Alden Landry, M.D., M.P.H., knew at a young age that he wanted to pursue a career in health care. He distinctly recalls being inspired when he first saw his grandmother dressed in scrubs with a stethoscope around her neck on her way to work as a vocational nurse. But for a black man in a military family originally from south Texas, the path to becoming an emergency medicine physician at Beth Israel Deaconess Medical Center was not an easy one. “My parents had no clue what it took to get into medical school or what it took to become a doctor,” Landry says. “It was uncharted territory for my family, but I decided this was what I wanted to do.”

While many of his peers with similar goals struggled to find their way into a career in health care, Landry took advantage of extracurricular educational programs in high school, which laid out the path to becoming a health care provider and ultimately set him up to be successful in medical school and beyond. Later, a more personal experience of accompanying his grandfather on a hospital visit in Texas was a reminder that he could use his position to affect change for minorities in the health care system. “No one should have to have a Harvard-trained physician in the family to ensure that the conversation with your doctor goes smoothly,” he says. “Seeing that disconnect firsthand really shaped how I felt about how health professionals understood and cared for patients who weren’t like them.”

Landry’s strong foundation of education and personal experiences set the tone for a career dedicated to identifying health disparities and

CONTINUED ON P. 2
ALDEN LANDRY, M.D., M.P.H.

Continued from p. 1

working with providers on cultural competency training to improve interactions with patients. He also strives to ensure students from disadvantaged backgrounds and other minority students have the opportunity to pursue their dreams of a career in medicine like he did—a path that not only benefits their lives but the lives of their future patients. “There is a huge amount of untapped potential, and there are a lot of students who, if given the right chances and the right opportunities, can accomplish amazing things,” he says. “They have been so overlooked at so many points in their lives that they are never given the right chances to succeed.”

During medical school, Landry got his first taste of the Berenson Emergency Department (ED) at BIDMC through the Visiting Clerkship Program at Harvard Medical School for minority students and later matched with the medical center for residency. He quickly determined that emergency medicine was the perfect fit. “There seemed to be organization amongst the chaos, which was attractive to me,” he recalls. “It seemed like a place where I thought I would thrive.” Not only does Landry care for a wide range of afflictions that come through his door, he also supervises residents during their ED rotations. “I love seeing that evolution from a novice in the emergency department to someone who is skilled at providing great care,” he says. “I love seeing people achieve their potential and that is what inspires me to do what I do.”

As a minority, Landry appreciates that he sees the world through a different lens than many of his colleagues. As a resident in 2006, he recognized the need for a voice working with providers on cultural competency training to improve interactions with patients. He also strives to ensure students from disadvantaged backgrounds and other minority students have the opportunity to pursue their dreams of a career in medicine like he did—a path that not only benefits their lives but the lives of their future patients. “There is a huge amount of untapped potential, and there are a lot of students who, if given the right chances and the right opportunities, can accomplish amazing things,” he says. “They have been so overlooked at so many points in their lives that they are never given the right chances to succeed.”

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As a minority, Landry appreciates that he sees the world through a different lens than many of his colleagues. As a resident in 2006, he recognized the need for a voice from the minority community at the hospital. He joined a multi-departmental team that started a committee to discuss diversity-related issues and implement programming to address health disparities and increase diversity in the workforce. The group helped to establish the Office of Multicultural Affairs, now the Office of Diversity and Inclusion. “You can’t attack any of these issues if you are operating in a silo,” he says. “You have to be able to work with different departments and work with different people. If we work as a team to address these issues, we have a better chance of being successful.”

As a result of the new programs, Landry has seen positive changes across the hospital, most notably the increase in use of Interpreter Services by non-English speaking patients. “We can provide better care when we actually speak to patients in their preferred language,” he says.
“I want to take care of every patient that walks into my emergency department, but I also want to make sure they don’t come back to my emergency department. I want to make sure they have the tools and resources to be healthier.”

— Alden Landry, M.D., M.P.H.

“It helps tailor treatments, and patients have a better understanding of their health in the long run.”

Now a full-time attending physician, Landry is continuing to find ways to improve care for minority patients. In this time of health care reform, he is investigating which populations are using the ED and particularly how minority communities access health care. Despite the mandate for all individuals in Massachusetts to have health insurance and a primary care provider (PCP), Landry and his colleagues found that patients were still coming to the emergency department for non-emergent care like management of blood pressure or diabetes. Many of those patients either did not know their PCPs or could not get an appointment. Others could not miss work during the day and chose the ED for its more flexible hours. “They still felt they had no place to go; they still felt they didn’t have the resources they needed, and they just didn’t have a command of the health infrastructure that we have in Massachusetts,” Landry says.

Landry is now building on this research to develop better methods to address this population. He has already instituted a call-back and text messaging program to remind patients to take medications or to call their PCP to set up a follow-up appointment. The next step is to improve the lines of communication between the ED and the PCPs at BIDMC’s affiliated community health centers to make them aware of the visit and encourage future non-emergent care in the community. “I want to take care of every patient that walks into my emergency department, but I also want to make sure they don’t come back to my emergency department,” he says. “I want to make sure they have the tools and resources to be healthier.”

Helping improve care for minority populations is only the tip of the iceberg. Landry also hopes for a more diverse health care workforce both at BIDMC and around the country. While blacks, Native Americans, and Hispanics make up 31.5 percent of the population, only 8.9 percent are currently practicing physicians and 6 percent are academic physicians. Landry points to research that shows that, when their doctors are of similar racial or ethnic background, patients are more likely to express trust in them, make their appointments and take their prescriptions, and adhere to their care plans.

In an effort to help more minorities start careers in medicine, Landry and his friend Kameron Matthews, M.D., J.D., started the national nonprofit group Tour for Diversity in Medicine to encourage, inform, and inspire young people who are interested in health professions. “Nobody in medicine has made it to where they are now without somebody pulling them up or pushing them along,” Landry says. Tour for Diversity in Medicine is a biannual bus tour that brings mentors from across the country to colleges for a full-day conference. Doctors, dentists, and medical students from disadvantaged backgrounds or racial and ethnic minorities share personal stories and tips on how to get into medical school. “It is really hard to become a doctor if you have never seen somebody who looks like you, who talks like you, who has the same experiences and has overcome some of the same obstacles as you to become a physician,” Landry says. “For the students, it is important because they have real life examples of people doing what they want to do.” Four years, 23 states, 34 campuses, and 2,700 students later, Landry is seeing results as students send messages of their successes in applying to medical school.

As residents filter through their rotations under his watch at BIDMC, Landry hopes he is able to similarly impart his experiences while training them to be outstanding, culturally compassionate clinicians not only for their future, but for their future students and patients. “What we do in the hospital is great,” he says. “But we need to make sure we are reaching beyond the walls of the hospital and giving back by supporting our communities, our patients, and those who want to become health care providers.”
LETTER FROM THE SENIOR VICE PRESIDENT OF DEVELOPMENT

Dear Reader,

Our job as a premier academic medical center is to ensure we provide the best possible care for everyone who walks through our doors, regardless of their background, condition, or circumstances. BIDMC has a longstanding history of inclusivity and anti-discrimination rooted in the traditions of its founding hospitals, and more recently we have been focused on pioneering efforts to more thoughtfully and thoroughly ensure that we preserve patients’ dignity and value throughout the healthcare process.

This issue of Giving Matters offers up a taste of our ongoing work in these areas. It highlights our efforts in improving diversity both among physicians (cover story) and on our Boards (page 5) to better reflect the broad range of constituencies we serve. It explores groundbreaking research to eliminate healthcare disparities (page 8) and pioneering clinical programs to improve wellness among the underserved (page 11, bottom story). And it recognizes creative efforts to ensure that patients with complex conditions like AIDS or kidney disease are accorded the respect and compassion they deserve along with the most advanced treatments available (page 13 and page 9, sidebar).

Our donors have been instrumental in the success of all these efforts, and we are so grateful for their support in making BIDMC the accessible and caring place it always has been and will continue to be. We also have them to thank for another record-breaking year for philanthropy at BIDMC in fiscal year 2015, with a fundraising total of $66.5 million. I look forward to sharing more achievements like these in 2016.

Sincerely,

Kristine C. Laping
Danielle Remis Hackel came to Beth Israel Deaconess Medical Center 10 years ago exhibiting a range of symptoms that other hospitals could not diagnose. She was having difficulty talking and swallowing and had lost 40 pounds throughout the past several months. Having just given birth six months prior, she was worried about taking care of her new baby as well as fulfilling her professional responsibilities.

Thankfully, physicians at BIDMC quickly diagnosed Hackel with a post-partum cardiac growth that had crept up through her larynx. Just a few days later, she underwent successful open chest surgery to remove the growth. It was this life-changing experience that helped shape her now decade-long connection to the medical center. “BIDMC saved my life,” says Hackel. “And during that frightening time, they didn’t just care for me, they cared for my whole family. When you have a complex procedure like emergency cardiac surgery, it’s not just the patient’s problem; it is incumbent upon the hospital to take care of the spouse, the parents, and the kids of that patient. At BIDMC, we got the whole package.”

During her recuperation, Hackel reached out to the medical center and asked how she could give back. Since then, she and her husband, Michael Hackel, have been involved with the hospital in a variety of ways. “I really didn’t know the best way to repay my debt to BIDMC, but I knew there was a team of two dozen caregivers here who made Team Remis Hackel possible,” she says. “And there were lots of draws to the medical center, not just for me, but for my whole family. I had my children here, and my father-in-law, Richie Hackel, who has amyotrophic lateral sclerosis, is part of a monthly ALS Clinic here, which my family also supports.”

Hackel, who is a managing director at State Street Global Advisors, ultimately decided the best way she could help was to participate on a Board. After serving on the Nominating Committee for several years, she became a trustee and, this year, the chair of the Board of Overseers (BOO)—a group of 114 individuals from BIDMC’s community whose goal is to share the medical center’s achievements and serve the community on issues relevant to the hospital. “These are young, accomplished people, and the two triggers that have really resonated with them have been making the medical center’s lay leadership more diverse and understanding the innovative research, techniques, and surgeries that we are doing here,” says Hackel.

The BOO has focused on many types of diversity—women, minorities, professional backgrounds, and ages. Explains Hackel, “To serve a community medical center, you need a Board that reflects the people who receive care here. Every year, we create diversity goals, and our recruitment efforts are targeted against meeting those metrics. As a result, we’ve flipped the composition of the Board over the last five years.”

On the innovation side, the BOO started an annual event several years ago called Critical Voices, which offers an educational forum for Board members and the broader BIDMC community to hear directly from leaders in the medical field and to discuss some of the more pressing issues in health care today. This past May, Hackel hosted her first Critical Voices event, which featured the theme “Up Close and Personalized: A New Era of Cancer Care at BIDMC” with a panel of Cancer Center leaders who presented their latest research and clinical work (see page 19).

To bring innovations like these to fruition, Hackel is continually inspired by BIDMC President and CEO Kevin Tabb, M.D. “It is a testament to Dr. Tabb’s leadership that many advances have been made since he joined the medical center, including acquiring community health centers and hospitals throughout Massachusetts, improving technology and the way patients and caregivers communicate, and participating in an extensive research agenda ranging from ALS to cancer,” she says. “His clarity of vision inspires the Board of Overseers to pursue the mission as a team.”

At the end of the day, Hackel is enormously thankful for her role at BIDMC. “Beth Israel Deaconess took a bet on me,” she says. “To look back 10 years ago, you would not think you’d be looking across the table at me. I am definitely a grateful patient, and my children always refer to the medical center not as the place Mom goes when she is sick, but the place where Mom goes to get healthy.”

“To serve a community medical center, you need a Board that reflects the people who receive care here.”
— Danielle Remis Hackel
Over the span of 10 years, Alfred Ross agonized as doctors diagnosed two beloved family members with breast cancer. His wife, Karan, was 35 years old when she was treated for the disease, and shortly thereafter, his aunt, Thelma Linsey, received her own diagnosis. He credits BIDMC breast surgeon Mary Jane Houlihan, M.D., for saving them both. More than two decades later, the family is still saying thank you and, in the process, improving care for thousands of patients enduring a similar experience.

Their experience, though life-changing, was not the first introduction to the hospital for the Linsey and Ross family. Thelma, and her late husband, Joe, have generously supported Beth Israel Hospital and BIDMC for more than 50 years, funding programs from oncology to neurology to nursing. When she and Karan were treated by Houlihan and her colleagues at the BreastCare Center, their passion for the hospital deepened. “I felt safe and comfortable with her,” Karan recalls. “She was so confident, and everything about her was so easy. She really took charge of the whole thing. We love her.”

In the most recent gesture of thanks, The Joseph M. and Thelma Linsey Foundation designated $1.8 million to breast cancer care at BIDMC, naming The Joseph M. and Thelma Linsey BreastCare Center. Alfred and Karan complemented this gift with a $750,000 contribution to the BreastCare Center in honor of Houlihan’s care. “It all goes back to Joe,” Alfred says about his uncle and close business partner, who managed greyhound and thoroughbred racing tracks for nearly 40 years. “He was very charitable. Thelma has taken up where he left off, and it has spilled over on Karan and me.”

Joe was a longtime board member and philanthropist at the former Beth Israel Hospital, first elected as a trustee in 1946 and earning honorary trustee status in 1967. “I have tried to continue what he started,” Thelma says, “because I, too, believe in the hospital, and I feel that the doctors and nurses have always been there for me when I or anyone in my family has needed them.”

Through their support of the BreastCare Center over the last 20 years, the Linsey and Ross family’s legacy of giving has built a foundation for the personalized and multidisciplinary approach to breast care that patients experience today. “They provided the funding for us to have a dedicated area in the hospital where we were able to do women’s imaging,” Houlihan says. “Women didn’t have to call into a general number and get in a queue. We were one of the first areas that had a scheduler that was completely separate. We would not be where we are today without Thelma’s support.”

These most recent gifts will help clinicians further improve this model through an ongoing facility renovation and process improvement. The BreastCare Center renovation project, which was designed with input from a diverse committee of patients and staff, will enhance coordination between the BreastCare Center’s breast surgery clinic on the fifth floor of the Carl J. Shapiro Clinical Center and the screening and diagnostic imaging service on the fourth floor. “It is going to be wonderful to be able to go into one area where everything is so comprehensive,” Karan says. “It is going to be a lot easier for women. It will be much more relaxing, and I think it is going to make something so terrible much easier.”

IT’S ALL RELATIVE

The Joseph M. and Thelma Linsey Foundation’s $1.8M gift to name BIDMC’s BreastCare Center solidifies a family’s legacy of support

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ASK THE EXPERT

with Rami Burstein, Ph.D.

Q. I suffer from chronic migraines and have tried many treatments over the years with limited success. What is happening in the field of headache research that might give me—and others like me—hope for finding effective and sustainable ways to manage our pain?

A. When I entered the field of headache research in the late 1990s, it was primarily the province of drug companies. Consequently, it was not conducted with the purpose of really understanding the pathophysiology—or underlying mechanisms—of migraine and how to help people get better. So with 45 million migraine patients in the United States alone, there was a huge opportunity to fill a big void in our knowledge.

What we’ve learned in the last 15 years or so is that you cannot make a significant difference in this field unless you have a translational research operation that facilitates a constant back and forth between the patient and the laboratory. I can think of only two or three places around the world that are on par with the translational research operation we have here at BIDMC in terms of the number and variety of patients and the multiple techniques and approaches we use.

What we do here is different from anywhere else is what we call a flipped concept, which uses a “bedside-to-bench” approach rather than the traditional “bench-to-bedside”. From bench to bedside, you study things you see in rats and mice that may in the end have nothing to do with humans. In contrast, if you go from bedside to bench, you only study things that you’ve seen in patients and that you know are significant to their disease. We don’t study something because we can, we study something because it is relevant to the patient we’ve seen that morning. We can never ask a rat to tell us about its headache.

This “start-with-the-patient” approach has led us to investigate prominent features of migraine such as the hypersensitivity to light, called photophobia, and the hypersensitivity of the skin, called allodynia. Eighty-eight percent of all migraine patients are photophobic. They can’t make dinner because they have to go into a dark room; they can’t hold a job because they can’t sit in front of a computer screen or in a well-lit office. And because migraines are recurring, there’s a huge financial and social burden, a price to pay, for these patients.

We have found that light can trigger or aggravate migraines, even in blind people, and with the help of a seven-year National Institutes of Health merit award, we have begun to explore, both in blind and non-blind migraine patients, the parts of the brain that are associated with this process. Our hope is to identify the molecules and mechanisms involved in the communication between the visual pathways and the migraine pathways so that we can come up with a drug or a device that blocks this communication.

By focusing on these characteristic features of migraines, we also hope to gain new knowledge to tailor treatment for patients. For example, hypersensitivity of the skin is the number one clue that tells us which patients will respond to triptan therapy, the most commonly prescribed treatment for migraine. Ultimately, we want to move the process of bringing new drugs to the market from an empirical, trial-and-error process to a logically driven process, where we know that in patient X there is pathophysiology that differs from patient Y and that patient X but not patient Y will benefit from a drug we prescribe, even though both have a migraine.

But to truly individualize headache care, we will need a conceptual change. We live in a conservative and time-constrained era of medicine. Researchers need more independence to take risks and pursue creative lines of inquiry. Physicians need more time to spend with their patients to help them make more thoughtful diagnoses and not rely on trial-and-error treatment. And right now, this freedom does not exist anywhere but in philanthropic giving.
Some diseases make headlines and pull at our heart strings. Others, like kidney disease, fly under the radar. But despite its relative obscurity, kidney disease is a major public health problem affecting primarily underserved populations in the United States and around the world. Without much fanfare, kidney disease causes significant illness and places an enormous burden on the health care system. “It is a big crisis in our country where we have an incredible medical infrastructure,” says Martin Pollak, M.D., chief of nephrology at Beth Israel Deaconess Medical Center, “but worldwide, in less developed countries and less wealthy countries, people don’t have access to transplants and access to dialysis, which compounds the problem. We are optimistic that the work we do here at BIDMC will lead us to new ways to prevent and treat kidney disease to help people everywhere.”

When functioning properly, the kidney is responsible for filtering waste and excess fluid out of the blood and regulating necessary substances like sodium and potassium. When function declines as a result of kidney disease, toxic substances build up in the blood and adversely affect the body’s performance. “Kidney disease puts you at tremendous risk for other problems like heart attacks, heart failure, or heart arrhythmias,” says BIDMC nephrologist David Friedman, M.D. “It is a much bigger issue than I think people are aware.” More than 26 million people in the United States are living with chronic kidney disease and are at risk for additional complications, and nearly half a million people suffer from end-stage kidney disease. African Americans, Latinos, and Native Americans are more likely to be diagnosed with the disease resulting in significant racial and ethnic disparities at every stage. If patients have access to care, current treatments for end-stage disease, such as dialysis or transplant, are costly, are often insufficient, and lead to a diminished quality of life. “Medicare spends more than 30 billion dollars a year taking care of kidney failure patients,” Pollak says. “That is about 6 percent of the Medicare budget.”

While diabetes and high blood pressure are considered the leading causes of kidney disease, researchers at BIDMC have made revolutionary discoveries to unearth genetic factors that explain why certain populations are more susceptible. Their work has already changed the way we approach kidney disease and may one day lead to better treatments and outcomes, and even reduce racial and gender disparities. “The real solution isn’t flashy,” Pollak says. “It is not necessarily a cure. It is preventing people from getting sick in the first place. I am hopeful that ultimately our division can put itself out of business by preventing all kidney disease.”

Through unique cross-disciplinary collaborations in the last 10 years, physician–researchers in BIDMC’s Division of Nephrology have focused on major populations disproportionately affected by kidney disease including pregnant women, African Americans, and Latinos. Nephrologist Ananth Karumanchi, M.D., identified a major protein involved in the development of preeclampsia—a life-threatening...
Giving Matters

A pregnancy condition characterized by typical symptoms of kidney disease like dangerously high blood pressure, edema, and protein in the urine; Pollak uncovered the genetic reason why African Americans are highly susceptible to kidney disease; and Friedman is close to untangling the mystery behind a unique kidney disease epidemic ravaging agricultural workers in Central America.

But these researchers haven’t rested on their laurels. Now, the team is building on their groundbreaking work to further understand the mechanisms that lead to kidney failure, not only to solve the problem for these specific populations of patients, but to find a solution for kidney disease in general. “It is clear that this is the best kidney disease research group in the country,” Karumanchi says. “We are studying big problems. The work that has come out of this institution has made a fundamental impact on the field of nephrology.”

Ten years ago, as a young physician–researcher, Karumanchi put the division on the map when he identified a protein responsible for preeclampsia. In this country alone, one to three mothers die each week from preeclamptic complications; in the developing world, where women might not have access to prenatal care, preeclampsia is the leading cause of maternal death. Combining his clinical background in nephrology with research training in vascular biology, Karumanchi collaborated with colleagues in the Department of Obstetrics and Gynecology and ultimately zeroed in on sFlt1, a naturally occurring protein that impedes the growth of blood vessels. Levels of sFlt1 were elevated in preeclamptic patients and fell after the delivery of the placenta. Karumanchi determined that the placenta was overproducing sFlt1, which spilled into the blood and damaged blood vessels in the kidney, brain, and liver. Further research uncovered that a second protein, soluble endoglin, when combined with sFlt1, escalated preeclampsia to a severe life-threatening state. The finding meant that clinicians can now measure protein levels in the blood not only to distinguish preeclampsia from other diseases with similar symptoms, like diabetes or lupus, but also to determine who is at risk for the disease and its rate of progression.

CONTINUED ON P. 10

SOMETHING TO TALK ABOUT

Major gift from the Bernstein family aims to improve communication skills among nephrologists

When the late Stanley J. Bernstein did not understand something, he would immerse himself in information until he grasped the concept. While undergoing 10 years of kidney disease treatment at BIDMC, he did just that—with a little help from his nephrologist, Robert A. Cohen, M.D. “When you are sick, knowledge is power,” Stanley’s wife, Cathy Bernstein, says. “Who would want to deal with dialysis on a daily basis if you didn’t understand it? Dr. Cohen took the time to describe things to Stan.”

Patients with kidney disease often experience additional complications that can be challenging to manage and face difficult decisions regarding their care. Cohen, the director of education in the Division of Nephrology, wants to educate future physicians on how to have more productive clinical conversations so that all patients like Stanley receive the necessary information to make the personal choices that are right for them. “We are training the rising generation of nephrologists on how to take better care of their patients,” Cohen says. “One of the fundamental parts of that process is improving communication.”

Inspired by communication training programs for residents and fellows in oncology, geriatrics, and palliative care, Cohen has been developing a communication skills curriculum in nephrology scaled at the national level. Cathy, along with Stanley’s sons, Geoffrey and Michael, contributed $500,000 toward this effort in memory of Stanley and in honor of Cohen’s brand of care. “I really credit Cathy and Stan’s sons with recognizing the importance of effective discussion between doctor and patient,” Cohen says.

One of only two programs of its kind in the country, the full-day workshop Cohen has created focuses on the complex conversations that occur along the course of treatment for chronic kidney disease patients—delivering the news of the approach of end-stage kidney disease, deciding whether to start dialysis or focus on quality of life, and discussing dialysis withdrawal and end-of-life care. “The skills we teach include learning the patient’s perspective—their values, goals, and concerns—in order to incorporate these essential elements into the shared decision-making process,” Cohen says.

The program was initially developed for fellows at BIDMC but has expanded in the past three years to include all first-year nephrology fellows at Harvard Medical School training programs. With support from the Bernstein family, Cohen is now offering similar workshops across the country and has developed an advanced program for academic nephrologists, enabling them to teach these skills at their home institutions.
CONTINUED FROM P. 9

Despite these critical findings, Karumanchi realizes that both the mother and the child still suffer serious consequences as a result of the disease. Women who have severe preterm preeclampsia are at an increased risk of hypertension and cardiovascular disease, and babies born preterm deal with long-term cardiovascular, metabolic, and chronic kidney disease. “While it has been great to help doctors better risk-stratify these patients, now is the time to really commit ourselves to go for full-out therapies and preventive strategies,” Karumanchi says. With support from Howard Hughes Medical Institute and the Burroughs Wellcome Fund, his lab is screening natural and FDA-approved compounds already proven safe for pregnant women, with the hope of identifying one that might block production of sFlt1 to delay onset of preeclampsia. Karumanchi is also investigating the damage preeclampsia causes to the mother’s vasculature to potentially define new ways to prevent stroke or heart attack. “This is a common problem that affects millions of women and babies throughout the world,” Karumanchi says. “I think we are now at a point where we believe it is a fixable problem.”

A few years after Karumanchi’s discovery, Pollak decided to take a closer look at another large population targeted by kidney disease: African Americans. In the United States alone, nearly 40 percent of dialysis patients are black. Through their investigations, Pollak, with Friedman and other members of his team, found that two common variations in a gene called APOL1 are responsible for African Americans’ greatly increased susceptibility to the disease. The high-risk forms of APOL1, which historically were helpful to protect against African sleeping sickness, occur in more than 30 percent of this ethnic group. Two copies of the gene, one copy from each parent, increase the risk of developing kidney disease to almost 10 times that of the general population. This seminal discovery allows clinicians to use genetic testing to predict who may be at high risk for kidney disease. But now Pollak, who was elected to the National Academy of Sciences last year for his achievements in research, wants to know how it works. “Not everyone with the high-risk genotype gets kidney disease,” he says. “One of the things we would like to understand is why some people with this genotype get kidney disease and some people don’t. That might give us clues on how to better treat people.”

With a generous matching grant from the NephCure Foundation, support from The Ellison Foundation, as well as more than $142,000 raised by fellow runners on the BIDMC Boston Marathon Team, Pollak has continued his work to understand the molecular mechanisms behind this gene. Using animal models, the team has identified certain signaling pathways that change the expression of APOL1 in the kidney and lead to an increased propensity for disease. By identifying what triggers APOL1 to cause damage to the kidney, researchers can potentially develop targeted treatments. However, the research is still in its early stages. “I am optimistic that a gene is going to lead us to ways to prevent and treat kidney disease, but I also think we need to do a lot more work to get there,” he says. Simultaneously, the team is also using the latest technology to screen thousands of compounds in search of one that may have an impact on the behavior of the mutant protein. “Support for this work would allow us to accelerate these experiments,” he says. “There is a lot more we can do.”

Researchers at BIDMC are also looking for answers beyond our borders. Friedman, in addition to his APOL1 research, is investigating an unexplained kidney disease epidemic in Central America known as Mesoamerican nephropathy. Agricultural plantation workers along the Pacific coast, primarily in El Salvador and Nicaragua, are suffering from high rates of kidney failure not associated with normal risk factors like diabetes or high blood pressure. In one community where Friedman’s team works, where a sugarcane plantation is the major employer, kidney disease is responsible for almost half of the male deaths in the last 10 years. While many assumed the epidemic was due to environmental exposure such as a pesticide or the intense heat, Friedman and a collaborating team at Boston University think the situation may be more complex. They contend that the disease is the result of a unique gene–environment interaction.

Working with a ground team in Nicaragua, Friedman and his colleagues have set up three studies with nearly 1,000 local participants—a family study, a case-control study, and a sibling study—to find possible genetic variants. The goal is to pinpoint a particular gene associated with this form of kidney disease and then look for an environmental factor that interacts with that gene. “In the short term, what is going to help these people is not developing a miracle drug, but instead using the biology of the disease-causing gene to figure out the environmental exposure with the idea that we can change the environment to eliminate the trigger of disease,” Friedman says. The results of this work will not only impact the residents of this region, but also individuals of similar origin in the U.S. “We think what we are going to learn will teach us fundamental things about kidney failure that will have tremendous implications for kidney failure in general, but particularly for the large Hispanic population,” says Friedman. Philanthropic support could not only benefit infrastructure on the ground and improve the ability to collect information and samples from more people, it could also help researchers take advantage of the technology at BIDMC to find answers. “Kidney disease is so underfunded and so neglected relative to the burden it places on public health that even relatively modest infusions of resources can make a huge difference,” Friedman says.

With philanthropic support and continued investigations, BIDMC researchers are poised to change the conversation about kidney disease again. “We know a lot more than we did 100 years ago or even 10 years ago about how the human body works and how the kidney works,” Pollak says. “It took evolution billions of years to figure out how to build a kidney, so it is going to take us a while to understand how it is put together and find ways to fix it.”
Sharing the Health
BIDMC receives $450K grant from The Commonwealth Fund to create OurNotes

Advances in technology have made it easier to better manage many aspects of our lives—we book flights in minutes, we find our dream homes from afar, we submit tax returns without stamps. So why shouldn’t the increased convenience, efficiency, and control that comes with these sophisticated technologies extend to our health? That’s a question that Beth Israel Deaconess Medical Center, a national leader in using information technology to improve patient care, has been working hard to answer. Now with a $450,000 grant from The Commonwealth Fund, the hospital is building on that foundation, developing OurNotes, an initiative to help patients take an active role in their health care by contributing to their own medical records along with their caregivers.

“This is really building for the future of what health care could and should be,” says the project’s principal investigator, Jan Walker, R.N., M.B.A., Division of General Medicine and Primary Care at BIDMC. Walker and her colleagues envision OurNotes as a unique way to ensure that patients and clinicians are always “on the same page” through features such as inviting patients to set an agenda by specifying topics to cover during an upcoming visit, journaling about non-urgent items between visits, or encouraging patients to review and perhaps even sign off on notes post-visit. All these transactions will take place on PatientSite, BIDMCs secure web-based patient portal.

OurNotes is the latest extension of OpenNotes, a movement to offer patients online access to their clinicians’ visit notes. Today, the number of patients who can read their medical notes online has risen to more than 5 million nationwide—a change in practice that followed the encouraging findings of the OpenNotes study, published in the Annals of Internal Medicine in 2012. Led by investigators at BIDMC, the study involved more than 100 primary care doctors and 20,000 patients in three areas of the country. Patients reported that they had better recall of their treatment plans and felt more in control of their health care.

“Our research has shown—and feedback from patients continues to confirm—that patients benefit from reading their visit notes,” says Walker. “We believe that OurNotes has the potential to further enhance communication and engage patients in managing illness more effectively, leading to improved safety and quality of care and, potentially, to lower health care costs.”

The Commonwealth Fund grant will support work at BIDMC and four other sites throughout the country. The multi-center team will work with industry experts, clinicians, and patients on a user-centered design process, focusing initially on primary care patients with multiple chronic health conditions. Says Melinda K. Abrams, M.S., a vice president at The Commonwealth Fund, “We know that increasing patient engagement is a critical component of improving health care, and we hope to build on BIDMC’s well-established work in this area.”

Generations of Generosity
Casty Family Continues Longstanding Legacy of Support with $290K Gift to Bowdoin Street Health Center

Ronald Casty’s family has a deep-seated connection to Beth Israel Deaconess Medical Center that spans nearly 100 years. Caregivers at the former Beth Israel Hospital treated his aunt for influenza in the early 1900s and Beth Israel Hospital treated his aunt 100 years. Caregivers at the former Medical Center that spans nearly our legacy, adding a fourth generation of philanthropists with a $290,000 gift to the BIDMC-licensed Bowdoin Street Health Center. Last year, Casty and his youngest of three daughters, Nicole Casty Vignati, visited the Dorchester community health center and recognized that they could have an immediate effect on patients’ lives by supporting the new wellness programming put in place by Executive Director Adela Margules and her staff. The holistic, preventive approach to care at Bowdoin Street struck a chord with Vignati, who worked as a teacher in Boston Public Schools and has seen the life-altering repercussions poor mental and physical health can have on a family. “Adela has her finger on the pulse of what is going on in the neighborhood and what the community needs,” she says.

The family gift will provide seed funding for critical pilot programs and initiatives that will improve the patient experience, such as further integrating a social worker into primary care teams. “There is enormous change in the health care industry today in cost, delivery, and science,” Casty says. “People in underserved communities don’t always have the opportunity to take advantage of those changes. This is an opportunity for creative new initiatives to have a major impact on both the health of the Bowdoin Street community and perhaps some of the processes and protocols at the main campuses of the hospital,” Vignati agrees. “Bowdoin Street Health Center and the new wellness programs are getting people healthier so they can face each day,” she says. “We are happy to be a part of that.”

For more information or to donate to Bowdoin Street Health Center, contact Rhea Brubaker at rhea.brubaker@bidmc.harvard.edu or (617) 667-4582.
The Tau of Lu
BIDMC researcher gets $250K grant to study protein’s role in Alzheimer’s

BIDMC investigator Kun Ping Lu, M.D., Ph.D., believes that the key to curing Alzheimer’s disease may lie in tau—a protein with something of a Jekyll and Hyde personality. Now with a recent $250,000 grant from the Alzheimer’s Association, Lu and his team are in hot pursuit of a specific antibody that can identify, and ultimately prevent, when tau is poised to manifest its dark side, wreaking havoc on the cells in the brain. Their promising research couldn’t be more timely. “Millions and millions of people are struggling with this disease,” says James Wessler, president and CEO of the Alzheimer’s Association MA/NH. “The Alzheimer’s Association is committed to advancing the science of investigators like Dr. Lu.”

Alzheimer’s disease is the most common form of dementia in older individuals. As the baby-boom generation ages and life expectancy continues to grow, the incidence rate is expected to increase dramatically; some estimates project that by 2050 the disease will affect 120 million people worldwide at a cost of more than $1 trillion in the United States alone. There is currently no effective treatment, but, with the help of his Alzheimer’s Association’s Investigator-Initiated Research Grant, Lu is committed to changing that situation.

Chief of the new Division of Translational Therapeutics at BIDMC, Lu discovered that tau can occur in two different orientations, known as trans and cis. While the trans orientation is healthy and necessary for normal brain functioning, the cis version becomes misshapen and can actually destroy brain cells, resulting in the protein “angles” characteristic of Alzheimer’s disease.

“Since this illness takes at least a decade to develop, the major challenge to halt memory loss is to identify the initial period when the brain’s tau protein is transformed from ‘good guy’ to ‘bad guy,’” he notes. “Our antibody can specifically detect this disease-causing tau transformation while leaving healthy tau intact to carry out its important functions.”

Backed by this grant, Lu and his colleagues are continuing their research in mouse models with the goal of eventually testing antibodies in patients with early-stage Alzheimer’s disease. They also recently demonstrated that tau’s sinister form is involved in traumatic brain injury, providing the first direct evidence linking this condition with Alzheimer’s and chronic traumatic encephalopathy. Says Lu, “I am extremely grateful for the Alzheimer’s Association’s generous funding that allows us to continue this important work.”

BIDMC received a $100,000 grant from the Alliance of Families Fighting Pancreatic Cancer for several projects under the auspices of A. James Moser, M.D., executive director of BIDMC’s Institute for Hepatobiliary and Pancreatic Surgery, which are designed to improve the quality of life of patients with pancreatic cancer.

In March, to mark five years of being cancer free, grateful cancer patient Rachel Dixon hosted a fundraiser called “Rachel’s Ride” at Soul Cycle, which raised more than $25,000 to support the communications training program at BIDMC’s Cancer Center.

Former BIDMC physician Michael Howell, M.D., M.P.H., returned to the medical center in April to give the Michael F. Epstein, M.D., Lecture on Clinical Quality and Patient Safety at this year’s Silverman Symposium.

Joanne Pokaski, director of workforce development, was in attendance as BIDMC’s efforts in providing skill and career advancement opportunities for its employees were highlighted at a White House “UpSkill America” summit in April.

Trustee Emerita Leslie Bornstein Stacks worked with members of the Bowdoin Street Health Center community, both adults and children, over the course of a year to create a handmade quilt that represented “wellness” to them. The finished product was revealed just in time for the ribbon cutting at Bowdoin Street’s Wellness Center in May (see page 19).

On June 7, led by captains Lauren Gabovitch, HIV case manager in Healthcare Associates, and Dan Barouch, M.D., Ph.D., director of the Center for Virology and Vaccine Research, Team BIDMC took part in the 30th Annual AIDS Walk Boston and 5K Run. The team had more than 60 members—the largest team in medical center history—and raised more than $10,400, making it a Gold-Level team and 12th on the AIDS Action Committee’s Top 50 Teams list.
When BIDMC Overseer June Tatelman first met John Doweiko, M.D., she knew she had found a partner in her push to further educate and better care for individuals infected with human immunodeficiency virus (HIV), the cause of AIDS. For more than 20 years, Doweiko has provided comprehensive care for HIV-infected patients at BIDMC’s Healthcare Associates (HCA). As a primary care physician, he is constantly managing the inherent challenges and persistent social stigma of contracting HIV to best treat his patients. For June, a former health education teacher, and her husband, Eliot, president and CEO of Jordan’s Furniture, finding ways to support HIV-infected individuals is deeply personal. In the early 1990s, Eliot lost his older brother, Milt, to AIDS. Today, through philanthropy and hands-on involvement, the Tatelmans are dedicated to educating people about HIV and AIDS and easing the burden of the disease for patients of all ages at BIDMC and around the world. “All of this is done in his memory,” June says.

The Eliot and June Tatelman Family Foundation recently contributed $282,000 to fund a Clinical Fellowship in HIV Medicine at BIDMC as well as administrative support for the fellowship. With the Tatelmans’ support, Doweiko and his colleagues at HCA are hoping to train primary care physicians to better address the challenging health care needs of the approximately 1,200 HIV-infected patients across the hospital. “HIV is not always on the radar anymore,” June says. “It is not a big part of education and there is little funding. But strong evidence has shown that education programs can help reduce the spread of HIV/AIDS. I am hoping patients that come to BIDMC will be able to talk to a doctor who understands their needs and can answer any questions they might have so they can live normal, healthy lives.”

While improved treatment options over the last two decades have helped HIV-infected patients to live longer and healthier lives, physicians like Doweiko are now facing a growing patient population with new health challenges and complications intrinsic to the HIV infection. According to the most recent report from the Centers for Disease Control and Prevention, an estimated 1.2 million people are living with HIV infection in the United States. “We are encountering physicians in the community who don’t know how to take care of somebody with cardiovascular disease who may be co-infected with HIV,” Doweiko says. “We are trying to train physicians to treat HIV-infected patients, become comfortable with the drug regimens that are used to treat HIV-infected patients, and also take care of some of the complications that occur with aging.”

The Clinical Fellowship in HIV Medicine will provide a unique training opportunity for primary care internists who are interested in gaining more clinical experience in HIV medicine and want to include HIV care as part of their clinical work. But the training is not just about understanding drug interactions and complications; it is also about enhancing the holistic care Doweiko has provided for more than two decades. It is about understanding that some patients might have difficulty getting and taking medications or are concealing those medications from family members and loved ones. “I want to see doctors who are like John,” June says. “Doctors who talk to patients and find out how they are coping with the disease; who care about them and who know how to educate them.”

“I am hoping [HIV] patients that come to BIDMC will be able to talk to a doctor who understands their needs and can answer any questions they might have so they can live normal, healthy lives.”

— June Tatelman
These modern-day Galileos of the cell are flouting traditional thinking and exploring how this previously overlooked genetic material might be the key to finding the answers to the most pressing medical mysteries of our time. "It's like putting pond water under the first microscope or turning the first telescope up at the sky—we are seeing stuff that we just didn't know existed," says Frank Slack, Ph.D., director of the Institute for RNA Medicine at Beth Israel Deaconess Medical Center. "With better tools and a bit of creativity, we are unshackling a whole new world."

Imagine handing Galileo the Hubble telescope. What awe would he have felt at seeing that there was an entire universe beyond the confines of his tiny lens? What untold opportunities would have been laid before him to profoundly change the fields of astrophysics and engineering? This is just how many contemporary geneticists feel about the fledgling field of non-coding RNA and its potential impact on medicine and health.

Frank Slack, Ph.D., is helping steer BIDMC into the uncharted world of RNA medicine

Many believed that the solutions for the most elusive diseases were imminent upon the completion of the Human Genome Project (HGP) in 2003. With the entire genetic blueprint for building a human being in our hands, it seemed like the cures for cancer and other complex illnesses couldn’t be far behind. But while it opened up an uncharted universe for exploration, the HGP also had the incongruous effect of limiting our focus to one tiny portion of the genetic cosmos. For decades, scientists concentrated their efforts on the part of our genome where they saw intense activity—the two percent that codes for proteins—reasoning that it would be the most logical place to find genes with a specific function. The remaining 98 percent appeared to be purposeless “junk.” As is so often the case in science, the reality turned out to be much more complicated.

"With the recognition that our genome has about as many protein-coding genes as that of the fruit fly came the idea that there must be a lot of other cool genetics going on in human beings to account for our complexity," says Slack. "And we and others are starting to show that the non-coding portion of our genome actually has function, which is changing our outlook on what constitutes an important gene."

Slack and the other leaders at the Institute for RNA Medicine have been pioneers in proving just how important non-coding genetics—and in particular the role of non-coding RNA—might be in human development and the progression of disease. Separately in the course of their research, they began to grasp that not only did these genetic components appear to be doing something significant but that they might actually be able to do something significant with them. In July 2014, Slack came to BIDMC to join fellow non-coding visionaries Pier Paolo Pandolfi, M.D., Ph.D., and John Rinn, Ph.D., in launching the Institute to build on this promise as a joint force. "I came from Yale to help direct this initiative because the preeminent leaders, the best of the best, in this field are right here. So the question is not why did I come to BIDMC but how could I not?" says Slack. "I'm banking my career on this. I truly believe we have the right team looking at the right science to develop better therapeutic options for patients."

Understanding why Slack is so optimistic about translating this science into treatments requires understanding what he and his maverick colleagues have already discovered about RNA, much to the surprise of many in the scientific community. Put simply, it is far from “junk.” A close cousin to DNA, the most well-known of genetic materials, RNA is found in abundance in our cells.

Understanding why Slack is so optimistic about translating this science into treatments requires understanding what he and his maverick colleagues have already discovered about RNA, much to the surprise of many in the scientific community. Put simply, it is far from “junk.” A close cousin to DNA, the most well-known of genetic materials, RNA is found in abundance in our cells.
“With better tools and a bit of creativity, we are unshackling a whole new world.”

—Frank Slack, Ph.D.

While a number are involved with the protein-coding process, translating DNA’s message to create protein end products, most RNAs are non-coding, regulating a whole range of cellular functions through a variety of genetic pathways. Think of RNAs as the cells’ office managers, responsible for ensuring that certain biological processes take place and conversely preventing others so the whole cellular system runs smoothly. Perhaps nowhere is this regulatory function so critical as during early human development, when we grow from a single cell to a complex organism made up of trillions of cells in a series of precisely ordered intricate steps. It may be that when these same processes run amok they cause deadly diseases later in life. “Cancer is a disease of intense cell growth and cell division, which is exactly what happens in the first few months of development,” says Slack. “But early on these genes get switched off or turned down. In cancer, because of mutations in the genome, those same genes get reactivated and now cells start dividing, sort of like they’re hallucinating they’re back in the womb. These developmental genes are the genes of cancer; it’s just that they’re not being regulated in the right way.”

Now that the Institute’s researchers have helped redeem non-coding RNA’s importance in the eyes of the world, their goal is to not only learn how RNAs manage—or in cancer’s case, mismanage—these types of processes but ultimately how to manipulate them to restore or reverse their function. “As we begin to recognize that diseased cells have altered levels of them, we can very quickly devise strategies where we can either give those missing RNAs back or inhibit those RNAs that are too abundant,” says Slack. “Over just the last two years, clinical trials have begun with these kinds of ideas, but there are only two such trials in the entire world. That shows you how the pursuit has not yet kept up with the promise.” It is a situation Slack hopes the Institute will remedy. He has set a target of uncovering at least five “actionable molecules” over the next five years, meaning RNAs implicated in particular disease pathways that can be pursued as potential clinical treatments. Given the enormous expense of clinical trials and the dominant role of the corporate world in bringing them to fruition, Slack also envisions philanthropy as a whole new world. “As we begin to recognize that diseased cells have altered levels of them, we can very quickly devise strategies where we can either give those missing RNAs back or inhibit those RNAs that are too abundant,” says Slack. “Over just the last two years, clinical trials have begun with these kinds of ideas, but there are only two such trials in the entire world. That shows you how the pursuit has not yet kept up with the promise.” It is a situation Slack hopes the Institute will remedy. He has set a target of uncovering at least five “actionable molecules” over the next five years, meaning RNAs implicated in particular disease pathways that can be pursued as potential clinical treatments. Given the enormous expense of clinical trials and the dominant role of the corporate world in bringing them to fruition, Slack also envisions philanthropy as a whole new world. “As we begin to recognize that diseased cells have altered levels of them, we can very quickly devise strategies where we can either give those missing RNAs back or inhibit those RNAs that are too abundant,” says Slack. “Over just the last two years, clinical trials have begun with these kinds of ideas, but there are only two such trials in the entire world. That shows you how the pursuit has not yet kept up with the promise.” It is a situation Slack hopes the Institute will remedy. He has set a target of uncovering at least five “actionable molecules” over the next five years, meaning RNAs implicated in particular disease pathways that can be pursued as potential clinical treatments. Given the enormous expense of clinical trials and the dominant role of the corporate world in bringing them to fruition, Slack also envisions philanthropy as a whole new world.

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molecules to the bedside. “I’m hoping to turn that model on its head to create investigator-initiated or philanthropy-directed trials at the Institute, where we don’t have to rely on a company’s interest,” he says. “That is absolutely the roadblock. There is so much interesting academic research that just dies at the pre-clinical stage because it is so hard to get the funding to go to the next step.”

If the funding hurdle can be overcome, the nature of non-coding RNAs offers distinct advantages when translating them to treatments. As these biological molecules are already found in the body and are typically very tissue-specific in their activity, safety should be less of a concern than when dealing with synthetically developed drugs. “And once you’ve identified the RNA involved in a disease pathway, it becomes the target for a drug—or the drug itself,” notes Slack. “We don’t necessarily have that second layer of trying to find a small molecule to affect the target, which shortens the time from discovery to the clinic by years.” In addition, these RNAs also usually regulate the activity of a number of different genes along the same pathway so they may act like a “drug cocktail” similar to those used successfully against HIV/AIDS to prevent potential resistance. Finding upstream regulatory mechanisms also opens up the prospect of eliminating multiple forms of a disease like cancer in one fell swoop by simply correcting one malfunctioning pathway. Perhaps the only serious physical barrier that remains is finding viable ways to deliver RNA-based therapeutics. “If you just inject RNA into the blood it gets degraded very quickly by enzymes,” says Slack, “so one of the huge challenges in the field is protecting the RNA and getting it to the right place. Currently, we are exploring the use of tiny molecules called nanoparticles to encapsulate the RNA and move it intact through the bloodstream to its target—almost like a slow-release Tylenol but on a microscopic level.”

Citing it as another area where philanthropy could have a profound impact, Slack hopes to build on these initial efforts by establishing a multidisciplinary “delivery core” at the Institute, which would draw on the creative expertise of a variety of fields including chemistry, bioengineering, and molecular biology.

As the field of non-coding RNA seeks answers in many disciplines, it may, in turn, find answers in many disciplines. With more than 65,000 new cellular RNAs uncovered in the last decade alone, their therapeutic possibilities may be virtually limitless. However, with only 24 hours in a day and finite resources, the practicality of their applications may not. “The challenge is that, realistically, we cannot look at every disease state,” says Slack, noting that the Institute’s initial focus will center around cancer and aging. “We have a big hammer, but how do you prioritize which nail? Ideally, I see our role as being able to show these things work in some diseases and inspire others to try them in their own areas. And some of that is definitely happening already.” While Slack hopes, of course, that his work will offer new hope to cancer patients, he’s still captivated by the idea that uncharted avenues of research have the potential to take you anywhere. “Scientists aren’t driven by bonuses,” he says. “The bonus for us is if we discover something new and it changes how we look at the world and how we can make it better. And for me that’s not by looking at the stars or the sea, but a cell.”

IN MEMORIAM

Robert C. Moellering, Jr., M.D.

The BIDMC community greatly mourns the loss of friend and colleague Robert C. Moellering, Jr., M.D., former chair of the Department of Medicine, who died on February 24, 2014. He was 77. “As a clinician, Dr. Moellering’s advice was sought on difficult infectious disease cases throughout the world, and as a teacher, the breadth of his medical knowledge was awe-inspiring,” said Peter Weller, M.D., chief of infectious disease at BIDMC.

“He was always a gentleman and devoted to his interns and residents, many of them going on to have distinguished careers in infectious disease. His legacy lives on.”

Moellering was a renowned researcher in the mechanisms of antibiotic action and bacterial resistance to antimicrobial agents, and held numerous leadership positions in the fields of infectious disease and microbiology. He served as chair of the Department of Medicine at the former Deaconess Hospital from 1981 to 1996. In 1998, he was named physician in chief and chair of the Department of Medicine at BIDMC. He also served as president and CEO of Harvard Medical Faculty Physicians at BIDMC and on the BIDMC Board of Trustees.

Moellering is survived by his beloved wife, Mary Jane Ferraro, Ph.D., and their children Anne Moellering and her spouse, Susan Cunningham, of San Francisco, CA; Robert C. Moellering III of San Francisco, CA; and Catherine Moellering and her fiancé, Anthony Buscemi, of Brooklyn, NY. He also leaves siblings, Gen. John Moellering (Ret.) of Chapel Hill, NC; Carl Moellering of Ft. Wayne, IN; and Barbara Greschaw of Ann Arbor, MI. An endowment fund established in Moellering’s memory, which will support educational activities for fellows training in infectious disease at BIDMC, has raised more than $540,000 from family, friends, and colleagues to date. To make your own gift to support Moellering’s inspirational legacy, please visit: bidmcgiving.org/Moellering.

Karl Gladstone

With heartfelt sadness, the BIDMC community acknowledges the loss of Karl Gladstone, member of the Board of Overseers, who died on April 26, 2014. He was 84. After successful treatment for prostate cancer by BIDMC oncologist Irving Kaplan, M.D., Gladstone and his wife, Joyce, made a generous gift to the medical center to purchase state-of-the-art equipment to improve brachytherapy, a technique that uses targeted radiation to eradicate cancer cells in the prostate. “Karl was my patient for about 15 years and was such a pleasant, down-to-earth guy,” recalls Kaplan. “He liked to reminisce about the good old days and how he built his business up from really nothing. Later in life, he paid that success forward through a variety of philanthropic endeavors, and our prostate program was fortunate to benefit from his generosity.”

Raised in Billerica, Gladstone was a well-known real estate developer and philanthropist in the Merrimack Valley. He was an avid supporter and trustee of Merrimack College, belonging to both the Men of Merrimack College and Friends of Merrimack College. He was a recipient of an honorary doctoral degree from the college. Gladstone was also a trustee of Bon Secours Hospital Men’s Guild and a trustee of Lowell General Hospital. He belonged to Rotary Club of Merrimack Valley, Billerica Elks Club, and the Aleppo Temple of Shriners.

Gladstone was the devoted husband of Joyce (Blumsack) Gladstone and the father of Heidi Gladstone, Elaine Baraby, and the late Richard Gladstone. He also is survived by many cherished grandchildren. He was a brother of Alfred Gladstone, Paul Gladstone, and the late Sumner Gladstone. He shall also be missed by his pet dog companions, Tommy, Timmy, and Teddy.
A Message from the President and CEO

HEALTH CARE IS CHANGING, ACROSS THE NATION AND HERE AT BIDMC. Still, I find that the old axiom “the more things change, the more they remain the same” holds true. As we make a shift toward more preventive, patient-centered models in medicine, this ongoing “revolution” in our industry is going straight to the heart of how we deliver care and is requiring all of us to rethink the nature of our role as a health care provider. But, for all that, we have never lost sight of our mission and our core values. Although we are dedicated to administering and discovering the latest treatments and to designing innovative delivery systems in quality and safety, ultimately BIDMC is about people—the patients and families who benefit from our efforts and the caregivers, researchers, and staff who make our efforts possible. This has never changed. And it has made the medical center an exceptional place in which to heal, work, and learn.

As the transformation in health care takes place, we recognize that as a prominent Harvard teaching hospital we have a momentous opportunity—and obligation—to play a critical role in perpetuating our enduring brand of medicine, not only for our own patients but patients everywhere. We also understand that in order to fill this role successfully we, in turn, must change, focusing on our unique assets in medically complex care and innovative research at our urban campus while at the same time creating new partnerships and systems to promote effective and efficient care more broadly in the community. It is an irony not lost on me. Fortunately, BIDMC is an institution that has not only withstood change but embraced it, emerging as one of the most progressive health care institutions in the nation. While change can be daunting, people here see this revolution as a time of opportunity, offering concrete and creative ideas for how we can make the process better for patients, families, and staff.

Together we have embarked on strategic initiatives to proactively respond to this new health care environment while maintaining the values for which we are known. And we are already seeing the fruits of our collaborative efforts. Perhaps most significantly, we have worked to more thoughtfully distribute our high-risk, critical care and our routine and preventive care services to ensure that our patients can be treated in the right place by the right caregiver at the right time. Much of this work has hinged on the exciting range of partnerships we have built over the past several years, from our acquisition of BID–Plymouth to affiliation agreements with New England Baptist Hospital, Anna Jaques Hospital, and Lawrence General Hospital.

We have also built new programs for urgent, walk-in treatment at our beautiful new Beth Israel Deaconess HealthCare facility in Chestnut Hill and the Dedham Medical Urgent Care Center at Norwood in partnership with Atrius Health. In fact, we have almost tripled the number of hospitals we own or are affiliated with. The promise of these new relationships has not gone unnoticed. We have received awards and media attention. Our outpatient volumes have grown exponentially, and physicians are hastening to join our network (the number of our primary care physicians alone rose by nearly 60 percent from 2013 to 2014). But publicity and growth are not our ultimate goal. Our ultimate goal is to serve our patients better. That’s why these partnerships are so important. By focusing on complex care at our Boston campus, we can serve the sickest of the sick with the advanced technology, clinical and surgical expertise, and access to research trials that only a major academic medical center can provide. But at the same time, patients who have less serious medical needs don’t need to sacrifice the quality of their care when seeking treatment in more convenient settings closer to home because our partners have the same world-class physicians and caregivers as our urban location. To put it simply, we’re offering our patients and families the best of both worlds.

But with all our successes thus far, we still have a great deal of work ahead. With our ongoing efforts come responsibilities and needs. We must ensure our facilities and technology are on par with the excellence of our caregivers. We must make our brand of care available to all patients regardless of their health condition or circumstances. We must continue our obligations as an academic medical center to generate new biomedical knowledge and to educate the next generation of outstanding physicians and researchers. Meeting all these needs relies substantially on philanthropy and is why fundraising is so important to our mission as a non-profit organization. We are so grateful to all the supporters in our community who have helped us achieve so much in this extraordinary time of growth and transformation. We look forward to continuing to partner with you as we lead the way in the health care revolution while ensuring that all that is special about BIDMC remains intact.

Sincerely,
Kevin Tabb, M.D.
President and CEO, BIDMC
ON THE SCENE

PALM BEACH CELEBRATION
February 11, 2015

In February, guests gathered at The Breakers hotel in Florida for BIDMC’s annual Palm Beach event. This year’s event, which was co-chaired by Sunny and Sam Gustin, showcased some of the medical center’s renowned innovators in cancer, digestive disease, and neurological disorders. Emceed by longtime WBZ-TV anchor Jack Williams, the “Who Wants to Be an Innovator?” program featured distinguished BIDMC specialists—David Avigan, M.D., Ram Chuttani, M.D., Tejas Mehta, M.D., M.P.H., and Seward Rutkove, M.D.—who discussed their tireless work to develop new diagnostic tests with fewer side effects, seamlessly integrate care, and deliver personalized treatment options with global reach. Joanne Casella, a longtime BIDMC employee and a grateful patient of Chuttani, also shared her experience with the medical center’s outstanding care.

1 Lois Silverman Yashar and Jim Yashar, M.D., Helaine B. Allen
2 Ted and Cynthia Berenson
3 Marty and Dena Trust
4 Johnny Lank, Buddy and Althea Lank, Sunny and Sam Gustin, Harley Lank

MANAGEMENT OF ATRIAL FIBRILLATION IN THE 21ST CENTURY
March 11, 2015

In March, Mark E. Josephson, M.D., chief of BIDMC’s Division of Cardiovascular Medicine and director of the Harvard-Thorndike Arrhythmia Institute, along with the Cardiovascular Advisory Committee (CVAC) hosted an interactive breakfast program on the topic of atrial fibrillation featuring presentations and open discussions with leading cardiovascular experts from the medical center. The educational symposium, which was emceed by CVAC Volunteer Chair and BIDMC Trustee Pamela Lesser, highlighted the potential causes, risk factors, and consequences of atrial fibrillation, as well as the latest research, technologies, and therapies for this increasingly prevalent and complex condition. The distinguished panel featured presentations from Josephson, Peter Zimetbaum, M.D., Alfred E. Buxton, M.D., Elad Anter, M.D., and Warren J. Manning, M.D.

5 Mark Josephson, M.D., Pam Lesser
6 David Weener, Kevin Tabb, M.D.
7 Terry Matichak, Deone Matichak, Bob McAulisse, Lisa Hope
BOSTON MARATHON
April 20, 2015

The soggy conditions did little to slow down Team BIDMC in April as 51 runners braved the elements for the 119th Boston Marathon. In its first race as an official Boston Athletic Association charity, Team BIDMC raised more than $360,000 to benefit a variety of BIDMC causes ranging from community health programs to groundbreaking research.

8 Caron Tabb, Shai Tabb, Kevin Tabb, M.D.
9 Jeffrey William, M.D.
10 Gina Evans, R.N.
11 Emmy Cunningham, Lori Cunningham, Jake Cunningham

WELLNESS CENTER RIBBON CUTTING
May 12, 2015

One year to the date after the official groundbreaking of its new Wellness Center, Bowdoin Street Health Center held a ribbon-cutting ceremony to celebrate the opening of its new space and the successful conclusion of The Campaign for Wellness. The program featured remarks from grateful patient Irvin Paul, Bowdoin Street Executive Director Adela Margules, BIDMC President and CEO Kevin Tabb, M.D., State Senator Linda Dorcena Forry, State Representative Evandro Carvalho, and City of Boston Mayor Martin J. Walsh. The 4,000-square-foot expansion and 1,700-square-foot renovation project will bring a range of new, fully integrated health and wellness services to the neighborhood.

12 Community, BIDMC, and Bowdoin Street dignitaries do the honors at the ribbon-cutting ceremony
13 Jill Cheng, Matthew Epstein, Phyllis Barajas, Nancy Kasen
14 Helen Chin Schlichte, Clayton Deutsch

CRITICAL VOICES—UP CLOSE AND PERSONALIZED: A NEW ERA OF CANCER CARE AT BIDMC
May 13, 2015

In May, BIDMC’s Board of Overseers hosted its annual Critical Voices event, which showcased how BIDMC is transforming the landscape of cancer research and care for patients at the medical center and beyond. Co-chaired by Anja Langbein-Park, Sharmil Modi, and Stephanie M. Pierce and emceed by Alexandra Drane, the program featured an esteemed panel of doctors and researchers—including Pier Paolo Pandolfi, M.D., Ph.D., Frank Slack, Ph.D., A. James Moser, M.D., F.A.C.S., Mary Ann Stevenson, M.D., Ph.D., and Nadine Ting, M.D.—who presented the latest in their groundbreaking work. BIDMC grateful patient and co-founder of the A Reason To Ride bike-a-thon Tom DesFosses also shared his inspiring story of fighting brain cancer.

15 Anja Langbein-Park, Stephanie M. Pierce, Kevin Tabb, M.D., Danielle Remis Hackel, Sharmil Modi
16 Sarah Salter Levy and Steven Levy
17 Pier Paolo Pandolfi, M.D., Ph.D., Letizia Longo, Ph.D., Pamela and Nina Micoczi
BIDMC honored former Massachusetts Governor Michael Dukakis with a 2015 Environmental Champion award at this year’s Healthy Work/Healthy Home breakfast. The annual event celebrates the medical center’s sustainability initiatives and, in particular, staff who have gone above and beyond to develop, implement, and oversee new practices that help the environment. In his keynote address, Dukakis described some of the ways he has witnessed Boston grow more environmentally friendly over the years. “BIDMC is part of what makes this city great. I’m very proud of you,” Dukakis said, complimenting the medical center on its “green” efforts. “I hope you’ll be a model for other institutions across the Commonwealth.”

Show your Gratitude@Work and support BIDMC’s mission to provide extraordinary care, where the patient comes first, supported by world-class education and research.

bidmcgiving.org/givingtuesday