Keeping your cool is a complex process

Amy Davis, APRN, Dermatology
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Rhea Hirshman, editor

Like other mammals, we humans are warm-blooded, maintaining a constant core body temperature by complex metabolic means. That temperature averages 98.6 degrees Fahrenheit for most of us, although the body temperature of healthy individuals can range from 97 to 100 F. Body temperatures in this range are unlikely to represent a fever, but this determination depends on the clinical situation. One’s body temperature may also vary throughout the day due to changes in bodily functions; this cycle is our “circadian rhythm” [from the Latin “circa” meaning “around” and “dies” meaning “day”]. Body temperature is usually highest in the evening and lower in the morning, and can be raised by physical activity, heavy clothing, some medications, high temperature, and high humidity. In women of childbearing age, a small temperature increase occurs following ovulation, during the menstrual cycle, and during the first trimester of pregnancy.

Our bodies work constantly to maintain internal temperature within the normal range in a process called “thermoregulation.”

There are two types of thermoregulation: behavioral and physiologic. Behavioral is what we do to keep ourselves comfortable—putting on a sweater when we’re cold or opening windows when we are too warm. Physiologic thermoregulation is the mechanism by which the body creates a more precise adjustment of heat balance. Physiologic thermoregulation is done by communication among organs including the brain, skin, muscles, and blood vessels.

continued on page 2

Who? Me? Change?

Carole T. Goldberg, Psy.D.
Department of Mental Health
Rhea Hirshman, editor

“Nothing endures but change” noted the Greek historian Heraclitus. While change all around us is constant, making permanent changes in behaviors or habits can seem daunting.

For some, changing the externals of life—cars, mates, homes, neighborhoods, geographic locations, jobs—may feel simple, while making internal changes in attitudes, habits, patterns, and behaviors may feel like trying to rewrite something written in stone. Others seem to change beliefs, attitudes, interests, likes and dislikes with the phases of the moon, while never budging from home base or while keeping the same job for decades.

continued on page 5
The brain receives signals regarding body temperature from nerves in the skin. These signals go to the hypothalamus, a small structure within the brain. The hypothalamus acts as a sort of thermostat, responding by making physiological adjustments in heat production and heat loss to resist disturbances in core temperature. For example: on a hot day, temperature receptors in the skin send signals to the hypothalamus to cool the body by increasing sweat rate.

Our bodies...maintain... temperature within the normal range in a process called thermoregulation.

When it is too cold, the body increases heat production and decreases heat loss. Blood is directed away from the skin by blood vessel constriction. The familiar “goose bumps” are a physiological response to cold which increases the insulation capacity of the skin. When goose bumps are not enough to increase heat, shivering develops through rhythmic contraction of skeletal muscles.

However, in extreme cold, for example immersion in very cold water, the body loses its ability to maintain its central [core] temperature. The result is a process known as hypothermia, when normal muscular and brain functions are impaired. Stages of hypothermia range from mild to severe. Symptoms include shivering, slurred speech, loss of coordination, irrational behavior, pale skin, dilated pupils, erratic breathing, cardiac arrhythmias. In extreme cases, death can result. The very young, the very old, those with metabolic disorders, those with Parkinson’s disease, and those on certain medications are most vulnerable to hypothermia.

On the other hand, when the body is too hot, more blood is directed to the surface of the skin through blood vessel dilation. Sweat glands are stimulated, resulting in an increase in the rate of water lost through sweating.

Sweat glands are also under the control of the body’s nervous system, so we sweat more in response to situations that make us nervous, angry, embarrassed, or afraid.

Humans have two kinds of sweat glands. Eccrine sweat glands are most abundant on the palms of hands, soles of feet, and on the forehead. They produce sweat that is composed mostly of water and salts. Apocrine sweat glands produce sweat mainly in the underarm and genital areas. When the sweat from these glands mixes with bacteria on the skin it produces an odor. Antiperspirants block the pores with astringents such as aluminum salts. Deodorants work by neutralizing the smell of the sweat and by antiseptic action against bacteria.

Fever—a higher than normal body temperature—can be caused by many diseases and disorders including infections from viruses and bacteria, certain autoimmune diseases, some malignancies, reactions to some medications, blood transfusions [the body may respond to the introduction of a foreign substance] and disorders which interfere with the brain’s capacity to regulate temperature [e.g. certain kinds of brain damage from accidents]. A significant fever is usually defined as an oral temperature of 102.

The body responds to fever by increasing the heart rate, breathing rate and blood circulation to the skin. While the purpose of fever is to help activate the immune system to make more white blood cells, antibodies, and other infection-fighting agents, a prolonged high fever can cause dehydration, fatigue, chills, sweats and nausea.

The degree of temperature elevation does not necessarily correspond to the seriousness of an illness. Children with fevers usually run higher temperatures than adults, while elderly persons and newborns may have less marked fevers.

Heatstroke is a particularly dangerous type of high temperature caused by external conditions such as extended exposure to heat or exercising too strenuously without adequate hydration. The body is unable to stop its temperature from continuing to rise; heatstroke is characterized by cessation of sweating, severe headache and hot dry skin. If not treated, it can result in coma and death. The elderly and others with impaired thirst are particularly susceptible, as they are more likely to become severely dehydrated. Avoiding heatstroke involves common sense measures such as never leaving children [or pets!] in hot cars; drinking water before, during and after exercise; exercising during cooler times of the day; and wearing light, loose-fitting clothing in hot weather. While our bodies do a remarkable job of temperature regulation, sometimes we have to help out.
Internationalization has emerged as one of Yale’s leading priorities. Ever-increasing numbers of faculty and students are coming to Yale from abroad, and the University has instituted major initiatives to send members of the Yale community to work and study in far-away places. Last year Yale enrolled nearly 1,800 international students from 108 countries, making up more than 15% of our student body. Yale also employed or hosted nearly 2,000 visiting scholars, faculty and postdoctoral fellows from 95 countries—and these figures do not include the many visitors from throughout the world who come to Yale for short periods of time. Yale has over 800 international projects and activities involving hundreds of faculty. Visit http://world.yale.edu/ to find information on Yale’s internationalization strategies, including “The Internationalization of Yale: The Emerging Framework,” published in January 2006.

The internationalization of the University has many ramifications for the delivery of health care. We are providing care for an ever-increasing number of members from Asia, Africa, South America and other regions where health care may differ from the American model and where people face clinical problems that we would otherwise rarely encounter. At the same time, travelers to many foreign destinations have a host of health care needs before they travel, while they are abroad, and after they come home.

As we read about the resurgence of mumps and measles, we must remember that some members come from countries where they may not have had the childhood immunizations—including for tetanus and hepatitis B—that Americans think of as routine.

In addition, some come from countries where tuberculosis is endemic, and we have seen other illnesses that we are less likely to encounter in American-born non-travelers. Many developing countries lack the technology to diagnose infections such as HIV and other diseases that we detect with serological studies.

On the other hand, if you are traveling abroad, keep in mind that travel illness may be more than jet lag and “turista” (traveler’s diarrhea). Major travel-related illnesses that we think about include malaria, yellow fever, dengue fever and a list of parasitic illnesses that you should not try to contemplate over lunch. Try “googling” leishmaniasis, schistosomiasis, leptospirosis, “botfly”-related illness, cystocercosis and filariasis. You will soon get the idea.

If you are traveling abroad, you should check the relevant Centers for Disease Control and Prevention web site (http://www.cdc.gov/travel/). If your destination carries health risks, schedule an appointment with our Travel Medicine clinic far in advance so that you can get the recommended vaccinations and information. Your travel history should be part of your discussion with your clinicians upon your return, especially if you have been in high-risk areas.

One set of health care issues relating to Yale’s internationalization involves the delivery of what we usually consider “medical care”—including diagnosis, treatment and prevention of illnesses such as those described above. The other major issues involve “cultural competency”—our need to understand health-related concerns arising from a person’s cultural background.

Many challenges arise when caring for patients who come from different countries. The most obvious is the language gap, so YHP provides members with translation services that allow them to communicate clearly with their clinicians. People from other cultures may have different understandings of (and cultural attitudes about) mental illness, sexually transmitted infections, and other medical conditions. We sometimes encounter patients with exaggerated stoicism and determination to avoid health care—attitudes which may be culturally-based or which may arise from poor access to medical treatment at home. Some patients are strictly observant of religious and/or cultural rules, such as those preventing a male clinician from examining a female patient. Another challenge arises when a patient uses herbal treatments that are unfamiliar to us, and which may interact with prescribed medications.

“Cultural competency” has become a sort of buzz-word, but its true meaning is not “cultural correctness.” For YHP, such competency is an essential part of understanding the needs of our members. We are systematically addressing the need to understand the attitudes and experiences of our patients who come from far away, including furthering our own education at numerous conferences about international medicine. If you have suggestions about how we can improve services to our growing international community, please let us know. And please reach out to your neighbors, colleagues and classmates to help them become more comfortable about seeking health care here at Yale.

from the desk of

PAUL GENECIN, MD
DIRECTOR, YALE UNIVERSITY HEALTH SERVICES

The internationalization of the University has many ramifications for the delivery of health care.
For a happier summer

- Reduce the presence of mosquitoes which, besides being annoying, can carry a number of illnesses, by eliminating standing water in your surroundings. For example: turn over cans in your recycling bin so that rain water does not collect; remove standing water from outside potted plants; keep bird baths away from walkways, entryways and windows.

- Any time you have been out of doors, whether in a grassy yard or in the woods, check yourself and your pets for ticks, which are potential carriers of diseases such as Lyme disease—the most common—and erlichiosis, babesiosis and rocky mountain spotted fever. To remove a tick, grasp it firmly with fine tipped tweezers as close to your skin as possible, and with a steady motion pull the tick’s body away from your skin.

- Lift that kale

Want to build strong bones without spending lovely warm days inside the gym? A recent study at the University of Arkansas supported the value of yard work as a bone-building exercise. Activities such as raking leaves, weeding, digging holes, hauling mulch, and pulling weeds require squatting, lifting and pushing—all good for maintaining or increasing bone density. Of course, you might still have to hit the gym in the depths of winter.

Do not use petroleum jelly or other substances which will make the tick difficult to hold onto. Cleanse the area with antiseptic. Be alert for a rash, fever, headaches or flu-like symptoms. If these occur, consult your clinician.

- Protect your eyes from the same ultraviolet rays that can damage skin. Wear sunglasses labeled as blocking 99-100% of UV-A and UV-B rays, or labeled “UV absorption up to 400 nm” (nanometers, a measurement of wave length). These phrases mean the lenses are chemically coated to block UV light.

- Keep food safe. Food left out of refrigeration for more than two hours may not be safe to eat. Above 90°F, food should not be left out over one hour. Put leftover perishables back on ice once you finish eating so they do not spoil or become unsafe to eat. When in doubt, throw it out!

- Keep a salad for French fries.

- New menus at many quick-serve restaurants also include smaller portions and readily available nutrition information.

I WANT TO BE A LAWN
Chemicals used to create a “perfect” lawn pose significant health risks to adults, children and pets. These substances eventually move into the ground water and that ground water travels into the public water supply. Lawn pesticides are poisons designed to kill living organisms and they are linked to higher rates of cancer, birth defects, nerve damage and learning disabilities in mammals. According to the (federal) EPA (Environmental Protection Administration), over 90% of the pesticides used on residential lawns are possible or probable carcinogens.

If you want to encourage the traditional turf lawn look while eliminating the poisons, do the following:

- Choose grasses appropriate for this environment.
- Mow high and mow often, with a well-sharpened mower.
- Water deeply but infrequently. This encourages deeper root growth, resulting in a more stable and disease-resistant lawn instead of one whose roots remain near the surface.
- Don’t worry about drought. Well-established lawns will not die under drought conditions. They will just turn brown and then green up again when the rain falls.

Healthy ideas

HEALTHIER CHOICES ON THE RUN
While our consumption of fast food should be kept to a minimum, eating at fast-food and quick-serve restaurants can be incorporated into a healthful diet if you make smart choices.

- Order tacos or burritos with salsa and skip the cheese to reduce your saturated fat intake.
- Top pizza with chicken or Canadian bacon with lots of vegetables.
- Ask for a grilled chicken sandwich served on a baguette.
- Drink water or skim milk instead of a soft drink.
- Substitute a salad for French fries.
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LIFT THAT KALE
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Being able to make significant changes may be related to character styles. We know people who readily drop conventional ties and use change to fuel their worlds. We also know those who are set in their ways and content only if they can keep change at bay.

Even when change is desired a great deal of emotion is often involved in giving up old behaviors and establishing new ones. The aphorism “Insanity is doing the same thing over and over and expecting different results” (which has been attributed to, among others, John Dryden, Albert Einstein, Benjamin Franklin and Rudyard Kipling), reminds us that in order to make meaningful and lasting change we have to understand our feelings and behaviors. Some people enter counseling or psychotherapy to develop greater self-awareness when the old ways are not working. But any of us can observe some of our own behaviors and focus on putting them into words.

Talking about something is a way of trying it out, opening up greater possibilities for understanding, leading to better-informed choices. Some questions we may ask ourselves: Do we really want what we are thinking about? Can we trust ourselves to make the best choices? Can we trust others who are encouraging us to change? What will this new behavior, experience, place, or person be like? How will I be different? What will I lose? What will I gain? How will others feel about me if I make this change? Will they be angry if I do? If I don’t?

If the changes are related to health, the stakes may be particularly high. Lifestyle changes can make a significant difference in well-being but, for some, only a life-altering event—such as a heart attack—activates the change process. Health professionals are often faced with the task of helping patients understand the behavioral changes necessary for health maintenance or improvement, or for managing long-term illness. These changes can range from the simple [walking a few times a week] to the complex and all-encompassing [the changes in diet, exercise and self-monitoring required when one is diagnosed with diabetes].

A “stages of change model,” has been developed by psychologist James O. Prochaska and others, (American Psychologist 1992; 47:1102-04). They note: “For most people, a change in behavior occurs gradually, with the patient moving from being uninterested, unaware or unwilling to make changes (the precontemplation stage), to considering a change (contemplation stage), to deciding and preparing to make a change. Genuine determined action is then taken and, over time, attempts to maintain the new behaviors occur. Relapses are almost inevitable and become part of the process of working toward life-long change.”

Remember that making and maintaining meaningful changes in one’s life is a process. If you need to make health-related changes, talk with your clinician to assess where you are in that process and to create a plan that is sustainable and increases the likelihood of success.

In A ‘Stage of Change’ Approach to Helping Patients Change Behavior, Gretchen L. Zimmerman, Psy.D and others outline these stages with examples.

**Precontemplation**
Here, patients do not even consider changing. “Smokers ‘in denial’ may not see that the advice to quit applies to them personally. Patients with high cholesterol levels may feel ‘immune’ to the health problems that strike others. Obese patients may have tried unsuccessfully so many times to lose weight that they have simply given up.”

**Contemplation**
Here, patients are ambivalent. “Giving up an enjoyed behavior causes...a sense of loss despite perceived gain. During this stage, patients assess barriers (e.g., time, expense, hassle, fear, “I know I need to, but...”) as well as benefits of change.”

**Preparation**
In this stage, patients prepare to make specific change. “They may experiment with small changes as their determination...increases. For example, sampling low-fat foods may be...a move toward greater dietary modification.

Switching to a different brand of cigarettes or decreasing their drinking signals that they have decided a change is needed.”

**Action**
This is an exciting stage to see. “Many failed New Year’s resolutions provide evidence that if the prior stages have been glossed over, action itself is often not enough. Any action taken by patients is worthy of praise because it demonstrates the desire for lifestyle change.”

**Maintenance and relapse**
This stage involves incorporating the new behavior “over the long haul.” “Discouragement over occasional ‘slips’ may halt the change process and result in the patient’s giving up. However, most patients find themselves ‘recycling’ through the stages of change several times before change becomes truly established.”
New Pharmacy benefit

- Beginning July 1, 2006, the prescription deductible increases to $200 per person, up from the current $150 per person. The family maximum (deductible) increases to $600 per year, up from $450.
- Pharmacy co-insurance remains at 20% up to a $700 individual out-of-pocket expense. Pharmacy expenses over $700 per individual are covered at 100%.
- The cap on Pharmacy reimbursement remains at $25,000 per person/year.

From the Pharmacy

Generic drugs offer quality and savings

While generic foods are often marketed as “no frills” items, generic medications have certain standards that must be maintained in order to be considered equivalent to, or interchangeable with their brand-name counterparts.

Every drug has a “generic” or “chemical” name. Lipitor—a cholesterol treatment made by Pfizer—is known also as atorvastatin calcium. People generally use the term Lipitor because, until its patent expires, it’s the only available version of atorvastatin calcium. Motrin is a medication that, at the end of its manufacturer’s 20 year patent, became available by other makers as ibuprofen.

The 20-year patent allows research-based manufacturers exclusive rights to the market with their unique products, in order to recover investments made in development, testing and marketing. Once the patent expires, other companies are allowed to make generic versions—therapeutic copies duplicating the original formulation. These also must be tested by the manufacturer and approved by the FDA. Because generic makers don’t have to prove product effectiveness (already done by the original producers), an expense of drug development is removed. Further, because many drug makers may introduce their own versions of an off-patent product, competition helps drive prices even lower.

Myths regarding generics include that they take longer to act, or are not as potent as brand-name drugs. In fact, companies selling generic drugs must demonstrate that they are “bioequivalent”—that they respond essentially the same—before they can be considered therapeutically interchangeable with the original. Those that meet the FDA’s stringent requirements for strength, quality, purity and stability are designated “AB-rated.”

The YUHS Pharmacy considers many factors when determining which generic drugs to stock. These include cost, FDA rating, the reputation of the manufacturer and its ability to continue to make product available (no back orders or shortages), as well as such matters as the appearance of the drug (allowing, when possible, the generic to resemble its branded counterpart).

Generic makers are not obliged to be consistent with each other regarding a medication’s appearance. Occasionally, when there has been a switch from one generic to another of the same medication, patients may see pills that are a different color or shape. Ask your pharmacist any questions you have about a change in a medication’s appearance. Remember that generic drugs are as safe and effective as brand-name drugs, and that using generics when available can result in significant savings.

Information from Martha L. Asarisi, RPh, staff pharmacist
Read this!

Members of the YUHS staff offer summer reading suggestions.

Martha Asarisi, RPh, staff pharmacist
Sacred Cows by Karen Olson. A murder mystery that takes place in and around New Haven so if you like mysteries and live in the area it might pique your interest!

Kristin Bradley, pharmacy technician
Black House by Stephen King and Peter Straub. This is a prelude to the Dark Tower series—a great multi-world adventure.

Kathy Connelly, pharmacy technician
Night by Elie Wiesel. A slim novel packed with the horrors of being the only family member to survive the Holocaust—and the effect on the narrator’s life.

Small Miracles by Yitta Halberstam and Judith Leventhal. A feel-good book about fate and how it affects everyday life.

Cynthia Eber, RN, MPA, Student Medicine
Beach Road by James Patterson and Peter de Jonge. An enjoyable summer vacation book, with something for everyone: basketball, murder, lost love, lawyers, the Hamptons. The use of multiple narrators to tell the story keeps your interest until the unpredictable ending.

Vicki Eisler, patient representative
Marley & Me by John Grogan. The heartwarming story of a family in the making and the wondrously neurotic dog who taught them what really matters in life. The book made me laugh and cry.

Paul Genecin, MD, director of YUHS
The Kite Runner by Khaled Hosseini is a vivid story about a boy who grows up in Afghanistan in a privileged family. Hosseini colorfully depicts his character’s experiences as a child when the Taliban come to power and his adventures as an adult expatriate returning to his country. The main character is complicated and flawed; his redemption for early transgressions is only partial. Despite the setting, the book is not a political tract. It is a good read for adults and older adolescents.

Some of my favorites are by the 19th century British novelist, Anthony Trollope. Among his 47 novels, he wrote two “series” of loosely connected books, the Barchester novels and the Palliser novels. All the books stand alone and are wonderful. My favorite Barchester novel is Barchester Towers. Of the Palliser novels, I like Phineas Finn and Phineas Redux. But my favorite Trollope novel is The Way We Live Now, which is not part of a series. Trollope’s Victorian upper-crust world is filled with political schemers, financial wheeler-dealers, newspaper reporters and all sorts of personalities that seem surprisingly contemporary. The books are long, but what’s the rush?

Robert Henry, assistant director of Finance
The Lake House by James Patterson. This sequel to When the Wind Blows is a great fantasy-thriller with a good mix of evil plots, bird children who can fly and two adults who take them under their wing! Read When the Wind Blows first—it is actually a better read and sets up this book.

Hour Game by David Baldacci is a thriller about a serial killer on the loose, a dysfunctional family and two ex-Secret Service agents on the trail. Fast-paced and gripping.

Cynthia Holland-Toftness, MSN, FNP, APRN, Internal Medicine
Dirty Blonde by Lisa Scottoline is a good, quick-read mystery. I also love anything by Vince Flynn. His political thrillers are not for the weak-hearted!

Margaret Hionis, Medicare/retiree coordinator
Dispatches from the Edge by Anderson Cooper. This passionate journalist writes in a fashion that allows the reader to see places and human suffering that most of us can not even imagine—also sharing with us the turmoil and personal reflections that have resulted from these experiences.

Douglas Idelson, MD, chief of Pediatrics
The Life of Pi by Yann Martel. An imaginative novel about a young Indian boy who survives a shipwreck, it cleverly chronicles his experience with adventure, endurance, and faith.

Marian Katz, medical transcriptionist
The Kite Runner by Khaled Hosseini [also recommended by Paul Genecin, MD, above]. About two boys growing up in Afghanistan. Absolutely spellbinding: coming of age, foreign customs, family values, social hierarchy, immigrants to America, suspenseful and dangerous rule of the Taliban.

Tracy LeClair, coordinator, Director’s Office
Suzanne’s Diary for Nicholas by James Patterson. A moving love story, consisting of two parallel tales. The first concerns a woman who thinks she has found the perfect man, only to have him disappear. The second story comes into play when she searches for answers about his disappearance and finds them in the pages of a diary that a young mother has written for her infant son.

The Rapture of Canaan by Sheri Reynolds. A story of a teenage girl growing up in an isolated religious community and daring to indulge a forbidden love.

Christa Mrowka, administrative coordinator, Director’s Office
And She Was by Cindy Dyson. Set in Alaska’s Aleutian Islands, this is the story of a woman living at the edge of the world and the edge of her life. Sweeping across centuries and cultures, mingling the past with the present, Dyson weaves a tale of secrets and truths, survival and change. A gripping, inspiring story that will stay with you.

Love Walked In by Maria de los Santos. A beautifully crafted tale of love, friendship, redemption and second chances. Touching, charming and heartwarming.

Joe Papagoda, account assistant, Billing
Ghost Rider by Neil Peart. The drummer of the successful rock band Rush writes about how he dealt with the death of his wife and daughter by going on a motorcycle trip.

James Perlotto, MD, chief of Student Medicine
The Whole World Over by Julia Glass. Her newest book, following up on her award winning first novel, Three Junes. We were classmates at Yale College in 1978. A beautifully interwoven story of the lives of a pastry chef and her psychologist husband and the interesting people in their world of the East Village of Manhattan. Thoughtful and dreamy.

Year of Wonders by Geraldine Brooks. Recommended to me by our nurse practitioner colleague Diane Paquette. A captivating and frightening tale, based on a true situation, about a English village visited by the Plague in the 1660’s, told from the point of view of a courageous young woman who survives. Very timely in light of current worries about how we all must respond to tragedy (and bioterrorism) as individuals and as a community.

Gerry Remer, manager of Building Services
The Birth of Venus by Sarah Dunant. Intriguing fictional account of a woman’s life and limitations in Florence toward the end of the Renaissance. Historical events, people and places, including Savonarola’s tyranny, are neatly interwoven into the main character’s passionate desire to pursue art and knowledge in world that is truly free only for men.

Carol Ursini, financial assistant, Finance
Passages by Gail Sheehy. This book explains crises of adult life. Reading this book enabled me to understand my mom and grandparents, and it can help you understand yourself. A useful book no matter what your age.
New physician and nurse practitioner in Internal Medicine

Slawomir Mejnartowicz, MD and Susan Langerman, APRN, MSN, FNP-C have joined the Internal Medicine Department. Mejnartowicz comes to YUHS from Maine, where he practiced internal medicine and geriatrics. He received his medical education in his native Poland at K.Marcinkowski’s Medical School in Poznan. Subsequently, he did his primary care internal medicine internship, residency and chief residency at Columbia University’s Roosevelt Hospital and a fellowship year in geriatrics at New York University’s Bellevue Hospital Medical Center. In addition to being fluent in Polish and English, Mejnartowicz has a basic knowledge of Spanish and Russian.

Langerman, a per-diem member of the Internal Medicine Department since July, 2005, is now a permanent member of our staff. She received her ADN from the University of Bridgeport and her MSN from Yale. She is board-certified as a family nurse practitioner with a specialty in diabetes, and is a certified diabetes educator. Her recent experience also includes teaching at the Yale School of Nursing, coordinating clinical trials at YSN, and working as a clinical nurse specialist at the Hospital of St. Raphael.

Morrison steps down as chief of Pediatrics, Idelson appointed

Carol Morrison, MD, who has led the department of Pediatrics since 1983, will be leaving her position as chief of the department as of July 1, while staying on part-time as a clinician. During her tenure as chief, Carol Morrison has recruited clinical staff and built a pediatrics department that many colleagues and families recognize as one of the finest. She has spearheaded a host of important projects to improve the health of Yale’s children, including an immunization initiative that has resulted in one of the highest immunization rates in the state and a comprehensive pediatric asthma initiative.

In addition, she has made numerous contributions to YHP, the School of Medicine and to the University as a whole. We look forward to her continuing presence as a clinician in the department.

Douglas Idelson, MD, will become chief of Pediatrics, also effective July 1. He attended Brown University as an undergraduate, earned his MD from Boston University, and was awarded a Masters of Public Health degree from Columbia University. He completed his internship and residency in Pediatrics at Yale and has been on the clinical staff at YUHS since 2001.

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Carol Morrison, MD, who has led the department of Pediatrics since 1983, will be leaving her position as chief of the department as of July 1, while staying on part-time as a clinician. During her tenure as chief, Carol Morrison has recruited clinical staff and built a pediatrics department that many colleagues and families recognize as one of the finest. She has spearheaded a host of important projects to improve the health of Yale’s children, including an immunization initiative that has resulted in one of the highest immunization rates in the state and a comprehensive pediatric asthma initiative.

In addition, she has made numerous contributions to YHP, the School of Medicine and to the University as a whole. We look forward to her continuing presence as a clinician in the department.

Douglas Idelson, MD, will become chief of Pediatrics, also effective July 1. He attended Brown University as an undergraduate, earned his MD from Boston University, and was awarded a Masters of Public Health degree from Columbia University. He completed his internship and residency in Pediatrics at Yale and has been on the clinical staff at YUHS since 2001.

New physician and nurse practitioner in Internal Medicine

Slawomir Mejnartowicz, MD and Susan Langerman, APRN, MSN, FNP-C have joined the Internal Medicine Department. Mejnartowicz comes to YUHS from Maine, where he practiced internal medicine and geriatrics. He received his medical education in his native Poland at K.Marcinkowski’s Medical School in Poznan. Subsequently, he did his primary care internal medicine internship, residency and chief residency at Columbia University’s Roosevelt Hospital and a fellowship year in geriatrics at New York University’s Bellevue Hospital Medical Center. In addition to being fluent in Polish and English, Mejnartowicz has a basic knowledge of Spanish and Russian.

Langerman, a per-diem member of the Internal Medicine Department since July, 2005, is now a permanent member of our staff. She received her ADN from the University of Bridgeport and her MSN from Yale. She is board-certified as a family nurse practitioner with a specialty in diabetes, and is a certified diabetes educator. Her recent experience also includes teaching at the Yale School of Nursing, coordinating clinical trials at YSN, and working as a clinical nurse specialist at the Hospital of St. Raphael.