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THE WISCONSIN MEDICAL ALUMNI MAGAZINE

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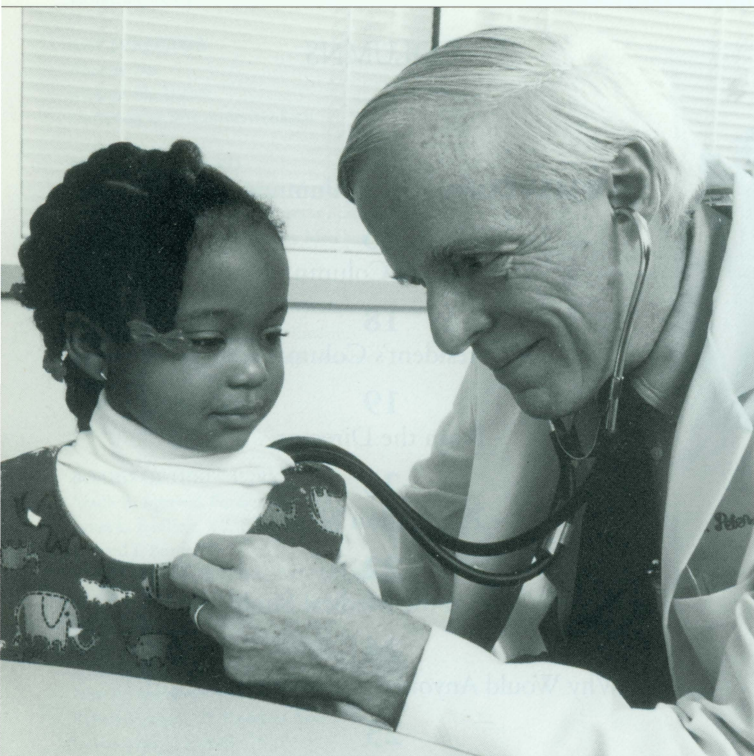
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Our Readers Write  
Necrology

*COVER: "Bobbie's Dock," a 30" x 24" oil on canvas, is a 1997 work by Madison artist Dagny Quisling Myrah, who concentrates on portraying landscapes. Her etchings and oil paintings have appeared in several venues, including the Grace Chosy Gallery, Madison.*

## WMAA Citation Recipient

H. Peter Chase '61



*Peter Chase made a midlife career change in 1980 to start the Children's Diabetes Center at Denver*

Dr. H. Peter Chase, Professor of Pediatrics at the University of Colorado and Director of the Clinical Division of the Barbara Davis Center for Childhood Diabetes, mirrored the work history of many professionals in recent times when he made a midlife career change in 1980 to start the Children's Diabetes Center at Denver which has become, under his guidance, probably the largest center for children with diabetes in the world.

"When I was asked to be the initial director, I said I'd do it for two years, then I'd return to my nutrition research," he said. That was 16 years ago. Today, Peter Chase is still Clinical Director of the Center. Although the Center began life with Dr. Chase as its only physician, its current staff follows about 1700 children and 800 young adults with Type I diabetes and educates families across the country.

Known internationally as an outstanding diabetologist, he also maintains an exceptionally busy practice while he teaches pediatric diabetology — courses he created and organized — and conducts clinical research.

Much of the Center's educational mission is accomplished through distribution of a popular book, *Understanding Insulin-Dependent Diabetes*, authored by Peter Chase in the guise of the Pink Panther. The 8th edition (1995) contains 254 pages of eminently understandable material covering essentially all aspects of insulin-

dependent diabetes, with helpful graphics as well as frequent appearances by the Pink Panther himself. Each edition is quickly consumed by families around the country through word of mouth; the Center does not advertise it. This non-profit book has become the main source of educating families about Type 1 diabetes nationwide, with the last four editions having sold 20,000-25,000 copies each. Peter and Pink Panther are already working on the 9th edition.

The Children's Diabetes Foundation also publishes a coloring book, a synopsis of each of the 25 chapters in the larger book.

During the past 10 years, Peter Chase's research has focused on basic aspects of childhood diabetes. He is especially involved in the National Diabetes Prevention Trial being conducted by ten centers. "We are trying to prevent diabetes," he said. "We're screening babies at birth for a genetic predisposition for developing diabetes and following them every six months. We look for circulating antibodies that show islet damage. It may become feasible to immunize high-risk children against diabetes right along with the DPT shots."

His work has earned Dr. Chase several honors, including multiple inclusion in *The Best Doctors in America* and, most recently, in *The Best Doctors in America: Central Region*. He also had been honored with an NIH Research Career Development Award, the Ross Award for Pediatric Research and several other honors.

After Peter Chase graduated from the UW Medical School in 1961, he interned at the University of Utah, served a pediatric residency and metabolic fellowship at Stanford, and trained further in metabolism at the NIH and at the University of Colorado Health Sciences Center, where he became a full professor in 1979. He has been actively engaged in training and teaching activities at the University since, and is the Course Director of a biannual national meeting on Type 1 diabetes that has grown to 280 attendees last summer.

His research during the first part of his career focused on metabolism and nutrition with special interests in the nutrition of migrant workers and children, including the effects of malnutrition on the developing brain.

A highlight of his nutrition studies occurred when he testified before the (Senator George) McGovern Food, Nutrition and Health Committee, where he showed the results of nutritional deficiencies among migrant children. McGovern later told Peter that his presentation was a major factor in broadening eligibility for receiving food stamps.

In his spare time, Peter Chase often enjoys activities designed for children with diabetes including Saturday ski trips to the mountains, an annual Halloween party and an annual Sports Picnic. And for 27 years, he has spent a week at a camp with 120 children with diabetes.

Church activities are also important in the life of the Chase family. Peter's wife is a minister with the United Methodist Church; he has sung in the church choir until last year and heads the church's inviting and receiving ministry team. He and his wife currently co-chair a four-state initiative on Children in Poverty.

## WMAA Emeritus Faculty Awardee in Clinical Science

Charles Lobeck



Charles Lobeck began his affiliation with Pediatrics in 1958, when the Department was in its early childhood, becoming intimately involved in its clinical, educational and administrative aspects. When he took over the fledgling department as chairman in '64, he became friendly with the pediatricians of the state, worked with the faculty, and melded them into a well-rounded, balanced department. Colleagues agree that it was Chuck Lobeck who was largely responsible for setting the tone and direction for today's outstanding Department of Pediatrics. He was, in fact, referred to as his father by many at the UW at the time of his retirement.

He was also described by a department member as "not a politician. You can trust him and you know just where you stand."

Former Dean Arnold Brown described Chuck's role with students as being confidant, stern father figure, gruff but soft-hearted uncle — everything but a mother. To Dean Brown he was an indispensable co-dean.

A native of New Rochelle, New York, Chuck Lobeck received his A.B. degree at Hobart College in Geneva, NY and his M.D. from the University of Rochester School of Medicine and Dentistry. He trained at Yale University and at Rochester, where he was chief resident and instructor.

At Wisconsin he served on many committees, especially those involving students, in whom he took great interest, listening to their problems and guiding them. At various times he was Associate Dean for Academic Affairs and Director of Clinical Affairs, all the while sharing his skills with many national professional committees and organizations. He was,

for example, actively involved in the Cystic Fibrosis Foundation and he was a leader in the humane treatment of animals used in biomedical research, receiving the first Bennett J. Cohen Award from the American Association for Accreditation of Laboratory Animal Care, of which he was Chairman.

Dr. Lobeck interrupted his career at the Medical School when he served as Visiting Professor at various universities and when he was Dean of the University of Missouri School of Medicine at Columbia for eight years.

In the educational arena, he was a leader in revitalizing the curriculum at the UW Medical School. He also developed the Class Mentor Program, originated the Recognition Ceremony, helped to obtain a cooperative agreement with the federal government for an Area Health Education Program, reorganized the structure of the Academic Affairs offices and enhanced services to students.

Chuck has long been interested in the education of medical students and how that education effects medicine. "Super specialization has gone too far," he said a few years ago. "We must educate more primary care physicians, and we should make medical education more enjoyable for students.

"The first and second years are too packed with memorization and there is little opportunity to think. The problem in graduate education is that of insulation. We are in danger of becoming uncultured, non-creative automatons, more technical and disciplined, but are we becoming less sensitive to human needs? This is a real dilemma, for without special knowledge one is a useless physician." As an observer of today looks back at recent philosophy in medical education and training, his words seem particularly prescient. He hopes that in the current climate of managed care, physicians will still try to deliver personalized care to each patient.

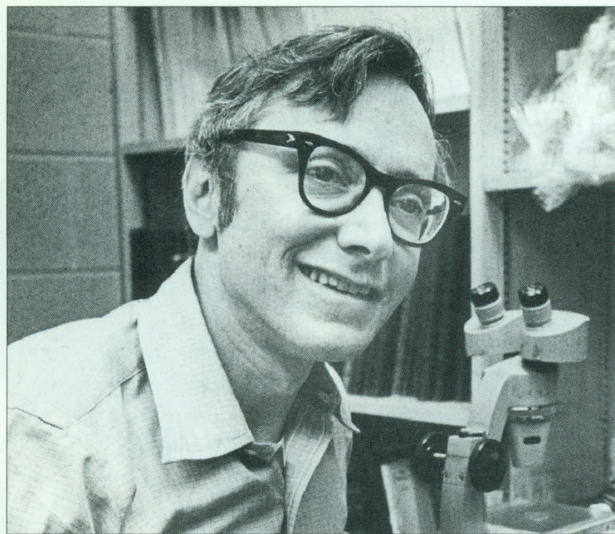
After his retirement in 1991, Dr. Lobeck took on another assignment, that of helping to develop the Non-Residential Administrative Medicine Program, initiated by Professor David Kindig in the Department of Preventive Medicine. Chuck has also been active recently in raising funds to support the JD Kabler Mentor Program.

Chuck left the program last July. He and his wife continue to travel leisurely and to concentrate on the joys of fly-fishing in Montana and vacationing in northern Wisconsin, and they visit children and grandchildren.

Their son is CEO of St. Mary's Hospital in Milwaukee and their oldest daughter is a professor of linguistics at Western Washington University. Their second daughter is a family nurse practitioner in Big Timber, Montana, near Yellowstone Park, and their youngest daughter teaches school in Dallas — a ready-made itinerary.

## WMAA Emeritus Faculty Award in the Basic Sciences

Robert L. Metzberg



*His research on the molecular genetics of the filamentous fungus Neurospora has brought him international recognition.*

**D**uring his 41-year career at the University of Wisconsin, Emeritus Professor of Biomolecular Chemistry Robert L. Metzberg earned an enviable reputation as an investigator and as a teacher.

His research on the molecular genetics of the filamentous fungus *Neurospora* has brought him international recognition. He has, for example, served as President of the Genetics Society of America, chaired and co-chaired many scientific conferences and study sections, and belonged to the editorial boards of *Genetics*, *Molecular and Cellular Biology*, and *Experimental Mycology*. He also co-chaired the Gordon Conference on Fungal Metabolism, presented the keynote address at the British Mycological Society meeting, and received an NIH MERIT grant award.

Bob Metzberg's decision to study *Neurospora* was deliberate and steadfast. "Although it is unfashionable right now, I always thought it was a good model," he said. "We needed a filamentous organism for doing work that couldn't be accomplished in other organisms. Besides, I like to work on something others don't, and I don't like to do hurry-up work."

*Neurospora* is an easily-grown, non-pathogenic model for less manageable fungi such as animal, human and plant pathogens and for agriculturally significant organisms such as mycorrhizal fungi. It also has a long academic track record, thanks in large part to Bob's efforts, in revealing the fine points of genetics and physiology to those who can ask it mean-

ingful questions. Many of his students and postdoctoral fellows in turn have asked good questions and become leaders in their field — clear evidence of the professional and personal influence of their mentor.

His classroom teaching likewise influenced hundreds of undergraduate, medical, graduate and postdoctoral students whom he also challenged to grow, to question and to look beyond the obvious. At one time or another, he taught every course offered by the Department of Biomolecular Chemistry, previously known as Physiological Chemistry, and he was an active and significant member of the highly successful UW Biology Core Curriculum, which he helped found. In recognition of his outstanding teaching, Professor Metzberg received the Medical School Dean's Teaching Award, as well as the John Bascom Professorship. He used part of the latter award to fund the departmental library and to support interviews by promising, prospective graduate students.

In 1968, he was a Visiting Professor at the University Nacional de Mexico, and in 1983 he served as Visiting Professor at Stanford University as a Guggenheim Fellow.

Now Bob Metzberg is back in California, where much of his family, including two sons and two grandchildren, reside. He enjoys brewing beer and wine as well as traveling, hiking, bird watching and music. (The piano, which he claims to play badly, and the banjo, which he says he plays even worse, are "at least two instruments I don't play.")

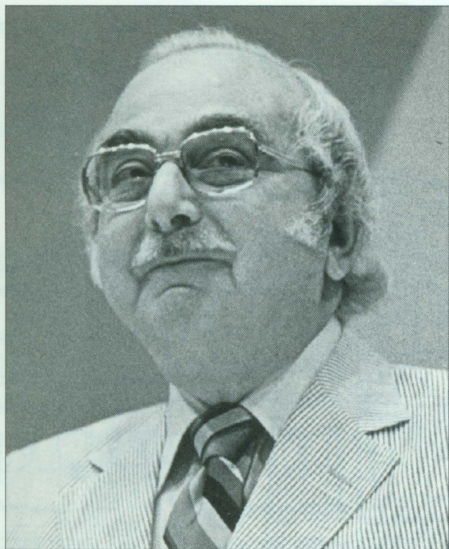
He also continues to "putter around" in a laboratory at Stanford with two colleagues he was anxious to work with.

Robert Metzberg's heart, however, remains in Wisconsin. He is grateful for his entire career at the UW and for the honor of being selected as the WMAA's 1997 Emeritus Faculty Awardee.

He also has some advice for the University. "I've always felt the University of Wisconsin deserves to be proud of itself for the way it teaches students how to think and for producing so much useful knowledge. Maybe it suffers a little from an inferiority complex. It shouldn't. It should tell about its accomplishments in a firm way (to the people of the state and others)."

## WMAA Lifetime Service Award

Mischa Lustok



During the May 1997 Alumni Day ceremonies, Mischa Lustok will receive the second Medical Alumni Association Lifetime Service Award. No one is more deserving. The quality, extent and diversity of his service to the Association and to his Alma Mater is unmatched. He participated in the conception, birth and maturation of the WMAA. His service spans its entire existence.

In addition to serving as an effective president of the Association, Mischa chaired the successful campaign to raise funds for the construction of the Middleton Library. He was a long-time board member, representative of his class and editor of the *Quarterly* for more than twenty-five years. He also served as a preceptor of U.W. medical students and is a clinical professor of medicine.

All of this was accomplished while he conducted a busy private cardiology practice, published scientific papers and served as chief of medicine and chairman of undergraduate medical education at Mt. Sinai Hospital, Milwaukee. He was also a member of numerous professional organizations and was Governor for Wisconsin of the American College of Chest Physicians.

During his tenure as *Quarterly* editor, Mischa was a symbol of stability and continuity. While a new president assumed office each year and Medical School deans did come and go, Mischa's avuncular visage and wise editorials were a constant in every *Quarterly* for more than twenty-five years.

His editorials were models of clarity, grace and precision—often including apt biblical phrases

and literary allusions. His topics ranged broadly—surveying complex issues in medical ethics, paying tribute to worthy individuals, counseling the current generation of medical students or illuminating scores of other interesting topics.

His final editorial in the 1986 *Quarterly* was not written for publication. It was decided to print his letter to me announcing his resignation from the office of *Quarterly* Editor. It was a typical Lustok product. He was eloquent, gracious in his warm words about our relationship and steadfast in pledging continued involvement and support: "My commitment to the Alumni Association and our Medical School is a non-cancelable life-long covenant."

Mischa's peers have previously recognized his accomplishments by awarding him the Medical Alumni Citation, the Max Fox Preceptor Award and the designation of U.W. Emeritus Clinical Professor of Medicine.

For the benefit of recent graduates who may not know the background of this 1935 Medical School graduate, a few biographical facts are presented.

Dr. Lustok received B.S., M.S. and M.D. degrees from the University of Wisconsin and served an internship at University Hospitals. Shortly after completing his residency in Denver, he entered military service serving from 1941-1946 primarily in the European theater of operations. He was discharged with the rank of Lt. Colonel.

His busy professional life was structured to permit him to fish for walleyes and muskies, to travel, to ski and to enjoy photography and music. Mischa and his late wife attended every Homecoming football game, all Milwaukee Alumni meetings and maintained perfect attendance at the Spring Alumni weekend celebrations.

Today his three married daughters and a pride of grandchildren are paramount in his life.

In retirement Mischa participates in the Learning Institute for Elders offered by the University of Central Florida. Recent topics studied include astronomy, religions of the world and oriental art.

The award the Association will present to Mischa Lustok, M.D. is recognition of the fact that his non-cancelable life-long covenant has been honored to the fullest. Congratulations and welcome home, Mischa!

*Ralph Hawley*

*Mischa's avuncular  
visage and wise  
editorials were a  
constant in every  
Quarterly for more  
than twenty-five years.*

# THE WHITE PLA

## A Story of Tuberculosis— Lest We Forget

By G. Stanley Custer '42



I was five or six years old when my father was biking home from work at Burgess Battery Company on East Washington Avenue to South Madison where we lived. He spit blood. Dr. Head consulted with Dr. William S. Middleton and they agreed that he had pulmonary tuberculosis. He was stunned in disbelief. It was the early 1920s and there

was no treatment for that dread, consuming disease except fresh air and bed rest.

He couldn't stay home with five little children aged three to eight. He was in the most productive years of his life. There was a large family to support. They sent him to Morning Side Sanatorium. His wife, our mother, went to work. We kids were not allowed to visit our father. I only remember seeing that low, screened, dark brown, lapstrake sanatorium on the far southeast outskirts of Madison along Monona Drive where he "took the cure" for a whole year.

After he was released from the san, Dad never lived at home again. Dr. Head and a judge advised my mother that her husband's "consumption" was only in arrested state and therefore he should not live at home until they were confident he was cured. Again, he was considered a threat to us children. Because of his tuberculosis (TB) history, Burgess Battery would not give him back his job.

I learned at a young age that tuberculosis was a dreaded disease. Like syphilis, it was talked about behind closed doors or in hushed, secretive tones. Victims of the tubercle bacillus were avoided, even after cure. I was told when riding past a tuberculosis sanatorium, "hold your breath."

In 1926 all five of us kids were sent to the first "Kiddie Kamp," created that year by the Capital Times newspaper for children of parents with tuberculosis. I was eleven. It was a large, stately, antique property located on the south shore of Lake Monona, which had been the home of Paul

*continued on page 8, column 1*



by John Aure Buessler '44



THE WHITE PLAGUE OF tuberculosis remained a centuries-old worldwide scourge until just fifty years ago. It was then that newly developed drugs and surgical procedures made the disease more manageable. Accompanied by universal euphoria over its "conquest," it faded into the background of public concern. But it did not disappear.

# GUE REVISITED



illustrations by Larry Hogan

Last year the editor of the *Quarterly*, the late Victor S. Falk, Jr. '39, in conversation expressed his concern over what he considered an impending recurrence of a worldwide pandemic of tuberculosis, this time drug resistant.

Since there are those among us who vividly recall those "bad old days" of the white plague, it seems appropriate and timely for us to relate some of our experiences when we were medical students working with TB patients. As might be expected, remembrances of our encounters with the dreaded disease are not all of tragedy, but reveal our youthful resilience through bits of humor and expressions of contentment with our lot.

Larry H. Hogan '44, has illustrated some of the moments remembered from our student rotation at Statesan, the State of Wisconsin Board of Health operated tuberculosis sanatorium near Wales, Wisconsin. G. Stanley Custer '42, and Sherman P. Vinograd '46, have each given their own personal insights regarding the disease. I have attempted to compile the recollections of twelve other schoolmates into a nostalgic tour of what many regarded as halcyon days in the bucolic environs of Statesan.

William T. Russell '46, in his search of the State of Wisconsin archives, informs us that the Wisconsin State Sanatorium at Wales was established in 1905 and was operational from 1907 to 1957 as a treatment and quarantine facility for state residents with pulmonary tuberculosis. Following the closure of Statesan, the institutional care of tubercular patients was transferred entirely to the counties. (Today, the buildings that constituted Statesan have been increased in number and are surrounded by a twelve-foot fence topped by coils of razor wire. They are used as the

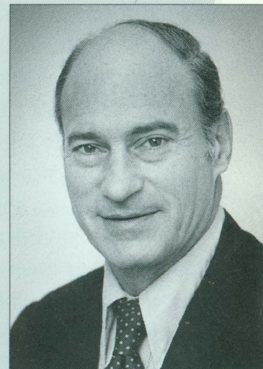
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## Recollections of Statesan

By Sherman P. Vinograd '46

Back in 1946 (now, suddenly 50 years ago) senior medical students spent four segments of the year away from the Madison campus. In retrospect, the intended purpose of this educational plan was very well served. It did give us both insight and hands-on experience in the field as medicine was actually practiced outside the ivory tower. It also gave us a lot more, which I am certain would have come as no surprise to our faculty planners. It gave us an understanding of the settings, both urban and rural, in which life was lived and medicine was practiced throughout the state. It served to broaden our sociological perspectives, profoundly so for many of us. How could one help but learn from the deplorable conditions and self-perpetuating social attitudes that prevailed in the multiple ghetto areas of Chicago, for example. It gave us a better understanding of what it was to be a patient, especially one afflicted with chronic illness. Dealing with tuberculosis at Statesan, for example, how could we help but feel strong empathy for the patients, and impatience for therapeutic advances after daily confrontation with the severe and prolonged isolation and treatment measures required at that time. These were strong lessons, deeply felt, but there were also those on the happier side. Our fourth-year rotation also gave us new friends, new colleagues, potential future colleagues, and a whole lot of new anecdotes, some of which could even be repeated in public.

It was a cold and snowy day in January 1946, when Jack Keefrey, my partner, and I arrived at Statesan to begin our two-week stint there. We had completed our two-month preceptorship at Sacred Heart Hospital in Eau Claire in November, and finished a very rich and very tough December of life on Halstead and Maxwell Streets (two "icicles" delivering babies all over Chicago traveling by streetcar at all hours of the day and night out of the Chicago Maternity Center). We were ready for a more serene learning experience, for we had heard about the relatively peaceful surrounds of Statesan. As it turned out, we were not disappointed.



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Harloff. We spent two enjoyable summers there under the watchful care of two nurses, Ruthe Coe and Cora Hardy.

I was always a skinny kid. But I was healthy, strong, and vigorously active. After high school I joined the CCC (Civilian Conservation Corps). This was during the depression of the 1930s. I worked hard throwing wet sand from a six-foot trench and lying on my back carving a narrow tunnel through sandstone with a jack hammer. There were some other less physically demanding jobs. When I left the camp I was a solid 165 pounds.

Mother saved my pay. Luckily, home was Madison and having earned enough for tuition I entered the University there. I stoked furnaces and mopped floors in two large apartment buildings and did yard work for fraternities and sororities to pay my way. By the time I entered medical school I was a scrawny 136 pounds. They used me as a first-rate model for physical diagnosis class. It was easy to palpate all of my organs. Besides, I had an innocent cardiac murmur for my classmates to auscultate.

During the fourth quarter of my last year in med school, I awoke one morning and with the first wakeful breath experienced a sudden, quick, sharp pain in my right upper posterior chest. It was gone with my next breath. "Right apical pleurisy?" I wondered. I didn't feel sick. I took a deep breath. It didn't recur. Thank God! But the same symptom recurred the following morning! Same place. Later in the week a vague soreness was felt there. I waited a day or so hoping it would go away but thought I better see a doctor.

At the student infirmary a tall staff internist asked, "What's your problem?" "I've got tuberculosis," I replied. The doctor asked, "Who says so?" "Well, I'm a med student and Dr. Middleton said that if a patient complains of right apical pleurisy, you should think of pulmonary tuberculosis first, and I've got right apical pleurisy." He examined me. "It's probably muscle pain." He was trying to assure me. I went to the lab and also had a chest X-ray. He told me to call him in three days. I did. He didn't have the results yet. "Give me a call." I did. Still no information from the lab.

I began to feel secure because the pains hadn't returned. After being told to call back too many times, I went directly to the doctor's office. I was amazed and a little angry. Into the second week he still didn't have the reports. While I sat there he called radiology and complained. He waited

*continued on page 10, column 1*



*We took the back path so we could avoid passing in front of Dr. Schmidt's house as we sneaked away. Emerging from the bushes, we came face-to-face with Dr. Schmidt watering his back garden.*

*continued from page 7, column 1*

Ethan Allen School of the Wisconsin Department of Health and Social Services in order to fight the current plague of juvenile criminality.)

**Bill Russell** also explains that: "At an early age I learned that tuberculosis was a bad disease. My physician uncle who was interning at Milwaukee County Hospital, came down with active tuberculosis and died of it in 1928. His sister, a mother of four young children, was admitted to Statesan where she died in the late 1930s. She exposed my younger sister who became a patient at Statesan in the early 1940s while I was a medical student. She was treated by means of a phrenic nerve crush performed by Dr. Tony Curreri and 'recovered' from the disease prior to the advent of antibiotics.

"She had held my son when he was less than a year old with the result that he became tuberculin skin test positive shortly thereafter. He was drafted into the Army in 1960 and while running, collapsed with hemoptysis. He called me from the hospital and asked, 'Dad, what are acid-fast bacilli?' Fortunately, by that time, tuberculosis was treatable by antibiotics and he was successfully treated at Valley Forge Army Hospital."

**Bill Russell** recalls his medical student days at Statesan where "bed rest and fresh air on screened-in porch bedrooms were still the primary treatment. Four of my classmates attended a postmortem examination on a dead patient there and three of them came down with active tuberculosis within a year. Fortunately, all have recovered."

*continued on page 9, column 1*

*It was a sobering experience to become acquainted with some of the men and women who suffered from advanced pulmonary tuberculosis and faced many months and years of sanatorium care and often major pulmonary surgery.*

*continued from page 8, column 2*

“Not all the Statesan patients’ health problems were tuberculosis related as attested to by two patients who developed an unexplained fever. Dr. Frank Maresh of the medical staff made an astute diagnosis after getting the story from them that they had caught and skinned a rabbit while they were walking near the sanatorium. Dr. Maresh’s diagnosis: Tularemia.”

**D**orothy and Eugene Betlach, both class of ’46, remember that even prior to service at Statesan, medical students were vulnerable to tuberculosis infection simply in the course of their daily contact with patients, some of whom had as yet undiagnosed but infectious tuberculosis. Dorothy relates that “. . . during our sophomore year one section of the class was present at an autopsy on a patient at which previously undiagnosed active TB was found. Of that group, two students developed active TB requiring bed rest for an extended period. They both survived, one dying later from unrelated carcinoma.”

What the Betlachs, Arvin Weinstein ’44, Lorraine Schultz-Sherman ’44, Charles Larkin ’49, Ann Bardeen-Henschel ’45, and James McIntosh ’47 all remember from their experiences as senior students at Statesan was the total dedication and clinical preoccupation Dr. R. H. Schmidt, Jr. had toward the well-being of the patients and the teaching of medical students in the art and science of their care. But William V. Luetke ’42 recalls, “It was the summer of 1941 and I have no fond memories of Statesan. Dr. Schmidt was in charge and his second in command was Dr. John Russo. Dr. Schmidt was a taskmaster and disciplinarian. On our arrival he stated, ‘We expect you to stay on the grounds at all times, study, review the X-rays, etc., etc., so you will appreciate the life a TB patient has to live.

“There was a tavern over the hill in Wales where the nurses and ancillary staff convened every night to forget Statesan. Bill Pollard was my partner and we immediately found the place.

“The therapy for TB was very simple and current at that time. Thoracentesis (air injection into the pleural space to collapse the affected lung) and, for advanced cases, thoracotomy (rib resection and then pressure to collapse the apex of the lung) was performed. Dr. Joe Gale came once a week from our medical school to do the surgery and we students got to scrub in and assist at the operations. I remember only one patient, a pretty young blond. I am wondering now what ever happened to her, if she got well or what.

“As I recall, the food was good and we had nice rooms provided. It was not a happy place or a very nice disease. Pollard and I were happy to get out of there.”

**I**n contrast to Luetke, Arv Weinstein waxes almost poetic as he reports, “My recollection of Statesan somehow summons up images of a Shangri-La-like mythical haven in a verdant Wisconsin landscape. The sanatorium nestled on a gentle hillside in a setting of mature trees and well-kept lawns. Presiding over this little fiefdom was Dr. Schmidt. His reserved and authoritative manner and well-rehearsed briefings left little doubt about our responsibilities and duties. We examined new patients, and reviewed cases with Dr. Schmidt on rounds and at conferences. The work load was not really very demanding and there was plenty of time to soak up sunshine and relax in the shade.

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As many will recall, Statesan was a group of institutional buildings situated on top of a hill bordering the north side of Highway 18, a two-lane road which, at that time, was a main route from Milwaukee to Madison. It was located in a sparsely inhabited rural area just west of the Waukesha city limits. The juncture of the short uphill road to Statesan with Highway 18 was marked by another significant, though smaller institution, known as Sig’s Bar & Grill, a place of *gemuetlichkeit* and distinction, as we were to discover later.

At Statesan we were under the guidance of two physicians who were in residence there. They were in their mid-thirties or early forties, pleasant and instructive fellows who freely gave us all the information we desired, and placed few demands on us. Our daily routine consisted of morning rounds, reading stacks of X-rays and informally discussing the cases as we read them, observing some procedures, mainly pneumothorax and pneumoperitoneum, and, novelty of novelties, free time - usually devoted to an afternoon nap. This was, indeed, a rare and most welcome form of R&R, albeit on a rather somber background.

**. . . the diagnosis of tuberculosis was really a terrible pronouncement at that time. It meant being yanked out of society, away from all one held near and dear-loved ones, friends, career, livelihood—and being placed at total bed rest for a period of months to years.**

In those days there was no specific therapy for tuberculosis. Treatment consisted essentially of isolation, bed rest (staged from absolute to ambulatory as the patient improved), fresh air, a nutritious diet, and the principle of rest of the affected part. This was manifested, other than bed rest, as various forms of temporary or permanent collapse therapy of the lung, mainly pneumothorax, pneumoperitoneum, phrenic nerve crush, and thoracoplasty. I suppose we were all, as a society, accustomed to living with the specter of the disease in those days, but the diagnosis of tuberculosis was really a terrible pronouncement at that time. It meant being yanked out of society, away from all one held near and dear-loved ones, friends, career, livelihood—and being placed at total

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and waited with the phone glued to his ear. After what seemed an interminable length of time he slowly hung up, gradually turned around in his chair and said in a low, anguished voice, "God, I'm sorry!"

I never forgot that incident nor that sentence. I had pulmonary tuberculosis, T-B, consumption! It was minimal they said. Here in 1942 only bed rest, fresh air, and plenty of good food were known to arrest the disease. Pneumothorax was available. For advanced cases a mutilating thoracoplasty like we watched Drs. Tony Curreri and Joe Gale do at Statesan was an option. There were some reports that promin, a sulfa derivative, might be of help.

I was to graduate in June and then serve an internship at Alameda County Hospital in California. The country was tooling up for World War II. I had already committed to the medical corps after internship and was working with Dr. Joe Evans to get my classmates to do the same. My brothers were already in the war. My mother had broken up housekeeping and left Madison. My family was gone. I was broke. I was bunking and boarding at the home of my best friend, gratis. They hustled me to bed in isolation at the Student Infirmary. My uncertain odyssey with an ugly disease began.

I had three visitors that first day. A resident came to do gastrics. He approached the task like a bull charging a matador. After a number of abusive efforts, I demanded, "Give me that tube. I'll put it in myself. It took awhile to really relax and breathe easy. With watering eyes, much salivation, and an occasional long restful pause, I slowly slipped that small red rubber tube through my nose into my stomach. I did my own gastrics ever after.

The second visitor was a pudgy county welfare nurse. She wore a mournful expression, bangs, and a short sleeved, dark blue uniform with white collar and cuffs. She sadly recounted my sorry plight, that I had no options but to enter a sanatorium and furtively assured me that the State would pay for my care. At the end, she also assured me that I would like Lake View Sanatorium—hardly a cheerful consideration.

Dean William S. Middleton appeared next. With genuine compassion he said, "General, you're in a difficult position." He explained that ordinarily a student would repeat the entire fourth year. Because I was so close to graduation he gave me another option. He said he would pick an examination panel. They would appear in this

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*I can still see those patients sleeping outdoors with no heat, on the porches, covered in blankets. Covered in snow, too, blowing through the screens. I shiver now thinking of them.*

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"It was a sobering experience to become acquainted with some of the men and women who suffered from advanced pulmonary tuberculosis and faced many months and years of sanatorium care and often major pulmonary surgery. Their life circumstances stood in sharp contrast to ours. The experience in this out-of-the-way corner of the medical world and its isolated community of patients and their medical attendants still linger in my memory. We did indeed carry away many lasting impressions from this exposure to the microcosm of the tuberculosis sanatorium."

**L**arry Hogan remembers, "An embarrassing episode involving me occurred during a Saturday morning session reading X-rays with Dr. Schmidt. I experienced a bout of coughing and Dr. Schmidt urged me to suppress the cough saying, 'A cough begets a cough.' I replied that I might have a cold and a fever, too. Dr. Schmidt thereupon strongly recommended that I rest in my quarters for the weekend. However, I had planned a trip to Milwaukee and I urged one of my partners, Bob West, to accompany me on the back path so we could avoid passing in front of Dr. Schmidt's house as we sneaked away. Emerging from the bushes, we came face-to-face with Dr. Schmidt watering his back garden, much to Bob West's amusement."

**Bob West** had his own embarrassing time later that weekend. While visiting his wife Pat in Chicago, he was stopped by the Navy Shore Patrol for traveling without written orders. As an Army enlisted soldier (like most of his classmates in that wartime period) he was subject to military regulations. Fortunately, a phone call to Statesan convinced the patrol that he was not AWOL and they let him go on his way.

My own recollections of my student days at Statesan with my partners Larry Hogan, Max Smith, and Bob West, are of experiencing a continuous low-level of anxiety over the probability of developing the disease myself. I compensated by wearing two surgical face masks, one on top of the other, while working with patients. It made breathing a little more difficult but I foolishly thought I was more secure.

Two patients come to mind, one a baker and the other a burlesque queen. The baker was a new patient and as I performed his physical examination prior to admitting him to the ward I was subjected to much verbal abuse and hostile behavior. He was seething with anger over having been "sentenced" by a county judge to "confinement" in the sanatorium. He had active TB with open pulmonary cavitation and sputum highly laden with tuberculous bacilli. He coughed repeatedly without shielding his mouth and with no regard for the people around him. He was angry first because he had the disease and secondly because his privacy and freedom had been invaded by the court order committing him to Statesan. He had refused medical instructions to stop working in food preparation and in serving the public; therefore, the county health department had him restrained from spreading his disease by having him sent to the sanatorium. He was indifferent to my explanations of why the general public needed to be protected. I couldn't help but feel sorry for him but I felt much more sorrow for the countless number of his customers whom he had exposed to his killer disease.

The burlesque queen was a 30-year-old dancer with well advanced tuberculosis who repeatedly refused to submit to the recommended but very disfiguring rib

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TB TREATMENT IN THE 40s

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resecting thoracotomy surgery. She was a tall, good looking, cheerful lady who harbored the hope that she would once again be able to return to work as a show girl. Fortunately, the vigorous occupation of a chorus-line dancer endowed her with very strong abdominal muscles. Dr. Schmidt yielded to her pleadings and depending on the strength of her abdominal wall resorted to treating her with non-disfiguring weekly pneumoparacentesis abdominis. This was infusions of air into the abdominal cavity in order to force the diaphragm higher into the thorax thus partially collapsing the diseased lungs. From time to time, I have wondered how those two very different patients fared.

**M**y partners and I also found Sig's Bar complete with his pet black bear in a metal cage out in front. We spent many an evening there relaxing over a beer while visiting with several of the sanatorium support-staff personnel. They lived at Statesan in the employee quarters and, although we never asked them about it, we knew they all were former patients. I vividly remember one as a 40-year-old pleasant woman with collapsed chest from rib resections only partly disguised with padded clothing. Another was a seemingly happy young girl in her 20s with a sparkling sense of humor and bilateral oleothorax (intrapleural injection of oil in order to compress the diseased lungs). They, like Dr. Schmidt himself, had survived the disease and had dedicated themselves to caring for its other victims.

**Dorothy Betlach** remembers that she and her partner Rosie Carlsen were at the Statesan at Christmas time. "We were housed on the hill with the nurses in an old, spacious house with a fireplace while the fellows, George Benish and Gene Betlach, had a very sparse, cement block walled building. We mentioned to Dr. Schmidt that it would be nice if we had wood for the fireplace. Within a day, he had wood delivered to the house."

In the spring of 1949, **Charley Larkin** was assigned to his student rotation at Statesan. He was there with classmates Bill Hayden, Sherm Holvey, Fred Krumenacher, and Doris Kuehn. He recalls while there that he encountered a

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In many ways the diagnosis was like receiving a prison sentence for these patients, even worse in some respects because it meant no physical activity, little social interaction, being kept physically and even visually remote from all others, living in a regimented environment.

bed rest for a period of months to years. In many ways the diagnosis was like receiving a prison sentence for these patients, even worse in some respects because it meant no physical activity, little social interaction, being kept physically and even visually remote from all others, living in a regimented environment controlled entirely by a medical staff of strangers, and living every day with a capricious and incurable communicable disease and all of the implications that go with it.

It was because of the severity of the disease itself, the extremity of the measures necessary to control it and the huge financial impact of both, that institutional care was established by various levels of government on behalf of the people afflicted. The State of Wisconsin was one of the most progressive in this respect. Statesan was one of four tuberculosis sanatoria set up by the state. In addition, there were some county institutions and others established by the federal government, particularly by the Veteran's Administration after WW II. Fortunately, the development of specific antibiotic regimens and great strides in thoracic surgery over the next four years resulted in dramatic therapeutic improvements by the end of that decade. The introduction of Streptomycin and para amino salicylic acid (PAS), and surgical advancements to permit resection of the affected lung tissue once the disease was quiescent, meant that, for the first time, tuberculosis could be not only attenuated, but actually cured. Only a couple of years later, in the early '50s, the addition of isoniazid hydrazid (INH) to our specific armamentarium provided a second medication which, like PAS, could be taken orally, now opening the possibility of ambulatory treatment using a two drug regimen. This marked the beginning of the end of institutional care of the disease, and by 1960 tuberculosis sanatoria were a thing of the past. Newer and better specific medications have become available from time to time since then

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room on an unannounced day and conduct a final oral examination. If I passed the exam, they would forgive the remainder of the final quarter and I would graduate with my class. If not, I must take the entire fourth year over again. I accepted his generous offer. What could I lose. There was little time to prepare so I didn't even try. Instead, I read Ralph Major's *Classic Description of Disease*, a treasured gift from my classmates.

In the afternoon, about ten days later, a hospital orderly surrounded my little white island with chairs. In marched Drs. Middleton, Lemmer, Thornton, Herring, Wirka, Gonce, Mortenson, and Tatum. I was nervous and tense but I found it was a lot easier to relax while recumbent in bed than it had been in other examination settings. They grilled me for what must have been two and a half hours. It was some time later, after I was settled in Lake View San, that I learned through the mail that I had passed. When June came it was a trying, lonesome time listening to the graduation exercises of my class on radio station WHA.

I saw my X-ray film for the first time. There was TB, all right. They offered me pneumothorax. Luckily I refused. I began that long stretch. They fattened me up with food and at least a quart of milk a day. I never got out of bed. I slept a lot. Even in the subzero temperatures of winter, I learned to sleep comfortably between layers of newspapers stuffed between the sheets and covered over with a couple of blankets.

Visitors rapidly disappeared. I can name and number the few. It was safest to avoid TB patients; avoid even going near, let alone into a sanatorium. Don't stand too close. The San is too far out. Nice postcards and letters took the place of visitors as did books such as *The Short Stories of Saki* by H.H. Monroe from the girl I left behind. There was always *The Physiological Basis of Medical Practice* to fill in the time. I read it from cover to cover.

The grapevine in a san is fine tuned. One learns quickly who are the dead and dying and much more. Many whom I came to know died during that year. Barbara, a cheerful, attractive, auburn-haired, healthy appearing teenager didn't last six months. Jim Foley was a furtive, soft spoken, nice guy about fifty. He only visited through my open door. He was short of breath and looked gray. He was married and talked about going home. He never made it. Norby was a typewriter salesman in his forties. He was the typical outgoing, gregarious, salesman type, good

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DOWN AT THE "BLACK BEAR"

*After hours, we walked down the road to the local saloon where the bear was tethered. We fed him, keeping a wide circle.*

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patient who had been a schoolmate of his in high school. "She had been at Statesan for a year and a half and was soon to be considered for release as her X-rays were stable and all of her sputa and gastric specimens were negative. We did get to talk about the impact her illness had made on her life. She was just 21 years old when she was initially diagnosed."

Under Dr. Schmidt's tutelage, Charley believes the medical students thoroughly learned the epidemiology and natural history of tuberculosis as well as other pulmonary conditions such as histoplasmosis, blastomycosis, and coccidiomycosis. The Statesan experience was a very good, practical, hands-on experience to many infectious pulmonary diseases.

**L**orraine Schultz and her partner Mary Helen Coenen-Chamberlin '44 both fondly remember Frank Zaic and his pet bear. Mary Helen tells us, "After sublime training at the sanatorium came the ridiculous. After hours, we walked down the road to the local saloon where the bear was tethered. We fed him, keeping a wide circle."

Lorraine remembers the bear too. "Because we had so much free time, many of us became friends with local citizen and character Frank Zaic who had a bar near the Statesan and had a pet bear cub in a pen outside his bar. He let some of us feed the bear! I still have a snapshot of Mary Helen Coenen, Art Scherbel, and myself (we were the team at the time) along with Art's wife Eleanore feeding that bear."

Lorraine best recalls the large wards of patients where curtains could be pulled between the beds for some privacy. "There were the ever-present sputum cups in which patients were to collect all the sputum they coughed up. It was a nasty, grey-green, foul smelling, necrotic gunk. Those rattling coughs left the patients even more exhausted than they usually were.

"So many of the patients were very pale, sickly, and emaciated looking. They were confined to the Statesan for many months, sometimes for years, of bed rest and nutritional therapy to 'arrest' the TB disease process so that the patient could go home. There were no antibiotics nor any other effective medications available at that time.

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*So many of the patients were very pale, sickly, and emaciated looking. They were confined to the Statesan for many months, sometimes for years, of bed rest and nutritional therapy to 'arrest' the TB disease process.*

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"For some patients, a phrenic crush was done to collapse a lung as a first procedure. But since this often was ineffective, it was usually followed by pneumothorax and/or thoracoplasty. The procedure mutilated the patient's chest so that they had a caved-in appearance both anterior and posterior for the rest of their lives. We students viewed the chest X-rays with the staff to check on the disease process or the effectiveness of the pneumothorax or thoracoplasty surgery in collapsing a diseased lung."

Although **Ann Bardeen-Henschel** missed being at Statesan as a student because of illness, she well remembers her weekly trips there as an anesthesiology resident physician at Wisconsin General Hospital. "I would accompany Dr. Joe Gale and Dr. Tony Curreri on the drive from Madison to Wales for the weekly sessions of thoracoplasties. One of the compensations was the good hot lunch served when we were done. Cyclopropane was commonly used as the anesthetic of choice as it allowed a rapid induction and recovery."

**Leroy Misuraca** '45 is another of our schoolmates who became a victim of the disease. He reports, "Tuberculosis was always in the background, not something we personally thought about every day, but certainly a popular disease of medical students. We could be sure that a certain number of every class would inevitably develop TB. I was surprised to be one of them."

"Remember, we were at the beginning of antibiotic therapy - sulfas and the introduction of penicillin - but nothing for TB. We had to consider that every patient might have TB, but today's concept of universal precautions was unknown. Remember also, in those days the whole specialty of pulmonary medicine was devoted almost exclusively to the care of one disease. The American Lung Association was known then as the TB Association. At Wisconsin General Hospital, Dr. Helen Dickie was up on the top floor with the TB patients. We all wore masks and hoped we would be safe."

"University of Wisconsin medical students who did not have a positive tuberculin skin test were inoculated with Bacillus Calmette Guerin (BCG). I don't remember whether BCG was voluntary, because I was positive. TB was important enough in the curriculum to have its own rotation at the TB sanatorium at Statesan near Waukesha. My group was there in January or February. I can still see those patients sleeping outdoors with no heat, on the porches, covered in blankets. Covered in snow, too, blowing through the screens. I shiver now thinking of them."

"After graduation I interned in Oakland, went of course into the Army and was fortunate enough to be the chief of anesthesia (thank you, Dr. Waters, et al) in Luzon at a hospital which is now under Mt. Pinatubo's ashes. After a year or so I developed pleurisy for no good reason anyone could determine and was shipped back to Letterman in San Francisco where I took my X-rays downtown to Dr. Seymour Farber, I believe, who saw the dreaded 'spot' no one else had seen. On to Fitzsimmons Army Hospital in Denver, the Army's TB facility. After a year there I was 'cured' and discharged. I met some wonderful people and had a good time at 5000 feet. The main treatment was afternoon naps, quiet hour. But some of our ward mates never walked out."

"One of the friends was discharged at the same time as I. Since I couldn't start a residency just then, we decided to drive to Mexico. I noticed that cerveza went

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and the range of antibiotic choices has continued to improve, thanks to a lot of dedicated researchers and the funds that support them.

In the face of all of this remarkable progress it is nonetheless important to continue to bear in mind how devastating this disease can be, and to avoid the pitfalls of both undertreatment and laxity in contact identification, adhering to follow-up and other measures to control its communicability. Tuberculosis continues to be an important disease worldwide, especially in underdeveloped countries. Surprisingly, considering all that we know about the disease and its treatment, there are current indications that it is on the increase even here, in the United States. Evidence of increasing drug resistance would seem to call for greater attention to adequacy of dosages, completion of full courses of medication as prescribed, and proper follow-up to assure patient compliance. Considering further the growing global prevalence of AIDS and the enormous expansion of world travel, it clearly follows that complacency in dealing with this disease must be assiduously and energetically avoided.

**... complacency in dealing with this disease must be assiduously and energetically avoided.**

At Statesan we "suited up" for morning rounds every day, changing gowns each time we moved from one to another of the graded barracks. Patient beds were aligned in long rows on enclosed porches. The large porch windows were kept open to provide the fresh cold air environment that was considered to be an important element of treatment. The patients, themselves, clad in hooded sweat suits or their equivalents, were virtually buried in piles of blankets. In general, patient attitudes were remarkably stoic. They seemed to derive a subtle strength from each other in a quiet camaraderie. Strangely enough, there was little evidence of depression. On the contrary, the prevailing tone among both patients and staff seemed generally to be a subdued kind of optimism. After all, from the staff point of view, we did have treatment to offer and, though it left much to be desired, it was effective far more often than not. Furthermore, we were confident that it was the very best treatment available at the time.

Jack and I hated to ask the patients to lift their shirts in that Arctic air to allow us to

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**I learned at a young age that tuberculosis was a dreaded disease. Like syphilis, it was talked about behind closed doors or in hushed, secretive tones. Victims of the tubercle bacillus were avoided, even after cure. I was told when riding past a tuberculosis sanatorium, "hold your breath."**

sense of humor, religious, and positive about everything but his future. He had already been in the san five years. His right upper lung was scarred and had two huge cavities and another smaller one. His sputum never converted to negative for tuberculous bacilli. He lived in a kind of symbiotic relationship with his disease. He had a pretty young wife—Deetz, he called her. They had three little children. Norb visited with his family from the porch of his second floor room to the lawn below where they appeared twice a week without fail to cheer him on. That was as close as they ever got. I was most fortunate by comparison.

After nine months, it looked like my TB was quiescent and I was allowed to ambulate. That was a high point. Walking returned slowly. I had muscle wasting from disuse. Balance was unstable because of pain in the feet and the Achilles tendons. They set me to work collecting blood, doing lab work, reading sputum slides, and studying X-ray films with Dr. John Russo. I sensed they thought I would make a good tuberculosis specialist. I wanted no part of that. I did not want to become institutionalized as happens to many who recover.

On my first day of leave, in April of 1943, I went to see Dr. Evans at the medical school and told him I wanted to go to work somewhere—anywhere. He highly recommended a little group of excellent doctors up north in Marshfield where the hospital needed an intern badly. I agreed to go. I got hold of my brother's '37 Ford, which he had stored for the duration of the war, and drove to St. Joseph's Hospital, Marshfield, Wisconsin, where the nuns and doctors welcomed me with open arms.

I worked hard doing histories and physicals, making rounds, holding retractors and delivering babies. The nuns knew I had just recovered from TB, and they worked diligently to make sure that I was well cared for. When either Dr. Middleton or Dr. Ovid

Meyer came to check on the preceptor program, they took me into an exam room and examined me thoroughly. I felt a little awkward among the other house staff.

The quality of medical practice was high in Marshfield. I liked the doctors and enjoyed the work. I took the State Board exams. I wooed Vi, a pretty blonde lab technician, but I made certain she knew I was a victim of tuberculosis and understood the risks. After I was convinced that she did, we married the following April, 1944. I remained on at St. Joe's as a medical resident. That spring I was frightened by transient radiographic changes occasioned by a bad case of the flu. I was assured that it was nothing to worry about! But I did. It hung over me like the sword of Damocles.

The war had reduced the clinic staff. The remaining clinic obstetrician had a myocardial infarction in early January, 1946. I was asked to fill in for him. There was no one else available with experience. My wife, one of his patients, was a primipara due about the middle of March. In mid-January I hospitalized her with signs and symptoms of pre-eclamptic toxemia. It became my hideous responsibility to manage her care until early February when the clinic obstetrician got back on his feet. He decided that she should have a Caesarean section. In surgery on the twelfth, a four-pound three-ounce premature boy was delivered. Vi's post-op recovery was long and difficult. So were the early weeks of life for our infant son. I continued working throughout this time and besides moved our furnishings to a larger apartment. Physical and emotional stress were heavy.

By May my tuberculous lesion broke down, had become active again. There still was nothing new in treatment. We had a nice screened porch off of our second floor apartment. Dr. Anderson thought it was satisfactory to "take the cure" at home. Our landlord was sympathetic too. His sister had spent several years in a sanatori-

um. She almost died. Fortunately, the clinic placed me on their sick leave income program. So I went to bed again. At least I was at home. I could enjoy my infant son at a distance. I read *The Physiological Basis of Medical Practice* from cover to cover once more.

After nine months the lesion stabilized and I returned to work "part time." One of the lessons I learned was that in the practice of medicine there is no such thing as "part time." There were physicians in the group who now felt that I was a poor risk for membership because of my TB history. I didn't blame them. I had serious doubts about my future too.

Doubts became reality in 1949. My tuberculosis became active a third time. But now medical science was ready for it.

Streptomycin had been discovered and PAS (para amino salicylic acid) was being used. I took eight of those pills at a time and Vi gave me streptomycin shots in the rump twice a week for a year and a half. I kept right on working. My mouth got numb and my ears rang and my lung cleared. I have not had any trouble since. But I haven't forgotten.

I was one of the lucky ones. It cost me only two years of productivity and a lot of worry. With the advent of many effective antibiotics and improved surgical procedures the scourge of pulmonary tuberculosis and its horrid complications could be wiped out. For example, remember Norby? He continued to live until streptomycin and PAS came along. With it his sputum became negative and after ten years they were able to resect his right upper lobe. Following surgery he returned to his family, and to his work as a typewriter salesman, saw his kids educated and married. Ultimately, he died from a myocardial infarct. Deets, his lovely wife, is alive today in her nineties.

History is full of the lives of great and small people who were wiped out by a centuries-old killer disease, tuberculosis. Today it seems to have been largely forgotten. There are rumblings in the distance. Resistant forms of the organism are emerging along with HIV disease and infecting others. TB may once again appear as the great white plague, the waster of life.

*But even today, I'm holding my thumbs, wondering when, if...*

*How discouraging to see the lessons of history ignored, the resurgence of the white plague, quietly waiting for us to let down our guard.*

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through me fast, fast, fast, and often, compared to my compadres. Back in Milwaukee at the Veterans Administration Hospital I was diagnosed as having genitourinary tuberculosis. Another year, X-rays, streptomycin, PAS, vasectomy, orchiectomy, ototoxicity, and 'cure.'

"So that's a story of two TB-lost years. Thanks to antimicrobials better than ever before in history, I'm still alive. But even today, I'm holding my thumbs, wondering when, if ...How discouraging to see the lessons of history ignored, the resurgence of the white plague, quietly waiting for us to let down our guard."

For the past 40 years we as a people perhaps have been living in a fool's paradise regarding the control that medicine, sanitation, and public health have had over infectious and communicable diseases. Unlike HIV infections and AIDs, tuberculosis and most other communicable diseases have not been politicized by supposedly well-meaning but certainly misguided, self-interested activist groups. The resurgence of TB, now frequently in its drug resistant form, is causing us once again to depend on the too often neglected principles of public health and sanitation as the first lines of defense in restricting its spread to the general population. It brings to mind the admonition by G. K. Chesterton, "Don't take a fence down until you know the reason it was put up."

The Center for Disease Control and Prevention, putting AIDs in statistical perspective, reports that tuberculosis is the world's top infectious killer, claiming 3 million lives each year and sickening 8 million annually. In the opinion of Dr. Charles Wells, a CDC medical epidemiologist, lack of compliance by tuberculosis patients in taking anti-tuberculosis drugs, such as rifampin and streptomycin, for the required period of several months prompts tuberculous bacilli to develop resistance to the drugs and become harder, if not impossible, to destroy.

Milwaukee reported 42 new cases in that city for the year 1995. Although many states no longer have tuberculosis sanatoria, Dr. David R. Smith, former Texas Commissioner of Health, states that Texas still operates two sanatoria at 85% to 90% capacity with as many as 12 patients quarantined with TB resistant to as many as five different antibiotics.

The problem of drug resistant TB is particularly severe along the Mexico border with California, Arizona, New Mexico, and Texas where drug resistant TB is present in a greater percentage of the population than elsewhere. A CDC study has found that Mexican-born Hispanics with TB were five times more resistant to the anti-TB drug rifampin than are whites, while Hispanics born in the United States were 3.2 times more resistant to the drug than whites. Both Hispanic groups were twice as resistant to streptomycin as whites. The CDC reports that TB cases among Hispanics now living in the United States have jumped 61% from 4,925 cases in 1986 to 7,930 cases in 1995. People born in Mexico made up 8% of the 22,860 tuberculosis cases in the United States in 1995. Most lived in border cities, according to the CDC<sup>1</sup>.

The resurgence of the white plague reminds us of the words of those two popular cartoon philosophers, Rocky and Bullwinkle, "What was, is."

<sup>1</sup>Some Hispanics Show Resistance to TB Medicine, Associated Press, Atlanta, Lubbock Avalanche-Journal, November 30, 1996, Lubbock, Texas.

The *Quarterly* thanks Cathryn Buessler for her considerable efforts and expertise in preparing this article.

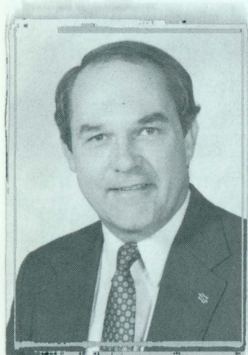
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examine their chests, but they were always pleasantly compliant, and we really did manage to visualize, palpate, percuss and auscultate all of the physical diagnostic signs in the book. In fact, we were exposed to enough clinical material to have invented a few clinical signs of our own. Later, Jack and I were grateful that one of the things we did not get to do was to observe at a postmortem examination there. We learned subsequently that a few of our classmates had come down with the disease afterward, probably from attending a postmortem during their stay at Statesan. Happily, they all recovered and all went on to successful careers, proving that you can't keep good people down.

**We soon discovered that things moved "exceeding slow" in a chronic hospital such as this. Decisions were made with snail-like deliberation,**

In any event, we soon discovered that things moved "exceeding slow" in a chronic hospital such as this. Decisions were made with snail-like deliberation, it seemed, and we found ourselves with plenty of time to read, sleep, and even get bored. Enter, Sig's Bar and Grill. Just a short, stimulating walk down hill in the brisk winter air and there was this neon encased, wooden roadside structure, a haven in the snow promising warmth and the friendliness of its proud owner. On our first trip down to Sig's a few evenings after our arrival I remember noticing a crude sign in front of the place advertising BEARBURGERS, which peaked my curiosity for several reasons. Could this be the same place I had noticed during one of the few automobile trips I had taken between Madison and Milwaukee in the past? The place that used to display a sign inviting tourists to stop in and see the pet bear? Could this be the same bear? What were the circumstances of its demise? Did it die a natural death? Wonder how bear meat tastes.

Well, kindly old Sig quickly put our minds at ease. Yes, it was the same bear. Yes, it was healthy - too healthy. He had to put it down because it got to be too hard to handle. And, the bearburgers were good, Jack and I agreed, not at all gamey. They went very well with the extra round of beer Sig bought us. We marveled at Sig's Yankee ingenuity—making a living off his pet bear, dead or alive. We dropped in many nights after that.



*Philip Farrell, MD, PhD*

The Annual Milwaukee Alumni Board Meeting, reception, and dinner in February provided a wonderful occasion to share with our Milwaukee colleagues many of the exciting projects and events of the UW Medical School. Compared to the meeting in February '95, when the temperature dipped to -360, it seemed like summer.

The main topic of the Board meeting focused on how to garner assistance and support for legislative approval of our \$150 million HealthStar Partnership Proposal. As you know, HealthStar will resolve critical facility deficiencies of the Medical School and advance health sciences learning and research, both basic and clinical. The project consists of two major facilities, an Interdisciplinary Research Complex (IRC) and a Health Sciences Learning Center (HSLC) which, if approved, could be occupied as early as 2002.

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*... the Board agreed to sponsor jointly with the UW Medical School an evening reception and welcome celebration for this year's graduates. ... It will provide a great opportunity to welcome our newest MDs.*

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Members of the Alumni Board enthusiastically agreed to contact their legislators to let them know how much they support the HealthStar Partnership. Board members urged my office to contact some of you who live in the key districts to see if you might be interested in contacting your legislative representatives in support of HealthStar.

In addition to helping us with HealthStar, the Board agreed to sponsor jointly with the UW Medical School an evening reception and welcome celebration for this year's graduates. The reception will follow the official UW-Madison graduation ceremony and include significant others, parents and relatives. It will provide a great opportunity to welcome our newest M.D. Alumni into the Medical Alumni Association. The students are excited and grateful to you and, of course, will be delighted if some of you are able to attend as well. Jim Griffith will provide you the necessary information.

Following the Board meeting, UW Medical School Alumni from the Milwaukee area and faculty from our UW Milwaukee Clinical Campus joined us at the Milwaukee Public Museum. A large, colorful poster presentation filled with information about our Robert Wood Johnson Health Professions Partnership Initiative with the Milwaukee Public Schools greeted us at the registration table. This project, part of the national program supported by the Association of American Medical Colleges and the Robert Wood Johnson Foundation, is a major new initiative of the health professions schools at the UW-Madison and UW-Milwaukee and will greatly enhance our ability to increase the number of minority medical students, particularly those from Wisconsin.

Leaving the registration area, we wandered through the Museum's "Streets of Wisconsin"

### **Annual Winter Meeting**

Medical Alumni and guests gathered Saturday evening, February 9 at the Milwaukee Public Museum for the WMAA annual winter meeting. A reception was followed by dinner.

Dean Philip Farrell presented a Medical School update, and Professor and Chair of Psychiatry Ned Kalin gave an overview of "Health Emotions," a relatively new area of exploration into the role of emotions — especially positive ones — in disease and health. Dr. Kalin directs the interdisciplinary HealthEmotions Research Institute, devoted to basic and clinical research on brain mechanisms that underlie emotions and how they influence bodily systems.

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*With the establishment of the first preceptorship in 1926, the UW Medical School, in keeping with the Wisconsin Idea, initiated a strong tradition of using the rich resources of the state to provide unique educational opportunities for students.*

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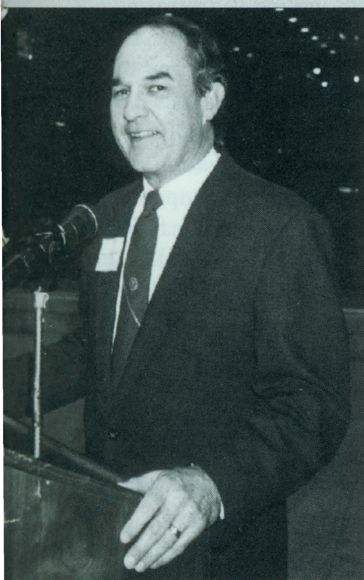
exhibit which provided a delightful, hospitable setting to mingle and talk with our UW Alumni and colleagues from our UW Milwaukee Campus before dinner. We were pleased to meet with many of our faculty from UWMCC.

We value our affiliation with the Milwaukee campus and appreciate the unique and diverse experiences the teaching faculty give to the education of UW medical students. Evidence of this is in the number of students that receive some part of their third and fourth year clinical training in Milwaukee—from 41 students in 1974 to now 160 in 1996. One of our goals is to continue to strengthen our programs and communications between the two campuses and all of our state-wide affiliations. With the establishment of the first preceptorship in 1926, the UW Medical School, in keeping with the Wisconsin Idea, initiated a strong tradition of using

the rich resources of the state to provide unique educational opportunities for students.

I look forward to seeing you at our Annual Alumni Weekend in May. A full array of activities are being planned starting with Class Reunions, Receptions and Dinners and ending at the Chancellor's House for Breakfast on Sunday morning. A special dedication of the new student garden lounge is planned at the Medical Sciences Center on Friday afternoon and tours of the other remodeled student lounges, for which you so generously contributed your funds, will also be available for viewing.

With your continued dedication and commitment to the UW Medical School, we will continue to make progress toward our goals. Thank you for your support.



*Left: Dean Philip Farrell addresses the Medical Alumni at their winter meeting.*

*Right: Assistant Dean Gloria Hawkins chats with Dr. Ned Kalin, Chair of Psychiatry and speaker at the WMAA winter meeting, and his wife.*



David C. Riese '68

## Dr. Bucky Badger Needs Your Help

**A**t the winter meeting in Milwaukee, the board of directors has taken steps to allow the Association to become more efficient and responsive to its functions. The term of President is now two years instead of one and members of the board may serve as long as the nominating committee believes they are productive, thus allowing for a greater continuity and still providing the influx of new members with new exciting ideas.

A new position is being created to better direct and organize the class representatives who in turn organize events and communication for each class. The need for the Alumni to become more efficient and active can be explained by reviewing the mission statement of the association which states, in part, "The Association mission shall be to organize the Alumni to stimulate among Alumni an interest in the University of Wisconsin Medical School, to supply financial support to the University of Wisconsin Medical School faculty and students, and to facilitate communication between the Alumni and the school and to promote free and friendly social and professional relations among Alumni, students and faculty."

In the last issue of the *Quarterly*, Dean Farrell's column expressed the dire need of a new combined research and education facility to be called HealthStar. I challenge each of you to support it both conceptually and financially. Start by evaluating your social and financial situation. If you were not a physician, it's very likely you would not enjoy the enviable position you currently have. You and your family are viewed as pillars of your community. You are asked to serve on the school board, the board of directors for the YMCA and financial institutions, and politicians always seek your support for their campaigns. When graduating from medical school, we all focus on the amount of debt we have generated during student days. What we fail to recog-

nize, is the fact we will not only be able to repay the loan but will also look forward to a new car and above average residence because, as a secondary benefit of being a physician, we will enjoy an income which places us in the top 5% of all wage earners.

We were able to receive our medical education because Bucky Badger provided a top-notch medical school for us to attend. Now it's time to help Bucky keep our school among the top in the country. First, please write or contact your state assembly and senate representatives and tell them how important these facilities are to enable the Medical School to fulfill its mission of meeting the future health needs of Wisconsin citizens. Secondly, one hundred million dollars of private money is needed to construct HealthStar. Our Alumni number 10,000 strong. If each of us would commit 10% of one year's income, \$10,000, to this project, we would have the necessary private support immediately, making it impossible for the politicians not to provide their full support. In the long term, I believe we should all support our alma mater on a monthly basis in the same manner we pay homage to the credit card, car or house. As little as fifty dollars monthly would provide the school with a constant influx of six million dollars yearly. Not only would you be expressing your gratitude for your education, you would be helping to ensure an adequate supply of well-trained physicians to treat you, your family, and neighbors in the future.



*We were able to receive our medical education because Bucky Badger provided a top-notch medical school for us to attend. Now it's time to help Bucky keep our school among the top in the country.*



James R. Griffith

## 1997 Medical Alumni Weekend

The Medical Alumni Weekend activities are one week earlier than last year. This will eliminate conflicts with the University of Wisconsin-Madison graduation and will allow more participation by Medical School students and faculty.

Eleven classes will have reunions in May: 1937, 1942, 1947, 1952, 1957, 1962, 1967, 1972, 1977, 1982, and 1992. The class of 1987 has elected

to have their reunion in July when more classmates will be able to return to Madison.

Medical Alumni activities will be the same weekend as the Wisconsin Alumni Association holds their reunions and Spring Days On Campus. We will participate in some of these activities and also have our own reunions, banquet and other special activities.

FRIDAY MORNING, MAY 9, activities will be located at the east end of campus. We are going to be joining the Wisconsin Alumni Association for Spring Day on Campus, a series of seminars featuring the University of Wisconsin's most dynamic and distinguished faculty and alumni. We also offer a variety of other activities for your enjoyment, including an alumni luncheon, a breakfast and scientific program, campus and Medical School tour, alumni reception and awards banquet and class dinners.

THE AWARDS BANQUET ON FRIDAY EVENING WILL HONOR Dr. Robert Metzberg and Dr. Charles C. Lobeck. Both will receive the Emeritus Faculty Awards.

Dr. H. Peter Chase, class of 1961, will receive our Citation Award for his outstanding work in children's diabetes. Dr. Mischa Lustok, class of 1935, will receive the Medical Alumni Service Award for his outstanding work with the University of Wisconsin Medical Alumni Association.

ALSO PLAN TO JOIN US ON SATURDAY MORNING, MAY 10, for breakfast and a scientific program. The program will highlight the work of Layton F. Rikkers, M.D., Chair and Professor of Surgery and Stuart Knechtle, M.D., Associate Professor of Transplant Surgery. They will speak on "Innovations in Organ Transplantation: A University of Wisconsin Medical School Legacy."

Please mark your calendar and plan to join us for a memorable Alumni Weekend. A more detailed program is enclosed in this *Quarterly*. If you want more information, please call the Medical Alumni Office (608) 263-4915 or access [www.biostat.wisc.edu/medalum/](http://www.biostat.wisc.edu/medalum/)

## ALUMNI WEEKEND SCHEDULE May 8-11, 1997

### Thursday, May 8, 1997

Class Reunions

### Friday, May 9, 1997

9:00-9:30 am

Registration & Coffee  
Below Alumni Center  
650 North Lake Street

9:45 am

Spring Day on Campus  
Wisconsin Center  
Continuing education seminars featuring our most dynamic and distinguished faculty.

12:15 pm

Wine Reception  
Lowell Hall  
610 Langdon Street

12:45 pm

50-Year Presentation  
Luncheon  
Lowell Hall

2:30 pm

Tours:  
Elvehjem Museum of Art or  
School of Veterinary Science

6:30 pm

Medical Alumni Reception  
Concourse Hotel  
1 West Dayton Street

7:30 pm

Awards Banquet  
Concourse Hotel

### Saturday, May 10, 1997

9:30-11:00 am

Alumni Breakfast & Medical  
School Scientific Program  
(CME)

Union South

227 North Randall  
Layton F. Rikkers, M.D.,  
Chair and Professor of Surgery  
and Stuart Knechtle, M.D.,  
Associate Professor of  
Transplant Surgery will speak  
on "Innovations in Organ  
Transplantation: A University  
of Wisconsin Medical School  
Legacy."

11:30 am

Campus and Medical School  
Bus Tour

6:30-9:00 pm

Middleton Society Dinner  
University of Wisconsin  
Foundation  
1848 University Avenue

### Evening

Class Reunions

### Sunday, May 11, 1997

8:30-10:00 am

Breakfast with Chancellor  
David & Judith Ward  
Olin House

130 N. Prospect Avenue  
(A special invitation and registration card will be sent with your confirmation)

*Class reunion information will be mailed separately.*



**In development, there is the belief that donors do not want to contribute to "bricks and mortar." As we continue our dialogue, we will focus on the reality that the HealthStar facilities will exist to advance programs. In the great Age of Discovery, ships were built to carry the Discoverers to the New World. Now, the HealthStar facilities will carry our Medical School into the 21st Century.**

### **HealthStar Facilities *and* Programs**

*By Mark Lefebvre  
Senior Director of Development*

**I**n an earlier column, I wrote about the partnerships that must exist in order for HealthStar to be successful. I stressed the important role that the Medical Alumni will play in ensuring success. I was also candid in my remarks that the Medical School must engage each and every one of you with its vision of the future.

While the months and years ahead will focus on the process of engagement, there is a critical point that I would like to make now: the future will be built on strong programs, but programs need a world-class environment in which to flourish. In our early discussions with alumni, many have viewed HealthStar as synonymous with facilities. The umbrella of HealthStar will encompass a strong commitment to programs. Yes, we need a new environment, a new building, in which to educate our students for careers in the 21st Century. The building, however, exists so the teaching can occur. The same can be said of the proposed research facility. We have an extraordinary faculty doing pioneering work in facilities that are inadequate.

In development, there is the belief that donors do not want to contribute to "bricks and mortar." As we continue our dialogue, we will focus on the reality that the HealthStar facilities will exist to advance programs. In the great Age of Discovery, ships were built to carry the Discoverers to the New World. Now, the HealthStar facilities will carry our Medical School into the 21st Century.

### **DEVELOPMENT REPORT**

#### **Medical School 1996 Major Donors**

- \$1,000,000 or more**  
Affiliated University Physicians
- \$500,000 or more**  
Donald Hedberg  
Geraldine Hedberg  
Surgical Science Foundation
- \$200,000 or more**  
CapCure  
Oscar Rennebohm Foundation, Inc.  
Sinai Samaritan Medical Center
- \$100,000 or more**  
Abbott Laboratories-Ross Products Division  
Donald W & Marilyn Anderson  
John Williams Doolittle  
Paul O. Madsen  
University Radiology Association  
Vannita Lucile Wesely
- \$50,000 or more**  
Allied International Holdings  
Donald E. Cheney  
Cynthia A. Crawford  
Garvin & Frances Cremer  
John J. Frautschi  
Genome Therapeutics Corporation  
Lora L. Marshall  
Oscar & Elsa Mayer Family Foundation  
Martha J. Okagaki  
UW Comprehensive Cancer Center  
Wyeth-Ayerst Laboratories
- \$25,000 or more**  
Roger E. & Jeanne De Meritt  
Glaxo Institute for Molecular Biology  
Charles H. Golden  
Robert Wood Johnson Charitable Trust  
Irving I. Moskowitz  
Milton & Lillian Peck Foundation  
SmithKline Beecham  
Jeffrey B. Soref  
Natalie Soref  
Betsy S. Trimble
- \$10,000 or more**  
American Medical Association  
Betty J. Bamforth  
Evelyn L. Baxandall  
Frederick J. & Mary M. Davis  
DNA Star Inc.  
Elan Pharmaceutical Research

## Middleton Society Members

The Society is formed to recognize its alumni, faculty, & friends who contribute a one-time gift of \$10,000 or \$10,000 payable over a 10-year period.

Eugene J. & Judith M. Flath  
 Grand Aerie/Fraternal Order  
 Joanne Haertle  
 John H. Juhl  
 Beatrice Kabler  
 Life Extension Foundation Inc.  
 Northwester Mutual Life Foundation  
 Harold L. & Jane R. Perlman  
 Pharmacia and UpJohn Company  
 Charles H. & Mary C. Phipps  
 Scott & Peggy Sampson Charitable  
 Foundation  
 Solvay Pharmaceuticals  
 Elizabeth G. Uehling  
 Helen M. Wasserberger  
 Marvin E. Watts  
 Wisconsin Lions Foundation/Rosholt  
 Myron Wojtowycz  
 Worldwide Charitable Trust

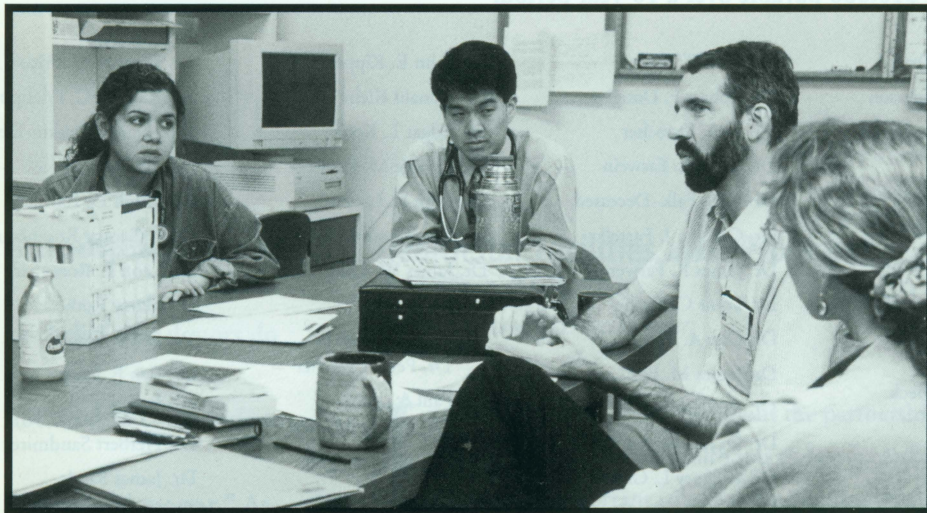
**\$5,000 or more**  
 Marvin H. Adams  
 Robert M. Bolz  
 Emy Brezinski  
 Cook Incorporated  
 Louis C. Fischer  
 Mark A. Fischer  
 James M. Fox  
 Pleasant Rowland Frautschi  
 Lloyd C. Furer  
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 John C. Mc Dermott  
 Medical Alumni Association UW  
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 Ocular Physiology Research Foundation  
 Nancy Pritchard Orbison  
 Wanda Luella Rood  
 Benton C. & Mary A. Taylor  
 David T. Uehling  
 Wisconsin Breast Cancer Coalition  
 Zonta Club of Green Bay

Dr. Daniel M. Albert  
 Dr. Charles J. Anderson  
 Dr. Richard B. Anderson  
 Dr. Mark &  
 Dr. Kelly Asperheim  
 Dr. Merne W. Asplund  
 Dr. Betty J. Bamforth  
 Dr. Ann Bardeen-Henschel  
 Dr. Barry V. Bast  
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 Mrs. Elinor Beck  
 Dr. D. J. Beltran  
 Dr. E. Maxine Bennett  
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 Dr. Dorothy Betlach  
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 Dr. Jean Chapman Born  
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 Dr. Alexander Braze  
 Dr. James W. Bringe  
 Deceased  
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 Dr. George T. Bryan  
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 Mr. Archie Budzaki  
 Dr. John A. Buesseler  
 Dr. Glen E. Burmeister  
 Dr. Robert D. Callahan  
 Dr. Ardis J. Candy-  
 Deceased  
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 Dr. Clarence P. Chrest  
 Dr. Manny N. Chudwin  
 Dr. Renee R. Coulter  
 Dr. James F. Crow  
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 Dr. Frederick J. Davis  
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 Dr. Richard K. Dortzbach

Dr. John W. Doty  
 Dr. Robert F. Douglas  
 Dr. A. A. Drescher  
 Dr. James L. Esswein  
 Dr. V. S. Falk-Deceased  
 Dr. Carolyn J. Farrell  
 Dr. James R. Ferwerda  
 Dr. Louis C. Fischer  
 Dr. Dan A. Fox  
 Dr. James M. Fox  
 Dr. William J. Fox  
 Dr. D. J. Freeman  
 Dr. Gregory L. Gallo  
 Dr. Susan L. Goelzer  
 Dr. Steven L. Goldberg  
 Mrs. Farrell F. Golden  
 Dr. Farrell F. Golden  
 Memorial  
 Dr. Richard S. Goodman  
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 Dr. Harold E. Gries  
 Dr. Thomas M. Grist  
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 Dr. Todd Hammer  
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 Dr. Peter G. Hanson  
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 E. Heggstad-Memorial  
 Dr. Roger E. Henning  
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 Dr. Marvin Hinke  
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 Mrs. Beatrice A. Kabler  
 & Family  
 Dr. Albert V. &  
 Mrs. Dolores Kanner  
 Dr. Anthony L. Karpinski  
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Dr. John E. Kippenhan  
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 Dr. George M. Kroncke  
 Dr. John R. Larsen  
 Dr. Roger Laubenheimer  
 Dr. James W. Long  
 Dr. Rolf Lulloff  
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 Dr. Peter Drescher  
 Dr. Paul &  
 Dr. Renate Madsen  
 Dr. George E. Magnin  
 Dr. Dennis &  
 Mrs. Gail Maki  
 Mrs. Laura E. Maki  
 Dr. Eric R. Marcus  
 Dr. Jacobs H. Martens  
 Dr. W. Bradford Martin  
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 Dr. Joanne A. Selkurt  
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 Mr. Marvin E. &  
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 Dr. Eugene L. Weston  
 Dr. Jon N. Winther  
 Dr. Wilbert Wiviott  
 Dr. Robert G. Wochos  
 Dr. John B. &  
 Dr. Sandra Lott Wyman



Top: Teaching conference at the end of a MEDIC Clinic.

Bottom: Some members of the MEDIC Council discuss an issue. From left: June Lewandoski, Kate Meyer, Stephanie Savage, Amit Bhargava and Linda Grossheim. (all are Med IIs).

**MEDIC**, the medical school's largest student organization, was established in 1990 with a dual mission:

(1) to help make primary medical care accessible to underserved individuals in Madison and (2) to enhance the education of UW medical students with exposure to diverse patient populations and presenting complaints. Since its beginning in 1990-1991, MEDIC has continually changed in an effort to forward its dual missions. In 1990-1991 the organization consisted of two clinics: Grace shelter clinic which serves homeless men who are staying at the Grace shelter, and the Salvation Army clinic which serves both adults and children who are staying in the Salvation Army shelters. In 1992, the second year of MEDIC, a third clinic, South Side, was established. MEDIC is a unique organization that is run through the joint efforts of student and staff clinic coordinators, physician medical directors, volunteer medical students, residents and physicians from both the UW medical school and the community, as well as paraprofessional students (physician assistant, pharmacy, social work, pre-medical). The number of physicians and students who volunteer for MEDIC is over 100 and 200, respectively. In addition to the on-site staff, student clinic coordinators, and physi-

### MEDIC Is Honored with National Award

The National Ambulatory Pediatric Association Health Care Delivery Award will be presented to the MEDIC Salvation Army Homeless Shelter Clinic on May 4, 1997 in Washington, D.C. at the Association's national meeting. This is the third year that the Association, an organization of academic general pediatricians, has given this award, which includes a plaque, a presentation at a national meeting and a \$500 donation to MEDIC.

cian medical directors for each clinic, the MEDIC council, which is made up of 14 medical students, helps insure that all the MEDIC clinics run smoothly.

A number of important changes have been made this year to try to improve MEDIC. For the second semester, in response to obvious interest from medical students, the MEDIC council and clinic coordinators for Grace shelter clinic decided to offer a Thursday evening clinic in addition to the regular Tuesday evening clinic. Another change instituted this year through the leadership of Council president Linda Grossheim, a Med II, was the formation of four subcommittees which will develop plans for more changes in MEDIC. The four committees are researching and making plans regarding the following

subjects: (1) educating medical students about the unique needs and issues of homeless/low-income populations, (2) promoting MEDIC and its activities within both the medical school and the Madison community, (3) researching/developing opportunities within MEDIC for interdisciplinary coordination with other UW schools and programs, and finally, (4) pursuing new funding sources for MEDIC. These committees were established with the hope that the MEDIC organization would continue to evolve and to meet its mission.

Another important change which occurred this year was the establishment of a fourth MEDIC clinic, the Safehavens Psychiatry Clinic. Safehavens Clinic offers psychiatric services to the mentally ill homeless who have no access to psychiatric care elsewhere. Dr. Ron Diamond, Medical Director of the Mental Health Center of Dane County, has long been aware of the population who were not being reached by the Mental Health Center. At the same time, he knew that many of his colleagues felt that they would like to do more for the community, but needed an infrastructure of social workers and other support staff in order to truly make a difference for the mentally ill. As a result, he worked closely with MEDIC to develop the new psychiatry clinic. The MEDIC clinic at Safehavens

opened in September and is held twice a month. It has been overseen from the start by student clinic coordinator Stephanie Savage, a Med II. By bringing medical student volunteers together with the Safehavens support team and volunteer psychiatrists, this clinic fulfills the MEDIC missions of both providing primary medical care and enhancing the education of medical students.

Currently, the Safehavens shelter and clinic are supported by both Dane County and a 5-year HUD grant which Transitional Housing Inc. has received to operate a shelter for the individuals who are both homeless and mentally ill. The Safehavens MEDIC clinic serves a population from the Safehavens shelter itself, in addition to patients referred from the other MEDIC clinics. Although it cannot provide long term psychiatric care, this clinic fills a gap in services by providing "a door into the system" of community mental health care. With the help of Crisis and Madison Community Health, patients receive follow-up care and medications. However, these and other social service systems are already stretched to capacity, so there is concern about ensuring follow-up care for these patients. MEDIC is excited about the addition of the new psychiatry clinic at Safehavens and the possibility of offering it on a weekly basis. Thanks to the dedication of the many student, resident, and physician volunteers and the generous financial support of the Cremer Foundation and Walgreen's drug store, MEDIC's future is looking bright.

*Megan Miller  
Elisabeth Tilleros*

The Advocacy and Intervention for Medical Students (AIMS) Committee was formed to support and direct medical students through difficulties they face in medical school. The committee is made up of a total of eight medical students and five faculty. Two students are elected from each class, and the faculty members are elected by the student members.

Although stress is considered a component of the medical school experience, there are situations which go beyond the typical challenges of medical school and can lead to student impairment. Student impairment can be manifested in problems such as substance abuse, depression and other mental disorders. The AIMS Committee assists students in finding help and balancing the necessary treatment or adjustments with the demanding lifestyles of medical school.

In addition to intervention on behalf of medical students, AIMS is also working on prevention of student impairment. Currently, AIMS has distributed questionnaires about student mistreatment and is working on developing a long term policy about mistreatment in medical school. AIMS is also trying to raise student awareness on issues such as depression, sexual harassment and discrimination with noon talks. A web-page is also being developed so students can find more information about the AIMS Committee and the issues it addresses.

*Mikyung Lee, Med I*

## The Polar Bear Plunge, 1996

On December 7th, 30 UW-medical

students plunged into the icy

waters of Lake Monona Bay and

raised more than \$2000 in the

process. The money will help fund

transportation and translation

services at the South Madison

Health and Family Center.





Donald Schuster '51

## Why Would Anyone Want To Be A Doctor?

IN DAYS PAST, although we didn't realize it, things were relatively simple, even if the diagnoses and treatment weren't. We did as we were trained and taught. We obtained a history, performed a p.e., and ordered appropriate laboratory studies. From all this information, we made a diagnosis and initiated what we felt was the best treatment regimen. Now things are a "little" different. Now we have Medicare, coding, PPO's, IPAs, HMO's, managed care, and insurance companies telling us how long our patients are "permitted" to remain in the hospital.

We have "drive through" deliveries, mastectomies, and hernia repairs. We have "gatekeepers" who may try to handle a problem no matter what it is. If the gatekeeper feels he can't handle the problem, he may refer the patient to a specialist who is better qualified to diagnose the illness and treat the patient. In the HMO's, only those medications that are approved for the formulary can be prescribed, even if there is a different one that the physician feels would be more appropriate.

In Medicare, we have participating and non-participating physicians who either accept assignment or do not. We have CPT and ICD coding. If our coding is not correct (are coding courses given in medical school?), we receive a limiting charge exception report (LCER). Get a few of these, and they may cause you to develop an ULCER. Coding specification changes continually. Reimbursement goes down every year for surgical procedures. They call us providers now, not physicians.

Medicare, in its sincere effort to be helpful and keep us up to date, offers a monthly communiqué. A few excerpts from the February 1997 issue include:

- 1) Under the Waiver of Liability Provision, is the provider bound by their limiting charge or Medicare's allowed amount if the service is denied and a waiver was obtained prior to rendering the service?
- 2) Extension of timely filing for MSP claims involving ESRD beneficiaries where there was a challenge to HCFS's modified construction of OBRA 1993 ESR-D MSP amendment.

In addition, we have new codes GOO 51-53 replacing 17000-17104, but the G codes are only expected to be "transitional." There is precertification, case management, medical necessity and the appeals process. Not to overlook the ever popular

outcome measures, critical pathways, and practice guidelines. I could go on.

Despite all of this, something happens in the practice of medicine. There is one on one contact between patient and physician (not provider). The patient comes to the physician because he or she doesn't feel well or is concerned about something regarding their health and well being. The patient has trust in the physician. The physician is faced with the exciting and exceptional opportunity to do two things: To figure out what the problem is and to help the patient. The challenge is comparable to that faced by the Master Detective when he was confronted with a new problem.

The Dermatologist, for example, can tell the patient that the lesion about which he or she is concerned is a seborrheic keratosis and not a melanoma. If the lesion is suspicious for melanoma, it will be excised as soon as possible. He or she can tell the patient that the skin lesions are those of nummular eczema and not tinea. The physician can tell the patient that the toenail changes are psoriatic and not fungal and avoid the expense of oral antimycotic medication.

These encounters occur in family practice and in every specialty. All physicians are able to perform this service for the patient. There is the opportunity to diagnose, to treat, to reassure. To do no harm, to allay fear and apprehension, to make each visit a positive experience. These are the goals of the physician. The physician won't let a "third party" interfere with his care of the patient. The ultimate objective of the practice of medicine: "Do what's best for the patient." Given these opportunities, to solve problems and to help people, why would anyone not want to be a Doctor?

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by Donald Schuster '51  
*Former Dermatology  
Representative to  
the Wisconsin Medical  
Alumni Association*

## Richard F. Daly

Emeritus Associate Professor of Neurology Richard F. Daly died in Madison October 1, 1996 after a long illness.

He received his M.D. degree at George Washington University, Washington D.C. and trained at Providence Hospital and Georgetown University Hospital in Washington D.C., the National Hospital in London, the University of Texas at Galveston and the University of Wisconsin-Madison, where he specialized in cytogenetics.

Dr. Daly was an outstanding researcher, teacher and clinician during his distinguished 23-year career at the UW Medical School Department of Neurology.

His diverse research studies included an exquisitely detailed and comprehensive study of XYY men in Wisconsin Correctional Institutions. He also investigated the immunologic aspects of multiple sclerosis, aspects of the muscular dystrophies, pain management in cancer patients, the auriculotemporal syndrome, epilepsy

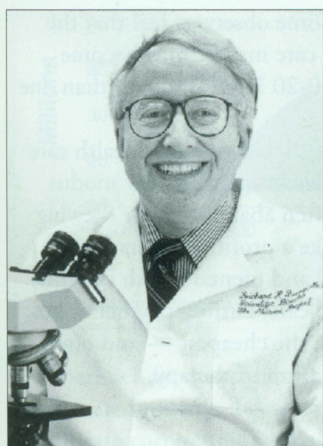
and its genetics, the diagnosis of optic nerve lesions, and other areas. His expertise was acknowledged by his peers when he was invited to contribute to the Handbook of Clinical Neurology.

As a clinical neurologist, Dick Daly was unusually kind and considerate. Well versed in neurology, neuroradiology, neuropathology and neurogenetics, he could detect and correlate subtle neurological findings frequently overlooked by housestaff and others. He shared his expertise and insights with medical students, staff and residents as he conducted various lecture series. He directed the Multiple Sclerosis Clinic for several years and administered a special clinic for evaluating possible neurologic disease in school-aged children in Milwaukee.

A compassionate, self-effacing man, Dr. Daly was known for his religious and charitable practices and his insightful sense of humor.

Dr. Richard Daly is survived by three sisters, Emily, Catherine and Ruth, and by his special friends Peter and Mae Hua Li of Madison.

## A Tribute to a Fruitful Collaboration



*Richard Bunge and Mary Bartlett Bunge*

One important function of the University is not on the list of courses offered nor in the budget. Providing opportunities for collaboration, life-long friendships and more intimate partnerships is in process day and night on campus. Wisconsin's famed "sifting and winnowing" is not restricted to ideas. What follows is a sketch of personal and scientific collaboration that began at our medical school and blossomed into a joint research venture of international acclaim, a happy marriage and successful parenthood.

Dick Bunge, a medical student from rural Wisconsin, spent the summer of

*by Robert F. Schilling*

Simmons College in Boston in 1953, Mary Bartlett, a dedicated scholar from New England, was attracted to graduate school at the University of Wisconsin. As a candidate for a master's degree in Physiology, her research project was under the guidance of a hematologist interested in nutritional anemia.

Though they worked on different projects, the small laboratory space available made personal interaction and accommodation a not unwelcome necessity. With the availability of a small boat from Hoofers (another great Wisconsin Idea) Mary taught Dick the rudiments of sailing. In 1956, following the conventions of the time, Mary Bartlett became Mary Bartlett

*In early 1996, because of their distinguished contributions to the field of neuroscience, the Bunges were chosen to receive the Wakeman Award.*

1954 working in the hematology research laboratory of the department of medicine.

Having just graduated from

Bunge. Mary parted from physiology and hematology when she took a course in cell biology taught by one of our distinguished teacher/scientists, Hans Ris. She opted for a doctorate with him. When she finished her Ph.D. and Dick his MD they went to Columbia University to do post-doctoral work in neuroscience. Subsequent faculty appointments at Columbia, Harvard and Washington Universities provided opportunities for their fertile minds to establish their reputations as leading scholars in neuroscience. After 19 years in St. Louis, Dick accepted the post of scientific director of the Miami Project to Cure Paralysis. In early 1996, because of their distinguished contributions to the field of neuroscience, the Bunges were chosen to receive the Wakeman Award. It is regrettable that Dick died of cancer of the esophagus a few weeks before the awards ceremony at Duke University on 22 November 1996. Mary and their two sons survive.

Surely 40 years is too brief a span for such a splendid collaborative cohabitation.

## The Case for NATIONAL HEALTH INSURANCE

### What is PNHP?

Physicians for a National Health Program is a coalition of 7,000 physicians who believe the only way to control our current out-of-control health care costs and inequalities is through a not-for-profit national health insurance system (also called "single-payer") similar to the type found in Canada and other first-world countries.

### The Problem

The number of Americans without health insurance has skyrocketed to 41 million. In addition, the organization feels that corporate costs and profits are beginning to overrule the needs of patients as fewer and larger firms are replacing a mixed marketplace. The goal of such firms is to maximize profits and to sign up as many clients as possible. Horror stories from around the country point to increasing patient discontent with unreasonable restrictions on medications, referrals and procedures and even on the range of information a physician is allowed to tell a patient. (Not-for-profit HMOs have elicited fewer client complaints to date. However, they may become a relic of the past because they are being bought up by the for-profits, and for-profit HMOs are the only type being started today.)

The profit motive is also diminishing the quality of care given by other health professionals such as nurses, who are being replaced in many instances by lesser skilled personnel, or not replaced at all.

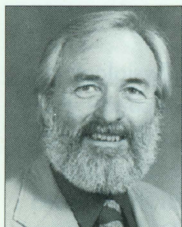
Mergers, buyouts and consolidations among health insurers, health providers, hospitals, and manufacturers of pharmaceuticals and medical equipment are increasing in an effort to raise profitability and reduce competition. Several of these large corporations have already proved themselves prof-

itable enough to attract substantial investment money. Some observers feel that the national health care market may become controlled by 10-20 HMOs sooner than one might predict.

In short, PNHP believes that health care in our country is changing its very modus operandi and often abandoning or skewing its ethics to make a profit. Insurers are gutting medical and mental health benefits, denying needed care, cutting payment rates, and insisting on the cheapest — and often not the best — form of therapy.

### The Costs

Corporations are expected to make a profit — to take in more money than they spend in making products or providing services — and return it to their investors.



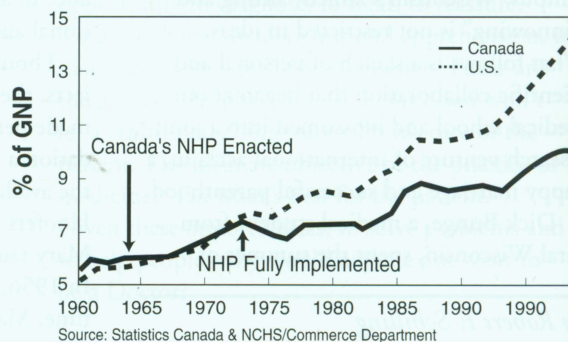
Gene Farley



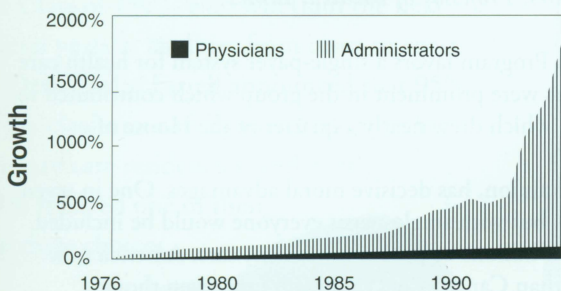
Linda Farley

**Note:** Two months ago, three physicians spoke on the University of Wisconsin campus on different occasions. One was **Quentin Young**, President-Elect of the American Public Health Association, Past President of Physicians for a National Health Program (PNHP), and Professor of Preventive Medicine at the University of Illinois School of Medicine. Another was Emeritus Professor and former Chair of Family Medicine at the Medical School **Gene Farley**. The third was **Linda Farley**, Medical School Emeritus Assistant Professor of Family Medicine, who spoke on Wisconsin Public Radio. Each is affiliated with PNHP and presented similar material, some of which is briefly described here.

Health Costs as % of GNP:  
U.S. & Canada, 1960-1993

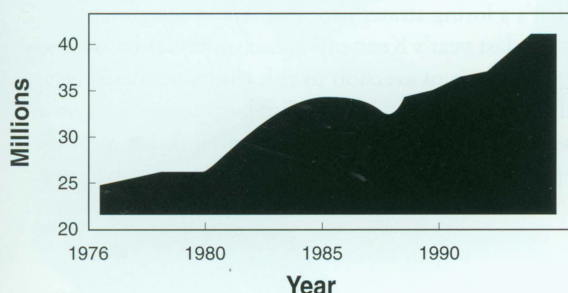


### Growth of Physicians & Administrators 1970-1994



Source: Bureau of Labor Statistics & NCHS

### Number of Uninsured Americans 1976-1994



Source: Himmelstein & Woolhandler—Tabulation from CPS & NHIS data

There is a further complication in the health care industry. These days, many health care corporations pay their top executives outrageously well. Leonard Abramson, for example, as CEO of U.S. Healthcare, was paid \$20 million in a single year, and he took profits of nearly \$1 billion when U.S. Healthcare merged with Aetna. Health care executives in general have sustained the largest increase in wages of any group of administrators. Salaries of physicians and allied personnel, on the other hand, have risen relatively little.

Further costs stem from the fact that there are more than 1,400 different health insurance plans in the United States. Each plan has a wasteful complex of expenses including overhead, sales, billing and huge advertising budgets. Such costs as well as profit and other expenses that emanate from a system of multiple private insurers, however, must be completely borne by the

insured clients to the tune of nearly 30% of the health care dollar. This means that almost 1/3 of a patient's outlay for health care cannot be used in his or her actual care; it is consumed in wasteful overhead and bureaucracy. To those who believe that health care is a right rather than a privilege, this is intolerable.

The paperwork demanded of hospitals and clinics requires many office workers to comply with the varying demands of the insurers, for each has its own set of rules and regulations and its own forms to be completed. This explains why an office staff of 30 to 40 people is necessary in a 300-bed American hospital, while an equivalent hospital in Canada, with its single-payer national insurance plan, can get by with two or three staffers.

Some of the costs associated with U.S. health care are less obvious. American-made cars, for example, sell for several

hundreds of dollars more than equivalent foreign-built autos because American manufacturers must assume greater costs for employees' health insurance. And the leading cause of individual bankruptcies is catastrophic health care bills.

Fraud in the health care industry is an additional waste of consumers' money.

#### Who Is Served?

Although health care in this country is the most costly in the world, consuming about 14% of our gross domestic product, about 40 million people in any given year don't have access to health care at all and another 20 million are underinsured. (Recipients of Medicaid and Medicare are not counted among the uninsured.)

The majority of these un- and underinsured are the working poor, whose employers don't offer health insurance. Most low-paid employees can't afford adequate

#### PNHP

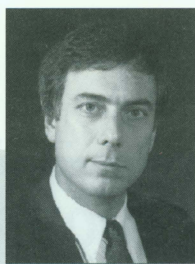
Physicians for a National Health Program, convinced that a single payer system of universal health care is necessary in the United States, is committed to changing the current system through public presentations, the media, the Internet, and any other means they think will influence others.

The organization is based in Chicago at 332 South Michigan Ave., Suite 500, Chicago IL 60604-4302. Phone 312-554-0382, Fax 312-554-0383. You can E-mail PNHP at [pnhp@aol.com](mailto:pnhp@aol.com) and visit their Web site at <http://www.pnhp.org>

In Wisconsin, physicians and the public are invited to join the Wisconsin Coalition for Health Care Reform. Call Dr. Linda Farley at 608-845-8724.

Students at the UW Medical School have formed a student chapter of PNHP, the first in the country. To educate students, faculty and people in the state who want to learn more, the students have written a primer that teaches how health care works now, provides access to data on special areas of interest, and links to national health care policy home pages. It can be reached at <http://www.biostat.wisc.edu/pnhp.html>

The student home page has been used by medical students, university students at large and high school students for school assignments. It links to the providers of information used throughout the nation to create health care policy.



## Single-Payer Health Insurance: Ethical Considerations

by Daniel Wikler, Professor of Medical Ethics

health insurance on their own, yet they don't qualify for Medicaid. Others lacking health care are between jobs. Increasing poverty in large segments of the population seems to portend that the situation will not improve. (As several economists have pointed out, because of economic policies that favor CEO's over the average worker [a trend very evident in health care], the U.S. is becoming a low wage country.)

### How Well Are We Served?

Although some feel that health care in the United States is excellent, increasingly large numbers of citizens are served poorly or not at all; access to health care as well as the quality of care are decreasing for all because of our emphasis on profits over patient care. This results in our faring poorly compared with other first-world and even some less developed countries in categories such as infant mortality and longevity.

### A Solution

PNHP believes that a not-for-profit, national health insurance health care system such as Canada's (but with our higher level of funding) is the most rational and equitable alternative to today's failing, corporate-style system. Without the expenses of administration, bureaucracy and profit taking, according to the Government Accounting Office in 1991, all American citizens could be insured with no additional funding. (In 1991, this amounted to \$100 billion.)

Contrary to frequent allegations, surveys show that 96% of Canadians like their health care system, which consumes about 10% of their GDP, while most Americans dislike ours. Only 11% of Americans think our system works "pretty well." Canadians receive more doctor visits and procedures, more hospital days, and even more bone marrow, liver and lung transplants than Americans. And a greater percentage of Canadian physicians are more satisfied with working conditions than their American counterparts, though they earn slightly less.

In some instances there is a waiting time for elective procedures (but not for emer-

Physicians for a National Health Program favors a single-payer system for health care financing. Its leaders and founders were prominent in the group which contributed to the McDermott single-payer bill, which drew nearly a quarter of the House of Representatives as co-signers.

A single-payer system, in my opinion, has decisive moral advantages. One in seven Americans lacks health insurance, but with single-payer everyone would be included. Its efficiency would free up tens of billions of dollars for patient care. America now spends a quarter to a third more than Canada does on health care, even though Canada provides care to everyone, so we could provide more than Canada does. We wouldn't have to put up with waiting lists.

The central problem with a system like the one we have now, which relies on competing for-profit insurers, is that the key to profitability is to avoid risks, i.e., patients who are sick or are likely to become sick. A health care system ought to seek out these people and offer them care, but that's a losing strategy for insurers in our system.

We can tinker with regulations, as last year's Kennedy-Kassebaum legislation does, but they do not change the underlying logic of aversion to risk which defines private health insurance. It is a health care system for the healthy. Single-payer is inclusive: a sick patient should be seen as a person deserving care, not a potential threat to profitability. Single-payer plans have problems, but their ethical failings, on balance, are less serious than ours.

gencies), and certain high-tech diagnostics are not so available in Canada. Patient outcomes, however, are about the same in both countries.

Many Americans distrust the federal government and feel it would run an inefficient and wasteful health care program. Perhaps. Economists have determined, however, that the overhead of private insurers is, on average, five times higher than that of public programs, and no private insurer's overhead is as low as Medicare's.

Is national health insurance the same as socialized medicine? Physicians for a National Health Program says no. It is socialized insurance, comparable to other "socialized" services such as Social Security, police protection, highways, fire protection, the military, etc.

Would physicians be told what to do by the government? The experience in every other industrialized country is that their doctors work with less interference and fewer restrictions than ours do. Under our

current system, corporations are calling more and more of the shots, with the major criterion being profit margin, not patient outcome.

### The Structure

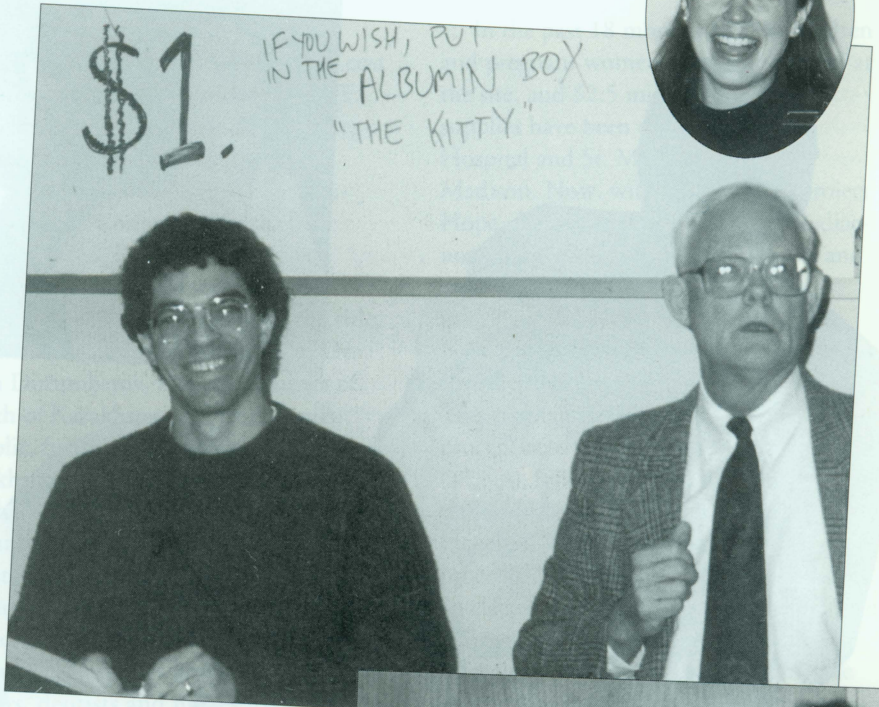
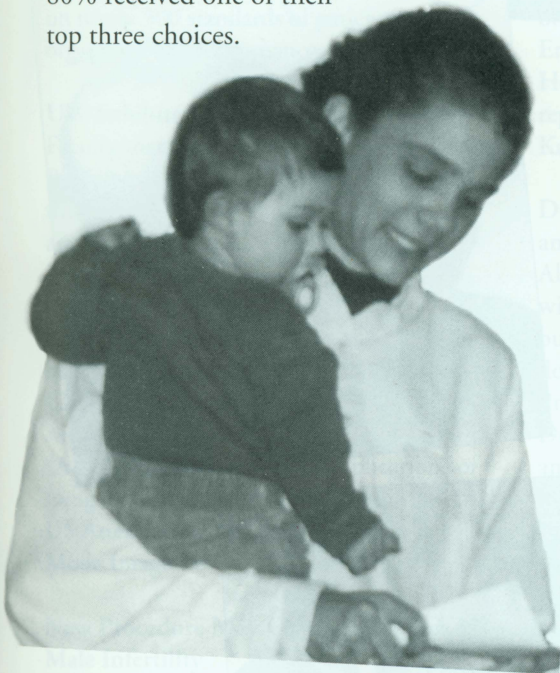
Financing of national health care would likely be at the federal level through taxes, or with shared federal and state responsibility, to insure that poor states receive adequate funding. Administration would probably reside at the state level, perhaps with regional entities in large states. Current not-for-profit HMOs would essentially continue as before. Organizations that are primarily financial constructs would be eliminated; this would do away with the jobs of tens of thousands of office workers, a problem that would have to be faced, perhaps by retraining them to provide care at home or in nursing homes where they are truly needed.

If *Quarterly* readers show interest, we will present the details of a proposed national health program in a future issue.

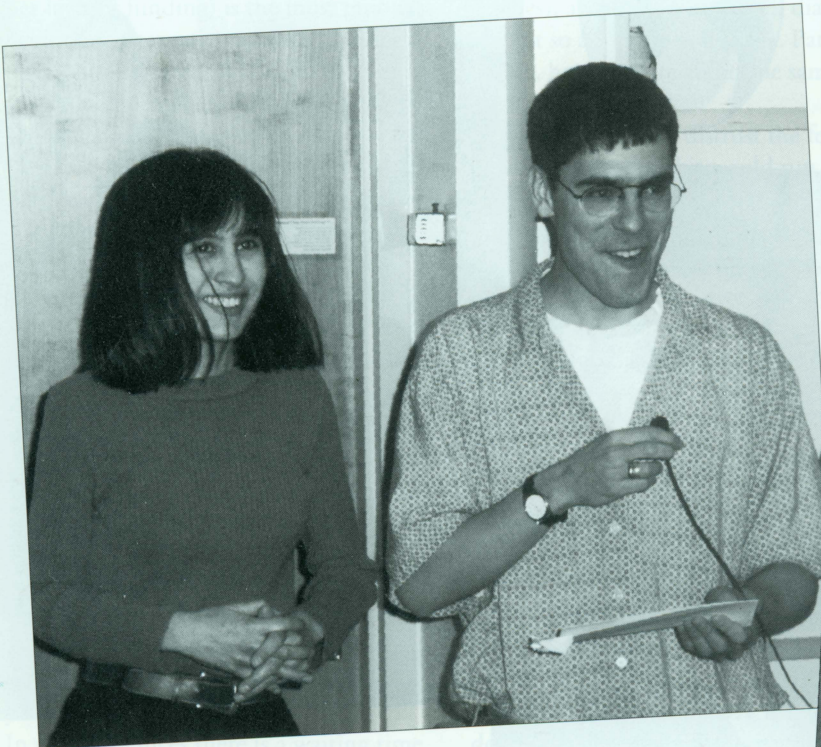
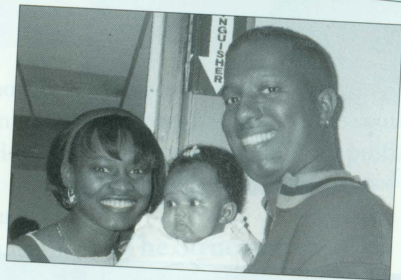
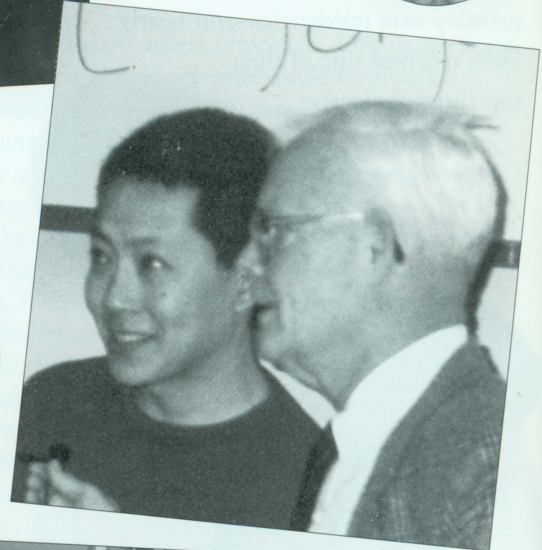
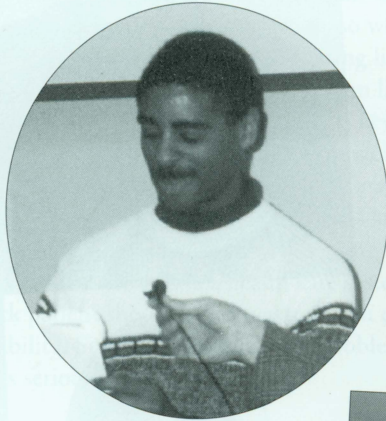
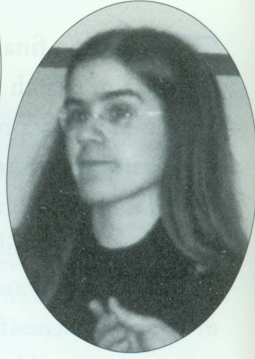
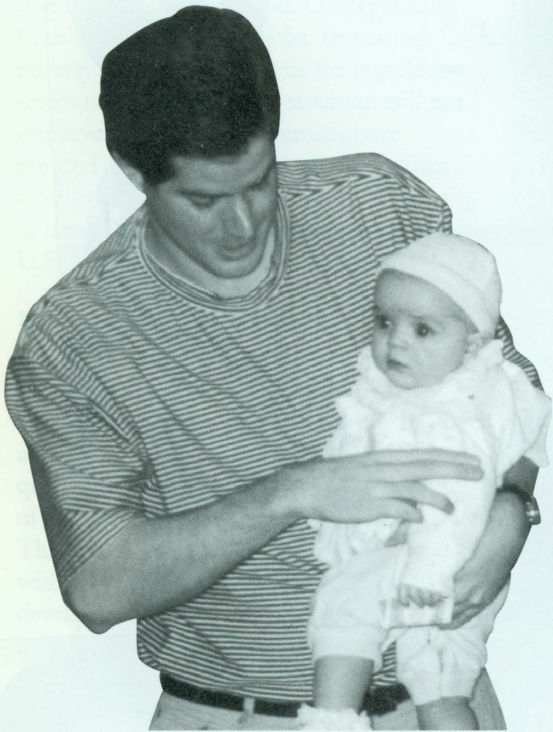
# Match Day 1997

The tension finally ended beginning at 11 am, March 19 in Medical Alumni Hall as emeritus professor of Anatomy Jim Pettersen handed envelopes to members of the Class of 1997, who will train the next several years at facilities from coast to coast.

Dean Philip Farrell announced that 95% of the class successfully matched—59% for primary care residencies—and nearly 80% received one of their top three choices.



Match Day 1997



**UW Hospital and Clinics Merits Highest Accreditation**

The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) awarded the UW Hospital and Clinics as well as its 27 satellite labs accreditation with commendation — the highest level — after an extensive and detailed survey. Only 11 % of hospitals surveyed in 1996 were awarded the top designation. JCAHO rates hospitals on nearly 500 standards of patient care, organizational performance and governance.

**UW Exhibits Win Honors at the RSNA**

Faculty members from the Departments of Radiology and Medical Physics received three of the nine "Magna Cum Laude" awards for scientific exhibits at last December's annual meeting of the Radiological Society of North America, attended by more than 60,000 radiologists, technicians, administrators and vendors in Chicago. The honored exhibits were: "CT Angiography in Renal Transplant Donors," "Acute Life Threatening Complications of Lung Transplantation," and "Quantifying US Attenuation and Backscatter on B-Mode Images."

**New Procedure May Overcome Severe Male Infertility**

The UW Hospital has begun to use a new procedure, called IntraCytoplasmic Sperm Injection (ICSI), that may enable men with the most severe infertility problems to father children. The procedure is essentially a variation of in vitro fertilization (IVF), which the hospital has been performing since 1983.

In both IVF and ICSI, mature eggs surgically removed from a woman's uterus are placed in a Petri dish in a proper solution. In IVF, sperm are added and one sperm penetrates an egg under its own power. In ICSI, a sperm cell is injected into the egg by a very fine glass needle under high-power microscopy. The resulting embryos — typically more than one — are transferred to the uterus, sometimes resulting in multiple births.

If the man's ejaculate contains no sperm, sperm can be retrieved from the testes or the epididymis.

The success rate is about 20-25%, roughly the same as IVF, although the cost is approximately \$1,500 more than IVF.

So far, two couples have become pregnant with twins at the UW Hospital.

**UW Expands Connection with Kazakhstan**

On February 20, UW Hospital and Medical School officials extended the title of Clinical Professor of Pediatrics to Dr. Erkin Durumbetov, Deputy Minister of Health of Kazakhstan, a former Soviet republic, further linking Wisconsin and Kazakhstan.

The connection began in 1995 when Durumbetov asked for help setting up and staffing a medical trailer in the Almaty-Oblast, a large state in a country with crumbling hospitals, no funds to buy medical supplies and a dearth of doctors, dentists and nurses. Associate Professor of Surgery John Doyle, Chief of Dentistry at the UW Hospital, was among the first Madisonians to volunteer for the project and has returned five times. Several other medical personnel have also volunteered.

In the past 18 months 12,000 children and pregnant women have been treated at the site, and \$2.5 million in surplus supplies have been donated by UW Hospital and St. Mary's Hospital in Madison. Now, with a grant from Project Hope, the trailer staff will be able to diagnose and treat TB and better control and treat sexually transmitted diseases.

**New Procedure Offers Alternative to Prostate Surgery**

This past fall the FDA approved a new procedure, transurethral needle ablation (TUNA), following a study conducted at seven medical centers including the UW Hospital. With only local anesthesia, the procedure uses two small probes to deliver an electrical current to areas of the prostate where tissue has overgrown. The current dries the overgrown tissue, removing the obstruction from the urethra. The outpatient treatment, which is now offered at the UW Hospital, takes about 30 minutes and involves only minor discomfort. TUNA and TURP (transurethral resection of the prostate) are recommended after medication treatment fails.

**"Our" Volunteer in South Africa**

Rhonda Dix, the artist who designs the *Quarterly*, just returned from South Africa where she was doing volunteer work for a non-profit, human rights organization called the Black Sash. Black Sash members and volunteers serve as advocates for needy citizens throughout South Africa in obtaining promised government and private services.



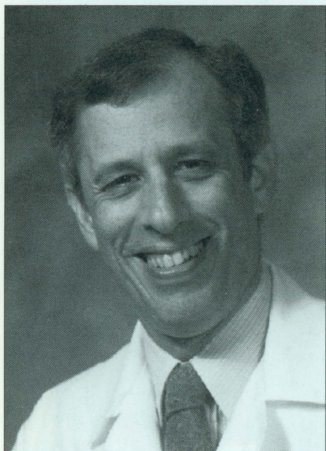
*The Black Sash Staff in Cape Town, South Africa*

Her project was to research, write and design an educational package that described the function of the organization and their available resources. This information will be distributed to inquirers and will also be used as fundraising material.

**Christopher Bradfield**, Associate Professor of Oncology at the McArdle Laboratory for Cancer Research, received a \$400,000 award from the Burroughs Wellcome Fund to continue his studies on dioxin's effect on genes. Dioxin still remains a controversial public health threat as a possible cause of cancer, birth defects and reduced sperm counts. Bradfield and his laboratory group have already identified several cell-surface receptor proteins that initiate cellular defenses against toxins such as dioxin.

Bradfield's investigations are also funded by two NIH grants.

**Paul L. Kaufman**, Professor of Ophthalmology and Visual Sciences and Director of Glaucoma Services at UW Eye Clinics, was elected President of The Association for Research in Vision and Ophthalmology (ARVO) for 1997-98. ARVO is the world's pre-eminent vision research society, with about 10,000 members from nearly 60 countries.



*Paul L. Kaufman*

Assistant Professor of Family Medicine and Orthopedic Surgery **Thomas M. Best** won the Arnold W. Siegel Award as an author of the most outstanding paper presented on automotive crash protection at the international 1966 Stapp Car Crash Conference. Best and colleagues had analyzed the properties of skeletal muscle and its relevance to crash dynamics of the upper spine.

Best joined the faculty in 1995 with an MD from the University of North Carolina and a PhD in Biomedical Engineering from Duke. He has published widely in orthopedics and sports medicine, particularly the biomechanics of muscle strain injuries.

Former Associate Professor of Psychiatry **Dean Krahn** recently left the Medical School to become Head of the Psychiatry and Behavioral Sciences Division of the University of North Dakota Medical School and Chief of Psychiatry at the Fargo VA Medical Center. He also serves as a Research Scientist at the Neuropsychiatric Research Institute in Fargo, which is devoted to the study of eating disorders and obesity.

Krahn is now Co-Moderator of the Psychiatry and Neurosciences segment of Cyberounds on the Internet. Please see box elsewhere in this issue for details.

**Suresh Chandra**, Professor of Ophthalmology and Visual Sciences, was again honored for his humanitarian work when the Rotary Club of Madison gave him its Paul Harris Fellow Award and

### Cyberounds –check it out

Psychiatrist Dean Krahn has become Co-Moderator of the Psychiatry and Neurosciences segment of Cyberounds, an Internet offering that presents experts each month who conduct an interactive conference about an important current topic. It is aimed primarily at medical students and residents. Bruce McEwen, PhD, of Rockefeller University is the other moderator.

Krahn left the Medical School and the VA Hospital to become Head of the Psychiatry and Behavioral Sciences Division of the University of North Dakota Medical School as well as Chief of Psychiatry at the Fargo VA Medical Center.

donated \$1,000 in his name towards his work in Sitapur, India. Chandra volunteers his services at home and abroad to combat blindness.

Associate Professor of Medicine **Molly Carnes** received a Women's Health Academic Leadership Award from the National Institutes of Health in recognition of her



*Molly Carnes*

abilities as a researcher and a coordinator. The \$395,000 five-year grant is aimed at developing research and education programs in the area of women's health.

**Richard Davidson**, William James Professor of Psychology and Psychiatry, was elected President of the Society for Research in Psychopathology.

He also was selected as the 1997 Distinguished Scientific Lecturer for the American Psychological Association.

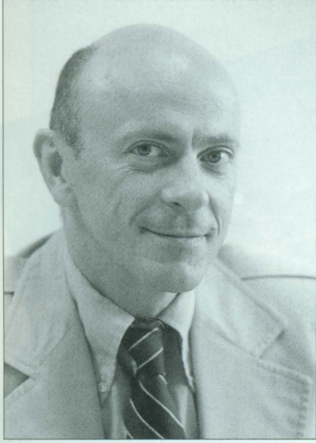
The National Institutes of Health recently honored him with a MERIT award, which doubles the length and amount of a recent grant renewal, with a total of \$2.5 million to support his work on brain mechanisms associated with individual differences in emotional reactivity.

Professor of Medicine and Head of Rheumatology **Frank M. Graziano** is the new



*Frank M. Graziano*

Governor-Elect of the Wisconsin Chapter of the American College of Physicians. After this initial term, he will serve a four-year gubernatorial term.



*James A. Liedtke*

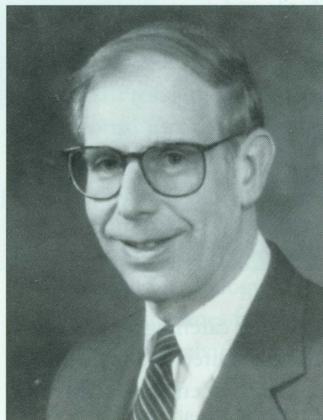
Professor of Medicine **James A. Liedtke** was presented the President's Award for the Advancement of Research by the American Heart Association for his considerable volunteer efforts in helping promote AHA research.

**R.W. (Ray) Guillery**, the recently retired Dr. Lee's Professor of Anatomy at Oxford University, returned to the Department of Anatomy last fall to be a Visiting Research Professor, studying the role of corticothalamic projections. While previously at the UW for 13 years, he did some of his most acclaimed work on organization and mechanisms in the development of the mammalian visual system.

Born in Germany, Guillery was sent to England as a child to escape the Nazi regime. He received his doctorate at University College London, where he later joined the faculty. He spent a sabbatical year in Madison and in 1964 returned for a 13-year

stint, becoming Professor of Anatomy. Then he became head of the University of Chicago's Program in Neuroscience. A Fellow of the Royal Society, he was the founding editor of the European Journal of Neurosciences and President of the Anatomical Society of Great Britain and Ireland.

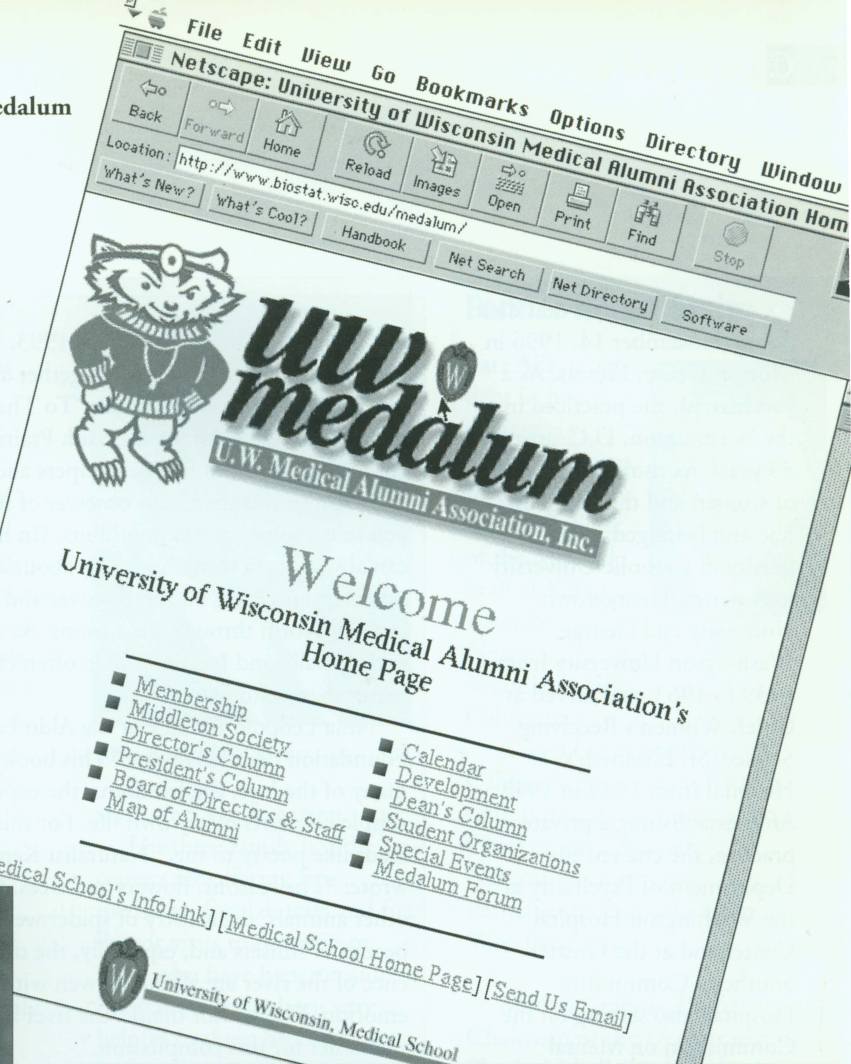
**Daniel M. Albert, F.A.** Davis Professor and Chair of Ophthalmology, co-authored a new book, *The History of Ophthalmology* (Blackwell Science), which



*Daniel M. Albert*

was officially unveiled last October at the centennial meeting of the American Academy of Ophthalmology. The other co-author is Diane D. Edwards, a doctoral candidate in the Department of the History of Medicine.

Professor of Medicine **Brad Schwartz** has been appointed Director of the Medical School's MD/PhD program. He will try to make the program as responsive as possible to faculty and student interests.



*Guillermo de Venecia examines a patient at the Free Eye Clinic in the Philippines. Another clinic physician, Edith Navarro, looks on.*

Professor of Ophthalmology and Visual Sciences **Guillermo de Venecia** now spends half his time working at the UW Hospital and Clinics and the other half as a volunteer in the Free Eye Clinic, which he has developed over the years to serve poor people in the Philippines.

**32** Anna Coyne Todd died November 14, 1996 in Morton Grove, Illinois. As a psychiatrist, she practiced in the Washington, D.C. area for 35 years, focusing on the care of women and the indigent. She also belonged to the faculty of Catholic University of America, Georgetown University and George Washington University from 1939 to 1963, and served as Chief, Women's Receiving Service, St. Elizabeth's Hospital from 1939 to 1948. After establishing a private practice, she chaired the Department of Psychiatry at the Washington Hospital Center and at the Greater Southeast Community Hospital, also serving on the Commission on Mental Health for the U.S. District Court for the District of Columbia.

When Dr. Todd retired and moved to St. Petersburg, Florida in 1972, she became involved in several civic, volunteer and Catholic Church activities.

She is survived by her children Thomas of Erie, PA, Margaret of Northfield, IL, and James of Newbury Park, CA as well as six grandchildren and her brother-in-law John G. Todd, Sr.

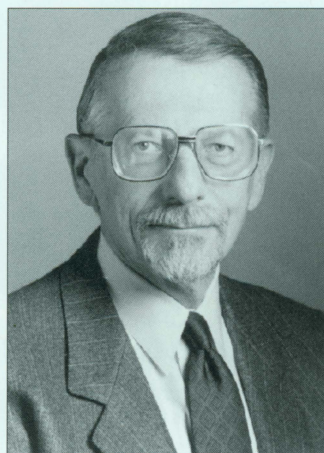
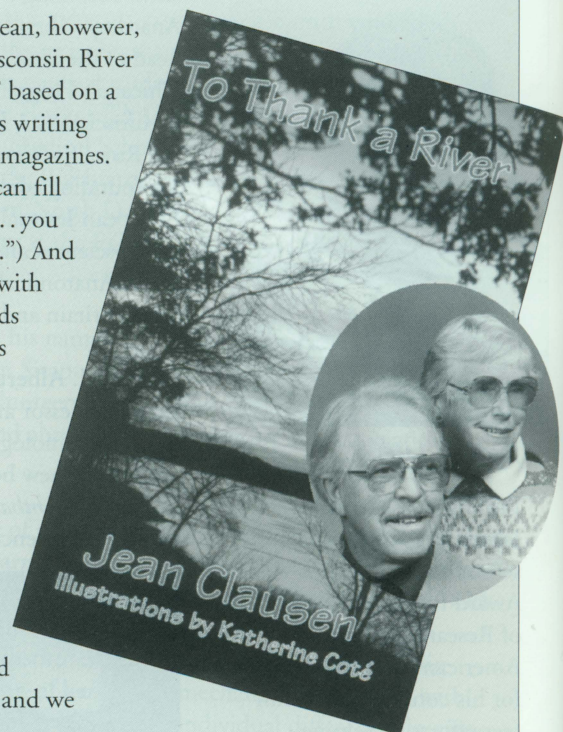
Memorials may be made to the UW Foundation for the furtherance of undergraduate, graduate and continuing medical education of women.

**43** N Norm Clausen died in 1993. His widow Jean, however, has recreated their life together along the Wisconsin River in a delightful soft-cover book, "To Thank a River," based on a series of her columns for the Sauk Prairie Star. Jean's writing has also appeared in five newspapers and a hundred magazines.

If you're already a keen observer of nature, Jean can fill you in on some interesting tidbits. (In her words, "... you can always learn something new about an old friend.") And if you're a novice, you can discover and learn along with her and Norm through the seasons. As visiting friends such as Sally and Joe Benforado often claim, "This is better than watching TV!"

Nina Leopold Bradley of the Aldo Leopold Foundation had this to say: "This book expresses many of the joys, the freedoms, the experiences, the simple comforts of my own life. For this reason, it reads like poetry to me." Naturalist Kenneth Lange wrote: "The seasons, flowers and trees, birds and other animals, the artistry of spider webs, the beauty of sunsets and, especially, the omnipresence of the river are all interwoven with sincerity and emotion. The author thanks the river for all its gifts and we thank her for this compilation."

"To Thank a River" is published by Badger Books Inc., P.O. Box 192, Oregon, WI 53575. It costs \$9.95.



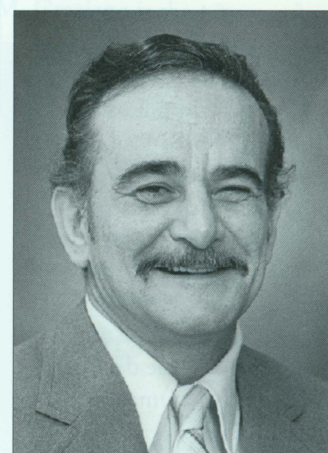
*I. Bernard Weinstein*

**55** I. Bernard Weinstein retired after 10 years as Director of the Columbia-Presbyterian Comprehensive Cancer Center at Columbia University. He will concentrate his efforts on his own research

in molecular carcinogenesis and will serve as Director Emeritus to the Cancer Center. He also is Frode Jensen Professor of Medicine, Professor of Genetics and Development and Public Health.

Professor Weinstein, recipient of the 1986 WMAA Citation Award, recently presented the Nakahara Memorial Lecture, sponsored by the Princess Takamatsu Cancer Research Fund in Japan. He also co-organized an international symposium held in Tokyo titled "Fundamentals of Cancer Prevention" that was also sponsored by the Fund.

**56** John D. Swingle died November 23, 1996 at home. He served a residency in radiology at the UW, 1962-65,



*John D. Swingle*

and was a faculty member of the Radiology Department from 1965-71, becoming Clinical Professor of Radiology. Later he joined the Gundersen Clinic, La Crosse, and chaired its Department of

Radiology from 1972 to 1980. He also served on the Gundersen Clinic Board of Directors from 1974 to 1980.

Colleagues at the Gundersen Clinic described Jack as "a good radiologist and a superb fluoroscopist ... who was a master in the interpretation of the abnormalities of the minutes ossicles." "He was truly a man of the earth. He deeply loved nature and was an avid sportsman, but his genius was in the field of Radiology. Few, if any, exceeded his professional skills."

He leaves his wife Carolyn, a son Mark and a daughter Jennifer.

**58** Anthony Atwell of Saratoga, CA was recently promoted to Clinical Associate Professor of Psychiatry at Stanford University School of Medicine, where he continues to supervise advanced child psychiatry fellows and teach a course in Forensic Child Psychiatry in the Department of Psychiatry and Behavioral Sciences each spring quarter.

Tony also has a private practice of child, adolescent and family psychiatry in Los Gatos and serves as an expert witness and special master for the Juvenile and Family Courts.

**71** Leslie E. Brody of Laguna Hills, California has been appointed Chairman of the Bioethics Committee at Orange Coast Memorial Hospital in Fountain Valley.

**72** In a national election, Warren R. Procci of Pasadena, CA was elected as Councilor-at-Large in the American Psychoanalytic Association for a four-year term. He also was elected as Dean of the Southern California Psychoanalytic Institute in Beverly Hills for a two-year term.

Warren remains in private practice in Pasadena and has a quarter-time appointment on the faculty of the UCLA Department of Psychiatry at Harbor/UCLA Medical Center.

**85** Bradley J. Fedderly of Fox Point, WI was elected President of the Wisconsin Academy of Family Physicians. He also was appointed as the Academy's representative to a national task force of the American College of Cardiology to develop guidelines for the treatment of valvular heart disease.

Brad practices with the Covenant Medical Group in South Milwaukee.

Rev. Ronald V. Myers, Sr. announces the Tchula '97 African-American Medical Missions Conference July 23-27 in Tchula and Belzoni, Mississippi. Last year's conference drew participants from Maine to California. For information and early registration, call (601) 235-4227.

Two of Ron's children, Eric and Vinnie, are attending Southern University in Baton Rouge and are roommates on campus. Michael is in 10th grade, Joshua in 2nd grade, and Neoma will



*Rev. Ronald V. Myers, Sr.*

soon start kindergarten.

His three family health centers are offering free medicine, free lab tests and free doctor visits to those 55 or older who have hypertension, a program that has been very helpful to those on fixed income.

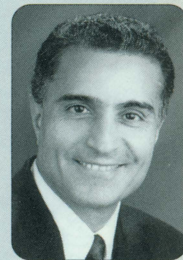
**91** Mary Wu Chang will become Assistant Professor in the Departments of Dermatology and Pediatrics at New York University in New York City beginning in July. She will live in Port Jefferson, NY.

Currently she is Chief Resident in Dermatology at Wayne State University.

**94** Erik Gundersen, a resident at St. Mary's Family Practice Residency in Milwaukee, WI has been elected to serve as resident delegate to the American Academy of Family Physicians Congress (AAFP) of Delegates, the AAFP governing body. As such, he represents the interests and opinions of the National Congress of Family Practice Residents to the AAFP Congress of Delegates.

## Former House Staff

Farr Ajir, a resident in neurosurgery 1976-1980, was recently named President-Elect of the Medical Staff at Kaiser Foundation Hospital, Woodland Hills, California.



*Farr Ajir*

A member of Southern California Permanente Medical Group Board of Directors, he is Chief of the Department of Neurosurgery at Kaiser-Permanente Medical Center, Woodland Hills.

**Martin Grabois**, Professor and Chairman of the Department of Physical Medicine and Rehabilitation at Baylor College of Medicine, Houston, was elected President of the American Pain Society at its annual meeting in November. The Society has 3,000 members who represent all aspects of the health care industry and it was instrumental in supporting the establishment of a Pain Interest Consortium at the NIH.

**Kelly and Karen Locke**, Family Practice residents at Eau Claire 1991-94, announce the arrival of Ethan Forbes Locke, born November at 8# 14oz and 21 inches. Kelly continues his work as a Family Physician for the Air Force at Spangdahlem, Germany, and Karen is a Family Physician Red Cross volunteer at the base.

Kelly and Karen invite friends to e-mail them at: [lockek@silyn.net](mailto:lockek@silyn.net)



## Our Readers Write



Alice Thorngate

*Dear Dave*  
(WMAA President  
David Riese '68)

The past season of exchange of greeting cards from former students and colleagues of my teaching days reminds me of my intention to send you congratula-

tions on assuming your active duties as President of the Medical Alumni Association. Now, when the *Quarterly* arrives, I look first at the President's Column.

In the fall issue of 1996, I was particularly appreciative of your tribute to Dr. Kindschi and the impression he made on you at an early age. (Also, I liked your

description of cracking your Swiss head on concrete.)

I still recall that remarkable evening in 1992 when you honored me for my teaching days. My many years with students enriched my life and, at age 91, I find great pleasure in my memories of those years and in my continuing contacts with various students covering a span of 36 years.

Congratulations to you, Dave, and highest regards to my first *male* student of that era.

*Sincerely*  
Alice

(Alice Thorngate, recipient  
of the 1992 WMAA  
Emeritus Professor Award)

Madison

*Dear Friends,*  
I look for news of the Class of '50 in each Alumni Bulletin — but, alas, only under necrology.

I'm still going but so slowly, I can't make news!

*Cheers,*  
Nancy E. Furstenberg  
Ann Arbor, Michigan

*Dear Mr. Griffith:*

I wish to thank you for selecting me to receive the Wisconsin Medical Alumni Association Low-Interest Student Loan. Medical school is proving to be a wonderful experience. As I complete my second year, I have no regrets regarding my decision to enter this challenging and reward-

ing profession. The concerns I do have about school are primarily related to financial hardships imposed on my family during my medical education. This low-interest loan does much to help minimize this hardship, and for this I am very grateful.

*Sincerely,*  
John J. Olson

*Dear Editor,*  
Ich dienen, bitte!

G.A. Nitshe, Jr.  
Resident in Medicine  
1944-'46  
Monroeville, N.J.

## NECROLOGY

Fred J. Ansfield, '33  
Milwaukee, Wisconsin  
May 2, 1996

Donald E.  
Barker, '39  
Agoura Hills,  
California  
May 23, 1996

George A.  
Berglund

(Former Intern & Resident  
Neurosurgery)  
Wauwatosa, Wisconsin  
July, 1996

Karl H. Beyer, Jr., '43M  
Penllyn, Pennsylvania  
December 2, 1996

Carl J. Bridge, '50  
Keene, New Hampshire  
July 5, 1996

Guy W. Daugherty  
(Former Intern)  
Winchester, Virginia  
May, 1996

Lyle E. Delap, '42  
(2 year)  
Narrows, Virginia  
April 5, 1994

John E. Faber, '32  
Rochester, Minnesota  
August 5, 1996

Emilia J. Giryotas, '27  
(2 year)  
Highland Park, Illinois  
January 13, 1997

Howard L. Hauge, '32  
Pompano Beach, Florida

Paul C. Hodges, '18  
(2 year)  
Green Bay, Wisconsin  
December 27, 1996

Charles R. Kempthorne,  
'32  
Manhattan, Kansas  
May 1983

Leonard Micon, '39  
Santa Barbara, California

Raul Montes  
(Former Resident  
Orthopedics)  
Merritt Island, Florida  
May 1996

Robert P. Montgomery  
(Former Resident in  
Orthopedics)  
Milwaukee, Wisconsin  
November 3, 1996

Eduard F. Poser, '27  
(2 year)  
Columbus, Wisconsin  
January 1, 1997

Elvira C. Seno, '43M  
Burlington, Wisconsin  
October 31, 1996

Katherine E. Stewart  
(Former Intern)  
Eau Claire, Wisconsin  
April 30, 1996

John D. Swingle, '56  
LaCrosse, Wisconsin  
November 23, 1996

Anna R. Coyne Todd, '32  
Morton Grove, Illinois  
November 14, 1996



## CONTINUING MEDICAL EDUCATION

### 1997

- May 1-2 12th Annual Comprehensive Management of Respiratory Problems  
*Sheraton Hotel, Madison, Wisconsin*
- May 2-3 10th Geriatrics Symposium: Paving the Way for Healthy Aging—New Directions in Women's Health  
*The Edgewater, Madison, Wisconsin*
- May 8-10 Sports Medicine Symposium  
*Holiday Inn West, Madison, Wisconsin*
- May 9 New Directions in Transfusion Medicine  
*Best Western InnTowner, Madison, Wisconsin*
- June 26-29 State Cancer Pain Initiative National Meeting  
*Saint Paul Hotel, St. Paul, Minnesota*
- July 20-24 Practical Imaging and Intervention  
*Knee Lake Lodge, Manitoba, Canada*
- July 26–August 1 Summer Update in Otolaryngology  
*Hyatt Regency Beaver Creek, The Vail Valley, Beaver Creek, Colorado*

For further information please contact Cathy Means, University of Wisconsin Continuing Medical Education, 2715 Marshall Court, Madison, WI 53705; phone 608/263-6637 or fax 608/262-8421.



### COMING EVENTS

April 28, 1997  
**American College of Obstetricians and Gynecologists**

Wisconsin Reception  
6:00-8:00 p.m.  
Hilton Hotel  
Las Vegas

May 8-11, 1997  
**Medical Alumni Weekend**  
Madison

November 1-5, 1997  
**American Academy of Pediatrics Annual Meeting**  
Date, time and place to be announced  
New Orleans

November 8, 1997  
**Homecoming**  
Tailgate lunch and football game with Iowa  
Madison



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and

University of Wisconsin Medical Alumni Association

## Advances in Allergies and Infectious Diseases

August 24-31, 1997

### Faculty:

*Robert F. Lemanske, M.D., class of 1975*  
Professor of Medicine and Pediatrics  
University of Wisconsin Medical School

*Dennis G. Maki, M.D., class of 1967*  
*Ovid O. Meyer Professor of Medicine*  
Head, Section of Infectious Diseases  
University of Wisconsin Medical School

*Educational Program—\$450.00*

16 hours AMA Category 1 credit

Cruise—from \$965–\$1,599 plus airfare (double occupancy)

Port tax: \$199 per person

For further information on the travel portion  
please call Burkhalter Travel  
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or

608-833-9339, Ext. 139

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