a fortune as a merchant and plantation owner—his early life and academic ascent differed significantly from those of the other black matriculants at P & S.

John McDonogh held ambivalent feelings about the “peculiar institution” of slavery. An active supporter of the ACS, he devised a scheme under which his 500 slaves could purchase their freedom if they would then emigrate to Liberia. Attempting to train a teacher and a minister among the 500, John McDonogh ran up against Louisiana laws prohibiting the teaching of reading and writing to slaves. He was also denied permission to provide adequate religious training to his missionaries. To get around these restrictions, he sent two of his most talented slaves to Lafayette College in Easton, Pa., where the college president, the Rev. Dr. George Junkin, was an ardent colonizationist.

Of the two slaves who enrolled at Lafayette in 1840, Washington McDonogh was selected to follow a teacher’s course of study while David McDonogh (who was not related to Washington) was to pursue a collegiate course with the expectation of becoming a minister. Washington, who completed his course in 1842, emigrated to Liberia along with his mother and 78 other former slaves of John McDonogh. But David followed another path. In 1841, he asked to add medicine to his missionary training. John McDonogh complied, granting him permission to study with Dr. Hugh H. Abernethy, a physician and pharmacist in Easton.

From the very start of his association with Abernethy, David felt that his life’s work would be medicine. But upon his graduation from Lafayette in 1844, he felt profoundly discouraged. He sensed that Abernethy had grown cold to him, perhaps feeling that he had risen above his allotted station in obtaining a bachelor’s degree. And John McDonogh’s only concession to David’s request to study medicine was to concede that he might complete his medical studies under one of the colony physicians in Africa. Furthermore, David was informed that no New York medical schools would accept him.

David expressed his frustration in a letter to John, writing that “the refusal on the part of the medical faculties, and the
worse than slavish treatment which I have suffered here, and from those, too, who are looked upon by their kind as saints on Earth, have given me the strongest reasons to distrust the fidelity of the white man. Therefore sir—with due deference to your honor, I have resolved to cover my sable brow with a cloud of despair and never more to look up to the white man, whatever may be his profession or condition in society, as a true friend. These concluding remarks are general and consequently liable to honorable exceptions.”

P&S professor Dr. John Kearney Rodgers, Class of 1816, was such an exception, securing David McDonogh's admission to P&S lectures during the presidency of Dr. Smith's successor, Dr. Alexander H. Stevens. Although P&S officials neither listed David McDonogh in the medical school catalog during his matriculation nor formally identified him as a graduate upon the completion of his studies in 1847, it appears that, like Brown, he was fully qualified to receive a diploma and subsequently recognized as a doctor by his medical colleagues. Rodgers appointed him to a staff position at the New York Eye and Ear Infirmary. Furthermore, David McDonogh apparently referred to himself throughout his career as having received an M.D. from P&S without challenge from the school.

In the early 1850s, David McDonogh married a woman named Elizabeth and opened an office at 213 Sullivan St., later relocating to 142 W. 33rd St. For a brief time, he was a member of the faculty of the Eclectic Medical College of New York. David and Elizabeth became the parents of two daughters, Christiana and Alice, and a son, John Washington, whom they apparently named in honor of his former master and his former classmate at Lafayette. But according to the census of 1870, only Alice survived to adulthood.

Dr. David McDonogh died in New York City on Jan. 19, 1893. Five years later, the McDonough Memorial Hospital opened at 439 W. 41st St. in honor of his pioneering work. (Most records about McDonogh, including an article after his death that listed the text on his tombstone, spell his name McDonogh. The spelling of the hospital's name and other official records, including his will, suggest that he may have changed the spelling of his name at some point in his life.) The hospital hired staff and admitted patients regardless of race. When it closed in 1904, its director was Dr. Peter A. Johnson, who had apprenticed in medicine under McDonogh.

Spanning the centuries

And it is here that an interesting link connects 20th century black P&S graduates with their 19th century precursors. Dr. Peter Johnson—who would subsequently found the National Medical Association (an organization of African-American physicians) and serve on the first board of directors of the National Urban League—was the father of Dr. Travis J.A. Johnson, the first black P&S graduate of the 20th century.

In light of the experiences of Drs. Brown, Davis, and McDonogh, the question of whether Travis Johnson should still be considered the first black P&S graduate warrants serious consideration. From the evidence accumulated thus far, it appears that although a number of 19th century P&S administrators, professors, and alumni fully recognized the credentials of the school's first black matriculants, the administration's practice of keeping those pioneers off official records has prevented them from receiving their just due.

Professor Irvine used the Columbia Health Sciences Archives and Special Collections to research this article and consulted several other sources, including American Colonization Society records, the Bulletin of the History of Medicine, Lafayette College publications, histories of P&S and other schools, and New York Times archives. David Marc Fischer, an editorial consultant, assisted in the preparation of this article.
While house calls are virtually unheard of in this age of managed care, they still occur in Cooperstown, N.Y., the home of baseball, the Leatherstocking Tales, and the Bassett Healthcare System. Old-fashioned values meet advanced technology within this progressive health-care network.

Surprisingly, Bassett has not allowed its sense of tradition to hold it back in the information age. In 1994, Bassett developed a medical telecommunications network to link the central campus to its regional health centers and affiliated hospitals by interactive video. This network provides for distance learning and facilitates video conference calls between Bassett Hospital and many other locations, including P&S.

The medical telecommunications program is an integral part of an emerging electronic network for all of Bassett Healthcare that also includes a medical informatics component. Later this year Bassett physicians should have immediate access to electronic records, lab and X-ray results, medical library resources, and the pharmacy system via their computers. “Bassett saw the development of a fully integrated information system to be one of the key strategies for future success,” says Dr. William Streck, president and CEO of Bassett Healthcare.

Regional Health Care
Generations of families from Cooperstown and the surrounding area have depended on the Mary Imogene Bassett Hospital, and the newer Bassett Healthcare System, for patient care. Recognized by the Carnegie Commission in 1970 and highlighted in a Time magazine article in 1971 for its excellence as

By Kristen Watson
What Students Tell Other Students About Bassett

From the “Clerkship Survival Guide” given to students beginning their third-year rotations.

“Cooperstown is a charming, small town in upstate New York, about five hours from New York City. It is home to the Baseball Hall of Fame, and a large part of the local economy is involved in catering to tourists. Another large part of the local economy is the hospital itself. Mary Imogene Bassett was a local doctor who was offered a gift by a grateful and wealthy patient. She asked for a laboratory and was given a hospital. Bassett has been associated with Columbia since 1947, and the majority of doctors who work there really enjoy teaching. The hospital serves a largely rural population who come from as far as 100 miles away. The Bassett system also has a number of primary care clinics scattered around central New York. You will see many of the same cases that are here in the city, but you may also end up taking care of a farmer who has been kicked by a cow.

“Cooperstown may be a bit slow after living in The City, but it is a great time to kick back, relax, and enjoy the fresh country air. There is a lake at the edge of town and a state park just up the road. You can enjoy water sports or golf in the summer and in the winter there is ice skating, snow tubing, and cross-country skiing. Cooperstown is also near a number of downhill ski resorts. Work hours are reasonable, so take the time to enjoy this rotation.”

Bassett’s Beginnings

The Mary Imogene Bassett Hospital opened in the 1920s as a living tribute to Dr. Mary Imogene Bassett, the daughter of two local physicians. Dr. Bassett told one of her patients, Edward Serverin Clark, a local philanthropist, that she could practice better medicine if she had access to a laboratory. Mr. Clark built not only a laboratory for Dr. Bassett, but also a 100-bed hospital to go with it. Dr. Bassett died of a stroke within six months of the hospital’s opening. After her death, local physicians returned to the smaller, simpler Thanksgiving Hospital. Unable to keep its beds filled, the Mary Imogene Bassett Hospital closed in 1925.

Shortly after the closing of Bassett Hospital, Dr. Henry S. Fenimore Cooper, a resident at Columbia-Presbyterian, heard Dr. James Greenough and Dr. George Miner Mackenzie talk about opening a group practice. Dr. Cooper, a Cooperstown native who descended from Cooperstown’s founder and his son, author James Fenimore Cooper, volunteered information about the vacant hospital and put them in touch with Stephen Clark, brother of the hospital’s benefactor. Drs. Greenough and Mackenzie flew to Cooperstown to examine the abandoned hospital. Pleased with what they found, they agreed to set up a group practice at Bassett with Stephen Clark’s backing.

The plan to open a multispecialty group practice with a medical education component and to develop a hospital practice with hospital employees was unique at the time. Dr. Greenough was the first director of Bassett Hospital and four local physicians were asked to join the staff. When Dr. Greenough left the hospital in 1929, Dr. Mackenzie became physician-in-chief and director. An informal affiliation with P&S provided for the instruction of small groups of fourth-year students. In 1947, Dr. Mackenzie established a formal affiliation with P&S (the school’s oldest affiliation), giving many members of the Bassett medical staff Columbia faculty appointments. In turn, the hospital established strong training programs for nurses and medical students and residencies in the major specialties. This arrangement gave students the opportunity to observe group medicine in operation and to experience rural medical practice.

Significant research, development, and expansion have changed Bassett over the years, but the Mackenzie values remain intact. The forward-thinking Dr. Mackenzie developed a revolutionary self-insurance plan during his administration, an early version of today’s HMOs. Early ambulation after surgery, a basis for today’s “same-day” surgery, was conceived by Bassett surgeon Dr. John H. Powers in the 1940s. In the 1950s and 1960s, Drs. E.
Bassett values its medical education mission because it attracts senior staff who enjoy teaching, allows new people and new ideas to renew the organization, and generates well-trained and well-rounded resident physicians. Dr. Gerald D. Groff is shown here with a group of medical students at Bassett.

Donall Thomas, Joseph Ferrebee, and David Blumenstock pioneered innovative research in bone marrow transplantation, performing the world’s first human bone marrow transplant at Bassett in 1956 (see related article).

Over the years Bassett expanded by opening modern inpatient facilities and state-of-the-art outpatient facilities, including a cancer center, sleep clinic, women’s health center, eye clinic, and more, forming a one-stop shopping center for health care. With the hospital and its mission expanding well beyond providing traditional inpatient care in Cooperstown, the needs of the community became more complex and Bassett evolved into an integrated network of providers, programs, and services to meet those needs.

The name Bassett Healthcare was adopted in 1994 to more appropriately reflect the wide range of care provided by this newly established regional health care delivery system. The network of 20 community health centers serves an area of approximately 5,000 square miles. Bassett Healthcare comprises the Mary Imogene Bassett Hospital, the Bassett Physician Group, the Bassett Clinic, the O’Connor Hospital (Delhi), Bassett Hospital of Schoharie County, regional health centers, the Bassett Research Institute, educational programs, New York Center for Agricultural Medicine and Health, the Louis Busch Hager Cancer Center, and the area trauma center.

Numbers illustrate the impact of Bassett Healthcare. In 1998, the system recorded 8,567 admissions to the Cooperstown hospital and almost 425,000 outpatient visits to the Cooperstown clinics and Bassett’s 20 community health centers. On a more human scale, Bassett Healthcare is a “physician group of 180 committed and knowledgeable physicians with a willingness to look at the way things are done and look for ways for things to improve,” says Dr. Streck.

Medical Education at Bassett

Cooperstown is located 200 miles northwest of New York City, a long way in both miles and perspective from Washington Heights. Students gain broad experience at Bassett, because of the rapid turnover of patients and because all beds are available for teaching. Since all staff physicians are full-time medical staff, they are always available for teaching.

“Students work closely with their assigned preceptors and are given the opportunity to accompany physicians to nursing homes, house calls, and jails,” says Dr. Alan Kozak. “The scope of clinical experience is different because the problems are unique to the farming population.”

Bassett’s student clerkships were expanded in the past year to include surgery, welcoming the first class of third-year P&S students for surgery clerkship rotations in June 1999. Bassett also offers internal medicine, general surgery, family practice, and transitional year residency programs.

A creative writing requirement has been added to the third-year P&S-Bassett curriculum. Each student must describe an aspect of his or her experience at Bassett. The exercise broadens the focus for students and helps them deal with the humanistic aspect of medicine. “This is an opportunity to deal with certain issues that don’t have a good venue otherwise, the issues of being new physicians,” says Dr. Kozak.

Members of the P&S Class of 2000 discussed their Bassett experience in a promotional video, to be used to
persuade P&S students to try the Bassett third-year program themselves. “It was a lot of fun to work with so many different doctors—everyone had a different style,” says Emmy Ludwig’00 in the video. “I was treated like a grown-up, not a student.”

“Patients are more a part of the teaching than at other hospitals,” says Jason Pollard’00. “People’s lives were more important than their diseases,” says Sue Cullinan’e00, explaining how Bassett physicians take the time to really get to know their patients. Ms. Cullinan’e also notes the broad experience she was exposed to at Bassett—visiting a nursing home and the local hospital each morning, the clinic in the afternoon, and occasionally joining Bassett physicians on house calls. “Students hate to leave here,” says Dr. Kozak, “They say ‘It’s a place where we really seem to make a difference.’”

The Bassett Research Institute

Research is one of Bassett’s founding missions and has continued at a vigorous pace throughout its history. Studies by Dr. Theodore Peters Jr. and Dr. Charles Ashley first explained the biosynthetic pathway of albumin, the major protein of blood plasma. Efforts to characterize albumin led to the discovery of a variant form of the protein, now known as “Albumin Cooperstown.”

Dr. Allan Green joined Bassett as director of the Research Institute in August 1998, bringing with him an important new focus: obesity, a serious problem in rural and low socio-economic areas such as central New York. Research programs focus on the mechanism by which obesity leads to development of type 2 diabetes, innovative approaches to prevention of childhood obesity, effective weight loss programs in a rural setting, and changes in fat cell metabolism during and after weight loss.

The Research Institute has conducted two health censuses in the surrounding area in the past 10 years, with a high rate of participation. The stable population of the area allows for continuous data. The first health census was taken in 1989, with an 87 percent response. The benefits of understanding its surrounding community’s health needs were so high that Bassett repeated the process in 1999, this time extending the survey to six surrounding counties.

The Research Institute, housed in approximately 20,000 square feet of laboratory and office space, has 12 principal investigators and a more than 60 employees. The institute is supported by an endowment from the Stephen C. Clark fund, which is dedicated exclusively to health research, and by grants from the NIH and many other federal, state, and private sources.

New York Center for Agricultural Medicine and Health

In the early 1980s, two Bassett physicians, Dr. John May and Dr. David Pratt, established the Bassett Farm Safety and Health Project, a research effort to find the major causes of health problems among farmers. Since then it has grown and become the New York Center for Agricultural Medicine and Health, a regional research, education, and service center addressing a wide range of rural occupational health needs. The center strives to promote safe and healthy farming through research, education, and service. Ongoing programs include farm safety training for adults and children, occupational health services, counseling and referral services for farm-
Beagles at Bassett: Birthplace of a Nobel Idea

Dr. E. Donnall Thomas, who shared the 1990 Nobel Prize in Medicine for his pioneering work in bone marrow transplantation, joined the P&S faculty in 1955 when he joined the staff of the Mary Imogene Bassett Hospital, a P&S affiliate in Cooperstown, N.Y. He served as Bassett’s physician-in-chief from 1955 to 1963. He laid the groundwork for the bone marrow transplantation procedure by doing bone marrow transplants in beagles, destroying their marrow with drugs and radiation and then dripping new marrow into their veins, where it would go to the center of the bones, take up residence, and grow.

Dr. Thomas performed the first human bone marrow transplant on a set of twins at Bassett Hospital in 1956. Use of identical twins created a perfect tissue and blood match. The bone marrow recipient survived for six months. Complications also arose in later transplants, and cancer recurred in many patients. Many of the first transplants were unsuccessful.

The Nobel Foundation quotes Dr. Thomas as saying, “Those years had a deep and abiding influence on subsequent work since most of the basic concepts were laid out during that time,” referring to his years at Bassett.

In 1963, Dr. Thomas moved to Seattle to become a professor of medicine and the first head of oncology at the University of Washington’s medical school. He has also worked at the Fred Hutchinson Cancer Research Center since it opened in 1975, where he built the world’s largest bone marrow transplant unit. Doctors now perform 450 transplants a year at “the Hutch.”

Dr. Thomas demonstrated that bone marrow transplants could be used successfully to treat a wide range of childhood and adult leukemias, other cancers, and a variety of non-malignant disorders affecting the bone marrow.

In 1977, Laura Graves became the first patient to receive marrow from an unrelated marrow donor, a success that led to development of the national marrow donor registry. Today international registries allow donors in one country to save lives of strangers in other countries.

Bassett Hospital honors Dr. Thomas each year with its annual E. Donnall Thomas Research Day, which features the work of residents and researchers involved in the E. Donnall Thomas Research program. The program was established in 1991 to encourage residents to seek answers to medical problems while gaining special skills and knowledge in specific areas of medicine. The program is also designed to encourage residents to consider research as part of their medical careers.

Awarded with a Nobel Prize after nearly 40 years of research on bone marrow transplantation, Dr. Thomas gave his award money to the Fred Hutchinson Cancer Research Center. Although Dr. Thomas and his wife Dottie (who was also his office assistant) are technically retired, they continue to work together to raise money for, and awareness of, the fight against cancer.

In 1956, Dr. Thomas completed the first bone marrow transplant in history. The bone marrow from a healthy twin was transfused to a twin with leukemia, after whole body radiation wiped out the sick twin’s malignant leukemia cells. In 1990, Dr. Thomas received the Nobel Prize in Medicine for his pioneering transplantation work, which led to successful treatment of leukemia.
A doctor once told a member of the Big Apple Circus Clown Care Unit that clowns don’t belong in ICUs. The clown’s response: Neither do children.

Since 1986, the Clown Care Unit has been administering clown rounds at the bedsides of young patients at Babies & Children’s Hospital and other facilities in New York City and nationally with the belief that laughter can be used to alleviate the anxiety and ease the pain of pediatric patients. The specially trained circus entertainers customize their clowning to fit audiences at pediatric facilities. Red nose transplants, kitty cat scans, and chocolate milk transfusions are just what the self-proclaimed “doctors of delight” ordered to soothe the usual distress and discomfort that often accompanies extended hospital stays.

Not many doctors remain opposed to the clowns. More than a decade of pranks and pratfalls seems to have overpowered the sentiment expressed by even the most conservative of the clowns’ detractors. Even though the medical community seems to have embraced this alternative practice, the general consensus is that the clowns provide nothing more than a very nice distraction while traditional practices of medicine are the only proven methods of pain management.

In 1995, researchers from the Department of Pediatrics set out to use scientific methods to gauge the value of the clowns by conducting three studies co-sponsored by an anonymous grant and the Richard and Hinda Rosenthal Center for Complementary and Alternative Medicine. To what extent these clowns aid in pain management is still debatable, but the researchers’ findings seem to have solidified an increased sense of belonging for the clown unit.

“The studies produced one clear finding that I have no reservation about stating,” says Dr. Kenneth Gorfinkle, assistant clinical professor of psychiatry. “The studies proved that it is not only feasible to have the clowns present during some invasive procedures, but in most cases it is desirable. The clowns used to only visit patients’ bedsides before or after surgery. Now we know they can succeed at a greater level of involvement.”

“These were pilot studies,” says Dr. Jonathan Slater, associate clinical professor of psychiatry. “From a scientific point of view, what you want to see resolved is the feasibility of the study itself. We showed that it is clearly feasible to conduct further studies on a larger scale.”

The three studies recruited pediatric patients in Babies & Children’s Hospital. Two sections were conducted primarily by Drs. Gorfinkle and Slater, and the third by Dr. Arthur Smerling.
assistant clinical professor of anesthesiology and pediatrics. In each study, the children were split into two groups: a control group that was not exposed to the clowns and a test group that underwent certain procedures accompanied by a two-clown team during various stages.

One study examined the benefits of having clowns present when cancer patients received spinal taps and bone marrow aspirations. Both procedures call for the patient to be punctured by a large needle or probe. The spinal tap extracts spinal fluid and the bone marrow aspiration takes samples of bone marrow for biopsy. Both the patients and their family members experience a great deal of anxiety with these procedures. "Basically, a very large needle is inserted into the child while he or she is still awake and aware of what is happening," Dr. Gorfinkle explains. Local anesthetics are sufficient to alleviate the immediate pain sensation of the needle, but the medication does little to allay a patients fear.

When the clowns performed their usual rounds—before the study was launched—they would have visited many of the pediatric spinal tap and bone marrow aspiration patients minutes before the procedure. The clowns' antics would help the patients relax and the distraction would be kept up as the clowns led them down the hall to the operating room. Then the door would close with the clowns on the outside and the child left to undergo the procedure alone. For the study, however, the act would not stop there. For 32 pediatric patients ranging in age from 3 to 18, the performers would enter the OR and remain during parts or all of the procedure.

A second study followed a similar protocol involving 27 heart transplant patients ages 6 to 20. A cardiac catheterization is a routine procedure for all heart transplant recipients. A large needle is inserted into either the neck or groin area and sent into the new heart where dye is squirted for imaging or samples of the organ are extracted for biopsy. As in the case of the spinal taps and bone marrow aspirations, this procedure also brings about a great deal of anxiety.

For both studies, the children's reactions with clowns present or in the control group were monitored. Patients were scored by parents, doctors, nurses, and specially trained observers tracking an established set of behaviors. A child received marks for a spectrum of behaviors such as struggling, crying, even facial expressions. The patients were asked to score themselves by picking from a set of drawn facial expressions.

A third study set out to quantify the effects of the clowns' established practices. One day of various surgeries was assigned to a group exposed to routine pre- and postoperative clown rounds, while another day was assigned to a control group. The patients and their parents were told that they were part of a study on patient distress but they were not told that the clowns were the focus of the study. The clowns did not accompany the children into the OR, and anesthesiologists were not informed which patients were exposed to the clowns. As in the first two studies patients, parents, and doctors observed and reported stress levels. The third study involved 292 patients with an age range similar to the first two studies.

The reported levels of distress varied from study to study. The cardiology section demonstrated trends indicating the clowns might have been helpful in stress reduction, as reported by patients, parents, and observers, but the oncology leg showed no significant distress reduction. The researchers reported that this difference might have been the result of pain-control measures already available in the oncology clinic. Patients from the third study who experienced both pre- and postoperative clown rounds reported less distress than the group who received only preoperative clown rounds. The group that experienced no clown rounds reported the most distress.

Although observations varied as to whether the clowns succeeding in soothing the patients, physicians who participated in all three studies reported an increase in patient cooperation. In the case of the oncology and cardiology studies, doctors and nurses found the procedures easier to perform. The anesthesiologists who took part in the third study noted that the clown-
exposed group was more cooperative, less distressed, and had easier inductions.

The clown unit performers had their own unique reactions to these studies. Some of them had accompanied children during certain procedures, usually when clown and child had already developed a relationship over time and the doctor approved of the request. But adding time in the OR to normal clown rounds proved challenging at times. “The pre- and postoperative clown rounds are still the best and most effective methods we can use. I think the third study shows that best,” says Deborah “Doctor Dibble” Kaufmann. “The other studies were successful, but it was very difficult to keep our acts going for extended periods of time in the operating rooms. I think the OR might still be a better place for the parents.”

A performer’s reaction shows strengths and weaknesses in the emotional side of the study. And the researchers are the first to point out scientific shortcomings in these three studies. Testing clowns is not like testing a new drug. Double- or single-blind studies through the use of a placebo are not possible. “One problem that can’t be avoided is that everyone knows whether or not the clowns are present,” says Dr. Gorfinkle.

A second problem is the inability to account for existing pain-control measures. Anesthetics alleviate much of the patients pain and anxiety, and it is difficult to discern the contribution of the clowns. Researchers cannot control this variable by testing patients during invasive procedures without using anesthetics. Finally, the studies were pilot programs, which meant observing a limited number of patients. A study must include more participants to arrive at more compelling evidence. Measuring positive findings against these shortcomings, the doctors are calling the three experiments on the clown unit a success.

“We now have firm evidence that the Clown Care Unit experience is a lot more than just apple pie and motherhood,” says Dr. John Driscoll, Carpenter Professor and Chairman of Pediatrics and director of Babies & Children’s Hospital. “The studies have given us a measurable difference in outcome. The clowns’ presence helps the doctors with their procedures, and anesthesiologists have an easier time putting their pediatric patients to sleep.”

An example of easier inductions came from an interesting necessity. Dr. Smerling and Ms. Kaufmann were confronted with the challenge of how to introduce bubbles—a clown kit staple—into the operating room’s sterile field. The two developed a sterile bubble solution, but the issue of the clown’s breath filling the bubbles remained. “First we figured out a way to use existing machinery that pumped oxygen,” Ms. Kaufmann explains. “Then we had the patients blow bubbles through the masks, which encouraged breathing, which put them asleep faster.”

That kind of success story is why Dr. Driscoll has been a staunch supporter of the clown unit since its inception more than a decade ago. “The group has grown over the years without the aid of statistical proof. I expect it to continue to grow in the future, becoming part of the fabric of every hospital. If I could figure out how to pay for it, I would have them here seven days a week.”

Three studies attempted to quantify the positive effect the clown unit has on pediatric patients. To many, those effects have long been obvious.
On the first cold autumn night of the year, as the glow of Yankee Stadium lights the sky over Washington Heights, 168th Street has grown dark and empty except for an all-night deli and an industrious coffee and donut vendor. The sound of an ambulance backing up pierces the air, as another night shift begins in the Columbia-Presbyterian emergency room.

Not far away, a young girl nearly chokes when a length of rope she is playing with gets caught between closing elevator doors. A police officer from New York’s Emergency Services Unit pops his ankle while descending a ladder. Near the northern tip of Manhattan, a 49-year-old woman begins having chest pain, sweating, and feeling her heart beat furiously. And a pregnant woman only a few blocks away has just felt her first contraction, four weeks before her due date.

Over the next half-hour or so, each of these people—and about a dozen others—will drive, walk, or ride an ambulance to the emergency room at Columbia-Presbyterian Medical Center. They will find themselves in a bright, tiny room near the Vanderbilt Clinic’s 168th Street entrance, greeted with an authentic smile and a stethoscope by Maggie Driano, triage nurse, halfway through her 12-hour shift.

Ms. Driano has seen most of what there is to see on the doorstep of an ER. She first came to Columbia as an ER nurse in the late ’80s and left seven years later for a management position at another hospital. After a year of administrative tranquility, she decided to return to Columbia, despite long hours, graveyard shifts, and a two-hour commute from her upstate home.

“There’s something about this place that pulls us back in,” she offers as a simple reason for her return.

She is not the only one who feels that way. Dr. James Giglio, assistant clinical professor of medicine, has returned more than once to the ER at Columbia-Presbyterian. He first came to P&S in 1989 as an intern in medicine. “I was aware of the overall quality of the institution and the incredible medical leadership that exists here,” says Dr. Giglio. “I was also aware that emergency services was a relatively weak link in both the medical school and the medical center.”

Christopher Tedeschi spent 150 hours as a volunteer in the emergency room last spring. He started medical school at Robert Wood Johnson Medical School in New Jersey in Fall 1999 and is considering a career in emergency medicine.
**Dr. Giglio left P&S, completed a residency in emergency medicine, and returned in 1995. In 1997, he left again to work with emergency medicine residents at St. Luke's-Roosevelt Hospital. Five months later he returned as director of emergency services, “with strong institutional support to create an emergency department that would become the strongest clinical department in the region, as well as a training ground for leaders in emergency medicine.”**

Dr. Giglio has taken advantage of that support to greatly strengthen the emergency room. “In the last two years,” Dr. Giglio explains, “we’ve hired 16 board-certified and board-prepared emergency physicians to work in the department and recruited a leadership team that has placed an emphasis on both the quality of clinical care and the actual experience of our patients. We now not only seek to provide the best medical outcomes but also strive to meet our patients’ concerns for quality.” Faculty physicians conduct advanced research and teach medical students without leaving the emergency room. In addition, the pediatric emergency room has been renovated and upgraded.

As a result of these improvements, physicians from around the city increasingly send patients needing emergency care to Columbia-Presbyterian. At the same time, the ebbing of the crack epidemic has reduced the number of trauma cases. The emergency room now sees more medical complaints, such as chest pain, complications of liver disease, and congestive heart failure.

Each year, more than 80,000 adult and pediatric patients pass through the emergency department. About 20,000 are admitted, which means that about 40 percent of hospital admissions begin in the emergency room. The patient volume has increased by about 20 percent during the past two years. Part of the increase reflects a nationwide trend of rising emergency room visits, which Dr. Giglio attributes to a greater number of uninsured patients who have nowhere else to go and the tendency of HMO patients to visit an emergency room when their managed care providers are not readily available. But the increase also signals recognition of improvements made in the emergency room.

In the triage room, Ms. Driano assesses incoming patients, one at a time, either guiding them to immediate emergency treatment or placing them in an appropriate position in the queue. Walk-up patients approach from a window on one side, ambulance personnel from another, and Ms. Driano sits calmly in the middle.

Through the door at the back of the triage room, the rest of the emergency room spreads out in highly organized chaos. The adult emergency department is divided into three continuous, but distinct sections: one for the most acutely ill patients in need of continuous monitoring; a larger section for patients who need relatively long-term care and observation; and a third area, reserved for surgical cases and trauma. Together, the three subdivisions contain designated spaces for 32 patients, but in the thick of the busiest nights, the census has topped 80.

Mobile patient beds line the periphery of each area, and central workstations create small center islands. The main medical area includes two specialized isolation rooms for patients with infectious diseases like tuberculosis, as well as a bank of oversized chairs for a nearly steady stream of asthma patients. Suspended over the workstation is a small green stuffed frog, watching silently. On the opposite side of the emergency room, the surgical area includes a high-tech crash room, which functions as a mini-operating room for the most serious trauma patients.

The physicians who staff the department specialize in having no specialty, routinely acting as orthopedists, pulmonologists, cardiologists, and neurologists. “This past year I took care of patients with meningitis, encephalitis, gunshot wounds, dislocated shoulders, and schizophrenia,” explains Dr. Robert Green, assistant professor of clinical medicine and assistant director of emergency services. “I delivered two healthy babies in our crash room after the moms arrived with very distraught taxi drivers.”

While most doctors first consider the most likely cause of a problem, Dr. Green and his colleagues must first consider the most deadly potential cause. Rule it out, then move on. When an elderly patient presents with vomiting and abdominal pain, for example, the most common instinct is gastroenteritis, a relatively benign condition. But the emergency physician first considers rare but potentially catastrophic conditions, like bowel obstruction or even a ruptured aortic aneurysm, before moving on to the more mundane.

Early on the night shift, a nurse walks into the acute care area, carrying his dinner on a tray with one hand. He glances over to the patient in bed A1, a woman who has just begun unconsciously to yank the respirator tube from her throat. This is bad news. Deftly, balancing dinner in one hand and leaning over to stabilize the respirator and restrain the woman’s wrist with the other, the passing nurse averts a mild disaster. The evening’s dance has begun.

Tonight, Alkain Andrews sits at the eye of the hurricane, as he has for 24 years. Mr. Andrews serves as a patient representative in the adult emergency department. From his desk in the center of the emergency room, Mr. Andrews can page a specialist with one hand, prepare stat blood samples for delivery to the lab with the other, and cradle a second, and occasionally third, phone on his shoulder. Like a Washington Heights Radar O’Reilly of “MASH”
Dr. James Giglio, director of emergency services

fame, it's not uncommon for a nurse or doctor to walk up to Mr. Andrews with a worried look, only to be greeted with, "I already paged her," or, "It's on the way to the lab," before the first word of a question can sputter out.

Emergency medicine at Columbia has come a long way since Ms. Driano and Mr. Andrews first walked into the emergency entrance. "Less trauma, fewer gunshot, fewer stabbings," Ms. Driano explains. At the same time, she says, the positive change in the neighborhood around the medical center has been "phenomenal."

A decade ago, recalls Ms. Driano, "there used to be gang wars outside, the drug dealers practically had banners draped across the streets for advertisements. People would get dropped on our doorstep on mattresses and out of cars." She remembers one woman, upright and conscious, being wheeled at breakneck speed by emergency medical technicians into the trauma room. As they sped by Ms. Driano looked up to see a butcher knife lodged in the middle of the woman's back.

In the wake of big changes in emergency services, Mr. Andrews says, patients now have a far better experience than they had in the past. "It's just a little bit better, a little cleaner, we have more doctors and certified emergency medicine attending physicians now. We can get beds for patients a little quicker, lab results a little quicker. We're getting more efficient."

These days the department serves an increasingly diverse group of people from a wider geographical area. On one night, a 24-year-old woman in the asthma section has taken a 45-minute subway ride here, because she grew up in the neighborhood and feels at home at Columbia-Presbyterian. A cancer patient and her husband have driven from New Jersey for help in dealing with the side effects of chemotherapy. Their regular oncologist will visit, only to be greeted with, "I already paged her," before the first word of a question can sputter out.

The emergency room serves the surrounding neighborhood as a member of the citywide 911 response system. Pediatric trauma patients from throughout the city and beyond are brought to the newly designated Level I pediatric trauma center operated by the emergency medicine division in the Department of Pediatrics. And patients normally treated at dozens of advanced, specialized centers throughout the medical center frequently come to the emergency room when they need immediate care. As a result, the waiting room almost always reflects a cross-section of New York City.

"The emergency room is the great equalizer," explains Dr. Giglio. "Part of our mission is a commitment to our immediate community. But increasingly, we are also providing services for sick patients from the larger community, many of whom have private physicians on staff and specialized needs. For all of these patients, we aim for the seamless delivery of services from the front door of the emergency room on into the entire hospital."

The emergency room's connection with other departments at P&S comes in both clinical research and teaching. The large number and great diversity of patients who present to the emergency room make it an ideal place to recruit patients for studies that examine acute events like heart attack or stroke. Once patients are identified in the emergency room, they can be closely followed from the first moments of their visit. Research protocols for myocardial infarction, stroke, dehydration, and tension pneumothorax recruit patients from the emergency room, which encourages close collaboration between researchers in emergency medicine and those in virtually every other department at the medical school.

"The community of patients here," adds Dr. Giglio, "plus the academic resources of the medical center make this one of the most exciting environments in the world to practice and teach emergency medicine."

For P&S medical students, working in the emergency room provides an opportunity to see patients from the outset of their care and to be one of the first to try deciphering what's happening with each patient. Both first- and fourth-year medical students rotate through the emergency room. Seven emergency room faculty teach the course "Community Emergency Medicine," a perennial favorite among first-year medical students.

A residency training program in emergency medicine will be the next step. Plans are under way to develop a combined emergency medicine residency program sponsored by P&S and Cornell Well Medical College. The program could enroll its first new residents as early as the summer of 2002, creating an even better emergency department and a stronger connection between the Columbia-Presbyterian and New York-Cornell sites in the coming years.

Sansan Lo, a third-year medical student, is about to pack up and head home for the night when Dr. Bert Johansson, assistant professor of pediatrics, finds one more teaching opportunity, something for her to think about on the way home. Consider a 15-year-old boy who says he feels freezing water in a hot shower, and a scalding sensation when drinking ice water. He eventually comes down with encephalitis. What could he have eaten that started all this? Ms. Lo walks out of the pediatric emergency room with a slightly puzzled look, wondering where to begin her search. The bizarre answer that she will eventually discover: a rare toxin from eating tainted barracuda.
Renovated Pediatric ER Combines High Tech, Comfort

A renovated pediatric emergency room and trauma center opened in the Vanderbilt Clinic in November 1999. The new facility features a combination of high-tech emergency medical equipment and low-tech tools designed to make the place as hospitable and comfortable as an emergency room can be for a scared child.

“There has been a focus on making the emergency room capable of handling the most critically ill children, including trauma,” explains Dr. Steven Miller, Arnold P. Gold associate professor of pediatrics and director of pediatric emergency medicine. Since August 1998, Columbia-Presbyterian has been designated a level I pediatric trauma center, serving as a receiving hospital for the most seriously injured children in the region.

But Dr. Miller also stresses the development of “kid-friendly procedures” in the new pediatric emergency room, along with such amenities as rooms with VCRs and CD players to help patients pass the time and a private room for longer stays while families wait for test results or consultations with specialists.

Much of the care in the pediatric emergency room is family-centered. Whether managing asthma—an especially common problem—or helping a patient with unusual or undiagnosed problems, the physicians must talk to both the family and the patient.

“In pediatrics we take care of families,” explains Dr. Bert Johansson, assistant professor of pediatrics. When we treat a specific patient, we need to know what’s going on with Mom, what’s going on with Grandma.”

The new facility and trauma center designation reveal a fundamental change in the makeup of the pediatric emergency division: an increasing commitment to emergency care in the academic setting. In the past few years, Dr. Miller explains, the department has recruited about 10 full-time physicians trained in pediatric emergency medicine, most of whom focus on both clinical practice and academic research. An active fellowship program, under the direction of Dr. Peter Dayan, assistant clinical professor of pediatrics, ensures that new researchers will be attracted to the medical center, bringing with them expertise from other academic institutions.

Some P&S pediatrics research originates in the emergency room. In the past year, the pediatric emergency room has contributed to studies of the necessity of X-rays in pediatric ankle fractures, the long-term outcome of febrile seizures, and the course of fever in infancy. Each of these projects involves close and ongoing collaboration with other P&S departments.

The emergency room’s endless day has its rhythms. Some last for minutes, some for months. Admissions generally seem to go up at around 10 or 11 p.m. Every five minutes or so, a pneumatic tube sucks up the yellow plastic container of samples for the lab, as if by some unheard signal. Chinese food is delivered every two to three hours. Once a month the ER sees new surgical residents, medical residents, and medical students. At the beginning of the Halloween, Thanksgiving, and Christmas seasons, paper decorations suddenly sprout up on walls and ceilings throughout the entire department, although an observer is left to wonder who changes the decorations and when they have time to do it.

At 11 p.m., a strange lull hits most of the emergency room, overhead page rings out, along with the sound of a machine typing out a patient’s new hospital card. Alkain Andrews is on the phone—naturally—trying firmly and gracefully to convince an apparently frantic caller that a relative has not come to the emergency room. Mr. Andrews then puts on his baseball hat, a sure sign that it’s almost time to drive home to Long Island. He’ll sleep for a few hours, get up to start his day job as a tailor, then return to the emergency room at 4 p.m.

By midnight the pace has quickened again. Two ambulances sit in the emergency entrance, and a third is backing in. Emergency medical technicians bring in a middle-aged woman with increasing chest pain. A brief flurry of activity ensues as she is given oxygen, several IV lines, and an electrocardiogram within three or four minutes of passing directly through triage. Blood is drawn to determine if she has experienced a heart attack in the last several hours. Once stabilized, she rests quietly and breathes easier.

Meanwhile, the police officer with the ankle injury has been sent home on crutches, and the pregnant woman was whisked to the labor and delivery unit of Sloane Hospital for Women (located in Babies & Children’s Hospital) minutes after she arrived. Dr. Green continues to observe the woman who arrived with chest pains at the beginning of his shift. It turns out that she has had a mild heart attack and will be transported to a room in the Milstein Hospital Building after spending about six hours in the ER.

Dr. Green will work through the night, finally leaving sometime around 8 a.m., but the graveyard shift has its advantages. “Finishing at eight in the morning is never difficult because I look forward to a nice stack of pancakes, reading the newspaper at my local diner, and then jumping into bed. The difficult task is going in at midnight to start work.”

In the earliest moments of morning, the lights at Yankee stadium have been replaced with the light of the sun rising over the rooftops. One or two ambulances idle in the driveway, the donut vendor has left and returned. And the rest of the medical center stirs: Students come to class and physicians come to work for the day.

The emergency room stretches and yawns for what will be a relatively quiet morning. Quiet, but needy. The controlled pandemic continues. Alkain Andrews, Maggie Driano, the night attending physicians, and the residents will be back in a matter of hours, and the dance will begin again.
The Class of 2001 is different. Jay Lefkowitch, the speaker at the ceremony marking the class's transition from basic science years to the major clinical year, reached that conclusion on the class members' first day in pathology lab when, as professor of clinical pathology, he found members of this class standing around and interacting with each other and with instructors on the first day instead of taking their seats and waiting expectantly for information to flow to them.

This class designed its own lapel pin, which members received at the Student Clinician's Ceremony. And the group photo taken that Sunday in June, just hours before the first surgical rotation was to begin, says it all: They are all in there together, this rite of passage.

At the 1998 and 1999 ceremonies—the first ceremony, held in 1998, was called the Clinical Transition Ceremony—student-produced videos were shown. In the 1998 video produced by Class of 2000 members Sara May, Anne Hudson, and Nicole Regent, the anxiety—fear, almost—is palpable as second-year students embark on what some describe as a bigger transition than the beginning of medical school.

The 1999 video produced by Class of 2001 members Danielle Goodman and John Dooley focused on the patient perspective and explorations by students into their new roles in a clinical setting. "We had a lot of classes about how to talk to patients, and we talked to [students in] both years," says Adam Rubin '01 in the video, "but none of that prepares you for having to realize that someone is really in bad shape."

Another student featured in the video, Michelle Grotz-Rhine '01, summarizes both patient and student perspectives: "There's always this tension of 'I'm trying to learn something' and really trying to think about what I'm trying to learn and also trying to have this awareness of what it's like from the patient point of view."

The idea for a ceremony marking the transition between basic science and clinical years grew out of discussions between the Arnold P. Gold Foundation and Dr. Ronald Drusin, professor of clinical medicine and associate dean for curricular affairs, and Dr. Steven Miller, associate professor of clinical pediatrics.

The 1998 and 1999 ceremonies were sponsored by the Gold Foundation, which is dedicated to fostering humanism in medicine and creator of the annual white coat ceremony for incoming P&S students. The P&S ceremony was one of five ceremonies in a pilot program to prepare students for the transition from the classroom to the hospital.

The ceremony also provided an opportunity for the outgoing third-years, the Class of 2000, to honor outstanding teaching by residents during their major clinical year. The class gave Arnold P. Gold Outstanding Teaching Resident Awards to William Burke, obstetrics and gynecology; Jonathan Chen, surgery; Janet Choi, obstetrics and gynecology; Robert Dabal, surgery (he won in 1998 too); Mauricio Herrera, surgery; and James Mckie, urology.

Members of the Class of 2001 received the second edition of "The College of Physicians & Surgeons Clerkship Survival Guide," written and edited by students to prepare their peers about to begin third-year rotations. "You will learn an enormous amount of medicine in the coming year in a setting unlike anything in your previous education," the editors write in an introduction. "Not only do you have to learn to think like a physician, but you have to learn to think like a different kind of physician every five weeks."

The guide provides practical advice ("best place to sleep is Hammer library's captain's chairs"), tips on surviving the mundane ("If you want your residents to teach you, you have to help them with their scut[work]"), myths to set your watch by ("it really is true that most patients [in Labor and Delivery] deliver when you start to fall asleep"), honest reality checks ("third years are the lowest life-form in the hospital"), safety hints ("watch where your head is at all times"), and wisdom for the ages ("what you put into it is what you get out of it"). Descriptions of other hospitals (Harlem, St. Luke's, Roosevelt, Stamford, Bassett, and others) help students adjust to clerkships at affiliated hospitals.

The Class of 2002 will prepare next year's edition based on the clinical year experience of the Class of 2001. "Keep track of everything you wish had been included here," the editors advise new third-year students.
Pardes Now Leads Hospital; Search Under Way for New VP and Dean

As a search begins for a new vice president and dean to succeed Dr. Herbert Pardes, who became president and CEO of New York-Presbyterian Hospital on Jan. 1, two longtime faculty members have been named interim deans.

Tom Morris ’58 is interim dean for clinical and educational affairs. David Hirsh, chairman of biochemistry and molecular biophysics, is interim dean for research.

Dr. Pardes’ appointment to the hospital’s top post followed the retirement of David Skinner, who led the hospital after the two hospitals—Presbyterian Hospital and New York Hospital—merged Jan. 1, 1998.

Although Dr. Pardes’ new role leaves a void at P&S and other Health Sciences schools, it is viewed as an opportunity for Columbia to strengthen its collaborations with the hospital, the regional hospital network, and Cornell’s medical school.

Dr. Pardes, who also served as chairman of the Department of Psychiatry at P&S, is a national figure in psychiatry and academic medicine. From 1978 to 1984, he was director of the National Institute of Mental Health. In 1984, he was appointed director of the New York State Psychiatric Institute and chairman of psychiatry at P&S.

In 1989, he was named vice president and dean, overseeing Columbia’s four health sciences schools. He accomplished major changes in the education of physicians, enhanced clinical and basic science research, and assumed a national role as an advocate for education, health care reimbursement reform, and support of biomedical research.

Dr. Morris has been a P&S faculty member since 1964, following graduation from P&S in 1958 and residency and fellowship training at Bellevue and P&S. He has been vice dean of P&S and senior associate vice president for the health sciences since 1994. He is also professor of clinical medicine, former associate chairman of medicine, former president of Presbyterian Hospital, former acting chairman of medicine, former associate dean for academic affairs, and former director of the student health service. He served as vice dean of P&S from 1982 to 1984 under Don Tapley until being named president of Presbyterian Hospital.

Dr. Hirsh received a Ph.D. from Rockefeller University in 1968. He joined Columbia in 1990 as professor and chairman of biochemistry and molecular biophysics. He became Robert Wood Johnson Jr. Professor of Biochemistry and Molecular Biophysics in 1991.

His research interests are nucleic acid structure and function, control of eukaryotic development, and developmental genetics. He did postdoc work at the MRC Laboratory of Molecular Biology in Cambridge, England, with Drs. S. Brenner and F.H.C. Crick.

Before joining P&S, Dr. Hirsh was a member of the faculty of the Department of Molecular, Cellular, and Developmental Biology at the University of Colorado. He also was executive vice president and director of research at Synergen Inc., a biotechnology company in Boulder, Colo.

A search committee headed by Columbia Provost Jonathan Cole and Dr. Timothy Pedley, Moses Professor and Chairman of Neurology at P&S, has been formed to identify Dr. Pardes’ successor.

Dr. Hirsh and Dr. Morris plan to work together not only to maintain momentum at P&S, but also to keep the school moving forward. “The whole point of this position is to maintain momentum and explore new opportunities, but I would like to do more than keep it going,” says Dr. Hirsh. One of the biggest challenges Dr. Morris and Dr. Hirsh face in the interim period is overcoming the idea that the Health Sciences and P&S will stand still. “I think standing still means we lose ground,” says Dr. Morris, “so I hope faculty and students will understand that we are going to move ahead and continue to prepare the schools for the future.”
Donald F. Tapley: Dean Through Years of Robust Growth

See related articles starting on p. 35

Donald F. Tapley, 72, died Dec. 16, 1999, at Columbia-Presbyterian Medical Center of cardiac arrest.

He led P&S through a decade of growth that added to the school’s international renown, serving as dean from 1974 to 1984, after spending one year as acting dean. He joined Columbia in 1956 after completing fellowships at Johns Hopkins University in Baltimore and Oxford University in England. A native of Canada, Dr. Tapley graduated from medical school at the University of Chicago in 1952 and did his internship and residency at Presbyterian Hospital. His specialty was endocrinology, and he published a number of papers in the field, with special emphasis on the role of the thyroid hormones.

At the time of his death, Dr. Tapley served as the Alumni Professor of Medicine and senior deputy vice president for Columbia’s Health Sciences Division. During his tenure as dean, Dr. Tapley recruited all but one chairman of the basic science departments, and he recruited new leadership for public health and nursing. Among his recruitments for clinical departments was Herbert Pardes, former dean and now president of New York-Presbyterian Hospital, to chair the Department of Psychiatry.

“Don Tapley steered P&S through an important part of its modern history, and we are indebted to him. His recruitment of young researchers in the basic sciences and appointment of some of the best names in clinical medicine today are among his legacies,” Dr. Pardes said. “Since leaving the deanship, he has earned credit for attracting the generosity of private donors to fund important research and clinical programs and to support the work of young investigators. These are contributions that will continue to pay dividends throughout the next generation.”

During Dr. Tapley’s time as dean, the college’s endowment grew from $78 million to more than $160 million, and federal funding for research at P&S doubled.

Dr. Tapley is credited with bringing more recognition to teaching, raising funds for student scholarships, and launching plans for what is now the city’s first research park, Audubon Biomedical Science and Technology Park at Columbia. It was during his time as dean that a new Presbyterian Hospital building was planned and a private doctors’ facility in midtown—Columbia-Presbyterian/Eastside—opened.


Contributions to a fellowship fund established in Dr. Tapley’s memory may be sent to the P&S Alumni Association, 630 W. 168th St., New York, NY 10032.

Donald F. Tapley as dean, in 1982

A memorial service for Donald F. Tapley will be held March 22 at 3 p.m. in the P&S Alumni Auditorium, 650 W. 168th St.

In Memoriam

Stanley Bradley, M.D.

Dr. Stanley E. Bradley, Bard Professor Emeritus of Medicine and chairman of the Department of Medicine from 1959 to 1970, died June 5, 1999.

A native of South Carolina, Dr. Bradley graduated from Johns Hopkins University and received his medical degree from the University of Maryland. After an internship in Baltimore and a fellowship at NYU, Dr. Bradley joined the medical faculty of Boston University. He joined the P&S faculty in 1947 and became full professor of medicine in 1958, a year before being named chairman of medicine and director of the medical service at Presbyterian Hospital.

His research interests were in nephrology and hepatology.

Malcolm Carpenter, M.D.

Dr. Malcolm Carpenter, a neuroanatomist and retired professor of anatomy, died June 25, 1999. He graduated from Columbia College in 1943 and received his medical degree from the Long Island College of Medicine in 1947.

He pursued a fellowship in neurology at the Neurological Institute and, after military service, returned to Columbia in 1952 to complete his training. He joined the anatomy faculty and became full professor in 1962.

Dr. Carpenter wrote a classic textbook, “Human Neuroanatomy,” which was reprinted many times and translated into many languages.

Dezider Grunberger, Ph.D.

Dr. Dezider (Dijon) Grunberger, professor emeritus of biochemistry and molecul-
lar biophysics and of public health, died Aug. 7, 1999, of colon cancer.

Dr. Grunberger was a cancer researcher whose work focused on chemical cancer-causing agents. His investigations helped develop drugs based on propolis, a substance collected by bees and used in their beehives.

Dr. Grunberger, a native of Czechoslovakia, received Ph.D. and D.Sc. degrees from the Czechoslovak Academy of Sciences in Prague. He founded the radioisotope laboratory at the academy. He began his long association with Columbia when he made his first trip to the United States in 1964 to work for the National Institutes of Health.

Lester A. Mount, M.D.

Dr. Lester A. Mount, professor emeritus of clinical neurological surgery, died March 28, 1999. He spent his entire career in the Department of Neurological Surgery after receiving his medical degree from the University of Cincinnati in his native Ohio.

Dr. Mount was chief resident in neurosurgery before joining the faculty at P&S in 1941. He became full professor of clinical neurosurgery in 1970 and was acting chairman of the department from 1972 to 1973. He became professor emeritus in 1975.

He was widely recognized as a pioneer in the surgical management of subarachnoid hemorrhage and intracranial aneurysms. He was president of the Neurosurgical Society of America in the early 1960s.

ALUMNI

Class of 1921

Robert A. MacKenzie of Toms River, N.J., died May 16, 1999. For 50 years, until his retirement in 1973, Dr. MacKenzie practiced OB/GYN and surgery in the Asbury Park area. When he retired patients and friends honored him by establishing the Robert Abbe MacKenzie M.D. Loan Fund at P&S. A former class chairman of what he once referred to as “the good old wartime class of 1921 at 59th Street West,” he rallied the ranks in support of the medical school. Predeceased by his wife, Anne, he is survived by four children and 14 grandchildren.

Class of 1923

Edward E. Williams, in 1992. He was affiliated with Waterbury Hospital. Dr. Williams, a veteran of both world wars, pursued a lifelong avocation in painting and was a member of the Washington Art Association. He was also an accomplished horseback rider.

Class of 1932

The Alumni Office has received word of the death of retired Connecticut internist, Edward E. Williams, in 1992. He was affiliated with Waterbury Hospital. Dr. Williams, a veteran of both world wars, pursued a lifelong avocation in painting and was a member of the Washington Art Association. He was also an accomplished horseback rider.

Class of 1934

Jule Eisenbud, psychiatrist and former clinical faculty member at the University of Colorado, died March 10, 1999, at age 90. A controversial author in the field of parapsychology, his book, “The World of Ted Serios,” describing his work with a Chicago bellhop who claimed to be able to produce dream-like images of his thoughts on film, brought him acclaim and some criticism. He was predeceased by his wife, Molly. Surviving him are a daughter, two sons, five grandchildren, and one great-grandchild.

Class of 1935

Edgar O. Martinson, a retired surgeon and specialist in emergency medicine, died April 2, 1999. Dr. Martinson had been affiliated with Middlesex Hospital in New Haven, Conn. In his extramural life, Dr. Martinson was Connecticut State Senior Citizens Spelling Champion in 1989. He leaves behind his wife, Margaret, a daughter, two sons, and five grandsons.

Class of 1937

Edward Hirsch of El Paso, Texas, died April 5, 1999. A retired general surgeon and former faculty member at Downstate Medical School in Brooklyn, Dr. Hirsch served on the surgical staff at Providence Memorial Hospital in El Paso. He is survived by his wife, Lillian, a daughter, a son, and a grandson. . . . Ferdinand L. Roth, a former industrial physician and surgeon with Standard Oil, died April 22, 1999, of complications of a massive stroke. After leaving Standard Oil, Dr. Roth had a private surgical practice, first in East Orange, then in Livingston, N.J. He retired in 1985, subsequently earning the 50-year service award from St. Barnabas Hospital in Livingston. He leaves behind his wife, Gladys, three sons, six grandchildren, and one great-grandson. . . . Norton Williams II died June 21, 1998, in his living room following a family vacation. He practiced pediatrics before being called to service in the U.S. Army Medical Corps in World War II, during which he was chief of medicine in the Second Evacuation Hospital. After the war, he returned to practice internal medicine in New York before moving to Wallingford, Conn., to become medical director at Choate-Rosemary Hall. As a volunteer he worked on several occasions with the Hôpital Albert Schweitzer in Haiti. Following his retirement from Choate, he became active with the hospice movement, serving as home-care doctor with the New Haven hospice, one of the nation’s first. Predeceased by his first wife, he leaves behind his second wife, Priscilla, a daughter, a son, and two stepsons.

OTHER FACULTY DEATHS

Alan M. Schwalb, M.D., assistant clinical professor of medicine (at Mary Imogene Bassett), died Feb. 2, 1999.

Sayed Haider Shamsi, M.D., associate clinical professor of obstetrics and gynecology, died April 21, 1999.

Ferdinand L. Roth, a former industrial physician and surgeon with Standard Oil, died April 22, 1999, of complications of a massive stroke. After leaving Standard Oil, Dr. Roth had a private surgical practice, first in East Orange, then in Livingston, N.J. He retired in 1985, subsequently earning the 50-year service award from St. Barnabas Hospital in Livingston. He leaves behind his wife, Gladys, three sons, six grandchildren, and one great-grandson. . . . Norton Williams II died June 21, 1998, in his living room following a family vacation. He practiced pediatrics before being called to service in the U.S. Army Medical Corps in World War II, during which he was chief of medicine in the Second Evacuation Hospital. After the war, he returned to practice internal medicine in New York before moving to Wallingford, Conn., to become medical director at Choate-Rosemary Hall. As a volunteer he worked on several occasions with the Hôpital Albert Schweitzer in Haiti. Following his retirement from Choate, he became active with the hospice movement, serving as home-care doctor with the New Haven hospice, one of the nation’s first. Predeceased by his first wife, he leaves behind his second wife, Priscilla, a daughter, a son, and two stepsons.
IN MEMORIAM

Class of 1939
James R. Otto, a retired general and thoracic surgeon and veteran of the Ninth Evacuation Hospital in North Africa and Europe during World War II, died Feb. 25, 1999. Until his retirement in 1983, Dr. Otto practiced in Everett, Wash. Surviving him are his wife, Ruth, two daughters (including Nancy Otto '77, husband of Philip Valente '77), three sons, and six grandchildren.

Class of 1940
Willbur B. Manter, a prominent retired cardiologist from Maine, died Jan. 19, 1999. Dr. Manter almost single-handedly brought the discipline of cardiology to the state of Maine as one of the co-founders and prime movers of the Eastern Maine Medical Center's Heart Center. A master of the electrocardiogram as a diagnostic tool, Dr. Manter conveyed that knowledge to others. He served as a member of a U.S. Army hospital based in the China-Burma-India theater during World War II, returning to his native Maine to open a private practice in internal medicine and cardiology, subsequently focusing almost entirely on the latter. Among other professional roles, he was a past president of the Maine Heart Association. He is mourned by his wife, Margaret, two daughters, three sons, and six grandchildren.

Class of 1941
Vernon E. Duckwall, a retired surgeon, died May 14, 1999, at age 91 following an automobile accident. In addition to his M.D. degree from P&S, he held a degree from the University of Pennsylvania Wharton School of Commerce and Finance. He served in the U.S. Army Medical Corps during World War II. Upon his return to civilian life, Dr. Duckwall began a general surgical practice and served on staff at the Golden Clinic and Memorial General hospitals in Elkins, W.Va. Dr. Duckwall was a past president, medical delegate, and national committee member of the West Virginia Division of the American Cancer Society. He leaves behind his wife, Betty Jean, a daughter, a stepdaughter, a granddaughter, two great-grandchildren, and two step-great-grandchildren.

Class of 1942
Word has been received of the Feb. 19, 1999, death of retired immunologist Eduardo R. Pons Jr. A former head of the allergy clinic at St. Vincent's Hospital, Dr. Pons also pursued a successful private practice, retiring in 1994. He was preceded in death by his wife, Carmen.

Class of 1945
Joshua R. Wood died April 11, 1999. A retired internist, he pursued a private general practice in San Bernardino, Calif., where he was affiliated with three local hospitals for 32 years. He is survived by his wife, Frances, a son, and two daughters.

Class of 1948
Theodore J. Capeci died, date unknown. Dr. Capeci, a retired general and plastic surgeon, was affiliated with Lawrence Hospital in Bronxville, N.Y., and Lenox Hill Hospital, where he served as chief of plastic surgery. He is survived by his wife, Margaret, two daughters, a son, and two grandchildren.

Class of 1949
The Alumni Office has received word of the June 19, 1998, death of Elsie A. Giorgi, a high-profile physician to the rich and famous and the poor and indigent alike. In her private practice in Beverly Hills, Calif., she treated and befriended such Hollywood celebrities as music producer Quincy Jones and actress Anjelica Huston. At the same time, she served as medical director of USC’s Family Neighborhood Health Services Center for Watts, a hard hit inner-city community. She also served as an active board member on the Watts Health Foundation, for which she received a Lifetime Achievement Award in 1987. She was particularly proud of the rededication of the medical library in the Watts Health Center in her name. An early proponent of the team approach to health care, she developed a curriculum to train primary care nurse practitioners and wrote a number of papers on community medicine and related social issues. Teaching at USC, UCLA, and UC Irvine, Dr. Giorgi was elected to the Institute of Medicine of the National Academy of Sciences. She served as a medical consultant to several Hollywood movies. She has no known survivors.

Class of 1950
Ruth Tiffany Barnhouse, a pioneer in the linked disciplines of psychiatry and pastoral care, died May 18, 1999. Dr. Barnhouse was an ordained Episcopal...
In Memoriam

Elliot Middleton

Class of 1956

Word has been received of the death of William C. Heady, a family practitioner from upstate New York, who chose to end his own suffering Sept. 15, 1998, following years of failing health. For 17 years he ran a thriving family practice in Waterford, N.Y. Director of the emergency department at Genesee Hospital, he also served as part-time medical director of the Jefferson County Public Health Service. Both his first wife and first-born son died of leukemia, which took a heavy emotional toll. Surviving him are four children from his first marriage, his second wife, Jean, her two children, and seven grandchildren.

See Letter, Page 3, for information about William V. Healey ’56.

Class of 1957

Word has been received of the tragic Jan. 13, 1999, death of Moses H. Mahoi in a wave of violence and political turmoil in his native Sierra Leone. Son of a chief, educated by missionaries, and later sent to college in the United States, Dr. Mahoi stepped off the boat in New York not knowing a word of English. Later accepted at P&S, he chose to complete his medical studies rather than accept his tribe’s call to return after his grandfather’s death to take over as chief. Following an internship at the Detroit Receiving Hospital and a residency in pediatrics at Children’s Hospital of Michigan he pursued a diploma in tropical medicine at the London School of Hygiene and decided to apply his medical knowledge back home where it was needed most. Committed, in his own words, to “the human approach to the care of the unwell person,” he sought to combine the psychology and profound human understanding of the native medicine man with the science of Western medicine. “Since 1963,” he once wrote, “I have been back home sharing with others what P&S shared with me.” In Sierra Leone he saw patients at the Mission Hospital and then “retired” to set up the Family Clinic, a holistic health center in a poor section of Freetown. Twice marauding rebels came through and ransacked his clinic, twice he refused to pack up and go. It is not known exactly how he died. In a 1992 letter to the Alumni Office he wrote: “The more I think of the opportunity afforded me to attend P&S, the more I appreciate the inscription at the West 168th Street entrance to Presbyterian Hospital: ‘FOR OF THE MOST HIGH COMETH HEALING.’” His only known survivor is his daughter, Boi-Tia Mahoi-Stevens.

Class of 1959

Mark Noble Mueller died of a brain tumor Jan. 7, 1999. A former associate professor of medicine and radiology and head of the rheumatology section of the Department of Medicine at the University of Wisconsin, Dr. Mueller and his family moved to Salt Lake City, where he joined the faculty at the University of Utah. He also ran a private practice specializing in rheumatology and metabolic bone disease in Salt Lake City. Dr. Mueller was a founding member of the Metabolic Bone Disease Society of Utah. Survivors include his wife, Jeanne Ann, two daughters, and two sons.

Class of 1960

Thomas Graves Smith Jr., chief of the sensory physiology section of the neurophysiology laboratory in the National Institute of Neurological Disorders and Stroke of the NIH, died in May 1999 of the aftereffects of a stroke. A former Rhodes Scholar at Oxford University’s St. John’s College in England, Dr. Smith trained at Bronx Municipal Hospital Center and joined the NIH as research associate in the spinal cord section. His early research was devoted to the description of electrical activity underlying circuits and networks in cat spinal cord. Dr. Smith invented a method of two-electrode voltage-clamp recording to read the ionic mechanisms of pacemaker activi-
ty in snail neurons and was the first to apply this method to neurons cultured from mammalian spinal cord. Among his publications, he edited the book, “Voltage and Patch Clamping with Microelectrodes.” He is survived by his wife, Jodie.  

Class of 1963  
Frederick L. Sachs, a respected pulmonologist and member of the clinical faculty at Yale University, died June 24, 1999. Dr. Sachs was associate chief of staff and associate chief of medicine at Yale-New Haven Hospital and a past president of the New England chapter of the American College of Chest Physicians. Dr. Sachs served in the U.S. Air Force at Andrews Air Force Base in Washington, D.C., from 1965 to 1967. He is survived by his wife, Ruth, and three daughters.

A Colleague Remembers Don Tapley

By Tom Morris,  
Interim Dean for Educational and Clinical Affairs

Don Tapley was a central figure at P&S from 1956 to 1999.  

My first personal encounter with him was in 1959 when I was a resident on the Columbia division of Bellevue. Don was a rising star in the division of endocrinology in the Department of Medicine. We had a particularly perplexing woman—perplexing because we could not control her diabetes. Don was kind enough to come down to discuss her with the house staff. The resident involved presented the patient in exquisite detail, and Don listened very carefully. We all expected to hear about an innovative approach to giving insulin or something like that. He looked at us and suggested that the first thing we should do was add wild currant jelly to her diet. Naturally, the kitchen at Bellevue didn’t have wild currant jelly, or any jelly at all, but that was typical of Don: He liked to get people to think outside of the box, long before it was fashionable. Then he always followed a suggestion like that with a huge grin.

Over the years he rose through the ranks of the Department of Medicine while he was doing research on thyroid disease. He increasingly became involved in teaching and administrative activities in the department. I joined the Department of Medicine on a full-time basis in 1964 and followed him as director of the third-year clerkship in medicine. He really had developed a collaborative relationship with students. He kept that sense throughout his academic career here; he loved the students and thought listening and responding to them was critically important.

As dean, Don recruited a large number of chairs and institute and center directors. During that time he began what I think characterized the last quarter century of his career. He established guidelines for academic excellence and ensured their effective implementation. He involved himself with the Committee on Appointments and Promotions in a very active way. He became the authority on criteria for promotion and the level of excellence we were trying to seek among our faculty members. He also introduced titles and procedures that allowed non-physicians to receive appointments in clinical departments. That wasn’t typical before. We began to see sociologists and others on the faculty, thanks to his leadership.

He also was critical in fund raising. When you’re the dean, the “d” stands for development. You have to raise a lot of money. He not only raised money, he pored through the books of the University and identified the Cartwright endowment, which had been fallow for a number of years, deliberately so as to allow it to grow. He re-established the Cartwright lectures.

We depended on each other a lot. I had been a member of the board at Mary Imogene Bassett Hospital for many years, so I recruited him to serve as a trustee of the hospital for the last several years of his life. Perhaps more importantly, I induced him to join the board of the O’Connor Hospital in Delhi, N.Y. The hospital has a maximum of 15 beds, so he added his perspectives to a totally different environment. He became a regular participant in those board meetings and contributed very effectively to the growth and stability of that small country hospital, which today is the only health care institution in that portion of Delaware County.

The other area where we collaborated was the Morris-Jumel Mansion. He wanted to help stabilize the mansion. As the driving force behind the board, he developed an endowment for the mansion and personally managed it. He took great pleasure in exceeding whatever Dow Jones did—and occasionally beating NASDAQ.

What I will remember, beyond his enthusiasm and knowledge, is his commitment to various activities. He was never daunted by what appeared to be insurmountable obstacles—be they political, financial, or regulatory. Perhaps the best example of that is the founding of the Faculty Club. He oversaw the building of Hammer Health Sciences during his tenure as dean and as soon as the old library moved over to its new quarters, he implemented a plan he had drawn up previously to put a slab over the upper level of the old library. What used to be an open reading room became a floor that he immediately converted into the Faculty Club. That was another example of his commitment to the institution and the faculty and his ability to innovate where it didn’t seem practical.

History will remember Don Tapley as an innovative thinker about P&S, someone who valued academic standards enormously, and one who was very proud of the medical center’s accomplishments—not only in research, but also in patient care. He did his best to promote an effective partnership between the school and the hospital.
I don’t have firsthand experience about the career of Donald F. Tapley or the highlights of his 11 years as dean. Those facts are included on earlier pages of this issue. The Dr. Tapley I knew—and he remained “Dr. Tapley” to me even after I started receiving notes from him signed “Don”—was a man who served as a mentor to me, but not in the traditional sense of the word. When I arrived at Columbia in 1991, my primary responsibility was to produce P&S Journal, but he was listed on the magazine’s masthead as Editor.

I soon learned that his role was more honorary and supportive than productive. Once he saw that I could produce the magazine on a schedule and produce three issues each year instead of two on the same budget, he stood back and let me take the magazine where I wanted it to go. He attended all editorial board meetings—except for the months in 1994 when he battled cancer. He read the entire manuscript (he was the only person I know who could spot a professor of clinical medicine that should be a clinical professor of medicine—but I never fully comprehended the difference). He listened to and gave his approval of my ideas for the cover of each issue, and he looked over the finished layout (the latter role was added in 1992 after my second issue carried a photo of a person misidentified as Andre Comand). He was my sounding board, my source of institutional history, my safety net. Only once did he veto a cover idea—and he felt bad about that, apologizing for not liking it. He was eager to try new things—to a point—and we often joked about printing something controversial as a way to generate more letters. He was always puzzled by the fact that we didn’t get many letters.

I appreciated his support and I admired his pride in the College of Physicians & Surgeons and the Columbia-Presbyterian Medical Center. That pride rubbed off on me, and I hope I have put it to good use in producing this magazine for all these years. This is my 25th issue—and Dr. Tapley’s last issue on the masthead. When I took on the title of Editor in 1996, Dr. Tapley became chairman of the editorial board, also an honorary distinction: He still expected me to plan and conduct the meetings and distribute minutes afterward.

I will long remember his economy of words: He never used a full sentence when a phrase—or one word—would do. In journalism school, I learned never to ask a question that could be answered with only a yes or a no. That training served me well in my dealings with Dr. Tapley. I learned to avoid asking a question that required a one-word answer unless I really wanted the “Yes!”, “No!”, or “Great!” that I can still hear ringing in my ears. No small talk for this man.

I didn’t know until he died that he conceived the idea of a glossy magazine to replace a more newsletter-like P&S Quarterly to communicate with alumni, faculty, staff, and other friends of the school. He was not the publication’s first editor, which debuted in 1981, but he was dean during its transition to P&S Journal.

In the months before he died, I updated him occasionally on my efforts to find a printer that could produce a full-color P&S Journal without increasing the costs. When I last saw him, I told him I was close to being able to print the Winter 2000 issue in full color. “Good!” he replied in his trademark staccato style. So it seems fitting that I dedicate this first new and improved P&S Journal to his memory. You can honor him by sending me letters and e-mail about how you like the change. If I get too many letters to print I will almost be able to hear him say, ever so succinctly, “Terrific!”

Bonita Eaton Enochs, Editor
psjournal@columbia.edu
To allay the fears of little patients in the OR, Martha "Bobby" MacGuffie'49 wears a specially designed child-friendly shirt with a jungle animal print. Around her neck dangles a bullet removed from the hip of an infant she and a colleague literally saved from the jaws of death in a refugee camp in Zaire. The apparent paradox of two such disparate symbols, one gentle, one fierce, both worn against her skin, tells much about the wearer.

Founder, president, and prime mover of the Society for Hospital and Resource Exchange (SHARE), a non-profit organization she created in 1988 to bring U.S. medical technology and manpower to people who need it most, the respected plastic and reconstructive surgeon divides her time between a busy practice in Rockland County, N.Y., and an even busier practice in the bush of western Kenya, tending to the diverse medical needs of AIDS orphans and anyone else who needs help.

Other medical missions undertaken on a moment's notice have included the treatment of African victims of the 1998 terrorist bomb at the American Embassy in Nairobi and the emergency care of survivors of Rwanda's bloodbath at a refugee camp in Goma, Zaire. "Well go where conditions are worst and where we're needed most," says the 76-year-old surgeon.

"Humanitarian Warrior-Woman of the Decade"

Featured on the CBS news magazine "48 Hours" for her work with the children of Kenya, she was saluted as the 1980 Harper's Bazaar Super Woman of the Year and the 1986 Red Cross Citizen of the Year. In 1996 Rotary International honored her with its Service Above Self Award and Lions Club International followed in 1998 with its prestigious Humanitarian Award, the latter formerly given to Mother Teresa. But perhaps the tribute that best bespeaks her true temperament is the 1996 "Humanitarian Warrior-Woman of the Decade" Award of the Martin Luther King Foundation. Dr. MacGuffie has been a lifelong fighter for causes close to her heart. "The fierceness is in the blood," she insists, a gift from her Scottish warrior ancestors.

The first woman to train in plastic and reconstructive surgery at P&S under the legendary Jerome Webster (who had publicly stated he would never train a woman—until Bobby MacGuffie came along, that is), she was the first woman surgeon to serve on the staff of a major suburban hospital, Nyack Hospital in Nyack,
A Self-Proclaimed “Misfit” Makes Life Fit Her Measure

ándose a su padre médico y apreciando su trabajo en la cirugía, can see that this field, though indisputably hard, has a noble and human purpose.

Born in 1924 in Passaic, N.J., she and her family spent summers in Maine, where the young MacGuffie, a self-proclaimed misfit, ran wild with her dogs in the woods. “They literally had to drag me home in the fall,” she recalls. She got her nickname “Bobby” from the unruly tuft of hair that perennially stuck up like the feathered crest of the bobolink. Following a reluctant and dismal educational beginning, she leapt from all failing grades to high school valedictorian and went on to study zoology as a premed student at Cornell, where she attended classes with beagle puppies in her knapsack and a crow perched on her shoulder.

Having tagged along on house calls with her physician father from an early age and watched him perform surgery, she had no doubt about her future calling. “It was just a matter of getting a license to legitimate my interest,” she says. “Medicine interests me because it has to do with people,” she put succinctly in her P&S student application, inadvertently writing her future credo: “Through my father’s work . . . I can see that this field, though indisputably hard, has a noble and human purpose.”

At P&S, she earned the respect of the faculty, including associate dean Aura Severinghaus, who wholeheartedly endorsed her application for an internship at Presbyterian Hospital, citing her academic prowess and clinical skills and praising her as a “large, powerful, and tireless individual with unbounded energy and a devotion to her patients.”

A medical internship and surgical residency at Presbyterian Hospital were followed by additional training there in orthopedic surgery and a chief residency in general surgery at Delafield Hospital. Her unquestionable expertise and the quality of care she gave to one particular Presbyterian patient (a man who, by chance, happened to be one of Jerome Webster’s close friends) so impressed Dr. Webster, an outspoken opponent of “wasting” training on women, that he ate his words and offered her the very last residency slot of his career.

Dr. MacGuffie went on to pursue a fellowship from the National Cancer Institute, collaborating with her second husband, Dr. Perry Hudson, then a member of the P&S faculty at Delafield, on research concerning tobacco condensates. Outside the lab she took on the tobacco lobby and launched an anti-smoking campaign well ahead of its time and saluted by the National PTA as the best of its kind.

On the home front, meanwhile, with two daughters from an earlier marriage, five more children with Hudson, and a child from his first marriage to help raise, Dr. MacGuffie had her hands full. The memory of juggling family and profession still makes her laugh—or shaking hands with a baby raccoon she saved from hunters and you can well imagine the wild child she once was.

From Burns to Water Beds and Scar Cream

She was drawn to surgery because of its ability to “put things back together and fix whatever’s wrong.” Undaunted by the ingrained anti-female prejudice of the field, strictly a man’s domain at the time, she sought out and studied with such legendary figures as Frank Meleney in surgical bacteriology, Cushman Haagensen in Halstedian surgery, and Arthur Purdy Stout in surgical pathology.

During her training at P&S, she received a special interest in the field of plastic surgery, and this interest was further cultivated during her time at Presbyterian Hospital, where she had the opportunity to work with such legendary figures as Frank Meleney in surgical bacteriology, Cushman Haagensen in Halstedian surgery, and Arthur Purdy Stout in surgical pathology.

At P&S, she earned the respect of the faculty, including associate dean Aura Severinghaus, who wholeheartedly endorsed her application for an internship at Presbyterian Hospital, citing her academic prowess and clinical skills and praising her as a “large, powerful, and tireless individual with unbounded energy and a devotion to her patients.”
surgery for burn victims. While operating on a patient who had suffered multiple burns she wondered aloud to a colleague in the OR, “Wouldn’t it be nice if he could float?”

The idea bore fruit. “We got a huge polystyrene block, hollowed it out, and filled it with water laced with copper sulfate . . . and we floated him.” That first prototype of the water bed, later commercialized and marketed by others and popularized in the 1960s and 1970s, eased the pain of countless patients. Another byproduct of her scientific savvy and ever-active imagination, Dr. MacGuffie’s Scar Cream, proved an effective and popular postoperative healing aid. This time, she decided to manufacture and sell it herself.

Her company, Narwhale of High Tor, produces scar cream, sun-block, and moisturizers considered among the purest and finest on the market. Most of the proceeds go to SHARE.

From Anguish to Africa

Tragedy disrupted her busy regimen when two of her three boys were diagnosed with Fanconi’s anemia, a rare congenital blood disease. Though she and the boys decided they would live active, normal lives (both became accomplished young athletes), frequent blood transfusions inexplicably caused them to waste away. Somewhere along the line they had contracted AIDS, then an unidentified disease.

Her sons’ deaths changed the ground rules of her life. Their loss was cataclysmic. Unable to cope with their passing, her husband left. “I could’ve either blown my brains out,” she calmly reflects, “or put the pain to good use. There’s a point at which you’re still salvageable to yourself and others.” As she said in the Denver Post profile, “I went from a full house to nothing and I headed for Africa.”

Ever since childhood, inspired by the stories of the returning missionaries her father treated, she had dreamed of going to Africa. Many times she would playfully tell her kids to buck up, or “I’m going to take a one-way ticket to Kenya.” When her youngest daughter left for college, the moment had finally come to follow her dream.

What began as a veterinary safari to Kenya, a futile attempt to try to take her mind off the loss of her sons, evolved into a lifelong mission. While ostensibly there to look at veterinary conditions, she could not turn a blind eye to the human condition. Appalled by the absence of basic facilities and medicines in the generally abysmal state of the government clinics she visited, “I came back home to the States and winced when I saw them throwing all the hospital stuff away.”

A subsequent trip to the United Nations and a fateful meeting with the Kenyan ambassador made her put two and two together. She pinpointed her target in the Nyanza province, a disease-ravaged region of western Kenya on the shore of Lake Victoria. The region has one of the world’s highest birth rates, infant mortality rates, and incidences of infectious diseases. One in three have HIV, and 90 percent of the children suffer from malaria and/or schistosomiasis. It is here on an island in Lake Victoria that paleontologists Louis and Mary Leakey discovered the earliest dated remains of human life on Earth and here that Dr. MacGuffie saw human life fading.

The odds notwithstanding, she decided to invest the pain of the loss of her sons by “helping the most disadvantaged children in the world.” The help has been unstinting. In a little more than a decade, SHARE (which Dr. MacGuffie co-founded in 1988 with Dr. Renee M. Brilliant, a pediatric hematologist who treated her sons) has built clinics, donated millions of dollars worth of medical equipment and drugs, educated local residents on how to avoid disease, and organized a program that allows American paramedics to train their African counterparts. In addition, the organization has funded and directed the expansion of the Homa
Bay District Hospital “from a grimy, run-down, poorly functioning unit to a clean, well-run facility,” and helped establish and run the Double Joy Children’s Farm, where Kenyan AIDS orphans are reunited with surviving siblings and cousins into family units and given the skills to survive and thrive.

African and American Children Pull Together

SHARE’s newsletter “HARAMBE!” takes its name from a word in the Luo dialect that means “Pull together.” From the very start, Dr. MacGuffie has sought to create lasting links between America and Africa. Her goal has been to educate, sensitize, and empower American children to make a difference in their own lives and the lives of those less fortunate. Lecturing on AIDS awareness to American schoolchildren, she pulls no punches in showing them vivid photographs of immeasurable suffering, stirring their conscience and rallying their support. Children, whom she calls “one of the world’s most powerful forces for good,” have responded with boundless enthusiasm. One group of schoolchildren in California started a successful program by contributing hundreds of teddy bears. Dubbed “SHARE BEARS,” these stuffed animals are dressed up by volunteers to be sold and promoted as a source of support and a symbol of caring.

Dr. MacGuffie has been eminently successful at gently twisting adult arms too. Celebrity friends like comedian Bill Murray and dancer Mikhail Baryshnikov have contributed their talents to fund-raising events. A retired former comptroller of Texaco now does SHARE’s bookkeeping. Pharmaceutical giants like Lederle and Bristol-Myers have donated life-saving drugs, including tetracycline and Cytoxan, the latter delivered four times a year to treat the disfiguring, albeit reversible, scourge of Burkitt’s lymphoma. The drugs are shipped free of charge, compliments of Federal Express. Transamerica Leasing contributes the containers. AmeriCares, a Connecticut-based relief organization, has provided aid and funded many of her emergency missions. The American Association of Retired Persons supported an emergency mission to Somalia to care for the survivors of tribal clashes. Rotary funded a custom-made Jeep built to her specifications, designed for every kind of road condition or even the absence of roads.

In a television special, “Stephen’s Story,” CBS documented one of the Luo tribe. Completing the four-year course of study in two and a half years, Stephen has gone on to pursue a master’s degree in computer science and another in biology. He wants to become a doctor and—“Why not?” Dr. MacGuffie grins—hopes to apply to P&S. “Stephen came along at a time when I was most upset about the disappearance of Scott. We’ve helped each other.”

A Humanitarian Willing to Risk Her Own Skin

She has risked typhoons, tribal clashes, a cholera epidemic, and the ever-present threat of a deadly strain of malaria from which one colleague died. Attacked and beaten by bandits on one occasion, she climbed back into her Jeep to complete her work. Not immune to the suffering she faces on each mission and the terrible specter of death, she manages to put the pain on hold. Asked about fear, she promptly replies: “I’m afraid of everything, but usually if something needs to be done, I’ll let myself get afraid afterwards.”

Dr. MacGuffie distinguishes between the role of the philanthropist, who helps but from afar, and that of the humanitarian, who gets involved, sometimes at considerable personal cost, both physical and emotional. While reticent to compare herself with a hero of her youth, Dr. Albert Schweitzer, she modestly acknowledges his influence. “I do not know what your future will be, but this much I know: The only ones amongst you who will be truly happy are those who have

Martha M. MacGuffie’49

with pet ferrets
learned how to serve.’ That’s Schweitzer,” she quotes from memory. And while happiness may not be her lot in life, she exudes a profound, if restless, satisfaction.

Colleagues say her face lights up whenever she gets to Africa. "It’s very energizing,” she admits. "It has something to do with being alive. I guess. . . . If you have an aching joint, you forget it, there’s no time for the pain.”

The Magical Light on Lake Victoria

Peering at a photograph of the shimmering surface of Lake Victoria, Dr. MacGuffie reflects, “That’s the direct sunlight on the lake; it’s like silver once you see it, a magical light, but it’s also very dangerous and can make you go blind.” Severe iritis, a frequent problem of local children, leads to panophthalmitis, which, if untreated, can lead to blindness. “That’s Africa, the beauty and the tragedy side by side,” she says.

Keenly conscious of the link between nature and disease, she has played an active role in environmental efforts. Working in conjunction with the International Center for Insect Physiology and Ecology, she raised the necessary funds to develop tsetse fly traps at Ruma National Park to help eradicate sleeping sickness in the area. The park is run by her friend, the paleontologist and conservationist Richard Leakey. She is currently engaged in an effort to build a bridge to replace a causeway that links the mainland to Rusinga Island. The causeway blocks a natural current, thus leading to the growth of a water hydracinth, a weed that chokes the wildlife and poisons the water, and the infestation of poisonous snakes and snails that carry schistosomiasis, a disease that kills thousands every year.

The Answer to AIDS is Out There

AIDS is what first brought Dr. MacGuffie to Africa and it is still her primary focus. In addition to her ongoing support of AIDS orphans at the Double Joy Children’s Farm, she launched a new program here in the States, SHARE Orphan Sponsorship (SOS), whereby American sponsors “adopt” an AIDS orphan, assuming the relatively modest expense of his or her care, feeding, and education. "The answer to AIDS is here,” she firmly believes. "These orphans are survivors; they don’t have the disease.” Can it be that they developed an immunity? Dr. MacGuffie nods. She also suspects that, contrary to conventional wisdom, mosquitoes may carry the HIV virus through their proboscis, which is structurally similar to a hypodermic needle.

"It’s Too Late to Retire"

Dr. MacGuffie’s beloved home base is a manor house built by an admiraltry lawyer in imitation of a 13th century Norman castle, on a 31-acre estate in New City, N.Y. Home and office, family compound and private retreat, the grounds include a Skin Care Center for postoperative patients and a former stable redesigned as studio and digs for one daughter, who is an artist and teacher. Two other daughters are physicians and two are teachers. Nine grandchildren return every chance they get. Her “extended” family includes five raccoons, two ferrets, two large dogs, six cats, and three horses, not to mention the wild turkeys, deer, and woodchucks that roam the grounds. Itinerant artists have workshops on the upper floors of the manor, the only rent paid in art, like the OR shirt with the jungle animal theme designed by an occasional tenant. And, when she’s not hosting her annual Scare Fair, a gala Halloween fund-raising event for SHARE, she lets other worthy organizations, like Children’s Rescue, borrow the place to raise funds of their own.

Dr. MacGuffie manages to find time and energy for it all. And if there were ever any question of slowing down or, heaven help her, retiring, she grins, "I’m afraid it’s too late now!"
Kramer Family Medicine Fund Perpetuates Legacy of a ‘Doctor’s Doctor’

By Peter Wortsman

Before the advent of antibiotics, immunizations, EKGs, and MRIs, physicians armed with little more than compassion and a stethoscope did the best they could. To that limited medical armamentarium, the late Isaac Golde Kramer ’08 added a keen eye, an ear attuned to the elusive sound of disease, and a sixth sense for the impalpable symptom. For more than 30 years, Dr. Kramer, a revered and beloved New York general practitioner, brought wisdom, an unquenchable thirst for learning, and an absolute commitment to the care of his patients.

“The technology has advanced but that kind of informed caring has been lost,” says his son, Robert S. Kramer. Hoping to perpetuate the kind of medicine his father practiced almost a century ago, Mr. Kramer encouraged his sister, Muriel Nachman, to establish an educational fund in their father’s name in the Center for Family Medicine at P&S. Dr. Kramer’s grandson, Dr. Melvin Kramer, a Baltimore-based environmental and infectious disease epidemiologist in the Public Health Service, has taken an active role in focusing the goals of the fund.

“My grandfather never sat on his laurels. He continued learning all his life,” recalls Dr. Melvin Kramer. “Keeping himself up-to-date on the latest findings, always attending medical lectures and conferences, he was teased by less assiduous colleagues. ‘Ike,’ they said, ‘when are you finally going to get your degree?’”

The Kramer family intends to support an annual Kramer Lectureship and a Kramer Scholars Program, the ultimate goal of which is to promote family medicine and encourage all physicians, no matter their specialty, “to use their eyes and ears and once again look at the whole patient.”

The “scholarly” family practitioner is a concept close to the heart of Dr. Vincent M.B. Silenzio, director of predoctoral education and assistant director of research at the Center for Family Medicine. “This gift couldn’t have come at a better time,” says Dr. Silenzio, who holds a joint appointment with the School of Public Health. Thanks to several public and private initiatives launched in the late 1980s, P&S became one of a small number of institutions around the country committed to a reintroduction of a population-based health model and a community-based approach into the medical school curriculum. The Center for Family Medicine hopes to become an academic department. The clinical practice is run out of the Nagel Avenue Family Health Center in Upper Manhattan, which logs about 25,000 outpatient visits per year. The program includes 13 M.D. and Ph.D. faculty and 18 residents plus students on fourth-year rotation, students on third-year primary care clerkship, and first-year students from the clinical practice course. Dr. Christopher Wang directs the center.

“The idea of the Kramer Scholars Program will be to identify individuals at the beginning of their training,” says Dr. Silenzio, “and to integrate that individual into all of the community medicine functions of this center from the very beginning.” In addition to three years of residency in family medicine, Kramer Scholars will benefit from an additional fourth year of advanced study in the School of Public Health, the substance of that year integrated throughout their training, culminating in a master’s of public health degree. The Kramer Fund will help cover the additional expense. “The idea,” says Dr. Silenzio, “is to enrich the background of folks, whatever type of practice they ultimately decide to pursue.”

The Kramer Lectureship, for which a selection committee has been set up, will have two purposes. “We want to identify and hear from a high-profile individual in general medicine at the national level who has made an impact,” says Dr. Silenzio. “In so doing, we also hope to inspire others to learn from his or her example.”

Dr. Silenzio calls Dr. Kramer a wonderful role model for today’s physicians. “Here was a doctor committed to the health of the community and really quite ahead of the curve in his desire to stay current. That kind of doctor is deserving of recognition and we want our students and residents to know about him.”

To help him document the history of general medicine at Columbia and among its graduates, Dr. Silenzio encourages alumni with related backgrounds to get in touch with him, either by phone at (212) 305-9107 or e-mail at vs146@columbia.edu.
Alumni Council

The official gavel changed hands from outgoing president Oscar B. Garfein'65 to incoming chief executive Marianne Wolff'52 at the Alumni Council dinner June 16, 1999. "His shoes will be difficult to fill," Dr. Wolff remarked of her predecessor. "They're at least four sizes larger than mine." When the laughter subsided, she moved to a serious note: "My term as president will straddle the millennium. This gives me pause, to say the least."

As his last official act, Dr. Garfein introduced guest speaker Stephen Novak, head of archives and special collections at the Health Sciences library. Mr. Novak made old papers come alive. He brought along and lovingly displayed a few treasures from special collections, including the 1765 medical school dissertation of Samuel Bard on the subject of opium; the first extant P&S student ledger, written in Latin; and a series of student notebooks from the 18th to the 20th centuries. "You are history, believe it or not," he said to spellbound alumni in attendance. "We all have archives. If it looks like it's going to be tossed out, we'd like to have it." He invited alumni to peruse the library's rare holdings, including the personal papers of Nobel laureates Drs. Andre Cournand and Dickinson Richards'23 and some 15,000 rare books dating back to 1776. Conservation is a costly and painstaking affair, he pointed out, and he asked anyone interested in "adopting" an archival treasure to ensure its survival to contact him through the Alumni Office at (212) 305-1472.

Eric A. Rose'75, chairman of surgery at P&S, was the guest speaker at the council dinner Sept. 15. Dr. Rose spoke on "Survival Strategies for Academic Surgery." Optimistic, despite market pressures, about the future of the department's research and teaching enterprise, he had glowing words about the quality of clinical care and patient satisfaction, based on the results of the department's outcomes research unit. He cited the increasing survival of coronary artery bypass graft patients and a low mortality in neonatal open heart surgery. Dr. Rose was pleased to report that the number of heart transplants performed at Columbia was now at 1,100 and the liver transplant program, begun a year ago, had treated 50 patients. P&S has the largest number of implanted prosthetic left ventricles in the country and the largest number of enrollees in a trial of minimal access surgery for colon cancer. The department is particularly proud of its Institute of Surgical Science, the only one of its kind in the country, a program generously supported by the Milstein family.
Reception for New Students

Four days into their medical school careers, members of the Class of 2003, still buzzing with excitement and anticipation, converged on the Faculty Club to celebrate the beginning of a great intellectual journey. The newcomers mingled over wine and cheese with faculty and alumni at the annual reception sponsored by the Alumni Association. “The question is how to get some generational mixing,” reflected Richard N. Pierson Jr.’55, who paused briefly at the door before diving into the crowd with customary warmth. Alumni Association President Marianne Wolff’52 welcomed the new recruits. “Study hard,” she said, “but don’t forget to relax and pursue other interests. Lord knows, this is the city to do it!” A few parents were also on hand to share in the excitement.

Regional Program

Resident, vacationing, and visiting downeaster alumni and friends met at the Asticou Inn in Northeast Harbor, Maine, on Aug. 8, 1999, for the annual alumni lobster bake, co-hosted this year by Richard Pierson’55 and Keith’65 and Carol Brodie. Dean Pardes was unable to attend and was represented by Oscar Garfen’65, who delivered an update on the latest news of professorships, scholarships, and space expansion at the Health Sciences. Cornelius Tyson’43M, a Mainer by adoption, discussed the latest on the hospital merger and the new entity of New York-Presbyterian Hospital. Jameson Thissell’03 offered the student perspective. He was there with his wife, Sarah, director of the P&S Annual Fund.
Minority Dinner

Yvonnes Thornton’73, clinical professor of OB/GYN at the University of Medicine and Dentistry of New Jersey and best-selling author of a family memoir, “The Ditchdigger’s Daughters,” brought her special blend of wit and wisdom to the speaker’s podium at the annual dinner for minority students and alumni, co-sponsored by the Alumni Association and the Black and Latin Students Organization. Dr. Thornton, a respected perinatologist known for her work on chorionic villi sampling, also holds an MPH degree from Columbia in health policy and management. The movie based on her memoir was nominated for an ACE Cable Award. Born at Columbia-Presbyterian Medical Center in 1947, she returned in 1969 as a medical student. The years in between were years of trial, hard work, and endurance for her family. With the management skills of her father, she and her sisters and mother formed a successful family band, “The Thornton Sisters,” to help pay for their education. The band members appeared on the “Original Amateur Hour” on TV, won the amateur contest at the Apollo Theater, and went on to make a name for themselves on the college circuit. For the sisters, however, music was not an end in itself, but rather a means to a more ambitious end. The sound of success was sweet when her late father, Donald Thornton, had Dr. Thornton paged at Roosevelt Hospital, where she was the first woman resident in OB/GYN, just to hear the words “Dr. Thornton” echoing through the lobby. A specialist in high-risk pregnancies, she has delivered 5,044 babies. She and her husband, orthopedic surgeon Shearwood J. McClelland’74, recently celebrated their 25th anniversary. Dr. Thornton, who is also the author of a book for patients, “Woman to Woman,” and recently was the first woman to win the competition in public speaking of the Daniel Webster International Platform Association, concluded her inspirational remarks with the bold declaration: “Education is the answer to racism, sexism, nepotism. Excellence is the answer.” She and Dr. McClelland have established a scholarship fund for minority women in her parents’ name at P&S.
ALUMNI NEWS AND NOTES

By Marianne Wolff’52

1937
Ephraim P. Engleman, director of the Rosalind Russell Arthritis Center at UCSF, has received the University Medal of Honor. He is past president of the American Rheumatism Association/American College of Rheumatology and the International League Against Rheumatism. He is also the former chairman of the National Commission on Arthritis. His efforts have been in the areas of education and therapy.

1941
Irwin Perlmutter has been awarded the title of Distinguished Practitioner of the Southern Neurosurgical Society.

1945
Michael S. Bruno is director of medicine and the internal medicine program at Lenox Hill Hospital in New York.

1950
Roger A. MacKinnon, professor emeritus of clinical psychiatry at P&S, received a Centennial Medal at the 100th anniversary of the New York State Psychiatric Institute. He also was named “Teacher of the Year” by the senior residents; Dean Pardes re-named this award “The Roger MacKinnon Award for Resident Training.”

1951
Following publication of “Textbook of Women’s Health” in 1998, Lila Wallis had another book published, “The Whole Woman—Take Charge of Your Health in Every Phase of Your Life.” She received the 1999 Charles R. Drew Health Professional Award from California State University Associated Students Inc. and was named by American Health Magazine as a 1999 Health Hero.

1954
Hueston C. Kings fourth textbook, “Allergy in ENT Practice,” was published in 1998. He directed a national workshop in allergy for otolaryngologists, under the auspices of the American Academy of Otolaryngic Allergy, and is editing the annual allergy issue of Current Opinion on Otolaryngology.

1956
Walton K.T. Shim, professor of surgery and pediatrics, now has additional duties as chief of staff at the Kapidani Medical Center in Honolulu for a two-year term.

1957
The American Journal of Psychiatry reprinted Ralph N. Wharton’s article, “The Use of Lithium in the Affective Psychoses,” in its sesquicentennial anniversary issue; this paper was named one of the 10 best articles in the development of somatic treatment in 150 years of publication.

1962
Donald Caton, who teaches and practices anesthesia at the University of Florida, is also interested in the history of his specialty. His first book, “What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800,” was published by Yale University Press.

1963
John Noble has received the Robert J. Glaser Award from the Society of General Internal Medicine for his contributions in the areas of education, research, program development, and health policy. He was a co-founder of the society. He helped establish the Agency for Health Care Policy and Research. He is now vice chairman of the Joint Commission on Accreditation of Healthcare Organizations and will become chairman in 2001.

1964
Stephen F. Wang was appointed clinical professor of pediatrics at the University of Medicine and Dentistry of New Jersey in 1998.

1967
H. Ascher Seliner is president of the Wilson’s Disease Association and a board member of the National Association for Rare Diseases. He has sponsored a professorship in human genetics dedicated to the study of Wilson’s disease at the University of Michigan.

1965
Tom Delbanco has been named Master of the American College of Physicians. He also received the Harvard Dean’s Award for support of women faculty. Tom is professor of medicine at Harvard and chief of medicine and primary care at Beth Israel Deaconess Medical Center.

1970
Barry M. Massie co-edited “Heart Failure,” published by Churchill Livingstone. He has completed a six-year term as chairman of the FDA’s advisory panel. He is principal investigator of a 4,500-patient trial of antithrombotic therapy in chronic heart failure. He still resides in the San Francisco area.
1974
Frederick Kushner completed a six-year term on the executive committee of the Council on Clinical Cardiology of the American Heart Association. . . . The second edition of “Sapira's Art and Science of Bedside Diagnosis,” authored by Jane Orient, was published by Lippincott, Williams & Wilkins in September 1999.

1975
Steven R. Gambert is professor of medicine at Johns Hopkins University and chairman of medicine and physician-in-chief at Sinai Hospital of Baltimore. He also serves as program director of the Johns Hopkins University/Sinai Hospital Internal Medicine Residency Program.

1977
Rogbert F. Phillips has been named into the YWCA of Atlanta's 16th Academy of Women Achievers. She is clinical professor of surgery at Emory and Morehouse medical schools. Her major interests are breast and laparoscopic surgery. Previous honors include being named one of the Outstanding Young Women of America, being given the Harris L. Rogers Jr. M.D. Award of Excellence in Medical Journalism, and receiving the city proclamation from Atlanta's mayor for outstanding community service.

1980
The School of Engineering at UCLA has appointed Warren Grundfest chairman of the biomedical engineering program and professor of electrical engineering. He will continue in his positions as director of the laser research and development program at Cedars-Sinai Medical Center and as the Dorothy and E. Phillip Lyon Chair in Laser Research. . . . Celia J. Maxwell, a recipient of a Robert Wood Johnson Health Policy Fellowship in 1997, served as a legislative assistant to Sen. Tom Harkin, D-Iowa, until 1998. On returning to Howard University, she took on the dual roles of assistant vice president for health affairs and director of the university's Women's Health Institute. . . . Mark L. Zeidel has been appointed chairman of medicine and the Jack D. Myers Professor of Medicine at the University of Pittsburgh. Mark is a nephrologist with particular interest in the kidney's role in salt and water excretion. He received an NIH Merit Award for outstanding research and the Young Investigator Award from the American Physiological Society and is an associate editor of the American Journal of Physiology.

1984
The greater Miami Chamber of Commerce Health Industry Group has named Arnon Kronberg Physician Health Care Hero for 1999 for his work as founder and director of the South Florida Prostate Cancer Project. He is chief of urology at the Miami VA Medical Center.

1985
Peter Bolo has been named medical director of the Department of Psychiatry at Overlook Hospital in Summit, N.J. . . . Assistant professor of pediatrics and surgery at the Mount Sinai medical school, Edward Shlasko was appointed director of pediatric surgery at the Maimonides Medical Center in Brooklyn.

1991
David C. Cone is chief of emergency medical services at the Medical College of Pennsylvania-Hahnemann School of Medicine, where he is assistant professor of medicine. He is also editor of the Society for Academic Emergency Medicine newsletter and an associate editor of Academic Emergency Medicine and Prehospital Emergency Care. . . . Carlo Rosen is assistant director of emergency medicine at Massachusetts General Hospital in Boston.

1992
Brian McGovern, a fellow of the American College of Emergency Medicine, has been named medical director of Wilton, Conn., Emergency Medical Services.

1995
Douglas Holden was selected “Resident of the Year” by the orthopedic surgery department of Long Island Jewish Medical Center for 1998, corresponding to his PGY III.

1996
Scott Martin, an emergency medicine resident at the University of Michigan, has received a Society for Academic Emergency Medicine Resident Research Year Grant; he plans to study the use of myocardial contrast echocardiography in emergency patients with acute coronary syndromes. During his research year he will complete his course work toward an MPH degree.

Send news and photos to
P&S Alumni Association
College of Physicians & Surgeons
630 W. 168th St.
New York, NY 10032
A Horse of a Different Color

By Daniel C. Schainholz’87

The warm summer breeze cascaded gently over the rolling hills of Mountain View, Calif. The tall grasses swayed gracefully in the wind, parched by the sun to the color of gold for which the Golden State is so aptly named. I am no stranger to the Shoreline Amphitheater, nestled in the outskirts of Mountain View, after yet another summer of volunteering for Rock Medicine, a program of the Haight Ashbury Free Clinics Inc. of San Francisco. Rock Medicine is an all-volunteer group of physicians, nurses, and ancillary medical staff that provides free medical care to the patrons and staff of outdoor music festivals and similar events. This was the penultimate show of the summer season, the first of Neil Young’s two Bridge Benefit shows, an annual event to benefit the Bridge School for multiply disabled children. The premium ticket price drew a more mature audience and what should have been a generally peaceful evening. But fate had another plan.

About an hour before the show began, one of the mounted security team was brought in to the “main hospital,” as it is euphemistically called. She complained of having been thrown from her horse after an attack by a pit bull. She was brought to the makeshift emergency room in full C-spine precautions. Cervical fracture was ruled out on clinical grounds. Physical examination revealed a somewhat agitated 37-year-old woman with multiple contusions but no evidence of serious bodily injury. She reported that she would be fine, but her concern was focused on the well-being of her horse, Lee.

Apparently, the pit bull had leapt from the open window of a truck when it saw the horse and instinctively went for the horse’s neck. The horse reared up three or four times and eventually threw the mounted security guard, but the pit bull continued its relentless attack. The dog’s owner then restrained. (I later recalled the children’s story of “Andy and the Lion.”) A semblance of sterile technique was maintained during the repair, but the location of the wounds and the sheer size of the beast made the situation less than ideal.

I placed approximately 40 sutures in the chest wound. During the course of the repair, I was informed that the horse was not the gelding I had suspected but rather a “paint” stallion, an 800-pound stud horse. I was even more impressed with the restraint the horse showed as I stood under it performing the repair. I had somewhat of an epiphany when I became aware that the horse seemed to understand that despite the discomfort of the needle pricks, I was there to help. The concept of a “dumb animal” was inconsistent with the moment.

The repair of the shoulder wound was hampered by an involuntary shrugging reflex whenever I touched the wound edges. Suture repair was impossible, but I was able to get in a significant number of well-placed skin staples before the staples ran out. A veterinary nitrofurantoin ointment was presented to me by one of the other mounted security guards and I applied it to the wounds as a dressing. I returned to the main hospital and found that I had missed much of the show.

Compassion comes in all forms, and this horse was no exception. Rock Medicine is a wonderful outlet for me to practice “real medicine.” The relief of suffering has taken my career path in a very different direction. I am the director of a low-vision rehabilitation clinic in San Francisco and rarely prescribe a medication, much less perform surgery, outside of my volunteer efforts under the auspices of Rock Medicine. This foray into the world of the care of farm animals was certainly a once-in-a-lifetime experience.

Unfortunately, the beast belonged to an HMO (Horse Maintenance Organization) and reimbursement for this unauthorized emergency visit was denied. The animal had to pay “out-of-saddlebag.” Anyone need a couple dozen buckets of oats? :-)

Daniel C. Schainholz’87 and patient
DONALD F. TAPLEY, M.D.
1927–1999

Professor of Medicine since 1972
Alumni Professor of Medicine since 1984
Honorary Alumnus of the College of Physicians & Surgeons since 1985
Acting Dean, College of Physicians & Surgeons, 1973–1974
Dean, College of Physicians & Surgeons, 1974–1984
Senior Deputy Vice President for Health Sciences since 1984
Medical Editor, “The Columbia University College of Physicians and Surgeons Complete Home Medical Guide,” since 1984
Chairman, Editorial Board, P&S Journal, since 1996
Lub dub redub

Reinventing the stethoscope.

HP Stethos fully electronic stethoscope. Amplifies sound up to 14 times greater than conventional acoustic stethoscopes. Programmable, 8-level volume control.

The ultimate acoustic control.
Customer satisfaction guaranteed. Purchase your HP Stethos electronic stethoscope, any time day or night.

www.hp.com/go/hapestethos
1-800-225-0230

HP.

Hewlett-Packard