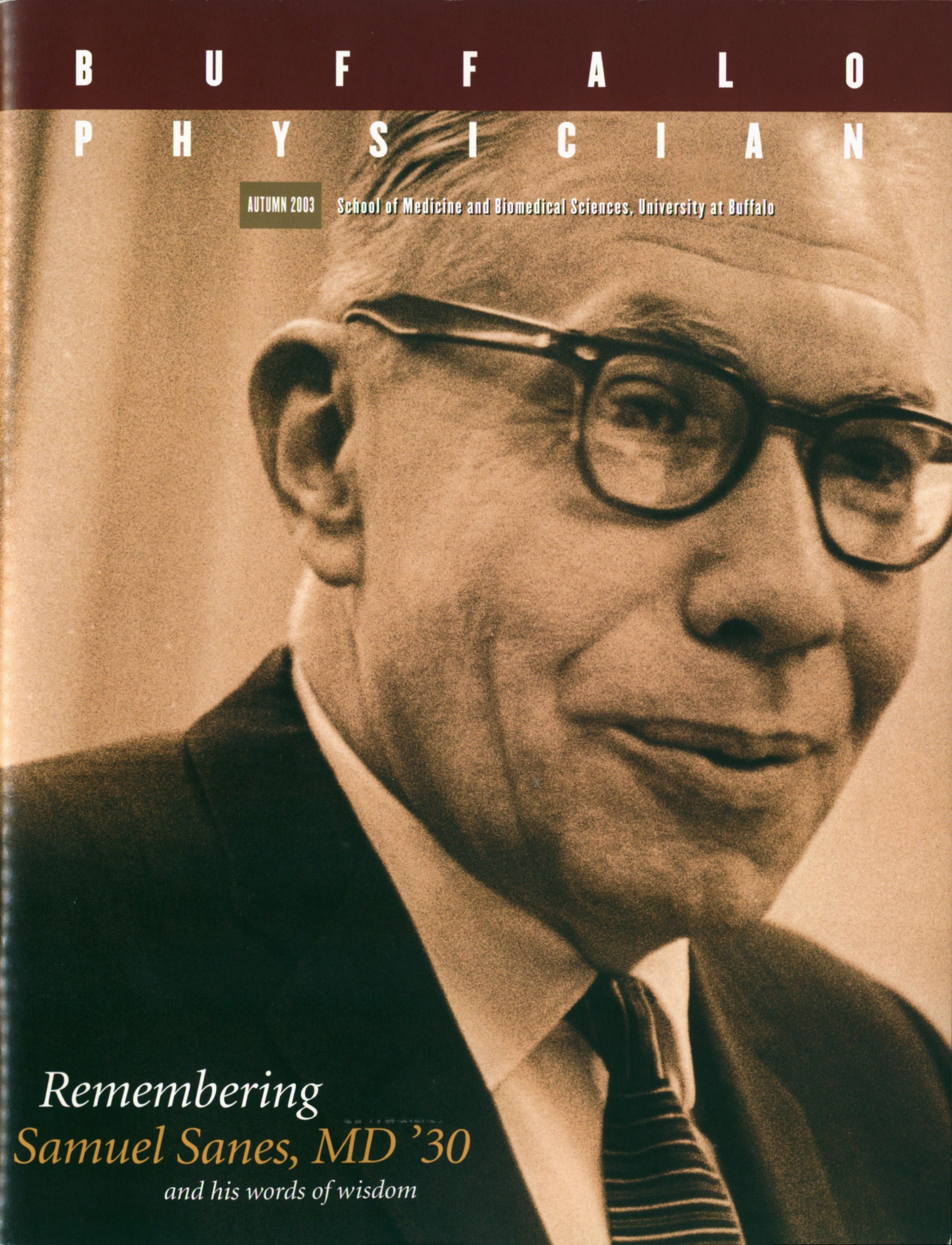


B U F F A L O P H Y S I C I A N

AUTUMN 2003

School of Medicine and Biomedical Sciences, University at Buffalo



*Remembering
Samuel Sanes, MD '30
and his words of wisdom*

Dear Alumni and Friends,

In August I had the pleasure of speaking to the Class of 2007 at their White Coat Ceremony. This ceremony is held as a symbolic "rite of passage" to mark their first steps towards entering the medical profession and emphasizes the importance of professionalism and empathy in the practice of medicine. I warned these students that part of our profession involves telling people things they don't want to hear. This is not restricted to telling a patient he or she is facing a fatal illness. We deliver far more mundane "bad news" on a daily basis. I recalled a colleague once telling me, "If you never want to see a patient again, tell them they're fat or tell them they're crazy. If you really never want to see them again, tell them they're fat *and* crazy!" While said in jest, this remark highlights how uncomfortable most physicians are about talking to patients about these issues. We don't want to embarrass an obese patient by bringing up the topic of weight loss, and as a result obesity has become a national epidemic. We don't want to upset a patient by suggesting that a referral to a psychiatrist would be helpful, so conditions such as anxiety and depression go untreated. Our discomfort with discussing these issues is hurting our patients and we need to address it.

Money is one of those topics that can be difficult to talk about. For years, our Medical Alumni Association has prided itself in being a "friend-raiser," not a fund-raiser. We were willing to solicit donations for class gifts at reunions, but otherwise wanted to stay at arm's length from the *perceived* distastefulness of fund-raising. We no longer have that luxury, because our discomfort with fund-raising is compromising the growth and evolution of our school.

Years ago, when my father, James A. Werick, MD '49, was chief of medicine at St. Francis Hospital, he was concerned about how little money the hospital had available for continuing education for the nursing staff. So he started a fund called "Gimme Your Dough" (I kid you not, that was really the name; subtlety was never my father's strong suit!). I once asked him if he found it embarrassing to strong-arm the medical staff (which by then included me) into making donations. Not at all, he assured me. Not only was he not embarrassed, he was proud to raise money for this worthy cause.

So today it is with pride, not embarrassment, that I am asking you to invest in the future of your medical school. Calvin Coolidge counseled us, "No person was ever honored for what he received. Honor has been the reward for what he gave." A recent cartoon in *The Chronicle of Philanthropy* showed one gentleman earnestly telling another, "I'm always embarrassed that I'm not giving more, so I don't give anything." Many of us assume that because we don't have the funds to endow a chair or a named scholarship, that our gift is meaningless. I assure you that every dollar donated makes a measurable difference in the quality of our school.

If you haven't already, you will be receiving a call from a student about making a gift to the annual fund for the School of Medicine and Biomedical Sciences. Your generosity will make a real difference and your investment will generate important and tangible returns for our students, faculty and programs.



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Letters to the Editor

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The staff reserves the right to edit all submissions for clarity and length.

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A look at how UB medical students and residents today are being trained to be skillful communicators







BY MARIA SCRIVANI




Photo by K C Kraft

Roseanne Berger, MD, senior associate dean for graduate medical education, *left*, and surgeons Robert Milch, MD '68, *center*, and James Hassett, MD, *right*, are leading efforts to teach communications skills to UB residents.


COVER: PHOTO OF SAMUEL SANES PROVIDED BY UNIVERSITY ARCHIVES

					
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Editor's note:




Samuel Sanes, MD '30, was a much-loved professor of pathology and legal medicine who taught at the University at Buffalo for forty years, retiring in 1971. In the 1950s, he was coordinator of *Modern Medicine*, one of the first medical shows on television. He was also a moderator of the university's *Summer Medical Roundtable*, a talk show first on radio, then television.  Sanes was dedicated to educating the public, and when he contracted cancer in 1973, he wrote a series of ten articles for *Buffalo Physician* on what he learned being a patient.

Remembering

 The articles evoked strong and widespread responses from readers; by the time the fourth article was published, Sanes had received more than 100 letters from 17 states and two foreign countries. The majority of writers were physicians, colleagues and former students representing 24 areas of medicine; others included residents, spouses of physicians, nurses, members of the religious community and the public, including cancer patients and their families.

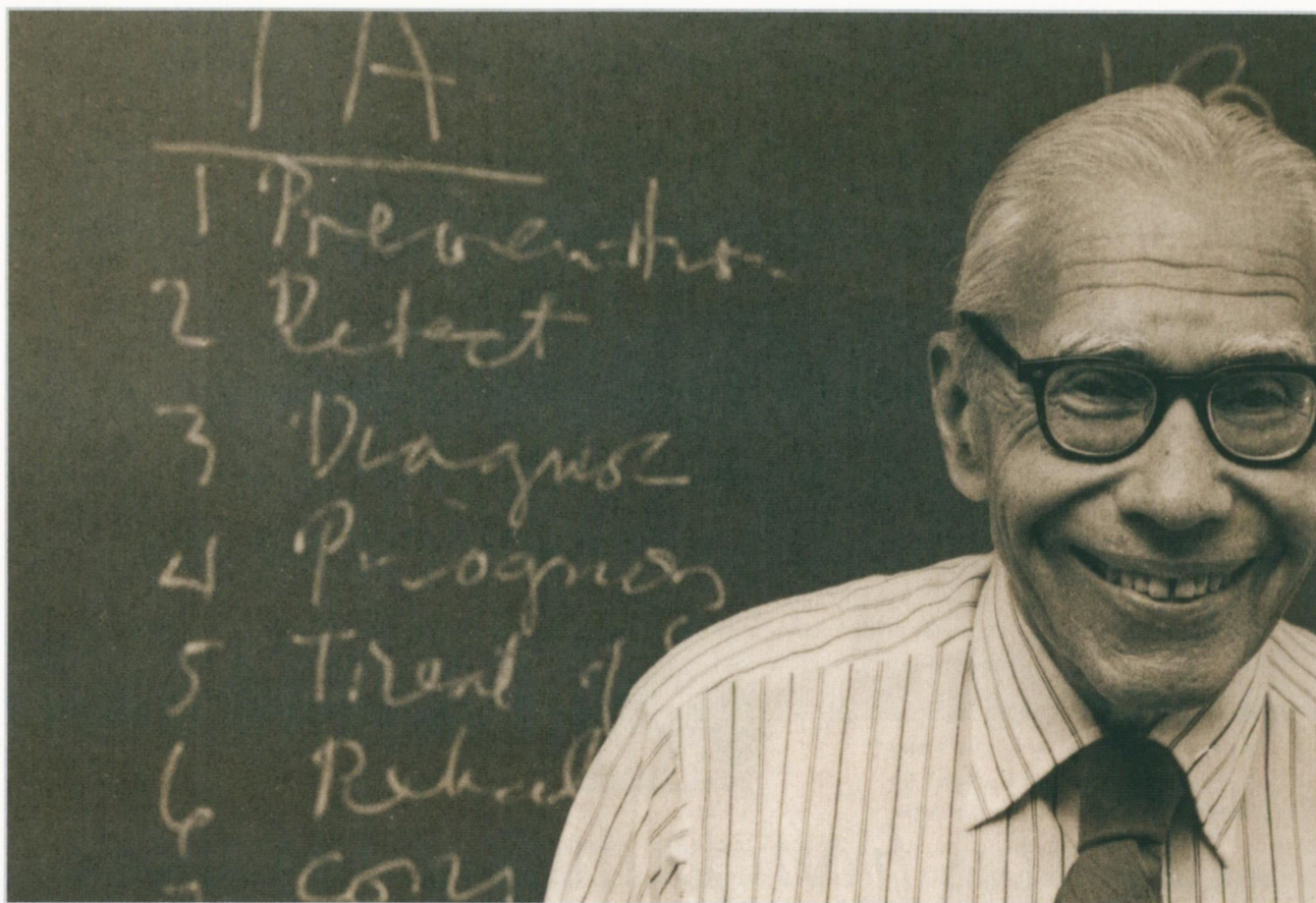
Samuel Sanes

P A T H O L O G I S T , T E A C H E R , F R I E N D

 This year marks the 25th anniversary of Sanes's death. In the following article, Jacob Steinhart, MD '45, a former student and friend of Sanes, honors this anniversary by reviewing and commenting on the articles Sanes wrote for *Buffalo Physician* about his illness.  In doing so, Steinhart acknowledges that, among other things, these articles played a role "in awakening our profession to the fact that medical students need to be taught communication skills while in school, rather than expecting them to learn these skills in a haphazard way through 'on-the-job-training.'"  He also commemorates the fact that "much progress has been made in end-of-life care over the past 25 years."

~S. A. Unger

ILLUSTRATIONS BY MICHAEL GELEN



In 1943, I was a medical student in Dr. Samuel Sanes's pathology class at the University of Buffalo* School of Medicine. I remember him so well. He was extremely popular.

No one fell asleep during a session with him, as his booming voice kept us alert and eager to be prepared when called upon. Some brave souls even volunteered to give answers. If a student did not give a correct answer, however, he was never berated or left to feel bad.

In the early 1970s I was invited to join the medical school's admissions committee and I sought Dr. Sanes's advice since he had been a member of the committee for many years.

He generously gave me advice, which made me enthusiastic, and three years of interesting experiences followed.

When he retired in 1971 after teaching at UB for 40 years, Dr. Sanes was looking forward to relaxation and travel. Because he was embarking on a new phase of life, he thought it advisable to have a thorough physical checkup. This he underwent, and his doctor gave him a clean bill of health except for previously detected cervical arthritis. He was ad-

vised to go ahead with the plans he had made for retirement and was not told to restrict his activities in any way.

Sadly, 17 months later, in February 1973, he found a lump on his shoulder that on biopsy showed disseminated reticulum cell sarcoma. He then had a complete diagnostic work-up, from urinalysis and blood count to lymphangiograms and total body gallium scan, which confirmed the diagnosis.

When I learned of Dr. Sanes's illness, I phoned him several times to see if he would like a visit. I felt close to him not only because of these calls and the earlier advice he had given me, but also because he had sent me postcards when he traveled abroad.

As his health continued to decline, he never had me over to visit. At first this left me disappointed and confused; later, I was able to understand his not wanting to be seen as his condition deteriorated.

He was a very courageous man.

He was a fabulous teacher.

He was always well organized.

He was a good friend and counselor.

~J.S.

*In 1962, the University of Buffalo, a private institution founded as a medical school in 1846, merged with the State University of New York system to become University at Buffalo, The State University of New York.

This year marks the 25th anniversary of Dr. Sanes's death. Those of us fortunate enough to be his students and his colleagues know that he not only was a talented teacher but also a gifted philosopher. This was demonstrated in a series of ten articles he published in *Buffalo Physician* between 1974 and 1978, titled "A Physician Faces Reticulum Cell Sarcoma in Himself," in which he chronicles his illness.

On the following pages are passages excerpted from these articles, along with brief commentaries I have added in an attempt to provide a context for Dr. Sanes's remarks where needed.

It is clear to anyone reading these passages—whether 25 years ago, or today—that Dr. Sanes hoped his experiences and insights would prompt physicians and other caregivers to closely reflect on how they care for and communicate with patients who have a terminal illness.

Certainly his writings had their desired effect on me, as having read them, I was—and am—more able to comfortably and competently visit and talk with cancer patients.

I can't help but think that Dr. Sanes's effort to publish these articles also played a role in awakening our profession to the fact that medical students need to be taught communication skills while in school, rather than expecting them to learn these skills in a haphazard way through 'on-the-job training.'

As Dr. Sanes's experience demonstrated, this former way of learning left a wide and lonely gap in the care provided to some patients and, at times, put the patient in the position of having to better educate the physician.

By publishing excerpts from these articles, it is my hope that we may be reminded of the fact that first and foremost Dr. Sanes was an exemplary teacher and that, through his writings, his legacy endures and is honored.

Perhaps by reprinting his words here we will also be reminded of how much progress has been made in end-of-life care over the past 25 years. This, in turn, may inspire physicians practicing today to rededicate themselves to ensuring that this momentum continues.

Excerpts from Buffalo Physician

Part I A Physician Faces Reticulum Cell Sarcoma in Himself

S

OMEONE ONCE SAID *cancer is a lonely disease. It is especially true if its victim is a physician.*

No one who hasn't faced cancer in himself can truly imagine what a cancer patient is experiencing. Even those closest to the patient, who love him, can only sympathize.

They can't empathize.

Individual reactions toward disease and death spring from individual minds and hearts. They depend on various factors in one's personal life situation, character and personality, social and cultural background, what one knows about his disease.

The cancer patient has not only a medical problem but a semantic one. The word "cancer" carries terrifying connotations accumulated over the centuries when it was practically 100 percent untreatable, incurable, fatal.



Dr. Sanes found that the first three months following his diagnosis were the most difficult, as they were devoted largely to treatment, follow-up examinations and resting at home. During this time, all of his physical problems seemed traceable to the radiation treatment; for example, loss of hair, loss and perversion of sense of taste, diminution of appetite, fairly constant nausea, dry mouth, painful swallowing, weight loss, fatigue, and an episode of herpes zoster with fever.

Before treatment he had no complaints apparently referable to his disease, except the lumps. He was active, met social obligations and traveled.

The disease and its treatment will be a monkey on a patient's back for the rest of his life. To the healthy person, even if he is no longer young, the future seems infinite. With his cancer diagnosis a curtain drops across it. Life becomes a matter of day-to-day planning. Goals are short-term ones.

There is gratitude for a remission and despair over a relapse or resistance to further treatment. Many patients have to curtail social, recreational, organizational and community activities... Before taking a trip he may have to make arrangements for seeing a physician or physicians at intervals during his absence from home.

To fight emotional and mental battles, Dr. Sanes formulated what he called "The Three A's": Acceptance of his disease, Adjustment to it, and

Assurance ... with the latter dependent on the attention, notice, understanding and sympathy of others.

When his cancer appeared, reason failed to allay and dispel his fearful thoughts and he became increasingly self-occupied. His fears were not so much for his life as for the loss of all that made life worthwhile and enjoyable: useful work, multiple interests, professional and personal relations.

His battle was won with time. Time, he found, was not only a medium in which reason could neutralize the potency of fears, but in itself acted as a diluent. His thinking and feeling became more positive. He determined to continue living and enduring, to make the best of life within the limits imposed by his disease, to fulfill as best he could his personal and social roles; in other words, not let the cancer take over all aspects of his life.

As the cancer patient adjusts to life with its limitations, through reason and determination or as many do, through faith and prayer, he also adjusts to death. No matter how self-sufficient the patient may have been before his disease was diagnosed, he cannot do it alone.

Like most cancer sufferers, I needed the assurance of others, wanted desperately to be remembered by family, friends, professional colleagues and co-workers.

Part II Responses of Lay Persons and Physicians to Patients with Disseminated Cancer



DR. SANES ATTENDED a clinic at Roswell Park Memorial Institute (now Roswell Park Cancer Institute), where he met patients with disease similar to his.

Forgetting the chronically ill—especially those with disseminated cancer—is easy for those who are chronically healthy.

When we do respond to disease in another person, we do so best when his illness is one that leads to recovery or cure after five to ten days in the hospital and a brief convalescence at home ... But what of the patient whose recovery is complicated; e.g., by a stroke? ... The visitors stop coming. The occasional person who does drop in enters the room reluctantly and departs as quickly as possible. Few Americans respond with understanding to chronic, lingering disease in other persons.

Patients with disseminated cancer carry the heaviest burden. Psychologically, I did need reassurance that I was still part of life. I didn't want to feel forgotten, discarded, cut off from the real world.

He quoted a nurse who had years of practice with cancer patients:

"People are cowards; they're terrified merely by the word 'cancer.' They don't want to see sickness or suffering. They

don't want to be reminded of death!"

Thus the patient with disseminated cancer, who must contend with his own fears, is deprived by the fears of the healthy of the assurance he needs. Unfortunately physicians in general have the same hang ups about cancer that lay persons do.

You might assume that as students in medical school and teaching hospitals they should have acquired a holistic and human approach to their patients, one that would enable them to look at anyone with cancer as a sick person with a variety of problems and needs, thoughts and feelings.

[The physician] looks at patients in terms of overcoming disease in as rapid a fashion as possible, or holding it in check over the long run. He is liable to think less about relief and almost not at all about comfort and consolation.

An empathetic physician can be the crucial factor in preventing a family from throwing away their time and money on quackery ... I realize that in what I have written about care and empathy for chronic "incurable" patients I may have done an injustice to today's medical

education and practice.

... during the past one-and-a-half years, with the exception of my immediate family, I have felt closer to no one more than my fellow lymphoma patients.

Dr. Sanes further felt that physicians who are trained in oncology approach the patient and his family in a more understanding way, yet hold out no false hope.

For medical students, Dr. Sanes quoted the following words from Dr. Frances Peabody, professor of medicine at Harvard University, who died from malignant disease at age 46:

"What is spoken of as a 'clinical picture' is not just a photograph of a man sick in bed. It is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, his sorrows, hopes and fears ... thus the physician who attempts to take care of a patient while he neglects this emotional factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiments ... Treatment of disease immediately takes its proper place in the larger problem of the care of the patient ... the treatment of disease may be entirely impersonal; the care of the patient must be completely personal."

Part III Responses of Professional Colleagues and Coworkers to a Physician with Disseminated Cancer



AM NOW—18 months after diagnosis of disseminated reticulum cell sarcoma and the onset of therapy—psychologically adjusted to my disease and its treatment. I am physically fairly comfortable and leading a satisfying active life intellectually and socially. Yet it is good to hear from old friends and former students, to know they are thinking of me, that I am not forgotten.

Based on his own experience, Dr. Sanes listed ways in which a physician should respond to a patient with disseminated cancer:

1. I would keep in touch with him, particularly during critical periods of his illness.
2. I would not necessarily express my assurance and good wishes in the conventional way ... such as those for a patient with a recoverable, controllable, curable disease.
3. I would determine whether he welcomes the opportunity to discuss his disease and its treatment and, if so, discuss it with him.



4. I would not overlook or minimize his symptoms or physical state and assume—or pretend—that everything is the same as it was before his diagnosis and treatment.
5. I would guard against revealing any undue pessimism or offering extravagant optimism on prognosis.
6. As to ways of expressing assurance, I would consider the needs of the patient.
7. As to discussions and conversations, I would keep in mind some patients with disseminated cancer want to talk openly about their disease.

Dr. Sanes found discussion of his experiences to be a catharsis. It helped him accept reality and make adjustments easier.

He appreciated receiving the following note from a former student of his,

Dana Launer, MD '73, who had been diagnosed with Hodgkin's disease while a second-year student. (Dana was in the last laboratory section Dr. Sanes taught before his retirement and, fortunately, his disease came under control and he graduated. Currently, he is chair of surgery at Scripps Memorial Hospital in La Jolla, CA. See related article on page 40; also, comments from John Wright, MD, on page 11.)

"Dr. Sanes, I heard through the medical grapevine of your illness and can't tell you what shocking news that was to me. To be faced with malignancy is never an easy experience, but to have this burden so soon after starting a 'new' life makes matters so much more difficult.

"I have felt the fear and frustration you feel now. I know very well what it is like to wonder what the future will bring.

"Carpe Diem.' We must learn to appreciate each day and prize every opportunity to enjoy our lives and loved ones."

Part IV His Relationship with Other Cancer Patients and Some of the Things He Learned from Them



As a surgical pathologist turned lymphoma patient I came to see cancer as more than a structural abnormality in a gross specimen and histologic specimen. I also saw it as involvement of the total human being in all the relatedness to himself, to other persons, and to the world around him ... I became keenly aware of the changes that cancer, particularly disseminated cancer, brings about in interpersonal relationships ... As a physician in the lymphoma-leukemia clinic of the



cancer institute I have found myself a source of information, a partner for scientific discussion, a depository for confidences and a provider of assurance and personal example to other cancer patients ... I have learned from my fellow patients ... of the fundamental mecha-

nisms of facing and coping with cancer, about the meaning of anger, of faith and prayer, of humor and wit, of mutuality.

I must go on. I'll beat this son-of-a-bitch.

This is the anger bent on life and survival. This is the anger I felt and expressed.

We derive our philosophic ways of coping from our upbringing, education and personal thinking and experiences.

Men and women who have prided

themselves on their self-sufficiency are no longer able to go it alone in the face of fear and depression, insomnia, pain, nausea and emesis, loss of weight, debility, cachexia and dehydration, urinary and fecal incontinence.

Dr. Sanes did not turn to the supernatural, but stated the following:

The cancer patient who believes in God as a loving Father, is never alone ... faith and prayer are important coping mechanisms for many cancer patients.

The wise physician will utilize a patient's faith and prayer as part of the therapeutic armamentarium ... He can call in a qualified clergyman to assist in the care of the patient, particularly if the patient indicates an interest in religion but has no clergyman of his own.

Conclusion



CANCER IS NOT a matter for levity and flippancy.

Cancer patients resent—even more than healthy patients do—any indication that others take cancer lightly.

A college girl composed ... an epic poem, covering the whole struggle for adjustment by the patient discovered to have lymphoma-leukemia:

'Mope

Hope

Cope'

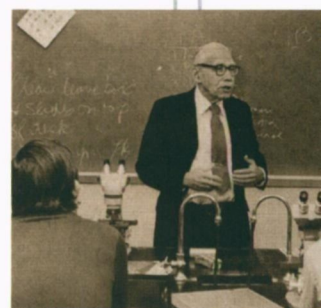
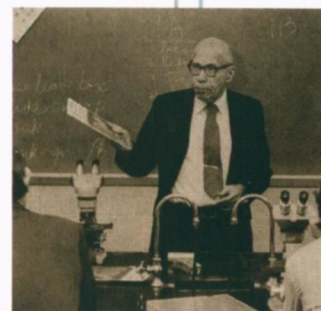
Humor, genuinely felt and expressed,

is an excellent coping mechanism for some cancer patients. It saves them from denying their predicament, from indulging in self-pity. It relieves inner tensions. It permits them to make other patients as well as themselves feel brighter and better.

Cancer patients identify with each other ...

The empathy of cancer patients for each other can be of real value as a coping mechanism ...

New patients are "surprised" and "relieved" that others felt helplessness, uncertainty and frustration just as they do.



Part V Response of Readers by Letter to Dr. Samuel Sanes's Series

There were many wonderful letters. The response to the series indicated that Dr. Sanes's experiences, observations

and reactions struck a common note beyond anything he had anticipated.

A typical letter stated, "I am glad

you chose to communicate your experience to us in order to help us treat our patients with more understanding."

Part VI, A, A Cancer: Its Effects on the Family of the Patient

Dr. Sanes introduced his next article, published in the winter 1976 issue of *Buffalo Physician*, with the following explanation:

In the autumn 1975 issue of Buffalo Physician, the Editors mentioned that my series of articles ... had ended 'for the present.'

A few months later, spending the

winter in Guadalajara, Mexico, I received a letter from a pathologist, one of my former students, who is now retired in Florida.

"What did that 'for the present' mean?" she asked? "When are you going to resume the series?"

Here is my answer.

How often I thought do physicians—healthy themselves and without the

experience of cancer in their immediate families—pay more than superficial attention to the family of a cancer patient for whom they have accepted primary responsibility?

The physician who accepts a cancer patient professionally ... has a dual responsibility. Primarily he is responsible for the well-being of the affected person, but also, in a measure for that of his family.

In any type and stage of cancer both may need help in coping with the initial psychologic shock and panic induced by the diagnosis.

Cancer in a family may be so divisive and destructive a force that it produces sufficient tension and friction to lead to estrangement, separation and divorce.

On the other hand, it may be so strengthening and unifying that it leads to a closer, deeper and more sustaining relationship than ever existed before.

Part VI, B, Cancer: Its Effects on the Family of the Patient



FOR SOME PHYSICIANS, communication with the family of the cancer patient is ... more difficult than communication with the patient ... Some physicians ... find it difficult to talk frankly and sufficiently, emphatically and helpfully with the family ...

The following are a number of factors Dr. Sanes identified in an attempt to explain this:

Even before applying for admission to medical school, some individuals through inborn and acquired influences develop a type of personality that will inhibit or prevent them from responding openly and confidently, understandingly and compassionately to

patients and their families as total, intimately related, interdependent human beings, especially in a chronic, serious illness like cancer.

Conventional medical education has done little to equip the young doctor with knowledge how to convey the diagnosis of a potentially fatal disease or how to offer continuing emotional support along with physical care.

Some primary care physicians relinquish their relationship with a patient and his family after they refer the patient to a center, clinic, group or specialist.

A physician who has cancer, and members of his family, can be just as vulnerable as lay persons to the mental, emotional, economic and other effects of the disease, sometimes more so. Lack of proper communication intensifies that vulnerability.

Some physicians may think or find themselves too busy professionally and personally to spend time communicating with patients and their families ...

I must be fair.

Sometimes communication with the family of a cancer patient is not a problem which lies in the physician's personality ... Rather, it's a dilemma imposed upon the physician by the cancer patient himself who requests that the family not be informed of his disease.

Part VI, C, Communication, continued

COMMUNICATION WITH a fellow professional or his family in regard to cancer involves the same consideration as communication with a layman and his family.

(It) should include not only the giving of the facts of the diagnosis and management of the disease, but help in understanding the treatment, course and prognosis. It embraces continuing professional attention, information and referral for certain practical problems that may arise (transportation, financial assistance, etc.) and psychologic

assistance and reassurance.

The patient who knows his diagnosis and understands his disease with its treatment and prognosis is better able to cope and adapt to it than the patient whose physician keeps him in the dark.

... and the knowledgeable, understanding family is better equipped to give him the day-to-day care and support he needs. In so doing the family is, at the same time, helping to preserve its own well-being, stability, unity, perhaps its very existence.

The physician, too, benefits from free and open communication with the family and with the patient. They will have more confidence in him, accept his recommendations and carry out his orders more faithfully.

(The physician) who so often feels defeated by medicine's failure when a patient dies may find positive satisfaction in continuing his relationship with and supporting the remaining members of the family.

Part VI, D, Communication, continued



WE MUST CONSIDER both the giver and receiver of information and support.

The first is the physician—or those members of today's medical team whom he calls in for communicating in their special fields of expertise.

The second is the family member or members who deserve, seek and need information and support.

Even when specialists enter the pic-

ture, the primary care physician should retain his relationship with the family, visiting the patient daily when he is in the hospital and continuing his visits as needed after the patient returns home.

Patients and family welcome ancillary personnel if they need and want information and support that their physicians cannot or will not give them.

Ancillary personnel can smooth the path almost every step of the way but ... will not satisfy patients and their families when it comes to information about the medical aspect and problems of their disease.

Part VI, E, Communication, continued



AT ALL TIMES the physician should tell the responsible family member or members the truth as far as it is known. That means during the initial workup, at diagnosis and throughout the entire course of the illness.

In his relationship with a family member, or members, a physician ought not be just a scientific diagnostician and therapist. He should also be an all-around compassionate communicator. He should supply factual information, educate, advise, counsel, make arrangements and referrals, support the family psychologically.

The family should be impressed with the fact that the threat of cancer never ends, even with a supposed "cure," and that it is good insurance to have periodic checkups.

(The physician) at no time should ... destroy hope by projecting personal feelings, fears and hang-ups. He should not make unjustified predictions based on his own lack of up-to-date knowledge and experience in oncology.

Hopelessness and helplessness may disorganize family life. They can send patients and families to other physicians or even lead them to consult quacks or to use scientifically unproven methods at a time when cancers may still be in controllable form.

Tell the truth as far as it is known from a scientific clinical basis. Beware of personal, emotional influences which project pessimism and defeatism or false optimism. Preserve hope if possible. Take all measurable and unidentified variables into consideration. Avoid specific chronologic predictions. Keep in mind the possibility of future diagnosis and treatment. Set up control as a more realistic goal than cure at a certain limit of oncologic knowledge and practice.



Samuel Sanes giving his final lecture upon retirement from the medical school in 1971.

Part VI, F, Communication, continued



OR THIS FINAL ARTICLE, Dr. Sanes no longer could write because of muscular weakness; instead, he dictated to his wife.

The **WAY** we tell a patient and the family is as important as **WHAT, WHY, WHEN** and **WHERE** we tell them.

... if a physician can't be all things to all people there are steps he can follow to communicate with all of his patients.

1. Establish rapport.
2. Be available and be on time.
3. Take time.
4. Go through the formalities of introduction. Be calm and poised, open but not casual, objective but not cold, warm and concerned.
5. Avoid interruptions.
6. Be truthful and honest within the limits of available knowledge.
7. Use simple, understandable English, not medical terminology or jargon.
8. Avoid expressing your thoughts and emotions in nonverbal form which may upset the patient or family (e.g., facial expression, tone of voice, etc.).
9. If the patient has cancer, say the word. And specify the type of cancer. When you do give a verdict of cancer, explain it.
10. Use a printed sheet or diagram to help get the message across.
11. Listen to the questions the family member asks and then answer them to the best of your ability.



12. See that the family gets information, education, advice and counsel about nonmedical problems that may arise as a result of the patient's cancer.
13. Give the family your phone number. Advise them they should feel free to call.
14. Advise the family that you will stick with the patient and with them for the duration of the illness and beyond.
15. Don't try to give all the information at one time. Be prepared to repeat ... and to expand upon it.
16. Keep the family informed as to new developments, including changes in treatment and reasons for them.
17. Keep your promises to the patient and the family.
18. Don't get angry if asked about a new proven or unproven treatment or procedure reported in the press or elsewhere and whether it could be applied to the patient's case.
19. Don't get angry if a friend of the family intervenes.
20. Preserve hope, encouragement and support as far as possible.

Here are some of the reactions he can expect from families:

1. No apparent reaction or denial
2. Psychologic shock
3. Tears
4. Anger or rage
5. Insistence on more communication, a second or third opinion, referral to another physician or to a medical or cancer center, a written report. Don't respond angrily.
6. An obsessive desire to know everything that is going to happen, and exactly how and when.

A final note by Dr. Sanes reads:

If I live long enough, if my physical condition permits and if Buffalo Physician is still publishing my articles, I shall write about the HOW of communication during the apparent terminal episode, of course based on my wife's observations and experience.

There were no more articles due to Dr. Sanes's death.

One can see that just as he taught us about tissues, organs, and the human body, he was even more determined to teach us about humanity, empathy and understanding of patients and their families facing the strong possibility of death from cancer.

We should be forever grateful. 



About the Author

Jacob M. Steinhart, MD '45, is a clinical professor emeritus of pediatrics at the University at Buffalo School of Medicine and Biomedical Sciences. From 1951 to 1995, he was in private and group practice in Amherst, NY, during which time he also served on the faculty of the UB medical school. He continues to teach one morning a week in the ambulatory clinic at Kaleida Health's Women and Children's Hospital of Buffalo, where he supervises students, residents and nurse practitioners.

Comments from Former Students and Colleagues

ONE OF THE MOST MOVING presentations I ever witnessed was one in which Sam teamed up with a UB medical student who, unknown to his classmates, was being treated for Hodgkin's disease.*

Since it was Friday afternoon, the class was, to put it mildly, 'restless.' He introduced the student and observed they had become close friends; then he asked what a young medical student and an older man like himself had in common. When the medical student replied, 'We both have cancer,' silence was immediate—you could hear a pin drop. Sam, as usual, had the students' rapt attention for the duration of the session and not only taught them the pathology of lymphoma but dealing with malignancy in general.

He was truly a marvelous human being and a teacher extraordinaire.

His former students—most of us getting a little on in years—fondly remember this outstanding mentor, educator and friend.

John R. Wright, MD

Professor of Pathology

**See page 40 for more about this student, Dana Launer, MD '73.*

DR. SANES SPENT much of his time at Millard Fillmore with the pathology residents and the OB/GYN residents ... He was always available to those of us who wished to learn and listen to his mini-lectures at our microscope. At these moments he was no longer the lecturer but an understanding teacher.

A few years later, something momentous occurred when this gentle, quiet, modest man startled us with articles about his own illness, and more importantly, how he had been received within the medical community.

In his later years he grew in stature. He became a voice for reform and compassion, and for some of us, a hero.

Ray G. Schiferle, MD

Clinical Assistant Professor Emeritus of Medicine

IT IS AN HONOR to be asked to comment on Dr. Samuel Sanes. I remember being so impressed with the series of articles he wrote in this very same [magazine]. Thankfully, I had a chance to express to him that I thought they should be required reading for everyone in family practice residency.

This is hereby recommended to every doctor who takes care of patients.

George Ellis, MD '45

Cornersville, Indiana

THE WEEK BEFORE SAM DIED, unable even to turn from one side to the other without assistance, he lay in his hospital bed in Roswell Park Memorial Institute. I sat at his side.

"Anyway," he murmured, knowing what lay ahead, "I still have my children."

For a moment I thought he was dreaming! "Children?" I asked.

"Yes," he replied, "my students."

That says it all. He loved you all. Thank you for loving him too.

Mrs. Mildred Spencer Sanes

Former Buffalo Evening News medical writer

Unabridged versions of the articles Dr. Sanes wrote for *Buffalo Physician*—and additional comments from former students and colleagues—can be read at www.smbs.buffalo.edu/bp. The articles are also published in a book, titled *A Physician Faces Cancer in Himself*, which is available at the University at Buffalo's Health Sciences Library.

Where ARE WE *Today?*

Assessing communication skills 25 years later

BY MARIA SCRIVANI

The practice of medicine, lately dominated by high technology and rampant pharmacology, is getting a heart transplant.

Credit a dedicated team of professors at the University at Buffalo School of Medicine and Biomedical Sciences for aiding in the development of this treatment, which focuses on training medical students and residents to be better communicators. Among other things, this includes education in ways to present bad news to patients, as well as how to skillfully address complex issues that arise in the care of patients with terminal or life-altering illnesses.

"It's not just about making patients feel better; it's about practicing better medicine," says Jack Freer, MD '75, an ethicist and UB associate professor of clinical medicine who helped develop the "How to Deliver Bad News" module in the clinical practice of medicine course at UB.

What is being taught today in the medical school classroom and on residents' rotations is "an alternative approach to being cool, collected and scientific," says Roseanne Berger, MD, a family physician and senior associate dean for graduate medical education at UB. It is

a return to the kinder, gentler medical art practiced before the mid- to late-20th century avalanche of information—and the more recent focus on costs—had a decidedly negative impact on the doctor-patient relationship.

Such was the insight of the revered UB professor of pathology Samuel Sanes, MD '30, who, prior to his death from cancer 25 years ago, wrote a series of articles in *Buffalo Physician* about his experience as a patient (see related article on page 2). "The physician looks at patients in terms of overcoming disease in as rapid a fashion as possible, or holding it in check over the long run," he wrote. "He is liable to think less about relief and almost not at all about comfort and consolation."

In the years since Sanes's death, an appreciation for the need to teach medical students and residents effective and sensitive communication skills has only increased, according to David Milling, MD '93, assistant professor of clinical medicine and director for the introduction to clinical medicine course for second-year medical students.

"What we've come to realize is how important it is for the physician to understand the impact information has on the patient. The patient must be made to feel comfortable asking questions and must get the answers needed," explains Milling, who is also assistant dean for multicultural affairs in the UB Office of Medical Education.

Giving students a global perspective is the goal, he continues. "They tend to have tunnel vision when they come in, thinking communication skills are important in delivering bad news to, say, a cancer patient. But it's much more than that. In a recent rehabilitation-medicine session, for example, we had a patient speak to a portion of the class about his experience with medical care. What he remembered most was *how* the news that he wouldn't walk again was delivered to him."

Starting about 25 years ago, three factors in health care began to push patient-physician communication skills to the foreground, according to James Hassett, MD, UB professor of clinical surgery and director of the medical school's surgical residency training program.

"The first was the realization that we had a responsibility to interact more effectively with patients who were dying," he says.

"The second factor was informed consent. How can a patient give this without being well informed?

"The third was malpractice—and, over the years, what we have learned is that physicians are vulnerable to this not because of what they *do* so much as what they say or don't say; that is, how they discuss issues with a patient and his or her family."

In the past five years, two additional factors have placed further emphasis on the need to train physicians to be good communicators, says Hassett.

"The first is that patients are much more knowledgeable about their health condition than they used to be," he explains. "They come to their physician's office with pages from the Internet and online queries and all sorts of other information. And they're right to do so, but they have much higher expectations and have learned to ask better questions."

The second new factor is that the Accreditation Council for Graduate Medical Education (ACGME) now requires that communication skills be taught to residents.

"And not only are we required to teach these skills to residents," Hassett notes, "but we must also *prove* that we have taught them before we can graduate the residents."

Berger points out that family medicine was the first area of medicine to formally recognize the importance of teaching communication skills.

"Ever since the inception of family medicine as a medical specialty, it has been mandated that all

teaching and training programs in the field include a psychologist or a behavioral scientist on its faculty to focus on teaching students and residents about communication and doctor-patient relations," she explains. "The expansion of this emphasis into other specialties has been very exciting."

STANDARDIZED PATIENT PROGRAM EXPANDED

A decade ago, UB instituted the Standardized Patient Clinical Competency Program to address concerns that third- and fourth-year students were not learning the skills necessary to forge good doctor-patient relations. Standardized patients are persons trained to portray patients in specific scenarios in order to help evaluate medical students' communication skills. "It's a way of carefully looking at performance and trying to improve it," says Karen H. Zinnerstrom, PhD, program coordinator for training and evaluation.

Since its inception, the Standardized Patient Program has expanded to include first- and second-year students, as well as residents.

During their first semester, first-year students are taught how to conduct a medical interview, including how to introduce themselves, how to elicit a chief complaint, how



Photo by K E Kratt

to do a history of personal illness, and how to take a pharmacy record, according to Zinnerstrom.

The students then combine what they have been taught and practice their skills with a variety of patients; for example they are required to complete a medical interview with a teenager and a geriatric patient. During the second semester, they also learn how to complete a medical interview with a patient involved in domestic violence.

In their second year, students take the "How to Deliver Bad News Module" and continue developing the clinical exam skills they were introduced to during the second semester of their first year.

"Currently, we also work with residents in surgery, family medicine and psychiatry," explains Zinnerstrom. "In psychiatry, for example, how do you tell someone that his or her son has schizophrenia? There are many different forms of bad news.

"Because we are teaching students and residents the skills required for such difficult interactions, I think they are a lot more comfortable than they used to be."

Getting doctors-in-training to hone their communications skills is sort of like "imprinting in ducks" in the sense that a skill learned early on is a skill retained and passed on, according to Robert Milch, MD '68, medical director for the Center for Hospice and Palliative Care and UB clinical professor of surgery and family medicine. "We have lost the opportunity to mentor, particularly at the bedside," he observes. "More and more medical work is being done in the office and at outpatient clinics. You don't get to see the great doctors at work anymore."

Milch sees a tremendous need for physicians to return to the old model of hands-on medical care, especially when treating highly symptomatic or terminally ill patients. "Our medical capabilities have rapidly outstripped our wisdom," he says.

PALLIATIVE CARE ELECTIVE

At Hospice, Milch and his colleagues oversee UB's palliative-care elective, designed to give participants "a full experience" with Hospice and palliative care—interdisciplinary care that addresses the multiple needs of patients with advanced illness. "They learn about our services, what we can offer, and when it is appropriate to make a Hospice referral," he explains. "They are taught about the hospice Medicare benefit on which all hospice care is based, regardless of whether someone is a Medicare patient or not. They spend time in the unit, and make home care visits with

doctors, nurses, social workers and chaplains, so they get to see the patient through other professional eyes. Too, they take part in team meetings and family conferences to get used to the idea of communicating frequently."

This is not the traditional multidisciplinary model, where the doctor is on top and "everyone else tags along after," emphasizes Milch. Communication in the old model is inconsistent, infrequent and too often "through the chart," rather than face-to-face or mouth-to-ear, he says.

In addition to gaining exposure to a rich hospice experience, participants in the elective also receive training in other kinds of palliative care, such as that available through Roswell Park Pain Clinic, where participants can learn firsthand about symptom management.

Within the elective, there is also a strong communication skills component, and the standardized patient program is implemented.

"The focus is on dealing with the family and psychosocial and spiritual issues," explains Freer, course coordinator for the palliative-care elective. This focus, he adds, must take into account the fact that "ours is a death-denying culture, and death has meant failure to us as physicians, as well as to the system within which we work."

Given this context, communication skills taught in the elective include how to begin talking to a patient about the possibility that there is no cure, that his or her hopes cannot be met, and that it is time to start thinking about hospice.

Establishing a comprehensive and patient-centered care plan is the goal under these circumstances, explains Milch. "The one thing we hammer home with residents and students is that they must ask: 'What are the patient's goals of care?' Then a plan of care is much easier to articulate. The goals might be to maximize comfort, provide psychosocial support to stressed family members, and to look at the body and mind needs in an advanced illness. It all adds up to better medicine for the patient and, professionally, it's a lot more gratifying for the doctor."

COMMUNICATIONS SKILLS—A CORE COMPETENCY

First-year surgical residents at UB are required to spend a week in the palliative-care elective, learning the kind of communication skills not generally attributed to those in this technology-driven specialty. (UB is one of the first schools in the nation to require this for surgical residents.)

"Communicating with a patient about routine health

concerns is one thing, but communicating about end-of-life issues is very different and hard for surgeons to do," says Hassett. "It's hard because they're accepting defeat."

"Many surgeons in training also have a sort of personal battle with cancer or trauma," he continues. "Although they realize they aren't going to be able to help everyone all the time, it's extremely difficult because they see themselves in that terminally ill patient and it forces them to admit, 'Hey, I'm just as vulnerable; that could be me.' So, it's a very complex process. That's why we place such an emphasis on learning these skills, not only in the one-week elective, but also at every conference we can, every activity."

Berger, who focuses on resident medical education, emphasizes the fact that the ACGME recently revamped its standards for residency program curricula across the country. "Communication skills have been identified as one of the core competencies physicians must acquire," she notes.

"Residents, as opposed to medical students, are playing a central role in patient care. My hope is that, through our initiatives, UB medical faculty and residents will become more comfortable with not just delivering bad news, but dealing with dying patients," she continues. "If your patients aren't comfortable sharing information with you, then you do not have all the data you need to treat them effectively, nor can you assist them in making informed decisions."

Hassett adds: "The most intimate thing you can do to someone else is operate on them, and if a patient is going to allow you the privilege of doing that, you have to be able to talk to them about their options and about the relative risk of doing a procedure. And if, as a surgeon, you don't have the communication skills to do that, it doesn't matter how much you know or how well you can perform a procedure. Sooner or later, you will have a real problem because the patient won't trust you."

The most common reason residents do not complete training today is their failure to communicate well, according to Hassett. "If they can't explain an issue to a patient or can't communicate well with other

physicians or colleagues, then we begin to exclude them because they can't compete," he says.

In an ongoing effort to teach residents how to communicate in a skillful, compassionate way, a new training tool called the National Wit Project was recently incorporated into UB's graduate medical education program at the suggestion of Milch.

Wit, a film in which Emma Thompson plays a literature professor afflicted with ovarian cancer, is a wrenching portrayal of a dying patient who does not receive the human contact she needs from her physicians. A copy of the film is distributed to all UB medical residents, who then attend discussions facilitated by Milch and Freer.

A ROAD MAP FOR DIFFICULT TERRAIN

In emergency medicine, physicians refer to the first hour of care following trauma as the "golden hour" because what happens—or doesn't happen—then determines treatment options from that point forward. For physicians working in the palliative-care setting, it could be said that the golden hour for their patients is the time they are told of the



serious nature of their illness, because *how* this information is presented will significantly affect the patient from that point forward.

Recognizing that the communication skills needed to deliver bad news in a caring, effective way are best learned in a supervised setting rather than haphazardly on the job, medical educators at UB have integrated the teaching of these crucial skills into the school's curriculum in recent years.

"When you give a patient unhappy news, it's difficult. And because it's something that's hard to do well, we've tended to avoid it. As a result, it's a skill that was not taught—until now," says Freer, who five years ago assisted Alan Baer, MD, associate professor of medicine, to develop the "How to Deliver Bad News" module at UB.

Though the structure of the module is continually being revised and updated, the key components remain the same. In a lecture format, Freer outlines a simple, clear protocol for breaking bad news, as developed by Robert Buckman, MD, an oncologist and professor of medicine at the University of Toronto. To help students quickly grasp the fundamentals of the protocol, the mnemonic "SPIKES" is used. "S" is for *setting*: arrange for privacy, close the door; both patient and doctor should be sitting down. "P" is for *perceptions*: find out what the patient knows. "I" is for *invitation* by the patient for the information: Do they want lots of detail? Is there someone else they'd like to be involved in the decision making? If a patient says, "Do you have my test results?"—that's an invitation to a dialogue.

"K" is for *knowledge*, as in sharing the knowledge. "E" is for *emotions*, and dealing with those emotions in a direct way. The final "S" is for *summarize*. Following the lecture, Freer shows a video of Buckman delivering bad news to a standardized patient. The class is invited to critique the doctor's performance, according to the objective outline.

"I've been doing this for about five years, and every year the students come up with new observations," says Freer.

The didactic portion of the program is followed by a more hands-on exercise that provides students with an opportunity to meet with patients one-on-one and in larger groups. Actual cancer survivors participate in a panel discussion with the UB class. Notes Freer: "This is a wonderful opportunity for students to learn from patients. How were they told about their disease? How might it have been handled better?

"In teaching clinical medicine, which is basically teaching someone how to practice medicine, there are cognitive elements—the book learning and the memoriz-

ing—in which all the medical students do well," he continues. "They're good at that; that's how they got into medical school in the first place.

"But then there are the skills like learning how to deal with actual patients. The truth is, [in this module] we're practicing on people; there's no other way to do it.

"People such as cancer survivors, who have been in dire situations, sometimes have been hurt by a caregiver's inexperience. That's why we take any opportunity to give students a chance to work with these patients, as well as standardized patients, *before* they talk to someone who is really vulnerable. It's as if we're providing a road map for how to do these things."

COMPREHENSIVE, INTEGRATED TRAINING

Milch envisions a coordinated curriculum in palliative care for all the health sciences schools at UB, a goal that is only partially attained right now, as each of the schools has at least some involvement with the program. "We need to start at the beginning of the education process to get that interdisciplinary communication going," he stresses. "Doctors should be learning early on to work with nurses and social workers."

In his articles in *Buffalo Physician*, the prescient Sanes warned 25 years ago of our current predicament when he commented that "... the treatment of disease may be entirely impersonal; the care of the patient must be completely personal."

At UB, the problem of physicians' poor interpersonal skills has been recognized and addressed, but how is progress measured? Anecdotally, there are many reports of residents and students feeling more comfortable and testing better in simulated patient settings. "In the real world, we have the instant feedback of compliments or complaints from patients," notes Berger. "Hospitals are asking patients to fill out satisfaction surveys after a stay, and physician communication skills are part of that."

In addition, the ACGME measures competency with tools like the "360-degree evaluation" in which residents are evaluated not only through the eyes of their attending physicians or their teachers but also through the eyes of nurses, other hospital staff, and patients, thereby providing multiple assessments of residents' skills. There also is a self-evaluation form, as well as peer-evaluation process in which residents observe and assess each other.


"Residents need to become good self-assessors," says Berger. "Some of our programs have begun to use portfolios in evaluations that contain written examples

of consultations, lists of procedures performed, letters from patients, and so on."

With all these efforts under way, Milch is full of hope. "It's a relief that we're finally doing something," he says. "We can identify deficits and figure out the tools we need to address them."

A challenge now, Freer concludes, is to "get this new

information out there, so more general internists, surgeons and neurologists who are teaching can incorporate it into their lessons and it becomes part of the medical culture.

"My hope," he says, "is that someday we won't need to teach these types of skills because everybody will be practicing them and learning from one another." 

Hospice Care in Buffalo

Almost 30 years ago, an ecumenical group of physicians, nurses, clergy members and University at Buffalo faculty members began discussing a concept that started in England. They wanted to bring to Buffalo a hospice, a unique organization that helps to comfort, counsel and care for the terminally ill and their families. Hospice Buffalo was born from these visionaries and celebrates its 25th anniversary of service this year. In fact, 2003 marks the silver anniversary of New York State's approval for hospice to become part of the state's health-care system.

Hospice Buffalo began in 1978 with 20 patients. Today, it is the core program of The Center for Hospice & Palliative Care, serving more than 2,400 patients a year in homes, hospitals, nursing facilities, adult homes, and at the Hospice Mitchell Campus in Cheektowaga.

—ROSEMARY COLLINS



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Medical Professionalism

UB selected to develop curricula

BY LOIS BAKER

The University at Buffalo School of Medicine and Biomedical Sciences is one of 10 medical schools nationwide selected by the American Medical Association (AMA) to participate in a new initiative aimed at integrating medical professionalism issues into the medical-school curriculum.

The initiative is called Strategies for Teaching and Evaluating Professionalism, or STEP. Nancy H. Nielsen, PhD, MD '76, clinical professor of medicine and interim senior associate dean for medical education, developed the UB medical school's proposal and will direct the project.

"We're delighted and honored to participate in this important undertaking," says Nielsen. "There's nothing more critical in the education of a physician than developing an understanding of professionalism."

Issues of professionalism unrelated to specific clinical proficiencies currently are addressed by each institution individually. Through the STEP project, the AMA aims to develop a set of educational tools that can be used by all medical educators and would establish consistency across U.S. medical education.

Today's physicians confront increasingly difficult ethical and professional challenges, given the scientific advances of modern medicine and the need to address issues such as end-of-life care, rationing of expensive medical technologies, potential conflicts of interest and disclosure of med-

ical errors, the AMA noted in announcing the selections. The 10 institutions taking part in the initiative will develop educational programs to incorporate these issues and others into a medical school curriculum.

UB's contribution will be to develop a model, four-year, self-directed course in professionalism. The plan involves Web-based and printed readings, case studies, standardized patient encounters, on-site experiences, and student journal keeping.

"There is a body of material that needs to be imparted," says Nielsen, "but the students also need to combine earlier knowledge with later experiences and to make the concept of 'professional' meaningful in their daily lives. Students need to reflect, to experience and to interact with faculty mentors who can serve as guides

and sounding boards for uncomfortable emotions and difficult situations.

"The integration we are planning combines a reflective look at the art and literature of medicine with their own daily encounters on the wards and a variety of experiences that we think are key to developing professionalism," she adds.

The readings, case studies and Web-based learning assignments will be based on specific study topics geared to each medical school year. The "Professionalism" course begins with the White Coat Ceremony that initiates students into the medical world. First-year issues to be addressed include medical codes and oaths, privacy and confidentiality, federal health-insurance regulations, paternalism in medicine, ethical disparities in medical care and impairment in health professionals.

Issues that will be studied during the second, third and fourth years of medical school include cultural competence, health literacy, domestic violence, end-of-life care, homelessness, human sexuality, organ donation, complementary medicine, spirituality in health care, ethics of managed

care and malevolent and benevolent uses of medical science.

Students will spend time at a refugee shelter, clinic for the homeless, hospice,

"Students need to reflect, to experience and to interact with faculty mentors who can serve as guides and sounding boards for uncomfortable emotions and difficult situations."

CONTINUED ON PAGE 21

2003 Humanism Award



Chester Fox, MD, clinical associate professor of family medicine, was presented with the University at Buffalo School of Medicine and Biomedical Sciences' Humanism in Medicine Award at this year's White Coat Ceremony. In addition to his teaching and practice responsibilities, Fox serves as sole physician advisor to UB medical student volunteers at the Lighthouse Free Medical Clinic.

Nominations for the award are made by students in the clerkship years.

In presenting the award, Charles Severin, PhD, MD '97, interim associate dean of medical education and admissions, read a composite of the comments made by students who nominated Fox for the award.

"I can think of no more deserving individual than Dr. Fox. He not only meets but far exceeds all of the attributes this award recognizes. Before the Lighthouse Free Clinic ever opened its doors, Dr. Fox worked tirelessly to establish its foundational building blocks. He selflessly set aside countless hours when we needed his guidance or that extra assurance that our dreams and our vision for this clinic were indeed obtainable.

"Dr. Fox consistently demonstrates compassion and empathy and delivers the same quality of care for the less fortunate among us as he does for his regular patients at Deaconess Medical Center. With our clinic's diverse clientele we are lucky to have Dr. Fox to demonstrate the sensitivity needed to develop a trusting, caring and productive relationship with all patients.

"It has been said that the most effective way to learn is by having a living example. Dr. Fox is ours."

Support for the Humanism Award is provided by the Healthcare Foundation of New Jersey. **BP**

—S. A. UNGER

White Coat Ceremony, a "Class Profile"

The sixth annual White Coat Ceremony at the University at Buffalo School of Medicine and Biomedical Sciences was held on August 15, 2003, in Slee Auditorium. During the ceremony, Charles Severin, PhD, MD '97, interim associate dean of medical education, shared the following "profile" of the Class of 2007:

Class Size: 135

Male-Female Ratio: 63 MEN, 72 WOMEN

Where They Call Home: 54 FROM WESTERN NEW YORK; 18 FROM EXTENDED WESTERN NEW YORK; 14 FROM UPSTATE; 30 FROM DOWNSTATE; 19 FROM OUT OF STATE

Age: AVERAGE AGE IS 23; THE OLDEST IS 34; THE YOUNGEST, 20; 12 ARE OVER 26

Academic Background: AVERAGE GPA IS 3.57; MEAN MCAT IS 9.48. ONE STUDENT HAS A PhD AND EIGHT HAVE A MASTER'S DEGREE; 109 ARE SCIENCE MAJORS AND 26 ARE NON-SCIENCE MAJORS

Number of Applicants: 2,063; INTERVIEWED 464

The White Coat ceremony is sponsored by the Arnold P. Gold Foundation, the University at Buffalo Medical Alumni Association, and the UB Medical School Parents Council.

Save the Date

The 2004 Spring Clinical Day and Reunion Weekend will be held April 30 to May 1 at Roswell Park Cancer Institute.

Events include the first-ever All Reunion Class Dinner at the Pierce Arrow Car Museum.

For more information, call the medical school's Office of Alumni Affairs and Development at (716) 829-2773; or email: kventi@buffalo.edu.



Residents Honored

Student Clinicians' Ceremony

Six University at Buffalo residents were presented the Arnold P. Gold Foundation Humanism and Excellence in Teaching Award at the Student Clinicians' Ceremony held on August 3, 2003, in Slee Auditorium on UB's North Campus. The ceremony was initiated last year by the School of Medicine and Biomedical Sciences' Professional Conduct Committee.

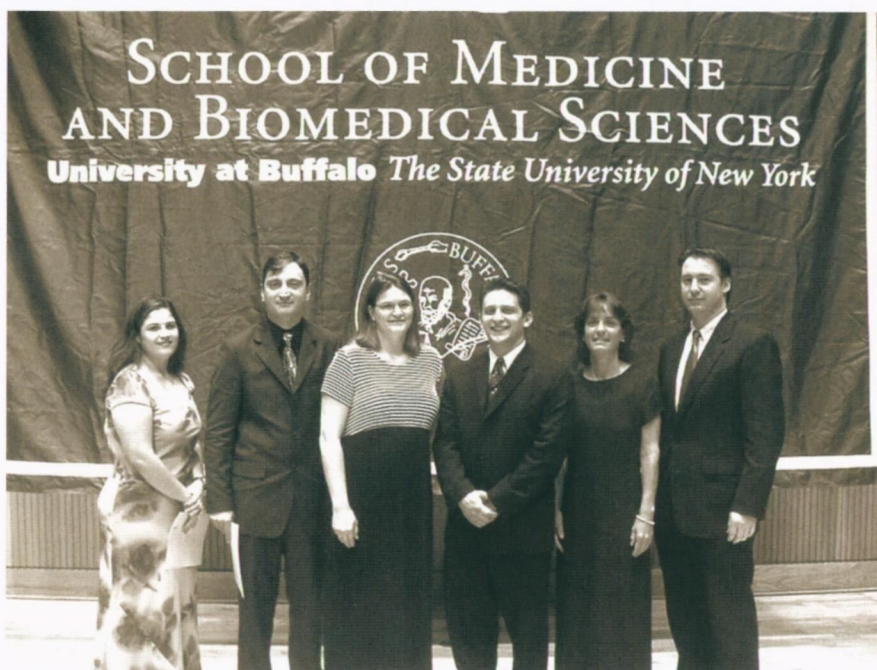
This year's awards were presented by Troy Pittman, Class of 2006, on behalf of

Recipients were chosen by the Class of 2004 based on demonstrating a commitment to compassionate treatment of families, students and colleagues. Residents selected to receive the award are listed below, followed by a comment by a nominating student:

George Deeb, MD, earned a medical degree from the University of Medicine in Budapest in 1998, after which he served a preliminary year in surgery at UB. Currently, he holds a position in psychiatry at the Medical College of Virginia.

"Dr. De Luca was always approachable and eager to help and teach me. Each day he tried to show me something new, and whether it was a new procedure or a new concept for me, he was the ultimate teacher. It was a pleasure to watch him and to learn from his interactions. I have come to think of Dr. De Luca as a mentor and a friend. He has all of the qualities of knowledge, understanding of disease, compassion and bedside manner that I hope to have one day."

George Deeb, MD, graduated from Damascus University School of Medicine in Syria, in 1995. He completed residencies in



Left to right: Jeanette Figueroa, MD '01; George Deeb, MD; Jan Penrose-Yi, MD; John Improta, MD; Toni Ferrario, MD, assistant professor of surgery, who delivered the keynote address; and Mark De Luca, MD.

anatomic pathology (1997) and anatomic/clinical pathology (2003), the latter of which was at UB. Currently he is an oncologic surgical pathology fellow at Roswell Park Cancer Institute. In 2004, he will begin a hematopathology fellowship at the University of Wisconsin, Madison, WI.

"Dr. Deeb is an outstanding teacher. He makes an effort to gradually increase students' responsibilities. He creates a relaxed environment that encourages discussion and questioning. He is always professional and respectful when interacting with colleagues. And, finally, he sets a superb example that I hope to emulate as I enter my residency."

John Improta, MD, a native of Buffalo, NY, earned a medical degree at St. George's

University School of Medicine. Upon graduation, he entered residency training in psychiatry at UB. Currently, he is resident representative for the American Psychiatric Association, Western New York chapter. In 2003, he received the Resident Service Award for outstanding service to the Department of Psychiatry.

"The special thing about Dr. Improta's teaching style is that he does not just talk at you. Rather, he draws the answers out of you, which builds your confidence and keeps you engaged. In addition to being a solid teacher, he demonstrates a professional attitude and solid ethical behavior. Dr. Improta personifies the energy and knowledge that medical students need to witness during their third year of medical school."

Jan Penrose-Yi, MD, a native of the City of Tonawanda, NY, graduated cum laude from Rensselaer Polytechnic Institute in 1992 with a bachelor of science degree in chemistry. She worked for several years as a medicinal chemist before returning to school to earn a medical degree at Michigan State University College of Human Medicine. Currently she is a second-year resident in obstetrics/gynecology at UB.

"Dr. Penrose-Yi is the type of physician that I want to be and the kind that I want as my doctor. She treats every patient with respect, regardless of their situation. She always has an encouraging word for her students and colleagues. When I think of an ideal physician, Dr. Penrose-Yi comes to mind."

Jeanette Figueroa, MD '01, a native of Buffalo, NY, graduated cum laude from UB in 1994 with a bachelor of science degree in biochemical pharmacology. She earned a medical degree from UB in 2001. Currently, she is a third-year resident in family medicine. Her outpatient clinic is located in Buffalo's Lower-West Side,

which is home to a predominantly underserved Hispanic population.

"Dr. Figueroa's most noteworthy characteristic is her sensitivity to others. She demonstrates compassion and empathy on a daily basis, not only to her patients, but to her colleagues and students. She is a role model of ethical behavior and cultural sensitivity. She knows what resources are available in the community so that she can provide advice that is specific and helpful. She treats all her patients with respect—so much so that you can't imagine her giving better, more sensitive care to her own family or friends. I hope to someday display a similar level of patience, empathy, sensitivity and competence in my teaching and clinical practice."

Emily Tenney, MD '02, graduated from St. Lawrence University 1997, after which she earned a medical degree at UB.

"From her dedicated teaching to her compassion and professionalism, Dr. Tenney is an intern that any medical student or physician would love to work beside. She respected and

Match Day

Correction

In the summer 2003 issue of *Buffalo Physician* it was incorrectly reported that Elizabeth Bourke, Melissa Franckowiak and Maria Podebry-Tsur-Tsar, Class of 2003, matched for residency training in anesthesiology at New York Presbyterian Hospital (Cornell Campus), New York. All three are training in anesthesiology in the SUNY at Buffalo Graduate Medical-Dental Education Consortium.

encouraged our desire to be active members of the team and therefore gave us the opportunity to do that. She not only answered our questions, but provided the context to apply the answers to other questions and situations. Her commitment to teaching is evident in every interaction she has with her students."

—S.A. UNGER

Medical Professionalism

continued from page 18

organ procurement agency and other sites as necessary. They will meet quarterly with faculty mentors to review their progress and to evaluate their understanding of the principles of professionalism studied.

Standardized patient cases, exams and essays will be used to assess students' competency.

"We've already begun planning activities," Nielsen says, "and we'll join with the other schools chosen in a fall meeting. Elements of the project will be implemented with the incoming first-year class."

Core faculty for the STEP program, in addition to Nielsen, are Margaret Paroski,

MD '80, professor of neurology, interim vice president for health affairs and interim dean of the medical school; Jack Freer, MD '75, clinical associate professor of medicine; Charles Severin, MD '97, PhD, associate professor of pathology and anatomical sciences and interim associate dean for medical education; David Milling, MD '93, clinical assistant professor of medicine and assistant dean for multicultural affairs; Robert Milch, MD '68, clinical assistant professor of surgery and medical director for the Center for Hospice and Palliative Care, and Jack Coyne, MD '85, clinical assistant professor of

pediatrics. David Block, incoming fourth-year medical student, who spent a year at the AMA Institute of Ethics before coming to medical school, will serve as the core's student advisor.

Also selected as STEP program participants were medical schools at Indiana University, Loyola University Chicago, McGill University, Michigan State University, New York University, University of Minnesota, University of North Dakota, University of Pennsylvania and University of Texas-Houston. **BP**

Lights,

BY M.K. KINNAMON

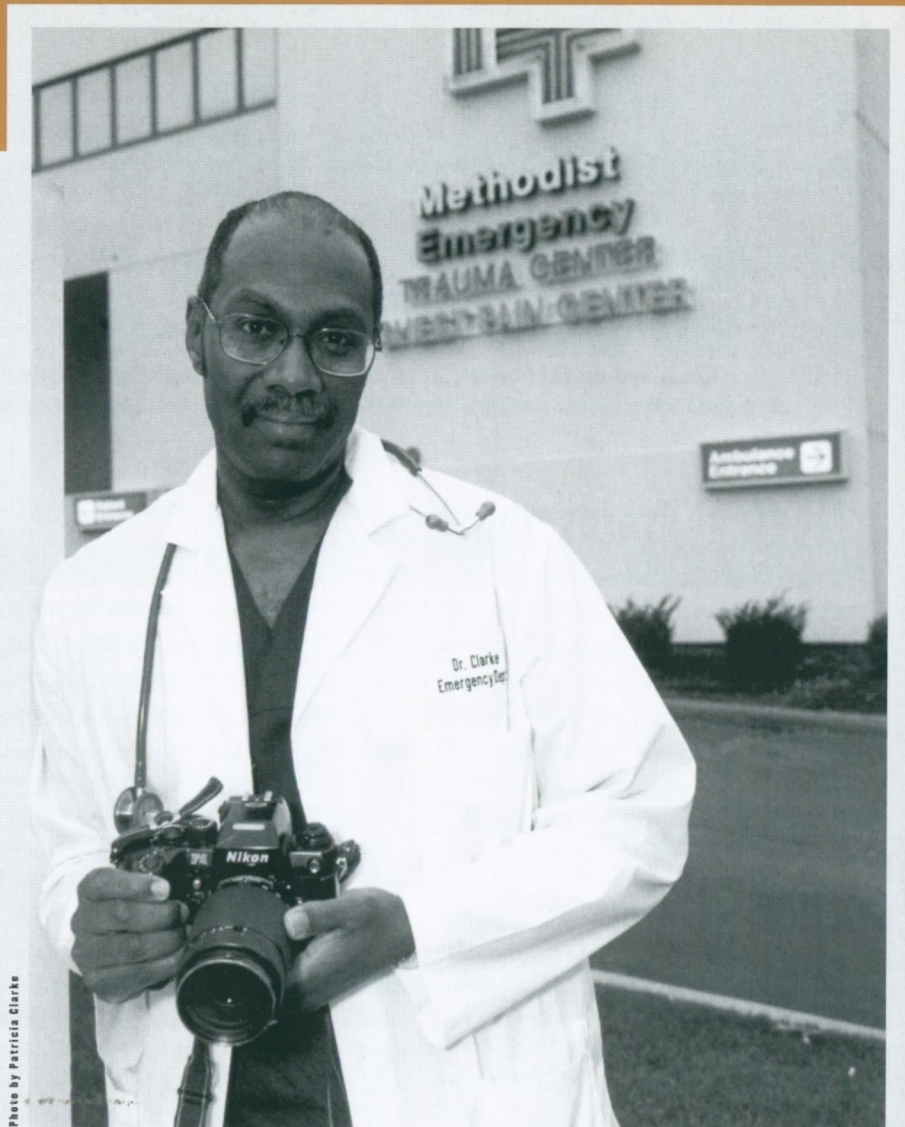


Photo by Patricia Clarke

Elsburgh Clarke

Camera. Suction

PHYSICIAN-PHOTOGRAPHER ELSBURGH O. CLARKE JR, MD '77

After 25 years as an emergency medicine physician, Elsburch Clarke, MD '77, is harmoniously in synch with an erratic and highly spontaneous line of work, the nature of which is aptly symbolized by the wide-angle lens and high-speed Kodachrome he reaches for to capture lives on film when he's not busy saving them.

In addition to his demanding work as a physician, Clarke is a professional photographer who, not surprisingly, is drawn to creating tableaux that are steeped in emotion and energy, whether they be of emergency departments, NASCAR race tracks, NFL end zones or U.S. Naval Academy midshipmen.

Clarke is currently medical director of emergency services at the Methodist Medical Center of Illinois in Peoria, Illinois, a 40,000-visit-per year, Level 2 trauma center. In this position, as throughout his career, he has successfully melded his dedication to medicine with his passion for photography, earning a reputation as a talented practitioner in both fields.

In 1997, photographs that Clarke entered in *Emergency Medicine News's* annual photography contest were selected "Best Overall" by a panel of judges, one of whom stated, "The emergency physician [who took these] may have missed his calling as a photographer."



Navy vs.
Georgia
Tech



In 1997, this photograph by Clarke was named "Best Overall" by the editorial board of *Emergency Medicine News* in its annual photography contest. It was taken at Milford Memorial Hospital in Milford, Delaware, where Clarke served as medical director of the Emergency Department prior to moving to Peoria.



Rather than feeling that he's missed out, Clarke prefers to think he's been extraordinarily fortunate to have the opportunity, and artistry, to fulfill his dual calling in life.

Born in Westchester County and raised on Long Island, Clarke remembers "always having an interest in photo-

graphy," but notes that it became more than a curiosity when he left home to attend Howard University in Washington D.C.

"My father used to take pictures, and he kept a scrapbook of his college days that he would show me," Clarke recalls.

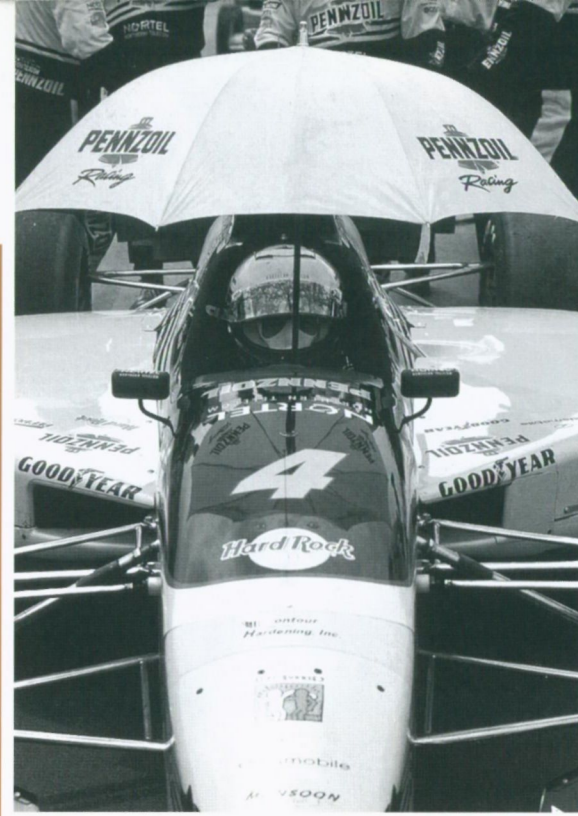
When it was time for Clarke to depart for college, his father gave him a Kodak Instamatic camera, thinking his son might like to chronicle his own college experiences. After graduating from Howard with a bachelor of science degree in zoology, Clarke bought himself a 35mm Pentax K1000 with his first American Express card. But it wasn't until he arrived at the University at Buffalo's School of Medicine and Biomedical Sciences in 1973 that his passion for photography started to become a force in his life.

Soon after arriving in Buffalo, Clarke began to take advantage of Western New York's world-famous scenery to improve his photography skills. "I lived in Tonawanda and I used to drive up to Niagara Falls in the dead of winter just to take pictures of the natural beauty," he says. "This allowed me to be outdoors, which I enjoyed."

Since Clarke had no formal training in photography, he learned by trial and error, by reading about photographic processes and by talking to other photographers.



**NASCAR,
Dover Downs**



**Indy Racing
League, Dover
Downs**



**San Francisco
49ers vs. the
Los Angeles Rams**

otos of his fellow classmates—between classes, at class functions, and any time an opportunity arose—gradually becoming a kind of unofficial documentarian of student life. Many of Clarke's photos from this time were published in the 1977 edition of *Iris*, the medical school yearbook. In particular, Clarke remembers how gratifying it was to have taken photos of classmate Leonard Spicer, who died several months before graduation.

The spontaneity of photographing unposed subjects is what appealed to Clarke early on, he says, as did the challenge of documenting the essence of a scene. "I enjoy capturing moments," he observes. "Every photographer's dream is to capture people's moments on film because those moments will never happen again."

After completing his internship at the University of California at Irvine, in 1978, Clarke began his residency in emergency medicine at the LA County/University of Southern California Medical Center. There he befriended Jeff Sipsey, MD, one of the attendings on staff, who was an experienced photographer with a strong interest in

working with black-and-white film. Using the darkroom facilities at the LA Arts Center, Sipsey taught Clarke how to shoot, develop and print black-and-white photographs, which further sparked his interest in the photo-journalistic style. It didn't take long for Clarke to get permission to photograph action in the hospital's ER and to launch an avocation that continues to the present day.

Following his residency, Clarke spent 13 years as a clinician and administrator in the emergency departments at a number of Los Angeles-area hospitals, including 10 years at Pomona Valley Medical Center, five of which were as assistant director of the emergency department.

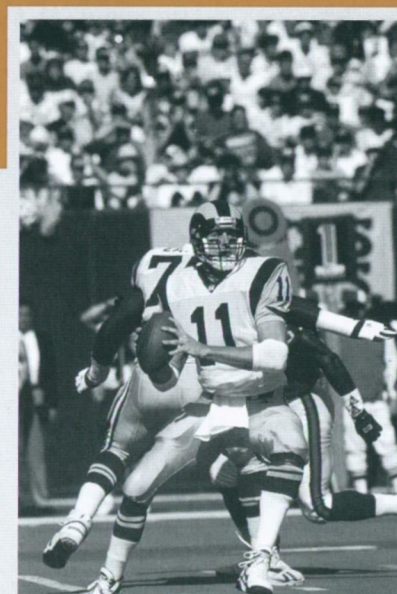
In 1993, he moved back East to become medical director of the emergency department at Bayhealth-Milford Memorial Hospital in Milford, Delaware, as well as medical director of the Sussex County Paramedics. At that time, the governor of Delaware also appointed him to the Emergency Medical Services (EMS) Improvement Committee and the EMS Oversight Council. In addition, Clarke served as chair of both the State Trauma Committee and the Sussex County EMS Advisory Committee.

While living in Delaware, Clarke continued to photograph hospital ERs, often collaborating with his wife, Patricia, also a photographer. Together they shot thou-



Firefighters, Los Angeles County Fire Department

Rams' quarterback in a 1993 game against the Giants



sands of emergency department photos in hospitals where Clarke worked, as well as at Bellevue Hospital and Bronx Jacobi Medical Center in New York City, and while accompanying paramedics at trauma scenes.

In 1997, Clarke was named photo editor for the magazine *Emergency Physicians Monthly*, a national trade magazine, and in 2001, a chapter he wrote, titled "Medical Photojournalism," was published in the *Handbook of Medical Photography*. An accomplished essayist, Clarke also published a series of photojournalism features for the regional magazine *Delaware Today* between October 1999 and June of 2000. These included an article titled "On the Edge," which gave an insider's view of two hospital emergency departments, including Bayhealth-Milford Memorial Hospital; an article, titled "Crash Course," on the NASCAR medical clinic at Dover Downs, where he'd worked as both a photographer and a physician; an article profiling three female midshipmen from Delaware who were attending the U.S. Naval Academy; and an essay about a historic black barbershop.

Sports photography, another one of Clarke's specialties, has led to freelance assignments with several National Football League teams, including the Philadelphia

Eagles, the Miami Dolphins and the former Los Angeles Rams. He has also completed assignments for the U.S. Naval Academy football team, NASCAR, and the 1995 United States Olympic Festival Committee.

Though action in the ER can at times be as fast-paced as a sporting event, Clarke's approach to photographing ER scenes is somewhat different. He almost always uses black-and-white film instead of color, which results in more dramatic pictures, he says, and avoids the greenish tint so often inherent in photos taken under an ER's fluorescent lighting. He rarely uses a flash, preferring instead to use a faster film speed of at least 400 or higher in whichever one of his eight Nikons he's using that day. He takes lots of pictures, sometimes as many as 30 to 35 rolls of 36-exposure film. (When using a motor-drive camera, as

Clarke does, and shooting 1 to 2 frames per second—compared to the 3 to 5 frames per second in sports photography—it's easy to go through a lot of film.)

Looking back on some of the photos he took 20-odd years ago, Clarke notes that he has not only chronicled patients and their caregivers, but also a bit of medical history. He says it's interesting to see that some equipment used at the time, such as an EKG machine, looks dated now because of rapidly changing technology.

When taking photographs, Clarke says he tries to capture the intensity, emotions and feelings of his subjects. "I like to photograph the eyes," he explains. "I like clarity; I like close-ups of a person's hands."

Clarke feels that one of his most enduring medical photographs in terms of emotion and intensity is a black-and-white shot he took of a surgeon holding a heart, "cradling and massaging it over the patient's open chest, literally holding life in his hands."

Since moving to Peoria in November 2000, Clarke

says he hasn't had as much time for taking pictures as he would like due to his increased responsibilities and the emergency department's high patient volume. Still, he and his wife plan to continue working on a book that will be a series of photo essays about the daily activities of emergency medical physicians, nurses and staff. When envisioning this ambitious project, Clarke says he'd like to take advantage of his close proximity to Chicago, two hours away, to shoot some of that city's ERs.

Another project he's considering is a 24-hour photo essay on Peoria.

Would Clarke ever give up emergency medicine for photography?

"Maybe—if I won the lottery," he says with a laugh. "But I love the ER, too," he quickly adds. "With photography I get to meet people and it's an extension of what I do every day, which is take care of people. Ultimately, it's about capturing moments: I love people, and I love to capture their expressions. To me, that's priceless." **BP**

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NEWS ABOUT UB'S SCHOOL OF MEDICINE
AND BIOMEDICAL SCIENCES AND ITS
ALUMNI, FACULTY, STUDENTS AND STAFF

AUTUMN 2003

Pathways

Fischer Joins Bioinformatics Center

Daniel Fischer, PhD, who coordinates the bioinformatics track at Ben-Gurion



FISCHER

University of the Negev in Beer-Sheva, Israel, has been named director of educational programs for the University at Buffalo Center of Excellence in Bioinformatics.

FISCHER WILL DEVELOP UB'S EDUCATIONAL PROGRAMS IN BIOINFORMATICS AT THE UNDER-GRADUATE AND GRADUATE LEVEL, AS WELL AS CERTIFICATE PROGRAMS.

In addition, he will serve as a professor in the Department of Computer Science and Engineering in the UB School of Engineering and Applied Sciences.

As director of educational programs for the UB Center of Excellence in Bioinformatics, Fischer will develop UB's educational programs in bioinformatics at the undergraduate and graduate level, as well as certificate programs. He will also teach and conduct research in the UB Graduate School of Education.

For the past five years, Fischer has been with Ben-Gurion University, where he is a tenured senior lecturer in its Department of Computer Science. He holds a bachelor's degree in computer science from Universidad Autonoma Metropolitana in Mexico, a master's degree in computer science with honors from Technion, Israel Institute of Technology and a doctoral degree in computer science with honors from Tel Aviv University in Israel.

Before joining the faculty at Ben-Gurion, Fischer was an assistant researcher in the Molecular Biology Institute at UCLA from 1995–1998. He also has worked as a CAD developing engineer with Intel in Haifa, Israel, and as a postdoctoral fellow in the Department of Mathematical Biology at the National Cancer Institute of the National Institutes of Health.

—ARTHUR PAGE

Kuramitsu Elected a Fellow in the AAM

Howard Kuramitsu, PhD, University at Buffalo

Distinguished Professor in the Department of Oral Biology in the University at Buffalo School of Dental



KURAMITSU

Medicine, has been elected a fellow in the American Academy of Microbiology, an honorific leadership group within the American Society of Microbiology. One of only 1,800 scientists elected to fellowship status in the academy's almost 50-year history, Kuramitsu was recognized for his work defining virulence factors of potentially pathogenic oral biology.

Kuramitsu holds a joint appointment in the Department of Microbiology in the UB School of Medicine and Biomedical Sciences and is a member of the Center for

Behling Endows *Dermatology Chair*



At his 60th Class Reunion in April, Ralph T. Behling, MD '43, announced plans to endow a \$1.5 million chair in dermatology at the University at Buffalo School of Medicine and Biomedical Sciences.

"Dr. Behling's generous gift will help the University at Buffalo attract nationally known faculty to the Department of Dermatology," says Margaret W. Paroski, MD '80, UB interim vice president for health affairs and interim dean of the School of Medicine and Biomedical Sciences. "Although he moved across the country years ago, he has never forgotten his roots here at UB, and for that we are grateful."

A native of Buffalo, NY, Behling graduated from UB with degrees in pharmacy and medicine. His remarkable career as a dermatologist and his pioneering work with penicillin and the Pap test were highlighted in the summer 2003 issue of *Buffalo Physician*.

The chair, which will be known as the Rita M. and Ralph T. Behling, M.D., Chair in Dermatology, in part memorializes his first wife, who died in 1998 and who also was a UB graduate. Behling says his motive for endowing the chair is to ensure that "future students enjoy the same kind of quality education I had at UB."

Behling lives in San Mateo, CA, with his second wife, Eileen. Between them, they have ten children, all over age 40.

—Lyn Corder, PhD, associate dean

Advanced Molecular Biology and Immunology (CAMBI) at UB. He and his colleagues have found that oral bacteria can exchange genes, raising the possibility that organisms in the oral cavity can be transformed from harmless to destructive, and from antibiotic-susceptible to antibiotic-resistant.

—SUE WUETCHER

Fudyma Named Medical Director

The Erie County Medical Center (ECMC) Healthcare Network Board of Managers has appointed John R. Fudyma, MD '85, to the position of medical director of the Healthcare Network.



FUDYMA

Fudyma previously served as associate medical director of ECMC (2001–2002) and as a member of the ECMC board of

managers (1998–2001). He is currently associate professor of clinical medicine in internal medicine (1998–present) and associate program director of the Internal Medicine Residency Program A (1996–present) at the UB School of Medicine and Biomedical Sciences.

Originally from Utica, NY, Fudyma obtained his undergraduate degree in biology from Hamilton College, Clinton, NY, and his medical degree from UB in 1985.

He completed his residency in internal medicine in Buffalo (1990) and a year as chief medical resident at ECMC (1991).

—JOE CIRILLO

Urologic Oncology Chair Named

James L. Mohler, MD, has been named chair of the Department of Urologic Oncology at Roswell Park Cancer Institute (RPCI). He comes to RPCI from the University of North Carolina

(UNC), Lineberger Comprehensive Cancer Center, Chapel Hill, NC, where he



MOHLER

served as associate professor of surgery, associate professor of pathology and laboratory medicine, and director of the UNC Prostate Cancer Research Program.

At RPCI, Mohler will work with Robert Huben, MD, chief of clinical urology, on training programs for urologic oncology residents and fellows, as well to enhance as RPCI's translational research activities.

Mohler received a medical degree from the Medical College of Georgia, Augusta, GA, and completed an internship in internal medicine at Duke University Medical Center, Durham, NC. He completed residency training in surgery and

urology at the University of Kentucky Medical Center, Lexington, KY, and a research fellowship in urologic oncology at The Johns Hopkins University School of Medicine, Baltimore, MD.

—DEBORAH PETTIBONE

Vision Research Funded by NIH

Two researchers in the University at Buffalo School of Medicine and Biomedical Sciences have received grants from the National Institutes of Health to conduct research into the function and development of the human vision system.

Malcolm M. Slaughter, PhD, professor of physiology and biophysics, has received a grant of \$369,700 to study the different ways in which glycine can increase vision clarity and benefit the nervous system.

A pioneer in the study of vision, Slaughter has

CONTINUED ON PAGE 31



BREAST CARE CENTER OPENED

KENNETH
ECKHART JR

LISA A. HANSEN



RICHARD W. ERBE

In July 2003, Kaleida Health opened its Breast Care Center on the fifth floor of the Women and Children's Hospital of Buffalo. Staffed by eight, the center includes state-of-the art mammography equipment, ultrasound, a patient resource center, and a stereotactic core biopsy suite. In addition, genetic counseling and evaluation are provided for patients and families.

The Breast Care Center's concept—which is to provide patients optimal diagnoses and treatment in days, instead of weeks—was developed by breast surgeon and center director **Kenneth Eckhart Jr, MD '68**, assistant clinical professor in the University at Buffalo School of Medicine and Biomedical Sciences.

Eckhart is a founding partner of Breast Health Associates, a private practice focused on the evaluation of management of breast conditions. Prior to joining Kaleida Health in October 2002, he served as chief of surgery at the Sisters of Charity Hospital in the Catholic Health System.

Lisa A. Hansen, MD '91, was recruited back to Buffalo to serve as a dedicated mammographer at the Breast Cancer Center. Following graduation from UB medical school, Hansen completed a pediatrics internship at Children's Hospital of Buffalo. She finished her residency training in radiology at the University of Toronto, followed by a breast imaging fellowship at Thomas Jefferson University in Philadelphia, PA. Prior to joining Kaleida, Hansen was director of the Breast Imaging Clinic at the University of Mississippi in Jackson, MS.

The Genetics Division located at The Women and Children's Hospital, led by **Richard W. Erbe, MD**, will provide genetic counseling and evaluation for Breast Care Center patients. **BP**

Hospital Name Change

THE WOMEN AND CHILDREN'S HOSPITAL OF BUFFALO



In April, Kaleida Health's Children's Hospital of Buffalo was renamed The Women and Children's Hospital of Buffalo. One impetus for the change, as reported in the KaleidaScope newsletter, was a decision by the hospital's OB/GYN group to remain at the facility, where it will play a key role in the development of new services for women in the entire Kaleida Health organization.

Another reason for the change was the hospital's history of offering specialized services and facilities for women, including care for low- and high-risk pregnancies, a perinatal center, and The Breast Care Center.

"We've been caring for women for more than 85 years. The staff is very excited that the hospital is being recognized for the work we do for women," says **Craig L. Anderson, MD**, the hospital's chief medical officer and Kaleida Health vice president.

In a parallel move, Kaleida Health is looking at the gap in women's services nationwide, asking health-care professionals, community leaders and women what services they'd like to see offered, according to **Cynthia Ambres, MD**, executive vice president and chief medical officer for Kaleida Health.

"It's critically important for us to listen to what the community has to say as we work to develop a strategic plan for women's services throughout our system," she says. **BP**

CONTINUED FROM PAGE 29

published past research findings in *Nature* and *Science*, as well as in leading journals in the vision field. His research focuses on information processing in the retina; in particular, the events that occur at synapses.

Shahrokh C. Khani, MD, assistant professor of ophthalmology and biochemistry, received a \$271,703 grant to study the enzyme rhodospin (which can cause retinal disease) and the susceptibility of the retina to light-induced injury and how to prevent

such injury. His research group is studying the molecular basis of inherited retinal diseases and is focusing on developing gene-directed therapeutic approaches for these blinding disorders.

—SUE WUETCHER

Bodkin Wins Top Research Honors

A project submitted by John J. Bodkin, III, a master's candidate in physiology in the University at Buffalo School of Medicine and Biomedical Sciences, received

second place at the annual international meeting of the Underwater Hyperbaric Medical Society held in Quebec City, Quebec. His project was titled "Prevention and Treatment of Decompression Sickness: Potentially Field-Usable Methods to Enhance Inert Gas Elimination."

Bodkin, who earned a bachelor of science degree in



BODKIN

physiology and neurobiology in 2000 at the University of Connecticut, was mentored on the project by Claes Lundgren, MD, PhD, professor of physiology and biophysics at UB and director of the university's Center for Research and Education in Special Environments. Timothy B. Curry, MD, PhD, at the Mayo Clinic in Rochester, MN, collaborated on the project.

Bodkin plans to continue research in hyperbaric medicine and to pursue a doctorate in physiology.

—S. A. UNGER

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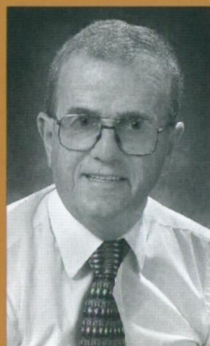
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Dean's Award

THE DEAN'S AWARD IS GIVEN IN SPECIAL RECOGNITION OF EXTRAORDINARY SERVICE TO THE SCHOOL OF MEDICINE AND BIOMEDICAL SCIENCES.



This year, Interim Dean Margaret Paroski, MD '80, presented the award to Alexander C. Brownie, PhD, DSc, SUNY Distinguished Professor Emeritus, "for his phenomenal dedication to developing and rolling out the new curriculum for the preclinical years."

"In addition to teaching extensively in the new curriculum, Dr. Brownie has helped collect feedback, integrate modules and revise the content of the modules," says Paroski. "He is ever present for the students and has helped soothe the anxieties—of students *and* faculty—regarding the new curriculum. This kind of commitment and enthusiasm is what impressed the LCME about our new curriculum."

A member of the University at Buffalo faculty since 1963 and former chair of the Department of Biochemistry (1977–1989), Brownie has received many awards from the UB School of Medicine and Biomedical Sciences. These include the Louis A. and Ruth Siegel Excellence in Teaching Award (1983) and the Stockton Kimball Award (1986) for his research on control of the adrenal cortex, as well as for his outstanding teaching and service to the university. In 1993, Brownie was named SUNY Distinguished Professor, the highest rank in the State University of New York System, by the SUNY Board of Trustees.

A native of Scotland, Brownie was educated at Edinburgh University. In 1996, he was elected a Fellow of the Royal Society of Edinburgh.

—S. A. UNGER

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Stockton Kimball Award

Stanley Schwartz, MD, PhD

The Stockton Kimball Award honors a faculty member for academic accomplishments and worldwide recognition as an investigator and researcher. Stockton Kimball, MD '29, was the dean of the University at Buffalo School of Medicine from 1946 to 1958, and his contributions to the training of physicians in Buffalo spanned more than a quarter of a century.

The 2003 recipient of the Stockton Kimball Award is Stanley Schwartz, MD, PhD, professor of medicine, pediatrics and microbiology, and director of the Division of Allergy, Immunology, and Rheumatology in the UB Department of Medicine.

Schwartz received a doctorate in cellular biology from the University of California at San Diego in 1968, and a medical degree from Albert Einstein College of Medicine in 1972. He was a postdoctoral fellow at the University of California, San Diego, and later at the Albert Einstein College of Medicine, where he was an American Cancer Society Postdoctoral Scholar. He completed residency training at the Albert Einstein College of Medicine and continued his research training as a clinical fellow in immunology at Memorial Sloan-Kettering Cancer Center and Sloan-Kettering Institute for Cancer Research.

Schwartz began his clinical academic career in 1978 at the University of Michigan, Ann Arbor, where he rose through the ranks to become professor of pediatrics and communicable diseases and professor of microbiology and immunology (1983-92). He also became a charter member of the University of Michigan Cancer Center.

In 1992, Schwartz joined the faculty at the University at Buffalo as professor of medicine and, subsequently was appointed professor of pediatrics and microbiology.

Throughout his career, Schwartz has primarily focused his research on the mechanisms of immunoregulation in humans and the immunopathogenesis of HIV infections.

"Stan has been consistently funded by NIH grants and other grants and awards to support his research," said Suzanne Laychock, PhD,

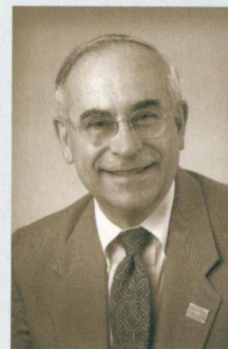
senior associate dean for research and biomedical education at UB, who presented him with the award.

"He has been recognized by his peers not only as demonstrated by his competitive funding record, but also his selection to serve on the editorial boards of several top immunology journals," she added. "In his career, Stan has been rewarded and honored with an NIH Research Career Development Award, the Meller Award for Outstanding Research (Memorial Sloan-Kettering Cancer Center), and as an American Association for the United Nations World Travel Fellow, among others."

According to Laychock, Schwartz has published well over 100 scientific articles, most recently on the subject of AIDS and immunoregulatory activities of HIV-1 proteins and their effects on cytokine expression.

Besides outstanding scholarship, the Stockton Kimball awardee also must demonstrate significant service to the University at Buffalo. Since joining the University at Buffalo, Schwartz has served as director of the Division of Allergy, Immunology and Rheumatology. He has also served as chair and facilitator for the Ad Hoc Committee on Specialist Training, on the Program Directors Committee for the Graduate Medical/Dental Education Consortium of Buffalo, as a member of the Buswell Fellowship Committee, and on the professional staff of the Witebsky Center for Immunology at UB, in addition to other service activities.

"Dr. Stanley Schwartz exemplifies the balance of research and clinical dedication that makes for an outstanding academic clinician and translational scientist," concluded Laychock. "The Stockton Kimball Award is a testament not only to the success of Dr. Schwartz as one of UB's most talented professors of medicine but also his participation as a generous and concerned faculty member who has contributed to the betterment of our university and the School of Medicine and Biomedical Sciences." **BP**



In Memoriam

AUTUMN 2003

Leon E. Farhi, MD

—Former chair of physiology and biophysics



Leon E. Farhi, MD, SUNY Distinguished Professor in the Department of Physiology and Biophysics, died on July 9, 2003,

in the Cleveland Clinic while undergoing surgery for a heart infection. He was 79.

A UB faculty member since 1958, Farhi studied physiological problems of human lung-gas

exchange and the human circulatory system. He was instrumental in developing new approaches for measuring cardiac output and distribution of respiratory gases within the lung and tissues of the body.

Farhi ran the Themis Project, a Defense Department-funded study that assessed the effect of different environments on breathing. Interested in how deep-sea diving and high- and low-gravity environments affected respiration, he conducted experiments for NASA with astronauts on Spacelab missions, as well as in the human centrifuge in UB's Center for Research and Education in Special Environments.

Born in Cairo and raised in Lebanon and Italy, Farhi moved to Israel in 1947 to fight for the Israeli underground. He received his medical degree in 1947 from the Université St. Joseph in Beirut and completed his medical training in Hadassah Hospital in Jerusalem.

A pulmonologist, he came to the United States in 1952 to treat tuberculosis patients at Saranac Lake. After serving postdoctoral fellowships at Johns Hopkins University and the University of Rochester, he joined the UB faculty as an assistant professor. Farhi rose through the ranks at UB, being promoted to full professor in 1966 and serving as

department chair from 1982 to 1991. He was promoted to the rank of Distinguished Professor—the highest rank in the SUNY system—in 1989.

Farhi received numerous honors and awards over the course of his career, including the Stockton Kimball Award from the UB School of Medicine and Biomedical Sciences, a Humboldt Fellowship and a fellowship in the American Institute of Medical and Biological Engineering.

Survivors include his wife of 54 years, Haya; daughter, Nitza F. Ellis, MD '77, clinical assistant professor of pediatrics in the UB

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School of Medicine and Biomedical Sciences; and son, Eli R. Farhi, MD, associate professor of clinical medicine, also at UB.

Contributions can be made to the Leon E. Farhi Memorial Fund c/o UB Foundation and addressed to P. Davison, Department of Physiology and Biophysics, 124 Sherman Hall, University at Buffalo, School of Medicine and Biomedical Sciences, 3435 Main Street, Buffalo, NY 14214.

—SUE WUETCHER

Ellen Dickinson, MD

—Interim chair of psychiatry

Ellen S. Dickinson, a neurologist and psychiatrist who served as



interim chair of the Department of Psychiatry in the University at Buffalo School of Medicine and Biomedical Sciences, died on

July 31, 2003, in Roswell Park Cancer Institute after a brief illness. She was 61.

A clinical assistant professor, Dickinson taught at UB since 1971

and had served the university in many capacities, including a term as co-chair of the medical school's admissions committee.

Dickinson also was clinical director of psychiatric services at Erie County Medical Center (ECMC) for eight years. In May 2002, she was the first woman honored as Physician of the Year at ECMC's annual Springfest.

A native of Barker in Niagara County, Dickinson received a bachelor's degree from Ohio Wesleyan University and a medical degree from Indiana University. She completed residency training in neurology at ECMC and worked as

a neurologist there and at Millard Fillmore, the Veteran Affairs Western New York Healthcare System and BryLin hospitals. She was chair of the psychiatry department at Millard Fillmore from 1992 to 1995.

Dickinson fulfilled her dream of having a double specialty when she attended Cornell University for residency training in psychiatry in 1983.

In May 2003, Dickinson was named a distinguished fellow of the American Psychiatric Association.

Survivors include her mother, Dorothy Wilson Dickinson, of Buffalo, and two brothers, James L. of Barker, and Robert J. of Buffalo.

—SUE WUETCHER

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Poxvirus

REPLICATION INHIBITED

Work could result in a new treatment for smallpox

BY LOIS BAKER

Molecular biologists at the University at Buffalo have discovered a novel way to inhibit the replication of poxviruses (the group that includes smallpox virus) by interfering with messenger RNA synthesis necessary for the viruses to reproduce in a host organism. The discovery, which has a patent pending, could lead to the development of drugs to treat the potentially deadly disease in the event of a bioterrorism-related outbreak.

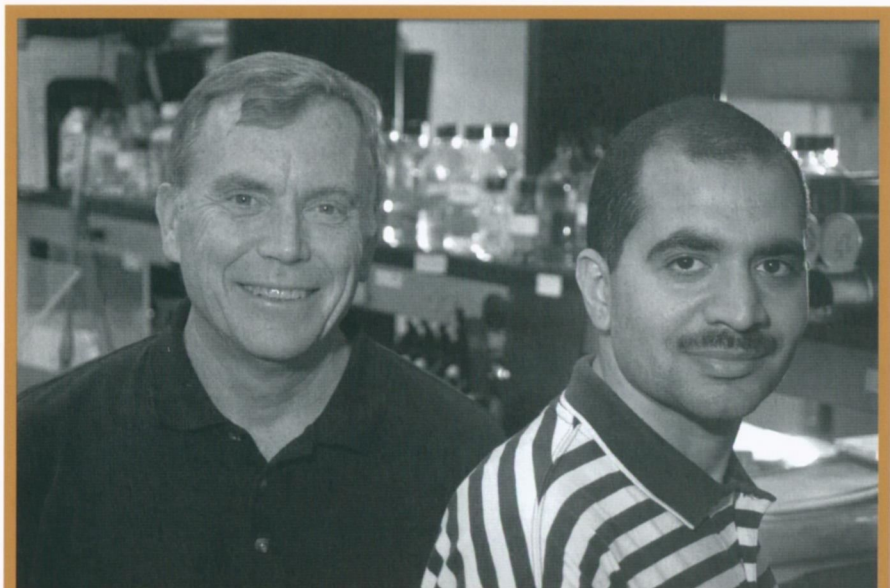
Such drugs also would be effective against related poxviruses such as monkeypox, which recently has infected dozens of people in the U.S who came in contact with animals imported from Africa, where monkeypox is indigenous.

"Any success that results in a treatment is a success for everyone," says Edward Niles, PhD, professor of microbiology and biochemistry in the University at Buffalo School of Medicine and Biomedical Sciences and primary discoverer of the new anti-replication mechanism. "We need something."

Work that could lead to new drugs is in the early stages, Niles notes.

To date, there is no effective treatment for smallpox or other poxviruses. Smallpox was declared eradicated in 1980 after a worldwide vaccination campaign. The U.S. and Russia maintain the only authorized repositories of the virus, but virologists acknowledge that the virus may exist outside these sites.

Existing vaccines that could be used to



Edward Niles, PhD, professor of microbiology and biochemistry, *left*, and Mohamed Ragaa Mohamed, PhD, *right*, a postdoctoral fellow who collaborated with Niles on the poxvirus research.

Photo by K.C. Kraft

protect against smallpox bioterrorism have a high incidence of side effects and may not be administered to certain segments of the population, notably pregnant women, persons with compromised immune systems due to disease or medications, persons with a history of eczema and children under one year of age.

Drugs developed using this novel approach could be stockpiled for use if an outbreak occurs, says Niles. If a new smallpox vaccination campaign were undertaken, such drugs also could be available to treat persons who have serious reactions to the vaccine.

Niles's discovery, achieved working with vaccinia virus, exploits a peculiar aspect of poxvirus biochemistry: Instead of creating copies of itself in the nucleus of the infected cell like other DNA viruses do (such as the herpes virus), poxviruses replicate in the cell's cytoplasm, the gel-like material surrounding the nucleus.

"Since poxviruses replicate in the cytoplasm, they can't use the host's enzymes present in the nucleus to make viral mRNA, which is translated to synthesize viral proteins," explains Niles. "These viruses have evolved in a manner that allows them to produce their own enzymes,

which are used to express their genes and permit their replication.

"This quirk in the poxvirus replication process should make it possible for scientists to design drugs targeted to those unique viral enzymes without interrupting normal cellular functions," he says.

Vaccinia virus is the virus strain used for immunization against smallpox. The initial interest of Niles and colleagues was to understand the basic process in the early stage of poxvirus gene expression (virus gene expression takes place in three stages: early, intermediate and late).

"The early phase is unique in that for transcription (mRNA synthesis) to proceed, it requires an initiating event at a site on the DNA called a promoter," he explains. "Another signal, called a terminator, is required to stop the early gene transcription. We wanted to know what that terminator signal does."

To study this mechanism, the UB researchers synthesized a short RNA fragment, or oligonucleotide, that contained the known termination signal. They then added the fragment to a test tube transcription reaction and measured RNA synthesis.

"We expected the oligonucleotide to inhibit the termination reaction," says Niles, "but instead of stopping it, the presence of the oligonucleotide stimulated premature termination. This resulted in the synthesis of truncated RNA molecules, which would be unable to direct the synthesis of normal proteins.

"This termination mechanism is unique to poxviruses, and this method of inhibition of gene expression should work on all poxviruses," he continues. "If this oligonucleotide could be delivered as a drug, it would inhibit synthesis of all poxvirus proteins early in infection and stop the virus from replicating in the host."

The work is in its very early stages, Niles cautions, with many steps that must be completed before a viable drug can be developed.

"We have to identify the most active compounds *in vitro*, test their activities on virus replication in tissue culture, and then figure out how best to deliver it in an animal model before we can even begin to test it in humans."

Mohamed Ragaa Mohamed, PhD, a postdoctoral fellow working in Niles's laboratory, collaborated on the research, which was funded by the National Institute of Allergies and Infectious Diseases of the National Institutes of Health. **BP**

An article about this work was originally published in the Journal of Biological Chemistry. An abstract can be found at JBC Online at www.jbc.org/cgi/content/abstract/278/14/11794.

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BY
CHARLES
BISHOP,
PHD



The Electronic Patient Record

Will it finally happen?

This past summer, I participated in a conference that could presage a sea change in the way patient medical records are kept. The conference, "Developing a National Action Agenda for NHII (National Health Information Infrastructure) 2003," was sponsored by the U.S. Department of Health and Human Services. It set forth what its organizers called "an initiative to improve the effectiveness and efficiency of overall quality of health and health care in the United States."

Keynote speaker Secretary Tommy Thompson challenged the invited stakeholders to "develop a comprehensive, knowledge-based network of interoperable systems of clinical, public health and personal health information that would improve decision making by making health information available when and where it is needed."

Over the course of the three-day meeting, certain standards were recommended, but the program is voluntary and does not envision a centralized database of medical records or government regulation.

Patient medical records are traditionally paper-based and kept by the patient's doctor or hospital. As a patient moves from one doctor or hospital to another, medical knowledge becomes fragmented and no one has a clear, long-term view of the patient's progress.

In an electronic era, medical data on a patient could be shared; however, all systems now in use were originated to address particular local conditions and utilize disparate hardware and software. As a result, data cannot be readily moved from one such system to another.

Government concern over this problem is not new. In 1991, the Institute of Medicine recommended that "health-care professionals and organizations adopt the computer-based patient record (CPR) as the standard for medical and all other records related to patient care." Since then, much effort has been expended to realize a common model, but consensus has

been elusive. The NHII initiative challenges stakeholders in health care to come up with a "national health information infrastructure" and offers leadership, as well as possible financial incentives. A point made at the conference is that health care currently spends much less on information technology than do many grocery chains. One expert warned, however, that throwing more money into conventional data-processing approaches would be pointless.

Patient Privacy versus Public Good

A fundamental tenet of medical record keeping is that patients are unlikely to disclose to their physician intimate details that are necessary for their proper medical care unless they trust the physician to keep that information confidential.

Clearly, no one should have access to private health-care information without a patient's authorization, and patients should be able to see their records

and correct erroneous information in them. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 tried to apply these basic privacy rules in an era of electronic communication, and at a time when the U.S. health-care market was driven by large health plans and fierce competition, as it is today. The original HIPAA rules were complex and have since been changed several times, reflecting the fundamental conflict between the need for privacy for the patient and desires of public health workers, researchers, insurers, employers and others to gain access to the patient data. Even the use of medical records in research currently has no national standard, and local institutional review boards often retain discretionary authority to grant waivers of consent.

My Interest in Medical Informatics

Throughout my professional life I have been fascinated by how medical information is categorized and utilized. A particular area of interest was how diagnoses were made. When individual computers became affordable I began to develop programs for that purpose. Gradually I became aware that the diagnostic problem was part of a larger task. If I could organize all medical knowledge, then diagnosis would be a subtask of a universal organization. This approach became "Framemed," a computer-based framework for medical knowledge that is based on hierarchies in various domains of medicine. "Diseases" became a hierarchy, as did "Agents," "Findings," "Tests," "Procedures" and more than 20 other traditional areas in medicine. When the concept of a computer-based patient record (CPR) became popular, that task began to dominate my activities with Framemed. Fortunately, I was able to interest my son, Geoffrey, who brought to the problem the newer computer skills involving Web technology with browsers and servers.

The Framemed CPR

The Framemed CPR is built on the premise that the patient controls his or her own record and how its content may be used. The key is that the patient appoints a surrogate (e.g., a hospital, health maintenance organization, or physician group) to maintain the CPR on its server. At each medical encounter, the patient asks the surrogate, over a secure Internet connection, to download the CPR. Results of the medical encounter are appended to the CPR, and it is uploaded to the surrogate's server. The patient may empower a doctor (or other health-care professional) to read or

write on the CPR. The results of all laboratory testing, procedures and consultations are returned to the CPR, where the patient can immediately see them. The patient may record his or her own findings, such as weight, blood pressure, blood glucose, accidents, etc. All encounters in the CPR are dated and signed by the initiator and may not be altered thereafter except that encounter amendments may be added. To further protect patient confidentiality, the CPR is divided into two parts: an administrative file and a medical file. The latter contains no direct identification of the patient and hence its data may be used for statistical purposes without infringing on patient confidentiality.

A surrogate managing many CPRs possesses a valuable cross section of medical data. With the patients' permission, the surrogate can make aggregate medical data available to outside agencies for various uses; for example, how many in the group have asthma and how many take a particular drug. The mortality and morbidity following certain procedures can be assessed. Unusual activity of a particular nature might signal an impending or even in-progress epidemic or terrorist attack. Such data could flow from the CPRs without revealing any patients' identities, hence reconciling patient privacy with public good.

Also, in the Framemed system, concepts in the various hierarchies (e.g., diseases, drugs, tests) are hyperlinked to corresponding knowledge records, a feature that can be utilized independently (as a medical encyclopedia) or as part of the CPR (to find out more about a concept before selecting it from a pick list in our CPR).

Moving On

Doctors have traditionally scribbled their patients' records and retained them. The government now asks if these can be incorporated into standardized, lifetime patient records for effective and efficient patient health care. Framemed has developed the software by which a patient can keep his or her own, professional-quality medical record. We have recently set up a secure Web site to test and improve this software. The next step is for surrogates to license our software and offer patients generally the ability to maintain their own medical records. Doctors and medical groups can use the same records, leading to true patient-centered medical records, as promoted by the NHII initiative. **BP**

About the Author

Charles W. Bishop, PhD, is associate professor of medicine and biochemistry at the University at Buffalo School of Medicine and Biomedical Sciences and a facilitator in the problem-based learning program for first- and second-year medical students. He can be e-mailed at cbishop@buffalo.edu.



Beyond the Classroom

By Linda J. Corder, PhD, CFRE

AS IS EVIDENT BY THIS ISSUE OF *BUFFALO PHYSICIAN*, memory of Samuel Sanes, MD '30, lives on at our school. It is here that he spent innumerable hours teaching students pathology, answering their questions and assuaging their frustration—and fatigue—by listening and providing responses that elicited laughter, or at least a chuckle. Sam Sanes's dedication to students extended beyond classroom doors, however, as reflected through myriad stories of former students.

Take Maxine Hayes, MD, '73, who returned to UB in 2000 to deliver the Stockton Kimball Lecture. Maxine was raised in the South in the 1950s. Her family was poor and "lived on the other side of the tracks"; however, they instilled in her the belief that there was nothing she couldn't do if she worked for it. She was awarded a scholarship to Spelman College in Atlanta and had an opportunity to study abroad in 1968. That year, Martin Luther King, Jr. and Robert Kennedy were assassinated, protests against the Vietnam War were at their height and demonstrators called for changes throughout society. As a result, leaders in higher education began to reconsider admissions policies. In 1969, UB sent recruiters to Atlanta who met with Maxine and offered her a place in its medical school and a scholarship.

During her time in Buffalo, Maxine, who is African American, had difficulty finding a place to live. However, she was mentored and encouraged by Sam Sanes and his wife, Mildred, who frequently invited her to their home. They applauded her residencies at Vanderbilt University and Children's Hospital Medical Center in Boston, her completion of a master's degree in public health at Harvard University and her establishment of a family health clinic in Mississippi (which recently celebrated its 25th anniversary).

Today, Maxine serves as the Washington State Health Officer, working closely with the medical community, local health departments and community groups to provide the public the latest scientific information on how to become and stay healthy.

Or ask Dana P. Launer, MD, '73, who was raised in New York City by his father and future mother-in-law after his

mother died of breast cancer when he was 11. Dana met Sam during his first semester in medical school; in his second year, he was diagnosed with Hodgkin's disease.

During Dana's initial treatments, Sam visited him every day in the hospital, taking a bus from Millard Fillmore Hospital to Buffalo General. He tutored Dana, kept his spirits up and convinced him to stay in medical school. When Dana returned to class and reported sitting through lectures in the middle of a ring of empty seats, Sam listened. When Dana's father died of lymphoma four months after Dana's diagnosis, Sam comforted him. He also encouraged him through clinical rotations and helped to find "someone to take a chance" on him for residency training.

Shortly before Dana began his residency, Sam was diagnosed with cancer, which subsequently claimed his life in 1978. Suddenly the tables were turned and Dana became the teacher, encouraging Sam through rounds of chemotherapy and radiation similar to what he had experienced. During his residency, Dana couldn't visit Sam often, but he wrote to him regularly.

Later, Dana moved to California. Currently, he is chief of surgery at Scripps Memorial Hospital in La Jolla.

For both Maxine and Dana, Sam's friendship made all the difference in their lives. Today they each remain friends with Mildred while carrying the memory of Sam—an extraordinary teacher and a true gentleman—in their hearts.

A decade after Sam's death, his sister, Thelma, established a scholarship in her name and the name of their brother, Harold. Neither Harold nor Thelma went to college, and Sam had to work his way through. This was the reason Thelma gave for wanting to help others at "Sam's medical school." **BP**



Lyn Corder, PhD, is associate dean in the Office of Development and Alumni Affairs. She can be contacted via e-mail at ljcorder@buffalo.edu; or by phone at 1-877-826-3246.

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*Endowments, especially for scholarships, are vital to the future of this school. A list of all of the school's current endowments—as well as those for the Health Sciences Library—follows. Those with an asterisk (*) were initiated during the past fiscal year. Those in bold print had one or more additional gifts during this time frame. New endowments that were funded or partially funded have both an asterisk and appear in bold. Read through the list. Thank your friends, colleagues, classmates who have initiated endowments or those you know who are helping to build funds, such as the Medical Alumni Endowed Scholarship Fund, through annual gifts. Please consider the school's endowment program in your philanthropic plans, either by adding to an existing fund or by setting up a new one. As always, your friends in the Office of Alumni Affairs and Development will answer any questions you might have.*

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Dear Fellow Alumni,

I hope you're having a great autumn! With the start of the academic year, the Medical Alumni Association (MAA) Governing Board has remained busy, organizing activities within student and alumni circles and making plans for next year's Spring Clinical Day and Reunion Weekend.

The board has been revitalized this year by the addition of three new members: Helen Cappuccino, MD '88, Charles Niles, MD '83, and Indrani Sinha, MD '96. Helen, Chuck and Rini have already proven to be energetic, outspoken board members who will play an active role in the functions of the organization. Additionally, we have been able to retain the expertise of our outgoing past president, John Bodkin II, MD '76, who has agreed to remain on the board as an emeritus member.



During Orientation Week, the MAA proudly sponsored the annual White Coat Ceremony, in which first-year students were presented with their first white coats. The association also sponsored the Student Clinician Ceremony, helping the third-year medical students "kick off" their clinical training.

In September, the past presidents of the MAA gathered with friends, guests and alumni of the medical school to honor our newest distinguished alumnus, Michael Cohen, MD '61. We congratulate Dr. Cohen on receipt of this award and invite you to read more about his career and accomplishments in the winter issue of *Buffalo Physician*.

Plans are taking shape for Spring Clinical Day and Reunion Weekend, scheduled for April 30-May 1, 2004. After noting the fantastic response to this year's program, which showcased downtown Buffalo, we will invade the city again next spring. The Clinical Day program is titled "Medicine 2004: Challenges & Innovations." We are pleased to report that Richard O. Dolinar, MD '72, a renowned expert on diabetes, will serve as our Stockton Kimball Lecturer. In addition to the wonderful venues utilized last year, the Pierce Arrow Museum (one of Buffalo's well-kept secrets!) will be the site of the Saturday evening Reunion Dinner Reception. In the next issue of *Buffalo Physician*, I will preview events planned for the weekend.

On a financial note, I must report that review of the MAA's annual budget has driven home the fact that the cost of providing these and other services continues to escalate. After many years of maintaining member dues at \$65 a year, it will be necessary to raise dues slightly, to \$75 a year, in order to continue to support our medical school, students and alumni. This increase will take effect with the 2004-2005 year. Additionally, the cost of lifetime membership will increase to \$1,000. That means that a lifetime membership—at this year's price of \$750—is a bargain! For your convenience, membership materials are enclosed in this issue of the magazine.

As always, your support of our alma mater through your interest, time, membership in the MAA and gifts remains the backbone on which our efforts and accomplishments are built. We are all part of the family; let's show it in any way we can.

STEPHEN B. POLLACK, MD '82

President, Medical Alumni Association

Classnotes

1940s Correction

Class of 1943



1940 Class chair Daniel Fahey, center, with classmates William Bloom, left, and Francis Peisel.

In the summer 2003 issue of *Buffalo Physician*, the photograph of the Class of 1948 on page 39 was incorrectly identified as the Class of 1943.

1950s

Jay B. Belsky, MD '51,

writes: "I have been retired since 1988, after practicing for over 33 years with Kaiser Permanente in Harbor City, CA. I was a staff internist, then chief of the Department of Internal Medicine, then area associate medical director. In 1976 I ended my administrative work, took a year off to retrain and recertify in internal medicine, then returned to practice as a staff internist until my retirement in 1988. After retiring, I became involved in adult literacy tutoring, and tutoring of young children through the local library and Boys and Girls Club. For the past several years, I have been a member of Omnilore, a learning-in-retirement program administered

through California State University, Dominguez Hills. I was fortunate to have been able to attend my medical school 50th Reunion in 2001, and I am looking forward to the 55th in 2006. My first wife, Georgette, died in 1983, after almost 38 years of marriage. I remarried a year later to Carolyn. Between the two of us, we have seven adult children, ranging in age from late 30s to early 50s, 20 grandchildren, ranging from 9 to 23, and three great grandchildren, ranging in age from several months to several years."

Favorite medical school memory: "I have loving and happy memories of Oliver P. Smith, who gave me the wonderful news that I had been accepted to medical school and who was my favorite teacher."

1970s

Maxine Hayes, MD '73,

MPH, Washington State health officer, was presented the Washington Health Foundation's 2003 Heroes of Health Care Lifetime Achievement Award on June 19, 2003. Hayes has been with the Department of Health since 1991 and is clinical professor of pediatrics at



the University of Washington, School of Public Health.

Peter R. Reczek, PhD '79, has

been appointed director of technology transfer in Fiscal Administration, Office of Health Research, Inc. (HRI) at Roswell Park Cancer Institute (RPCI). Reczek has served as a consultant to RPCI since 2001 and is



also assistant professor in the Department of Molecular and Cellular Biophysics at RPCI. Reczek earned his doctoral degree in Physiology and Biophysics from RPCI Graduate Division, University at Buffalo in 1979 and completed a postdoctoral fellowship in biochemistry at Brandeis University in 1980. He served on the faculty at Harvard Medical School and the Dana Farber Cancer Institute until 1989.

What's Up, Doc?

New online submission form

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- click on Alumni
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Things your fellow alumni tell us they would like to read about:

- family updates
- interesting 'trips and trails'
- happy occasions, humorous interludes
- moves/promotions
- retirement
- honors and awards
- publications
- public service/election to office
- research endeavors
- musings on life as a doc . . .



1980s

Thomas P. Koestler, PhD '82, has been appointed executive vice president for worldwide regulatory affairs, worldwide research quality assurance and project management at Schering-Plough Research Institute (SPRI). In this role, he will also assume leadership of the allergy and inflammation therapy team at SPRI, charged with ongoing development of strategies and direction for this area of research. Before join-

ing Schering-Plough, Koestler served as a senior vice president and head of global regulatory affairs at Pharmacia Corporation, which has since merged with Pfizer. He has more than 20 years experience in the pharmaceutical industry and is credited with securing more than 60 regulatory approvals, including approval of 24 new molecular entities.

Andrew M. Knoll, MD '84, JD, FACP, internal medicine, graduated from Syracuse University Col-

lege of Law on May 18, 2003, summa cum laude (highest academic average). A member of the *Syracuse Law Review*, his note, "Mea Culpa, Mea Culpa: A Call for Privilege for Self-Disclosure of Error in the Setting of Primary Medical Education," won the 2002 American Health Lawyers Association Student Writing Contest and was published in *35 Journal of Health Law* 419 (2002). He has accepted a position as an associate in the health law department of Scolaro, Shulman,

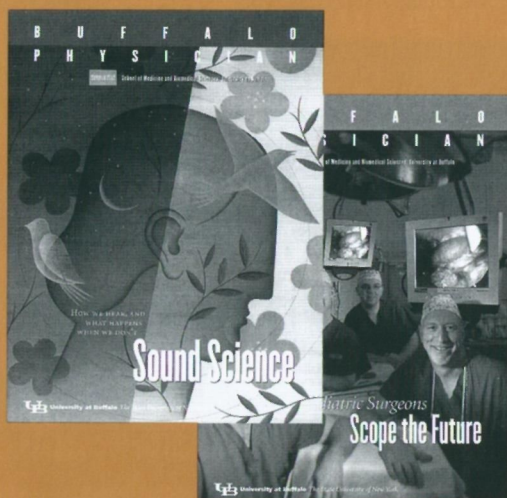
Cohen, Fetter & Burstein, PC, in Syracuse, NY. Knoll's wife, **Maritza Alvarado, MD '85**, continues her work as an attending neonatologist. The couple celebrated their 17th anniversary in October.

Helen Cappuccino, MD '88.

The collaboration between Roswell Park Cancer Institute (RPCI) and Niagara Falls Memorial Medical Center (NFMCC) to

provide health services to women has been expanded to include consultative second opinions for breast cancer. The services are being provided at NFMCC by Helen Cappuccino, MD '88, clinical assistant professor of surgery at RPCI.

"Dr. Cappuccino brings an expertise in breast cancer that previously was unavailable to women locally," said Joseph A. Ruffolo, the medical center's president and chief executive officer at the time the ex-



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pansion in services was announced. "Roswell Park is nationally renowned as a cancer treatment center. We are most fortunate to have one of its physicians as a consultant to our outstanding team of surgeons."

1990s

Paul Seeman, MD '93, is currently living in Alexandria, VA. In June 2003, he earned a master of public health degree. E-mail address is: paul.seeman@sprintmail.com.

Dominic J. Smiraglia, PhD '97, has been appointed assistant member in the Department of Cancer Genetics at Roswell Park Cancer Institute (RPCI). He returns to RPCI from the Division of Human Cancer Genetics at Ohio State University (OSU), where he served as a research scientist. In 1997, Smiraglia earned a doctoral degree in the

Department of Cell and Molecular Biology from RPCI's Graduate Division and completed postdoctoral training in the Department of Molecular Virology, Immunology and Medical Genetics at OSU. His research interests include the study of DNA methylation, its contribution to the carcinogenesis and identification of potential DNA methylation targets for early detection and diagnosis of cancer. Smiraglia has authored or co-authored more than 30 journal publications, book chapters and abstracts. He is an ad hoc reviewer for the *Journal of Medical Genetics and Cancer Research*.

Susan McCann, PhD '98, has been appointed assistant member in the Division of Cancer Prevention and Population Sciences at Roswell Park Cancer Institute. Prior

E-mail Us

Classnotes can also be submitted by
e-mail to: hp-notes@buffalo.edu

to that, she served as research assistant professor in the Department of



Social and Preventive Medicine at UB. McCann earned a

doctorate in epidemiology and community health at UB in 1998 and is also a registered dietitian. Her research interests focus on nutritional and molecular epidemiology, including the impact of diet on cancers of the reproductive organs. She is currently conducting an investigation of the relationship between dietary phytoestrogen intake and genetic susceptibility to breast cancer.

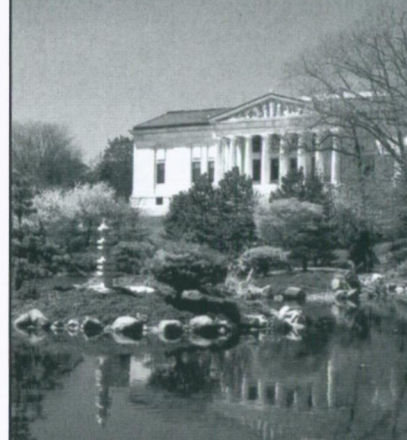
Michael D. Banas, MD '00, and Anne C. (Wolpiuk) Banas, MD '02



Michael writes [in late June]: "Anne and I just returned from our honeymoon in Maui. We are living in Williamsville, NY. Anne finished her preliminary year in internal medicine at UB, where she is now a neurology resident. I finished my residency in internal medicine at UB and started a fellowship in cardiology at UB, where I am also working as a research fellow at The Center for Research in Cardiovascular Medicine."



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Victor A. Filadora, Jr, MD '99, has been appointed to the Department of Anesthesiology and Critical Care Medicine at Roswell Park Cancer Institute. He comes from Brigham and Women's Hospital, Harvard Medical School, Boston, MA, where he completed



residency training in the Department of Anesthesia.

He earned his medical degree in 1999 and completed an internship in medicine in 2000 at UB.

2000s

Rose C. Graham-Maar, MD, '00, writes: "I completed my pediatrics residency at The Children's Hospital of Philadelphia and began a three-year fellowship in pediatric gastroenterology and nutrition at CHOP on July 1, 2003. I married Stefan Maar on June 14, 2003, in Delaware. We had a fantastic honeymoon in Hawaii. E-mail address is: rosecorinne@alumni.brandeis.edu.

BP

In Memoriam

Harold K. Palanker, MD '40

Harold K. Palanker, a long time Buffalo surgeon, died on March 24, 2003, at his home in Albuquerque, NM. He was 89.

A native of Romania, Palanker moved to the United States in 1930 at the age of 17. Following graduation from UB medical school in 1940, he completed his residency at Buffalo General Hospital (BGH). He then entered private practice and held surgical and teaching positions at Children's Hospital of Buffalo and BGH. Palanker was also associate professor of surgery at UB and served as president of the Buffalo Surgical Society. After retiring from private practice in 1979, he moved to Albuquerque, where he worked for eight years in the Ambulatory Care Unit of the Veterans Hospital.

Surviving are his wife of 55 years, the former Janice Powsner of Albuquerque; four daughters: Maureen Leshendock of Reno, NV, Robin and Abby Gail, both of Los Angeles, CA, and Leslie of Paris, France. BP

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Vincent Cotroneo, MD '42, retires

BY JAZMYN BURTON



Photo by Amy Young

Unsatisfied with midafternoon programming, 17-year-old Melissa Stagg sat in front of a 25-inch television screen, changing the channels with a remote control.

"Stop flipping those channels like that," her mother, Shirley Dawson of Buffalo, called out. "You're not at home."

But for Melissa, a senior at Grover Cleveland High School, making a trip to Dr. Vincent Cotroneo's office was like visiting a relative.

Cotroneo, 86, who recently retired from his practice after 57 years of service, said he wouldn't have had it any other way.

At first glance, the reasons for Melissa's comfort were obvious. The wildlife paintings covering the walls and the oversized chairs and large brown couch made for a seating area with all the comforts of home.

Signs on the walls, encouraging patients to "Make an appointment for your next mammogram" and "Sign in at the desk," were the only indications there was a doctor behind the dark wooden doors leading into the office.

"I've always wanted my patients to feel comfortable," Cotroneo said. "I try to take care of both their physical and emotional needs. I've always tried to be both a friend and a doctor." An old-fashioned family practitioner and surgeon, Cotroneo said he has delivered thousands of babies over the years, including members of the Stagg family.

"He took care of my mother, father, aunts, uncles and my grandmother, too," said Melissa. "He took care

of my whole family. He even delivered me and my brother and my mother."

"I really don't want to see him go," said Dawson. "I'm really going to miss him. He's an honest man, he comes right out and tells you what's wrong without beating around the bush."

Born and raised in South Buffalo, Cotroneo earned his medical degree from the University of Buffalo and served as a physician during World War II.

For his efforts during the war, he received the Silver and Bronze stars.

Shortly after returning from the war, Cotroneo purchased his home at 777 McKinley Parkway. The first floor became his family practice, and on the second floor, he and his late first wife, Rose, raised eight children.

"We would come home from school and there would always be patients sitting on the steps, waiting to see him," said his son, Carl. "I think some of them were there more to socialize than to be treated for an illness."

Cotroneo continued to make house calls and was a member of the medical staff at Our Lady of Victory and Mercy hospitals until he retired at the end of June.

"He's a little sad about leaving," said Paula, Cotroneo's wife. "Many of his patients begged him to stay. He's always treated his patients as if they were family members. I know he'll miss them all." **BP**

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RESTORATION

Remember this old friend? Between June and November of 2003, University at Buffalo undertook an ambitious project to renovate the Hayes Hall bell tower, restoring the South Campus landmark to its former glory. Masonry was updated, windows replaced and rust from structural steel removed.

Before UB acquired the 1870s Georgian-style building, it served as an insane asylum, as the Erie County Almshouse and, later, as the county hospital. UB added the tower during a 1927 renovation. The bell chimes and tower clock were installed in 1928, a gift of Kate Robinson Butler, wife of a former publisher of The Buffalo News.

The four gigantic bells inside the tower range in weight from 400 to 1,800 pounds. They are Westminster chimes and are tuned to F, B flat, C and D. When the bells were temporarily silenced during the renovation project, UB received calls from residents in the university neighborhood: "Hey, what happened to the bells?"



Photo by Donna Longenecker