

THE GOOD LIVING MAGAZINE from MONMOUTH MEDICAL CENTER

MONMOUTH

health & life

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The Beauty Issue

- Top local treatments
- Luxe spa getaways
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Chute
the breeze
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health
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- Having a baby after 35
- Saving smiles: New fixes
for a common birth defect
- Meet medicine's super sleuths

Welcome LETTER

Pioneering skill and surgery

FOR MORE THAN 60 YEARS, Monmouth Medical Center has been a leader in surgical services, earning a statewide reputation for excellence. Throughout its history, the hospital's team of skilled surgeons has quickly adopted the latest surgical innovations—and this pioneering spirit has set the stage for bringing the most advanced procedures to the region.

Adding to its surgical milestones, the medical center recently became the first hospital in New Jersey to offer a new incisionless procedure to reverse weight gain following bariatric surgery. In some cases following these surgeries—through no fault of either patient or surgeon—the stomach and its opening to the small intestine stretch, allowing patients to eat more without feeling full and therefore gain some of the lost weight back.

The new procedure is a better remedy than endoscopic methods because it doesn't require an incision into the skin, resulting in less pain, faster recovery and no scars. On page 22 of this issue of *Monmouth Health & Life*, a patient shares her successful experience, and tells how it helped her get her weight back under control and avoid the complicated risks of morbid obesity.

Over the past few decades, there have been incredible advances in the surgical field, and many have occurred in teaching environments such as Monmouth. At teaching hospitals, physicians take part in important clinical research, with resident physicians working closely alongside. In fact, Monmouth Medical Center is the nation's only hospital to track surgical outcomes and complications over the last 10 years, leaving little doubt as to why our surgical outcomes rank us among the state's elite with New Jersey's lowest surgical mortality rate.

As surgeons and teachers, Monmouth Medical Center's dedicated team of surgical specialists is constantly challenged to stay current. And because of this commitment to teaching, Monmouth always has been able to attract top physicians who want to work in an academic environment—where innovation is born.



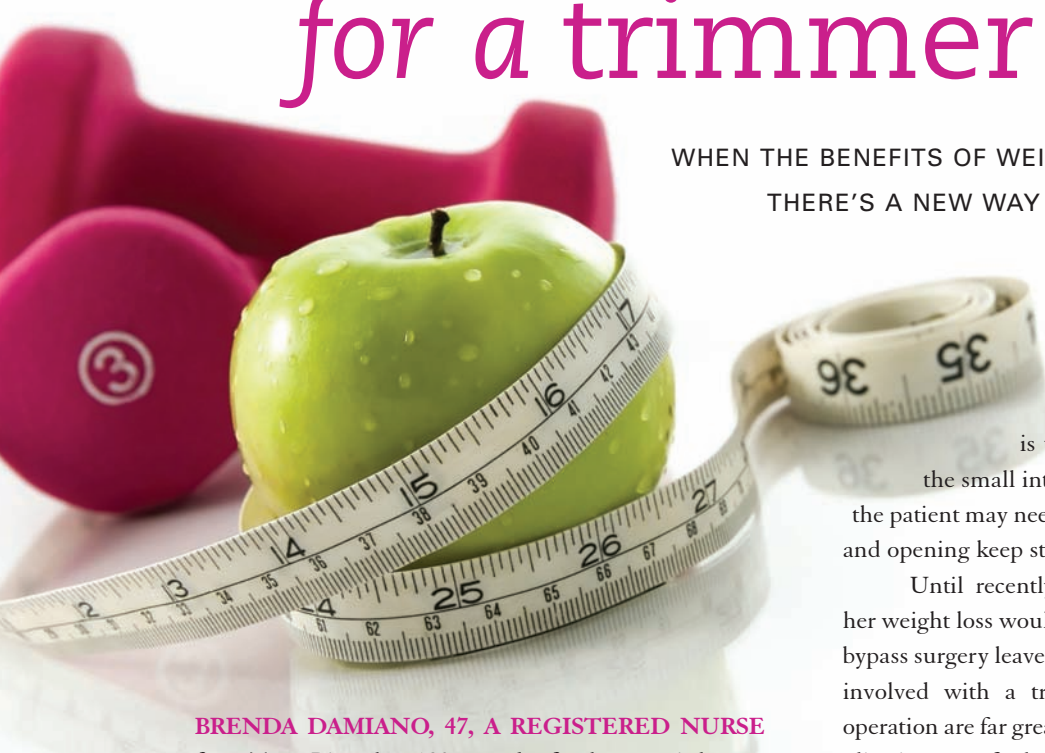
Sincerely,

A handwritten signature in black ink that reads "Frank J. Vozos".

FRANK J. VOZOS, M.D., FACS
Executive Director
Monmouth Medical Center

A second chance for a trimmer you

WHEN THE BENEFITS OF WEIGHT-LOSS SURGERY FADE,
THERE'S A NEW WAY TO RESTORE THEM



BRENDA DAMIANO, 47, A REGISTERED NURSE from Toms River, lost 120 pounds after her gastric bypass weight-loss surgery in 2002. Then, during the past year, some 25 pounds crept back on. She wanted a second chance. Fortunately, thanks to a new procedure Monmouth Medical Center is helping to pioneer, she got it.

Gastric bypass, one of the key bariatric (weight-loss) operations, has helped many obese individuals lose dramatic amounts of weight. It involves making a smaller stomach “pouch” and then bypassing the large intestine to reduce both the amount of food the patient can eat and the amount of calories absorbed.

Keeping all that weight off, however, can be a challenge. “Most patients do well for one to four years,” says Frank Borao, M.D., director of minimally invasive surgery and bariatric surgery at Monmouth Medical Center. “But after that, many hit a plateau and begin to regain lost weight.” Sometimes they backslide when they fail to maintain proper nutrition and exercise habits after their surgery. “If patients continue to

eat well and exercise, they do fine,” says the doctor. “But maintenance is up to them—they have to make an effort.”

What complicates that effort is that the stomach and its opening to the small intestine tend to stretch. “After a while, the patient may need more food to feel full, as the pouch and opening keep stretching,” says Dr. Borao.

Until recently, Damiano’s options for renewing her weight loss would have been limited. Because gastric bypass surgery leaves a lot of internal scar tissue, the risks involved with a traditional second—or “revision”—operation are far greater, says Dr. Borao. “First-time complication rates for leaks at the attachment sites, for example, are about 1 percent, but rise to 10 percent with the second surgery,” he says. “In fact, all complications increase with revision surgery.”

But Damiano got lucky. Monmouth Medical Center is the only hospital in New Jersey and one of just six nationwide to offer a new procedure, dubbed ROSE, for restorative obesity surgery, endolumenal. This operation avoids cutting through scar tissue, and instead allows the surgeon to get his tools to the stomach through the mouth and esophagus. (Endolumenal means “inside the tube,” indicating that the approach is from within the stomach rather than by cutting in from the outside.) Once there, the doctor can reduce the size of the stomach pouch and the opening to the intestine from the inside, without having to cut through previously damaged tissues.

“It will help so many people who are gaining weight after bypasses,” says Steven Gorcey, M.D., chief of Monmouth’s division of gastroenterology.

5%
of Americans
are more than 100
pounds over their
ideal weight.

ROSE represents a new surgical trend: performing operations through existing orifices so that no open incisions are needed. In other recent examples, doctors have removed women's gallbladders transvaginally and patients' appendices by going down their throat and through the stomach.

"This is the third phase in the history of surgery," Dr. Borao explains. "The first was open surgery. Then laparoscopy arrived in the late 1980s. Now we are moving toward natural orifice surgery. I think it will be a big turning point."

"It's the next frontier," agrees Dr. Gorcey. He was looking for a way to help struggling bariatric surgery patients when he came across the new procedure at a medical trade show about a year ago. He thought Damiano would make an excellent candidate, and she became the first to undergo ROSE at Monmouth.

To be sure she qualified, Dr. Gorcey sent an endo-

scope down into her stomach to measure her pouch and opening. For ROSE, the pouch needs to be at least 4 centimeters—about double its size following the original bypass surgery; the opening should be at least 2 centimeters, also double the post-bypass size. These requirements are important because "the surgical equipment is pretty large," Dr. Gorcey explains. "It's like trying to park a bus in a Manhattan parking garage—it's very tight getting the tubes down there."

Drs. Gorcey and Borao perform the procedures together. "It takes two people, a laparoscopic surgeon and a gastroenterologist," Dr. Gorcey says. Done under general anesthesia, the surgery takes about an hour. The patient goes home that day, and according to Dr. Gorcey, "every patient so far has had absolutely no pain. Some had a little soreness in the throat that resolved in 24 hours. Most of them could go back to work the next day."

The only concession patients need to make is to consume only liquids for a day or two after the surgery, then slowly add soft, pureed foods for about two weeks before resuming a regular diet.

The results are immediate. Damiano had her ROSE procedure February 28, and says she felt her stomach pouch, reduced back down to 2 centimeters, full again the next day. She lost about 15 pounds in the first six weeks. "Now, if I eat too much, I feel it," she says. "It's a sharp pain in my back that stays until I digest."

How long will the restorative surgery hold? That's being studied at Monmouth and the other centers gathering data for a national study. Monmouth will treat about 20 of 150 patients across the country and follow their progress for 18 months. Damiano knows that long-term success is about more than just surgery. She exercises regularly and pays closer attention to her eating—all habits she let slide after her first operation.

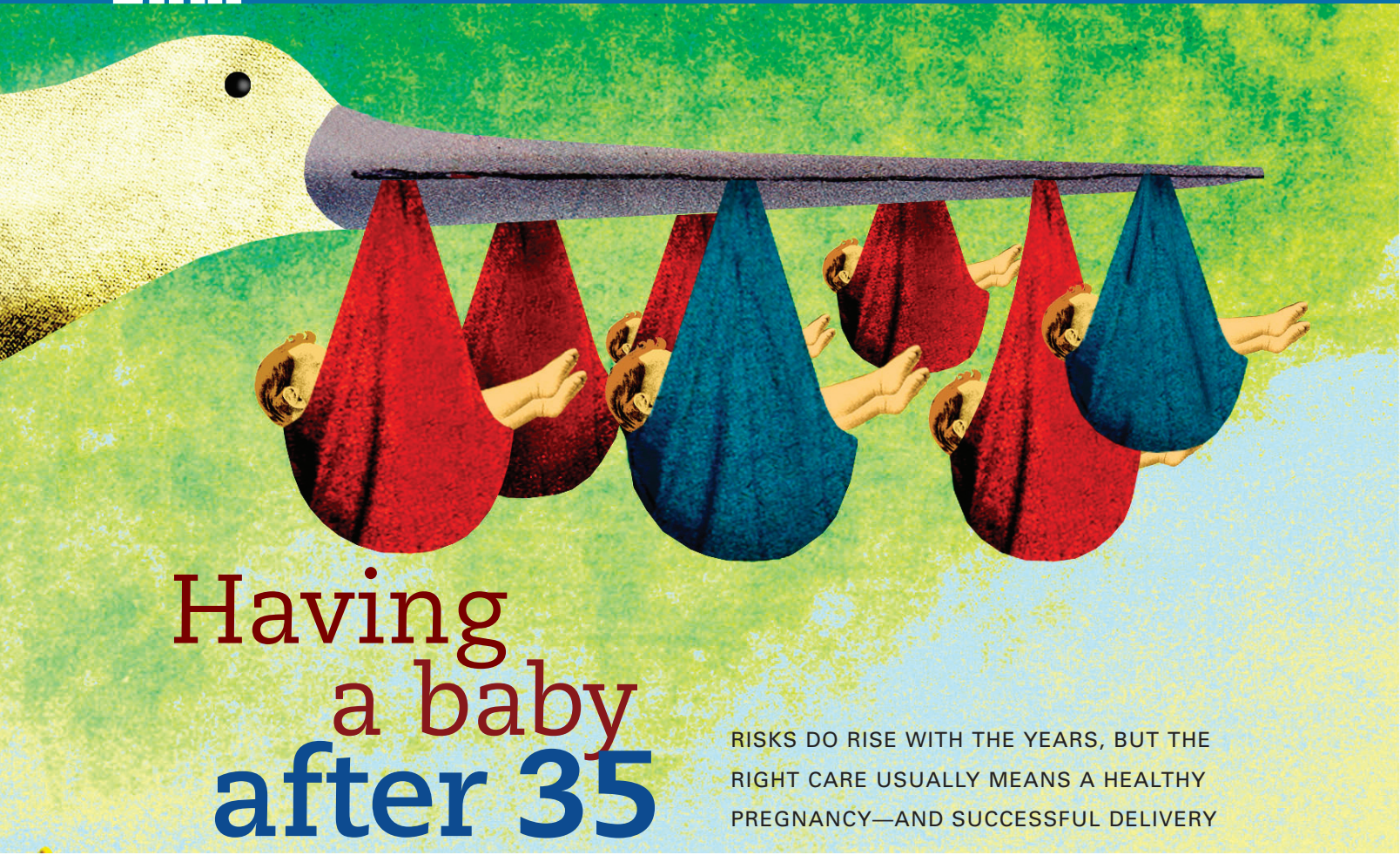
"The surgery is just a tool," she says. "You also need a lifestyle change." Because she comes from an obese family—her father and his siblings died young of obesity-related diseases and her three siblings all needed gastric bypass surgery as well—she knows what's at stake.

"I've been given a second chance," she says. "If I mess up, shame on me." ■



Brenda Damiano was the first patient to undergo restorative obesity surgery at Monmouth Medical Center to combat post-gastric bypass weight gain.

To find out more about restorative obesity surgery at Monmouth Medical Center, please call 1-888-724-7123.



Having a baby after 35

RISKS DO RISE WITH THE YEARS, BUT THE RIGHT CARE USUALLY MEANS A HEALTHY PREGNANCY—AND SUCCESSFUL DELIVERY

LIKE MANY WOMEN OF HER GENERATION, Susan Walker of Middletown waited until she was in her 30s to have children. Walker, a registered nurse, and her husband, William, a software engineer, wanted to establish their careers, buy a house, build up a bank account so she could stay home when they did start a family.

Walker's first child, Alex, was born prematurely when she was 33. Complications arose when it became clear that she had an "incompetent" cervix, which often leads to early labor and delivery. Her second son, Mark, conceived when she was 35, also arrived prematurely. Both boys did well; they're now healthy 11- and 8-year-olds, respectively. But the Walkers wanted another child. Now well into her 40s, and with two complicated births behind her, Walker and her husband faced a question: Would it be dangerous for her to become pregnant again?

"Not necessarily" was the answer, according to

"It's no problem for older women to become pregnant, as long as they're followed closely."

David Gonzalez, M.D., maternal-fetal medicine specialist at Monmouth Medical Center. "By itself, carrying a baby in your late 30s and early 40s is not a problem," he says. "A 40-year-old body is quite capable of carrying a baby." Indeed, the American College of Obstetricians and Gynecologists (ACOG) says there is no specific age after

which women shouldn't get pregnant. With good preconception and prenatal care, the chances of a mom past 35 having a healthy baby are usually good.

ACOG does say older women have pregnancy issues younger women don't. It may take them longer to get pregnant, because all women (and men as well) have some decrease

in fertility starting in their early 30s. The risk of high blood pressure also rises with age and can cause problems with the placenta and with the growth of the fetus. Older women are more prone to develop pregnancy-induced high blood pressure (preeclampsia). They're also more

likely to have diabetes or to develop gestational diabetes, which increases the risk for high blood pressure, miscarriage and macrosomia, a condition in which the fetus grows too large.

The good news is that all these conditions are easily recognized and often easily treated. Older moms-to-be may need to visit their doctors more often than younger ones, and they may need more special testing and more care during labor and delivery. But none of that typically interferes with having a normal, healthy baby.

Women over 35 do have a higher risk for genetic abnormalities with their eggs. (See “How the Risk of Birth Defects Rises,” right.) Dr. Gonzalez recommends these women talk to their doctor about genetic counseling. A counselor can help assess risks so couples can make an informed choice about getting pregnant or having testing done during pregnancy to rule out chromosomal abnormalities.

Otherwise, older moms need to take the same precautions as younger ones: follow a healthy diet, exercise regularly (with a doctor’s OK), keep weight under control and take prenatal vitamins containing at least 400 micrograms of folic acid to help prevent neural tube defects such as spina bifida.

“Older women make excellent parents,” says Carlos Alemany, M.D., a neonatologist at Monmouth. “They have had a lot of life experiences and can handle a variety of situations. In terms of evolution, we are geared to have babies early, but that’s in the wild. As we have evolved socially and intellectually, we have learned that things such as higher education equal better outcomes, so it’s no problem for older women to become pregnant, as long as they’re followed closely.”

Susan Walker proves it. “We made the decision to have another child with our hearts, not our brains,” she says with a laugh. “As a nurse I know a little too much and could have talked myself out of it, but we just did it and prayed and hoped for the best.”

She understood her risks, but her Ob/Gyn, Anthony Giovine, M.D., “was extremely supportive—he gave us hope I might pull it off,” she says—as did her high-risk pregnancy specialist, Dr. Gonzalez. She visited them both “a lot,” she says—especially when she learned she was pregnant with twins.

How the risk of birth defects rises

Older women do have a greater chance of having a baby with genetic abnormalities, but the likelihood remains statistically low throughout a woman’s 30s.

Mother’s age	Cases per 1,000 live births
20	1.9
25	2.1
30	2.6
35	5.2
40	15.2
44	47.6

To help prevent another early delivery, Walker received injections of progesterone. At 28 weeks of gestation she also had two steroid shots to help her twins’ lungs mature more rapidly in case they arrived prematurely.

It turned out that problems did arise. She developed preeclampsia late in her pregnancy. Her doctor had her admitted to the hospital, where she gained 30 pounds in a week—caused by the preeclampsia. At 35 weeks, she had a C-section. On November 9, Christina, at 5 pounds, 6 ounces, was born, followed one minute later by sister Nicole, at 4 pounds, 6 ounces. Both were healthy, and only Nicole had to stay an extra day in the hospital. “This was the first time I was able to leave the hospital after a delivery with a baby in my arms,” Walker says.

She had her twins at age 44. Her own mother was 43 when she was born. “When I was a child she used to tell me, ‘I won’t be around to see you graduate from high school or college,’” Walker recalls. “But she’s now 88 and still here.

“Things have definitely changed,” Walker concludes. “I don’t think people should think of 35 as a cutoff. At that age, you’re still in the prime of your life.” ■



David Gonzalez, M.D.

From 1980 to 2004, the number of U.S. women giving birth at age 35+ tripled.

Surgery to replace an elbow

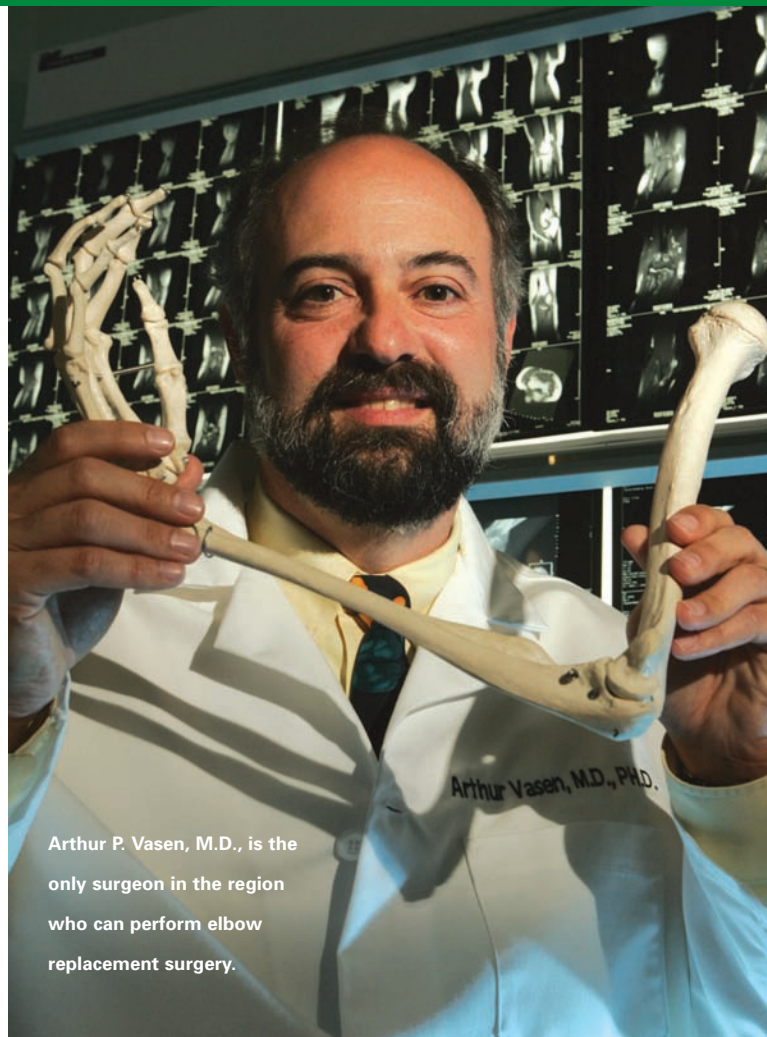
TODAY, JOINT OPERATIONS
GO BEYOND HIPS AND KNEES

YOU PROBABLY KNOW SOMEONE who has had a hip or knee replaced. Each year, about 650,000 total joint replacement procedures are performed by orthopedic surgeons in the U.S. The vast majority involve hip and knee joints—but not all. Total joint replacement also can be performed on other damaged or diseased joints, but it takes special skill and training to do so. One Monmouth Medical Center orthopedic surgeon, in fact, is the only surgeon in the region able to perform elbow replacement surgery.

Arthur P. Vasen, M.D., of Seaview Orthopedics in Ocean Township, says the procedure is pretty rare. “I only do one or two a year,” he says, “because elbow replacement is indicated only for a few select patients.” Seniors who have fallen and broken their elbows make up about 90 percent of his cases, he says. The rest are younger patients with very severe arthritis.

As we age, our bones naturally grow thinner and more brittle. When older elbows break, they often shatter into many small pieces—“like Humpty Dumpty, but with an extremely fragile shell,” says Dr. Vasen. Putting the pieces back together again is nearly impossible. “The screws don’t hold well, the bones don’t heal properly, the recovery takes a long time,” he says. “A new joint gets them up and moving right away and lasts 10 to 15 years, which is usually the rest of their lives.”

To replace an elbow, Dr. Vasen makes an incision along the back of the arm to expose the elbow joint. He then drills into the lower end of the humerus (the upper arm bone) and the upper end of the ulna (the larger of the two bones in the lower arm) and inserts a metal stem



Arthur P. Vasen, M.D., is the only surgeon in the region who can perform elbow replacement surgery.

into each bone. Once secured with special bonding cement, the stems are joined together with a metal and plastic hinge system that allows the artificial elbow to bend.

Patients are usually in physical therapy within a week and moving independently in two to four weeks. By six months, they are fully recovered and have “functional mobility”—they won’t ever have full motion, but they are able to do all normal activities.

Most large academic medical centers such as Monmouth have surgeons trained to do these unusual procedures. “You want a doctor who is fellowship-trained in upper extremity surgery and has done at least a couple of them,” says Dr. Vasen, who trained at Brigham and Women’s Hospital in Boston. He knows his skills will be in greater demand as the population ages and requires better options for staying independent. ■

To learn more about joint replacement surgery at Monmouth Medical Center, please call 1-888-724-7123.

HAVE SCALPEL, *will travel*

HOW MONMOUTH CLINICIANS VOLUNTEERED
TO TREAT POOR CHILDREN IN GUATEMALA

NEUVA PROGRESO IS A TINY, REMOTE AND extremely poor village in the mountains of Guatemala. The local “Hospital de la Familia” has no surgeons on staff and can offer only the most basic medical care. Supporting the hospital, though, is a remarkable philanthropic organization. Four times a year, the Berkeley, California–based Hospital de la Familia Foundation sends teams of U.S. surgeons, specialists, nurses and medical technicians to the facility for two weeks. They contribute their time, pay their own expenses and help to secure donations of medical and surgical equipment and supplies, which they bring with them. This past February, a team from Monmouth Medical Center, made this worthy trip. Team members included orthodontist John M. Young, DDS; pediatrician Debra Harmady, M.D.; anesthetist José Gomez, M.D.; surgical chief resident Adam Silverman, M.D.; and nurses Phyllis Marberry and Evette Robato, along with clinicians from other hospitals on the East and West coasts.



John M. Young, DDS, examines a Guatemalan child with a cleft lip and palate.

“We did clinics every morning, examining 20 to 25 people, and set up surgeries for the next day,” says Dr. Young, a specialist in cleft palate surgery. “Our three surgical teams did 93 operations in 5½ surgical days. Back home I do one or two a day. There I did 10 a day.”

Yes, the surgeons were “worn out,” he says. But it was worth the exhausting effort. “It’s very rewarding,” he says. The patients, mostly Mayan descendants, lived in the jungle. “They would walk for days to bring their kids in. They were so appreciative of the work we did.”

“Monmouth sends a team every two years, so our next mission will be in 2010,” says Dr. Young. “I hope I’m on that one too.” ■

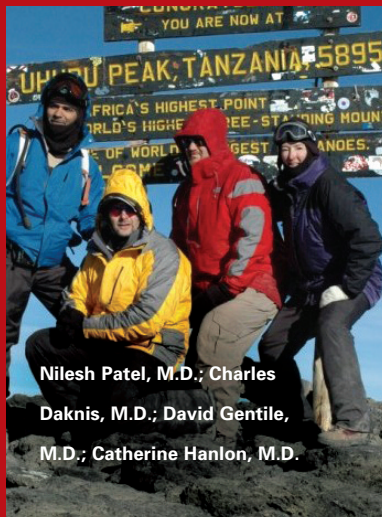
Another intrepid traveler

Catherine Hanlon, M.D., acting chair of Monmouth Medical Center’s department of emergency medicine, has journeyed as a medical volunteer to such far-flung locales as Antarctica, the Sea of Cortez and the Amazon. But when she turned 50, she needed to tackle a more personal challenge: hiking Africa’s famed Mt. Kilimanjaro.

“I wanted to prove I was still in good shape at 50, and I had always dreamed of climbing it,” says the former Air Force officer from Millstone Township.

An adventure-seeker her whole life—her moniker in the Air Force was Madmedic—Dr. Hanlon had never tried anything as dramatic as a seven-day trek up a 19,340-foot mountain. But she recently took the climb, and she reports that the experience was everything she had dreamed of.

“You start the approach to the summit at night with just a headlamp,” she says. “It’s cold, you can’t see very well. Then there’s a flash of red on the horizon. The sun comes up. It gets warmer. You reach the summit, and it feels like the resurrection.”



Nilesch Patel, M.D.; Charles Daknis, M.D.; David Gentile, M.D.; Catherine Hanlon, M.D.

PATHOLOGISTS: medicine's super sleuths

THESE PHYSICIANS STRIVE TO SOLVE THE MYSTERY IN EVERY MEDICAL CASE



The pathology team at Monmouth Medical Center: Wendy Shertz, M.D.; Plamen Kossev, M.D.; Louis Zinterhofer, M.D.; Arpad Szallasi, M.D.; and Yong Kang, M.D.

IF ANYONE WAS BORN TO BE A PATHOLOGIST, it is Louis Zinterhofer, M.D., chair of the department of pathology and clinical laboratories at Monmouth Medical Center. A photograph on his office wall proves it. In aged, sepia tones, it shows a 2-year-old Zinterhofer peering into a microscope. The caption reads, “I think it’s cancer, but I’m not sure.”

The microscope belonged to his mother, who was a pathologist herself in Midland, Texas. His father was a surgeon, but that specialty didn’t engage Dr. Zinterhofer, now 65, the way his mother’s profession did. “Everything in pathology is an intellectual process, endlessly challenging,” he explains. “There is always a mystery in every case, something you don’t know, a problem to be solved.”

Dr. Zinterhofer is the director of Laboratory Medicine Associates, the pathology and lab center at Monmouth. There he and his staff of 100 perform about 3.5 million lab tests each year. Those tests range from everyday reports on Pap smears to complex analyses of cancer biopsies. “Because Monmouth is a breast cancer center, we do an extremely high volume of breast tissue

pathologies,” he says. With state-of-the-art technology, the pathologists can even study DNA sequencing in unusual tumors to refine diagnoses and make them more accurate.

Along with Dr. Zinterhofer, Laboratory Medicine Associates includes five other pathologists. Yong Kang, M.D., specializes in molecular diagnostics and microbiology. He grows bacteria cultures to determine which antibiotics are suitable. He is also involved in the rapid diagnosis and treatment of MRSA (methicillin-resistant

Staphylococcus aureus), the antibiotic-resistant staph infection that has become a serious concern in all health care settings. Plamen Kossev, M.D., is in charge of hematopathology—blood diseases such as leukemia. Arpad Szallasi, M.D., another hematopathologist, oversees the hospital’s transfusion and blood bank services. Wendy Shertz, M.D., is an expert in cytogenetics, chromosomal analyses of amniotic fluid samples and other prenatal concerns. She also heads all areas of pediatric pathology. Gilbert Solitare, M.D., is a neuropathologist. He studies the pathology of the brain and peripheral nerves to diagnose brain tumors and neurological diseases. “When I was a resident at Yale, Dr. Solitare was my professor of neuropathology,” Dr. Zinterhofer says. “He is now semi-retired, but still vigorously involved with the practice.”

Dr. Zinterhofer lives in Rumson with his wife, Susan. He has a grown son and daughter, and four grandchildren. He enjoys snow and water skiing, tennis and attending classical music and arts programs in Manhattan. ■

Pictures of a HEARTBEAT

THE NEW 64-SLICE CT SCANNER
CAPTURES IMAGES OF THE
ORGAN IN MOTION

IF YOU HAVE A SUSPECTED CARDIOVASCULAR problem, your doctor needs the best image possible to diagnose your condition. But as anyone who's ever taken a photograph knows, movement leads to blurry pictures. So imaging a heart while it's in motion has been nearly impossible—until now.

The 64-slice computed tomography (CT) scanner acquired by Monmouth Medical Center in June represents a great leap forward in the hospital's imaging capabilities in the diagnosis and treatment of heart disease. "Before we acquired this scanner, we couldn't scan the heart fast enough," explains John Checton, M.D., chair of Monmouth's department of cardiology. "Now we can take images of a beating heart. It is truly revolutionary."

In particular, the new 64-slice CT will allow patients who have already undergone revascularization procedures, including stenting and bypass, to be imaged noninvasively. With the new scanner, visualization of the coronary arteries can not only determine the severity of blockages, but also directly visualize the atherosclerotic plaque deposited in the vessel wall. Also, a 64-slice can identify the early stages of soft (fatty and fibrous) plaque formation even before it can be seen on X-ray angiography images. It also shows calcified plaque, which occurs in more chronic coronary artery disease.

According to Richard Ruchman, M.D., a specialist in radiology and nuclear medicine and chair of Monmouth's department of radiology, CT scanners use X-ray technology to take multiple pictures, or "slices," at the same time. As CT scanners evolved from two slices to



Images
from a 64-slice CT
scanner help doctors
find plaque build-ups
linked to early heart
disease.

four, then 16 and 64 (they increase exponentially), they grew capable of producing more and more images from many different angles. "This allows us to scan a volume of tissue in an infinite number of ways," he says.

Indeed, the 64-slice scanner can produce detailed, high-resolution, three-dimensional images of a beating heart in just a couple of minutes, without the need for heart-slowing medications. Dr. Ruchman injects an iodine-based contrast dye into the patient and starts scanning immediately. The CT scanner's special software measures the patient's heart rhythm and times the scan to acquire images just when the heart is moving the least.

Machines like this represent what Dr. Ruchman calls "the major change in imaging" over the past few years. "What was once that single slice of tissue has become the ability to visualize things in three dimensions," he says. "This technology can create an image that looks exactly like what the surgeon will see." ■

To find out more about scanning available at Monmouth Medical Center, please call 1-888-724-7123.

Helping kids smile brighter

TODAY'S TREATMENTS TRANSFORM THE APPEARANCE OF BABIES BORN WITH CLEFT LIP AND PALATE

IT'S HARD BEING DIFFERENT WHEN YOU'RE A kid. Just ask anyone who grew up with a cleft lip and palate. One or both of these common birth defects affect one baby in 700. Doctors don't know what causes them, but they occur when tissue fails to fuse together properly in the developing embryo, and they can complicate feeding, hearing and speech as well as mar a child's appearance.

Treatments have been refined and improved in recent years, says Eric Wurmser, M.D., plastic surgeon and director of the Cleft Lip, Palate and Congenital Anomalies Center at Monmouth Medical Center. "Today, patients need fewer procedures, lose less blood, recover faster and have less obvious scarring," he says.

Surgeons can also help kids achieve a normal look sooner. No one appreciates that better than Debra Harmady, M.D., a pediatrician who works with the center. She was born with a cleft herself, and her experiences—most of them bad—motivated her to help others with the same condition. "I am close to 40 now, and I had surgeries starting in infancy right through my 20s," Dr. Harmady says. "My lips didn't look natural until late in the process. Now we make the appearance more natural right away."



Debra Harmady, M.D.

Many children with cleft lip and palate also suffer

the psychological trauma that comes with looking different, says Dr. Wurmser. So they need the kind of multi-disciplinary approach only a center like his can offer. The center includes specialists in those areas, as well as plastic surgeons, dentists and orthodontists, mental health professionals and geneticists. "When the doctors are all available in one place, there is more cohesiveness in care," he says. "Our care optimizes the final result."

Those results are much better than in the past, he says. "I'm 65, and when I was a kid you could tell when someone had a cleft lip," he says. "I would defy people now to tell. The repairs are much more sophisticated, and most people end up looking quite good."

Many of the physicians associated with the center take their skills overseas to help kids born with clefts who don't have access to medical care (see "Have Scalpel, Will Travel" on page 27). For Dr. Harmady, the ability to help others like her is extremely gratifying.

"I get far more back than I give, especially going overseas," she says. She recalls one boy from Mexico, who was 17 and had never been treated for his cleft. "He had lived his whole life with his face covered by a bandana. His older brother saved enough money so they could travel to Guatemala to pay for one surgery. We of course did everything he needed. When his bandages came off and he smiled without his bandana for the first time, we were all hugging and crying." ■



‘Too good to lose’

A GIFTED FUNDRAISER LEAVES A HOSPITAL FOUNDATION POST—BUT IT’S NOT GOODBYE



THAT OLD SAYING ABOUT LOVING someone enough to let them go? It only works with romance. In big-time hospital fundraising, if you find somebody great, you hang on tight. And Lucia Baratta is somebody great.

Trained as an opera singer, the former Interlaken resident has all it takes to be a “diva” except the self-importance. “She makes you feel *you’re* the most important person in the world,” says friend and colleague Tammy Murphy. “That’s a great attribute in fundraising.”

So when Baratta gave her notice recently after three successful years as the Monmouth Medical Center Foundation’s vice president of development to take a new dream job, her associates weren’t ready to say goodbye—and neither, it turned out, was she. They agreed that Baratta, a former member of the foundation’s volunteer

Board of Trustees, would return to the board to serve as its chair for a key transitional year.

“It felt right to get her back on the board,” says Murphy, her predecessor as chair.

In her youth, Baratta wouldn’t have predicted she’d be raising hospital funds. “I was all about music and the arts,” she says. She studied music and art history at Indiana University School of Music and Fordham University, then after graduating from Fordham moved to Italy to indulge her love of her grandparents’ native land—and study opera. Then she went to work as a fashion editor for a European magazine.

Over time, business edged out music (though Baratta still sings occasionally for private gatherings). She moved to Monmouth County and eventually landed a job in sales and marketing with the real estate division of Sotheby’s. She also began looking for volunteer opportunities, and found Monmouth Medical Center, serving on the board of the Women’s Council of the Leon Hess Cancer Center (she chaired it in 2002) and joining the foundation board in 2000. Then, she says, came “an unprecedented invitation”: to become full-time vice president of development in 2005.

Though Baratta had little fundraising experience, says Murphy, “she knew everyone in the community and could engage with donors. And she had incredible energy.”

Baratta reorganized the department and refocused its marketing strategy. Under her leadership, annual donations shot up from \$3 million her first year to \$6 million in her second and \$10 million in her third.

“I loved working for Monmouth and representing the Saint Barnabas Health Care System,” she says.

The new job for which she has moved to Manhattan is an Italophile’s joy. As a vice president of the Brunello Development Group, she is working with the Ferragamo family of fashion fame to develop Castiglion del Bosco, a luxury resort in an 800-year-old castle in Tuscany.

But Baratta is also delighted to be staying active at Monmouth’s foundation in the key capacity of board chair. “My work here isn’t finished,” she says. She will serve a one-year term as interim chair, helping to acclimate the new vice president and meet capital campaign goals “that could be in excess of \$30 million,” she reports.

Says Murphy: “She’s simply too good to lose.” ■

What's HAPPENING at Monmouth Medical Center

CHILDBIRTH PREPARATION/ PARENTING

Programs are held at Monmouth Medical Center, 300 Second Avenue, Long Branch. To register, call 732-923-6990 unless otherwise noted.

■ **One-Day Preparation for Childbirth** June 22, July 20, August 17, 9 a.m.–4:30 p.m. \$179/couple (includes breakfast and lunch).

■ **Two-Day Preparation for Childbirth (two-session program)** July 12 and 19, August 2 and 9, 9 a.m.–1 p.m. \$150/couple (includes continental breakfast).

■ **Preparation for Childbirth (five-session program)** July 15, 22, 29, August 5 and 12, 7:30–9:30 p.m. \$125/couple.

■ **Two-Day Marvelous Multiples** July 27 and August 3, 9 a.m.–1 p.m. For those expecting twins, triplets or more. \$150/couple (includes continental breakfast).

■ **Eisenberg Family Center Tours** June 29, July 13, 27, August 10, 24, 1:30 p.m. Free. (No children under 14 years old.)

■ **Make Room for Baby** June 21, July 26, August 16, 10–11 a.m. For siblings ages 3 to 5. \$40/family.

■ **Becoming a Big Brother/Big Sister** July 19, 10–11:30 a.m. For siblings age 6 and older. \$40/family.

■ **Childbirth Update/VBAC** July 9, 7:30–9:30 p.m. Refresher program including information on vaginal birth after cesarean. \$40/couple.

■ **Baby Care Basics (two-session program)** June 21 and 28, noon–2 p.m. July 10 and 17, 7:30–9:30 p.m. \$80/couple.

■ **Breastfeeding Today** August 7, 7–9:30 p.m. \$50/couple.

■ **Cesarean Birth Education** June 18, August 20, 7:30–9:30 p.m. \$40/couple.

■ **Grandparents Program** July 14, 7–9 p.m. \$30/person; \$40/couple.

■ **Parenting Young Children Through S.T.E.P. (five-session program)** September 17, 24, October 1, 8, and 15, 7–9 p.m. Systematic Training for Effective Parenting from infancy to age 6. \$75/person or \$100/couple.

■ **Adoptive Parenting** Private, two-session programs conveniently scheduled to accommodate your needs. \$150/couple.

■ **Gestational Diabetes Education Program** One-session class for women who develop gestational diabetes during pregnancy. Convenient appointments available by calling the Center for Diabetes Education at 732-923-7550. Fee required.

JUST FOR KIDS

■ **Safe Sitter (one-session program)** June 21, July 26, August 23, 9 a.m.–4 p.m. For 11- to 13-year-olds on responsible, creative and attentive babysitting. Monmouth Medical Center. Call 1-888-SBHS-123, \$50/person. (Snack provided; bring bag lunch.)

GENERAL HEALTH

■ **“To Your Health” Showcase** June 13, July 11, August 8, 11 a.m.–1 p.m., Monmouth Mall near the Food Court, Routes 35 and 36, Eatontown.

■ **Blood Pressure Screening** June 13, July 11, August 8, 11 a.m.–1 p.m., Monmouth Mall near the Food Court, Routes 35 and 36, Eatontown.

■ **Monmouth Medical Center Community Health Fair** June 25, 11 a.m.–1 p.m., “Holistic Health,” at Monmouth Medical Center, ground floor lobby, 300 Second Avenue, Long Branch.

■ **Diabetes Self-Management Series** Four-session diabetes education program focusing on diet, nutrition, glucose monitoring, medications, meal plans prevention/treatment of complications, dining out and exercise. For dates and times, call the Center for Diabetes Education at 732-923-5025. Fee required.

SENIOR HEALTH

■ **Health Information on the Internet: The Good, the Bad, the “Don’t Go There”** July 9, 1 p.m., SCAN.*

■ **The Importance of Having an Advance Directive/Living Will** July 23, 1 p.m., SCAN.*

■ **Don’t Suffer With Foot Pain: Nonsurgical and Surgical Treatments** August 6, 2 p.m., presented by Frances C. Fittanto, DPM, podiatry. Free foot screenings will be available by appointment following this program. SCAN.*

■ **Exercises to Relieve Back Pain** August 20, 1 p.m., SCAN.*

*SCAN Learning Center (Senior Citizens Activities Network, age 50 and over) is located at Monmouth Mall, Eatontown. To register for programs, call 732-542-1326. SCAN Membership is not required. ■