

HSL

THE WISCONSIN MEDICAL ALUMNI MAGAZINE

QUARTERLY



HEALTH SCIENCES LIBRARY
University of Wisconsin

APR 18 1996

1305 Linden Drive
Madison, WI 53706

volume 36 • number two • spring 1996

WISCONSIN MEDICAL ALUMNI MAGAZINE
QUARTERLY

vol 36 • no.2

spring 1996

EDITOR

Victor S. Falk, '39

ASSOCIATE EDITOR

Jacqueline Kelley

ART DIRECTOR

Rhonda Dix
Medical Illustration
University of Wisconsin-Madison

EDITORIAL BOARD

Paul M. Apyan, '80, At Large Member
Dorothy W. Betlach, '46, Assistant Editor Emeritus
John A. Buessler, '44, At Large Member
D.J. Freeman, '52
Larry H. Hogan, '44
George W. Kindschi, '68
Mischa J. Lustok, '35, Editor Emeritus
Carol M. Rumack, '69, At Large Member
Thomas E. Ryan, '52
Robert F. Schilling, '43M
Student Members

BOARD OF DIRECTORS

Avadh B. Agarwal, Former Resident
James L. Basiliere, '62, President
Richard J. Boxer, '73
Kathe S. Budzak, '69, Secy.-Tres., Ex Officio
Hulon E. Crayton, '85
Jan E. Erlandson, '68
Victor S. Falk, '39, Editor, Ex Officio
Philip M. Farrell, Dean, Ex Officio
James R. Griffith, Executive Director, Ex Officio
John P. Hermann, '74
Christopher L. Larson '75
Johan A. Mathison '61
William C. Nietert, '78
Sandra L. Osborn '70
Thomas H. Peterson, '58, Past President
Henry C. Rahr, '58, Past President
David C. Riese, '68, President elect
Harvey M. Wichman, '65
Marc S. Williams, '81
John B. Wyman, '58

CORRESPONDING BOARD MEMBERS

Paul M. Apyan, '80, Hixson, Tennessee
John A. Buessler, '44, Lubbock, Texas
Walter H.C. Burgdorf, '69 Germany
Mary Kay Favaro, '69, Charleston, South Carolina
William E. Gilmore, '43, Vienna, West Virginia
Sylvia E. Griem, '53, Portage, Indiana
Eric R. Marcus, '69, New York, New York
Nola M. Moore, '58, Seattle, Washington
Frank E. Murray, '60, Palos Verdes Peninsula, California
Kenneth H. Oberheu, '61, Dayton, Ohio
Carol M. Rumack, '69, Littleton, Colorado
Eugene L. Weston, '55, Golden, Colorado
Harold C. Youngreen, '41, Irvine, California

STUDENT MEMBERS

Class I, II, III, IV Presidents
MSA President

Published quarterly by
The Wisconsin Medical Alumni Association, Inc.
Room 4245, 1300 University Avenue
Madison, WI 53706-1532
Phone (608) 263-4914

CONTENTS



FEATURES

3

UW Cardiac Rehabilitation Program

Custom designed and carefully monitored exercises help cardiac patients beat the odds after a heart event or a diagnosis of high risk.

12

Curriculum Revision Marches On

As a result of major changes in the Medical School curriculum, students are experiencing patient contact in their first two years, many lectures have given way to small-group discussions, and clinical and basic-science courses have become more integrated and consolidated.

14

Atomic Bomb Survivors

In commemoration of the end of World War II, the *Quarterly* has carried a series of war-related articles. In this issue, we look at survivors of the two atomic bombs dropped on Japan.

COLUMNS

2

Medical Alumni Day 1996 Schedule

6

Distinguished Alumnus Awards

9

Doctors, Beware!

10

President's Column

11

Dean's Column

19

Leavitt Becomes Associate
Dean of Faculty

20

Mad King George III

22

Good-bye to Joyce Meier, Jean Weber

24

From the Medical Student Association

26

Class of 1946 Photo

28

Medical Scholars Summer Experiences

30

Winter Meeting

32

Foundation News

34

Medical School News

36

Class News

38

Faculty News

40

Our Readers Write
Necrology

COVER: COVER: "Leftover Bouquet: Yellow Background" is an etching and drypoint monoprint, measuring 29.5" x 41.75" available through the Grace Chosy Gallery, Madison. Artist Paula Schuette Kraemer, who studied with UW Emeritus Professor of Art Warrington Colescott, shows her work across the midwest. Currently her one person show called "Trees or Tulips?" can be seen at the Wisconsin Academy, 1922 University Avenue, Madison from April 3-29.

MEDICAL ALUMNI DAY



HONORING CLASS REUNIONS

1936	1956	1976
1941	1961	1981
1946	50th	1966
1951	1971	1991

May 17, 1996

University of Wisconsin Medical Alumni Association
University of Wisconsin Medical School

Friday, May 17, 1996

- 9:00 a.m. *Registration & Continental Breakfast*
Union South
227 North Randall
- 10:00 a.m. *Seminars & Tour*
Union South
- 11:30 a.m. *Wine Reception*
Union South
- Noon *Welcome Back Luncheon*
Honoring the 50 Year Class
Union South
- 2:00 -
4:00 p.m. *Business Meeting & Scientific Program*
What's New in Ophthalmology
Medical Sciences Center—Room 227 SMI
1300 University Avenue
- 6:30 p.m. *Reception & Awards Banquet*
Medical Alumni Citation & Emeritus Faculty Awards
Holiday Inn East Towne
4402 East Washington Avenue



The University of Wisconsin **Cardiac Rehabilitation Program**

**Individuality and comprehensiveness are
key elements of the UW program.**

If you observe men and women exercising in the UW Cardiac Rehabilitation Program now located in the new UW Clinics-Research Park, you might be disappointed. There's no blaring music with throbbing beat, no bouncy exercise leader shouting out encouragement to a group more or less in synchrony, no neon leotards with color-coordinated tights. Instead, you'll see a wide variety of calm individuals, including seniors and those who need walking aids; they go about the business of improving their health by walking on treadmills, cycling on stationary bikes, rowing, using arm ergometers, lifting weights or perhaps stretching, walking or jogging in the adjacent gym.

The atmosphere seems relaxed — almost muted — as each participant obeys his or her own drummer to the cadence of a schedule specifically designed for that person, occasionally consulting with one of the program's on-duty personnel such as an exercise physiologist. One can almost feel the satisfaction of individuals taking charge of their own well-being and steadily improving their quality of life.

A cardiac rehabilitation program, according to the UW program's co-director Patrick McBride, Associate Professor of Family Medicine and Medicine (Cardiology), consists of comprehensive services that help a person recover from an episode such as a heart attack, bypass surgery, or angioplasty or from a diagnosis of high risk for heart disease. "It allows them to return to what we consider optimum functioning — feeling better and having more capacity than prior to the diagnosis," McBride explained. "It should help the patient reduce risks and lead a full and active life."

A number of physicians in the recent past were skeptical about such programs and didn't themselves have the time to give detailed guidance to their recuperating

outpatients. They thought, "I'll tell the patient to go home and start walking and eat better." But for many patients, doing-it-on-their-own wasn't enough. They didn't know when to get started, what to do, and how much is too much — or too little. For these people, the UW Cardiac Rehabilitation Program and similar ones fill a genuine need. McBride believes that all cardiac patients upon discharge from the hospital should become part of a comprehensive, multidisciplinary program that treats and educates the whole person rather than participate in individual components the doctor may prescribe or simply follow his or her own inclinations.

Studies have demonstrated that comprehensive cardiac rehabilitation reduces death rates in heart attack patients by 25% over usual care — results that are hard to ignore. Unfortunately, fewer than one third of the 13.5 million people with heart disease participate in a full program for cardiac rehabilitation.

History of the Preventive Cardiology Program

The Preventive Cardiology Program did not appear in full bloom at its state-of-the-art facility in west Madison. It began in 1968 as a small program in far less auspicious circumstances under the direction of Dr. Bruno Balke, an early leader in the application of exercise training for rehabilitation of cardiac patients. Balke conducted one of the initial studies of the effects of exercise in middle-aged men with risk factors for coronary heart disease, and he developed diagnostic exercise testing protocols that could be used for exercise prescription in cardiac patients.

Dr. Peter Hanson became Director of the Cardiac Rehabilitation Program in 1975 and initiated a rehabilitation program that emphasized basic science and clinical research.

In 1986, Dr. Patrick McBride joined the program, aiming to expand clinical programs to include primary prevention and aggressive secondary prevention. He received an NIH Preventive Cardiology Academic Award in 1987; part of it was used to establish a comprehensive Preventive Cardiology program including a lipid intervention clinic, and to increase training in Preventive Cardiology for physicians.

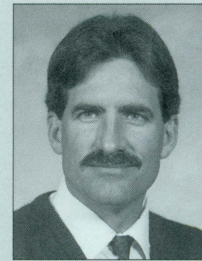
In 1986, Hanson established the Preventive Cardiology Exercise Laboratory, the site of research by graduate students and professional staff under Hanson's direction. Hanson also served as principal investigator of the Monitored Atherosclerosis Regression Study, a \$1.8 million trial to evaluate the effect of a lipid lowering diet and the drug lovastatin on the progression of coronary atherosclerosis.

For more than 25 years, the Cardiac Rehabilitation Program has maintained international prominence and provided leadership in training of exercise specialists at every level, and it interacts with many programs and departments on campus.

The UW Program's Nuts and Bolts

Individuality and comprehensiveness are key elements of the UW program, McBride said. "Once a patient has had a heart event, or has been diagnosed at high risk for developing heart disease, and is referred to us by the person's doctor, we evaluate the person and create a program specifically for that individual."

Individual evaluation is necessary. Some patients, for example, in addition to their heart disease, have disabilities such as spine or leg problems or other medical conditions that must be taken into consideration before recommending the type and pace of a safe exercise regimen, and they must be closely monitored during the initial stages. Others have risk factors that need individual attention. And each patient has unique goals in mind, which are also woven into the individual's program to provide psychosocial motivation.



Patrick
McBride

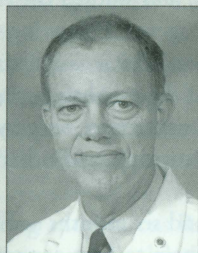
New Guidelines for Cardiac Rehabilitation

Associate Professor of Family Medicine Patrick McBride and several other cardiac experts authored guidelines for expanding and improving cardiac rehabilitation. The federal Agency for Health Care Policy recently announced these new clinical practice guidelines, which include:

- exercising 20 to 40 minutes three times a week
- nutritional counseling to reduce/maintain weight and lower cholesterol
- programs to help patients quit smoking
- psychosocial strategies to help patients reduce stress and acquire/keep a positive attitude
- home-based cardiac rehabilitation guided by health care professionals for patients not living near a service such as the UW Cardiac Rehabilitation Program

Dr. McBride, recently named to the National Heart, Lung and Blood Institute's Panel on Physical Activity, also co-authored guidelines on risk factor intervention for patients with heart disease for the American College of Cardiology 1995 Bethesda Conference.

**Peter Hanson,
Program Co-Director**



Professor of Medicine Peter Hanson, co-director of the UW Cardiac Rehabilitation Program, Director of the Biodynamics Laboratory and a nationally recognized leader in the medical aspects of exercise, developed the UW Cardiac Rehabilitation Program into the comprehensive unit that exists today, which sets the standard for rehabilitation medicine. He was one of the first in the field to combine multiple services for the management of both cardiology and cardiac surgery patients, and he recognized early on the importance of proper evaluation of patients entering such a program.

Hanson was responsible for several innovations in exercise medicine such as development of an arm stress testing program for peripheral vascular disease patients who cannot undergo regular stress testing. Under his guidance, graduate students have delved into exercise studies including left ventricular imaging as well as hemodynamics in static exercise, in borderline hypertension, on B-blockers and as therapy in end-stage renal disease. In all his research activities, he has been able to relate basic science projects to clinical medicine.

In spite of his heavy schedule at the UW, he has helped to establish outstanding cardiac rehabilitation programs in several outlying locations in the southern half of the state.



CARDIAC REHAB. REGIME

Larry Hogan '44

At first a certified exercise physiologist meets with the patient to tailor a program that eventually will allow the patient to do those things he or she wants to do and get back to normal daily functioning. Proper nutrition, along with management of cholesterol levels, hypertension, and stress are also vital components of the program. The exercise physiologist keeps close tabs on the patient for three to six individual sessions, teaching safe exercise and monitoring the patient's responses. The patient usually then joins a group.

Each group exercise session, with 30 to

40 participants, lasts about 1.5 hours on three week days. At any one time, there are approximately 100 participants in the overall program. Their ages range from the late teens to nearly 90 with the average age at about 67. There are more men than women, although the numbers of women joining the program are increasing. Most of the exercisers remain in the classes for three months after which many of them transfer to a fitness center; approximately 80% continue to exercise. A few high-risk patients stay with the program for years.

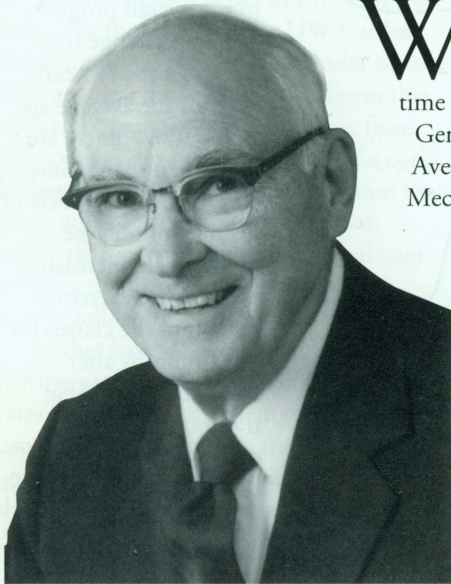
On specified days staff physicians conduct exercise stress tests, and, upon the request of an employer, evaluate strength, agility, and endurance to determine whether a patient can return to work. Individual exercise "prescriptions" are also developed.

The program has become known throughout the Madison area and beyond by word of mouth from current and former participants and their doctors. Most medical plans and Medicare cover about 80% of the expense.

"I feel good about this program, which is one of the oldest in the nation," McBride said. "We have a model program, right on the cutting edge, and we utilize innovations developed by others. We are most proud of our attention to individual needs and our comprehensiveness. We also train health professionals here in various aspects of preventive cardiology."

WMAA Citation Recipient

William P. Young
Professor Emeritus of Surgery



*Bill Young was
General Surgery's
infielder— and
outfielder.*

William P. Young's desire to attend the Medical School began when he worked part-time as an orderly in the Wisconsin General Hospital, 1300 University Ave., while an undergraduate in Mechanical Engineering. There he found that he liked hands-on work helping people. At another part-time job in Agricultural Chemistry (now Biochemistry), he discovered that he enjoyed research with animals.

His career during the following decades clearly reflected these early interests. While a medical student, for example, he investigated secondary

amyloidosis in animals, earning a master's degree in Pathology under Dr. Charles H. Bunting. As a graduate assistant in Medical Bacteriology under Dr. Paul Clarke, Bill Young helped with an immunology lab course, worked on determining some of the physical properties of poliomyelitis virus, and made preparations of bacteriophages for clinical trials.

After graduation came four years of military service in World War II followed by a residency in General Surgery under Drs. Erwin Schmidt, Joseph Gale, Kenneth Lemmer and Anthony Curreri, who not only prepared Bill Young well to practice surgery but also let him carry on some clinical investigation. He demonstrated that both morphine and Demeral produced spasm of the sphincter of Oddi and that amyl nitrite and nitroglycerin relaxed the sphincter even partially overcoming the effect of morphine or Demeral; papaverine did not. In those days, these findings had significance in the treatment of cholecystitis.

Upon completing his residency, Dr. Young remained at the hospital as a U.S.

Public Health Fellow to study carcinoma of the lung, which was becoming epidemic. He investigated the growth of lung transplanted into the anterior chambers of the eyes of guinea pigs, gained more experience in the surgical treatment of pulmonary carcinomas, and studied the effects of the very first chemotherapeutic agents. Following that, as a newly appointed faculty member, he was assigned most of the patients requiring surgery of the esophagus, vascular surgery, common bile duct reconstruction, surgery for magacolon or perforate ani, peritoneoscopy, and other uncommon or new procedures.

Soon he left Madison to spend six months at Florida State Tuberculosis Hospital System to help correct their extremely high mortality from surgical resections of tuberculous lesions. There he taught the techniques he had learned from Dr. Joseph Gale and the preparation of patients for surgery and the postoperative care taught to him by Dr. Helen Dickie.

Three months after he returned to Wisconsin, Bill was asked by Dr. William S. Middleton to become temporary Chief of Surgery at the new Madison Veterans Administration Hospital, which was to accommodate 495 patients with tuberculosis, most of whom were to have pulmonary surgery. With Dr. B. Jack Longly, Bill initiated a pulmonary surgery program that was continued by Dr. John Mendenhall. The Madison VA Hospital was one of the very best tuberculosis treatment centers in the VA System.

Next in Dr. Young's diverse career, his request for an experimental surgery laboratory was honored when he was given a room previously used by Pharmacology. Here, at the behest of Dr. Schmidt, Bill began to investigate what was known in experimental animals as irreversible shock. At Dr. Charles Crumpton's suggestion he studied the myocardial cells using Dr. Helen Hift's electron microscope preparations. A two-hour period of shock produced interesting changes in mitochondria; hypothermia during a similar period of shock, however, seemed to prevent such changes. Fortuitously, Bill's work with hypothermia led him into cardiac surgery, the next phase of his pioneering career.

Hypothermia was being introduced into clinical surgery at several medical centers for the correction of intracardiac defects under direct vision, but some of the centers were experiencing unacceptable mortality. Dr. Young's animal laboratory work with hypothermia was shifted to the Cardiovascular Research Laboratory on the sixth floor of the original McArdle building, where he began using hypothermia and inflow occlusion on experimental animals. This was followed by very successful surgery on humans using this technique.

The University of Minnesota and the Mayo Clinic each demonstrated that the pumpoxygenator technique, which had been developed by Dr. John Gibbon of Philadelphia,

Fortuitously, Bill's work with hypothermia led him into cardiac surgery, the next phase of his pioneering career.

could be used successfully to correct intracardiac defects that required longer periods of direct vision. Again, a very unacceptable mortality plagued most other medical centers when they tried to adopt the technique.

Dr. Young and Marcus Ravnar worked with a pumpoxygenator in the laboratory until the animals on which it was used routinely survived. They even operated twice on animals in the human operating room with complete OR teams before using the technique on human patients. Bill carefully trained the entire team that was to be involved with surgery using the pumpoxygenator and the team that would care for patients on whom it was to be used. Training was especially important because in the earlier years the team had to depend very heavily upon trained observations using all of the senses except taste. They had no blood gas determinations, no electrolyte determinations with the exception of sodium and potassium one time each weekday, no electronic nor hemodynamic monitoring, no diuretic except the only slightly effective IV ethyl alcohol (mercuhydrin was totally ineffective under the circumstances), no respirators (ventilators), and they had to make their own oxygenators.

Thus began a remarkable series of accomplishments. Dr. Young's first 49 intracardiac procedures with hypothermia and inflow occlusion were all successful, without a death or serious complication. Likewise, he achieved very acceptable mortality when he used the pumpoxygenator on critically ill patients. He was the first to demonstrate the advantage of total correction of some very young infants with Tetralogy of Fallot, among the first to use the pumpoxygenator successfully on adults with endstage rheumatic heart disease, and among the very first to use artificial valves with good long-term results. He also demonstrated the clinical advantages of the Gott-Daggett artificial valve, had one of the very few programs using homografts to replace destroyed aortic valves, and had excellent results with coronary endarterectomy.

In spite of his wide-ranging types of surgeries, Dr. Young encountered essentially no bacterial infections in more than 2,000 cardiac procedures, and his overall patient mortality was considerably below the national experience.

In addition, he collaborated with Dr. John Foltz in determining regional (organ) blood flow during heart-lung bypass and in mapping the conduction system in certain congenital defects of the heart.

Bill was one of the very few surgeons to successfully use the Sondergaard technique for closing ostium secundum interatrial septal defects of the heart without either hypothermia or pumpoxygenation.

William Young's most gratifying achievement was training Dr. George Kroncke, who — according to Bill — became a better surgeon and teacher than his mentor.

As to his successes in the early years of heart surgery, Dr. Young gives great credit to many of those with whom he worked: Dr. George Rowe's excellent preoperative diagnoses and his memory bank of all things "cardiac" as well as his advice, encouragement, instructions and hands-on help; anesthesiologists Drs. Karl Siebecker and Betty Bamforth with their knowledge, skill and cooperation; Marcus Ravnar, originally an orderly, who learned along with Bill and became a professional perfusionist second to none; a team of nurses who also learned along with him and who became critical care nurses before any nurses were recognized as such; a series of outstanding assistant surgeons, six of whom went on to develop successful heart surgery programs of their own; Dr. Helen Dickie, who taught Bill how to care for patients having intrathoracic surgery; Dr. William S. Middleton, who gave him continuous encouragement even from Washington, D.C.; Dr. J. LeRoy Sims, who impressed him with the value of thoroughness and completeness in all patient care; Dr. Paul Clark, who instilled into him an "aseptic conscience"; Dr. Herman Shapiro, who was always a proponent of heart surgery; and many more.

Professor Emeritus William Young appreciated being part of an exciting, brief period in the history of surgery. He liked his patients and he liked helping them; his patients, in turn, as well as their families loved him and some continue to regularly call him for advice, usually medical. He also is satisfied that he functioned as a general surgeon doing whatever the Medical School asked of him, and that he did not operate on humans until he was fully prepared and everything and everybody involved were also well prepared.

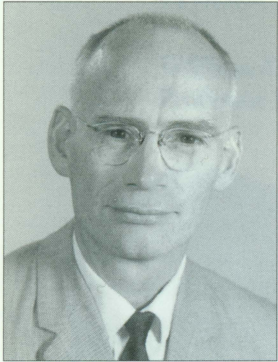
During his long and eminent career at the Medical School, Bill Young was, according to a friend who had kept track of him since his early days in the military, General Surgery's utility infielder — and outfielder.

William Young's most gratifying achievement was training Dr.

George Kroncke, who — according to Bill — became a better surgeon and teacher than his mentor.

Emeritus Faculty Awards

Clinical Science



George G. Rowe
Emeritus Professor of
Medicine

I routinely tell medical students it is a rare privilege to make a living doing exactly what you want to do.

Young George Rowe entered the University of Wisconsin to become a creative writer. After just a year in the School of Journalism, though, he knew he didn't want to be a reporter. He even took chemistry against the warning of his adviser that a discipline no more complicated than geography should be the choice of a journalist.

Then George was beset with acute appendicitis. This was bad news, indeed, for he had always feared nurses and doctors. In earlier years, even a routine check by the school nurse would induce in him a fever and other ominous symptoms. But to his surprise Dr. Schmidt, who operated on him, the nurses and other hospital personnel weren't nearly so bad and scary as he had envisioned. Thus began his resolve to go to the Medical School, and an eminent career was launched.

After graduating from the Medical School but before returning for a residency in internal medicine and a fellowship in cardiology, Dr. Rowe interned at Philadelphia General Hospital, served two years in the armed forces at the VA Hospital in Wichita, Kansas "60 miles from the geographic center of the country" instead of the China/Burma/India front for which he had volunteered, and taught anatomy at Washington University, St. Louis.

As a young researcher, he was named the Medical School's first Markle Scholar in Medical Science, a highly competitive and prestigious five-year award, and he was encouraged to spend a year abroad. Dean Middleton assured him that the Hammersmith Hospital in London was the only place for him. So it was that the Rowe family spent a delightful year in England, sometimes taking hairy car trips through the byways of England and the Continent in a car that occasionally proved undependable. The Rowes lived in a suburb where the rigid Brits rarely mingled with one another. Their five-year-old son, however, made the acquaintance of everyone in their court within two weeks, and brought neighbors together as only an outgoing child could have managed.

Back in Wisconsin, where he remained for the rest of his career, Dr. Rowe spent much of his time in the cardiac catheterization lab. "I was there in 1952, when the lab first began. I've been involved in 9,000-10,000 human cardiac catheterizations," he said. "(Besides people), we catheterized rats, guinea pigs, dogs, cats, cows and pigs. Pigs' coronaries are the most similar to people."

Along the way, George Rowe produced 220 journal articles, 14 book chapters and 4 invited editorials. His main research interest was in measuring the factors governing regulation of flow in regional circulations, principally the cerebral and coronary vascular systems. He held many important positions such as President of the Association of University Cardiologists, President of the Central Clinical Research Club, President of the Wisconsin Heart Association and many other professional posts. He also was a member of the NIH Cardiovascular Study Section from 1966 to 1970, recipient of an NIH Health Career Development Award, and a listee in "Who's Who in America." At the Medical School he served as Director of the Cardiovascular Research Laboratory for several years. All this time he was a highly regarded, busy clinician as well as a mentor for many residents and postdoctoral fellows from the U.S. and abroad.

While contemplating his eventful career, George reminisced that he hoped the next 50 years in medicine would be as good as the 50 he has experienced. "Beginning in my senior year in medical school, I watched children die from heart defects we couldn't do anything about. Almost every year since then, some new defect could be repaired.

"I've had just a wonderful time. I don't think there has ever been a period when there has been so much progress. I routinely tell medical students it is a rare privilege to make a living doing exactly what you want to do. I can remember when penicillin came in, and when patients with active TB just sat in big wards with feverish-looking faces, coughing something awful."

Dr. Rowe must have transferred some of his upbeat attitude to members of the Medical School Class of 1993, which he mentored, for he was very popular and nearly always in demand. In the halls of the Medical School one could often see George Rowe, in Pied Piper style, walking briskly and sur-

Emeritus Faculty Awards

Basic Science

rounded by several enthusiastic students, all trying to listen to him or get his attention.

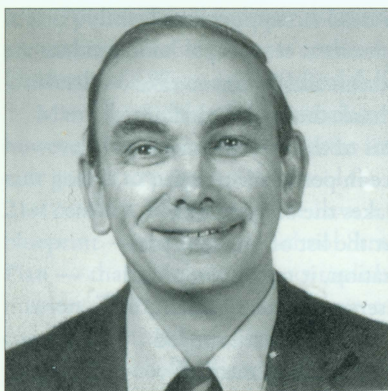
"Mentoring was a great experience," he said, "and I made 140 new friends. Medical students are so idealistic and industrious, so exciting to work with. I attended all the classes for the first two years and I attended their parties and several weddings. I had a very good time.

"Sometimes they would ask me about the significance of some of the material. All I could say was that you never know for sure what will be significant for you."

Even in retirement, Dr. Rowe keeps busy teaching medical students in first year anatomy and in a fourth year anatomy elective and attending conferences at the UW Hospital. He keeps his body in good shape by eschewing elevators and, when possible, walking over the hill and down to the lake and back.

As for the future, Dr. George Rowe said "I did exactly what I wanted to for 50 years. Now it's up to my wife Pat to decide what we do. If she says we'll go someplace, we'll go." They've already visited Alaska, Africa, Scandinavia, Russia, South America, Australia, New Zealand and Europe. Next comes Ireland — and then?

We'll have to ask Mrs. Rowe.



Donald W. Smith

Professor Emeritus of Medical Microbiology Donald W. Smith retired from the Medical School after a distinguished career spanning 37 years.

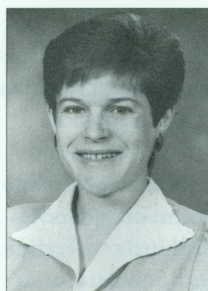
Internationally recognized for

his research on tuberculosis, he still consults with colleagues abroad.

He was, in fact, on a trip to India, China, Greece and Egypt when we planned to interview him. An article about Dr. Smith will appear in the summer issue.



A word to the wise...



Mary Zupanc, MD

Mary Zupanc recently received national exposure on TV. She was the featured interviewee in the first segment of CBS's 60 Minutes on February 25. She told how someone had mailed to the U.S. Postal Service a change-of-address card with her name and a new (fraudulent) address in New York City. This address turned out to be a storefront with rental mailboxes. That simple duplicity nearly cost her many thousands of dollars when the perpetrators, armed with key information obtained from her intercepted mail, tried to withdraw funds from

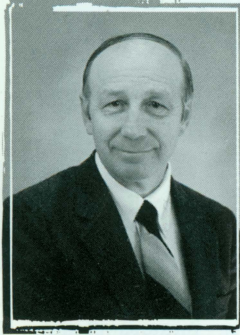
her Mayo retirement account and her daughter's college fund. By luck and fast action she was able to intercept the scheme just in time, although psychologically her identity had been hijacked and she felt violated.

When she notified the postal authorities of the crime and asked them why they don't require change-of-address forms to be presented in person along with photo identification, they replied that such a process would be inconvenient for some people. Furthermore, they said, the problem was too insignificant to take such measures. Perhaps she should change her name!

The TV sleuths, however, found that the practice is fairly widespread, and that physicians and others with presumed high incomes are the primary targets. In a period of just a few days, such mischief, which often includes credit-card fraud, can reach disastrous proportions.

Mary Zupanc, who served a fellowship in pediatric neurology with Professor Emeritus of Neurology Ray Chun, and later joined the Medical School faculty, left Wisconsin as Associate Professor of Neurology and Pediatrics two years ago to join the Mayo Clinic. While on staff at the UW Medical School, she was a very busy and popular clinician and researcher. Quarterly readers might be interested in learning that she worked with John Cameron, Professor Emeritus of Medical Physics, Physics and Radiology, on neuromagnetism.

Dr. Zupanc earned her medical degree at UCLA and further trained at the University of Washington and Stanford as well as Wisconsin. As an undergraduate at the University of Wisconsin, she was named to Phi Beta Kappa and other honor societies. She was selected as one of the Ten Outstanding Young Women of America in 1987 and received several other honors, and she was active in several capacities in Physicians for Social Responsibility. Her extracurricular activities also included being a classical pianist, marathon runner and Girl Scout leader.



James L. Basiliere, '62

"We have met the enemy and he is us."

Pogo

In the previous columns I have attempted to characterize a relationship between the Alumni Association and the medical school in this time of radical change. In this column I would like to address some of the issues concerned with competition, in this changing environment, as it relates to the university alumni and practicing physicians. The system is evolving from a provider driven to a consumer driven system and medicine is no longer a profession but an industry. Managed care and integrated systems are a reality and shortly will cover a major share of the patient population. At that time the independent hospitals and practices will not survive. The rapidity of change is, to say the least, frustrating and confusing. How hospitals including university hospitals, medical schools and physicians cope with this is causing a great deal of anxiety and fear. The scenario that develops is that primary care providers, health insurers and managed care drive the system, and the specialist, academic centers and hospitals are dependent on these groups for their business.

Capitation is coming and is based on large primary care networks resulting in a surplus of hospital beds and specialists. The physicians need to control health care. They control delivery, quality and the cost of health care. They also persuade other physicians to change their practice habits to be more efficient. Herein lies the impetus for practice parameters and outcomes research.

How does all this relate to competition? As these integrated systems develop they will be competing for patients. In some areas these systems may cooperate and in other areas they may be competitive. The same system could be participating in competitive insurance plans in the same area. In essence, competing against themselves. To paraphrase Pogo's statement above, we have met the competition

and they are us. The University needs to be more involved in these systems, and they need to form closer relationships with local integrated groups. This could include sharing responsibility for patient care, follow-up and training of students and residents, and continuing medical education for the practicing physician. After all, the University is probably its own worst competitor as they train many specialists who go into the community and manage problems that formerly were referred back to the University. I believe the University needs to negotiate with various systems to provide these services and maintain their patient referral base. The negotiation will be critical in the attempt to affiliate with all of the players in a specific area and not to appear to favor one system over another. If one system is favored over another they certainly will risk alienating the other players in an area. This certainly will require careful and informed negotiations. We as alumni and practicing physicians need to support the University in this endeavor.

This is my last column and I want to take this opportunity to thank the staff, board of directors and members of the various committees for their diligence in performing their jobs. That is what makes the organization work. When I look at the list of previous presidents of this organization, it makes me proud and humble to have served as the president. I do hope in some small way we have moved the association along. We have a medical school and our Alumni Association of which we can be extremely proud.



Philip Farrell

The Medical School Continues to Advance Strategic Priorities

The Medical School's Mission: Meeting the health needs of Wisconsin and beyond through comprehensive excellence in education, research, patient care and service, responsive to the evolving expectations of society.

During my first year as Dean of the Medical School there have been many challenging issues that have required the "sifting and winnowing" processes the University's founders so ably prescribed. We, and all the other medical schools in this country, must constantly try to adapt to an extremely dynamic medical, economic and political environment. I believe we are making notable progress at the University of Wisconsin Medical School.

Many formidable issues remain, however. My immediate and most important goal is to prepare our school for the 21st century. Fortunately, we have a blueprint — the Medical School Strategic Plan — that is helping us accomplish this mission. The challenges are enormous and complex, but, as I was recently reminded in a fortune-cookie message, finding the solutions is very stimulating. The message, a familiar Chinese proverb, read "May you live in interesting times."

There are seven overall goals in our Strategic Plan. They are:

- I. Increase the diversity of faculty, staff and students in order to enrich our learning environment and to better reflect the society we serve.
- II. Foster research and educational initiatives which will facilitate the

achievement of the vision and mission of the Medical School.

- III. Ensure that the campus master plan reflects future planning of the Medical School in coordination with other campus units.
- IV. Further develop and link the state connections of the UW Medical School to serve the State of Wisconsin.
- V. Enhance the educational and research infrastructure of the Medical School

to ensure optimal productivity and responsiveness.

- VI. Accelerate the development of cost-effective, integrated health care delivery systems.
- VII. Develop management mechanisms to ensure the most efficient use of financial, space and human resources of the school.

As we are addressing goals I-IV, our initial efforts have concentrated on recruiting leaders for programs and departments. One of these is our new Associate Dean for Faculty Judith Leavitt, who has already made good progress in her task of increasing diversity in the Medical School Community. (See profile of Dr. Leavitt in this issue.) Gordon Ridley, who previously served as Associate Director of the UW Hospital and Clinics, has assumed responsibilities as the Medical School Associate Dean for Administration, responsible for re-engineering our Administration (Dean's Office). Mr. Ridley, incidentally, initiated the Hospital's very successful Med Flight program. Dr. Janet L. Greger, a distinguished Professor of Nutritional Sciences and Associate Dean for Administration in the Graduate School, will be our new Associate Dean for Research. And Dr. Donald Harkness, Professor and former

Chair of Medicine, as the Assistant Dean for Continuing Medical Education, will carry on the highly rated program developed by Dr. Thomas Meyer. Dr. Harkness plans to enhance the CME organization to better meet the educational needs of community physicians, facilitate integration of the Medical School's CME and UWHC/UHC outreach education, develop a business plan, and assess and evaluate ETN long-distance communications.

I'm also pleased to inform you that Dr. Gregory Crosby, a distinguished physician-neuroscientist, has been appointed Chair of Anesthesiology. His appointment concludes the searches for departmental chair positions that were vacant when I began in the Dean's Office. Only the Chair of Pediatrics, which I vacated last year, remains unfilled.

We are grateful to have been able to acquire such outstanding people for these important positions. There are still ongoing searches for Associate Dean for Clinical Affairs and Associate Dean for Students. The search committees would welcome suggestions from Medical Alumni.

The Howard Hughes Medical Institute four-year grant to the Medical School, that we mentioned briefly in the last Dean's column, was officially announced in January. The \$2,800,000 award will be used to expand the scope of research in neuroscience, molecular genetics and immunology with special emphasis on the areas in which these disciplines intersect — neurogenetics and immunogenetics. Grant funds will help underwrite the research of junior faculty and recruit new young faculty.

Now I'd like to bring you up-to-date on the future of our facilities (Strategic Goal III.) Last November, the Campus Planning Committee unanimously endorsed a new funding partnership aimed at transforming the Medical School and other health sciences facilities into a major medical and research training center. HEALTHSTAR,

continued on page 31

As we reported to readers in earlier issues, the Medical School has made major — some would say dramatic, even drastic — changes in its curriculum.

Every few years the curriculum here and elsewhere undergoes revision. Changes have generally been modest, reflecting the innate conservatism of medicine.

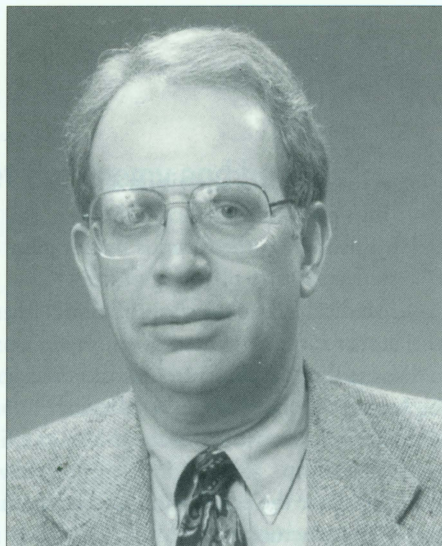
In recent years, however, a number of disturbing factors converged more or less simultaneously upon the medical scene. Medical students were being hit harder and harder with information overload, which showed no signs of slowing; how could they possibly keep up? The health care delivery system was changing rapidly with the growth of managed care and the demand for more primary care physicians. Research and training funds were dwindling. Society's deferential attitude towards physicians was beginning to turn around.

Heads were spinning.

Medical schools had to respond to many of these forces and do so quickly if they wanted to survive and thrive; business as usual wasn't going to work. No longer could they rely on the old pattern of students spending two years with books, labs and massive memorization followed by two years of experience with clinical medicine.

At the University of Wisconsin Medical School, a large number of faculty, students and administrators spent two years intensively reviewing and evaluating the curriculum. They concluded that medical students of the future would be better served by exposure to a mix of basic and clinical sciences throughout their four years, and that students would need to participate more in their own learning.

Associate Dean for Medical Education and Professor of Pediatrics Sheldon Horowitz summed up the spirit of the new approach. "Instead of taking a passive role in their education, students will be encouraged to become active, self-directed learners, continually seeking, for the rest of their lives, new and relevant information as it becomes available." He added that basic sciences should still remain the main focus of the first two years but be more integrated



Sheldon Horowitz

CURRICULUM REFORM MARCHES ON

**The Medical School
has made major —
some would say
dramatic, even
drastic — changes
in its curriculum.**

with one another and with clinical applications. This would require that basic science and clinical science faculty work together to better prepare their students for the real world of medicine.

Dr. Horowitz also said that the school would "institute a comprehensive four-year plan for primary care that builds on our long-running and widely recognized primary care programs for third- and fourth-year students."

Now, nearly four years after curriculum evaluation began and a year and a half into implementation of the new curriculum, the early fruits of the revision can be surveyed.

The Generalist Partners Program (GPP), headed by Susan Skochelak, Associate Dean for Primary Care and Outreach and Associate Professor of Family Medicine, has been received enthusiastically by students, faculty and community primary care physicians associated with it. The program, which began with the first year class in the fall of '94, pairs a medical student with a community-based doctor for an afternoon every other week. The original GPP students are now in their second year of working with the same physicians. During this year, however, since their experience and skill levels have increased, they are allowed to participate more in interviewing patients and conducting focused physical exams.

Students are also learning more about how to assess and handle a range of clinical presentations. In addition to the office visits, for example, they attend lectures designed to highlight topics such as prevention and outcomes, then assemble in small groups of 10 students with a primary care faculty member to expand upon the topics.

As another part of the GPP experience, a student selects a clinical case he or she has seen in the office and delves into the literature for answers to the patient's problem. "This is a very important skill that will help students when they reach their third year and beyond," Horowitz said. "We (practicing physicians) often face situations we don't know quite how to handle, and we must consult various sources."

"Instead of taking a passive role in their education, students will be encouraged to become active, self-directed learners, continually seeking, for the rest of their lives, new and relevant information as it becomes available."

Horowitz added that current first and second year students are much more advanced in a clinical sense than those who came before them, who received little clinical experience in their early years. Although the GPP has generated national recognition, curriculum revision has progressed on several other fronts. Dr. Horowitz said that the new curriculum has focused on increased active learning, more problem-based learning, small-group discussion, and less time devoted to lectures. (In year 2, 22 courses have been reduced to 13, 8 of which are new.) Furthermore, courses have become far more integrated and interdisciplinary.

For example, a new year-long course called Infection and Immunity has replaced separate courses in Medical Microbiology, Immunology, and Infectious Diseases. Basic science faculty work cooperatively with clinical faculty to present the scientific rudiments of a disease entity such as HIV, quickly followed by its clinical manifestations and treatment options. Small group discussions follow. The course has proved to be very popular with students.

The curriculum now includes a course in nutrition and a course in human sexuality, which considers normal and abnormal sexual functioning and how to discuss sensitive information with patients.

Third year clerkships are also being revamped. Neurology, for one, has made major changes with the introduction of a new core curriculum using case-based topics. Surgery has taken great strides in

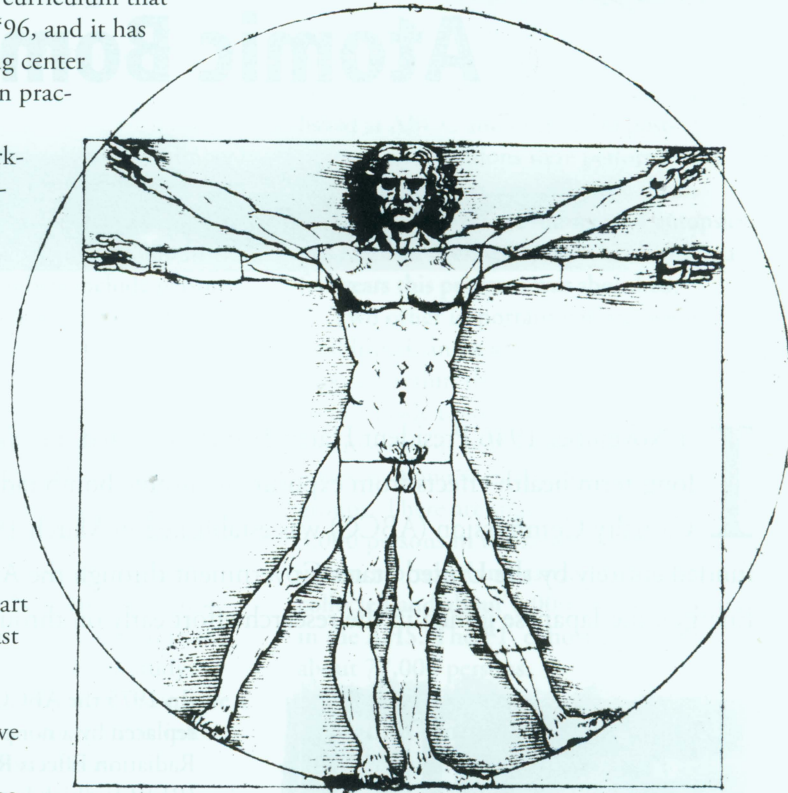
developing a core curriculum that began in January '96, and it has designed a learning center where students can practice skills.

Third year workshops include subjects such as patient relations and how to support families in difficult situations. The near future will increase students' exposure to social medicine, ethics, humanities and other topics not part of the standard past curriculum.

Although a student may receive respectable grades and assessments, he or she may harbor a deficiency that could prove undesirable or unacceptable in a practicing physician. Therefore, a comprehensive assessment exam has been established for the end of the third year to determine student/patient communication, diagnostic proficiency and other clinical skills as a student passes from station to station, encountering a variety of patients with a faculty member in attendance.

Since the new curriculum changes have focused on the first two years, with other changes currently under development, it is not possible to comprehensively assess their impact. The Medical School was appraised, however, by the Liaison Committee on Medical Education (LCME), the national medical school accreditation authority, in November of 1995 as part of their seven-year accreditation process and deemed to be doing very well. Such outside validation indicates that the curriculum planners and implementers are on the right track.

Mark Albanese, Director of the Office



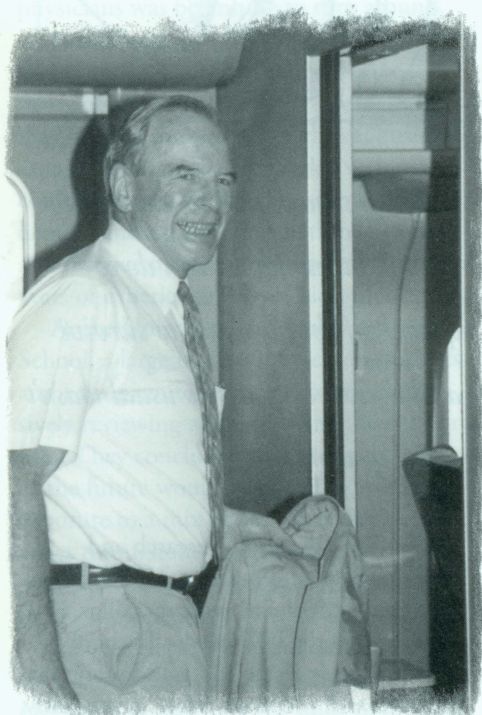
Medical schools had to respond to many of these forces and do so quickly if they wanted to survive and thrive; business as usual wasn't going to work.

of Medical Education Research and Development and Associate Professor of Preventive Medicine, recently polled 1994 graduates of the UW Medical School a year into their residencies and found that they felt well prepared. More importantly, he also surveyed their residency directors and found that UW graduates, compared with their colleagues from other schools, received high marks.

It seems that the old curriculum, which apparently had served students well, was a solid foundation from which to launch the revisions we see unfolding today.

The Study of the Atomic Bomb Survivors

In November 1946 President Harry Truman directed the National Academy of Sciences to initiate a study of the long-term health effects from exposure to atomic bomb radiation in Hiroshima and Nagasaki. The Atomic Bomb Casualty Commission (ABCC) was established in March 1947 and studies were begun the following year. Although funded entirely by the United States Government through the Atomic Energy Commission (now the Department of Energy), the Japanese joined in the research effort early on through the newly-created Japanese Institute of Health.



The author boarding the bullet train on his departure from Hiroshima.

In 1975 the ABCC was dissolved and replaced by a nonprofit foundation, the Radiation Effects Research Foundation (RERF), which has continued the research program but with both countries sharing governance and cost.

The early research efforts were uncoordinated and disjointed and an overall strategy was lacking. Research projects and population samples were left to the discretion of individual investigators and these changed as tours of duty, usually two years or less, were completed. The entire research program was nearly abandoned altogether in the early fifties. In 1955 the NAS appointed a committee to review the situation and recommend a course of action. The Francis Committee, named after its chairman Professor Thomas Francis, Jr., of the Department of Epidemiology at the University of Michigan, recommended that fixed study cohorts be established and that long-term epidemiologic studies be initiated. These far-sighted recommendations were adopted in their entirety and the cohorts established remain the basis of the studies that have been ongoing to this day.

It will be of special interest to our

readers that a second equally important committee was assembled in 1975 under the very able leadership of Professor James F. Crow of the Department of Human Genetics here at the University of Wisconsin. This committee recommended continuation of the major epidemiologic studies and significant changes in the direction of the research program in genetics. The Crow Committee Report was completed just days before the dissolution of ABCC and the new Foundation implemented all of its recommendations. For many years thereafter Professor Crow helped evaluate and guide the research program at RERF as a member of its Scientific Council.

There has actually been a fairly strong Wisconsin faculty connection to the studies on the atomic bomb survivors. During the days of ABCC, the late Dr. Murray Angevine directed the autopsy program for a time and Dr. Robert Barreras (Medicine) served his required two years of military duty there as a medical officer in the mid-sixties. Since reorganization into RERF, four of our faculty have each spent two or more years as Directors and Chiefs of

Though the bombs exploded over the two Japanese cities were different in design, composition and explosive power, their effects were quite similar.

Research: Roswell Boutwell (Emeritus Professor, Oncology), Kelly Clifton (Human Oncology), Seymour Abrahamson (Genetics and Zoology) and myself (Medicine). Seymour Abrahamson is currently serving as Chief of Research and has twice previously served two year terms.

Before describing some of the findings of the major studies conducted at ABCC/RERF let me first mention something about the bombs, the study populations and the assignment of radiation exposure doses.

The Bombs

Though the bombs exploded over the two Japanese cities were different in design, composition and explosive power, their effects were quite similar. The energy released from each was about 50% blast, 35% heat and 15% radiation. The radiation from both bombs was primarily gamma though there was some neutron release which was apparently more significant in Hiroshima.

The bomb exploded over Hiroshima on August 6, 1945 was a uranium 235 bomb with an explosive equivalent of approximately 15 kilotons of TNT. Its blast effect extended to 4 km, the heat to 3.5 km and the radiation to nearly 2 km. The Nagasaki bomb detonated 3 days later was made from plutonium 239 and had an explosive equivalent of 21 kilotons of TNT. Its blast extended to 5 km, the heat to 4 km and the radiation to about 2.5 km.

Both bombs were exploded at between 500 and 600 meters above the ground to maximize their destructive forces. Fortunately this minimized both fallout and residual radioactivity at the site of impact. To be sure there was a small measurable radioactive fallout in both cities and some radioactivity at the hypocenters which decayed quite rapidly but medical consequences from these sources of radiation is thought to have been minimal.

There is uncertainty about the number of people killed by the bombs. It is estimated that from 80,000-120,000 died in Hiroshima and from 60,000-80,000 in Nagasaki. These numbers include persons killed outright and those who died from injuries or radiation effects before the end of 1945.

The Study Cohorts

Based upon the 1950 Japanese National Census there were 284,000 atomic bomb survivors. At the time of the census 98,000 were living in Hiroshima and 97,000 were in Nagasaki. Most of these 195,000 persons were placed in the Master Sample from which the study cohorts were derived although there were a few names added later based upon information from the 1960 census.

The composition of the Life Span Study Sample (LSS) was based upon the distance the individual was from the hypocenter at the time of the bombing (ATB). The proximally exposed group consisted of persons who were within 2,000 m of the hypocenter. The distally exposed were 2,500-10,000 m from the hypocenter and were matched to the first group by age, sex and city. A third group, also matched to age and sex, included persons not in the city ATB. There have been a few additions to the group from time to time bringing the total in the LSS to approximately 120,000.

The Adult Health Study Sample, a sub-cohort of the LSS on whom biennial health examinations have been performed, was constructed with 5,000 persons within 2,000 m of the hypocenter who reported acute radiation signs or symptoms (e.g., hair loss, petechial hemorrhages), 5,000 persons who were within 2,000 m but without apparent radiation effects, 5,000 persons who were 3,000-4,000 m from the hypocenter ATB, and 5,000 persons not in the city ATB. Each group was matched to those in the first group by age and sex.

The Pathology Study Sample was made up of approximately 70,000 exposed persons living within the two cities. A large and thriving autopsy program was established at ABCC and over 7,000 post-mortem examinations were performed on persons from this sample. By the time RERF was formed the numbers of autopsies per year had declined severely and within a few years this program was abolished.

Two other important cohorts were established, an *in utero* sample of those exposed within the womb and the F₁ cohort made up of offspring born to parents, one or both of whom had been exposed, along with appropriate control groups. There are slightly more than 3,000 persons in the *in utero* cohort on whom mortality and cancer data are being collected and about 1,000 are participants in the AHS. The F₁ cohort contains about 77,000 persons.

Radiation Dosimetry

Of critical importance to all of the studies at RERF has been the assignment of an approximate radiation exposure dose to persons within the study groups. Scientists at Oak Ridge National laboratory devised the tentative 1965 dosimetry (T65D) system which allowed original dose estimates for survivors. This required knowing precise locations of persons ATB and the type of shielding (e.g., cement construction, Japanese home, etc.). Because this system did not prove to be altogether satisfactory, committees of scientists from Japan and the United States, after many years of intense effort, came up with a dosimetry system in 1986 (DS86) which was adopted by RERF in 1987. DS86 is generally considered to be more accurate than T65D and it allows calculation of individual organ doses. Because DS86 dose estimates are somewhat different from T65D, some in the scientific community have questioned its acceptance by RERF so late in the study. It should be remembered that these assigned exposure doses are only approximations. For groups of individuals the values are probably quite satisfactory but for a given individual that might not be true.

Deaths Attributable to Radiation

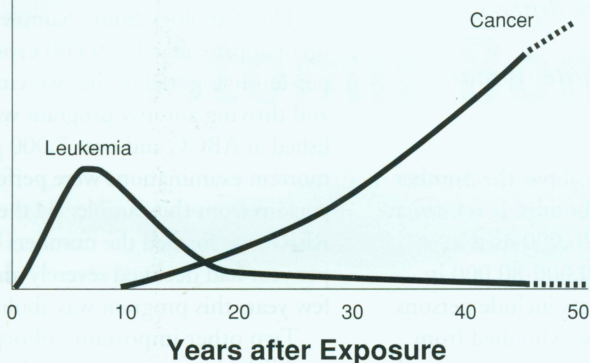


Figure 1. Pattern of excess deaths from cancer and leukemia following A-bomb radiation exposure.

Relative Risk at 1Gy

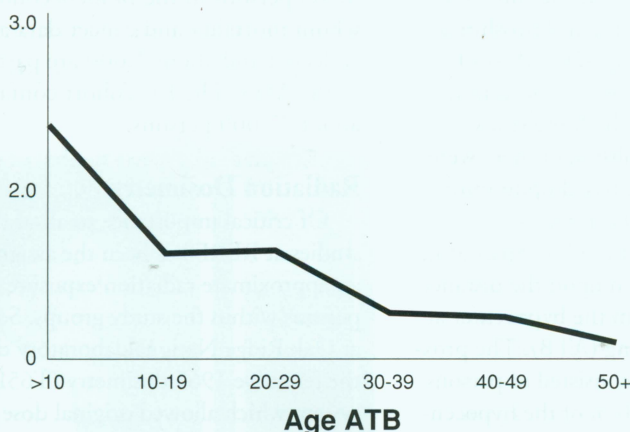


Figure 2. The effect of age at the time of radiation exposure upon the risk of developing cancer. (ATB, age at the time of the bomb.)

Life Span Study

The purpose of this study is to define the cause of death of persons in the LSS cohort. To date it has been possible to assign DS86 dose estimates to approximately 90,000 persons within the group so currently risk estimates are based on that sample. By agreement of the Japanese government ABCC and RERF have been allowed to use information from the highly accurate family registration system (koseki) to determine dates of death of study cohort members. Another branch of government then supplies a copy of the death certificate. Staff members are given access to hospital records and slides from autopsies and surgery to verify causes of death and the presence of cancer. Access to the koseki has been of enormous help in retrieving the necessary information, even for persons who have moved abroad. ABCC financed and helped establish excellent tumor registries in Hiroshima and Nagasaki prefectures. Information from these registries enables RERF to determine cancer incidence in addition to the cancer mortality within the LSS.

Some of the most useful and widely publicized data from ABCC/RERF are those from the LSS. A dramatic increase in deaths due to leukemia amongst the survivors became apparent a few years after exposure, peaked at 6-8 years and then gradually fell back to nearly the level seen in the unexposed group (Fig. 1). The types of leukemia induced by radiation were those which most frequently occur naturally in Japan: chronic myelocytic leukemia and both acute lymphocytic and acute non-lymphocytic leukemia.

Excess deaths from solid tumors, on the other hand, first became apparent about 10 years after exposure, have risen steadily since and are still rising (Fig. 1). This increased risk of cancer is linearly dependent upon exposure dose even at exceedingly low doses. Because of this linearity it is possible to assign risk for any given exposure; RERF has frequently expressed its data at exposures of 1 gray (roughly equivalent to 100 rads). This is approximately equal to one-fourth the LD50 for whole body radiation in man.

Taken all together there is a 60% increased risk of death due to cancer at an exposure of 1 gray. The average exposure of the proximally exposed survivors is, however, only about 0.16 gray. Whereas nearly all types of cancers are increased, those for which there is the greatest excess risk are breast (in women), thyroid, colon, stomach and lung. If one plots the relative risk for a given cancer against age ATB one can see that the risk of developing a cancer as a result of radiation exposure is much higher for those who received their exposure at younger ages (Fig. 2). It is not known yet whether this is due to greater sensitivity to radiation damage in the young or simply that the exposed young have a longer time in which to accumulate the additional mutational events necessary for a cancer to be expressed.

Most of those in the LSS who have died of cancer did not develop those cancers from the radiation exposure. Table 1 gives the total number of deaths from cancer and leukemia in the LSS from 1950 - 1990. Note that half of the deaths due to

Table 1

Life Span Study: Deaths From Malignancies, 1950-1990

	Total # of deaths	Estimated # of deaths due to rad.	% of deaths attributable to rad.
Leukemia	176	86	49%
Cancer	4,687	341	7%
Total	4,863	427	9%

A dramatic increase in deaths due to leukemia amongst the survivors became apparent a few years after exposure, peaked at 6-8 years and then gradually fell back to nearly the level seen in the unexposed group

leukemia are "excess", or attributable to the radiation but that is true for only about 7% of the deaths due to cancer. Since the LSS cohort is thought to include about 50% of all proximally-exposed survivors, by doubling the numbers in the table it can be estimated that through 1990 somewhat less than 1,000 persons have died from malignancies attributable to the radiation exposure from both bombs. For solid cancers this may yet rise considerably since those exposed while under the age of 10 years are only now entering their most cancer prone years.

Adult Health Study

Biennial physical examinations were begun on the AHS cohort in both cities in 1958 based upon a general protocol to which specific studies may be added in any given biennium. The first relevant finding which arose from these examinations was the discovery of a recognizable form of cataract which occurred in a linear relationship to exposure doses above 1.5 gray. A threshold has not been found for any of the other medical effects related to atomic radiation. It is worth noting that the cataract data also show an age effect; those younger ATB had a greater incidence of cataract at any given exposure dose.

Not surprisingly the dose-related increased risk of cancer and leukemia first detected in the LSS has been verified in the AHS. In addition dose-related increases in two benign tumors, uterine myomata and parathyroid adenomas, have been noted as well as increases in nonmalignant liver diseases (e.g., cirrhosis and chronic active hepatitis) and various benign thyroid disorders. Deaths due to all causes other than malignancy and deaths due to myocardial infarction are very slightly elevated in a dose-dependent manner. Whereas there is no evidence that radiation exposure causes premature aging, women exposed to higher amounts of radiation experience

menopause at a slightly earlier age.

An enormous amount of valuable longitudinal clinical data have been collected on members of the AHS, many of whom have lived into their 80's. Certainly it is the largest such study in Japan and it resembles in size the Framingham study. RERF scientists have compared the data of the AHS to those of other large longitudinal clinical studies in Honolulu, San Francisco, Seattle and Olmstead County, MN, and other such cooperative studies are planned. Health authorities in Japan are beginning to show considerable interest in the AHS database because the population in that country is aging rapidly.

Another very important role played by members of the AHS cohort is that they are the source of the biological samples for the basic scientific studies conducted in the genetics, immunology and radiobiology laboratories of RERF. The tireless and willing cooperation of the AHS participants for nearly 40 years has been nothing short of extraordinary.

In Utero Cohort

There are no reliable data concerning fetal wastage amongst the women pregnant ATB since no systematic studies were carried out in the immediate aftermath of the bombings. Subsequently it became clear that there had been an increase in severe mental retardation with higher exposure, most critically between weeks 8 and 15 of fetal life. Also evident was a dose-dependent increase in the numbers of newborns with small head size. In a rather small study, a measurable decrement in IQ was related to *in utero* exposure dose.

Although the numbers of cancers detected thus far is small, there does appear to be an increased risk of cancer in the *in utero* survivors. That risk, however, seems no higher than in those who received comparable radiation exposure in infancy or early childhood. Stature and weight at maturity was less in those

exposed in utero but, again, was similar to those exposed in infancy.

Somatic cell mutations

Cytogenetic studies on peripheral blood lymphocytes and bone marrow precursor cells from survivors have yielded most interesting results. It has long been known that radiation of cultured cells causes chromosomal breaks. Many such breaks lead to loss of critical genetic material and result in cell death or inability to form viable progeny. In the survivors, however, stable reciprocal translocations are readily demonstrable by standard banding techniques or by fluorescence in situ hybridization (FISH). Their numbers and type remain stable for years and they are proportional to exposure dose. Presumably these cells which carry evidence of their donor's radiation exposure have not lost any necessary genes.

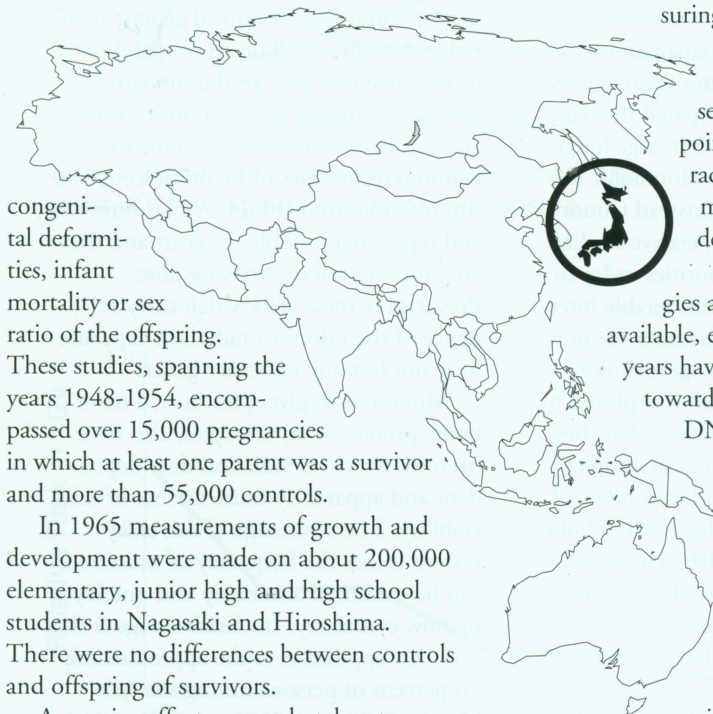
Mutations in glycophorin A, a membrane protein of erythrocytes, also have been shown to be radiation dose dependent and apparently cause no loss of cell viability. The advantage of this assay system is that the frequency of mutation can be measured accurately and quickly by flow cytometry. Its disadvantage is that it is only applicable to the approximately 50 percent of persons having the MN blood type.

Both of these assay systems continue under extensive study at RERF because of their potential use as biological dosimeters. In both assays Hiroshima survivors have significantly higher somatic mutation rates per unit dose exposure. This has caused considerable consternation for it could indicate some systematic error in the DS86 exposures assigned for the two cities.

Studies of the Offspring of Survivors

From the earliest days of ABCC one of the greatest concerns was that the atomic radiation had created germ cell mutations and that the future generations would suffer the consequences. For the first few years the major research efforts at ABCC were directed towards this likelihood. No evidence was found for an increase in sterility in survivors or for any dose effect in the number of abortions, still births,

No evidence was found for an increase in sterility in survivors or for any dose effect in the number of abortions, still births, congenital deformities, infant mortality or sex ratio of the offspring.



congenital deformities, infant mortality or sex ratio of the offspring. These studies, spanning the years 1948-1954, encompassed over 15,000 pregnancies in which at least one parent was a survivor and more than 55,000 controls.

In 1965 measurements of growth and development were made on about 200,000 elementary, junior high and high school students in Nagasaki and Hiroshima. There were no differences between controls and offspring of survivors.

A massive effort was undertaken to search for chromosomal aberrations in the peripheral blood lymphocytes of over 8,000 children of exposed survivors and nearly 8,000 controls. Forty-three aberrations were noted in the former group and 53 in the controls. Protein electrophoretic patterns on sera from 11,000 children of survivors and 12,000 controls were screened to search for mutations which altered protein mobility (mutations causing a change in protein surface charge). Only 6 abnormal proteins were detected and 4 of them were from controls. The activities of 18 enzymes were measured in erythrocyte hemolysates of approximately 10,000 children, about half of whom were children of survivors. Only one example of altered enzymatic activity was detected.

Essentially all of these labor intensive studies failed to detect an increase in mutations in the offspring of exposed survivors. Although this might have been quite reas-

suring, at least some of these studies have been criticized as being most sensitive for detecting point mutations whereas radiation is known to more frequently cause deletions.

Using newer technologies as they have become available, efforts over the last 5-6 years have been directed towards studies directly on DNA itself. Many of these methods also are very labor intensive. Researchers have been doing pilot studies with techniques such as denaturing gel electrophoresis,

microsatellite screening and southern blotting to determine their potential for detecting mutations in members of the F₁ generation. Very recently a new method to screen for mutations using two dimensional electrophoresis of DNA digests is being perfected in collaboration with investigators at the University of Michigan. The electrophoretic patterns of DNA from both parents and the children, each containing hundreds of spots, are scanned and analyzed by computer. It remains to be seen whether this method will prove suitable.

The oldest of the F₁ study sample are just now turning 50 years of age. However their parents, the survivors, are shrinking in number as they die, mostly of natural causes. Anticipating this attrition, about 10 years ago RERF began establishing permanent lymphocyte cell lines on members of families with the ultimate goal of storing cell lines from 500 survivor families and 500 control

families. Collection is now nearly completed and these samples will be available for study at some future time when more suitable and cost effective methods have been developed to detect alterations in the DNA.

Mortality studies of the F₁ cohort have not turned up differences between controls and children of survivors. Altogether then, as of this writing there is no evidence that mutations occurred in germ cells of the atomic bomb survivors and were passed on to their offspring. This seems improbable. It is more likely that the numbers of mutations are small and not detectable by current technology. Perhaps a more acceptable statement at this time would be that there is no evidence that clinically relevant mutations have been passed on to the F₁ generation.

Let me conclude by simply stating that much has been learned about the long-term medical effects of atomic bomb radiation from the studies in Hiroshima and Nagasaki. To be sure, the ABCC/RERF data are heavily relied upon by the various national and international committees which set radiation exposure standards for workers. Clearly the most important positive finding is the radiation dose-related linear increase in risk of malignant disease. To many, even more important will be a negative finding in terms of genetic effects in the F₁ cohort if the observations to date hold up.

At this point it is reasonable to wonder how much longer the research program at RERF need be continued? My own bias is that there are portions of the research which could be stopped now or transferred to one or more universities. But it would be a shame were the mortality and cancer incidence studies of the LSS not continued for at least another decade since those who were youngest when exposed are just entering the age of greatest cancer risk. Currently a new international committee is reviewing the research at RERF and will undoubtedly be making recommendations on research priorities, duration of studies, facilities, and funding. Hopefully the recommendations of this body will be as prescient and forward-looking as were those of the Francis and Crow Committees.

Leavitt Becomes Associate Dean for Faculty



Judith Walzer Leavitt, PhD, Professor of the History of Medicine, the History of Science and Women's Studies, has been appointed University of Wisconsin Medical School Associate Dean for Faculty. She will help guide the hiring, retaining, mentoring, reviewing and promoting of faculty members.

When he announced the appointment, Dean Philip Farrell stressed that one of Leavitt's major missions will be to increase diversity among the faculty in

terms of race, gender and ethnicity, a top priority in the Medical School's strategic plan for the future.

Dr. Leavitt takes the assignment seriously. "It is very important for our faculty to reflect the makeup of the population. Although our Admissions Committee has been doing a good job in diversifying the student body, the faculty (which includes a fairly low percentage of tenured women and a negligible number of minorities) doesn't yet reflect the population as a whole or even the student population," she said. "This presents all sorts of problems for our students. They have few role models and little sense that they might have a career in academic medicine. It's important for them to see that someone like them has made it, and for them to feel comfortable and welcomed."

Leavitt added that conversations with students have led her to believe that the lack of role models affects the learning capacity of minority students and leaves them feeling like outsiders in their own school. Such an unfriendly-appearing environment, inadvertent as it may be, likewise affects minority faculty, who report feeling lonely and isolated, a situation in which academics cannot work productively to their full abilities.

To help her increase the percentage of minorities and women on the faculty and to foster a better climate for all members of the Medical School family, Professor Leavitt has appointed a

team with wide representation. It will develop and then implement a plan that will include incentives for departments to widen their pool of job candidates, an effort that should lead to higher quality faculty and help maintain the Medical School's distinguished reputation. The committee also will work to establish a stronger mentoring system available to all faculty to help them in becoming better scholars and teachers, and to assist the faculty in becoming more sensitive to what they say and the way they interact with others.

"We inadvertently hurt people every day," she explained. "We don't mean to, but we do. We must become more aware of our words and actions and how they might affect someone else."

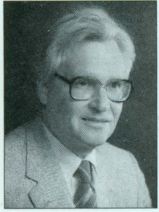
Judy Leavitt intends to listen carefully and to learn. She already has had a listening session with interested first and second year students which she dubbed a "small group with big ideas." Another session included chairs of the basic sciences. She plans to hold about eight more listening sessions so that she and the team can gather insights from varied perspectives and formulate a plan that reflects the ideas and concerns of those most intimately connected with the Medical School. Healthy two-way communication, she believes, will develop better understanding for everyone. Professor Leavitt comes to her new assignment well prepared. Her interest in recruiting minority medical students was manifested when she was a member and Chair of the Medical School Admissions Committee as well as Chair of its Minority Subcommittee, and as a member of the Women's Studies Program since its inception in the '70s. Her administrative capabilities were honed as Chair of the Department of the History of Medicine from 1981-1993. Her academic credentials have established her as a first-rate scholar, and her research program and writing have brought her and the University national acclaim.

Teaching has always held a special place in Leavitt's heart. She will continue to teach both undergraduate and graduate classes during her tenure as Associate Dean.

"I'm very optimistic we will accomplish what we have set out to do," she said. "That's why I accepted the job. We will keep this school excellent, and make it a little more interesting and friendly in the process. The goals of good research and good teaching can best take place in a diverse and cooperative atmosphere."

"We inadvertently hurt people every day," she explained. "We don't mean to, but we do. We must become more aware of our words and actions and how they might affect someone else."

BAD KING GEORGE III



*Summary of a paper given to the
Madison Literary Club
Edited and Revised December 1995
by Laurence T. Giles '51 MD, FACP*

In 1776 the sky was red
and bad King George couldn't
sleep in his bed. . .

Ballad for Americans, 1939

THE MAN

There is renewed interest in the life and times of King George III, subject of a brilliant play (1993) by Alan Bennett, *The Madness of King George III*, and who also authored the motion picture this past year (1995). George was played to perfection by Nigel Hawthorne as "bad, mad and sad."

George was America's last King; he lost the Colonies in 1783, and lost his mind, 1788, big time, the major illness with crises lasting nine months. He lived 1738-1820, reigned 1760-1810. George had a series of illnesses characterized by five major psychotic breaks, raving behavior, agitation, depression, generalized body pain, "fever" (delirium), blue-red urine, in 1765, 1788, 1801, 1804, 1810, and suffered several more minor episodes as well. This major illness of 1788-89 has been studied in most detail, and is instructive for what it tells us about the King's physical and mental breakdown, and how Parliament and society responded to this. The King was struck down with a "bilious attack" in the summer of 1788 which rapidly deteriorated into "flying gout."

There was a communication problem: protocol demanded that the King speak first. Examination was rudimentary, for the King was not disrobed. Seven royal physicians were in attendance. They were inadequate, medically confused, and they prescribed horrendous treatments including bleeding, cupping, enemas, emetics, and blistering of legs and scalp, "to let the morbid humours out." The King subsequently had a seizure and lapsed into coma. It was thought he was close to death. At this point, Parliament authorized calling in a "mad doctor" i.e. a doctor of the mad. The Reverend Doctor Francis Willis was chosen. He was a cleric and physician with 28 years of experience at an asylum for the mentally ill.

The King emerged from coma, still plagued with abdominal and chest pain, dyspnea, flushing, yellow eyes, itching, dark urine, edema, and numbness of feet and legs. He remained rather crazy, was confused, agitated, hallucinating. The doctors announced that their Monarch had a "mental incapacity between mania and delirium, but not insanity." (Mumbo-jumbo to reassure the common folk and political enemies.)

Sometimes George made crazy sense. He noted Dr. Willis' clerical collar, and was informed that the Reverend Doctor had forsaken the pulpit for medicine. George said: "You have quitted a

*George was America's last King; he lost the Colonies in
1783, and lost his mind, 1788, big time. . .*

profession I have always loved, and you have embraced one, I most heartily detest." "Our Saviour himself went about the world healing the sick," replied Willis. "Yes, yes," conceded the King, "but he had not £700 a year for it."

Mostly however, the King was muttering drivel and obscenities 20 hours at a stretch. He couldn't sleep or eat. He went from 210 to 170 pounds (height 6'1"). He talked to trees. He said he could see Germany with a telescope. London had disappeared in a flood. He tried to kiss the Queen's Lady-in-Waiting. He announced all marriages were to be dissolved, including his own.

Dr. Willis isolated the King from his family, kept his quarters cold, didn't hesitate to use the straight waistcoat or restraining chair. He did, however, stop the blistering as "barbaric." He allowed a visit to the Queen who became hysterical: "His eyes are like black current jelly." These were the effects of illness plus iatrogenic medicine. The King rallied in February of the New Year. "There was much rejoicing and public thanksgiving." Dr. Willis had a medal struck March 1, 1789 with his own likeness, as healer of the The King. "Britons rejoice—your King's restored." "London was illuminated end to end. Cannons were fired and church bells tolled. The King returned to Windsor Castle, and the mad doctor departed."

What did King George recover from?

THE MALADY

“. . . We are not ourselves

When nature, being oppressed, commands the mind

To suffer with the body." Shakespeare, *King Lear*

(Act II, Scene IV)

Up until 1968 it was thought the King suffered from a manic-depressive illness with intermittent agitation and severe physical breakdown. One psychoanalyst thought the King to be a closet homosexual: unlikely, for he was married and he and Queen Charlotte had 15 children!

In 1968, Doctors Ida Macalpine and Richard Hunter, London psychiatrists, noted the royal history of red urine and psychosis and proposed a diagnosis of porphyria. They published a landmark paper, indicating George III had either acute intermittent porphyria (AIP) or more likely variegate porphyria (VP), associated with neurologic, hepatic and photosensitivity findings. The word porphyria means purple, and is characterized by porphyrins which are purple-red pigments. The disease is rare, affecting 1/50,000 persons in the U.K., and is inherited as an autoimmune dominant disorder. The human gene locus and coding for PBG deaminase has been assigned to chromosome 11.

Dr. James F. Crow, the distinguished geneticist, writes: "Porphyria is a disease or collection of diseases greatly clarified in

In 1968, Doctors Ida Macalpine and Richard Hunter, London psychiatrists, noted the royal history of red urine and psychosis and proposed a diagnosis of porphyria.

recent years. There are eight chemical steps from the amino acid glycine and succinyl CoA to protoporphyrin IX which complexes with iron to make heme—the oxygen-binding element of red blood cells. Each of these eight steps is catalyzed by an enzyme which is produced by a specific gene. The enzyme is present but in only half the normal amount. Most of the time this is enough to catalyze the normal process, but in a crisis it may not be. Hence the intermittent nature of the symptoms. The AIP gene is a very complicated one with 15 active components or exons. Moreover, the same gene produces two products, depending on which of the 15 exons are used. One gene product is found everywhere in the body; the other is active only in red blood cells. The one that is active in red blood cells has almost the same start signals as other genes that are active in red blood cells, such as those producing hemoglobins.”

THE LABORATORY

The important enzymatic defects causing clinical presentations are:

AIP: deficiency in porphobilinogen (PBG) deaminase with resultant high levels of PBG and delta-amino-levulinic acid (ALA), measuring the enzyme level is specific to the diagnosis.

VP: the enzyme defect is protoporphyrinogen oxidase. Neurovisceral studies are similar to AIP with the additional finding of sunlight induced bullae.

Congenital erythropoietic porphyria: these little patients have erythrodontia, hemolytic anemia, and splenomegaly. Defect is uroporphyrinogen I synthetase and uroporphyrinogen III co synthetase. There are high levels of uroporphyrin in the urine and coproporphyrin in feces and uroporphyrin in RBC. Normoblasts are present in the bone marrow, showing cytoplasmic fluorescence.

Porphyria cutanea tarda (PCT): there are findings of red urine, fragility of skin exposed to the sun with pigmentation, scarring, hypertrichosis on face and forearms. This appearance, especially in young people, led to werewolf fears at night among witnesses in the 19th Century! Here the deficiency is uroporphyrinogen decarboxylase, with high uroporphyrin levels. .

Summarizing, the acute porphyries may cause death. In an attack there is motor and sensory loss over the extremities, abdominal and chest pain, dyspnea, nausea and vomiting, seizures, violent agitation, hypertension and tachycardia.

The retrospective diagnosis of porphyria won't help poor George III, but it does establish a rational therapy. Avoid trigger agents: stress, fatigue, dehydration, intercurrent infection, sunlight, alcohol, barbiturates, sulfonamides, estrogens, and birth control pills. For AIP, use hematin infusions to decrease PBG and ALA excretion, propranolol or other beta-blocker for hypertension and tachycardia, phenothiazines or diazepam for agitation. Surgery and anesthesia become dangerous, but can be carried out under controlled conditions, if the diagnosis is known.

GENEALOGY

Doctors Macalpine and Hunter investigated the genetic backgrounds of The Royal Malady in some detail. Porphyria has affected members of the House of Hanover, the House of Stuart, and the House of Prussia. Most of the Royal Houses of Europe in the 18th and 19th centuries can trace their origin to Mary Queen of Scotland and her son James VI of Scotland (then James I of England). Both had clinical symptoms, and James passed red urine. Frederick the Great was touched by it and passed red urine as well. Porphyria caused two national crises in England:

- (1) The Regency Crisis of 1788-89, and
- (2) The death of Princess Charlotte in childbirth, delivered of a dead male infant. Charlotte was age 20, the only daughter of George IV.

George III passed the disease to four of his sons, including George IV, who as the drunken Prince of Wales waited, skulking in the wings, for a call to the throne he never received, at that time.

Dr. Macalpine has found four survivors of the Royal Line of Hanover, with porphyria and red urine. These findings strengthen the argument for inheritance of this rare metabolic disease.

In conclusion, I am asked whether the American Revolution would have occurred if King George III had not had porphyria. The answer is yes, since it was the character of the King that caused the war with America and not his bodily and mental misfortunes. He was not open to new ideas. He said, "I wish nothing but good, therefore everyone who does not agree with me is a traitor or a scoundrel." He had a stubborn Germanic core and would not be moved. His last episode was in 1810, after which he never recovered. He tottered into the twilight world of Lear. Stanley Ayling, historian, writes: "He was now a pathetic figure in his purple dress and gown, with his wild white beard and hair, totally blind, deaf, playing on his harpsichord, and talking of men and women long since dead."

He died in 1821, beloved of his people, a bad King, but not a bad man.

Bibliography on request.

Good-bye, Friends



Joyce Meier and grandchildren

As Third Year Coordinator, Joyce's job was often a maze and her office a site of controlled chaos, especially in the spring.

On her first day at the Medical School 23 years ago, Joyce Meier promptly locked her purse and desk key inside the desk. After a locksmith came to her rescue and Joyce managed to get through that inauspicious first day, her job performance was nothing but uphill. Medical students made their assessment clear when they chose her five times for the Goodfellow Award for making their sometimes hectic lives less bumpy and more pleasant.

As Third Year Coordinator, Joyce's job was often a maze and her office a site of controlled chaos, especially in the spring. Students would visit, sometimes in groups of two or more and sometimes in panic, once they realized that the clerkship schedule Joyce had assigned to them wasn't going to work well. Perhaps an illness, a family crisis, a new baby or an imminent wedding complicated matters, or perhaps academic deficiencies would introduce a

monkeywrench. Occasionally new wives and husbands would object to being separated by 100 or more miles. Then Joyce would need to get on the phone to negotiate with clerkship personnel, rearrange schedules, soothe frayed egos, and so on. Now and then she had to deny a request.

"We do our scheduling in April," Joyce explained, "and it's never simple. Grades are not always in, and if a student has failed a course or a Board exam, he can't go on to third-year clerkships. Then we try to get tutoring help, rearrange schedules and reschedule course work (like a coach may have to hustle when faced with shuffling his roster), or even arrange a leave of absence. In my early days, when there were fewer students and all the clerkships were in the Madison area, we had an easier time." She added that these days, a student may well spend more than half of the 11 months of year three away from Madison.

Student visits sometimes concerned personal relationship problems requiring Joyce to put her accumulated life experiences to use as she became counselor Meier — definitely not part of her job description but a role in which she was fully appreciated. "When I could make them feel better or make them smile, it was worth whatever effort that took," she said.

Students' problems also occupied part of her time at home, for students knew they could count on her sage advice or at least a

"When I could make them feel better or make them smile, it was worth whatever effort that took."

sympathetic ear on the other end of the phone line. She thoroughly enjoyed working and empathizing with students and they seemed to know that she was accessible as well as willing and usually able to help.

Scheduling, however, was only part of Joyce's duties. She also was Certification Officer, meaning that she replied to inquiries concerning graduates: when did they graduate, did they receive any honors, why did they require more than four years to graduate, and countless other questions. This part of the job also required a great deal of time on the phone and correspondence.

Furthermore, she kept track of students' grades — not always a cup of tea, as some teachers needed repeated reminders to send in their final assessments. For five years Joyce served as a Notary Public for Medical School personnel and an occasional student.

And, being an old-timer in Medical School Administration, Joyce Meier was the person to consult about many other issues. Hence her phone kept ringing and all sorts of people would appear in her office, sure that they could count on willing assistance.

Now Joyce can focus more on her children and seven grandchildren, ages 4 to 15. And she may even go into business with her daughter-in-law, running a gift shop in Egg Harbor, Door County.



Jean Weber

For more than 11 years, Jean Weber began and ended each workday with a fifty-mile commute between Watertown and Madison as part of a state van pool. The hour and a half consumed by the ride, zigzagging to collect or drop off riders, meant that she had to be ready for pickup by 6 in the morning, no matter what, and didn't reach home until six in the evening. We suspect that Jean will scarcely miss the traveling part of her Medical School employment, but students and others will surely miss her smile and the gentle voice that graced the Administration area.

Jean had her fingers in many activities affecting students, although they often didn't know who it was that smoothed their way as they progressed from tentative first year scholars to more confident graduates. One of Jean's jobs, for example, was to see that the Dean's letters were in the mail by or shortly after November 1 — no easy task, considering that some students apply to a number of institutions in their quest for a residency that would suit them.

In a similar vein, Jean was instrumental in helping with the details surrounding the fateful Match Day in mid-March. She also played a large part in putting together the figures for the Report on Residency Selection for the Medical School, an annual accounting that collated the statistics following Match Day.

Jean Weber also helped plan and carry out the many events that make life more interesting for medical students. Was the pizza ordered for the noon meeting? Was a room reserved for the event? Has information been sent to all those who need it? How many have said they are coming?

A tradition that began only last year, the White Coat Investiture, also required her tending to some of the details.

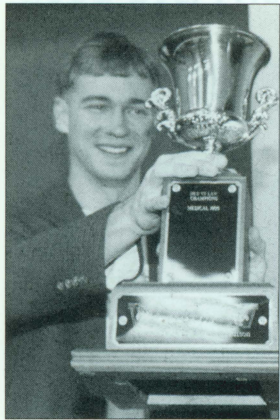
Sometimes, when needed during the earlier years, Jean took over duty as receptionist at the front desk in Administration. The questions she was called upon to answer or try to find the proper person to answer were broad-based and sometimes outright strange. "By the time you think you've heard every question possible, a new one pops up," she said. "Sometimes you have to figure out what the person is really asking. If they ask about residency, do they mean establishing where they live, a training program they are applying for, statistics about different training programs, or are they trying to locate someone who is doing a residency/internship? Or if asking for information about a particular illness or subject, which department would be knowledgeable about it?"

Jean added that she enjoyed the variety in her work and appreciated the "very nice, helpful people" around her. "I think it would be boring to sit in front of a computer and type all day." In contrast, she described her multifaceted duties in student services as fun and always interesting.

Her six children and her grandchildren will surely keep Jean on her toes after retirement. And she plans to travel, sometimes to Montana to visit relatives who live near where she was born and raised, sometimes to Michigan to visit sons, sometimes, perhaps, to unfamiliar territory. (As the widow of a Lutheran pastor, Jean was used to pulling up stakes and moving on when a new calling came.)

Jean Weber might even consider a part-time job — especially if the Medical School should graciously move its operations to Watertown!

Jean was instrumental in helping with the details surrounding the fateful Match Day in mid-March. She also played a large part in putting together the figures for the Report on Residency Selection for the Medical School, an annual accounting that collated the statistics following Match Day.



Tim Richer
MSA President '95-'96

GREETINGS medical alumni and students from the UW Medical students! For those who have not met me I'm happy to introduce myself. My name is Tim Richer and am a second year medical student and current president of the Medical Student Association (MSA). I am writing on behalf of my student colleagues for several reasons. First, it has come to our attention that alumni, upon graduation, know very little of the goings on in the medical school which to me seems rather ironic. You complete four years of perhaps the most vigorous and yet rewarding work of your life and yet are quick, not necessarily by choice, to sever the ties as you jump into a residency and (eventually) practice. Time and distance are both obstacles to keeping in touch and therefore it is our goal to help you feel like you're still part of your old "home" by reading about those who are following in your footsteps at the medical school. Beginning with this *Quarterly*, our column will offer several points of interest in student life:

- ◆ Current events
- ◆ Future events so that if you happen to be in town, you might be interested in attending
- ◆ Focused column on one of the many student organizations at the medical school

What is the Medical Student Association?

MSA is basically the medical student government that oversees literally everything that affects student life here at the med school. For example, we are actively involved in establishing search committees for dean positions, we work on the tiny day to day issues (which never appear to be that tiny) at school, and everything in between. The MSA council is made up of elected officials from all four med school classes and includes representatives and a class president (or co-presidencies). Students may take on larger roles in the second year as president or treasurer of the council. The council has several committees that deal with the day to day operations of student life such as book sales, community service, legislative affairs, social activities, and noon time speaker topics. Each member in the first two years serves on several committees and has the opportunity to play a key role in meeting the needs of students. You may recall in your days at the medical school attending blood drives, participating in a white coat sale, doing COOP notes, giving prospective medical students tours of the building, or attending TGIF's with other students and faculty! MSA essentially makes sure the traditions and legacies of students are carried on while at the same time adapt to meet the ever changing student concerns, needs, and interests.

Individual student organizations are one way in which students might explore common interests and goals with other students. There are currently over 20 student groups operating by students for students at the medical school. Each year, these groups submit budget applications to our Treasurer who has the challenging job of distributing MSA funds to these groups so that they might pay for their individual operating expenses associated with their own activities. Our Treasurer this year, Kari Lathrop, has done a superb job keeping the books as well as keeping people happy! It might interest you to know that MSA operates on approx. \$3,500 each year. Where does this money come from? It comes from you! The Alumni Association generously provides funds for MSA for its operations

and to distribute to the individual student groups. You don't need to be a scholar to figure out that each group receives between \$25 and \$150 for a year's worth of expenses. It is rather amazing what student groups are able to accomplish with this limited funding which is, as I mentioned before, something we take pride in and will be sharing with you in our columns. The last Quarterly included an excellent look at women in medicine. As a follow up and as a means of introducing our various student groups, this quarter we are featuring an article from the Women In Medicine student organization as Chrissy Chuppa, president of the group, provides a look at what this student group has to offer medical students, both men and women.

Just as students have carried on many of the traditions and legacies of our predecessors, this year many students have taken the initiative to start their own traditions...

"THE DEAN'S CUP" was one such event. The last issue of the *Quarterly* featured a collage of pictures from the noon-time pre-exam holiday party and "The Dean's Cup" presentation. Since there was no accompanying explanation of this event I thought this would be a perfect opportunity to share with you what turned out to be a fun and worthwhile event. The Dean's Cup is an event that several schools across the nation have been taking part in for years which is where students came up with the idea. The UW Dean's Cup was a competition held between Law students and Medical students this past fall and involved a number of events including basketball, football, soccer, Frisbee, mini-golf, racquetball, tennis, 5k run, bowling, volleyball, softball, darts, billiards, TV trivia, and blood drive.

Students organized teams from both schools and engaged in a week long mini-Olympics for the thrill of competition and fun, but also for much more. Unlike other schools, we chose to turn the competition into a community service event as well. Dan Schraith, a MED II, designed T-shirts for the event which we sold to faculty and students. See the last Quarterly - even Dean

UPCOMING STUDENT
EVENTS: all are welcome!

May 3: TGIF—social with med students and faculty (Tripp Commons, Mem. Union (8pm-lam) featuring the med school's own band, "The ArrhythmiAs" (runners-up in last year's Battle of the Bands at Memorial Union!)

Farrell is sporting one! Participants were also required to bring a nonperishable food item to each event they participated in to be donated to the Salvation Army—we collected over 200 pounds of food! We also attempted to get sponsors to donate money—Quarles and Brady and State Street Brats both donated money to the cause. Our most generous donation was a \$500 gift from our own Anatomy Department with much thanks to John Harding, Chair of the department. With their help and T-shirt sales, we are proud to say that we were able to donate \$500 to both the Dane County Chapter of the Red Cross and to the Rape Crisis Center! We also collected over 60 units of blood through our blood drive!

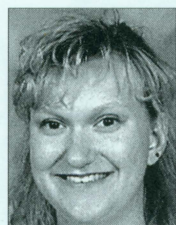
Along with Tim Stewart and several other law students, medical students planned the events, arranged for sites of competition, organized competition brackets, and performed a number of other time consuming tasks to make the competition a success. Who won the event? The medical school, of course, despite losing the faculty softball game at the Dean's Cup picnic. The trophy you saw presented in the previous issue is, for this year anyway, the medical school's as "The Dean's Cup" will travel to the winning school as the tradition carries on. It was donated jointly by the Law School and Medical School Alumni and is on display in the Dean's office at the Medical School.

Carrying on the tradition is the trick, of course, but with the help of enthusiastic students and faculty, we can make the Dean's Cup a successful and valuable community service event for years to come - perhaps you might want to participate in the future or offer a gift to the event! Stay tuned for details of Dean's Cup '96...

Finally, I would like to say THANK YOU, on behalf of all medical students, to the Alumni Association for their ongoing commitment to helping students. I've real-

ized by attending their board meetings how active they are in planning for OUR future while at the same time providing for us now. Without their help and yours, our student groups would have no budget, there would be no low interest student loans, no Dean's Cup, no medical student lounge project, no TGIF's... Your past and future help is generously appreciated. It certainly has not gone unnoticed!

Please feel free to contact me regarding any student issue at tmricher@students.wisc.edu or at (608) 251-5306. I'd be happy to answer any questions or take suggestions for future events, etc!



*Christine Chuppa
MedII*

WOMEN IN MEDICINE is a group of medical students, both women and men, who are interested in exploring issues of special concern to women in medical training and beyond. The goals of the group include providing a support network for students, creating a forum for the discussion of gender issues, and educating our fellow students on women's health issues. We work towards achieving these goals by planning various activities throughout the year. This year, events included brown bag discussions with professors and physicians, and a potluck dinner during which third and fourth year students shared their experiences of the clinical years with first and second year students. We were honored to hear Professor Judith Leavitt of the History of Medicine Department give a lecture on the history of childbirth. We sponsored two well-attended panel discussions: one featured residents from family medicine and urology who told us all about life as physicians, and another panel addressed gay and lesbian health issues. WIM held a workshop on gender issues which was facilitated by the group Men Stopping Rape, as well as a "snappy comeback" workshop which gave students a chance to practice responses to

verbal harassment. We are fortunate to have had the opportunity to shadow Dr. Elizabeth Karlin at her clinic, and we participated in this year's Take Back the Night rally. Our group was able to almost scrape enough money together to send two representatives to the American Medical Women's Association National Meeting in Seattle in November, and several WIM members attended the Midwest AWMA/WIM student conference in Chicago in September. These conferences provided an excellent opportunity to meet other students and physicians from all over the country and to thus expand the support network that WIM strives to create.

The Women Medical Student Mentor Program and the Medical Student Volunteer Corps are also connected to Women in Medicine. The WMSMP was created in response to a need for role models for female medical students (who, by the way, make up over half of the first-year class) and pairs up first and second year medical students with women physicians from the Madison area. This year, there were 75 women in the first year class, and 50 requested mentors. Thanks to the efforts of Dr. Tina Iyama and students Jennifer Bauer, Alison Craig and Heather Wells, all 50 first year students who requested mentors were matched! By the way, the WMSMP still needs mentors, so any interested physicians out there are welcome to join in the fun! The Medical Student Volunteer Corps is in its second year of existence and is led by second-year students Tracy Niemeyer and Anna McKeown-Lugaro. The MSVC trains medical students in counseling victims of domestic violence and then puts them to work on weekend shifts in the UW emergency room. Students are on call for 24 hours and are paged when a woman needs counseling. The training has been very popular among medical students, and about 40 women and men are trained each year. Anna McKeown-Lugaro stresses that this training is extremely valuable for all physicians, regardless of specialty: "If you have women patients, you probably have patients that have experienced domestic violence". The MSVC may be soon expanding its coverage to Meriter and St. Mary's Hospitals as well as the UW.

Class of 1946



Top: W. Russell, J. Stuffer, L. Keller, L. Ganser, J. Frye, T. McDonell, G. Magnin, S. Rubin, J. Clark, H. Gladstone, R. Johnson, J. Davis, Fr. Stringer, R. Wichser.

2nd: R. Schuyler, S. Vinograd, A. Limberg, P. Settlege, C. Brooks, J. Keefrey, I. Klitsner, T. Beno, J. Suits, A. Fidler, K. Humke, S. Chapman, J. Strang

3rd: D. Peck, G. Mueller, J. Russell, D. Arvold, G. Garnett, L. Elkind, G. Benish, A. Britt, H. Mayer, R. Salter, A. Leiser, B. Koch (Erven)

4th: R. Carlsen (Nadler), H. Oppert, F. Hodges, A. Liebman, P. Stange, A. Hardtke, I. Teplin, F. Rosen, R. Wasserburger, C. Brindley, K. Schwerma



5th: M. Schaeffer (Harris), E. Betlach, C. Allan, J. Gajewski, B. Waisbren, W. Harve, M. Brose, H. Eisen, A. Wilets, J. Abrams, M. Chudwin, J. Chapman (Born), M. Estabrooks (Murphy)

Missing: M. Apell, H. McGaughey, W. Thomas, G. Stannard, J. Barbour, D. Wilcox

Married name of women is in parenthesis after each name.

6th: J. Van Driest, D. Wittmann (Betlach), Dr. W. Middleton (Dean), Harold Coon (superintendent of hospital), B. Lawton, Dr. Meyer (internal medicine), C. Rothe, C. Cullender

"HOW I SPENT MY SUMMER VACATION"

For the second consecutive summer, several UW undergraduates who belong to the Medical Scholars Program (MSP) tackled a variety of medically oriented activities at sites around the state under the auspices of the Medical Scholars Summer Fellowship Program.

The participants, who plan to become UW medical students after graduation, were assigned to facilities in or near their home town. There, during a ten-week period, they were able to gain a hands-on, insider's appreciation of patient management or the operation of a public health agency replete with the difficulties and complications that textbooks fail to mention. They also learned, sometimes the hard way, that individuals are very different from one another and not always cooperative — a taste of medical practice in its unvarnished reality.

Most of the students, when asked about their experiences, express similar feelings, such as "I never realized that ..." or "I had no idea of ..." Their eyes were opened to real-life circumstances and possibilities that should help them to better understand the extended world of medicine, and perhaps even direct them towards unanticipated medical careers.

The encounters of some of the Medical Scholars during the summer of 1995 follow.

Erica Berger worked at the Gundersen/Lutheran Medical Center in La Crosse, where her first day turned out to be less than auspicious. The physician she was shadowing had to make a hurried trip to the emergency ward. Because of the fast-paced schedule, Erica had had neither breakfast nor lunch and soon found herself becoming weak and nauseated. After stumbling into the hall, it happened — she slumped to the floor and was out for 45 seconds. Never would she miss breakfast again.

As the summer progressed, she helped

in the frozen section service in Pathology, Pulmonology, Oncology, Obstetrics/Gynecology, Orthopaedics and Pediatrics, gradually becoming transformed from a scared newcomer into a calm and confident assistant able to converse with staff and students. She discovered the extent to which medicine is an apprenticeship and the extreme emotional and physical ranges a physician can experience throughout the day. She is now impatient by having to complete undergraduate studies before entering the medical environment.

Arnold Yoon likewise worked in La Crosse during the summer but in a much different setting. At the La Crosse County Health Department, he learned that a health department is a highly structured organization with a multitude of responsibilities that he, along with probably most other citizens, had never imagined.

In the Environmental Health Division, he checked the temperatures of food warmers and refrigerators at temporary restaurants set up during a festival in downtown La Crosse while others made sure that sanitizing washes and rinses were being used properly. Later on he visited homes to check for lead contamination on surfaces and learned, to his surprise, that feeding children raisins, which contain high levels of iron, helps preserve the integrity of the children's hemoglobin as an immediate medical treatment.

At the county landfill, he helped purge leachate from some of sixty monitoring wells to be tested in the lab for contaminants including sixty volatile organic compounds. He also worked in the office,

They also learned, sometimes the hard way, that individuals are very different from one another and not always cooperative — a taste of medical practice in its unvarnished reality.

helped coordinate volunteers for a blood drive, developed an employee survey, performed uninalyses, prepared immunization records, worked on developing a simple pediatric blood pressure mapping chart, balanced financial records, and fine-tuned the computer network.

Shannon Geroso spent her summer at a regional public health agency to complement her prior summer's experience at a local agency. The Bureau of Public Health Southern Regional Office, a sort of mediator between the state and local health departments, assists with developing and maintaining programs and oversees compliance with statutory mandates in 15 counties.

Using computers, she prepared documents for local departments; for example, she tapped into the CDC's Assessment Information Manager program to prepare a document showing the mortality rate in Lafayette County from motor vehicle accidents. She also worked on a community health care needs assessment program, organizing questionnaires previously completed by county boards, hospitals, health departments and citizens into a format local agencies could use to set priorities and courses of action.

Shannon was able to follow the continuity between state and local programs from her last summer's experience in Manitowoc with the Wisconsin Women's Cancer Control Program and the Women, Infants, and Children (WIC) project as she observed program coordinators discuss their successes, problems and obstacles with state personnel. She became further convinced of the value of prevention programs.

Cynthia Singley interned at another regional office, the Southeast Regional Office of the Bureau of Public Health and found that the fine art of marketing and an effective sales pitch can add up to a successful public health effort. In her case, the effort was to convince low-income women over the age of 50 to get free mammograms as part of the Wisconsin Women's Cancer Control Program. At the State Fair, she attended to the many details necessary to run a booth and a raffle, which induced many women to fill out forms that included the date of their last mammogram — valuable information for a public health agency. Similarly, in other settings she encouraged low-income women to get a mammogram with gifts, which she found to be good motivators.

Working with the Women, Infants and Children program, Cynthia found that the program wisely bent their rules to accommodate Hmong women. And she tried to insure that reasonably priced bottled water was for sale in poorer neighborhoods, with mixed results.

Some of her findings were discouraging. For example, she found vendors trying to fool health inspectors at the State Fair in an ongoing battle. She heard about local physicians not cooperating with public agencies and their clients. And she found a large amount of client non-compliance — no shows — after appointments had been scheduled.

Andreas Ostenso devoted his summer fellowship, at the Medical School Department of Medicine, to creating a database that could be easily used by practitioners in making diagnoses of occupational diseases.

He learned early on that patients rarely present with a textbook set of symptoms. This is especially true in the case of occupational disease. The physician often doesn't know the full range of occupational hazards a particular patient is exposed to, and, to further complicate matters, people can react very differently to a chemical agent. Some may react not at all, some may react violently, and some may tolerate it for many

The summer of '95 proved to be an altogether memorable experience for the medical scholars who delved into new worlds, meeting healers and patients, along with a few rogues, they will not soon forget.

years before showing symptoms. Identifying the chronic effects of low concentrations of chemicals and other occupational hazards can be a particularly hard nut to crack. Because there are so many occupational hazards and they are so difficult to access, it is essentially impossible for a generalist to keep abreast of potential problems, and misdiagnosis is not uncommon.

In conjunction with Dr. Richard Friedman, Andreas developed a more user-friendly and useful database that should help doctors make diagnoses in a matter of minutes as long as they keep in mind the complex nature of occupational afflictions. And he had to do battle with a major computer bug along the way.

Kelly Andren departed from her experiences at the Wausau Family Practice Center far wealthier than she arrived, for she learned first-hand about cultural differences between Americans and Southeast Asians and about the joys and burdens of handicapped children. She also discovered the areas of medicine most interesting to her — and those she would want to avoid.

For the first month she shadowed a different doctor in a different area every day. At the Family Practice Center and the Bridge Clinic, a Medicare/Medicaid clinic for the underprivileged, she met many Southeast Asian patients (mostly Hmong) and families, whose day-to-day life styles and beliefs are much different from those of Americans. Concerning medical care, the Hmong are reluctant to receive shots and be hospitalized. They believe, for instance, that a hole in the body (as from a syringe needle or an IV) will let one of their souls escape; and they are accustomed to treatment with medicinal herbs.

With such information in hand and by calling various organizations, Kelly was able to update the Southeast Asian

Resource Manual, which is used by physicians at the Center.

Next, Detective Andren investigated Hmong clan charts and tracked hepatitis histories through families, identifying those persons who aren't immune to hepatitis B and have a family member who is a carrier.

Lastly, Kelly volunteered at Rainbow's End camp for disabled children and learned to appreciate the constant attention they require and the joy they can experience.

Lisa L. Boyle was mainly concerned with a study of the effects of Estrogen Replacement Therapy (ERT) on postmenopausal women with Dr. Molly Carnes and colleagues, specifically the effect of ERT on the cytokine-6 (IL-6) plasma levels. She first found that recruitment is much harder than she had imagined as she contacted, screened and further tested potential candidates.

She helped with memory, balance, sweet preference and pain tolerance tests as well as obtaining 15-minute blood samples over a 24-hour period. Patients also had PET scans to determine effects on brain activity before and after 6 weeks of ERT treatment.

While shadowing Dr. Carnes at the VA hospital, Lisa learned about the clinical aspects of diabetes, which she had studied in nutrition classes, and other conditions common in older people. She was particularly impressed with the team approach used with geriatric patients and the importance of simple observations, and she found the swallowing clinic especially fascinating.

The summer of '95 proved to be an altogether memorable experience for the medical scholars who delved into new worlds, meeting healers and patients, along with a few rogues, they will not soon forget.

WINTER MEETING



Although Sunday, February 15 was bitterly cold, a day when cars start reluctantly if at all, 85 people attended the Wisconsin Medical Alumni Association's annual Winter Meeting held at the Sheraton North Hotel, Milwaukee.

The Board of Directors met at 9 a.m., and other alumni and friends gathered later for a reception and brunch. Past President Henry Rahr welcomed the participants.

Dean Philip Farrell and Associate Dean Thomas Jackson discussed the UW Medical School's Madison Campus and its Milwaukee Campus. The guest speaker was Dennis Krause, Sports Director of WTMJ TV, Milwaukee, substituting for Jessie Garcia, Sports Reporter for WTMJ, who had to attend to a family emergency.



continued from page 11

a \$150 million alliance between the state and the University, has been proposed to consist of two-thirds funding through gifts and grants and one-third through general purpose revenue borrowing. The committee approved the HEALTHSTAR concept and requested enumeration for the project as a special initiative in the 1997-99 budget biennium.

As you know if you're a regular reader of this column, many facilities are seriously in need of repair, remodeling and/or expansion. The University is seeking UW System and Board of Regents authorization of HEALTHSTAR so that fundraising can begin immediately. The University intends to raise \$100 million of the total package, and hopefully the state will contribute \$50 million so that we can prepare for the 21st century.

Let's look at two major components of HEALTHSTAR. The Interdisciplinary Research Complex will house programs that focus on the bridge between clinical and basic sciences; it will be located between the Waisman Center and the Clinical Sciences Center. The Health Sciences Learning Center, which will house advanced instructional and computer technologies as well as a library with electronic technology capabilities, will be located near the WARF building (on the far west side of the campus) and adjacent to the future School of Pharmacy.

In addition, the Medical School plans to move many programs in academic primary care, prevention and community health into the WARF building. This will bring the Madison-based Department of Family Medicine onto campus for the first time and enable us to centralize and merge interdisciplinary programs in response to state mandates.

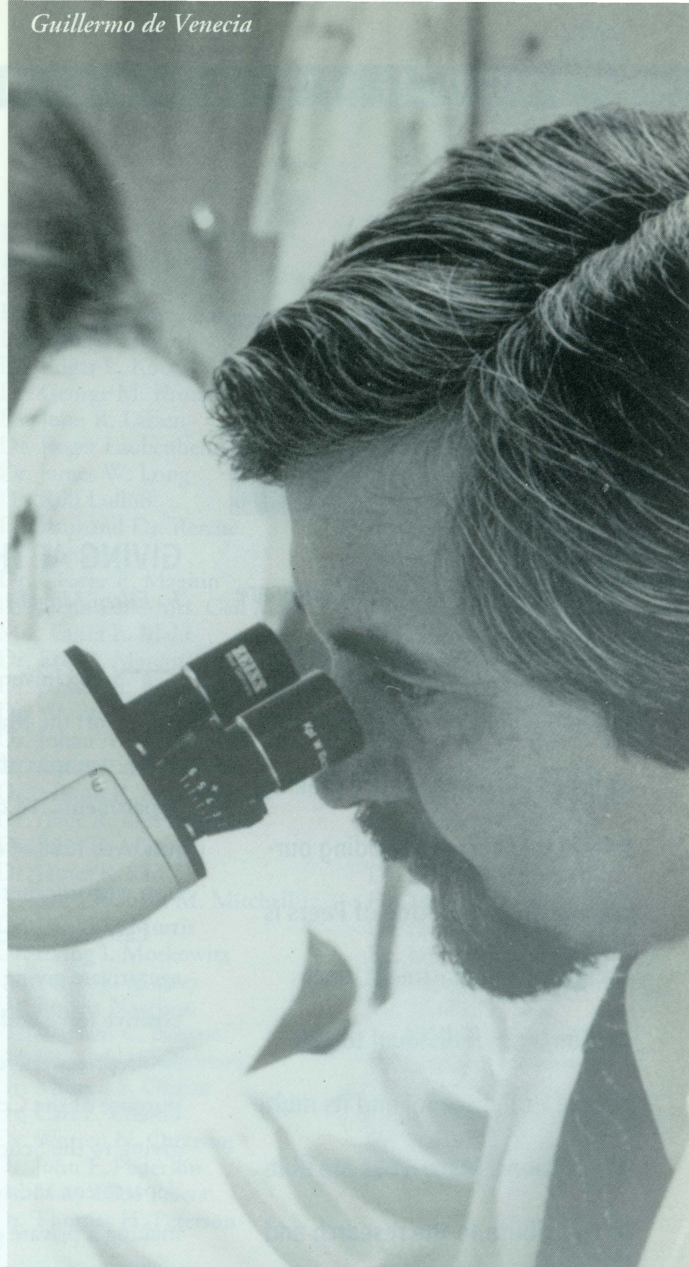
I enjoyed the opportunity of meeting with several of you at the Wisconsin Medical Alumni Association's Winter Meeting in Milwaukee in early February. We discussed the importance of the Milwaukee Clinical Campus to the Medical School and some of the activities that surrounded its beginnings nearly two decades ago.

The next day, February 5, we participated in a press conference to officially announce receipt of the Robert Wood Johnson Health Professions Partnership Program. Representatives from the UW-Milwaukee Campus, UW-Milwaukee School of Nursing, and the Milwaukee Public Schools also attended. The initiative aims to increase the size and diversity of the pool of future health care professionals by generating interest in the sciences among Milwaukee middle and high school students, especially minorities. (See Medical School News in this issue for more details.)

Medical Education Day, April 17, will be held at the Promega Corporate facility in Fitchburg. We will hear reports on the progress in curriculum revision and data from curriculum evaluation in progress, and we will learn the results of our accreditation visit by the Liaison Committee on Medical Education. Elsewhere in this *Quarterly*, you can find a discussion of the current status of our curriculum revision.

Note to readers: If you want details on topics such as the strategic plan, research programs and the Medical School's annual report, you can consult our home page on the Internet using <http://www.biostat.wisc.edu/medschool> as the address.

If you need help, please call Joan Bunazza at (608) 265-6688 or contact Mike Dykstra at dykstra@biostat.wisc.edu using E-mail.



JOIN THE ALUMNI ASSOCIATION

Join the Wisconsin Medical Alumni Association. Be an active member.

Dues are automatically waived for the first year following graduation. Dues are \$10 per year for the next four years and \$100 per year thereafter.

Send your payment to:
Wisconsin Medical Alumni Association
1300 University Avenue, Room 4245
Madison, Wisconsin 53706



"The UW Medical School faculty are beginning to realize that federal funding will never be as generous as it has been and we are looking to private sources, including ourselves. The Committee of Peers is asking each department, each section, each individual to contribute to the school and its multiple missions. Many of us are able to contribute to the research and educational goals of our own departments, and we are striving for 100% participation each year. In addition, we are looking to the generosity of our medical school and residency alumni and private foundations as well."

**J. Bryant Wyman, M.D. '58
UW Faculty-Gastroenterology
and Member, Committee of Peers**

GIVING AT THE GRASSROOTS LEVEL

by Eileen Murphy

The University of Wisconsin Medical School is huge. If you took the Medical School off the Madison campus, and put it say, in Waunakee, it would be the second largest campus of the University of Wisconsin System. There are 743 faculty members, 26 departments, 14 of which are clinical and 12 in the basic sciences. Only 92 individuals, or just over 12% of our faculty, are UW Medical School alumni. Everyone else has some affiliation with another institution.

Last year, a faculty based committee was formed through the UW Foundation to encourage private giving from the faculty. The Committee of Peers has become a viable, active and positive force within the Medical School community. The membership is made up of one or two representatives from nearly every Department, Center and Institute in the School. The purpose of the Committee is multiple: to educate the faculty about the importance of private giving to the School and join in the development process; to identify priorities within each department and set goals; and to encourage every faculty member to show a commitment by making a private gift.

We look to any number of sources for gift-giving to the Medical School. As alumni, you receive multiple mailings or phone calls asking for support. Our largest gifts have historically come from patients, individuals who are grateful for care received personally or by a family member or friend. In addition, it is becoming more common to benefit from corporate gifts or support from private foundations, particularly in the area of education and research.

Included as a source of private support is the faculty. From 1994 to 1995, faculty giving increased by 53%. While faculty gifts increased substantially in 1995, the Committee of Peers expects to reach their 100% goal in 1996. It should be noted that through the Clinical Practice Plan, the clinical faculty make a donation for departmental research and development. The Committee of Peers asks for an additional private commitment.

The Committee of Peers is leading the way by encouraging the faculty to support the Medical School. If our own faculty give to the School, it is easier and more effective to ask others to give. When you make a gift, you join with many others who believe in the mission and future plans for the Medical School at the University of Wisconsin and its graduates.

MIDDLETON SOCIETY MEMBERS

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

Dr. Daniel M. Albert
 Dr. C. Joseph. Anderson
 Dr. Richard B. Anderson
 Dr. Merne W. Asplund
 Dr. Betty J. Bamforth
 Dr. Ann Bardeen-Henschel
 Dr. Barry V. Bast
 Dr. James P. and Elinor Beck
 Dr. D. J. Beltran
 Dr. E. Maxine Bennett
 Dr. Theodore B. Berndt
 Dr. Louis C. Bernhardt
 Dr. Eugene and
 Dr. Dorothy Betlach
 Dr. Paul R. Bolich
 Dr. Jean Chapman Born
 Dr. Alexander Braze
 Dr. James W. Bringe
 Dr. Henry W. Brosin
 Dr. F. Martin Brutvan
 Dr. George T. Bryan
 Dr. Kathryn S. Budzak and
 Mr. Archie Budzak
 Dr. John A. Buesseler
 Dr. Glen E. Burmeister
 Dr. Ardis J. Candy
 Mr. and Mrs. Donald E. Cheney
 Dr. Clarence P. Chrest
 Dr. Renee R. Coulter
 Dr. Andrew B. Crummy
 Dr. Vincent H. Dahl
 Dr. Frederick J. Davis
 Dr. Richard K. Dortzback

Dr. John W. Doty
 Dr. Robert F. Douglas
 Dr. A. A. Drescher
 Dr. James L. Esswein
 Dr. V. S. Falk
 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. Steven L. Goldberg
 Dr. Richard S. Goodman
 Mrs. Lola Gordon-Hickey
 Dr. Harold E. Gries
 Dr. Thomas M. Grist
 Dr. Edward J. Guilfoyle
 Dr. James E. Gutenberger
 Dr. Todd Hammer
 Maurice Hanson Family
 Dr. Diane Heatley
 Mrs. (Helen) Gilman E.
 Heggstad
 Dr. Roger E. Henning
 Dr. John P. Hermann
 Dr. Thep Himathongkam
 Dr. Marvin Hinke
 Dr. John M. Irvin
 Dr. Sture A.M. Johnson
 Dr. John H. Juhl
 Dr. Albert V. and
 Mrs. Dolores Kanner

Dr. Anthony L. Karpinski
 Dr. Thomas J. Karras
 Dr. Hugh A. Kennedy
 Dr. John E. Kippenhan
 Dr. Ronald Klein
 Dr. Edgar L. Koch
 Dr. George M. Kroncke
 Dr. John R. Larsen
 Dr. Roger Laubenheimer
 Dr. James W. Long
 Dr. Rolf Lulloff
 Dr. Paul and Dr. Renate
 Madsen
 Dr. George E. Magnin
 Dr. Dennis and Mrs. Gail Maki
 Mrs. Laura E. Maki
 Dr. Eric R. Marcus
 Dr. Jacobs H. Martens
 Dr. W. Bradford Martin
 Dr. Johan A. Mathison
 Dr. Andrew A. McBeath
 Dr. Milton R. Mc Millen
 Dr. Alice R. McPherson
 Dr. John R. Milbrath
 Dr. James R. and
 Dr. Elizabeth M. Mitchell
 Dr. David L. Morris
 Dr. Irving I. Moskowitz
 Dr. Frank E. Murray
 Dr. Robert Natelson
 Dr. William C. Nietert
 Dr. Kenneth H. Oberheu
 Dr. Milford S. Ofstun
 Dr. Carl E. Olson
 Dr. Warren N. Otterson
 Dr. John F. Pederson
 Dr. Mary Ellen Peters
 Dr. Thomas H. Peterson

Dr. Thomas and
 Mrs. Nancy J. Plank
 Dr. Myron A. Pozniak
 Mrs. Nancy Rankin-Dewey
 Dr. Thomas J. Rice
 Dr. Hugh D. Riordan
 Dr. J. George Rosenbaum
 Dr. Harry Roth
 Dr. Royal Rotter
 Dr. Joseph F. Sackett
 Dr. Herbert Sandmire
 Dr. James Sands
 Dr. Robert F. Schilling
 Dr. Walter Schwartz
 Dr. James A. Sebastian
 Dr. Joanne A. Selkurt
 Dr. Michael J. Smullen
 Dr. Gilbert H. Stannard
 Dr. E. Richard Striehm
 Dr. Bruce J. Stoehr
 Dr. Charles M. Strother
 Dr. Loron F. Thurwachter
 Dr. Palmer G. Tibbetts
 Dr. Herman Tuchman
 Dr. Mark A. Urban
 Dr. Michael J. Urban
 Dr. Barry H. Usow
 Dr. John Vander Heyden
 Dr. Raymond C. Waisman
 Mr. Marvin E. and
 Mrs. Barbara J. Watts
 Dr. Eugene L. Weston
 Dr. Jon N. Winther
 Dr. Wilbert Wiviott
 Dr. Robert G. Wochos
 Dr. John B. Wyman

TAKING CHARGE

As you take charge of your own future, you will also help the UW Medical School enhance its future. Americans have a great history of philanthropy and volunteerism. For example, nationally, in 1994 total giving to charitable causes reached \$129.9 billion! More than 80% of this came from individuals, the balance from corporations and foundations. Within the past ten years, total giving — adjusted for inflation — has increased by nineteen percent.

Downsizing government means that even more dollars must flow through the private sector to social causes. But this offers an opportunity to exercise more control over where and how your dollars are used, rather than having it decided for you. We would be pleased to discuss with you the purposes for which your gift could be applied, and we could help you design your gift to meet your family's financial needs.

Reprinted from: Wisconsin Dividends, Year-End Planning in a Time of Transition

For more information or to receive a copy of "A Guide for Planned Giving," please call the University of Wisconsin Foundation at (608) 263-4545 or send your request to 1848 University Avenue, P. O. Box 8860, Madison, WI 53708-8860.

Year-end figures for all private support given through the University of Wisconsin Foundation during 1995 will appear in the next issue of the *Quarterly*.



Lowell Hokin and Mabel Hokin-Neaverson

Pharmacology to Sponsor International Symposium in June

The Department of Pharmacology has organized an International Symposium on the Role of Phosphoinositides, which will take place June 20-23 in Madison. Twenty participants from the U.S., Europe and Japan will deliver papers.

The symposium honors Professor of Pharmacology and Psychiatry Mabel R. Hokin-Neaverson and Professor and former Chair of Pharmacology Lowell E. Hokin, who jointly discovered in the 1950s an increased phosphate turnover involving cellular lipids phosphoinositides and phosphatidic acid rather than nucleic acids as the conventional wisdom would have suggested. They proposed a model, the "phosphoinositide cycle," far ahead of its time; it has been proven correct in recent years and shown to be involved in all sorts of hormone-mediated behavior as well as brain function, vision, fertilization, hormone secretion, multiplication and tumor growth. The spring '91 *Quarterly* carried a more detailed description of the Hokins' research.

Colleagues consider their pioneering work brilliant as well as courageous, for they persisted in uncovering mechanisms responsible for intracellular responses to hormonal signals when the hot topic of the day was probing the flow of information from DNA to RNA and protein. Their studies, which now have garnered worldwide recognition, were paid scant attention when first published.

If you are interested in more information about the symposium, call (608) 262-1733 or fax (608) 262-1257.

Medical Students Visit Cuba

Nineteen medical students, physicians and other professionals, organized by Med III Peter Dull, visited Cuba last spring as a one-credit class on health care after

petitioning the U.S. Treasury Department and lobbying Wisconsin Senator Russ Feingold. They attended talks and visited a family/doctor practice, a psychiatric hospital, a school for the blind and a medical school. They also walked the streets of Havana, talking with local people. The group took with them about \$30,000 worth of medicine and medical supplies as well as journals.

The visitors found generally good health care, although Cubans sorely lack medicines. In the last ten years, a Family/Doctor Program with primary care teams composed of a family physician

and a nurse who live and work in a community of 600-800 that they serve seems to be working well, for each team is aware of the unique problems of their people. Cuba's 18,000 medical students (compared with 22,000 in the U.S.) are mainly trained in primary care. Their first major course, for example, is "Health and Society," which envisions medicine as a sociobiological science.

Piano Music Greets Hospital Visitors

For several hours each week, piano music - sometimes soothing and classical, sometimes more bouncy and popular - gently permeates the large atrium of the UW Hospital Clinics Lobby thanks to the efforts of a variety of volunteers. They include retired people, patients, patients' family members, medical students and even security guards who realize that this touch of unexpected beauty can help to calm or cheer those who may be distressed, distraught or dispirited. The piano was donated by the Friends of the UW Hospital two years ago.

The pianist pictured here plays during the noon hour on Fridays. Jee yune Jung, an electrical engineer from Korea, currently is studying at the UW to satisfy course requirements so she can apply to the Medical School. She hopes eventually to work with children and to make use of her electrical engineering skills to help patients with brain or nervous system diseases.



Jee yune Jung

Dean's Cup Won by Med Students

In a "mini-Olympics" competition held last fall between medical and law students, \$1,000 was raised and presented to the Madison Rape Crisis Center and the American Red Cross. The games, held last September, included basketball, football, soccer, golf, frisbee, bowling, darts, pool, television trivia and mini-golf. The Medical School team won 533 points as well as the Dean's Cup, and the Law School team earned 322 points. Points also were awarded for blood donations.

Med II Tim Richer and second-year law student Tim Stewart, the organizers, hope the competition becomes an annual event.



Gloria Hawkins

Minority Recruitment to Focus on Milwaukee Schools

Although 16% of the UW Medical School class of 1994-95 were minority students, only 5% were Wisconsin residents. Dean Philip Farrell said that increasing those proportions, especially the number of students from Wisconsin, is a top priority of the School's new strategic plan. To reach such a goal, the health professions schools on the UW Madison and Milwaukee campus and the Milwaukee Public School system have joined forces in a major project, the new Health Professions Partnership Initiative (HPPI), to better prepare minority students for health sciences careers. Milwaukee was chosen because it includes nearly half of all under-represented minority students in Wisconsin.

Initiative participants will plan an enriched middle-school curriculum that includes a complete range of sciences so that students can succeed in a rigorous high school program that helps to prepare them for professional schools. The initiative also will suggest specific ways to adjust curricula to enhance interest and proficiency in science from the early school years through high school and to encourage parent participation. Medical School Assistant Dean for Student Academic Affairs Gloria Hawkins, HPPI program manager, said that mentoring and academic support programs also must be approved.

The Health Professions Partnership Initiative is funded by the Robert Wood Johnson Foundation.

New Radiation Equipment Promises Better Treatment

With the help of a \$1.1 million grant as well as equipment from GE Medical Systems, Medical School researchers are exploring a new technology called tomotherapy, which combines computerized tomography (CT) and radiation therapy in one machine that allows radiotherapists to see malignancies and adjacent structures inside the body more clearly as they deliver optimum doses of radiation even to complexly shaped tumors. The combination of technologies also lets the radiologist deliver radiation beams to the same place during each treatment. The tomotherapy machine has a ring-like CT scanner and a rotating linear accelerator that generates and fires high-energy radiation beams from many different angles; each beam's intensity can be controlled.

Associate Professor of Medical Physics Rock Mackie has worked several years on the technology, licensed through the Wisconsin Alumni Research Foundation.

The project also has received support from several other sources.

Howard Hughes Grant Concentrates on Molecular Mechanisms of Disease

The Medical School has been awarded a \$2.8 million grant from the Howard Hughes Medical Institute, which stresses cooperation among scientists of diverse backgrounds, a practice that the University is well known for. The program focuses on research in neuroscience, genetics and immunology, with special emphasis on the two areas in which the three disciplines intersect — neurogenetics and immunogenetics. Grant funds will help bolster research programs of junior faculty and recruit new young faculty.

The Hughes awards were created to help medical schools carry out research as



budget pressures increase and even some established, valuable researchers are hard pressed to obtain adequate funding.

She's Back!

The Statue of Liberty returned to Lake Mendota in early February, about 300 feet from the shore behind the Memorial Union, in time to help celebrate Winter Carnival. Vandalism had left the proud lady battered and in need of repair, but Hoofers Club members worked hard to restore her to her original glory after she had rested 16 years in a series of barns. Her 40-foot torch, destroyed in the 1984 Barneveld tornado, needed to be rebuilt from scratch. To prevent vandalism, Hoofers maintained 24-hour guard duty inside her head, which accommodated cots, recliners and a space heater:

The statue first arose from Lake Mendota in 1979 thanks to the Wisconsin Student Association's Pail and Shovel Party, which managed to fulfill extravagant pledges such as bringing the Statue of Liberty to Madison and 1000 flamingoes to Bascom Hill.

Med Flight Keeps Flying High

In 1995 Med Flight (the emergency helicopter service) logged 1,025 flights and flew the equivalent of 3.6 times around the world. It also celebrated 10 years of service with a perfect safety record. More than a year ago, the FAA awarded Med Flight one of the country's first Global Positioning Systems, which use 24 satellites to provide precise navigational information. The new Medical Director is Bart Hobson, clinical instructor of medicine.



Bernard H. Kampschroer

51 Bernard H. Kampschroer, who is associated with the UW Medical School, the Medical College of Wisconsin, and St. Joseph Hospital in Milwaukee, has been named a Fellow of the American College of Radiology for his outstanding contributions to the field of radiology.

71 After spending 19 years in Baltimore, Jacob K. Felix and his wife Jeanette (UW PhD, 1971) have moved to the Finger Lakes area of south central New York, where he joined a private practice neonatology group, PEDI-ATRIX Medical Group, Inc.

78 James R. Dyreby, a partner at Northland Orthopedics in Rhinelander, Wisconsin, volunteered during the month of December 1995 for service at St. Jude's Hospital in St. Lucia under the auspices of Orthopedics Overseas and Health Volunteers Overseas. His partners, Drs. Robert Kitzman and Jonathan Berry, kindly covered his practice and call schedule while he was in St. Lucia. Jim completed his orthopedic



Angelica Go, Maria Teresa Curet-Salim and Nathaniel Fullerton

residency at the UW-Madison in 1983.

89 Jon J. Cherney, who served his residency in orthopedic surgery at the UW from 1989-94 and was Chief Resident in '93-94, completed a Hand Fellowship with Cincinnati Hand Surgery Consultants in July, 1995. Currently he works with the Orthopedic Department at the Dean Medical Center in Madison.

90 Charles E. Boetsch completed his residency in diagnostic radiology in June of 1995. Now he is serving a fellowship in nuclear medicine at the University of Washington in Seattle.

93 Eric D. Miller will complete his family practice residency at St. Mary's Hospital, Milwaukee, this June. He currently serves as Chief Resident. He will join three other family practitioners in Beaver Dam, Wisconsin, at the University Community Clinic, affiliated with the University of Wisconsin.



95 Angelica Go, Maria Teresa Curet-Salim and Nathaniel Fullerton co-authored the book, First Aid for the USMLE 2, a student-to-student guide for the USMLE, step 2, the national board exam taken by 4th year medical students. It is published by Appleton and Lange.

Angelica is at UCLA Medical Center in pediatrics, Maria is at Johns Hopkins in pediatrics, and Nathaniel is at the Marshfield Clinic/St. Joseph's Hospital in internal medicine. If you want more information, write to Angelica Go, 3219 Overland Ave., Apt. 7200, Los Angeles, CA 90034, or call her at (310) 838-5659.



Alfred S. Evans receives the 1992 Distinguished Alumnus Award of the University of Buffalo School of Medicine and Biomedical Science during a dinner in his honor on September 24, 1992.

Former Faculty

Alfred Spring Evans, M.D., died January 21, 1996 from complications of cancer at his Connecticut home. He was 78.

Dr. Evans, a widely acclaimed epidemiologist and infectious disease expert, came to the Medical School in 1952 as Chairman of the Department of Preventive Medicine and Director of the State Laboratory of Hygiene. At Wisconsin, he confirmed that infectious



Dr. Francis Forster hugs Dr. Raymond Chun during presentation of a bound volume of Dr. Forster's Christmas letters.

mononucleosis was transmitted mainly through kissing and popularized the term "the kissing disease" for the illness, caused by the Epstein-Barr virus. He later applied his findings on mononucleosis to chronic diseases, including lymphoma and other forms of cancer, and established the role of Epstein-Barr virus in Hodgkin's disease. In Madison, Dr. Evans also developed the first comprehensive graduate summer program in epidemiology and biostatistics.

He developed the infection quarantine programs for the Apollo space missions and was a consultant for the Navy nuclear submarine programs and for the Surgeon General. Dr. Evans' military service during and after World War II resulted in many commendations and, in 1983, in his election as President of the Society of Consultants to the Armed Forces.

After he left Wisconsin in 1966, he returned to Yale where he became the John Rodeman

Paul Professor of Epidemiology and the Director of the World Health Organization Serum Reference Bank.

As an investigator, advisor and educator, Dr. Evans pursued his world-wide traveling until a few months prior to his death. His great sense of humor was one factor that attracted audiences of diverse background to him. Knowledge, energy, proficiency in language, and a love of computers enabled him to author more than 230 papers and edit five textbooks.

A long-standing professional friend called Dr. Evans "a

man for all seasons" in a 1987 tribute, considering that he was also a sports enthusiast, a medical historian, and an exemplary family man beloved by his wife, three children and four grandchildren.

Francis M. Forster of Cincinnati, Ohio received the American Academy of Neurology's Distinguished Service Award "in recognition of outstanding contributions and commitment to the development and promotion of the neurosciences and as a founding member of the academy."



John H. Juhl *John R. Cameron*

To commemorate the discovery of the X-ray by Wilhelm Konrad Roentgen 100 years ago, the Radiological Society of North America and the American Association of Physicists in Medicine jointly selected four outstanding contributors to the fields of radiology and medical physics to receive a special Roentgen Centennial Commemorative Medal Award. Two of the four recipients are emeritus members of the Medical School faculty: **John H. Juhl**, Professor Emeritus and former Chair of the Department of Radiology and **John R. Cameron**, Professor Emeritus and former founding Chair of the Department of Medical Physics and also Professor Emeritus of Radiology and Physics.

Although Juhl retired from the UW in 1980 and currently lives in Texas, he returns to the Medical School and UW Hospital every summer to instruct medical students and residents. While a faculty member, he was widely known as a leader in interpreting chest and bone films, intravenous urograms and other radiologic procedures. In 1959 he first co-authored *The Essentials of Roentgen Interpretation*, since re-named *Essentials of Radiologic Imaging*, considered by many to be "the text" in radiology. Dr. Juhl also helped

change the direction of radiological post-graduate training nationwide by championing its division into diagnosis and therapy. He was instrumental in recruiting young John Cameron to the Medical School in 1958.

Cameron soon developed the photon absorption method of measuring bone density, now the basis for evaluating osteoporosis. He also developed instruments to test and evaluate imaging equipment so that patients would receive the lowest radiation exposure commensurate with high-quality images, and he helped develop thermoluminescent dosimetry, which evolved into the badges worn by patients and technicians to measure the amount of radiation they have received. In 1981 Professor Cameron became the first chair of Medical Physics, once a division within Radiology, and led it until his retirement in 1985. The department and its graduates have gained worldwide recognition.

Both professors have been honored by the Medical School by creation of the John Cameron Medical Physics Professorship and the John Juhl Radiology Professorship.

Susan Skochelak, Associate Professor of Family Medicine and Associate Dean for Primary Care and Outreach, served as a consultant to Harvard Medical School's Family Medicine Clerkship Advisory Committee as Harvard is beginning to develop a medical student program in family medicine. She also delivered a keynote address, which focused on



Susan Skochelak

interdisciplinary teaching in primary care, at the annual conference of the American Association of Cancer Education in Tampa, Florida.

Ovid O. Meyer Professor of Medicine **Dennis G. Maki**, head of the Section of Infectious Disease, was awarded a \$1.5 million grant from the Oscar Rennebohm Foundation to establish the University of Wisconsin Program for Research in Nosocomial Infection. The five-year grant will allow Maki and his colleagues to establish a statewide hospital network to monitor and identify emerging problems with hospital-acquired infections and will support efforts to improve infection control and antibiotic use in general.

The rise in nosocomial diseases is attributed to the growth of technologies that, while life-saving, increase patients' vulnerability to catch diseases while hospitalized, and the overuse and misuse of antibiotics.

Last year, Dr. Maki received the International Congress on the Prevention of Infection



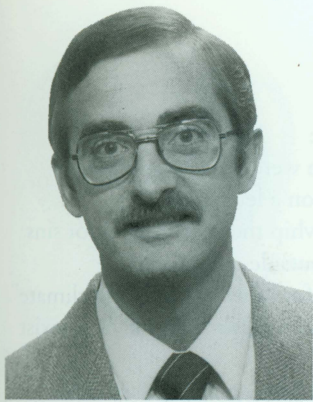
Dennis G. Maki

Award from an international panel of more than 100 scientists.

James Ervasti, Assistant Professor of Physiology and a member of the Cardiovascular Research Center, has been given an American Heart Association Established Investigator Award. The five-year \$299,000 grant will help him continue to study a protein important in muscular dystrophy. The protein may also play a part in cardiomyopathy.

Assistant Professor of Obstetrics and Gynecology and fertility specialist **Omid Khorram** is one of three researchers nationally to be honored with the 1996 Berlex Scholar Award, an annual fellowship to further research in reproductive medicine by new faculty early in their career. With the \$60,000 grant he will continue his investigations into the role of growth-hormone releasing hormone in the regulation of immune function.

Professor of Family Medicine **Jeff Patterson** was honored last May 11, which was declared Jeffrey Patterson Day in Madison by Mayor Paul Soglin. At a dinner and reception, friends, colleagues and family thanked him for 15 years of



Jeffrey Patterson

leadership in the Madison Branch of Physicians for Social Responsibility. Congratulatory letters from around the world concerning his dedication to work against national and international violence were read, and colleagues whom he had inspired testified to his enthusiasm and influence.

Professor of Medicine (Pulmonary and Critical Care Medicine) **Guillermo do Pico** has been elected as regent-at-large of the American College of Chest Physicians (ACCP). He also chairs the ACCP Health and Sciences Policy Committee and serves on the editorial board of CHEST and the ACCP scientific journal.

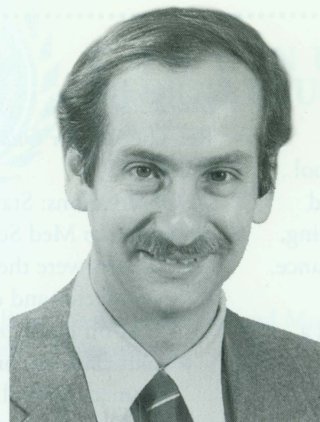
Professor of Pathology and Laboratory Medicine **Russell Tomar** was appointed to the College of American Pathologists' diagnostic immunology resource committee and standards committee. He previously served on the College's government affairs committee.

C. Brooks Brenneis, Clinical Associate Professor of Psychiatry and Lecturer in the Department of Psychology, received two prestigious awards for his published research. His paper *On the Relationship of Dream Content, Trauma and*

Mind: A View From Inside Out or Outside In? was awarded the Austen Riggs/Rapaport-Klein Study Group Scientific Prize. A second paper, *Belief and Suggestion in the Recovery of Memories of Childhood Sexual Abuse*, was judged the best article published in 1994 in the *Journal of the American Psychoanalytic Association*. Both papers will be included in a forthcoming book tentatively titled *Recovered Memories of Abuse: Transferring the Present to the Past*.

James Crow, Professor Emeritus of Genetics, Medical Genetics and Zoology as well as former Acting Dean of the Medical School, received the 1995 Distinguished Service Award from the College of Agriculture and Life Sciences for his contributions as a population geneticist, teacher and textbook author. His work has earned him membership in many of the nation's most prestigious scholarly groups such as the National Academy of Sciences, the National Academy of Medicine, the American Philosophical Society, and the American Academy of Arts and Science.

The National Eye Institute (NEI) has given its National Eye Education Program Outstanding Achievement Award to **Ronald Klein**, Professor of Ophthalmology, for his role in helping to develop an education campaign about diabetes and glaucoma based on observations from recent studies that many people with these diseases may not be receiving adequate care. He provided epidemiological information about diabetic retinopathy and information about health care from The

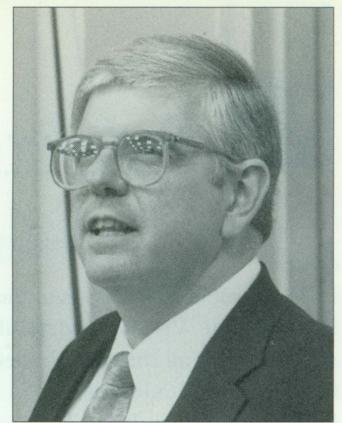


Ronald Klein

Wisconsin Epidemiologic Study of Diabetic Retinopathy, a longitudinal study funded by the NEI and headed by Klein. The study, which involves about 2,300 people, is beginning its 17th year.

Associate Professor of Pathology and Laboratory Medicine **Daniel S. Greenspan**, along with collaborators in Israel, have found a link between genes involved in embryo formation in species ranging from fruit flies to sea urchins and enzymes that convert proteins into the major structural components of human and mammalian bodies. Researchers hope the finding will lead to new approaches to healing wounds and bone fractures. The study can be seen in the January 19, 1996 issue of *Science*.

Judith Kimble, Professor of Medical Genetics, Molecular Biology and Biochemistry, was elected to the National Academy of Sciences. The Howard Hughes Medical Institute Investigator studies the development of a species of nematode. In her model, she is able to monitor each cell as the worm progresses from its beginnings to its adult form.



Frank Graziano

Frank Graziano, Professor of Medicine and head of the Section of Rheumatology, received the Distinguished Internist Award from the Wisconsin Society of Internal Medicine. He is founder and codirector of the UW Hospital's HIV Care Program.

Professor of Ophthalmology and Visual Science **Guillermo de Venecia** retired in January after spending nearly 40 years at the Medical School.

Since 1979 he has contributed his vacation time and money to provide free medical and surgical eye care to poor people in the Philippines with the help of his wife and other medical volunteers. Now he is raising funds to renovate an abandoned government hospital close to his home north of Manila. He plans to build operating suites so that surgeons will be able to perform six operations simultaneously. With the help of two other Filipino eye surgeons, who will carry on in his absence, de Venecia will donate six months a year to the Free Eye Clinics in the Philippines and work the other six months at the UW Hospital and Clinics.

The Free Eye Clinic will utilize used equipment for eye surgery donated by the UW and other hospital furnishings donated by Don Nevasier, owner of Madison's Howard Johnson Hotel.



Our Readers Write

Editor:

In 1950, some 65+ years ago, the University of Wisconsin Medical School marked down all the good grades I had from Hibbing Junior College in Hibbing, Minnesota. This is Ivory Tower arrogance. Then, after I made good grades at Wisconsin U. Med School and earned a Bachelor of Arts in Medicine, I had to transfer to the U. of Minnesota at Minneapolis. They would not recognize the U of Wisc. degree and made me take their sophomore comprehensives — told me to apply elsewhere, as no student from other universities had ever passed their examinations. Well — Hallelujah — I DID pass and they accepted me as a junior Medical Student, BUT — like Wisconsin — marked all my good grades from Wisconsin to “C”s — putting me at the BOTTOM, as internships were awarded by scholastic standing. Another Ivory Tower Arrogance! This is why I haven’t supported either University.

Charles L. Concklin '36 (2 year)

Gentlepeople:

I still enjoy your magazine although many years removed from Madison. Once again you have continued to frustrate an old timer with fading memories and other faculties with unlabeled pictures in your Winter 1995 Vol 36, number one. Those on pages 7 and 10 look like folks I should know. The bloke in the snow on page 12 needs no identification.

*Best Wishes,
James A. Tibbitts '53*

Editor’s note: Other readers have also written that they missed seeing captions with pictures. We, too, regret not labeling photos from class reunions and other special functions. Now that Ralph Hawley is gone, there is no one in the WMAA office who can readily identify most of the participants, so we are forced to give up on the job of labeling altogether. We are indeed sorry about our inadequacies.

Dear Editor,

Re: The Winter *Quarterly’s* “Women in Medicine”

Observations: Starting in 1950 on my admission to Med School, UW-Madison:

- ✓ Grades were the determining admission factor and everyone knew the “cut-off grade point” for their class.
- ✓ Our class was only about 10% women. Several of the women shared with me that the negative opinions of family, high school teachers and peers were their biggest hurdles for pursuing medical studies.

After their training, 30-40% of these women found employment in medical teaching, beating out the men’s percentage.

- ✓ The school climate was not considered “nurturing” by either the men or the women.
- ✓ There was firm camaraderie throughout the class.
- ✓ Dean Middleton would have been Hell on Wheels for anything smacking of sexual harassment.

Conclusions:

- ✓ Women were taken into Medical School on a level field.
- ✓ Don’t whip the Med School for sins of the outside community.
- ✓ Asking for “special nurturing climate” for women (*Quarterly*, pg. 5) is sexist in itself.
- ✓ I would have greatly missed camaraderie with the women in our class had they been pursuing feminist activities and goals to the exclusion of males.
- ✓ Right on! for 52% women in the class this year.

*Yours,
Robert Brown M.D. '55*

NECROLOGY

Jane Reeve Allen, '34
(2 year)
Atlanta, Georgia
Spring 1995

Willard B. Bloemendal,
'27 (2 year)
Grand Rapids, Michigan
March 20, 1995

Bertram F. Bruenner
(Former Intern)
Los Altos, California

John M. Grindrod, '50
Madison, Wisconsin
January 3, 1996

Herbert J. Hatem
(Former Intern)
Methuen, Massachusetts
November 11, 1995

Eugene R. Hering, Jr.,
'31 (2 year)
Santa Fe, New Mexico
April 1987

Haytham Jabi
(Former Resident Internal
Medicine)
Albany, New York
November 27, 1995

John A. Kopfinger, '48
Baton Rouge, Louisiana
December 26, 1995

Thomas W. McNamara
(Former Intern)
Felton, California

Jean C. Roberts, '56
Eules, Texas

Jack D. Schroeder, '42
Janesville, Wisconsin
February 27, 1996

Adolph Shor
(Former Resident
Anesthesiology)
Milford, Ohio
May 28, 1982

Ronald A. Simpson
(Former Resident in
Anesthesiology)
San Francisco, California
October 31, 1995

Howard M. Templeton,
'50
Boscobel, Wisconsin
December 2, 1995



**COMING
EVENTS**

April 26, 1996
American College of Physicians
Wisconsin Reception
Place and time to be announced
San Francisco

April 29, 1996
American College of Obstetricians
and Gynecologists
Wisconsin Reception,
6:00 to 8:00 p.m.
Marriott/Colorado, Ballroom H
Denver

May 17, 1996
Medical Alumni Day
Madison

October 19, 1996
Homecoming
Tailgate lunch and game with
Northwestern University
Madison



**C O N T I N U I N G
M E D I C A L E D U C A T I O N**

1996

May 2-4
Electrophysiologic Basis for the Diagnosis and Management of Cardiac Arrhythmias
Hyatt Regency Hotel, Milwaukee

May 9-11
19th Annual Sports Medicine Symposium
The Concourse Hotel, Madison

May 14-15
The Heart of Cardiology is (Still) Echocardiography
The Milwaukee Hilton Hotel, Milwaukee

May 16
Wisconsin Back Society
The Concourse, Madison

June 6
Contemporary Management of Cardiovascular Disease
Grand Geneva, Lake Geneva

June 21-20
The Ray Owen Symposium: Transplantation and Immunogenetics—
Past, Present and Future
The Wisconsin Center, Madison

July 12-13
4th Biennial Phonosurgery Symposium
Engineering Hall, Madison

All conferences qualify for AMA Category 1 credit.

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.

*Keep in touch with the Alumni Office and
classmates. Let us know what's happening in
your life—and add a photo if you can.*

Name, year _____

Home Address _____

City, State, Zip _____

Have you moved? Please send us your new address.

Mail to

Wisconsin Medical Alumni Association
1300 University Avenue, Room 4245
Madison, Wisconsin 53706

The Wisconsin Medical Alumni Association
Room 4245
1300 University Avenue
Madison, Wisconsin 53706-1532

Nonprofit Organization
US Postage
PAID
Madison, WI
Permit No. 2117

89055959704

b89055959704a

