# NexBioHealth

## Shaping Futures

November 2026 | ISSUE 8

## The Evolving Physician

**NEXUS INSIGHTS**

Meta-Research
Prevention Beyond the Clinic
A Promise That Became a Blueprint
Becoming a Psychiatrist in the Age of AI
The Price Is Out There. Good Luck Finding It.

**CAREER DEVELOPMENT**

Dr. Hong's Reflection
A Life Shaped by Emergency & Humanitarian Medicine
From Neglected to Noticed
Book Review

**STUDENT HUB**

Dear Mentor
Beyond the Surface: Why Both?
Q&A: Beyond the Operating Room
Becoming the Physician I Want to Be
New Editor in Global Health & Partnerships

**UPCOMING ISSUE**

Physicians Building Community



The Evolving Physician

## Ian Tong, MD

From Academic Medicine to Digital Health Leadership

ISSN 3055-7595 · Published Quarterly

# NexBioHealth: What Makes It Unique

*NexBioHealth is a global magazine dedicated to empowering and connecting medical students, residents, and budding physicians worldwide. The magazine is a dynamic platform designed to foster global networking, knowledge sharing, research collaboration, and professional growth for young healthcare professionals.*




## Vision

***NexBioHealth aims to foster an international community where future leaders in medicine can learn, collaborate, and grow together. Building on the 10-year legacy of the World Asian Medical Journal (WAMJ), NexBioHealth expands its scope to engage a broader, global audience, creating a platform for medical professionals worldwide.***

## Key Features

**01. Career Development & Mentorship:**

This section offers guidance and mentoring to help young medical professionals navigate their career paths. It includes contributions from experienced physicians and focuses on professional growth, education, and research opportunities.

**02. Health Equity and Engagement:**

Focused on addressing health equity and global health, this section highlights innovations in public health, healthcare delivery, and international healthcare innovations. Through in-depth articles and interviews with global health leaders, we aim to promote discussions around equitable healthcare access and inclusion worldwide.

**03. Global Networking for Physicians:**

NexBioHealth connects medical students, residents, and physicians worldwide by featuring leading organizations, providing networking opportunities, and facilitating international collaborations.

Conferences: This section highlights important medical conferences and events around the world, providing readers with opportunities for learning and professional development.

**04. Medical Report & Healthcare Updates:**

A comprehensive section delivering the latest news in medicine and healthcare, covering advancements, policy changes, and industry trends.

**05. Student and Resident Engagement:**

NexBioHealth is committed to representing the interests of medical students and residents through the formation of the Student Advisory Committee (SAC). These committees help shape the magazine's content, organize events, and promote mentorship opportunities.

NexBioHealth is more than just a publication-it's a vibrant community and resource hub for the next generation of medical professionals. By bringing together students, residents, and physicians from across the globe, NexBioHealth is dedicated to supporting the growth and development of future leaders in the medical field.

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**The NexBioHealth Editorial Board comprises a diverse group of physicians and healthcare professionals from various specialties who are recognized as thought leaders with innovative ideas and notable accomplishments.**

**This distinguished group is united by a shared mission: to make NexBioHealth a unique platform for addressing the most pressing issues in medicine and healthcare today and into the future. Their goal is to nurture, motivate, and inspire the next generation of healthcare professionals.**

## Diverse Expertise

Unlike the typical editorial boards of academic journals, the NexBioHealth Editorial Board is intentionally diverse. It includes physicians from major university settings, private practices, and community health centers, not only in the United States but also globally. This diversity ensures that the magazine reflects a wide range of perspectives and experiences, making it relevant and impactful for a global audience.

## Interdisciplinary Approach

In addition to physicians, the board includes prominent individuals from the scientific, legal, health industry, and public health fields. This interdisciplinary approach is crucial for interpreting and providing insights into medicine and healthcare from unbiased and diverse viewpoints. By integrating expertise from these various fields, NexBioHealth is positioned to offer comprehensive and balanced coverage of the issues that matter most to healthcare professionals and the communities they serve.

## Supporting Young Minds:

To further enrich the content and ensure it resonates with the emerging generation of medical professionals, NexBioHealth has established two additional boards:

### Student Advisory Committee (SAC)

- The SAC is designed to represent the interests and perspectives of medical students. Members provide feedback on articles, suggest relevant topics, and help tailor the content to meet their peers' needs. They also liaise between NexBioHealth and medical schools, assisting with student outreach and event coordination. Their involvement ensures that NexBioHealth remains a vital resource for students, providing content that is both educational and inspiring.

### Resident Physicians Advisory Committee (RPAC)

- The RPAC represents residents across all specialties, offering valuable insights into the challenges and opportunities faced by physicians in training. The RPAC helps guide the magazine's content by contributing articles, organizing networking opportunities, and supporting mentorship programs. Their participation ensures that the magazine addresses the specific needs of residents, helping them navigate their careers with confidence.

## A Growing and Evolving Board:

Our editorial board is in the beginning phase and continues to grow, inviting more great minds to join us in our mission. As we expand, we are committed to bringing together a broader range of expertise and perspectives to enhance the magazine's quality and impact. We seek thought leaders and innovators who share our vision to join us in making NexBioHealth a powerful voice in medicine and healthcare.

## A Truly Unique Platform:

NexBioHealth's combination of a diverse, interdisciplinary editorial board and the inclusion of the SAC and RPAC makes it a truly unique platform. It is a magazine that not only raises important issues in medicine and healthcare but also fosters a collaborative environment where young minds are nurtured, motivated, and inspired.
NexBioHealth is committed to being more than just a publication-it is a community and a resource for those who aspire to lead and innovate in the healthcare field. Through the collective efforts of its editorial board, students, and residents, NexBioHealth aims to be the best platform for shaping the future of medicine and healthcare.



## *The Evolving Physician:* ***Ian Tong, MD*** *From Academic Medicine to Digital Health Leadership*



### *My Father's Journey: From Gaesong to an American Medical Degree & Interview with Dr. Walter Choi*

A remarkable journey of Dr. Chai Chang Choi, from colonial Korea to American medical education, told through the reflections of his son, Dr. Walter Choi.



### *Meta Research: Building a More Reliable and Self-Correcting Science*

Dr. Jae Il Shin explores how meta-research can strengthen scientific rigor, transparency, and reproducibility, fostering a more reliable and self-correcting research ecosystem.



### *A Promise That Became a Blueprint: Building a Community-Based Model of Care in Kenya*

Jess Danforth shares how personal loss inspired The Leo Project, a community-centered initiative bringing healthcare, education, and hope to underserved families in Kenya.



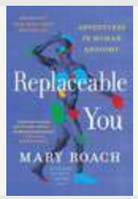
### *A Life Shaped by Emergency and Humanitarian Medicine: An Interview with Dr. Killiam Argote-Araméndiz*

Experiences across conflict zones reveal the challenges of humanitarian medicine, the importance of supporting local healthcare teams, and the personal costs of service.



### *From Neglected to Noticed: Bringing Tropical Diseases Back into Focus*

Neglected tropical diseases continue to affect vulnerable populations, highlighting the urgent need for stronger public health systems, disease prevention, and equitable access to care.




### *Book Review: Replaceable You by Mary Poach*

Through a surgeon's perspective, "Replaceable You" explores innovations in bodily repair, emphasizing curiosity, patient-centered outcomes, and the meaningful impact of medical advances.

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## From the Publisher



***Chul S. Hyun, MD, PhD, MPH***

Div. of Digestive Diseases
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Dear Readers,

Medicine asks us to keep evolving. We learn new skills, reconsider familiar ideas, and sometimes discover a direction we could not have imagined when we first became physicians. The theme of this issue, **The Evolving Physician**, invites us to reflect on that continuing journey.

Our cover story featuring Dr. Ian Tong offers one perspective on how a medical career can grow and take new forms. We also begin a special feature on Dr. Chai Chang Choi, a founder of the Korean American Medical Association, through the story shared by his son, Dr. Walter Choi. His journey reminds us that the opportunities we have today were shaped by people who persevered through uncertainty, separation, and the challenges of building a life in a new country.

Across these pages, heartfelt accounts from colleagues working in global health bring us closer to the people behind the work. Their experiences in community care, humanitarian medicine, and public health remind us how much we can learn from lives and settings different from our own. Our Editor-in-Chief will introduce the individual contributions more fully. As publisher, I want to express my gratitude to everyone who has entrusted us with a story, an idea, or a personal reflection.

NexBioHealth is evolving as well. Beginning with this issue, we are moving from four issues a year to three, published in **November, March, and July**. Each issue will be more substantial, with more content and room to explore the subjects and experiences that matter to our readers. We hope this rhythm will give contributors more time to develop their work and readers more to enjoy in each edition.

This magazine comes together through the generosity of many people: our contributors, editors, volunteers, production team, and readers. I cannot name everyone here, but I am grateful for the time, care, and thought you bring to it. You make NexBioHealth a place where our medical community can stay connected and continue learning from one another.

As Thanksgiving approaches, I hope you will find time to pause, gather with those you love, and appreciate the people who have helped you along your own journey. Thank you for being part of ours.

Wishing you and your families a warm and peaceful Thanksgiving.

Chul S. Hyun, MD, PhD, MPH

## From the Editor-in-Chief



***Joseph P. McMenamin, MD, JD, FCLM***

Christian & Barton, LLP

Rarely have we presented such a varied, heartening collection of motivating stories as in the current issue.

After teaching at Stanford, Ian Tong, MD, helped bring a young telemedicine company to maturity and is now an advisor to investors  After practicing emergency medicine, Dr. Killiam Argote-Araméndiz cares for victims of disasters in trouble spots around the world.

Dr. Walter Choi introduces us to his father, Dr. Chai Chang Choi. A Korean immigrant, Dr. Choi had to take a long series of low-wage jobs to make ends meet. Dr. Choi not only survived; he achieved, becoming a founder of KAMA. In several instances,  our self-starters acknowledged the help of the Divine. People of faith provided much needed help to Dr. Choi. Dr. Joseph Lee, already a minister, is studying for a Master of Divinity.

Mexico's Dr. Juan Carlos Anguiano concentrates on neglected tropical diseases ("NTDs"), including such exotica as, Zika, chikungunya, leprosy, onchocerciasis, taeniasis and cysticercosis, and leishmaniasis, among others.

After the death of a close friend, Jess Danforth founded, in her honor, the Caitlin O'Hara Community Health Clinic in rural Kenya, "where care is shaped with the community it serves."

Drawing on his substantial experience, our publisher,  Dr. Hyun, discusses "Why Community Medicine Matters for Research and Care."

Two articles focus on the literature. Dr. Jae Il Shin teaches us about reading the literature critically.  Dr. Mun K. Hong argues that "Quality rather than quantity should guide research efforts."

Philip Wang, MD explains "Becoming a Psychiatrist in the Age of AI."  Sung Hwi Hong, MD. MPH describes how difficult it is, despite enactment of legislation, to obtain reliable information on the prices of healthcare. In "Why Both?" Emily Choe , MD/PhD student, answers her own question. Orthopedist Dr. Robert Sorrell discusses his evolution from orthopedist to wellness advocate. Dr. Sanghyun Alex Kim reviews "Replaceable You" by the inimitable Mary Roach.

Enjoy.

Joseph P. McMenamin, MD, JD, FCLM




**www.NexBioHealth.org**

**We invite you to become part of a vibrant community of medical professionals, where experienced leaders and emerging physicians from around the world collaborate, share knowledge, and drive the future of healthcare. This global network fosters mentorship, research collaboration, and leadership development across generations, ensuring that the next wave of medical leaders is well-equipped to tackle the challenges of tomorrow.**

**For more information or questions email: info@nexbiohealth.org**




## Medical Report

I have had the pleasure of knowing Dr. Jae Il Shin for the past two years as both a colleague and collaborator. We have worked together on several projects in gastric cancer and global disease burden, and through this collaboration I have come to know him as an exceptionally hardworking investigator with broad intellectual interests and a clear vision for advancing science.

Although his original specialty is pediatric nephrology, Dr. Shin's academic work has extended across many fields, including evidence-based medicine, medical education, epidemiology, and meta-research. This breadth has given him a distinctive perspective on how scientific evidence is generated, evaluated, and ultimately used.

Dr. Shin and I are now working together toward establishing a meta-research program at Yale University. At its simplest, meta-research can be thought of as "**research on research**": a systematic effort to examine how scientific research itself is conducted, evaluated, and improved. I believe this is an exciting opportunity to bring investigators from different disciplines together to improve the rigor, reliability, and impact of science.

In his article, "**Meta-Research: Building a More Reliable and Self-Correcting Science,**" Dr. Shin introduces us to this rapidly developing field and explains why it matters to researchers, physicians, educators, and academic institutions. His article invites us to look at science through a different lens: not simply asking what we know, but how we know it, how reliable that knowledge is, and how we can do better.

Chul S. Hyun, MD, PhD, MPH
Publisher, *NexBioHealth*

# Meta-Research: Building a More Reliable and Self-Correcting Science

*By Jae Il Shin, MD, PhD*

### What Is Meta-Research?

John Dewey, an American philosopher, psychologist, and educational reformer, emphasized the necessity of "reflective thinking," suggesting that we learn not merely from experience itself, but from deeply reflecting upon it.

While countless research papers are continuously being published, there is a need for ongoing evaluation to determine whether research is being conducted, analyzed, and interpreted appropriately. The study of the research process itself is known as "meta-research." Taking a slightly broader perspective, the term "meta-science" is also used when this inquiry extends beyond individual research practices to the broader scientific ecosystem and science policy.

In the early 2010s, assessments of the reproducibility of key studies in oncology and biology raised serious concerns when many published findings could not be successfully replicated. These findings contributed to growing recognition of what became known as the "replication crisis." Potential contributing factors included the "publish or perish" culture, statistical errors, intentional data manipulation, and publication bias. Such low reproducibility can result in substantial waste of resources and, in biomedical research, may ultimately threaten patient safety. Meta-research developed in part as a systematic response to these concerns.

While many people confuse meta-research with meta-analysis, which statistically aggregates data from individual studies, meta-research is not merely about combining study results. Rather, it is a discipline that examines and reflects on the entire research process, including study design, conduct, analysis, peer review, publication, and implementation.

The modern development of this field was strongly influenced by the 2005 publication of "Why Most Published Research Findings Are False" by Professor John Ioannidis, followed by initiatives such as the




establishment of the Meta-Research Innovation Center at Stanford (METRICS). Although meta-research is a crucial discipline applicable to academic fields well beyond medicine, relatively few universities or scholarly societies currently have formal programs devoted to it, due to various structural barriers and a general lack of awareness. Nevertheless, the UK government recently established a government-level Metascience Unit to examine and improve the research ecosystem, reflecting the growing importance of this field.

## The Five Domains of Meta-Research

While meta-research can evaluate many aspects of research, five major domains provide a useful framework.

First, the **Methods** domain of meta-research identifies structural flaws, biases, and statistical errors in the research process and seeks to develop rigorous, standardized methodologies for future scientific inquiry.

Second, the **Reporting** domain focuses on maximizing research transparency and reproducibility by creating standard guidelines for sharing study protocols, raw data, and complete methodologies. Although specific reporting guidelines for various study designs are available through the Enhancing the Quality and Transparency of Health Research (EQUATOR) Network, and many of these standards are endorsed or recommended by journals and editorial organizations, adherence remains inconsistent.

Third, the **Reproducibility** domain systematically repeats or reanalyzes existing studies to determine whether the original scientific findings can be reproduced or replicated. When research cannot be replicated, it may lead not only to substantial waste of funding and resources but, in biomedical research, also to potential harm to patients. Therefore, continuous efforts are needed to investigate reproducibility and improve scientific reliability through systemic reforms, such as facilitating the publication of negative findings and reconsidering academic incentive and reward systems. As part of these efforts, the UK Reproducibility Network (UKRN) was established, inspiring similar national networks worldwide, while Stanford University established the Stanford Program on Research Rigor and Reproducibility (SPORR) within its School of Medicine to strengthen meta-research education and scientific training.

Fourth, the **Evaluation** domain encompasses not only the assessment of research through peer review, but also the important question of how researchers themselves should be evaluated using fair and robust criteria.

Fifth, the **Incentive** domain addresses how academic rewards and incentives can be structured to foster a healthy scientific ecosystem. Without careful consideration of funding allocation and academic incentives, research can become heavily concentrated in fashionable or high-profile areas, while rarer but critically important diseases and research areas may receive insufficient attention.

These domains do not exist in isolation. Rather, they are closely interconnected. Through continuous self-reflection driven by meta-research, we can establish a rational scientific ecosystem that minimizes bias, promotes rigorous methodology, supports transparent and open science, and encourages adherence to reporting guidelines. This holistic approach can improve the reproducibility and reliability of research while ensuring that negative findings are also valued and evaluated fairly. Ultimately, cultivating such a robust and self-correcting scientific ecosystem can better equip us to address complex medical and scientific challenges in the future.

## Applying Meta-Research Beyond Research Itself

Once we recognize the concept and importance of meta-research, we can apply it to virtually any academic field. Meta-research allows us to examine past practices, identify important gaps, and develop directions for improvement.

Regarding Evidence-Based Medicine (EBM), although it was introduced into medicine more than 30 years ago, many ambiguities remain regarding what to teach, how to teach it, and how teaching methods should be differentiated between undergraduate and postgraduate medical education. Furthermore, the definition of "evidence" itself remains subject to debate. When interpreting evidence, we should look beyond the results of randomized controlled trials (RCTs); we need to build the capacity to evaluate whether benefits and harms have been appropriately analyzed and whether the evidence is being correctly interpreted.

Medical students who learn to critically examine research through meta-research will not blindly trust an author's conclusions when reading papers. Instead, they can develop the critical eye needed to detect flaws in study design, identify biases hidden within the data, and distinguish evidence that is both credible and applicable to real-world patients.

In addition, university presidents and deans can use the principles of meta-research to examine how institutional policies are developed, evaluated, and implemented. For example, students often experience significant mental health problems, such as depression, anxiety, and suicidal ideation, related to academic stress and other challenges. Consequently, it is important to critically evaluate mental health programs across universities, including how effectively they are implemented and the extent to which they are based on evidence.

## From Meta-Research to a Scientific Community

Over the past decade, I have conducted meta-research alongside internationally recognized experts in the field, including Professor John Ioannidis. Returning to my primary discipline of pediatric nephrology, I came to recognize how much work remained to be done. I subsequently gave an invited lecture to the European Society for Paediatric Nephrology (ESPN), which ultimately helped pave the way for the establishment of the "Meta-Research and Quality of Evidence" Working Group, which I now lead within the society.

Furthermore, I am planning to establish a **Meta-Research Community at Yale University** in collaboration with Professor Chul Hyun, Director of the Gastric Cancer Prevention and Screening Program at Yale School of Medicine. Our goal is to create a collaborative forum that brings together investigators interested in improving how research is designed, conducted, reported, evaluated, and translated into practice. While meta-research remains an emerging institutional field, I envision our efforts growing into a multidisciplinary think tank that can contribute to research across academic departments and scholarly societies and potentially inform broader university research policies.

In an increasingly vast and complex scientific landscape, meta-research can serve as a compass, helping us continually examine where we have been, determine whether we are moving in the right direction, and improve the path ahead.



**Jae Il Shin, MD, PhD**

Dr. Jae Il Shin is Professor of Pediatrics and Professor of Medical Education at Yonsei University College of Medicine and Chief of the Division of Pediatric Nephrology at Severance Children's Hospital in Seoul, South Korea. He also serves as Deputy Director of the Center for Medical Education Training and Professional Development at the Yonsei-Donggok Medical Education Institute, where his work includes leadership in evidence-based medicine education.

Dr. Shin was a visiting scholar at Emory University, where he conducted meta-research on scientific rigor in stem cell research from 2018 to 2020. In 2022, he became an affiliate of the Meta-Research Innovation Center at Stanford (METRICS), Stanford University. In 2023, he launched the Severance Underwood Meta-Research Center within the Institute of Convergence Science at Yonsei University.

MEDICAL REPORT

# Prevention Beyond the Clinic

## Why Community Medicine Matters for Research and Care

*By Chul S. Hyun, MD, PhD, MPH*

*Much of what we know about disease comes from encounters within healthcare institutions. Hospital records, clinical trials, pathology reports, and specialist visits help us understand risk, establish diagnoses, and evaluate treatments. These sources are indispensable, but they offer an incomplete view of how prevention happens in everyday life.*

*People enter a medical record when they reach care. What happens before patients reach care and between their visits may remain less visible. Who knows that they could benefit from testing? Who feels comfortable participating? Who receives a result but cannot arrange an appointment? Who finishes treatment without knowing that another test is needed?*

*These questions belong to medicine as much as the choice of a diagnostic test or prescription. They also require research that reaches beyond the clinic.*

*Our recent* ***Health Promotion Practice article*** *describes a community-based* ***Helicobacter pylori*** *screening and navigation project conducted through a partnership between Yale and Korean Community Services of Metropolitan New York (KCS). The project offered an opportunity to examine what happens between identifying an infection and completing the care it requires. It also highlighted the contributions of community workers, bilingual staff, navigators, and volunteers whose efforts made that work possible.*

### The Community as a Place of Prevention

Community medicine brings clinical knowledge into the settings where people live, gather, and develop relationships. Churches, cultural organizations, and community service centers can provide opportunities to reach people who might not otherwise seek a particular preventive service.

This does not mean that everyone attending a community screening event lacks healthcare. Some have regular physicians and established access to care. Others face language, insurance, scheduling, or transportation difficulties. Even people who routinely use medical services may never have discussed the risk being addressed.

The community offers a different starting point. Participation can begin with an explanation from a familiar organization, an announcement in a preferred language, or a conversation at a local event. These encounters can bring prevention into view before symptoms prompt a medical visit.

They can also generate evidence that is difficult to obtain from clinical records alone. Community-based research can examine who participates, how people understand an offer of testing, and what happens when an identified need must be connected to the healthcare system.

Such research has limitations of its own. Participants recruited through community networks may differ from those who are less connected or less inclined to volunteer. Community data should therefore complement institutional research. Together, they can provide a fuller picture of disease and the delivery of care.

### Why *H. pylori* Is an Important Example

*H. pylori* is a bacterial infection of the stomach and a major modifiable contributor to noncardia gastric cancer. Infection is often acquired in childhood and may persist for years without obvious symptoms. Eradication can reduce subsequent cancer risk, although it does not necessarily remove the risk associated with established gastric atrophy or intestinal metaplasia.

For immigrants from regions with a substantial gastric cancer burden, earlier infection may remain relevant long after relocation. Yet testing may occur only when symptoms develop or when a clinician recognizes an increased risk.

This creates a practical prevention challenge. There is a medically actionable infection, a noninvasive means of detecting it, and treatment that can clear it. What is less consistently established is a pathway that helps people move through all the necessary steps.

The sequence extends beyond screening: receiving and understanding the result, obtaining clinical evaluation, accessing medication, completing treatment, and undergoing testing to confirm eradication. A program that measures only how many people were tested may miss much of what determines its eventual benefit.

### Building the Program Together

The Yale–KCS collaboration brought screening to 17 community sites serving Korean American populations. Between June and November 2025, 323 Korean-born adults completed screening and survey procedures.

Events were organized with community service organizations, churches, and cultural groups. Outreach used Korean-language and bilingual materials, local announcements, partner networks, and community communication channels. Participants completed a questionnaire and an on-site urea breath test, which detects active infection.

The partnership involved more than providing a venue. Community organizations helped shape event logistics, language needs, and how the purpose of the program was explained. Bilingual research staff, navigators, community workers, and volunteers supported participation and continuing engagement.

Their contribution deserves explicit recognition. Clinical expertise can establish what should be offered. Community expertise helps determine how an offer can be understood, accepted, and followed through.

A resource guide becomes useful when it identifies care that participants can realistically access. A test result becomes actionable when someone explains its meaning in a language the participant understands. Follow-up becomes possible when staff maintain contact respectfully and respond to practical questions as they arise.

These functions are part of the intervention itself.

### What Happened After Screening?

Active *H. pylori* infection was identified in 58 of the 323 participants, or approximately 18%. All 58 were successfully contacted for confidential result disclosure and counseling.

That was an important accomplishment: every participant with detected infection received an explanation and an opportunity for assistance.

Subsequent progress, however, was less complete.

During follow-up of up to six months, 31 participants reported completing a clinical evaluation, 15 completed eradication therapy, and nine underwent post-treatment testing. Eight of the nine retested participants had confirmed eradication.

The difference between successful disclosure and completed care is the central observation. Contacting someone and explaining a positive result did not automatically lead to an appointment, treatment, and confirmation of cure.

These figures should not be interpreted as final outcomes for everyone. Some participants remained engaged with navigators but had not completed later steps by the end of observation. An appointment could still be pending, treatment could be delayed, or retesting might not yet have occurred. The study captured progress within a defined period, rather than a permanent division between those who completed care and those who never would.

Nor can the eight successful eradications among nine retested participants establish treatment effectiveness for the entire infected group. They show what was documented in a small subgroup that reached the final stage.

The findings are most informative as a description of the work between screening and completed care.

## The Distance Between a Result and Care

A positive test creates a medical recommendation, but acting on it requires a series of practical arrangements.

Participants may need to determine where to seek care, whether insurance covers the visit or testing, how to obtain an appointment, and how to manage transportation or time away from other responsibilities. Prescription access and medication tolerance can introduce additional difficulties. After treatment, arranging a separate test may require another encounter with the system.

The program documented barriers involving insurance, appointment availability, transportation, prescription access, and post-treatment testing. Each may appear modest in isolation. Across several steps, however, they can slow or interrupt care.

It would be easy to describe incomplete follow-up simply as a lack of adherence. That interpretation can overlook the circumstances in which participants are trying to obtain care. Continued navigator contact helped make some of those circumstances visible.

Navigation included explanations, bilingual materials, laboratory reports, clinician letters, information about local providers and safety-net services, and repeated follow-up. Its purpose was to help participants connect a community screening result with clinical care.

This also shows why navigation requires sustained resources. The work continues after an event has ended and may extend across several months. It involves maintaining records, answering questions, identifying unfinished steps, and coordinating across organizations with different responsibilities.

## Community Work Is Also Research

Community-based research connects a biological question—does someone have an infection?—with a delivery question—can that person obtain and complete the care it calls for?

Both are necessary. A prevalence study helps define the size and distribution of a problem. An implementation study examines how a response functions in practice. Following participants beyond testing revealed where progress slowed and where additional support might be needed.

The collaboration also illustrates a productive relationship between academic medicine and community organizations. Academic teams bring research methods and clinical knowledge. Community partners bring local experience, communication skills, established relationships, and an understanding of barriers that may not be obvious from within a medical center.

Working together allows those perspectives to inform both the service and its evaluation. It also recognizes community workers and volunteers as contributors to knowledge. Their observations and continuing contact can help explain why a medically appropriate recommendation has not yet become completed care.

The model should not be assumed to work identically everywhere. Other populations may have different languages, healthcare arrangements, community networks, and preferences. The useful question is which functions should be preserved—accessible engagement, understandable communication, and continuing assistance—and how they can be delivered locally.

## What This Early Project Can Teach Us

This was a descriptive evaluation of an early program. Participants were volunteers recruited through community settings, not a representative sample of all Korean Americans. There was no comparison group, so the effect of navigation could not be isolated. Later outcomes relied on participant reports and navigator documentation rather than systematic medical-record verification. Follow-up was limited, and gastric cancer outcomes were not measured.

These limitations define what the project can claim. It demonstrates that screening and confidential result communication could be delivered through this partnership, and it describes the challenges encountered afterward. It does not establish population-wide infection prevalence, prove that navigation improved outcomes, or show that the program reduced cancer incidence.

Nonetheless, it identifies questions worth pursuing. How can appointments and prescriptions become easier to obtain? What arrangements improve access to retesting? Which forms of navigation are most useful? What resources allow community organizations to sustain this work?

Those questions extend beyond gastric cancer prevention. Many preventive services require people to move between community settings, primary care, laboratories, pharmacies, and specialist services. The strength of a recommendation matters, but so does the ability to complete that journey.

Community medicine makes that journey visible. It reminds us that prevention is delivered through relationships, communication, and practical support as well as tests and treatments. To understand whether medical knowledge is improving health, we need to follow it beyond the clinic—and learn from the people doing that work in the community.

*This commentary draws on the collaborative study by Hyun CS, Roh A, Lee YJ, and Kim SS, "Implementation of Community-Based Helicobacter pylori Screening and Navigation in High-Risk Immigrant Communities," published in Health Promotion Practice (2026). It discusses the findings in the broader context of community medicine and prevention delivery. Original article.*





# The Evolving Physician, Ian Tong, MD



## Ian Tong, MD, is a nationally recognized health care executive with deep operational and strategy experience in digital health transformation.

A graduate of The University of Chicago  Pritzker School of Medicine, Dr. Tong was Chief Resident in Internal Medicine at Stanford before joining the faculty, where he served and mentored for two decades. As President and Chief Medical Officer at Doctor on Demand (DOD), 2013-22, Dr. Tong designed and scaled a digital health platform serving patients in all 50 states. In 2021, he helped direct the merger of DOD and Grand Rounds and the acquisition of Included Health. Currently, Dr. Tong serves as Chief Clinical Officer at Foresite Labs, incubating companies at the intersection of care delivery and data science.

At his career's start, in 2006, Dr. Tong launched the award-winning Health Resource Initiative for Veterans Everywhere (THRIVE) for homeless vets. He has multiple peer-reviewed publications and has been a sought-after speaker at CES, "The Next Big Thing", HLTH and Health 2.0. He has also been invited for multiple television appearances on Good Morning America, Dr. Phil, Rachel Ray and multiple local news outlets. Dr. Tong was recently recognized for his physician executive accomplishments with the Excellence in Medicine Award from National Medical Fellowships.  He has served on numerous boards, including those of Thyme Care, Sollis Health and the Family Caregiver Alliance.

Joseph P. McMenamin, MD, JD, FCLM
Editor-in-Chief, *NexBioHealth*

**1. Many physicians view becoming an attending physician as the destination. Looking back, when did you realize that becoming a physician was actually the beginning of a much broader professional journey?**

When I first stepped onto the Stanford campus, it became clear to me that I was probably limited only by my imagination. There were amazing medical students starting companies, attending physicians who also worked in venture capital and our Program Director, Kelley Skeff, MD, was  a world-renowned educator with a Clinical Educator Training Program that drew in professors from around the globe. All of these people were good at their primary roles and then they sort of elevated and expanded beyond the original scope of attending physician. In my mind, this meant I needed to do everything I could to be a great doctor, healer, educator first… and then I could earn the privilege to broaden my professional journey.

**2. Your career has evolved from academic medicine to digital health leadership and healthcare innovation. Despite these changes, what aspects of your identity as a physician have remained constant throughout your journey?**

My dad ran a sole provider practice for 38 years in the Central Valley. He always said that his goal with each patient was simple, "I want each patient to walk away from me feeling better than they did when they walked up to me." That is a pretty simple and maybe obvious concept, but medicine and doctor-patient relationships can get very complex. I always carry his wisdom and humility with me. Sometimes it may make me stand out like a choir boy in board meetings or corporate leadership meetings, but I think the principles of medical ethics of "do no harm, act in the interest of your patients, champion justice and what is right and respect individual patient choice and dignity" are strong principles for any industry. My medical school friends and I used to ask: Are you comfortable with that showing up on the front page of the New York Times? Or, is it good enough that I would use it for my grandmother? These may be superficial examples, but they have guided me through many difficult professional decisions.



**3. Every career is shaped not only by pivotal decisions but also by pivotal people. Looking back, what moments, and perhaps more importantly, which mentors or individuals most influenced the direction of your career? What qualities should young physicians look for in a mentor as they navigate their own evolving careers?**

My grandmother was one of the first Black nurses to be a chief floor nurse in the Kaiser Permanente Hospital in San Francisco. Her supervisor actually lied and listed her as Portuguese, because Black women were not allowed to be in supervisor roles. She was smart and very down to earth. She was kind, but also could flare up and let you know when you were out of line. She was a tough woman. She taught me it was important to know right from wrong and how to be a professional. My Father was also a strong mentor. He showed me how being a hard worker could make up for any lack of privilege. But I think it is important that I acknowledge a mentor whom I barely knew. I sought him out as a mentor, because he didn't know me and therefore I knew he had no preconceived notion of what my interests or my biases were. He showed me that a great mentor sometimes asks questions rather than answers them, listens rather than tells and always assesses what you already know or can see before he tells you what he sees. Look for the people who are curious about you and how you think, not what you have accomplished.

**4. Many physicians measure their impact by the number of patients they personally care for. At what point did your definition of "making an impact" begin to change, and how do you think physicians should think about impact today?**

Oh, I think that is a mistake to measure impact in quantity. In fact, I might suggest it is a mistake to even attempt to measure your own impact. I currently work for a venture capital firm. I have a colleague who is about 14 years my junior. We have now worked together for four years, but she was in the audience for a panel I gave 14 years ago. When I joined Foresite Labs, she reminded me that she walked up to me after the panel and she told me I gave her amazing advice and it inspired her to pursue her path in health care startups. Given that the interaction was so brief, I cannot recall to this day what I said to her. If I didn't work with her now, I can assure you I would have no idea that interaction meant anything at all to anyone. I would say that physicians can always take extra time with a patient if they sense the need. They can just stay human and never forget that the relationships with patients are a privilege. Maybe never underestimate the power of time and caring. You are probably making a bigger impact than you are giving yourself credit for.


The work-from-home doctor will see you now

**5. Several times in your career, you chose paths that were less conventional and undoubtedly involved some uncertainty. How did you decide when it was worth taking a professional risk, and what advice would you give young physicians who are hesitant to step beyond the traditional career path?**

A mentor once told me that altering one's path is a lot like being at a party. All your friends are there, the music is playing, the drinks are flowing and you are standing at the door of the apartment where the party is being held looking out down a long dark hallway with a flickering light bulb in the distance. It looks cold out there and everyone you know and love is in the apartment. So why would you leave? Well, it is hard to change paths, but when you close that door behind you and start walking down the hall the lights go on, the music starts back up and you look around and the same people are there all around you having a great time. That happens because it is YOU!

**6. Looking back over your own career, every generation of physicians has had to adapt to major changes in medicine. For today's generation, AI may be that defining change. If you were starting residency again today, what would you do differently knowing what AI is likely to bring over the next decade?**

Hahaha! I might have taken the time to do another residency in psychiatry or maybe have gotten training in psychology. No, seriously, I think I would place more value on developing my motivational skills so that I could help my patients with behavior change. So much of what harms patients is poor understanding of the root cause of their behaviors. I just feel I would be a better clinician and more valuable in a post-AI workplace if my people and behavioral health skills were more magical. I suspect AI will democratize knowledge work enough that the best outcomes will be found where clinicians and patients have the strongest and most trusting relationships.

**7. You've spent your career working both inside and outside traditional healthcare organizations. What do you wish physicians understood earlier about leadership, communication, or business that isn't typically taught during medical training?**

I may be unique as a multi-ethnic physician answering this question, but I really think physicians need to




embrace the fact that we all carry implicit bias. It is just unavoidable, and acknowledging it and learning where it impacts our patients is one of the most important practice innovations that could ever occur in my opinion. We owe this to women, LGBTQIA+ and BIPOC members of our communities. Recognizing our biases is just too important and it has been neglected for too long.

**8. If you could sit down with your younger self on the first day of residency, knowing everything you've learned over the past two decades, what conversation would you have?**

I might say you have so much to learn so don't be afraid or impatient. Don't doubt yourself or give up on being better everyday. Medicine and science are not about what we know. They are about what we don't know and great clinicians honestly seek the answers or the tradeoffs with humility while always maintaining their patients' dignity.

**9. At NexBioHealth, we believe that a physician's career continues to evolve long after training is complete. What does the phrase "The Evolving Physician" mean to you, and what do you hope it will mean for the next generation of physicians?**

"The Evolving Physician" is a great concept, because each of us is on an individual journey of growth and change, but we are also walking alongside each other evolving as a collective as well. I hope future physicians respect, modify and maintain some of the valuable healing rituals of those who have come before. Holding a patient's hand in silence as she contemplates her cancer diagnosis is a privilege and a moment only humans can share. No AI or "bot" can replace human touch and empathy. We need science and knowledge to evolve, but maintain your humanity.



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## LIFE IN MEDICINE

# My Father's Journey

## From Gaesong to an American Medical Degree

*By Walter Choi, MD*

**Part One**




*Dr. Chai Chang Choi with a patient in rural West Virginia, circa 1951*

My father and I took a trip to Chicago in 1995. We visited the storage space where he had lived during his first summer in America. It was a tearful moment. There had been no bed or bathroom, and he had to bathe outside in the dark. The restaurant owner had allowed him to sleep there while he washed dishes, made ice cream by hand, peeled potatoes, and cleaned the restaurant after closing. This was the only way he could save money.

He earned $80 a month for that hard work. But the work did not discourage his commitment to becoming a medical doctor. He had decided in ninth grade that he would go to America for higher education. He had no idea how difficult it would turn out to be.

### Gaesong and the Decision to Leave

My father, Chai Chang Choi, was born in Gaesong, Korea, on January 12, 1907. He was the eldest son of farmers who raised the famous Korean ginseng, which provided a relatively comfortable childhood. His missionary school was at least three miles from the family farm. Nevertheless, he was always the first to arrive in the classroom. Sometimes he took farm products to market before school and was able to save money from this assignment.

At school, he was impressed and inspired by teachers who had been educated in America. Their forward looking thoughts and open attitudes were refreshing in a society shaped by Confucian ways. Their Western clothing also impressed him. Compared with traditional Korean clothing, it seemed more colorful to the young student. That early impression stayed with him, and he wore clean and proper clothing throughout his life.

The teachers described America as a land of opportunity. By ninth grade, my father had decided to study there, despite his limited English and lack of money or connections. Japanese colonial policies were becoming more intolerable every year, strengthening his wish to leave. His parents did not object, and at nineteen he began applying for a passport and visa with help from his teachers.

The application went through the Japanese controlled foreign service office. A local officer was amazed by the tenacity of this young man from an ordinary farming family. He needed an acceptance certificate from an American college, and his English teacher, who was studying at Yale University, arranged one from Lynchburg College in Virginia.

It took a year to obtain passport permission. The good news brought growing anxiety. He still had to pass an English examination, and flooding had damaged his parents' ginseng harvest. The cost of travel would be a difficult commitment for them. He went alone to Seoul for the examination at the American Consulate, where a kind Korean employee helped him pass.

Once his visa was approved, he bought his first Western suit, a couple of shirts, two pairs of socks, a suitcase, and a toothbrush and toothpaste. These were his possessions for the long journey. For his passport photographs, he had borrowed a friend's suit. Despite the poor harvest, his parents raised 280 won, approximately $140 in 1927. His limited budget did not dampen his excitement about going to America, a country entirely unknown to him.

### An Uncertain Beginning in America

His mathematics teacher, Gyunam Choi, traveled with him. Proficient in English, he was a kind companion, like a big brother. They left Busan on a Japanese freighter, paying approximately $80 for third class passage. They shared quarters with about thirty people, mostly Chinese or Filipino laborers. Poor accommodations and seasickness made the journey through Yokohama to Honolulu seem very long.

Honolulu seemed a small, sleepy port city to my father. He noticed its large Asian and Polynesian population, including Korean laborers. Syngman Rhee was organizing Korean independence activities there, and Dr. Youchan Yang, who later became Korea's ambassador to the United States, was practicing medicine.

When they reached San Francisco, Mr. Paik, a Korean newspaper editor and a friend of his teacher, welcomed them. He took them to a restaurant owned by Mr. Jueun Yang, an unofficial host to arriving Korean students. Mr. Yang even brought packed food and drinks to the station for their train journey to Chicago. My father remembered that generosity all his life and always tried to help struggling Korean students in America.

They chose Chicago because they hoped to find work before the school term. My father arrived with only $50. Minister Joontaek Noh provided shelter at his church and found Gyunam Choi work as a cook in

an American home. My father obtained a hotel job through an employment agency, paying $5 for the placement and another $5 for proper shoes.

His first assignment was to deliver food to Room 408. He did not understand that the room was on the fourth floor, and the delivery took too long. The guest complained, and the manager dismissed him without hearing his explanation. His English was too limited to obtain any sympathy.

He had not had a proper meal that day and could not even ask for one before leaving. By evening, he was unemployed and did not know how to return to the church. A policeman helped him find his way. He was very homesick in the lonely foreign country and cried for a long time. The agency fee and new shoes had depleted his reserve, making him even more nervous.

A minister accompanied him to Korean restaurants to look for work. At one, he met H. K. Park's grandfather, who was working as a waiter. They met again in Washington in 1950 and became good friends. Employment opportunities for Asian students were limited, and three Korean restaurants employed most of the twenty Korean students studying around Chicago.

One kind owner hired my father as a general helper and gave him the storage space where he could sleep. During that summer, he also met Korean students from wealthy and well established families. These friendships gave him a new perspective, since he had come from an ordinary farming household in a provincial town. Some later became politicians, artists, educators, and physicians in Korea.

Gyunam Choi went to the University of Michigan for graduate study. Their busy schedules allowed little contact until they were reunited in Seoul in 1945. His former teacher later became chancellor of Seoul National University and minister of education.



### Working His Way Through College

At the end of that summer, my father left Chicago for Lynchburg College with $200 in savings. A Ford sedan cost approximately $300 then, but his savings did not cover even half his college expenses. Arrangements for student work had already been made. Nevertheless, the college found him a job tending the boiler at the president's residence and a small adjoining room in which to live.

He began feeding coal into the boiler at five in the morning and worked again late at night. This habit made him an early riser all his life. He was the first and only Asian student at Lynchburg. Even "yes" and "no" were difficult because answers to negative questions worked differently in Korean. Sometimes he answered incorrectly when kind people offered him meals.

He studied English, French, chemistry, and biology. His classmates had completed twelve years of schooling, while he had completed ten. With poor English and constant financial worry, the courses were difficult. But teachers and students were exceptionally kind and sympathetic. He studied with dictionaries beside him and barely passed his freshman courses. He wished he could attend a preparatory school, but his finances and desire to finish medical education as soon as possible would not permit it.

There were also many American customs to learn. Exchanging pleasant greetings with strangers later helped him become a friendly physician. With female students, he had to learn unfamiliar etiquette, including helping them sit down in the dining room. He ate soup noisily, as he was accustomed to doing in Korea, and drew many eyes. He tried to be careful, but old habits were difficult to correct. He noticed male students showering before dinner and later learned they were trying to impress the women. He envied students who mingled easily at dances.

To save money, he washed his clothes by hand, bought a $1.50 iron, and repaired socks and underwear with a needle and thread. He had one suit from Korea. During his first year, he bought only a pair of pants, two pairs of socks, and two neckties. He kept his limited wardrobe clean, especially for Sunday church.

The local Methodist church supported the missionary school and hospital in Gaesong and had pictures of the city. When members learned where he came from, they welcomed him with open arms. Sunday dinners in their homes gave him a break from the boiler room and a chance to observe American family life. He always appreciated their welcome.

After his first year, Lynchburg had no scholarship or further work available for him. A minister found Emory and Henry College in rural Virginia, which offered a partial scholarship and summer work cutting grass and cleaning a swimming pool. During the school year, he carried bricks at a construction project and worked in the dining room. Heavy labor was unfamiliar and difficult for his small frame. The dining room food was poor, but it was free, and he was grateful.

His English improved, making his studies easier. A seminary student took him on Sunday visits to rural communities, where some residents had never seen an Asian person. Kind farmers welcomed him into their homes and shared bountiful dinners. Work and study left so little time that, after two years in America, he still had not written home.

He accumulated $300 in debt. Unable to find enough employment nearby, he sought a college near a larger city. A kind minister cosigned his debt so he could transfer to Emory University near Atlanta. The university was familiar to Korean students, and one of his missionary school principals had graduated there.

Employment remained difficult for Asian students and professionals. A Korean MIT engineering graduate had been unable to find work in his field and had opened a chop suey restaurant in Boston. My father visited him in 1945 and found him still running it.

In Atlanta, my father became a waiter at a restaurant owned by a Japanese American, working alongside three Korean students. The owner provided a small space in his apartment for minimal rent. After two isolated years, Korean companionship and Asian food were welcome. My father also realized that his earlier isolation had helped his English improve.

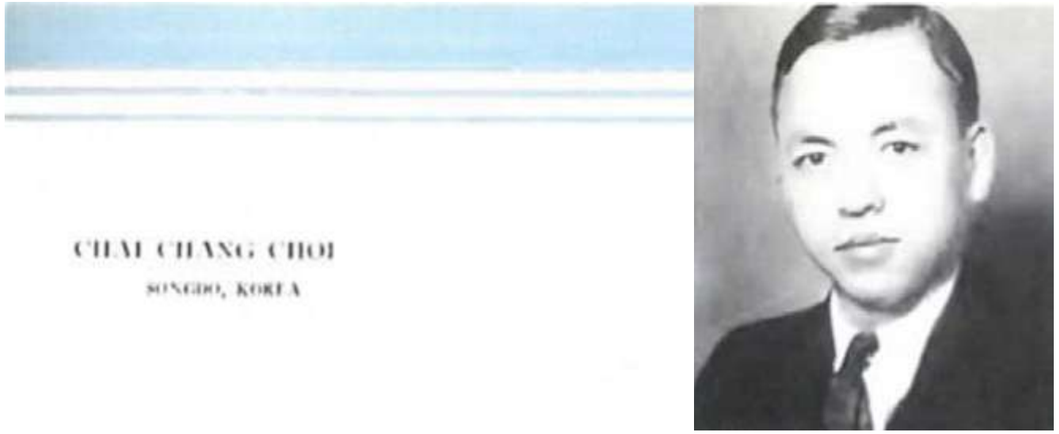
He worked at least six hours a day and had only one day off a month. He saved small change in a sealed wooden crate, following a Gaesong merchants' practice called a "dummy bank." When he opened it before the school term, he found $400. He celebrated by buying a $17 suit, $5 shoes, and a $3 hat.

His days began with toast and milk provided free by the restaurant, followed by classes, laboratory work, and study in the library. He worked from five until eleven in the evening, then studied for two more hours. Weekend shifts began at ten in the morning. Before putting away his earnings, he kept twenty cents for streetcar fare and thirty cents for lunch.

One day, William Weems, the son of his Gaesong missionary school principal, came into the restaurant. He was studying aviation engineering at Georgia Tech. Their happy reunion began a lifelong friendship. They met again in Washington decades later, after William had retired from MIT and was working independently as a plumber.

### Becoming a Physician

My father completed his premedical studies in 1930. Medical school was competitive and expensive, and the Great Depression made work harder to find. He applied without much hope of acceptance and considered changing careers. A fellow Korean student proposed opening a restaurant, and my father invested his $400 savings. Fortunately, the money in his dummy bank had been safe during the banking crisis.




*Dr. Chai Chang Choi, Medical College of Virginia, 1935*

They moved to Nashville. A Korean seminary student's criminal conviction had made headlines in Atlanta, giving my father another reason to leave. Three Korean students joined them as waiters. The five shared an apartment, hardships, close fellowship, and occasional picnics. Although the business went smoothly, the possibility of running a restaurant for the rest of his life made my father sleepless.

Around this time, his former English and Bible teacher, Minister Yim, visited Atlanta. He brought news of Gaesong and encouraged my father to continue studying medicine. Having faced similar difficulties as a foreign student, he understood. His advice came at a time when my father had no close guardian to guide him.

In March 1931, the Medical College of Virginia accepted him. He replied by telegram and told his partner he would leave the business. He lost his hard-earned investment, but he never regretted it. He was thankful that he could attend medical school.

My father needed to earn tuition money before the term began. He had only $100, and finding a job was a must. On his way to New York, he stopped in Richmond to buy an anatomy textbook. He also stopped in Washington, where he met Korean students who became close friends after Korea's liberation. In New York, he stayed at a Korean church, the main place where students could gather. A room cost $1 and a meal twenty five cents. He skipped many lunches to save money.

An older student introduced him to his former job as a housekeeper and cook in a retired physician's Long Island vacation home. My father arrived with a small bag, his anatomy textbook, and a used left handed golf club given to him by his friend. The physician did not appreciate his arriving with a golf club, but he was impressed by his hardworking employee.

My father prepared three meals a day, cleaned the house, and attended to the garden. His habit of rising early gave him time to walk around the golf course in the morning. He did not know what to do with the club, but he copied other golfers' swings. Although he was right handed, he played golf left-handed throughout his life because his first club was left handed. Those morning walks were his only recreation that summer. He was very lonely, but he learned to cook Western food and saved several hundred dollars.

When school began, he settled at the Richmond YMCA. The rent was reasonable, and it was close to the school. He thought the YMCA would be patient with him if his payments were late. His class had eighty six students, including three women and one other Asian student. They carried heavy textbooks and wooden boxes of bones through Richmond's humid weather. Many students smoked during dissection. My father smoked occasionally, but the expense prevented him from becoming a chain smoker.

He needed a microscope for microbiology and pathology. It cost $120, and he arranged to pay for it over two years. Physiology was especially difficult. He felt that studying at three different colleges had left gaps in his preparation. The first year was the busiest of his life as a student and part time waiter. Church on Sundays gave him a break, and friends there offered meals and encouragement. Our family later returned to Richmond many times to visit them. He passed the year owing $200 and was saddened when six classmates, including his dissection partner, were dismissed.

He returned to New York for summer work. His pride would not allow him to tell friends at school that he worked as a servant to earn tuition money. In segregated Richmond, many classmates associated domestic service with Black workers. His attitude changed in later life. He became proud that he had done everything necessary to achieve his goal.

On the journey north, he visited an older schoolmate studying medicine at Hahnemann in Philadelphia. They shared lunch prepared over a small stove. My father enjoyed it so much that he never forgot the menu: miso soup, Korean style chicken, and rice. Returning to the Korean church in New York felt like going home. But he waited days for work, ran short of money, and missed meals. A friend employed as a cook invited him to his employer's back door and fed him several times.

Eventually, he found work as a butler in a wealthy lawyer's vacation home. He cleaned, served meals, did laundry, pressed suits, and shined shoes. This practice made him keep his own shoes shiny throughout his later life. The household had a Japanese cook who was kind to him. Although his experiences in Korea had left him with resentment toward Japanese people, he treated the cook with respect. The summer passed peacefully, and he even had time to read medical textbooks. He saved $400, then earned another $15 washing cafeteria dishes during a few days in New York before returning to school.

The second year was more interesting, with biochemistry, microbiology, pharmacology, physiology, and introductions to medicine and surgery. He needed new textbooks, an ophthalmoscope, and a blood pressure instrument. Once again, he arranged to pay in monthly installments. Classes began at nine in the morning and ended at five. He worked a couple of hours afterward and studied until midnight, often studying again before school. He was always short of time. Missing even one day was unthinkable.

That summer, another butler's job offered no place to sleep. He moved to a Long Island tomato and corn farm rented by a Korean minister and his wife. Other Korean students worked there, making the hard labor a little easier. Breakfast prepared by the minister's wife was the highlight of the day. Syngman Rhee visited and encouraged the students to study and work for Korean independence. My father remained focused on finishing his education rather than entering political disputes.

The third year gave him the feeling of being a doctor. He enjoyed Saturday grand rounds and learning how to obtain a history, discuss a differential diagnosis, and plan treatment. Six more classmates had left, and new students arrived from a two year medical school in West Virginia. He continued to accumulate debt.

After another short summer job as a butler, he tried selling incense in Harlem at the suggestion of Korean students. His earnings were slightly better, but selling in a poor community was difficult. My father was not a good salesman, and he never tried it again.

Employment was becoming harder to find, and some discouraged Korean students returned home without completing their education.

The fourth year consisted entirely of clinical courses. He enjoyed assisting surgeons, even when he was only the third or fourth helper, and delivering babies, some in patients' homes. A rotation at a state mental hospital made him compare Virginia's psychiatric services with the limited care he understood to be available in Korea.



*Dr. Chai Chang Choi in post-liberation Korea, circa 1946*

Several families offered him room and board during the final year. They had followed his progress and knew his hardships. One family had little money, and he appreciated its generosity even more. He repaid his debts and kept those who had helped him informed of his progress. With less financial worry and interesting clinical work, the final year was easier. He passed the written examinations and a stringent oral examination given by four professors. He was happy and proud, but never forgot his parents, teachers, and church friends.

My father considered neurosurgery, but the training would take too long. He was homesick and wanted to practice what he had learned to help sick people in Korea. His professors recommended Charity Hospital in New Orleans, where he took a general internship with an interest in infectious diseases and parasitology. He was disappointed that there were not many patients with parasites. But for the first time in America, he could learn and treat patients without constant financial worry. New Orleans also introduced him to French food, jazz, and dancing.

### Returning to Korea

After nine years away, my father worried about his role in Korea. Communication had been difficult, and he had not followed independence politics closely. He boarded an American freighter in New Orleans as its medical officer. During a stop in Houston, a newspaper reporter interviewed him. Introducing Korea to unfamiliar readers gave him even more satisfaction than recognition of his accomplishment.

Passing through the Panama Canal, he knew little of the hardships associated with its construction. Later, as a public health official, he learned about the toll of malaria and helped control it in Korea after liberation.

In Honolulu, Minister Yim welcomed him with Korean food. The expertly prepared naengmyeon was his first experience of the dish. He enjoyed it throughout his life and introduced me to it as a child. It remains my favorite.

His teacher described Japanese expansion into Manchuria, restrictions in Korea, and divisions within the independence movements in America and Shanghai. My father understood that Rhee favored diplomatic efforts while others favored more militant approaches. Even Minister Yim's congregation was divided. This disappointed him, and he decided that his contribution should be as a physician.

On the voyage to Yokohama, he read medical books and worried about inspection. He destroyed independence documents he had hoped to share at home, keeping only a photograph with Rhee hidden inside a thick medical textbook.

A terrible storm made him pray for safety. He also remembered thanking God for the healthy body and courage that had enabled him to complete his medical education. In Yokohama, police questioned him. His Japanese and the officer's English were poor, making the interrogation difficult. While searching his belongings, the officer took American medicines for himself, then ended the inspection.

Officials searched and questioned him again in Busan. Japanese merchants and soldiers filled the city, and Koreans were forced to use Japanese in public. The changes made him feel unwelcome in his own country. On the slow train to Gaesong, he saw poor, dispirited Koreans treated as second class citizens. He believed that better education would help them gain respect.

Nobody met him in Gaesong because communication had been poor. He celebrated with family and friends for only a few days. He was anxious to begin working.

He had returned as a physician, ready to practice what he had learned.



*Dr. Chai Chang Choi with his signature warm smile, early 1990s*



## Myung (Scott) Choi, MD

Dr. Chai Chang Choi's legacy in medicine continues through three generations of his family. His grandson, Dr. Myung (Scott) Choi, is a gastroenterologist practicing in Connecticut who carries on this family tradition. We look forward to featuring his story in our next issue.

Dr. Myung (Scott) Choi grew up in Alexandria, Virginia. He received his undergraduate degree from Cornell University. He then completed his medical school, internal medicine residency, and gastroenterology fellowship at the Medical College of Virginia. After finishing his training in 2001, he practiced in New Haven, Connecticut for four years, serving as the director of the Esophageal Manometry Unit at Griffin Hospital, and clinical instructor at Yale University. Before joining Gastroenterology Associates in 2006, he served as an attending physician at Metropolitan Hospital in New York City, and assistant professor of clinical medicine for the New York Medical College. While at Metropolitan Hospital, he received an award for the Best Physician-Teacher. Dr. Choi is currently an assistant professor of clinical medicine at yale University. His special interests include fatty liver, inflammatory bowel disease and the role of probiotics in digestive disease. He enjoys skiing, golf and spending time with his family.

## Interview

# Remembering My Father

## A Conversation with Dr. Walter Choi about Dr. Chai Chang Choi

**1. When you think of your father today, what small, ordinary moment comes back most vividly? What does that memory tell us about him?**

I think of the way he greeted people. He would give them a firm handshake, smile, and make them feel welcome. He had a way of making people feel important. He never forgot the people who had helped him, and I think that had something to do with how he treated others.

He also liked to dress well: tailored suits, pocket watches, hats, and nice shoes. Some of his first impressions of America came from seeing the educators at his high school in Gaesong wearing Western clothes. He wanted to dress that way himself. His children and grandchildren picked up some of that attention to appearance.

And he loved his big blue Cadillac Seville. It had his initials, "CCC," and the number "25," for the year he came to America. He was very proud of it.

**2. Your father's journey took him from Gaesong to a medical career in America. How did that earlier life remain present in your household?**

One way was through my mother's cooking. At New Year and family gatherings, she would make Gaesong dishes such as galbi-jjim with ginkgo nuts, kalguksu, naengmyeon, and piji. Those recipes stayed in the family and were passed along to the next generation.

My father would talk about his long walks to and from school in Gaesong. He also told us about people who had been kind to him when he first arrived in America. He had no financial support from his family while studying here. It was hard, but he was determined to become a physician and serve people.

He rarely talked about the family he had left behind in Korea. That was much more painful for him.

**3. Others knew him as a physician and a founder of KAMA. What did you see within the family that people outside it might never have known?**

People saw someone who enjoyed company, told wonderful stories, and was comfortable speaking to a room full of people. They might not have realized how lonely he had been at times.

When he graduated from medical school, no one from his family was there to celebrate with him. He went back to his room and cried. He would also cry when he looked at a photograph of his mother. He never saw her again after leaving Korea.

Later, he worried about my mother and us three children as we adjusted to life in America. We came from a very traditional Korean family, and there was a lot to get used to.

When Korean newcomers moved to the Washington, D.C., area, he would welcome them into his home and try to help in whatever way he could. He knew what it was like to arrive in an unfamiliar country and need someone's kindness.

**4. Did his commitments to medicine and the Korean medical community compete with family time? How do you understand those commitments now?**



*The Choi family celebrating the 1995 MCV graduation*

He was busy with his general practice and had many other interests. We saw him as a traditional Korean father, so we largely accepted that he had responsibilities that kept him occupied.

But being close as a family mattered a great deal to him. He expected loyalty and togetherness. Family, friends, church, and the Korean American community were all important parts of his life.

Looking back, I can see how much he accomplished through those relationships. The people around him were the foundation of his work. At home, we knew how strongly he felt about keeping the family together.

**5. While writing your father's story, what helped you see him differently?**

It made me appreciate just how hard the adjustment to America had been for him. He came from a very conservative Gaesong. He had to support himself through school and learn a different way of life, far from his family.

We knew him as our father and as a physician. Writing his story made me think more about the young man who had to find his way here before he became either of those things.

I understood more clearly how much effort it had taken, and how lonely parts of that experience must have been.



**Walter Choi, MD**

***Retired Radiologist, Alexandria Hospital***

Dr. Walter Choi was born in Gaesong, Korea in 1939, and later immigrated to the United States in 1954, settling in Alexandria, Virginia. He graduated from the University of Virginia School of Medicine in 1965 and completed his radiology training in 1971. He also served in the U.S. Army as a general medical officer. Dr. Choi dedicated 30 years of his medical career to Alexandria Hospital as a radiologist before retiring. He currently resides in Alexandria, Virginia, with his wife of 60 years. They have three sons, two of whom are physicians, and six grandchildren.



# Digital Healthcare Ecosystem for a Healthy Future Life

## Data Platforms

· Healthcare data center
· Digital transformation for healthcare businesses
· Development of AI technology for healthcare

## Bio Platforms

· AI-driven novel drug discovery consulting
· AI-powered novel drug target and lead compound identification
· Development of AI-based diagnostic algorithms

## Services



MY ONE CARE
Health checkup & management platform



BIONECT
Bio cold chain logistics service



PHR
Personal health record management service



Hi Image
Teleradiology interpretation service




Medical Devices
Medical hemostatic products

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HEALTH EQUITY & ENGAGEMENT

# A Promise That Became a Blueprint: Building a Community-Based Model of Care in Kenya

*By Jess Danforth, MPH*

## *Editor's Note*

*Jess Danforth's account of The Leo Project is a beautiful, painful, and deeply hopeful story about what can grow from friendship, loss, and a promise kept. The death of her friend Caitlin O'Hara, and Danforth's own experience with cancer, gave rise to an ambitious vision for healthcare in rural Kenya. Yet the most striking part of this story is not ambition alone. It is the decision to begin by listening.*

*Before building a clinic or designing programs, Danforth and her team listened to mothers, elders, traditional birth companions, community health workers, and local leaders. They learned that the barriers to better health were not only medical. They were also rooted in trust, distance, information, family decision making, and whether people believed the health system would be there when they needed it. The Caitlin O'Hara Community Health Clinic emerged from those conversations as a place where care is shaped with the community it serves.*

*In our previous issue, Dr. Peter Smith of Outreach EMR explored a related challenge in global healthcare: the absence of reliable medical records in many low resource settings. His work has shown the importance of practical digital systems that preserve patient histories, support clinical decisions, improve follow up, and allow health teams to recognize patterns that might otherwise remain invisible.*

*Jess Danforth's work adds another essential dimension to that conversation. Data can tell a clinic what is happening. Trust and local partnership help ensure that people seek care early enough for it to make a difference. At The Leo Project, clinical information is used alongside community education and local leadership to strengthen maternal care, mental health support, chronic disease management, and preventive care.*

*This is especially relevant to our readers, many of whom are working to advance health through clinical innovation, research, technology, advocacy, and policy. The stories of Dr. Smith and Jess Danforth remind us that lasting progress rarely comes from one solution alone. It depends on systems that are practical, responsive, and rooted in the lives of the people they are intended to serve.*

We would be glad to hear from readers whose work, experience, or questions connect with the ideas in this story. If you are building more equitable, community-centered health systems, exploring the role of data and technology in care, or have a perspective you would like to share with our readers, please contact the NexBioHealth editorial team at nexushealthhubed@gmail.com.

Caitlin O'Hara was a year ahead of me at our New England prep school, a place where animal heads hung on the walnut walls of the dining halls and we wore lacrosse kilts to class on Saturday mornings. She knew everything about English literature, spoke French, and played varsity squash. When I was sixteen, at a Dave Matthews concert, she told me she had cystic fibrosis. I had no idea what that was.

At Caitlin's twenty-first birthday party, under a tent in her parents' backyard, her mother cried because the doctors didn't think she would live past twenty. But Caitlin played squash, she went to George Washington University, lived in Paris, worked at a gallery, and started a belt company. Every so often she vanished for a course of IV antibiotics delivered through a PICC line, but she always came back.

A lung transplant was on the horizon for most of her adult life. Because of a Burkholderia cepacia infection, no hospital in Boston would take her case; the risk was too great. When UPMC finally listed her, she uprooted herself to Pittsburgh and moved into an apartment with her boyfriend and her parents, chosen mostly for how easily it accommodated the tubing that tethered her to 24/7 oxygen.

She was thirty-two and I was thirty-one. All of our friends were getting married and having babies. She was waiting for lungs when I was diagnosed with stage three breast cancer.

Everything after that happened quickly and all at once: chemotherapy, thirteen surgeries, radiation, a series of clinical trials. In the middle of it all, Caitlin got very sick and was placed on life support. I flew to Pittsburgh to be with her when she received new lungs, perfect lungs, as it turned out. But her body had been through too much. She didn't make it.




*The Caitlin O'Hara Community Health Clinic, Laikipia County, Kenya*

Before she died, we had made each other a promise: if something happened to either of us, the other would start something in the other's honor.

### Listening first

In 2018, from a hospital bed at UCSF, I started The Leo Project in Caitlin's memory. It began as a GoFundMe. In Swahili, Leo means today, and being an astrological Leo was part of what defined Caitlin; she loved her late July birthday.

When my doctors finally permitted me to travel, I flew to Kenya for two weeks and bought an acre of land in Nanyuki, three hours north of the capital city at the base of Mt. Kenya. When I was able to return, I spent the first months doing nothing more strategic than listening: to community leaders, to mothers, to health workers, to anyone willing to talk to me.

***One theme kept coming back. People in Laikipia County were not dying of rare diseases. They were dying of a lack of access.***

My first instinct was to build something in the spirit of Paul Farmer's integrated model, one that met the educational, psychosocial, and medical needs of a community at once. But this was a region whose residents had long felt marginalized by the health system, and our early outreach was met with skepticism, which was entirely reasonable. Before we could provide care, we had to earn trust.

So we held listening sessions with local elders, traditional birth companions, and community health workers, not to prescribe solutions but to learn what they themselves considered the priorities. We hired locally. We set up a community advisory committee to guide our decisions and to hold us accountable. And we worked with Kenya's Ministry of Health (MoH) to align with sub-county, county, and national policy, so that we would be strengthening the existing system rather than building a parallel one.

### The Clinic

The clinic began as a tiny pencil sketch on a legal pad. I took the idea to Build Health International, who agreed



*John Ndegwa, TLP's resident Clinical Officer*

to take us on as a client, their smallest yet. On August 23, 2023, we opened the doors of The Caitlin O'Hara Community Health Clinic.

Today, with a team of fewer than twenty, we see approximately one hundred patients a day. Our direct catchment area is roughly 50,000 people, within a broader Laikipia County population of more than 560,000, many of whom previously had no reliable care. The Ministry of Health has designated the clinic as a Center of Excellence.

But the number I find most telling is not a headcount. Once the community trusted us, the clinic stopped being an outside intervention and became theirs. Women began completing up to eight antenatal visits, an unprecedented number in Kenya. Vaccination rates rose. Antibiotic misuse declined. People began seeking preventive care, which requires a particular kind of trust: that the system will be there when you need it.

The clinic provides comprehensive primary care, including maternal, newborn, and child health services, mental health services, HIV testing and counseling, nutrition support, management of non-communicable diseases, a point-of-care ultrasound, laboratory diagnostics, and a pharmacy. Underneath it all runs a proprietary electronic medical records system that captures clinical and population health data in real time. It lets us see emerging needs as they appear, measure what is working, and change course when something isn't.

Since opening, we have provided more than 33,000 patient visits.

## Three families

Numbers can describe a health system, but they cannot describe what it is like to be inside one.

When Eustine went into labor, she did something she had never done: she went to the hospital. Like most women in her community of Soit Narok, in rural Laikipia, she had always delivered at home. This time was different. Eustine had joined The Leo Project's group antenatal program. Her husband, Peter, had completed our program for fathers. Her mother-in-law, Grace, had trained with us as a Traditional Birth Companion. When Eustine's labor turned difficult, it was Grace who recognized the danger signs and insisted she seek care. The family had already saved money for the delivery, something Peter began doing after the course he took. Eustine gave birth to a healthy girl by cesarean section.

That story is how we think about maternal health. A pregnant woman is often not the person deciding whether she delivers at a facility. So we work with her husband, and we train the birth companions her family already trusts.

Rose was one of the first participants in our Mental Health for Mothers course. She had never received any mental health support during pregnancy. After hearing about the program from Shadrack, our Community Liaison, she decided to come. She learned practical tools, like meditation and breathing techniques, for managing the stress and uncertainty that accompanies pregnancy. She also formed a bond with Alice, our lead maternal, newborn, and child health nurse, who teaches the course alongside providing routine antenatal and postnatal care. "She has become a friend to me," Rose told us, "and I'm really grateful." Mental health, in her case, was not a separate service. It was part of being cared for.

John lost his eyesight temporarily and without warning. Frightened, he learned that he had diabetes. He was referred to our Monthly Diabetic Clinic, where a nutritionist taught him what to eat and what to avoid, small changes that gave him back a sense of control. The group he joined gave him something else. "During our classes, everyone shares their experiences," he said. "Listening to others made me realize I wasn't the only one facing these challenges." And then: "Diabetes changed my life, but this clinic taught me that I don't have to face it alone."

For nearly five years, Salat struggled to breathe, enduring repeated misdiagnoses of pneumonia and unnecessary antibiotic prescriptions. His attacks were so severe that his children would stay awake at night, afraid for his life. When he came to The Caitlin O'Hara Community Health Clinic, he was nebulized for the first time and finally diagnosed with asthma. With a proper diagnosis and an inhaler, Salat has regained his strength and no longer experiences severe attacks. Today, he has stable work and is grateful to be independent again. "The fact that I can wake up and work with my own two hands is the best feeling I have had in the longest time."

Eustine, Rose, John, and Salat's stories show what it takes to keep a community healthy. Sometimes it starts in the exam room, with an accurate diagnosis and the right medication. Just as often, it depends on what happens beyond the exam room. While medicine does its work at the clinic, health is maintained in the families and communities where patients live.

## A feedback loop

That understanding shapes the community-based health education programs we offer alongside clinical care. We offer perinatal mental health education for mothers and fathers; training for Traditional Birth Companions; mental health education for primary school students and teachers; sexual and reproductive health education for primary and secondary school students; and a Community Mental Health Literacy course for community leaders.

The design is deliberate. Clinical services generate insights that inform community interventions. Trained community members improve prevention, early detection, and timely referral, which sends patients back to the clinic sooner and




*The Caitlin O'Hara Community Health Clinic Laboratory*



*Maternal Child Health Clinic, Alice with one of her patients*



*Monthly Diabetic Clinic*



*Nutrition Clinic*

in better shape. Data connects the two. The result is a loop rather than a pipeline, and we have come to believe that this is what a resilient rural health system looks like.

## What the data say

Mental health has become central to this model. We have provided nearly 2,300 counseling sessions and run a psychiatric clinic twice a month. Sixty-three people, among them police officers, religious leaders, teachers, and health workers, have graduated from our Community Mental Health Literacy course and returned to their communities able to support people who are struggling.

In 2025, we built mental health directly into maternal care. Every pregnant and postpartum woman we see is screened with the Edinburgh Postnatal Depression Scale. Of more than 330 women screened, 30 percent were identified as at risk for perinatal depression, and 7 percent reported thoughts of self-harm. Those findings prompted us to create programs for mothers and for fathers. Every woman in our first maternal cohort finished the course knowing where to turn for help, compared with only half before it. Among fathers, 70 percent reported better emotional regulation. In a predominantly Maasai community, where men rarely discuss emotions and patriarchal norms shape the wellbeing of women during pregnancy, that is not a small thing.

## What comes next

The work has taught me what stands behind poor health outcomes: unreliable data systems, workforce shortages, inconsistent policy implementation, gaps in supply chains, and corruption. These lessons, along with a comprehensive needs assessment, are shaping our next phase, an inpatient hospital focused on maternal, newborn, and child health, and oncology care.

I think of what we have built as a blueprint for a scalable, data-driven model that shows what is possible when clinical care, community education, and evidence are designed to work together. In July, I began the Doctor of Public Health program at Harvard, where I hope to test and refine that blueprint and, with time, share it widely.

Before all of this, before Caitlin died, before I got cancer, I worked in tech startups and finance—as an associate at Fidelity, an analyst at a Boston venture capital firm, and at a technology startup in San Francisco. I never imagined I would end up here. But when I think about Caitlin, who spent her life being told what she couldn't do and then did it anyway, a promise kept in a place she never saw does not seem so improbable. It seems like exactly the kind of thing she would have had a plan for.




### Jess Danforth, MPH

***Founder and Executive Director, The Leo Project***

Jess Danforth is a Doctor of Public Health (DrPH) candidate at Harvard T.H. Chan School of Public Health and the Founder and Executive Director of The Leo Project, a nonprofit organization dedicated to advancing equitable access to healthcare in rural Kenya.

Jess founded the organization in 2020 in honor of her best friend, Caitlin O'Hara. What began as a GoFundMe campaign launched from a hospital bed during her own cancer treatment has evolved into an organization operating a fully licensed outpatient medical clinic. Recognized as a Center of Excellence by Kenya's Ministry of Health, the clinic as serving a broader catchment population of more than 560,000 people who lack reliable access to healthcare. She is currently leading the development of an inpatient hospital focused on maternal, newborn, child health, and oncology care — the first facility of its kind in the region.

Originally from Boston, Massachusetts, Jess earned her MPH from Harvard T.H. Chan School of Public Health in 2025 and holds a BA from Boston College. Prior to her work in global health, she held positions in venture capital, financial services, and the technology sector, including roles at Fidelity Investments, a Boston-based venture capital firm, and a technology startup in San Francisco. Her professional interests center on health systems strengthening, oncology, maternal and child health, and the role of health data infrastructure in improving outcomes across resource-constrained settings.


AI AND HEALTHTECH

# Becoming a Psychiatrist in the Age of AI

*By Philip Wang, MD*




In 1966, the Advanced Research Projects Agency of the United States Department of Defense explored how remote computers could share resources. The scientists working on that project explored this technology as an ecosystem for sharing scientific data and never imagined it being commercialized. Sixty years later, the internet has radically transformed the way we live, conduct business, and practice medicine. As a psychiatry resident approaching the transition to attending hood around the advent of AI, it is hard not to draw parallels.

Just in the past year, AI has begun to enter clinical workflows at an accelerating rate. Clinical decision support platforms such as OpenEvidence have partnered with major medical journals and are increasingly used at the point of care, while AI scribes are writing notes in more and more clinics. Meanwhile, I keep reading headlines about AI solving mathematics problems that I couldn't even begin to understand that were previously considered unsolvable. As a young psychiatrist preparing to launch my career in this uncertain and rapidly changing world, I often wonder how replaceable I will be. AI models certainly "know" more psychoanalytic theory than I do, they can challenge automatic thought processes using CBT techniques quite effectively, and can rattle off clinical trials, dosing regimens, and binding affinities in seconds. AI never gets hangry, tired, or wonders what they're going to eat for dinner that day. And this is the least capable it will ever be, and it's getting better every day.

However, the further I get in my training, the more

hopeful I feel. I have come to believe that the primary treatment psychiatry offers to most patients is relational. Decades of psychotherapy research point to the quality of the alliance between therapist and patient as one of the most consistent predictors of how well patients do, regardless of the type of therapy delivered. That would come as no surprise to most therapists, but the effect extends beyond the couch to the prescription bottle. One mistake I have made is prescribing a medication before the patient was truly on board, only to watch them develop unexplainable, strange side effects and quit the medication quickly. The research backs up what those moments have taught me. When researchers reanalyzed a large NIMH depression trial, they found that the most effective psychiatrists prescribing a placebo had better results than the least effective psychiatrists prescribing an antidepressant.[1]

On a personal level, I'm not a perfect human or psychiatrist. The quality of my patients' relationship with me fluctuates. Sometimes patients and I aren't aligned on our goals, sometimes I have to enforce professional boundaries, and sometimes I just straight up say something foolish. These moments of rupture offer the opportunity for repair, which allows an opportunity to strengthen the relationship. In contrast, AI is endlessly patient and agreeable and is frictionless, which provides no opportunities for genuine, interpersonal repair.

I don't know what AI will be able to do in ten years, but it will probably write my notes and catch medication interactions I might miss. Last month, I spent nearly an entire visit looking through wedding photos with a patient who was stable and doing well, which I felt improved our therapeutic relationship. I feel so lucky that this is my job. It's hard to imagine a chatbot doing that in a meaningful manner. A large part of why it mattered was that I was a real person who had chosen to be interested.



1) McKay KM, Imel ZE, Wampold BE. Psychiatrist effects in the psychopharmacological treatment of depression. Journal of Affective Disorders. doi:10.1016/j.jad.2006.01.020



**Philip Wang, MD**

Dr. Philip Wang, is a PGY-3 psychiatry resident at Brigham and Women's Hospital in Boston. He went to Auburn University for college and then completed medical school at Cleveland Clinic Lerner College of Medicine. Academically, he is interested in psychosis, addictions, palliative care, and psychedelics and some of his hobbies include birdwatching and hiking.



COMMENTARY

# The Price Is Out There. Good Luck Finding It

*By Sung Hwi Hong, MD, MPH*

You know roughly what a carton of milk costs, and you've probably noticed, without trying very hard, when it's cheaper at one store than another. Now ask yourself: do you know what a consultation costs at your doctor's office? An X-ray? A CT scan? Federal law says that information should be online, no matter where you live. Go ahead and try to find it. I'll bet you can't.

This isn't an abstract inconvenience. A 2022 KFF survey found that 41 percent of U.S. adults, 107 million people, carry some form of debt from medical or dental bills. Nearly one in five adults say their own health got worse because they delayed or skipped care they couldn't afford, which is another way of saying the price tag itself becomes a medical risk factor. Americans want to know what things cost, but the system makes not knowing the default condition, and then bills people for the gap.

I recently moved to Boston and don't yet have a primary care doctor here. Before getting an echocardiogram, I wanted to know what it would cost, and so I searched. Nothing useful came up. I asked ChatGPT, which told me I'd need my Blue Cross Blue Shield (BCBS) ID, a number I apparently already owned. Finding it meant logging into my affiliate's health portal, handing over my information again, then logging into BCBS of Massachusetts separately. Another password. Another form. The same data, typed a second time into a second system that didn't talk to the first.

Once I was in, I entered the procedure — "echocardiography with contrast" — and waited for a number. Not enough. The tool wanted a hospital. I tried Brigham and Women's, then Beth Israel. Neither returned anything useful. Buried in the options was a field for a physician's name, so I opened a hospital directory in a second tab, found someone double-boarded in cardiology and radiology with good reviews, and typed her name into the estimator. Only then did a price appear: zero dollars, fully covered under my plan.

Forty minutes. Three logins. A conversation with a chatbot just to locate a number that was already mine. I have a graduate degree and I still had to guess my way through it. I keep thinking about my grandmother's generation trying this from a Medicare Advantage portal, with no one to call.



Another problem awaits even those with patience, time, and memorized ID number. The number on the other side may still be wrong. Federal regulators required hospitals to post these prices starting in 2021, with a matching rule for insurers phased in over the following two years. The data exists. But KFF, the same health policy research group, has gone looking and found a mess: inconsistent formats, missing files, numbers that don't match reality. Patients have been saying some version of this for years: most don't know the tools exist, and the few who find them rarely land on a number they can trust.

Solving those two problems still wouldn't close the case. A correct, cleanly displayed price only tells you what the hospital charges today. It says nothing about whether the insurer will honor it tomorrow. Prior authorization can be denied after the fact. A price quoted in July can be overridden by a claim denial in September, arriving as a code on a letter with no explanation attached. Transparency law was written to fix what providers disclose. It was never built to touch what insurers decide.

Luckily, none of this happened because I was sick. There was no diagnosis, no scare. I wasn't the patient. I was a DrPH student at Harvard's health economics class, assigned to find out what an echocardiogram actually costs nearby. That was the whole stakes: a homework problem.

So the failure isn't one problem. It's at least three, stacked on top of each other. Almost no one can find the door. The few who do may be handed the wrong number once inside. And even the right number, honestly quoted, can be reversed by a company that was never part of the conversation. We passed a law requiring transparency and called the job done, without checking whether a real person could get real information. A price that, while technically public, stays practically impossible to find, comes down to the same thing as a secret.







## Sung Hwi Hong, MD, MPH

Dr. Sung Hwi Hong is a physician and public health researcher whose work spans clinical medicine, global health, and cancer prevention. He earned his BA in Economics-Mathematics from Columbia University, his MD from Yonsei University College of Medicine, and his MPH in Global Health from Harvard T.H. Chan School of Public Health. He is currently affiliated with Yale's Gastric Cancer Prevention and Screening Lab, where he focuses on disparities in gastric cancer screening and outcomes. Dr. Hong has authored numerous peer-reviewed publications and has led medical, research, and humanitarian initiatives across Asia, Africa, and the United States.







# Addressing Stomach Cancer Disparities

## Our Mission

Uniting communities, physicians, and policymakers to create innovative approaches for gastric cancer awareness, prevention, screening, and early detection. SCTF seeks to empower the medical community and governments to ensure equitable access to these services for high-risk populations.

## Key Partnerships

Yale School of Medicine
Smilow Cancer Hospital
Lombardi Cancer Center
Georgetown University Medical Center
Cedar Sinai Medical Center
Debbie's Dream Foundation
Hope for Stomach Cancer

**Get Involved**

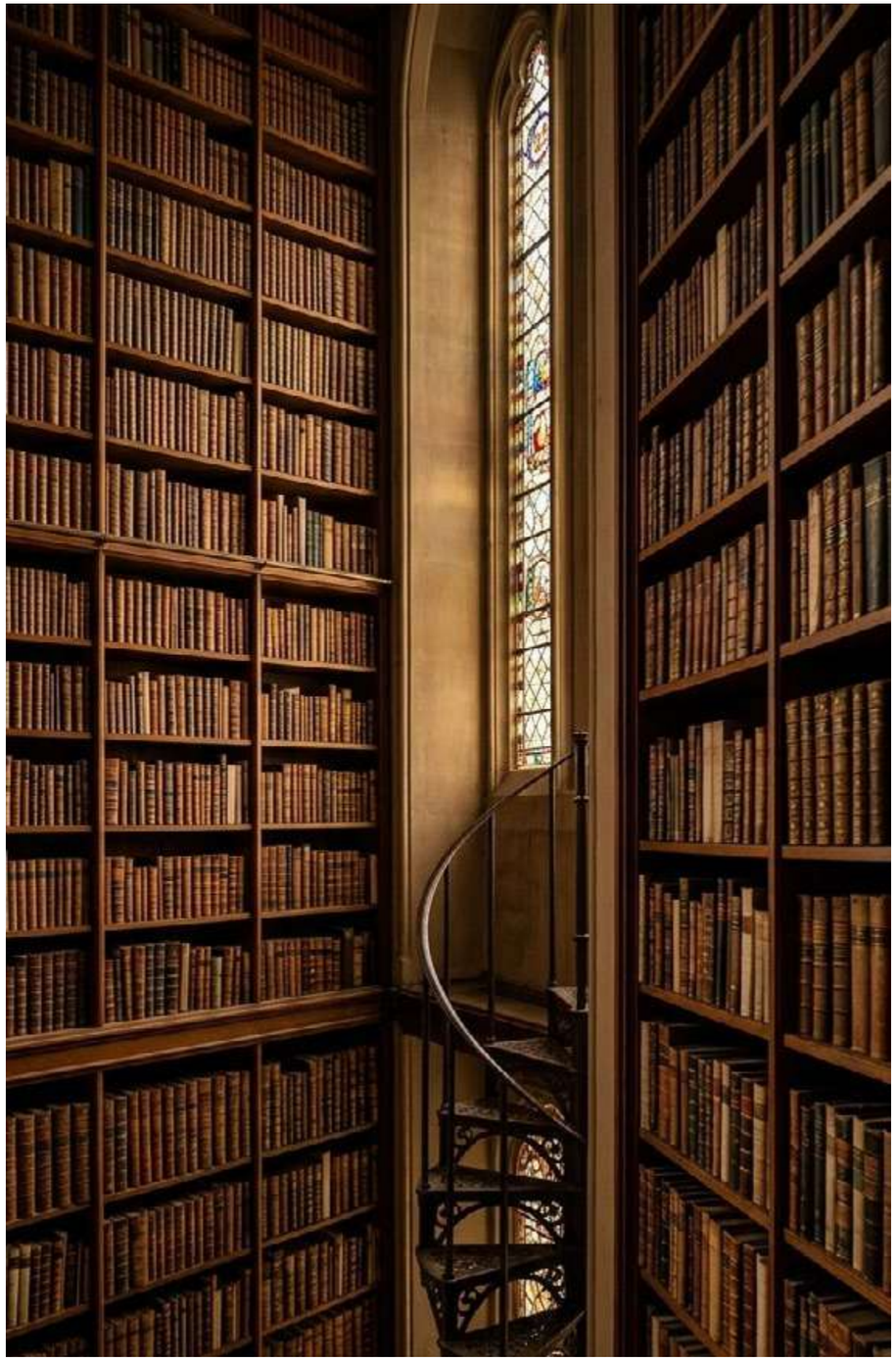
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## Dr. Mun K. Hong's Reflection

# Quality Rather Than Quantity Should Guide Research Efforts

*By Mun K. Hong, MD, MHCM, FACC*



As a first-year cardiology fellow, I devoted the entire year to animal research, having been given only the main hypothesis of the study and entrusted with finding the necessary animal model, experimentation, and collaborators for completing the study. It was both exhilarating and daunting as my mentor was one of the busiest clinical interventional cardiologists and my collaborators were non-cardiologists and basic scientists. In addition, I was the solo researcher as I had no technicians or helpers. Despite the obstacles, I finally succeeded in completing the study at the end of my research year, having presented two abstracts at national cardiology conferences and the manuscript published in Circulation, the authoritative cardiology research journal. The entire year thus resulted in one peer-reviewed publication, which had an impact on how interventional cardiology viewed the successful treatment of restenosis, the most frequent complication following coronary angioplasty at the time.

I review many applications for cardiology fellowship and have been not impressed with but troubled by the numerous publications (60 publications in one applicant's case!) in the CV. These are mainly meta-analysis and repeat analysis of publications that do not add any original data or expand our knowledge to the literature, but "rehash" of other research efforts. Not only are they mainly statistical analyses but are co-authored by a double-digit author list that is difficult to comprehend. They also tend to be in obscure journals that many physicians are not even aware of.

So the question is – should the quantity of publications matter as much as the quality? In my approach I value those publications that required original work, not just using other researchers' data for minimal contribution to the literature and our medical knowledge. I completely understand the competitive landscape of medicine, especially from the perspective of trainees, but we should strive for quality work, not quantity when it comes to research.



Mun K. Hong, MD, MHCM, FACC





### Mun K. Hong, MD, MHCM, FACC

Dr. Mun K. Hong, born in Seoul, Korea, immigrated to America at age 15. He earned his BA-MD from Johns Hopkins University School of Medicine in 1986 and completed residencies and fellowships in internal medicine and cardiology at Johns Hopkins, Georgetown, and the Washington Hospital Center. Dr. Hong has held leadership roles, including Director of Cardiovascular Intervention at Weill Cornell and Chairman of Cardiology at Medstar Southern Maryland Hospital. He currently practices at Bassett Hospital Center as Inaugural Chief of Cardiovascular Services. A dedicated mentor, he sponsored over 10 interventional cardiologists from Korea, helping them achieve significant academic success. During the pandemic, he earned an MHCM from Harvard. Dr. Hong enjoys family time with his wife of 37 years and their three children in New York City.

## Journeys In Medicine

# A Life Shaped by Emergency and Humanitarian Medicine: An Interview with Dr. Killiam Argote-Araméndiz

*Interview by Sung Hwi Hong, MD, MPH*
*Editor of Global Health and Partnerships, NexBioHealth*

*From Colombia to Afghanistan and Ukraine, Dr. Killiam Argote-Araméndiz has worked where delivering care requires much more than clinical expertise. Now pursuing a Doctor of Public Health(DrPH) at Harvard, he reflects on humanitarian medicine, the people who sustain it, and learning when to leave—and how to stay.*

### 1. Could you introduce yourself and tell us what drew you to emergency and humanitarian medicine?

I am a physician from Colombia, trained in emergency medicine at the Universidad de Antioquia. Before entering international humanitarian work, I led the Emergency and Trauma Unit at the Hospital Internacional de Colombia.

During medical school, I was drawn to both surgery and emergency medicine. I enjoyed working directly with patients, using my hands, and solving problems. But I have atopic dermatitis, and repeated surgical scrubbing made my skin progressively worse. It was a close decision, but the balance eventually tilted toward emergency medicine. I also needed to take care of myself.

In the emergency department, I found a place that brings together so much of the human experience: pain, uncertainty, relief, fear, and companionship. You meet people when they need help, often before anyone knows exactly what is happening. I liked the breadth of the specialty and the responsibility of making sense of that uncertainty.

During residency, I discovered disaster medicine and the possibility of helping whole populations during emergencies. In 2018, I moved to Boston for a fellowship In Disaster Medicine at Beth Israel Deaconess Medical Center and Harvard Medical School. An opportunity with the International Committee of the Red Cross followed. Over more than six years, I worked in Honduras, El Salvador, Mexico, Venezuela, Ukraine, Lebanon, Afghanistan, and Gaza.

As my responsibilities grew, I wanted to understand the political, social, and institutional circumstances surrounding the clinical work. That led to a master's in International Humanitarian Affairs at the University of York. I am now pursuing a DrPH at Harvard, focusing on humanitarian leadership and the institutions that make effective care possible.

### 2. What do people who have never worked in a conflict zone most often misunderstand about humanitarian medicine?

People see the headlines: Afghanistan, Ukraine, Gaza. What is less visible is the preparation it takes to be useful there, and the weight carried by you and the people close to you.

Clinical experience is essential, but the resources you trained with may not be available. You need to understand your strengths, recognize your limitations, and know when to seek support. Experience in one setting does not give you every answer in another.

The family who stays behind needs nerves of steel, too. They follow the news and wait for your next message. You have some understanding of your surroundings and the precautions being taken; they may have only a headline. The deployment becomes part of their lives, even though they never chose it as a profession.



*Dr. Killiam Argote-Araméndiz in the Emergency Department at Hospital Escuela, Tegucigalpa, Honduras, 2022*

Then there are the colleagues you join. They may be caring for patients while worrying about their own families and safety. I arrive knowing my presence is temporary. I will eventually leave; they will continue living with the situation.

That awareness shapes what I hope to contribute. I bring clinical experience, but also energy, companionship, and a willingness to listen. Sometimes being useful means solving a difficult clinical problem. Sometimes it means making a demanding shift more manageable for the people beside you. Both matter.

### 3. When you enter an emergency department, what tells you how well the system is functioning?

I look first at the people, then at how patients move through the department, and whether the team has information to understand how well care is working.

If I am receiving a shift, I start with my colleagues. How was the night? Have you eaten? Did everyone on the incoming shift make it to work? Then we review the patients, what is pending, and the supplies and resources we actually have.

When my role is to strengthen the department, I talk with people and join their rounds before proposing changes. I follow the patient's journey: where triage happens, how quickly someone receives care, and whether they can reach surgery, a hospital bed, or another facility. I also examine the connection with prehospital teams and referral services.

One telling sign is whether the team routinely reviews waiting times, transfer delays, and outcomes—and uses that information to make decisions. At Hospital Escuela in Honduras, our triage analysis covered more than 161,000 consultations over thirty months. It helped us understand demand and patient flow.

Following patients beyond resuscitation also showed why we needed to examine what happened after initial treatment.

A department needs to recognize urgent needs and respond appropriately. It also needs to see where the process is failing and whether changes are helping in daily practice.

### 4. Can you describe an experience that showed why strengthening systems matters—and how you balance that work with immediate needs?

In Lebanon in 2023, we were helping hospitals prepare for a possible escalation of hostilities in the south. We were developing procedures and training teams to receive large numbers of casualties when we learned that the Ministry of Public Health was working toward a unified national approach.

That raised a practical question: we could prepare our hospital, but how would it work with everyone else? Patients would arrive through ambulance services. Some would need surgery; others would need transfer. We had to understand what neighboring hospitals could manage and how we would coordinate.

You can know what a patient needs and still be unable to arrange it. Sometimes making treatment possible requires services and institutions to agree on how they will respond together.

Immediate needs remain urgent. But a response that depends on temporary staff, supplies, or funding may be difficult for the local system to sustain after an emergency operation ends. We need to develop it with the people who will continue the work: understand what has already been tried, what they can maintain, and what they consider most important.

We still have to make urgent decisions. We also have to keep reviewing those decisions with our partners and be willing to change arrangements that do not work over time.



*Red Cross Field Hospital, Rafah, Gaza, August 2025*

### 5. What did Afghanistan teach you that you could not have learned inside a conventional hospital?

Afghanistan taught me to think much more about what happens before a patient reaches the emergency department. My responsibilities included first aid, prehospital care, support to emergency departments, and emergency preparedness. I had to understand how those parts of the patient's journey connected.

Inside a hospital, my starting point is usually the patient who has arrived. In Afghanistan, I also had to ask who could help where the emergency happened, how the patient would reach a facility, and whether that facility could provide the necessary care. Improving the emergency department would address only part of the problem.

Medical logistics was another responsibility. We reviewed contingency stocks, anticipated supplies, and planned where to position them and how to deliver them. I was using clinical knowledge to prepare for patients we had not yet received.

Working with existing departments also allowed me to follow changes over time. Providing equipment or introducing a protocol was only the beginning; we needed to see whether it was useful and what still required attention. Local colleagues helped me understand both the problems and what would make a solution work.

A treatment can be straightforward medically, while making it available to the person who needs it can be much more complicated.

### 6. You were in Ukraine when the war escalated in February 2022. What happened?

I arrived in November 2021 and was based in Sloviansk. Almost every morning, our team drove to Bakhmut, where we were working on an emergency care pilot: an integrated emergency department model that could later be expanded nationally.

We had built a new department and were preparing its handover. My role included staff training, protocols, and coaching the senior clinicians who would lead it. We were close to putting the work into practice.

When the conflict escalated, our team had to relocate. Over several days, we organized our movement toward western Ukraine, finding routes and places to shelter as conditions changed. We were making decisions with incomplete information while worrying about what might happen next.

We never returned to the project. The hospital later stood in the middle of the battlefield. We had spent months preparing something with our colleagues and never saw it operate as intended.

Later, I participated in humanitarian operations in Mariupol, including at the Azovstal steel plant. Our interdisciplinary team observed the surrender process involving combatants leaving the plant, including compliance with obligations under international humanitarian law.

I was the team's medical specialist and only healthcare professional. My principal responsibility was preparing for my colleagues' medical needs: checking supplies and medications and planning evacuation routes. I also advised on medical aspects of evacuation from the plant. My role at that stage was advisory; the parties carried out the evacuation.

### 7. What happens when you encounter a problem that medicine alone cannot solve?

I first encountered these problems as an emergency physician in Colombia. Sometimes we knew what a patient needed and had the staff, equipment, and expertise, but insurance coverage or arrangements between the insurer and hospital became a barrier.

That creates an ethical tension. What you know you should do and what you are able or allowed to do begin

to move apart. You remain responsible for the patient, but you do not control every decision affecting their care.

In humanitarian settings, the tension takes other forms. A hospital may be near the frontline, a referral route may be unsafe, or healthcare workers may themselves be at risk. You have to consider the patient's needs alongside team safety and the consequences for other patients.

I try to understand what is preventing care, who can help change it, and what options remain. Humanitarian access, protection, coordination, and international humanitarian law became directly relevant to my medical work.

Over time, I realized that identifying a possible solution was only part of the challenge. I also needed to understand how to bring people together and change the decisions preventing care. That is one reason I pursued further study and eventually came to Harvard.

### 8. How can we better care for the people who provide humanitarian care?

For international workers, support starts before deployment: appropriate selection, preparation for the context, clear responsibilities, and access to confidential physical and psychological care. During assignments, we need reasonable rotations, rest, and someone we can speak with openly.

Support must continue afterward. Returning home does not mean everything you experienced stays behind. Sometimes you only understand how much something affected you once you have left.

But local workers face different circumstances. I generally know my assignment will end and I can leave. Our local colleagues may not have that possibility. In Ukraine, restrictions under martial law can prevent male colleagues from travelling abroad. Afghan colleagues face visa and entry restrictions. In Gaza, restrictions at crossings may make leaving impossible.

Organizations still need to arrange relief from duties, practical family support, and access to care. Finishing a shift may offer little recovery when someone returns to the same insecurity.

We also need to address economic pressures, abuses of power, and whether colleagues can raise concerns without fearing consequences for their employment. If local teams are expected to assume greater responsibility, resources and decision-making authority must reach them, including support for protection, healthcare, professional development, and rest.

For my master's dissertation, I reviewed 60 studies and found gaps in psychosocial support and ethical and legal preparedness. Clinical training alone cannot compensate for harmful working conditions.

We should ask local workers what they need—and act on their answers, including when the problem comes from within our own organization.

### 9. Why was this the right time for a DrPH, and what would you like your next chapter to involve?

Humanitarian work has been fulfilling, and I want to remain involved. But I needed to change how often and how long I was away, particularly because of what deployment means for my family.

I have a wife and two daughters, now four and almost two. During deployments, my wife was caring for the girls and managing daily life while worrying about where I was. They were growing, and I was missing everyday moments. Seeing them through a screen was different from being there. I want to share more of those responsibilities and be present as a father.

My work has also given me questions I want to study more deeply. Knowing what might help does not always mean knowing how to make it work. I want to understand leadership and change within health systems, including what I need to improve in my own approach.

Harvard gives me time to reflect, learn from other perspectives, and build on field experience through research and teaching. Academia may be a path that suits me, although the exact role remains open.

I would like to improve how healthcare workers are prepared and supported for emergencies: communication, coordination, ethical decisions, mentorship, and care for themselves and their teams. I also want to understand what happens after training. Can people use what they learned? Do they have the resources? Does care improve?

I will always remain an emergency physician. What I am learning now may change how I contribute.

### 10. What would you tell the young physician you were before your first humanitarian mission?

I am picturing the 23-year-old Killiam who received his medical degree in Colombia in 2009.

I would tell him to buckle up. The road looks smooth now, but there are potholes and bumps you cannot see yet. At some point, the road may disappear altogether. Pay attention to where you are going, but do not spend the whole journey watching for the next bump. Look around, too. The view is amazing, and there is a lot ahead worth reaching.

Keep that curious mind, keep preparing yourself, and keep fighting for the causes that matter to you. You will face situations without all the answers, so learn from the people around you. Take time to understand them before making decisions.

Take care of your relationships. This work will give you a lot, but being away has a cost for you and the people who love you. Make time for them, for yourself, and for a life that does not always revolve around the next assignment.

And learn how to stay. Give yourself time to belong somewhere, build a community, and let people become part of your life. Learn to work through difficulties together and be present for everyday moments.

Some things need time, and you have to be there to see them grow.




## Killiam A. Argote-Araméndiz, MD, MSc

Dr. Killiam A. Argote-Araméndiz is an emergency and disaster medicine specialist with extensive experience in humanitarian settings, including Afghanistan, Gaza, Ukraine, Lebanon, Venezuela, Honduras, El Salvador, and his home country, Colombia. He holds an MSc in International Humanitarian Affairs from the University of York and is currently pursuing a Doctor of Public Health (DrPH) at the Harvard T.H. Chan School of Public Health, while collaborating with the Harvard Humanitarian Initiative (HHI) team. He serves as faculty for the Fellowship in Disaster Medicine at Beth Israel Deaconess Medical Center/Harvard Medical School and as a Board Director of the World Association for Disaster and Emergency Medicine (WADEM). His work focuses on emergency care, preparedness, disaster response, health systems, and leadership in complex humanitarian environments.
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## Journeys In Medicine

# From Neglected to Noticed: Bringing Tropical Diseases Back into Focus

*By Juan Carlos Anguiano, MD, MPH*

For those who have had the privilege to visit the World Health Organization headquarters in Geneva, Switzerland, there is a beautifully striking bronze sculpture titled "Sightless Among Miracles." It depicts a young boy guiding an older man who has lost his sight to "river blindness," or onchocerciasis. The sculpture is a reminder not only of the devastating consequences of this neglected tropical disease, but also of the global efforts undertaken to control and eliminate it.

For centuries, infectious and parasitic diseases, many of which are now in the field of tropical medicine and disproportionately affect tropical and subtropical regions, represented a major public health burden around the world, long before the field of tropical medicine or even public health efforts had a name.

However, as living conditions improved and science advanced, the burden of many infectious diseases gradually declined in many parts of the world. In contrast, chronic diseases became increasingly prominent in what we call the epidemiological transition. As attention shifted toward other health priorities, many tropical diseases received less attention from health systems including healthcare institutions, the pharmaceutical industry, and medical schools. Eventually, the term "neglected tropical diseases" (NTDs) became widely used to describe a group of preventable and treatable conditions that primarily affect marginalized populations living in poverty.

Despite the limited attention and restricted resources dedicated to many of these diseases, NTDs remain an important public health problem, particularly in low- and middle-income countries. Today, NTDs still affect approximately one billion people worldwide, and Mexico is no exception. Climate, living conditions, and limited access to healthcare services continue to create conditions in which these diseases can persist.

I still remember the first time I heard about this epidemiological transition. Something about it resonated with me, and putting efforts into eliminating these diseases in my country made complete sense. It was precisely my interest in this epidemiological transition, and my willingness to improve living conditions, that led me to focus on this field. For countries like mine, NTDs are not diseases from the past. They are part of everyday public health practice.

My name is Juan Carlos Anguiano. I am a physician from Mexico. I specialized in Preventive Medicine and Public Health and obtained a Master's in Public Health and Health Services Administration from the National Institute of Public Health of Mexico. For the past few years, I worked as a community health specialist and epidemiologist for the Mexican Social Security Institute, Mexico's largest public healthcare institution.

During my years as a clinician, I realized that many of the cases encountered by epidemiologists in my country are related to tropical and vector-borne diseases, as well as other conditions that disproportionately affect low- and middle-income countries. Dengue, for example, is so common in Jalisco that I doubt there is a single licensed physician in the state who does not know how to diagnose and manage non-severe dengue.

However, Mexico also has patients affected by other diseases that, despite continuing to generate an important burden in the country, remain less familiar to many physicians. Diseases such as Chagas disease, tuberculosis, and rickettsiosis may be underdiagnosed because of limited diagnostic capacity, lower clinical awareness, and unequal access to specialized healthcare services.

There are patients I simply cannot forget, sometimes because they teach me something about life itself. I still remember a six-year-old boy who was brought to my office one day and whom I diagnosed with scabies. The disease itself was interesting to me, but what really caught my attention was that his family lived only about five blocks from the clinic, in the downtown area of a major metropolitan city. Yet they were still affected by a disease closely associated with poverty and inadequate sanitation.

It was precisely my interest in improving those living conditions that, after working for a couple of years, led me to pursue a Professional Diploma in Tropical Medicine and Health at Nagasaki University in Japan, in collaboration with San Lazaro Hospital in the Philippines.

During this experience, I was able to study these diseases in much greater detail, hear from tropical medicine specialists, and share my own thoughts with physicians all over the world. At the same time, my background in public health and preventive medicine allowed me to focus not only on treatment, but also on what is needed to prevent these diseases and improve patients' quality of life.

During my time in the Philippines, I experienced again the same nature of NTDs, having the opportunity to diagnose and treat patients with leprosy, snakebite envenoming, schistosomiasis, and even rabies. That experience enforced the way I see public health. It helped me realize that the epidemiological transition I was committed to addressing in my own country remains at an earlier stage in some other countries, whether because of climatic conditions, living conditions, or limited access to health education.

After completing my diploma in tropical medicine and returning to Mexico, I made a personal commitment to help close these gaps that are affecting my country, doing what I can to eliminate the burden that they are causing. Since I came back home, much of my work has focused not only on treating patients, but on educating future physicians, nurses and other health professionals on how to diagnose and prevent tropical diseases.

These topics have included medical entomology, dengue, Zika, chikungunya, malaria, rabies, tuberculosis, leprosy, Chagas disease, onchocerciasis, scabies, snakebite envenoming, taeniasis and cysticercosis, yellow fever, leishmaniasis, and others that are not in the list of NTD but still remain in the field of tropical medicine.

My commitment to teaching and infectious disease prevention eventually led the institution where I worked to send me to represent Mexico and my former institution at an international seminar on medical entomology and vector-borne diseases in Austria, organized through the Open Medical Institute in collaboration with the Institut Pasteur. There, I had the opportunity to discuss vector-borne disease

control with some internationally recognized experts in the field of vector-borne diseases worldwide. This experience definitely motivated me to continue working in this field and made me realize that there are many professionals around the world working toward controlling these diseases and improving health outcomes in their own countries.

Currently, I am pursuing a Doctor of Public Health (DrPH) degree at Harvard T.H. Chan School of Public Health. One of the main reasons I decided to take this next step in my professional career is that I see an important window of opportunity for Mexico and Latin America to modernize and strengthen their public health infrastructure, including health workforce training and epidemiological surveillance systems. I also believe that if I am going to commit myself to a challenge of this magnitude, I need the right education, tools, and preparation to take it on.

I am also interested in improving the social determinants of health, such as the living environment, which is closely related to improving health conditions and preventing the spread of these diseases. At the end of the day, I believe that every part of my career is pointing in the same direction: closing health gaps and contributing to the elimination of diseases that continue to affect vulnerable populations.

We still have a long way to go. We need better and stronger surveillance systems, continued social development, improved living conditions, stronger healthcare institutions, and definitely more leadership within the institutions we already have. However, despite these challenges, I strongly believe that little by little, and by doing the right work, we can close health gaps in our countries.

At the end of the day, NTDs are neglected not because they are rare, but because the populations affected by them are often neglected. If we truly want to take the neglect out of tropical diseases, we must begin by making sure that the people affected by them are no longer neglected.






## Juan Carlos Anguiano, MD, MPH

Dr. Juan Carlos Anguiano is a Mexican physician and public health specialist whose work spans preventive medicine, epidemiology, and health systems strengthening. He earned his MD from the University of Guadalajara and his MPH from Mexico's National Institute of Public Health, where he completed specialty training in Preventive Medicine. Before his doctoral studies, he worked as a Community Health Specialist and Epidemiologist at the Mexican Institute of Social Security (IMSS). He is currently pursuing a DrPH at the Harvard T.H. Chan School of Public Health. His doctoral work focuses on strengthening health institutions, improving social conditions, and enhancing responses to public health challenges across Latin America.



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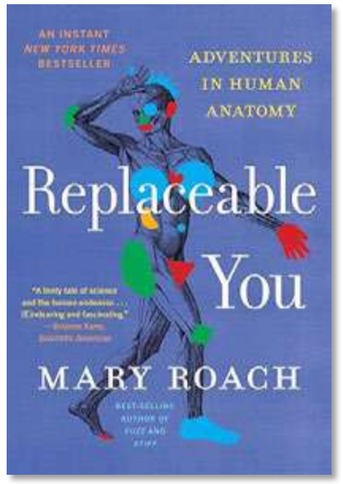
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# Replaceable Parts, Irreplaceable People

## Review of "Replaceable You"

## by Mary Roach

*By Sanghyun Alex Kim, MD*




As a surgeon, I spend much of my professional life thinking about anatomy, function, and what we can do when the human body fails. Yet reading Mary Roach's Replaceable You offered something surprisingly refreshing. I was hearing about familiar medical challenges through the curiosity of someone outside our profession. Her questions reminded me how extraordinary our work can appear when we step beyond the routines and vocabulary of our own specialties.

The book unfolds through encounters with physicians, research scientists, and patients whose experiences reveal both the possibilities and the difficulties of this work. Its subjects range from skin grafting and organ transplantation to genetically modified pigs, ostomies, reconstructive procedures, and gender affirmation surgery. These seemingly disparate fields share a practical question. How can we restore something that disease, injury, or circumstance has taken away?

What I enjoyed most was Roach's perspective as a nonphysician. She asks questions that specialists may stop asking because the answers seem obvious within their own fields. She notices details that we may overlook because we have become accustomed to them. Her humor and willingness to explore uncomfortable subjects make the science approachable, while her conversations with highly specialized experts give the reader plenty to learn.

For me, the experience was both entertaining and educational. Some discussions touched on the familiar territory of colorectal surgery, particularly ostomies and the challenges of restoring bodily function. Others opened windows into specialties and research programs far removed from my daily practice. Medicine has become so specialized that even an experienced surgeon can know relatively little about the remarkable work taking place in the next department. Roach makes those introductions with energy and curiosity.

Her approach also highlights something that technical discussions can miss. A successful reconstruction means more than an anatomically sound result. For a patient, success may mean returning to work, feeling comfortable in public, recovering intimacy, or managing daily life with greater independence. These outcomes give the science its purpose.

For readers of NexBioHealth, with its growing emphasis on artificial intelligence in medicine, the book offers a




valuable lens through which to consider innovation. My connection to AI comes from the questions the book raises. What problem are we trying to solve? How will we recognize meaningful improvement? And whose definition of success will guide us?

As we evaluate AI tools, I believe those questions should remain central. A system's performance on a technical task matters, but so does its usefulness to the physician making a decision and to the patient living with the consequences. Roach's attention to the practical details of bodily repair encourages us to examine new technologies with the same curiosity. Promising ideas deserve enthusiasm, careful questions, and an honest understanding of their limitations.

If the book has a limitation for a physician reader, it is that its breadth sometimes leaves us wanting a deeper discussion of a particular procedure or scientific challenge. I occasionally wished I could stay longer with an expert and hear more. But that desire reflects one of the book's strengths. It makes unfamiliar fields interesting enough to pursue further.

Replaceable You reminded me why I continue to find medicine fascinating after many years in surgery. There is always another problem to understand, another inventive colleague to learn from, and another patient whose needs challenge our assumptions. Mary Roach brings those discoveries to life with warmth, humor, and a welcome sense of wonder. In a time of rapid technological change, that is a perspective worth keeping.



**Sanghyun Alexander Kim, MD**

Dr. Sanghyun Alexander Kim is a colorectal surgeon at Mount Sinai who immigrated to the United States from Korea at age 17 and completed his education, medical training, residency, and fellowship entirely in New York. He joined the Mount Sinai surgical faculty in 2005 and currently serves as Program Director of the Robotic Colorectal Surgery Fellowship, where he trains surgeons in advanced minimally invasive techniques.

Dr. Kim's clinical practice focuses on colon and rectal cancer, inflammatory bowel disease, fecal incontinence, robotic colon and rectal surgery, and painless hemorrhoid treatment. He also has a large clinical practice performing high-resolution anoscopy, a specialized camera-based examination used to detect precancerous lesions and early anal cancer. In addition to caring for patients, Dr. Kim actively teaches medical students, residents, and surgeons, with a strong commitment to early cancer detection and serving diverse and underserved communities throughout New York and New Jersey.



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# Research for a Healthier Future

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# Balancing Multiple Roles in Medicine

## Dear Mentor,

Many students enter medical school with the assumption that they will primarily serve as clinicians. However, throughout training, they are exposed to physicians who contribute in multiple capacities—conducting research, leading organizations, mentoring trainees, developing new initiatives, while continuing to care for patients. Seeing these diverse career paths can be both inspiring and overwhelming, especially when it is unclear whether pursuing multiple roles is realistic or sustainable.

How can students determine whether pursuing multiple roles is realistic, and how do successful physicians balance these responsibilities without compromising patient care?



**Stephen Park**
*Sophomore at Washington University in St. Louis*

## Dear Stephen,

Many students assume the path is a straight line: train, graduate, see patients, repeat. Mine has not been. I care for children, conduct clinical trials, lead physician teams building clinical AI, advise health organizations, serve as a pastor, and am studying for a Master of Divinity. So I understand the inspiration and the anxiety behind this question. Let me be honest from the start: this is not the easy path. The traditional clinical route is simpler, more predictable, and entirely honorable. If you add roles, do it because you are drawn to the work—not because you think you should.

If you do feel that pull, here is what I have learned.

Say yes to almost everything early. In training and your first years out, breadth is a gift—research, advocacy, teaching, administration—because that is how you discover your own appetite. Later, you narrow. Early breadth and later focus is a far healthier arc than the reverse.

Then apply, apply, apply. I still apply to new roles every few weeks, more than a decade in. You genuinely do not know what is out there—or even your own financial worth—until you see the opportunities. Most people never find out, because they disqualify themselves first, telling themselves they are not qualified enough. Hear me: if you are a physician, you are plenty qualified. Do not be afraid to not know something, or to not be the best in the room. Try your best, take the leap, and you will learn the skills along the way. The people who advance are rarely the most credentialed—they are the ones who actually applied.

And find mentors. Ask, ask, ask. Stay curious. Reach out on LinkedIn, join physician groups, message someone whose career you admire. People are far more generous than you expect.

Now the most important part, and the part rooted in my faith: whatever roles you hold, care for people—all of them. Your patients, yes, but also the staff beside you, those you oversee, your employers, and the janitor



emptying the trash at day's end. For me this flows from my faith. Two verses guide how I try to carry myself: "Let your speech always be gracious, seasoned with salt, so that you may know how you ought to answer each person" (Colossians 4:6), and "with all humility and gentleness, with patience, bearing with one another in love" (Ephesians 4:2).

This is not only conviction; it is practical, and increasingly rare. In every initiative I have joined, the people who rise share two traits: they try to fix problems, and they genuinely care about others. In an age of AI and virtual meetings, that second trait has become more valuable, not less. Technical skill is abundant; people who make others feel seen are not.

Through all of it, patient care stays the anchor that keeps the rest honest. The clinical encounter reminds me what the other work is for. Protect that time rather than treating it as the flexible part of your schedule, and be honest when you have taken on too much. If a role ever erodes the attention your patients deserve, recalibrate—do not push harder.

One last principle reshaped me: give others exponentially more benefit than they could ever give you. This was hard. For years I felt I was always serving, often without thanks, with no one helping me in return. Changing that posture—giving freely, without keeping score—changed everything about how I work. Generosity turns out to be its own reward, and it returns in ways you cannot predict.

So you do not have to choose today between being "just" a clinician and something more. Be an excellent clinician first. Stay curious, apply boldly, care for everyone in front of you, and give more than you take. The physicians who seem to do everything are not superhuman—they found a thread worth following and walked it faithfully. For me, that thread is children, my faith, and the people God places in my path. Find yours, and build it one faithful season.



**Joseph Bokum Lee, MD**

Dr. Joseph Bokum Lee is a board-certified pediatrician whose calling has carried him from the classroom to the clinic, the executive suite, the pulpit, and the frontier of clinical artificial intelligence. He began as a Teach for America middle school science teacher before earning his MD at Rush Medical College and completing pediatric residency at the University of Chicago Comer Children's Hospital, alongside a master's in public policy. He has since served as a Chief Medical Officer, founded a school-based health practice, directed a network of more than 200 providers, and now leads physician teams training large language models for clinical use while conducting clinical trials. A pastor currently pursuing a Master of Divinity, he grounds his work in his Christian faith. He continues to care for children, mentors students across the medical pathway, and holds medical licenses in fourteen states.

# Why Both? The MD-PhD Journey

*By Emily Choe, MD/PhD student*

**As an MD-PhD student, one of the questions I get asked the most often is, "Why did you choose to do both rather than getting an MD or a PhD?"**

I answered with a laugh, "I thought to myself, if I am in the lab all day every day, I might go crazy, and if I am only seeing patients all day every day, I might go crazy. So I thought, why not both?"

In reality, I wanted to do both so badly and could not see myself being happier doing anything else.

My college was a very research-heavy experience. The pursuit of knowledge and deepening one's own intelligence were highly coveted and central to the educational training. I absolutely loved this. I love the feeling of learning something new. The fact that I could make a career out of asking random questions about the world we live in, letting the scientific inquiry answer back, and potentially finding something completely novel in the process is so incredibly fascinating, exhilarating, and rewarding to me. This drew me to research.

However, I wanted my questions in science to benefit society in some way. One may argue that this can be done in many ways. But for me, humans and how we operate have always fascinated me the most. How other people and I operate, how we form our thoughts, behaviors, and feelings, piqued my curiosity like no other subject. Ever since I learned we are the way we are because of our brains, that it was merely a giant, complex electrical and chemical circuit operating in that tiny head of ours, neuroscience became my obsession.

How does a cell develop and know to divide in the specific ways it does to become a whole person? How do some electrical potentials in the brain firing create complex emotions, behaviors, and memories? What goes wrong in disease? Can we pinpoint exactly what is going wrong in which circuitry of the brain that creates depression, anxiety, dementia, or intellectual disability? Can we reverse it?

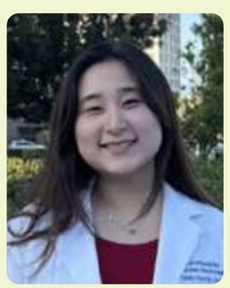


Ma1a was the first course all undergrads were required to take. It was an inauguration and a rite of passage for my undergraduate institution. Here, we learned proofs for every calculus equation we have learned in our previous studies. We would sit together, struggling to define how to derive simple equations we accepted as fact for all of our lives, humbled by the complexity that led to such simple, beautiful equations. Sitting in front of my desk late at night, only my desk light on, I was inducted into the belief that we can obtain mechanistic understandings of everything. To find the root, the derivation, of everything. How do we derive the biological basis of behavior, memory, emotions, and illness? How do I get to the bottom of every complex question we have about biology?

Research would allow me to do so – to go so deep in my hole of inquiry to maybe one day find a gem of truth. Thus, I fell in love with research. Research, for me, became the practice of becoming so obsessed with a single question and tackling it relentlessly until the universe has to spit out an answer for me. Staring at that answer, and asking it again if what I found is true. Will it stand the test of time and further science? How will I apply this to help patients in the future? These questions continue to linger as I pursue research.

Now the final question I must answer is, why medicine? I selfishly wanted to learn all the possible facts about the human body, physiology, and illness to own that knowledge. To have all of that to draw from felt like the most comprehensive, bulletproof way to ensure I am truly exploring scientific questions that we do not have answers to yet. But beyond this, I found immense joy in interacting with patients in the small ways I did before medical school. That I would be able to draw from that knowledge and rigorous training to actually touch someone's life. To feel the deep level of reward, and the greater weight of responsibility, as I saw the patients put their trust in the expertise of the physician. To know that there is such a training process that would allow me to one day feel confident and competent enough to do the same. To work constantly to better someone else's life, help them live another day, assist them so they can recover and revisit the things that bring them joy. If I am in a society that allows me to selfishly explore my curiosities, the only natural thing for me to do is to give back and make someone else's experience a little bit more pleasant.

And therefore, medicine. Research. Learn, struggle, inquire, advocate. Rinse, repeat.



**Emily Choe**

Emily Choe is a current second year MD/PhD student at UC Irvine. She received her Bachelor of Science in Computation & Neural Systems at Caltech.

## Q&A with Dr. Robert Sorrell:

# Beyond the Operating Room: A Physician's Journey into Wellness and Innovation

*By Jason Cowan*

**Jason: Could you please introduce yourself, give us a brief overview of Appell & Sorrell Wellness, tell us a little about your background in medicine and what led you to where you are today?**

**Dr. Sorrell**: I'm Dr. Robert Sorrell, an orthopedic surgeon in Birmingham, Alabama, and co-founder of Appell and Sorrell Wellness. I attended medical school and completed my orthopedic surgery residency at the University of Alabama at Birmingham. Since finishing residency in 1992, I have been in private practice in orthopedic surgery in Birmingham, Alabama. Throughout my career, my focus has been helping patients restore mobility, remain active, and improve their quality of life.

The idea for Appell and Sorrell Wellness actually grew out of our orthopedic practice. We frequently cared for patients with severe hip and knee arthritis who needed joint replacement but whose weight increased their surgical risk. We began offering medically supervised weight-loss treatment, including GLP-1 medications, to help appropriate patients lose weight, improve their health, and become better candidates for surgery.

**Jason: How did the idea for Appell & Sorrell Wellness come about, and what made you want to build something like this alongside your existing clinical practice?**

**Dr. Sorrell**: What began as a solution to a specific orthopedic problem quickly opened our eyes to something much broader. Patients weren't simply losing weight—they were feeling better, becoming more active, and taking a greater interest in their overall health.

That experience ultimately evolved into Appell and Sorrell Wellness. Today, we combine medical weight management with hormone optimization and a personalized approach to helping patients improve how they feel and function. For me, it's a natural extension of what I've always tried to accomplish in medicine: helping people live healthier, more active, and fulfilling lives.

**Jason: What were some of the biggest challenges you faced while building Appell & Sorrell Wellness and balancing those responsibilities with your clinical practice?**

**Dr. Sorrell**: The biggest challenge has simply been time. I'm 66 years old and at a point in my career when I had actually begun thinking about slowing down a little. Instead, starting Appell and Sorrell Wellness has given me an entirely new area of medicine to learn and a new practice to help build, while I continue to maintain an active orthopedic surgery practice.

Balancing those responsibilities has certainly required a significant commitment of time and energy. At the same time, it has been incredibly rewarding. After practicing orthopedic surgery for more than three decades, I've enjoyed the opportunity to expand my knowledge into areas such as medical weight management, hormone optimization, and preventive wellness.

In many ways, Appell and Sorrell Wellness has given me a renewed enthusiasm for medicine. Rather than simply slowing down, I've found myself learning, growing, and becoming excited about another way that I can make a meaningful difference in my patients' lives.

**Jason: Many of our readers are aspiring physicians or are early in their careers. As both a physician and as someone developing something new, what have been the biggest lessons you've learned about innovation and building something meaningful?**

**Dr. Sorrell**: One of the biggest lessons I've learned is that you have to love what you're doing. Building something new requires a tremendous amount of time and energy, and if you're not genuinely passionate about it, it's difficult to sustain that commitment.

I've also learned that you don't have to reinvent the wheel. There are tremendous resources available if you're willing to seek them out. Find people who have successfully done something similar, reach out to them, ask questions, and learn from both their successes and their mistakes. Most people are surprisingly willing to share their knowledge and experience.

Finally, surround yourself with people who share your goals and values and, just as importantly, people you genuinely enjoy working with. Building something meaningful is rarely an individual accomplishment. Having the right people around you makes the process more productive, more enjoyable, and ultimately more successful.

**Jason: What impact do you hope Appell & Sorrell Wellness will have on your patients and the broader Birmingham community, and what advice would you give to medical students or young physicians who hope to build something of their own while practicing medicine?**

**Dr. Sorrell**: Our goal at Appell and Sorrell Wellness is really very simple: we want to help our patients feel better, look better, and live longer so they can fully enjoy their lives. We want to help people take a more proactive role in their health—not simply treating disease when it occurs, but improving their health, energy, strength, and overall well-being as they age. If we can make that kind of difference for our patients and ultimately within the broader Birmingham community, I think we will have accomplished something very meaningful.

Perhaps the most important lesson for me personally has been to never stop learning. Over the past year and a half, as we've developed our approach to hormone optimization, wellness, and longevity, I haven't just been learning how to help my patients—I've incorporated many of these same principles into my own life. At 66, I've experienced a considerable difference in how I feel, my energy, and my overall well-being. That has made this work very personal for me.

For medical students and young physicians who hope to build something of their own, my biggest advice is this: you have to love what you're doing. Medicine already requires an enormous commitment of time and energy. If you decide to build something in addition to your clinical practice, it will require even more.




### Jason Cowan

Jason Cowan is a graduate of the University of Alabama at Birmingham, where he earned his undergraduate degree while preparing for a career in medicine. At UAB, Jason served as a teaching assistant for General Chemistry II and Organic Chemistry I laboratory courses. He also conducted undergraduate research in the Constraint Induced Movement Therapy Lab, studying neural plasticity and cognitive rehabilitation following stroke and COVID 19.

Jason has gained clinical experience through volunteering at Children's of Alabama and working as a medical assistant in an orthopedic clinic. He has also shadowed physicians across several specialties, including orthopedic surgery, general surgery, pediatrics, cardiology, internal medicine, family medicine, and anesthesiology. He is passionate about serving others and hopes to pursue a career in medicine centered on compassionate, patient centered care.





### Robert Sorrell, MD

Dr. Robert Sorrell is a lifelong resident of Birmingham. He is a graduate of Vestavia Hills High School and received his undergraduate degree from Auburn University where he was an Academic All American and All SEC performer in baseball.

Board certified by the American Academy of Orthopedic Surgeons, Dr. Sorrell is a diplomate of the American Academy of Orthopedic Surgeons. He specializes in sports medicine, joint replacement, and arthroscopic surgery.

Dr. Sorrell earned his medical degree at the University of Alabama at Birmingham. He completed his orthopedic surgery residency at University of Alabama Hospital. He has been in private practice in the Birmingham area since 1992.

Dr. Sorrell and his wife, Robbin, have three grown children. He enjoys playing sports particularly golf and tennis and exercising. He is also very involved in his church.

## Reader's Perspective

# Becoming the Physician I Want to Be

*By Kendrick Yu*

### *Editor's Note*

*After reading Dr. Paul C. Kang's "Medical Education Beyond the Classroom: A Physician Shaped by Practice, Service, and Mentorship" in our previous issue, medical student Kendrick Yu reflects on Dr. Kang's story and what it means for his own journey toward becoming a physician.*

After every shift, I called my mom from the car during my ride home. I would tell her what I had seen that day, struggling to find the Korean words for each organ. She never fully grasped what I was describing, but she listened anyway, exclaiming at the foreign procedures, asking questions, and ending every call with "수고했어." Roughly translated to "good work today." I did not realize the impact these conversations had until I watched my first ICU patient pass away, and I instinctively called, knowing I would feel comforted.

The first advice I received before medical school was to never forget why I do it. My why was simple: I wanted to guide the care of as many patients as I could. But Dr. Kang's article made me reflect on the "how" of pursuing medicine. As an aspiring first-generation physician who spent hours researching medicine alone, never sure if I was doing it right, I want to be the mentor I needed. Through mentorship, mission work, and leading innovation, Dr. Kang shows the flexibility a physician can have in defining their unique practice style. This reassured me that my passions outside of medicine are not separate from becoming a strong physician; they are a foundation for the physician I want to become.

I also think his article points to an underlying question: how do you stay yourself while becoming a doctor? Dr. Kang emphasizes that being a doctor is not the full image of who you are. Instead, he points out that we are also a son or daughter, a friend, and a member of the community. Reading this reminds me of my phone calls with my mom. My mom has no medical training and could not help me study or work through a patient presentation, but she did something no curriculum could: she reminded me that I am her son first, before medical school.

I cannot say my parents directly inspired me to pursue medicine as Dr. Kang's father did for him. They never told me they wanted me to be a doctor, and I am not sure they understood what it involved. But they did motivate me to become the best doctor I could and supported me financially and emotionally. Dr. Kang writes about a father who held him and urged him to cross a bridge he was afraid to cross. To me, my parents did something similar. They supported and taught me that a goal without support is fragile because everyone needs someone to pick them up when an obstacle knocks them down.

We spend years deciding what kind of physician we want to become, but very little time remembering who is waiting at the other end of the call when a shift is over. Dr. Kang's article answers many versions of the "how": how to become the physician you want to be, and how to get there. Who is the person you call? And can we learn to be that voice for someone else?



**Kendrick Yu**

***UAB Heersink School of Medicine | MD Candidate***

Kendrick Yu is a fourth-year medical student at the University of Alabama at Birmingham Marnix E. Heersink School of Medicine. He is currently applying for residency in internal medicine and has a research interest in improving care for patients with mobility limitations. He hopes to build a career as a clinician-educator while also serving uninsured and underserved patient populations.





# Introducing Our Editor of Global Health and Partnerships

**Sung Hwi Hong, MD, MPH**

Some people bring ideas to a conversation. Dr. Sung Hwi Hong brings ideas, questions, energy, and usually a good laugh. I am delighted to welcome him as our Editor of Global Health and Partnerships at *NexBioHealth*.

I have known Sung Hwi for three years and consider him one of the most gifted people I have had the pleasure of working with. What stands out to me is his appetite for learning. He approaches unfamiliar subjects with curiosity and enthusiasm, and his sense of humor makes working with him a pleasure.

A physician and public health researcher, Sung Hwi studied Economics-Mathematics at Columbia University, earned his medical degree at Yonsei University, and completed an MPH in Global Health at Harvard. He is now pursuing a DrPH at the Harvard T.H. Chan School of Public Health and contributing to gastric cancer prevention research at Yale.

His work and volunteer experience have taken him to Africa, India, and South America. These experiences bring a personal dimension to his interest in global health and a broad perspective to the stories he helps us tell.

Readers can already see his contribution in this issue. He interviewed Dr. Killiam Argote-Araméndiz and connected us with Jess and The Leo Project, as well as Dr. Juan Carlos Anguiano. Their stories introduce different paths into community care, humanitarian medicine, and public health. Bringing these voices together is precisely what we hope this new editorial role will encourage.

Sung Hwi will help develop our global health coverage and build partnerships with people and organizations whose experiences can deepen our understanding of medicine. I look forward to seeing where his curiosity and connections take us, and I am pleased that our readers will now have the chance to get to know him, too.

Please join me in welcoming Sung Hwi to *NexBioHealth*.

Chul S. Hyun, MD, PhD, MPH
*NexBioHealth*

# UPCOMING CONFERENCE ALERT

### American Heart Association (AHA) Scientific Sessions 2026
**Dates: November 6–9, 2026**
**Location: Chicago, Illinois, USA**

**Focus**: A major global cardiovascular meeting featuring advances in clinical cardiology, cardiovascular and brain health research, prevention, resuscitation science, and healthcare innovation

**Website:** American Heart Association Scientific Sessions

### HLTH USA 2026
**Dates: November 15–18, 2026**
**Location: Las Vegas, Nevada, USA**

**Focus:** A leading healthcare innovation conference bringing together health systems, clinicians, technology companies, startups, investors, and industry leaders to explore AI, digital health, care delivery, and the future of healthcare.

**Website:** HLTH USA

### Radiological Society of North America (RSNA) Annual Meeting 2026
**Dates: November 29–December 3, 2026**
**Location: Chicago, Illinois, USA**

**Focus:** One of the world's leading medical imaging meetings, highlighting advances in radiology, AI, imaging technology, diagnostic innovation, and image-guided care.

**Website:** RSNA Annual Meeting

### San Antonio Breast Cancer Symposium (SABCS) 2026
**Dates: December 8–11, 2026**
**Location: San Antonio, Texas, USA**

**Focus:** A major international breast cancer meeting covering experimental biology, prevention, diagnosis, translational research, treatment, survivorship, precision care, and emerging technologies.

**Website:** San Antonio Breast Cancer Symposium

### J.P. Morgan Healthcare Conference 2027
**Dates: January 11–14, 2027**
**Location: San Francisco, California, USA**

**Focus**: A premier healthcare investment conference connecting global healthcare leaders, biotechnology and pharmaceutical companies, medical technology innovators, emerging companies, and the investment community.

**Website:** J.P. Morgan Healthcare Conference

### ASCO Gastrointestinal Cancers Symposium 2027
**Dates:January 21–23, 2027**
**Location: San Francisco, California, USA**

**Focus**: A multidisciplinary oncology symposium presenting new research and clinical advances in gastrointestinal cancers, including colorectal, pancreatic, hepatobiliary, gastric, and esophageal cancers.

**Website:** ASCO Gastrointestinal Cancers Symposium

### Society of Thoracic Surgeons (STS) Annual Meeting 2027
**Dates: January 28–31, 2027**
**Location: San Diego, California, USA**

**Focus:** A leading cardiothoracic surgery meeting featuring new science, surgical techniques, technology, translational research, and education for the cardiothoracic surgical community.

**Website:** STS Annual Meeting

### ASCO Genitourinary Cancers Symposium 2027
**Dates: February 11–13, 2027**
**Location: San Francisco, California, USA**

**Focus**: A multidisciplinary oncology meeting highlighting advances in prostate, kidney, bladder, testicular, and other genitourinary cancers, with an emphasis on emerging science and patient-centered treatment strategies.

**Website:** ASCO Genitourinary Cancers Symposium

### AAAAI Annual Meeting 2027
**Dates: February 19–22, 2027**
**Location: New Orleans, Louisiana, USA**

**Focus**: A major international meeting in allergy, asthma, and immunology featuring new research, emerging therapies, biologics, precision medicine, and advances in immune-mediated disease.

**Website:** AAAAI Annual Meeting

### American Academy of Orthopaedic Surgeons (AAOS) Annual Meeting 2027
**Dates: March 3–6, 2027**
**Location: Las Vegas, Nevada, USA**

**Focus**: A major orthopaedic meeting featuring advances in surgical techniques, clinical research, medical education, technology, and innovation across orthopaedic specialties.

**Website:** AAOS Annual Meeting



## UPCOMING ISSUE

# Physicians Building Community



In our first issue of 2027, NexBioHealth will explore Physicians Building Community, with a cover feature on Dr. Chai Chang Choi, founder of the Korean American Medical Association. His life story brings together immigration, medicine, and the work of bringing physicians together around a shared purpose. Alongside his story, an interview with his grandson, Dr. Scott Choi, will offer a contemporary perspective on family influence, professional identity, and service. Together, these features will invite readers to consider how a physician's contribution extends beyond individual patients to the communities and institutions that endure.

The *NexBioHealth* Editorial Team



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