UPCOMING RFA MEETING
MARCH 2, 2018

“Current Approaches to the Study of Autism Spectrum Disorders”

Emanuel DiCicco-Bloom, MD
Professor of Neuroscience and Cell Biology and Pediatrics

March 2, 2018
Noon to 1:30 p.m.
Dean’s Conference Room
Rutgers Robert Wood Johnson Medical School
Piscataway, New Jersey

Emanuel DiCicco-Bloom, MD

Dr. DiCicco-Bloom completed his AB in biology at Princeton University in 1973. After obtaining his MD in 1977 from Cornell University Medical College, he completed his training in pediatrics and child neurology at New York Hospital-Cornell Medical Center and then joined the faculty there. He came to Robert Wood Johnson Medical School in 1990. His research interests are in gene and growth factor regulation of neurogenesis during mammalian brain development, with a focus on models of human neurodevelopmental disorders, including autism, schizophrenia, and environmental teratogens. Currently, some of these studies are performed in stem cells (induced pluripotent stem cells) from individuals with autism. From these stem cells, early neuronal precursor cells are produced and studied to identify abnormalities in proliferation and differentiation that contribute to the disorder. He sees patients at a weekly Child Neurology and Neurodevelopmental Disabilities clinic at the Child Health Institute of New Jersey.

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Dr. DiCicco-Bloom (continued from page 1)

Dr. DiCicco-Bloom serves on several autism and brain disease related journal editorial boards and scientific panels including the Autism Science Foundation, the International Rett Syndrome Foundation, the NIH Developmental Brain Disorders study section, and the Rutgers University Brain Health Institute. He has served the Society for Neuroscience on many committees including Government and Public Affairs, Public Education, and Communication.

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PARKING RENEWAL NOTICE

Retirees must request renewal of their parking privilege every two years by emailing Info_dots@ipo.rutgers.edu

DECEMBER SPEAKER:
Michelle Papka, PhD

TO TELL OR NOT TO TELL?
THAT’S NOT THE QUESTION.
CURRENT THINKING REGARDING ALZHEIMER’S DISEASE: DIAGNOSIS, TREATMENT, AND RESEARCH DIRECTIONS

Dr. Papka is director and founder of the Cognitive and Research Center of New Jersey. (CRCNJ). She has been co-director of the Cognitive and Memory Disorders Program at Saint Barnabas Medical Center in Livingston, New Jersey and is affiliated with the Atlantic Neuroscience Institute and Department of Psychiatry at Overlook Medical Center.

Dr. Papka began by telling us that nervous system diseases, especially ones that cause cognitive changes, are particularly frightening to patients. A 2015 report indicated that less than half (45%) of patients diagnosed with Alzheimer’s Disease (AD) are told their diagnosis. It is even lower (worse) with other dementias; only 27% are told. By contrast 72% of Parkinson’s patients are told their diagnosis at first. This compares with 93% of cancer patients and 90% of cardiovascular disease patients being given their diagnosis as soon as it is made.

But should patients with AD be told? The diagnosis of early stage disease is not straightforward. Our clinical perceptions of patients depends on how well they can converse with us, and a doctor can be fooled in a 15-minute conversation, particularly if the patient is high-functioning.

There is a need for more education and more support for doctors to engage AD patients and families, and there is likewise a deficit of support for patients’ families for counseling and access to treatment, depending on their geographic location. Doctors are aware that time spent talking with patients needs to be compensated. Creation of a new code G0505, “Cognitive impairment assessment and care planning,” gives doctors a reim-

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bursement code for making this diagnosis and enter-
ing into a discussion with the patient and family.

Most patients with mild dementia do want to be
told their diagnosis. Anecdotally, Dr. Papka has
noticed that spouses often want to be told as well,
while some adult children try to protect their parent
from knowing the diagnosis.

AD was first recognized as pre-senile dementia in
1901 by Dr. Alois Alzeheimer in a 51 year old
Frankfurt woman, suffering progressive cognitive
decline, hallucinations, delusions, and social in-
competence. At autopsy, he identified amyloid
plaques and neurofibrillary tangles in her brain.

We now know that beta-amyloid protein starts to
clump up and form plaques that sit outside the
cells. Neurofibrillary tangles occur within the cells,
are associated with the tau protein, and cause cell
dearth. Research shows that it is the tangles, ra-
ther than plaques, that are correlated with cogni-
tive and behavioral decline. Plaques begin to form
in the brain decades before the first symptom of
AD is evidenced. In general, where there are
plaques, there are tangles, with the plaques pre-
ceding the tangles. Loss of function is directly re-
lated to the number of synapses lost. The more
neuronal networking we have to begin with, the
more protection we have against dementia.

Physiologically, amyloid plaque is caused by a di-
minished clearance process. In an AD brain, the
beta-amyloid is not being cleared into the cerebro-
spinal fluid (CSF), hence low concentration in the
CSF is a biomarker of early stage disease. The
plaques and tangles start forming decades before
any symptoms are evident and can progress sub-
stantially before Mild Cognitive Impairment is rec-
ognized. After the plaques start forming, the next
phase involves disruption of the normal microtu-
bules in the axon, as the tau protein disrupts their
function and communication.

Autopsies would allow pathologists to count the
plaques and tangles per microscopic field to stage
the extent of the degeneration. But now, relatively
few autopsies are performed. Temporal lobes
(memory) are usually the first brain area to be im-
pacted. For function, it doesn’t matter whether it’s
a plaque, tangle, or stroke; it matters where in the
brain the neuropathology occurs.

The definitive diagnosis of AD is determined by
the underlying pathology and by its effects on lan-
guage, visuospatial skills, and memory. The
tauopathy is associated with brain degeneration
and shrinkage. There are different approaches to
AD as a clinical syndrome versus neuropathologi-
cal process. Until recently, AD has been defined
mainly as a clinical syndrome, but that is changing
as we have recognized biomarkers, which have
resulted in the evolution of diagnosis.

The Criteria and Guidelines for Diagnosis of AD
were revised in 2011, and new criteria are being
considered. Brain imaging and biomarkers in the
CSF can be used for diagnosis. Patients can be
classified as pre-symptomatic, mildly symptomatic
(predementia), or seriously symptomatic. AD is a
diagnosis of exclusion. The core diagnostic criteria
of cognitive decline interfering with daily function-
ing are present, and all other causes have been
excluded. Brain MRI and blood work help rule out
other causes.

There are now several biomarkers that help iden-
tify people in their pre-symptomatic stage. Beta-
amyloid can be measured in CSF and a low AB42
indicates that protein is not being cleared into the
CSF. Tau can be detected on PET scans. How-
ever, as with many diseases there is no clear diag-
nostic cutoff. Neuronal injury and neurodegenera-
tion can be inferred from a structural MRI or a
fluorodesoxy glucose (FD) PET scan or from
measuring total tau in the CSF.

There are ways of quantifying uptake of amyloid
on a PET scan, but usually there is only a qualita-
tive reading. Amyloid PET is approved by the
FDA, but is not covered by many insurance plans.
The Tau PET scan is not yet approved by the
FDA. However, management of the patient can
be positively influenced by amyloid PET scan, so
in the future insurance may cover it. The beta-am-
yloid and the tau PET scans can tell the same
story, years in advance. Is that good news?
Would we want to know? If so, when?

Genetics plays a role. Most cases do not have evi-
dent familial inheritance. A mutation at APOE4 is
a risk factor. Mutations of APP, PSEN1 and PSEN2 account for about 1% of cases. If you have these mutations you have a 100% chance of developing the disease and at a young age (before 50). Autosomal dominant inheritance can be identified and treatment initiated earlier than waiting for clinical signs of dementia.

There remains much unexplained variability in onset and progression of the disease. Some people may have plaques and tangles, yet not develop the symptoms of the disease. Conversely, some people have tau without beta-amyloid but still manifest AD clinically. The disease can progress rapidly or slowly. AD patients may drop 0.4 standard deviation units per year in memory tests with loss of episodic memory.

**Risk Factors or Susceptibility Factors:** Females are at greater risk for AD than males. Lower education level is a risk factor, while persons with cognitive reserve will be missed. Lower social interaction and any systemic medical condition (hypertension, heart disease, diabetes, cholesterol, elevated homocysteine) are risk factors. Unrelated neurologic condition (transient ischemic attack, lead poisoning, PD, vascular disease) as well as substance abuse, alcohol or smoking worsen the prognosis. Stress can speed the decline.

**Diagnosis** is often suspected by patients and families, although by this time the disease process is quite advanced. The delayed word recall test is the single most sensitive test for AD and related dementias. The examiner reads a list of words and then asks the patient to recall those words 10 minutes later.

**Treatment:**
Available drugs include cholinesterase inhibitors (Donepezil). Namenda is approved for moderate and severe AD. Future goals include stopping the beta amyloid from forming or increasing its clearance. Ideally we need to get the right drug to the right patient at the right time. Early treatment is beneficial. This is difficult because diagnosis is often delayed by uncertainty and denial. High-performing patients can mask the onset of AD. Earlier Dx and Rx should lead to a slower decline.

The inclusion/exclusion criteria for clinical trials are important. It’s necessary to identify high risk patients early. Unfortunately subjects are often beyond the inclusion criteria of a study by the time they are ready to participate. Lack of participants is the biggest obstacle to AD research and eventually finding a cure.

**New Tax Law May Change the Way You Handle Your Charitable Giving**

Eckard Kemmann, MD

The new Federal Tax Law increases your standard deduction to $24,000 in 2018. This may mean that rather than individually deducting allowable expenses, many more taxpayers now will take the standard deduction and contributions to charities will not be deducted. Charities are indeed concerned that donations from people with average income will decrease once the “tax deduction” incentive is gone. Taxpayers who itemize will continue to take a deduction for contributions.

My accountant pointed out a way to continue donating to charities and still deduct by bundling charitable deductions for several years, thereby exceeding the $24,000 standard deduction limit in some years. He advised me to open a “charitable account.” Money from this fund can be used ONLY for “grants” to charities of my choice. I can do this at my discretion donating to various registered charities once, repeatedly, or on a regular basis. There is full flexibility, and I can do this on the internet. I deduct the money or assets I place in the fund. In order to get the tax benefit I would “fill-up” or front-load my program for donations for several years getting a one-time deduction in the year I make the transfer to the program. I do not deduct the individual grants as they are made, and after a number of years, I will replenish the program, and will take another deduction.

There is another benefit. The program allows me to transfer stocks directly into it in lieu of cash. So by transferring appreciated assets I do not have to sell them and save capital appreciation expenses. And, of course, capital gains within the program are not taxed.
My charitable giving to the RWJMS RFA Global Health Fund will be using this system. Tax situations are different from person to person, so this should be discussed with your tax advisor or accountant.

STATE OF OUR UNIVERSITY 2017

On November 29, 2017, the Rutgers Foundation hosted a State of Our University meeting centered on the theme “Rutgers Grows the Garden State—Our Impact on the Economy of New Jersey.” Attendees received that document as well as “A Strategic Plan for the New Rutgers (2014).” In a period in history when the value of higher education is under assault and the reliability and even the utility of science widely doubted, Rutgers plays a crucial as well as iconic role in New Jersey. Although the relative contribution of public funding to the Rutgers budget has declined, the University’s contribution to the state economy has grown. President Robert Barchi provided the optimistic overview of the University’s contribution to New Jersey.

The following is extracted from Dr. Barchi’s introduction to the booklet:

“Rutgers plays a crucial role in New Jersey. We educate 69,000 students...provide continuing education to approximately 50,000...provide health care to tens of thousands of New Jerseyans...our service and outreach benefit small businesses, farmers, families, schools, and local governments in every county. We are alma mater of more than 280,000 Garden State residents. Just as important, Rutgers is a job creator and an economic engine. Rutgers puts people to work all across New Jersey—and helps the Garden State economy grow.”

“Our annual operating budget of $3.5 billion supports nearly 58,000 jobs statewide and generates $5.2 billion in economic activity in New Jersey.” This is not to mention the “nearly 12,000 short-term construction-related jobs.”

See the entire statement and report at:

https://president.rutgers.edu/economic-impact-rutgers-grows-garden-state

NOVEMBER 29, 2017

The overriding message of the report is that:

- “Rutgers delivers a strong return on investment—for every $1 the state invests in Rutgers, the university returns almost $7 to the New Jersey economy.”
- “Rutgers fuels the New Jersey economy, generating $5.2 billion in economic activity, $4.3 billion in annual wages, and $798.2 million in state and local taxes.”
- “Rutgers supports 58,000 New Jersey jobs (26,000 directly and 32,000 indirectly).”
- “Rutgers spends $658.1 million on research and development that sparks innovation and supports the economy—more than all other public and private universities in the state combined.”

Speakers identified aspirational peer universities such as Michigan, UC-Berkeley, North Carolina.

The evening concluded with a panel discussion featuring three speakers:

- Dr. James Hughes, university professor and former dean of the Edward J. Bloustein School of Planning and Public Policy, illustrated how Rutgers is New Jersey’s “Economic Locomotive” by fostering the knowledge-based economy, supporting business, and advancing the marketplace. Rutgers leads all New Jersey colleges in Research and Design expenditures.
- Dr. Brian Strom, Chancellor, Rutgers Biomedical and Health Sciences, emphasized the future of inter-professional education and the expansion of “Rutgers Health,” creating the most comprehensive academic health care system in NJ.
- Dr. Kevin Lyons, Associate Professor of Professional Science, Rutgers Business School, a supply chain researcher, reported on the (continued on page 6)
success of a program to encourage the University and local companies to purchase supplies from local vendors, thereby contributing to the economy of Newark.

**GENEALOGY AND DNA TESTING**
David J. Riley, MD

Personal DNA testing using commercial kits is being widely promoted for genetic genealogy. The tests are used to determine genetic relationships among individuals and to infer “ethnicity” or a family’s geographic origin. DNA testing complements traditional genealogy which uses documentary sources to identify relationships. Generally, results of DNA testing fall short of expectations and marketing hype. However, when used correctly in conjunction with standard genealogy methods, the tests can confirm one’s ancestry and identify new relationships. This article is about the basics of DNA testing for those interested in genealogy.

**Three Types of DNA Testing**
Y-DNA testing assesses genetic makers from the direct male line and mitochondrial DNA (mtDNA) from the direct female line (figure). Information about ancestors between the two extremes is evaluated by autosomal DNA testing which looks at all chromosomes including the Y chromosome. Y-DNA testing goes back about 338,000 years and mtDNA 150,000 years whereas autosomal testing has a reach of about seven generations, or roughly 200 years. Each test is done separately and answers different questions. When used together they may break down barriers to genealogical research, so called “brick walls.”

**Scientific Basis**
Humans share 99.9% of DNA with other humans and the remaining 0.1% is unique to an individual. The differences are in short segments of DNA, single-nucleotide polymorphism (SNP), and short tandem repeat (STR) sequences; these are called genetic markers. STRs and SNPs are analyzed separately and results cannot be compared. They provide insight into the recent (via STRs) and ancient (via SNPs) genetic ancestry. The usual starting place is a Y-DNA test done by a testing company such as 23andMe, AncestryDNA, or Family Tree DNA.

**Y-DNA Testing**
Because men inherit the Y-DNA virtually unchanged from their fathers, Y-DNA is easiest to use for genealogical purposes. Y-DNA testing involves STR and sometimes SNP testing of the Y-chromosome. This test has the advantage that the family surname is passed down through the patrilineal line in many cultures and results can be collated within ongoing surname projects, taking into account variations in spelling. Results allow one to connect via Y-DNA to anyone else in the companies’ databases who has genetic markers for the same male line. This involves comparing genetic markers (typically 23) and analyzing for exact or close matches. If matched, the results indicate genealogical cousins within a specific time frame.

Due to mutations, slightly different genetic signatures may arise when comparing descendants from a common progenitor. Females need to have a close male relative tested. If no match is found, it could indicate no relationships due to genetically distinct families having a common surname or a non-paternity event such as illegitimacy or adoption. Alternatively it could reflect a limitation in the companies data bases, which are being updated continuously.

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A Y-chromosome STR test will also reveal a haplotype (a set of genetic markers giving a unique signature) which should be similar among all male descendants of a common ancestor. SNP tests are used to assign people to patrilineal haplogroups, which are used to define much larger genetic populations.

**Ethnicity Profiles**

Haplogroups, or individuals with a similar genetic signature, is a crude way of grouping people together into separate genetic families. Haplogroups occur with different frequencies in specific regions of the world. Datasets of individuals of known geographical origin are used to compare an individual’s DNA to crudely determine “ethnic” makeup. Admixture with other genetic populations is typically reported as percentages of geographic areas.

**Mitochondrial DNA Testing**

MtDNA detects relatives on the maternal side and is passed from mother to sons and daughters but only the daughters pass it on. It involves sequencing two regions (HVR-1 and HVR-2) and may include SNPs to better assign a matrilineal haplogroup. These haplogroups may indicate European, Asian, or Native American lineages. The test is best used to identify others who share the same mtDNA profiles. Because mtDNA carries ancient DNA, however, an exact match between two females may not prove they share a recent common maternal line. Additional research using standard genealogical methods may be required to prove a relationship.

**Autosomal DNA Testing**

There are two basic ways autosomal DNA test results can be used in genealogy. The first is asking whether you are related to someone else in a family with a common ancestor. A high level of shared autosomal DNA is found only in identical-twin, parent–child, and full-sibling matches. Accuracy is usually good up to second cousins, but results for second cousins once removed and beyond have to be interpreted carefully. In some cases, more family members need to be recruited and tested to insure that a statistically significant average amount of autosomal DNA is present for analysis. Above fifth cousins, relationships using autosomal DNA testing may require special approaches such as triangulation and the use of Y-DNA and mtDNA data. In these more complex relationships, test results are technically difficult to interpret. Special care is needed in endogamous populations since marriage within close communities amplifies shared markers. All relationships need to be confirmed using genealogical information.

The second way of using autosomal DNA is by discovering high level matches to previously unknown relatives in a company’s database, i.e., a *fishing trip*. This approach is a bit hit or miss and has significant limitations. With luck, you may identify a person with a high amount of shared DNA who may be willing to provide genealogical information that confirms the existence of a common ancestor.

**Reviews of the Companies**


All DNA services provided broadly similar test results for ethnic origins. *Wirecutter*’s top pick was **AncestryDNA**, which presented data in a clearer manner. The company claims to have the largest database of customers (5 million) which increases the odds of a match. Unlike the other services, AncestryDNA cannot track maternal and paternal lineages independently. **Family Tree DNA** offers affordable autosomal testing and additional offerings for Y-DNA and mtDNA testing which could drive up prices. It may be preferred by more dedicated users and claims a DNA database of 1.5 million. **23andMe**, the most popular service, offers a product on a par with the others. The company’s focus is on collection of biomedical DNA data. Although one can purchase separate ancestry-only and a combined ancestry and health package, the testing and analysis of DNA is identical. This might be a concern to those sensitive about disclosure of health-related data.

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**Conclusion**

DNA kits offer convenient, relatively inexpensive ways to supplement family research. Interpreting results requires familiarity with what each test does and awareness of its limitations. With correct use and a little luck, the tests may extend a biologic family by breaking down "brick walls" encountered using standard genealogical methods.

See also the website of the International Society for Genetic Genealogy: https://isogg.org/wiki/Wiki

Dr. Riley’s latest book is *Nathan Terriberry (1815–86) of Hunterdon County, New Jersey, His Descendants, and Allied and Associated Families* (Berwyn Heights, Maryland: Heritage Books, Inc., 2017).

**ADAPTING TO CHANGE: ENVIRONMENTAL SCIENCE AND POLICY IN THE TIME OF TRUMP**

The 2018 Bloustein Fund lecture by Thomas Burke, PhD, MPH, the Jacob I. and Irene B. Fabrikant Chair of Health Policy and Management at Johns Hopkins Bloomberg School of Public Health.

THE BLOUSTEIN FUND LECTURES
The Ruth Ellen Steinman and Edward J. Bloustein Memorial Lecture Fund was established by the late Rutgers University President, Ed Bloustein, and his daughters, in memory of Ruth Ellen Steinman, MD. The president died a year later and the fund continues to commemorate both of them for their contributions to the university community and New Jersey by supporting a lecture series (see details at https://bloustein.rutgers.edu/lectures/)

**Thomas Burke, PhD, MPH**

Thomas Burke, PhD, MPH, a professor at Johns Hopkins Bloomberg School of Public Health, was on leave at the EPA for two years until January 20, 2017. A Jersey City native, Burke served in the 1980s in the NJ Department of Environmental Protection, becoming director of science and research, and was then recruited as assistant commissioner of the NJ Department of Health. His many years of experience in New Jersey provide a rich source of case studies of environmental toxicology impacts on public health.

**Introduction**

Michael R. Greenberg, interim dean of the Bloustein School introduced Dr. Burke by reference to the unwelcome epithet, “Cancer Alley” in 1980, alluding to very high rates of certain cancers in New Jersey that prompted New Jersey to invest heavily in environmental science. At a time when toxic waste, burning rivers, and choking ozone days were prominent, New Jersey emerged as a leader emphasizing that “a healthy environment is in no way incompatible with a healthy economy.”

Dr. Burke explained that he joined the NJDEP Division of Science and Research at an exciting time. The department conducted statewide surveys of carcinogens, of workplace hazards, dioxin pollution and of cancer clusters. Since then, the state’s emphasis on science and research has swung like a pendulum, not always in synch with the political climates, but reaching a new low in recent years.

This is a tough time for environmental health professionals, as the federal government and EPA systematically and proudly dismantle the regulations that protect air, water, and health from a variety of toxic chemicals. Growing up in Jersey City, near chemical dumps containing hexavalent chromium that periodically made streams run yellow, impressed upon Dr. Burke the proximity of communities to toxics.

He reminisced about good days for research and bad days for the Jersey Shore, raising the spectre of medical waste washing up onto beaches, requiring the closure of beaches in mid-summer.

After many years as professor of public health at Johns Hopkins, Dr. Burke was recruited to serve as deputy assistant administrator to head the Office of Research and Development at EPA. Science was highly valued by the administrator Gina McCarthy, and Burke recalled that President Obama had said “My administration will value science.”  

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He recalled that in the 1970s and 1980s one could focus on discrete environmental problems: cancer, pesticides, chromium, clean drinking water, whereas today, problems are complex and intertwined. It’s not just pure water but a shortage of water, and the impact of fracking.

Energy isn’t just about fracking and the petroleum industry.

It’s time for scientists to abandon their silos and engage in multidisciplinary systems approaches necessitated by complex problems, beyond the scope of any single discipline. For example, childhood lead exposure in Flint extends beyond lead in old pipes. It involves the political/economic decision to switch a poor community to a cheaper new water source, failure to include corrosion protection, and finally ignoring the public outrage.

California drought, wildfires and mudslides make it very clear, at least to Californians, how changing climate impacts many aspects of life and livelihood. Dr. Burke was active in investigating the impacts of fracking in a nation hungry not just for energy independence, but for energy dominance. Water withdrawal, spills of hydrofracking fluids, well failures, wastewater flowback, exemplify the complexity of studying this secretive industry.

As Trump came in to office, Dr. Burke exited EPA and returned to Hopkins. It was soon clear where the administration was heading, fulfilling its promise to deregulate, and ignoring, or worse, deprecating science. The “environment” seemed to be a major target, as the new administrator, Pruitt, speaking in coal-country, said “the regulatory assault on coal is over.” In March, Dr. Burke co-wrote an editorial in the NEJM emphasizing the importance of making policy decisions “evidence-based.” The new EPA is far from fulfilling the former mission of “protecting human health and the environment by enforcing laws and assuring compliance.” The new mission seems to include a return to something called the “core mission,” cooperative federalism (letting states do it), and the “rule of law and process,” as well as retreating from the Paris agreement on climate, from Clean Power, from the Lautenberg Act on toxics, from risk assessment, pesticide control, and cutting the Office of Research and Development. This includes stacking the Science Advisory Board and the Board of Scientific Counselors with representatives of the regulated industries. Valuable web-based resources have been removed, and the Integrated Risk Information System (IRIS), the underpinning of much environmental regulation, may be abandoned.

Everywhere the role of science in policy is being eroded. Dr. Burke called attention to the dishonest Honest Act, which requires that any and all data on which any policy or regulation is based, must be available for public scrutiny. This sounds benign on the surface, but not all data from decades ago can be recovered, and not all the people who examine the data will be objective.

The assault on climate research, not only in Washington, but in Trenton, is serious because in the long run Dr. Burke considers climate change the major public health problem. States, cities, and NGOs can pick up only part of the slack. Climate research requires a systems approach, as it interfaces with energy, water, food production, air quality, and even emergency medicine. The old exposure paradigm is being replaced by the approach to cumulative exposure. The problems facing us [as a nation and world] are complex, multifactorial, and have large spatial extent and long temporal scale. They are truly global and difficult to define. Moreover, there isn’t a clear solution or endpoint for this problem, even more so than for the challenges of violence, guns, obesity, and opiates. Problems tend to interact. Systems thinking must replace silos. In some ways, “we are at our best when things are at their worst.” Dr. Burke seems optimistic that a period of complacency has passed and the time for engagement is at hand.

REMINDER: You don’t have to actually be FAR AWAY to contribute a note to “News from Afar” Send to: gochfeld@ehsio.rutgers.edu
Robert Wood Johnson Medical School Retired Faculty Association
Global Health Fellowship Fund

The RFA is sponsoring medical students to learn, help, and teach in foreign countries, a potentially life-changing experience under the aegis of the Global Health Initiative of Rutgers Robert Wood Johnson Medical School. The RFA is helping to support summer programs or international electives for medical students and is asking you to consider adding your support to this effort. All funds go to help the students without any deduction for administrative expense.

You can submit your donation to support the RFA Global Health Fellowship Fund by sending a check made payable to the “RWJMS Retired Faculty Association” and mailing it to:

Paul Lehrer, PhD, RFA Treasurer
Department of Psychiatry
Rutgers Robert Wood Johnson Medical School
671 Hoes Lane West,
Piscataway, NJ 08854.

All contributions are tax deductible as charitable contributions. The RFA is a 501(c)(3) tax-exempt organization.

Global Health Experiences for Robert Wood Johnson Medical School Students
By Javier Escobar, MD, associate dean for global health

According to AAMC (Association of American Medical Colleges) data, there has been a significant increase in the number of medical students who participate in overseas clinical activities (from 6% a decade ago, to almost 40% since 2000) and these numbers keep growing. Here at RWJMS, student surveys show that over one third of RWJMS medical students express an interest in participating in a rotation abroad during their medical school years.

The major goals of the global health programs are to:

- Enhance medical students’ awareness of global issues related to health.
- Encourage medical students to immerse themselves in the culture and health system of other countries.
- Facilitate the learning of other languages (e.g., medical Spanish, medical Mandarin) that are relevant to clinical practice in many cities of the US, including New Brunswick.
- Send groups of medical students for exchange educational experiences to different institutions all over the world with whom we have ongoing educational collaborations.
- Provide information about clinical and community programs in diverse ethnic communities in New Jersey that would benefit and enhance the clinical experiences of students.
- Stimulate and support educational, clinical and research international activities of the Robert Wood Johnson Medical School faculty.
MESSAGE FROM THE RUTGERS FOUNDATION
Tiffany Swinarski, associate director of gift planning

Making a planned gift (i.e. bequest intention, beneficiary designation, gift annuity, or charitable trust) is a wonderful way to show your support and appreciation for Rutgers University and its mission while accommodating your own personal, financial, estate-planning, and philanthropic goals. With smart planning, donors may actually increase the size of their estates and/or reduce the tax burden on heirs. Just as important, a planned gift is a meaningful contribution to Rutgers.

An Invitation to Join
We invite you to join the Colonel Henry Rutgers Society if you have made a commitment to support RWJ or any other Rutgers program through a gift in your will or other planned gift, including a tribute gift. Benefits of membership include:

- A certificate of membership
- A commemorative lapel pin
- Invitations to special university events
- The pride of knowing that your gift will help sustain Rutgers' future

Find out more by contacting the Office of Gift Planning at 848.932.8808 or via email at giftplanningoffice@ruf.rutgers.edu.

RUTGERS EAGLETON POLL  November 2017
“The Rutgers-Eagleton Poll is a statewide telephone survey that measures public opinion about politics and policy in New Jersey. Founded in 1971, the poll, which is conducted by the Eagleton Center for Public Interest Polling, examines everything from job approval ratings for presidents, governors and senators to attitudes regarding property taxes, public corruption, homeland security and a host of other issues”. http://eagletonpoll.rutgers.edu/rutgers-eagleton-poll/

Polling is conducted at regular intervals on a variety of topics. The November 2017 poll was based on 1,203 interviewees. (see more results at https://twitter.com/EagletonPoll).

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<th>Excellent or Good</th>
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<td>Quality of life in garden state</td>
<td>61%</td>
<td>39%</td>
</tr>
<tr>
<td>Quality of life in city or town</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Quality of life in community</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>April 2001</td>
<td>Nov 2017</td>
</tr>
<tr>
<td>Wanted to move out of state</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Very or Somewhat Satisfied</td>
<td>Very or Somewhat Dissatisfied</td>
</tr>
<tr>
<td>Air and water quality in NJ</td>
<td>64%</td>
<td>32%</td>
</tr>
<tr>
<td>Health care</td>
<td>52%</td>
<td>44%</td>
</tr>
</tbody>
</table>
Retired Faculty Association

The annual dues period now corresponds to the calendar year. Dues are due now for calendar year 2018. Also, if you would like to support medical students to have an opportunity to participate in the global health program, consider donating to the RFA Global Health Fellowship Fund. Please send your check to Paul Lehrer. Both donations are tax deductible as charitable contributions. Thank you.

**RWJMS Retired Faculty Association 2018 (January 1, 2018 – December 31, 2018)**

**Benefits of RFA Membership:**

- Defining, advocating for, and publicizing the benefits of retired faculty at RWJMS
- Fostering ongoing engagement and participation of retired faculty in RWJMS activities
- Promoting continuing interaction among retirees
- Providing information and options for faculty considering retirement, and
- Interacting with other academic retired faculty associations (e.g., The AAUP Emeriti Assembly of Rutgers University, The Rutgers Retired Faculty and Staff Association).

Please cut along the dotted line below and return that portion with your payment.

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**Please Print:**

Name: _______________________________________________________________
Address: _______________________________________________________________
Phone: _______________________________________________________________
E-mail address: __________________________________________________________

Please enclose a check for a donation to the global health program and/or for dues ($15) made payable to the “RWJMS Retired Faculty Association,” and mail the check to Paul Lehrer, PhD, at the address shown below.

**Global Health Program (indicate dollar amount) **______________
**RWJMS RFA Dues ($15) **______________
**Total Amount **______________

Paul Lehrer, PhD  
Department of Psychiatry  
Rutgers Robert Wood Johnson Medical School  
671 Hoes Lane West  
Piscataway, NJ 08854

Please include any personal information that you wish to share with others. Thank you.