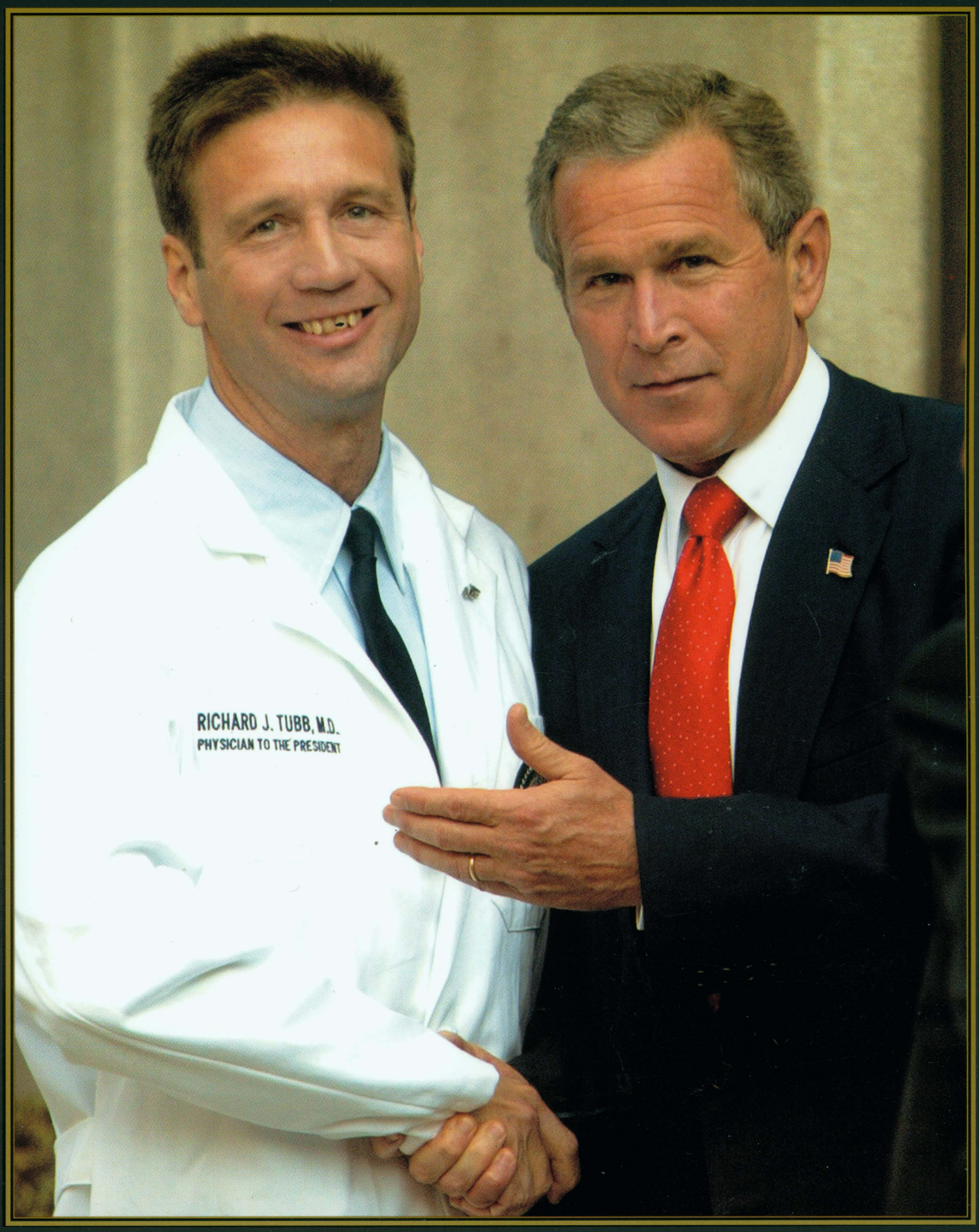
The Magazine for University of Wisconsin Medical School Alumni and Friends

QUARTERLY



Richard J. Tubb, MD '85
White House family practitioner

VOLUME 4
NUMBER 4
FALL 2002

QUARTERLY
The Magazine for
University of Wisconsin Medical School
Alumni and Friends

Published quarterly by the Wisconsin Medical Alumni Association and the University of Wisconsin Medical School

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Contents

FALL 2002
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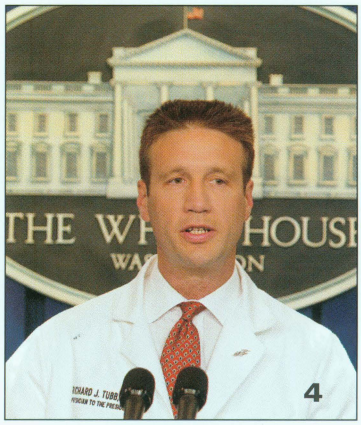
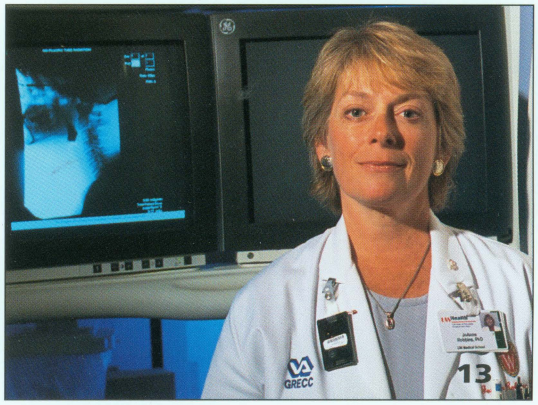
FEATURES



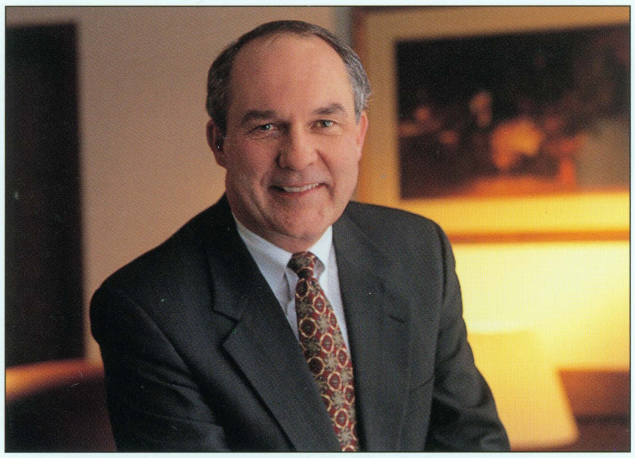


On the cover: Prior to his annual medical examination in August, President George W. Bush jokes with his physician, Richard J. Tubb, MD '85.
(AP/Wide World Photos)

DEPARTMENTS

From the Dean

Welcome to the Class of 2006! As with all classes at University of Wisconsin Medical School, the Class of '06 is unique and special. With a total enrollment of 152, 81 are women and 71 are men. Students attended undergraduate colleges and universities all over the country—from nearby Edgewood College to as far away as the University of Alaska. Their scores on the Medical College Admissions Tests (MCATS) were strong. The average biological science score of the class was 10.8 on a scale of 1 to 15, with 15 being the highest. The average physical science score was 10.4 and the average verbal score was 9.9.



Philip Farrell, MD, PhD
UW Medical School Dean
UW–Madison Vice Chancellor for Medical Affairs

Needless to say, the students are well rounded—they enjoy all manner of sporting, musical and cultural activities. And like so many previous UW Medical School students, members of the Class of '06 are socially conscious and involved. We predict that they will be outstanding physicians. Their medical education will be filled with challenges, but their next four years will pass quickly, and in no time these young people will join you as fellow alumni.

Homecoming is coming up quickly, and I hope to see many of you back on campus for this annual autumn get-together. This year, I look forward to visiting with many "junior" alumni—graduates of the past decade—as well as "senior" alumni. We're eager to have greater numbers of relatively recent graduates on campus, as the Wisconsin Medical Alumni Association begins a new program of holding 10-year class reunions in the fall. We are very enthusiastic about welcoming back many members of the Class of 1992 for their reunion at Homecoming Weekend 2002.

We also are excited about celebrating the tenth anniversary of the creation of "The Arrhythmias." This student band began as an activity that busy medical students—who also happen to be good musicians—took up for fun. Subsequent students have carried on the tradition for a decade, and the band has been a source of excellent entertainment for students and alumni at our social gatherings and formal events over the years. The band is a wonderful extra curricular activity for students; I encourage all medical students to engage in similar kinds of outlets. No one can deny the importance of bringing balance to our lives. It affects all of us personally as well as professionally.

I believe that alumni spirit is particularly high right now. Like the rest of us, UW Medical School graduates are excited about the new Health Sciences Learning Center, which is progressing beautifully. What's more, we are fortunate to be experiencing several new opportunities in the medical field—advances in imaging, non-invasive surgery and stem-cell research, to name a few. We can be extremely optimistic about these advances.

Despite the scandals in business (or maybe because of them), I sense that physicians these days are recognizing exactly what society expects of them—a strengthening of values and a clear display of professionalism. Here at UW Medical School, these are areas that we always try to emphasize. We recently finalized a code of professionalism for students, and we are developing a similar code for clinical faculty and all our residency programs. This is indeed a time for re-dedication to professionalism, integrity and altruism.

From the WMAA President

When I took the helm as your president on May 11, 2002, I began with the satisfaction of knowing that all is well at the Wisconsin Medical Alumni Association (WMAA). While the organization took on an unprecedented number of new challenges during the last two years, the resulting changes have made it much more visible and responsive to medical students' needs, and better able to involve alumni. Simply stated, a strong alumni association should appeal to alumni of all ages. It should be a resource for current medical students, link members with Medical School priorities—teachings, research and service—and serve as an advocate for students and alumni alike. The organization should foster excitement about what is happening on campus.

There is much to be excited about. With much help from WMAA past presidents, board members, UW Foundation, the Dean's office and our new executive director, Karen Peterson, the WMAA has been walking lockstep with the Medical School in its expansion into the new Health Sciences Learning Center. WMAA was present at critical junctures. It provided recommendations on size, location and other specifics; it also invited student input and offered reflective criticism. The finalized plans include a state-of-the-art high-tech lecture hall, ample space for study, an inviting open air look, and room in the midst of it all for new WMAA offices.

Christopher Larson, MD '75
WMAA President

It is much more than brick and mortar: the project stands as a testament to three organizations working together for the good of UW Medical School. Many will benefit—students, future doctors, patients, research scientists—from the joint efforts of the WMAA, the Medical School and the UW Foundation. Together we were willing to dream, and commit to this ambitious project.

I am excited also about the newly configured WMAA board of directors and committee structure, which I believe makes participation among alumni much easier. The restructuring also lets us more effectively serve the differing needs of graduating classes young and old. Our agenda includes many opportunities to return to campus for WMAA-sponsored activities.

I hope that you will plan a campus visit for Homecoming on October 19th and join our alumni gatherings. The scheduled activities begin with a pre-game tailgate party at Union South followed by the UW versus Ohio State football game and conclude with a 10th anniversary celebration for the medical student band, "The Arrhythmias." Former band members will return and join students for a unique performance.

As your president, I celebrate the many elements that have brought us successfully to this important time in our history, and I look forward to working closely with you.

A family practice in the White House

BY DIAN LAND

Air Force Colonel Richard J. Tubb, MD '85, originally dreamed of practicing family medicine in a small, rural town in his home state of Wisconsin, but an unexpected journey has taken him to another place altogether. He is physician to the president of the United States and director of the White House Medical Unit. To most people, the gap between the two worlds may seem enormous. But several factors—including Tubb's military and medical training and perhaps his willingness to remain open to all possibilities—appear to have combined to help him make the transition easily. He has found similarities in both worlds.

TUBB'S OFFICE IS ONE OF ONLY A handful to be located in the White House proper. The proximity to the First Family's residence reflects the close relationship that traditionally exists between the senior White House physician and his or her primary patients. The office affords a serene view of the South Lawn, Tubb says, but the West Wing, where the hectic business affairs of the presidency take place, is only a short walk away along the connecting colonnade.

Tubb's office is steps away from the First Family's residence, located on the second floor of the White House, seen here from the South Lawn. The proximity reflects the close relationship that exists between the senior White House physician and his or her primary patients.

Thanks to the popular television series "West Wing," the public has seen a version of the fast-paced and pressurized working environment in and around the White House. But Hollywood rarely portrays the efforts of several lower-profiled units that provide the commander-in-chief essential services within the context of the highest levels of security.

Many of the support services are orchestrated through the White House Military Office. Seamlessly coordinating with the United States Secret Service, the Military Office oversees food security, transportation, communications and the medical unit that Tubb directs.

"Everyone associated with all divisions of the Military Office is a member of the service and brings unique military capabilities to the job. And a paramount responsibility of the job is safeguarding the continuity of the office of the presidency as well as the president himself," says Tubb, who has been a commissioned officer in the Air Force since 1981. "We approach this job as a military operation."

The medical unit consists of approximately 25 people—physicians, physician assistants, nurses, technicians and support staff. In overlapping shifts, the medical staff is poised around the clock for any White House emergency. The urgent care clinic is located on the first floor of the Dwight D. Eisenhower Executive Office Building while the unit's administrative offices are on the fifth floor.

THE NUMBER-ONE MISSION OF THE unit is comprehensive medical care of the president, vice president and their families. "We are the White House family docs," says Tubb, who is the president's personal physician. "We make house calls—it just happens to be the White House."

At first glance, this portion of Tubb's job may appear relatively simple: President George W. Bush is known to be in excellent health. The doctor coordinates with specialists, such as the anesthesiologists and gastroenterologists from the National Naval Medical Center in Bethesda, Maryland, who performed a colonoscopy on the president in June. He also oversees annual physical examinations, including the latest three-hour

check-up conducted on August 6, 2002. Results of all medical tests on Bush have been outstanding, reports Tubb.

Like all good physicians, Tubb is eager to maintain patient confidentiality, but he also acknowledges the public's right to medical information that potentially impacts the health of one of the most visible patients. "Fortunately, this president is in extraordinary health, so it's not difficult to discuss the matter," he says. "I have a responsibility to assure the country that this man is 'fit for duty' and, in all likelihood, will remain so for his tenure."

Tubb generally deals with the media only when the president or the White House press office needs him to answer medical questions. He prefers it that way. "I feel that in the military and medical professions we approach our work as background people," he says. "It's also the nature of my personality to be positioned behind the scenes as much as possible."

He offers quickly, however, that the president is an exceptional patient. "President George W. Bush is every doctor's dream patient," he says. "In my opinion, he's the real deal in terms of total fitness. And not just fitness of the body, but fitness in the context of what American medicine is re-discovering—fitness of the mind and soul as well."

The medical responsibilities of the unit extend to the nearly 3,500 people who work in the 18-acre White House compound, which Tubb says can resemble a small town. "Working so closely together and under such stressful conditions, we all have developed relationships of trust and confidence," he says. "These kinds of relationships are the foundation of good medical practice. For me, it's family medicine and flight medicine at their finest."

Tubb believes that this corollary mission of "care by proxy" is also critical in helping the president perform optimally. As a family physician, he assesses his patients' health by looking at all facets of their lives. The flight surgeon's perspective is similar.

"If the aircraft mechanic is not functioning at his or her full capacity, there's a very real risk that the pilot is not going to be able to perform at peak capacity either," says Tubb, an Air Force senior flight surgeon. "The analogy here is that by taking care of the president's speech writer, for example, we can help the president perform his job better."

The medical unit also provides emergency coverage for all White House visitors, including international heads-of-state and other diplomats as well as the 1.5 million tourists who typically visited the White House annually before September 11, 2001, when security was tightened.

THE SECOND PRIORITY OF THE MEDICAL unit—being prepared for emergencies that threaten the office of the presidency—may be

WHITE HOUSE PHOTO

less visible than directly caring for the president's health, but it is decidedly demanding. In this function, the unit works extremely closely with both the Secret Service and the Military Office to support them in providing protection and emergency responses.

"Any time the Secret Service is called upon to act, the situation automatically becomes a medical event too, because the very first question everyone asks is, 'Is the president all right?' A physician must be available to answer that question," notes Tubb.

With the Secret Service, Tubb's team has gone through many half-day drills simulating scenarios involving attacks on the president. The exercises are so life-like, he says, that they usually are held away from the White House, where they could be mistaken for a real emergency response.

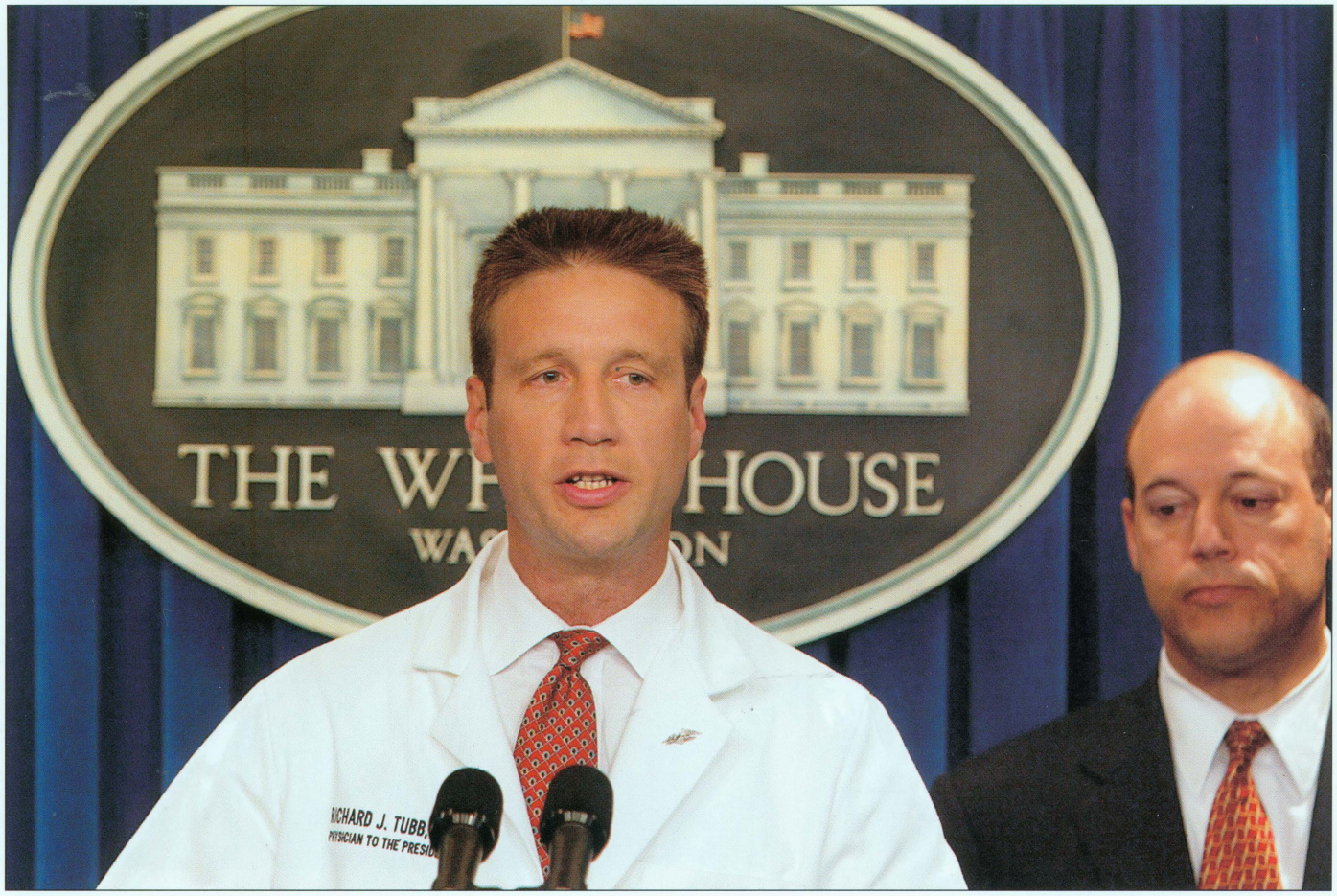
In addition to the obvious medical implications, each scenario has multiple layers of possibilities that must be addressed—issues involving security, the media, continuing governance. "This forces us to look at situations from perspectives we normally might not consider," says Tubb. "I like this challenge."

Each member of the medical unit must have completed advanced cardiac life support and advanced trauma support training. They all have had years of medical experience supporting military operations—in the field, at sea and in flight—and have completed advanced chemical, biological and radiological training. Some also have taken clinical training to support special weapons and tactics (SWAT) teams.

The White House physician must also be ready to offer critical advice regarding implementation of the 25th amendment to the United States Constitution, which is meant to ensure continuity of the presidency under all circumstances. The amendment allows for the temporary transfer of all presidential power and duties to the vice president when the president is unable to carry out his responsibilities due to a medical disability.

Before Bush's recent colonoscopy, Tubb served in an advisory capacity to the president, who decided to invoke the amendment during the short period he was under anesthesia. It was the second time the amendment had been implemented.

Preparing for a medical emergency at the White House is challenging enough, but when either the president or vice president travels, many more factors come into play to further



AP/WIDE WORLD PHOTOS

Tubb prefers to stay in the background, but he deals with the media when medical questions must be answered. At a White House press conference in June, he reported results of the president's colonoscopy.

complicate the preparations. Before any trip is made, Tubb sends unit personnel to investigate hotels, visit hospitals and meet with local physicians, searching for potential medical threats. "Global medical intelligence includes evaluating host-country health threats that may include endemic diseases, epidemics, and food and water borne diseases," he says. "Since we do this throughout the world, we practice a good deal of travel medicine."

Once again, the medical unit coordinates intensively with the Secret Service and the Military Office to prepare for the 'what ifs.' "We bring personnel and equipment on all trips so that we have the capabilities with us at all times for any contingency," Tubb says. "We also construct detailed plans to provide definitive follow-through care."

Overseas trips can include hundreds of people—White House staff, State Department employees and members of the media. "In theory, our primary mission is direct care of the president or vice president. But in practice, if something goes wrong, we take care of each other," he says. "The trips are exciting. They're like a small military deployment. Our role is to help make sure the mission is accomplished."

In fact, a physician and a critical care or emergency room nurse are with the president at all times, whether he is traveling to nearby Camp David, Maryland, or as far away as Russia. Tubb, who makes most of the out-of-town and all overseas trips, has logged hundreds of thousands of miles on Air Force One.

He rarely has needed to deal with serious cases in the medical suite on board the jet, which is outfitted for almost any capability, including acute in-patient care. But non-emergency cases are not uncommon. Otherwise, Tubb spends time on administrative work he brings from the unit, while others also attend to official business, or hold meetings, in the office-like surroundings.

The long flights provide ample downtime as well, and as a result, he says, "the traveling staff does become very tight." Some people watch movies in the entertainment center, or news on television. "The president takes a great deal of interest in his staff, on trips as well as at home," he says.

WHITE HOUSE PHOTO

Tubb has logged hundreds of thousands of miles on trips with the president. Here he takes a short flight on the White House helicopter, Marine One, to catch Air Force One, the jet that is outfitted for almost any medical emergency.

For Tubb, humor is part of the relaxing and relating, and not just when he's traveling. "Humor is one of the ways I deal with stress. It has helped me more than ever in the past seven years on this job," he says, adding that the president and his staff clearly enjoy a good laugh. "I think humor plays an important role between physicians and their patients. It humanizes medicine."

DICK TUBB WAS RAISED ON A FARM outside Viroqua, Wisconsin. When he was 10 years old, his schoolteacher parents moved the family to Washington, D.C., for a year of "home-schooling" in the nation's capital and on the East Coast. "History and the movies tell me that 1969 was a tumultuous time to be living in Washington, D.C., but as a child I was more interested in the pool in the apartment complex than the reflecting pool at the National Mall."

Tubb followed his older brother, with whom he was very close, to the Air Force Academy. He excelled there, graduating second in his class. He had been accepted into pilot training, but decided at the last moment to take advantage of the military's Health Professions Scholarship Program, which supports qualified officers through medical school. A self-described "type-A" personality, Tubb planned to become both a pilot and a physician, but he learned later that flight school was not an option for physicians.

When Tubb was a boy, his parents moved the family from Wisconsin to Washington, D.C., for a year in the nation's capital. In a foreshadowing of things to come, Tubb, leaning against the lightpole, stands in front of his future office.

He chose to attend UW Medical School because it was close to home—he knew his military career would take him away often—and because he felt it would afford a very different experience from what he had had at the Air Force academy. "I embraced the academy way of life, and I embraced the university way of life," he says, adding that both places helped crystallize his life view. "Without either experience, my education would be been incomplete."

In the back of his mind, Tubb had a vision of what a "real doc" should be like, and UW Medical School had produced one that perfectly fit the image. "My vision came from the general practitioners I'd grown up with in Viroqua," says Tubb, noting that it was the personal style of their doctoring that remained so memorable. "I believe Dr. Robert Starr, of the UW Medical School Class of 1950, was unparalleled."

Tubb's expectations of UW were confirmed. "Academically the Medical School was tremendous," he says, noting that he found the eight-week preceptorship during his fourth year to be particularly important. "The school drilled into me that to be a good doctor, you have to learn to get your patient to talk and you must listen."

Before beginning his four years in Madison, Tubb, always conscious of growing as a person, made a decision to be less obsessive than he had been at the academy. He made sure to have fun during medical school, rekindling relationships with family members and developing new ones with friends who remain close. "I think my time at UW taught me the importance of people," he says.

Wisconsin is also where Tubb began running, something he had hated all his life, even though he had been a serious high school and college wrestler. "While I was in medical school, I spent an enormous amount of time in the gym and running," he says. "I did that to help keep balance and perspective in my life."

Athletics have always been important to him, and the military has kept him active. He's completed scuba and parachute training, is an expert marksman and has gone through several rigorous survival training programs. Today, he sometimes runs with the president and a group of Secret Service agents. The president is always at the head of the pack. "Here, as elsewhere, the leader leads," says Tubb. "Also, it's hard to keep up with him."

Following medical school, Tubb's career as a military physician took him to various posts and new learning experiences in this country and abroad. He completed a family practice residency, earned his senior flight surgeon badge and became board certified in family practice. He has held leadership positions in all facets of Air Force medicine, assisted the National Aeronautics and Space Administration in key aspects of space shuttle flight support, and has taught numerous advanced training programs. He has been an assistant professor of family medicine at the Uniformed Services University since 1991.

In 1994, Tubb, his wife, Kathy, and their three children were settled in southern Illinois, where he was teaching in the family medicine residency program and directing the flight medicine office at Scott Air Force Base. "Our plan originally had been to leave the Air Force as soon as practical and return to Viroqua, where we had both grown up, and for me to set up a general practice," Tubb says.

After careful evaluation, however, the Tubbs concluded that the military offered things that they strongly valued—educational opportunities, travel, a chance to practice in non-traditional settings. "We also felt we wanted to give something back, to be part of something bigger than ourselves," Tubb explains. "The military let us do that, so we decided to stay on."

But disappointments followed. Tubb lost out as a finalist in a bid to become an astronaut, a goal he had held for years. He felt obligated to turn down a dream job giving medical training to special forces personnel in New Mexico, because it meant he would have to leave his family for nine months. And the brother to whom he felt so connected had recently died of colon cancer at age 33.

"I was pretty discouraged, perhaps even a little depressed," Tubb admits, conceding that it became a time of serious soul searching. "When the Air Force called and said they wanted me to consider a job at the White House, I said that, for a variety of reasons, I wasn't interested."

Tubb's vision of life in highly urbanized Washington, D.C., where he imagined the job would have him supporting people driven by their egos, was diametrically opposed to the quiet life in which he and his wife were raising their children. They were living on their own small farm, replete with red barn and chickens.

But the Air Force persisted with encouragement and endorsements, and Tubb sensed that the job possibility had taken on a life of its own. As a result, he was compelled to re-evaluate his priorities again. "I thought that if I'm going to trust God with the things I want in life, then I need to trust Him with the things I don't want," says Tubb.

He finally agreed to an interview, thinking it would end the process, as he felt job interviews often went poorly for him. But this time it went extraordinarily well. Furthermore, everything about the White House and Washington, D.C., felt natural to him, he recalls.

Tubb was offered the job, and joined the White House medical unit in June 1995. He started as one of six military physicians serving President Bill Clinton and his staff. He immediately began taking his turn in the medical staff rotations, traveling with both the president and vice president. In 1996 he was appointed director of Vice Presidential Medical Operations, and became personal physician to Vice President Al Gore and Tipper Gore.

Tubb's guide and mentor during the Clinton years was his immediate boss, Navy Captain Connie Mariano, MD, then head of the medical unit and physician to the president. "Connie was a very important mentor who taught me much about the job," he says. Tubb became her deputy director.

When the Bush administration made the transition into the White House in 2001, the new president recognized Tubb's leadership skills and appointed him director of the medical unit. In March 2002, Bush commissioned him "Physician to the President."

Tubb had expected to serve in the White House only two years, but as he begins his eighth year, he can't predict when his tenure will end. "Either I'm doing something terribly right or I'm doing something terribly wrong," he jokes. "Like so many other people, I serve at the pleasure of the president. When he no longer is pleased, I'll be happy to serve somewhere else."

Tubb is grateful for having trusted that larger forces would guide him to the right place. "The things I thought I didn't want have turned out to be the best experiences and opportunities of my life," he says.

He now sees Washington and the White House through different eyes. "I've found that the people I'm working with are far from egocentric," he says. "They believe in something besides themselves."

And Tubb strives to uphold those same principles in his medical practice. "The heart of the servant is not dependent on the response, title or power of the patient," he says. "I want my office to be a sanctuary, a place where my patient, the president, knows without a doubt that I and my staff want nothing more from him other than the satisfaction of providing comprehensive care in a way that will allow him to be the best president he can be—not only now, but for years to come."

Tubb has discovered that no matter where a doctor works, the job essentially boils down to the basics. "It's about creating good interpersonal relationships and paying attention to the context of your patient's life," he says. "I've got my own small-town family practice right here at the White House."

UW Medical School looks for solutions

Grappling with high tuition

By Aaron R. Conklin

Attending medical school in the 21st century is expensive. Brian Arndt can tell you exactly *how* expensive.

Arndt, a 24 year-old second-year student at University of Wisconsin Medical School, earned an undergraduate degree in mechanical engineering, then earned enough money to purchase a comfortable house in Madison. When he decided to enroll at the Medical School in 2001, he knew that to succeed, he'd need to focus solely on his studies. To cover his first two years, he took out $72,000 in student loans to pay for tuition and living expenses. He currently is on-track to graduate in 2005—with a debt load of $155,000.

Assuming hefty educational debt has been seen as something of a rite of passage for budding physicians for decades. As tuition rates and student debt load continue to skyrocket at UW Medical School and across the country, that rite of passage is turning into a lifelong burden, one that many believe may have a detrimental effect on medical residents' career choices.

Arndt, who also is the president of the Medical Students Association, was part of an *ad hoc* student tuition committee formed two years ago by the Wisconsin Medical Alumni Association (WMAA) to, as Arndt puts it, "get everyone on the same page" on the topic of rising medical school tuition. The committee conducted extensive research, comparing UW Medical School to other schools, both national-

Second-year medical student Brian Arndt (center) worked as a summer teaching assistant in gross anatomy to supplement his income during medical school.

ly and within the Big Ten. They presented their findings to the UW System Board of Regents, which establishes tuition rates, in May. Their report included these facts:

- With its current cost of one year of tuition and fees at $21,725, UW Medical School ranks third highest among public institutions that are part of the Association of American Medical Colleges.
- Since 1991, tuition at UW Medical School has increased 110 percent. In the last four years, it has jumped 25 percent.
- Medical students comprise 1.5 percent of the total student population at UW–Madison, yet they contribute 5.5 percent of total tuition dollars collected annually.

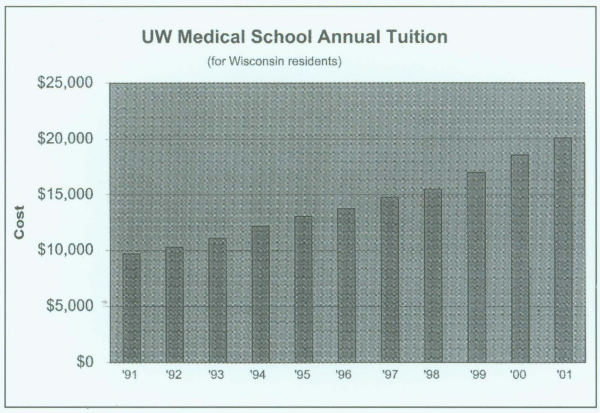
"There's no question that students are satisfied with the quality of the educational experience they're getting for their tuition dollar," says Susan Skochelak, MD, senior associate dean for academic affairs at the Medical School, adding that tuition covers only a fourth of the roughly $80,000 it costs UW to educate each medical student. "But there isn't any prestige for your cost of tuition. It's a negative factor, because if students can go to comparable educational institutions and they have to pay more tuition at one than the other, that will be the deciding factor."

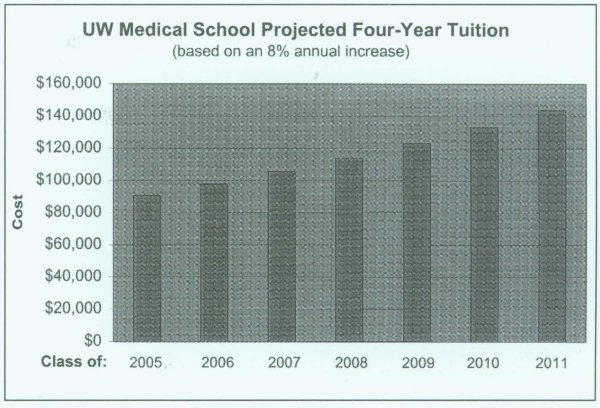
Assuming they qualify, UW medical students can currently access about $16 million in financial aid to help offset tuition costs. But of that figure, only $3 million is in the form of scholarships, and many of those are offered through the National Health Service Corps or the military, and must be repaid. Last year, UW medical students assumed a whopping $14.5 million in student loans, a figure that averages out to about $30,000 per student.

Not including diversity-based scholarships, the Medical School will offer 60 scholarships to second-, third- and fourth-year students in the 2002–2003 academic year, totaling $93,000. The scholarships will range in size from $350 to about $5,000, with the average student receiving about $1,500. With tuition and fees already soaring above $21,000—not to mention living expenses—that money represents a small drop in a sizable bucket.

At the moment, federal and state loan forgiveness programs for those choosing to practice in underserved areas are few, and don't cover all specialties. As a result, many medical residents are forced to moonlight to make ends meet.

The potentially negative effects of this trend were recognized in two recent reports published in the American College of Physicians' *Annals of Internal Medicine*. They noted an alarming rate of cynicism, stress and depression among residents balancing patient care and monthly student loan payments. There's a growing concern that sizable debt loads—the national average for each medical student is $90,000—may begin to limit students' career choices, as graduates shun lower-paying specialties such as family practice, pediatrics and psychiatry in favor of procedure-based specialties that generally offer higher salaries.





Source: WMAA/student tuition committee.

Nationwide, this has proved true. In 1999, the number of medical students going into family practice declined 30 percent. At UW, the effect has been less severe. Arndt says the Class of 2004 is still on track to meet the Medical School's unstated goal of placing at least 50 percent of each graduating class in family and other primary-care practices.

"Most of my fellow students know that they'll probably have a difficult time paying off their student loans, yet they're choosing up front to go into family practice anyway," says Arndt. "But I think we're balancing on a teeter-totter. If tuition costs keep going up, we could see that change pretty quickly."

Arndt isn't the first UW student to raise the issue of spiraling tuition rates. That distinction belongs to a group of students that includes Dan Jackson, the co-president of the current group of Med 4s. Two years ago, Jackson and his colleagues collected similar tuition data and presented it to the regents. The result was a State Medical Society of

Opportunities on the horizon

The Health Sciences Learning Center represents a big opportunity. Scheduled to open in 2004, the new $55 million facility signals the dawn of a new era. It will be an important recruitment tool and a potentially powerful new fund-raising engine for scholarship dollars.

The University of Wisconsin Foundation, working in partnership with the Medical School, has looked at endowing scholarships tied to the five student learning communities that will form the organizational heart of medical students' life in the new building.

"The opportunities to build the learning communities got us thinking about how to recognize the excellent physicians in our history," says Susan Skochelak, MD, senior associate dean for academic affairs. "With the question of naming the communities, we thought about whether we'd be able to offer scholarships to members of the learning communities, so that the top students who come here might be recognized with particular scholarships."

By 2003, the UW Foundation hopes to establish as many as 15 full scholarships that may share the names of the physicians for whom the learning communities are named. These will address one of the two scholarship goals Skochelak believes the Medical School needs to meet. The other is a larger number of modest-sized scholarships that could reach more students. The school's primary target is to raise enough money to fund scholarships for a third of the class; the next step is to bump that up to 50 percent.

"It will require a lot of fund-raising, because we want to give the scholarship based on the endowment's interest earnings," says Skochelak. "That way, the principal is always there for other students to use." Skochelak is optimistic that alumni who benefited from scholarship dollars during their tenure as medical students will be willing to help ensure that similar opportunities exist for others.

Efforts already are under way. Last year, the Wisconsin Medical Alumni Association board of directors established a scholarship fund, with the eventual goal of creating an endowment that will fund student scholarships. Last fall, a fund-raising drive was launched to solicit donations, and plans are in place to make the scholarship campaign an ongoing one.

Wisconsin resolution to look at ways of slowing tuition increases—and two more years of 8 percent jumps.

Jackson, who'll begin his residency in June, is planning a career in pediatrics, but admits to considering more lucrative fields to help offset the $140,000 debt he'll carry when he graduates.

"Our debt load is a major concern, and there's no guarantee of what will be there for us in 15 years," says Jackson, noting that the modern managed-care environment limits physicians' salaries in many fields. "Physician salaries are going down, with primary-care physicians feeling the brunt of this decline."

The increasing cost of medical school—and its potential psychological costs—are issues about which UW Medical School administrators are acutely aware. In fact, they've been working for years to try to address them, through the creation of new scholarship opportunities.

Already, success stories have begun to emerge. Last year, using monies drawn from the Herman and Gwen Shapiro Marital Trust Gift, an on-campus endowment established in 2001, the Medical School was able to carve out 25 four-year scholarship offers of $10,000 each to last year's class of first-year students. Fifteen scholarships ended up going to Wisconsin residents, while the other ten went to out-of-state candidates.

The extra scholarships have impacted the school's ability to attract its top academic recruits. In 2000, the Medical School was able to attract only one-third of its most-wanted students. This year, approximately three-fourths of the target group matriculated.

Mikel Snow, PhD, dean of students and admissions at the Medical School, admits that the extra scholarship dollars probably accounted for only part of the recruitment increase. The draw of the new Health Sciences Learning Center and students' desires to stay closer to home in the wake of September 11 were also factors. Still, at a time at which even a modest source of scholarship dollars can make a big difference, Snow is happy to take it.

"What concerns me is that we maintain our competitiveness as other schools come up with solutions of their own to these issues," he says. "We need to find every mechanism we can to address this."

Radical notions about swallowing

By Dian Land

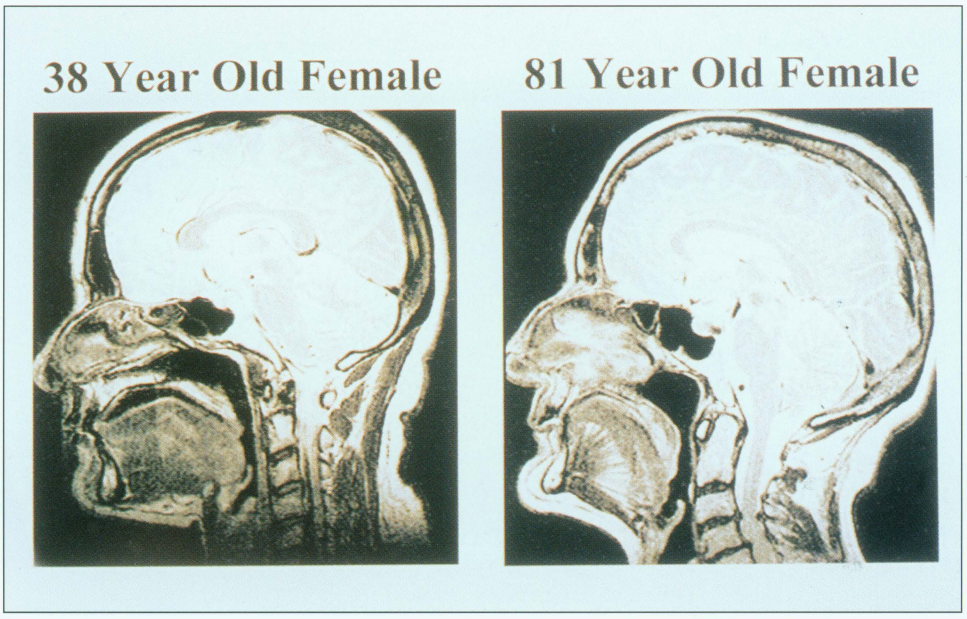
Twenty years ago, JoAnne Robbins, PhD, was the first speech-language pathologist to complete a National Institutes of Health (NIH) post-doctoral training program concentrated solely on swallowing disorders. Today, as the field continues to develop, she remains one of only a handful of specialists in her profession whose work is devoted entirely to swallowing.

In the intervening two decades of clinical practice and laboratory research continuously funded by the NIH, Robbins, an associate professor in the gastroenterology section of the University of Wisconsin Medical School Department of Medicine and the associate director of the Geriatrics Research, Education and Clinical Center at the William S. Middleton Memorial Veterans Hospital, has helped define the way people think about swallowing.

Her ideas about this first crucial step in eating and drinking have been—and continue to be—radical. In one of her first NIH-funded studies, for instance, she dispelled the long-held notion that swallowing is a typical reflex when she showed that people could modify a swallow through voluntary control. Currently she is pushing the traditional boundaries of swallowing beyond the head and neck to the esophagus, suggesting that it may play a more important, complex role in swallowing disorders than previously thought.

The outcome of Robbins' body of work points to important new ways to detect, behaviorally treat and even prevent swallowing disorders, whether they originate in the mouth, throat or esophagus. Millions of people, particularly older adults, stand to benefit from the advances—including those who may be at risk for fatal pneumonia, dehydration and malnutrition, and those who simply may not be enjoying their meals.

(Continued on next page.)



Robbins observed that normal aging results in loss of muscle mass and strength in the tongue, which can disturb the precise coordination required for successful swallowing.

"When I first started my clinical practice, I saw only patients who had very specific reasons for having swallowing problems—mostly stroke or Parkinson's disease," says Robbins. "But before long, I was getting called in on a wider variety of cases, such as patients on the cardiovascular and transplant units and in the endocrinology, kidney and liver clinics."

The thread that seemed to unify so many of the cases, Robbins soon noted, was that the patients were relatively old. With an emerging picture in the back of her mind, she began paying closer attention to magnetic resonance images (MRIs) that were taken of brains of stroke patients, who typically were older. In those images, she observed that tongues, the major propulsive force in swallowing, appeared to lose muscle mass with aging.

The pattern suggested that dysphagia—or swallowing problems—could be related not just to disease, but also to normal aging. Robbins developed a theory, which she later tested and confirmed: In the same way that the aging process affects other muscles in the body, it also results in a reduced reserve of muscle in the head and neck. Robbins and her UW team named the phenomenon presbyphagia.

"The reduction in muscle strength and mass means that the precise coordination required for successful swallowing is slightly thrown off and the whole process slows down," she explains. "When this happens, even if you are healthy, you may not get optimal protection of the airway, and so you may be at risk for aspiration, or inhaling food, liquids or secretions into the lungs, the most common cause of pneumonia."

In older patients with additional health problems contributing to frailty—from acute problems such as stroke, to chronic conditions such as diabetes and arthritis—swallowing can become even more compromised and risk of aspiration even greater.

Robbins insists, however, that an "old swallow" is not necessarily an impaired swallow. "We have some concern that normal characteristics of an old swallow are being misdiagnosed as dysphagia," she says. "We are hoping that continued research will provide a better understanding of the effects of aging on swallowing, and that this will help us safeguard against over-diagnosis of dysphagia. Older people often have enough problems without us giving them an additional unneeded diagnosis."

"The question then became: Can we improve the situation by rebuilding that diminished muscle strength and mass in the tongue through specific exercises?"

IN THE MID-1990s, AT APPROXIMATELY the same time that Robbins was formulating her theory of presbyphagia, the NIH identified sarcopenia, or generalized muscle loss related to aging, as a national health problem. The NIH was responding to growing awareness that sarcopenia was linked to gait problems and resulting falls that could lead to fractures. Experts knew that sarcopenia in the legs could be avoided with exercise.

"I started to think of aspiration associated with muscle loss in the mouth as analogous to falls stemming from muscle loss in the legs," says Robbins. "The question then became: Can we improve the situation by rebuilding that diminished muscle strength and mass in the tongue through specific exercises?"

Robbins now directs two clinical trials—funded by the U.S. Department of Veterans Affairs and the University of Wisconsin Graduate School—aimed at answering the question. The studies test the effect of a progressive resistance exercise program on tongue function and swallowing efficiency. One study involves older volunteers with swallowing problems resulting from a variety of conditions contributing to frailty, including stroke; the other enlists healthy older subjects.

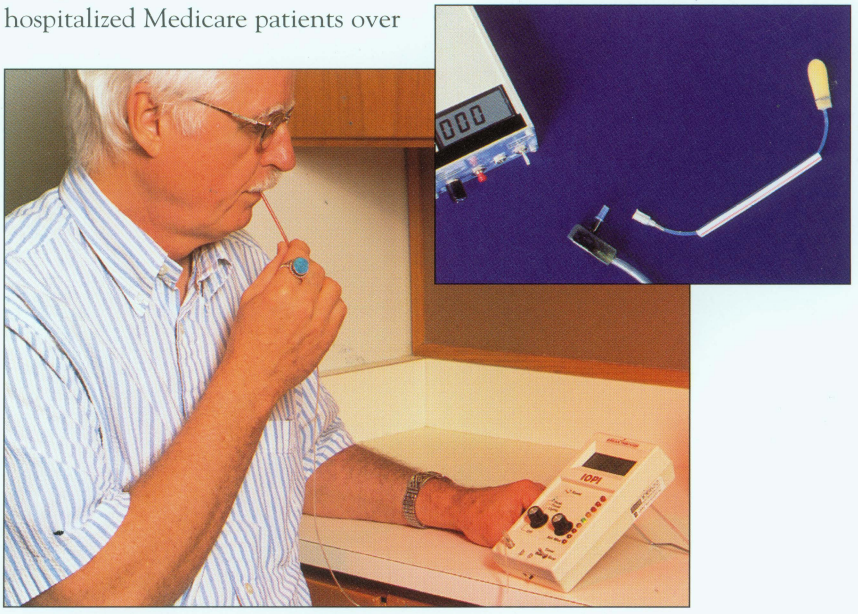
To perform the exercise, subjects use their tongue to press a pressure-sensitive, inflated bulb against the roof of their mouth. They repeat the isometric exercise 30 times, three time daily, three days a week. The program reflects the general sports medicine protocol that results in increased strength and muscle mass in arms and legs.

Before and after patients complete the eight-week workout, researchers will measure tongue pressure to determine whether strength improves, and evaluate MRIs to see if tongue size increases. Videofluoroscopy, the most common X-ray technique used to record swallowing as it is occurring, will show how effectively a barium-coated mass of food moves through the mouth and throat.

Initial results of the lingual exercise studies are showing that the activity consistently and dramatically increases tongue strength as well as volume. Anecdotal evidence is supporting the numbers. "People are telling us that they are able to eat more solid foods, which can be difficult to get down if you have a swallowing problem," Robbins notes. "They all attribute this improvement to the exercise protocol."

Robbins hopes that the clinical trials will determine exactly which of the many muscles in the tongue and mouth should be targeted to develop optimal swallowing, and whether an exercise program of four or eight weeks is sufficient or if sustained exercise is best. She is eager to conduct additional studies to determine if the exercise can *prevent* aspiration pneumonias by delaying the onset of age-related swallowing changes.

"Pneumonia is a huge problem with the elderly population," she says, noting that it is the fifth leading cause of death in people over age 65, and the third leading cause of death in people over 80. "Significant increases in aspiration pneumonia have been found in hospitalized Medicare patients over the past decade. Not surprisingly, there has also been an increase in the reported prevalence of dysphagia in the geriatric population."



Subjects in Robbins' lingual exercise study press a pressure-sensitive, inflated bulb against the roof of their mouth. Initial results are showing that the activity dramatically increases tongue strength and volume.

Robbins is chairing a $5 million NIH study comparing the two most common treatments currently used for compromised patients to avoid aspirating liquids and acquiring pneumonia. One treatment is swallowing using the "chin-down" posture, which positions structures in the throat to better protect the airway. The other is swallowing thickened liquids, which are less likely than thin liquids to spill into the airway.

Robbins and collaborators at some 120 hospitals and extended care centers in nine states are conducting swallow studies on patients with dementia or Parkinson's disease. Nearly 1,000 patients ultimately will be enrolled. Once they are placed in a treatment group, patients will be monitored for three months to see if and when pneumonia develops.

In the study, Robbins also uses a 44-item questionnaire that she and her colleagues developed to better quantify how swallowing problems may affect patient quality of life.

Recipes for the X-ray suite

To clinically evaluate a swallow as it occurs, swallowing clinicians ask the patient to swallow liquid barium, which shows up clearly on videofluoroscopy, or X-ray video, and coats soft tissue structures in the mouth, such as the tongue. Until a few years ago, standard off-the-shelf barium originally made to coat the stomach was used for the newer swallow exams. But for some people with swallowing difficulties, the thin liquid could enter their lungs, causing them to choke.

JoAnne Robbins came up with a solution. She designed bariums in a variety of thicknesses—thin, nectar-thick and honey-thick—of known viscosity values. Now, if patients choke on thin barium, they are then tested with the thicker nectar or honey barium. At the same time, Robbins and her team created recipes for thickening dietary fluids—including water, milk, soda, juices, coffee and broth—to match the barium thicknesses. The Wisconsin Alumni Research Foundation filed a patent on the new system, and the largest barium company in the country has licensed the patent.

The diagnostic information gained in the X-ray suite helps clinicians suggest the appropriate treatment. "Once we determine the right barium viscosity during the exam, we can then tell patients which thickness of the liquids they can safely and comfortably drink," says Robbins.

"Certainly some of our most meaningful moments in life—particularly during holidays and other special events—focus on mealtime. And as we grow older and have more leisure time for cooking and dining with friends, eating and swallowing may be a critical component of our quality of life," she says. "Difficulties with swallowing not only may be uncomfortable and embarrassing, they also may be isolating at a time when socializing and human contact is most important."

Robbins hopes that, ultimately, all clinicians dealing with swallowing problems will use the patient-centered questionnaire to assess quality of life issues. "Then we all can communicate more effectively, and understand the impact our efforts have on our patients who are living with dysphagia," she says.

In addition to being uncomfortable and embarrassing, swallowing difficulties in older adults can be isolating at a time when socializing and human contact are most important, says Robbins.

ALWAYS CHALLENGING HERSELF TO THINK ABOUT swallowing in new ways, Robbins recently was drawn to the esophagus as a potential source of problems. The new perspective came from complaints of many patients who felt as if food became stuck in their throat after eating, but in whom no structural or functional problem was found with a standard swallowing test.

"If you don't find the problem in the throat, you have to keep looking, you can't discount the patient's complaint," says Robbins with an attitude that has earned her the nickname of "case cracker."

She knew that disturbances in the lower esophagus can produce feelings in the throat. This "referred sensation" can occur with stimulation of the vagus nerve, which runs the length of the upper digestive tract. No matter where they originate, sensations can be felt along the entire nerve.

Collaborating with gastrointestinal (GI) radiologists, Robbins developed a new clinical test, called the oral-pharyngeal esophagram, to increase the chances of finding the source of the unexplained problems. The exam shows how barium that is designed to simulate liquid and solid foods people normally consume moves through the mouth and down the esophagus.

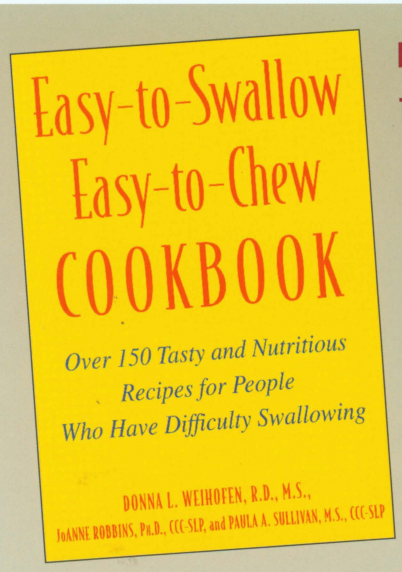
"The more I look at these studies, the clearer it becomes that many people have esophageal swallowing problems, which often have a mouth and throat component as well," says Robbins, adding that two physicians training to specialize in GI disorders are conducting research with her to clarify the problem. The unexplained sensations may relate to food not being propelled effectively through the esophagus, she suspects, or food not passing properly into the stomach through the lower sphincter of the esophagus.

Robbins believes that clinicians may be confusing gastro-esophageal reflux (GER) and asthma with the problem she has identified, termed intra-esophageal reflux (IER). With GER, food that has reached the stomach backs up into the esophagus, potentially burning tissue due to the acidic contents of the stomach. With IER, food that has not entered the stomach, and therefore hasn't been affected by its acidic environment, may remain in the esophagus and back up even further into the throat. From here the food can be inhaled into the lungs, producing a misdiagnosis of asthma.

The implications for treatment are important. "By remediating the movement of food through the esophagus, we can clear up the airway disease that traditional asthma inhalers won't affect," she says. "If the problem is IER, we would recommend behavioral changes first—no meals containing acidic or spicy foods, no caffeine, no reclining for an hour or two after eating, no pills with water at bedtime—instead of prescribing GER medications."

"At least 20 percent of patients diagnosed with GER don't respond to standard reflux medications, and we think we know why," she adds. "They may have an entirely different entity—IER—that needs to be addressed completely differently."

Robbins says she is eager to test the theory in a clinical trial. In the meantime, she will be on to analyzing swallowing in radical new ways.



Recipes for the kitchen

In her 20 years of clinical practice specializing in swallowing problems, JoAnne Robbins has offered her patients and their families dozens of tips on ways to prepare food so that it is palatable and nutritious—yet easy to swallow. At first she made brochures to hand out. But as the number of her patients grew into the thousands, she realized that much more needed to be done.

To address the problem, she enlisted the efforts of Donna Weihoefen, RD, MS, a nutritionist and lecturer at University of Wisconsin Hospital and Clinics, and Paula Sullivan, MS, a swallowing rehabilitation colleague at the William S. Middleton Memorial Veterans Hospital. The product of their collaboration is the just-published *Easy-to-Swallow, Easy-to-Chew Cookbook*.

The cookbook is targeted to the millions of people who are challenged with chewing and swallowing problems, from those with stroke, Parkinson's disease, cancer, multiple sclerosis, and amyotrophic lateral sclerosis (ALS) to those who have no specific diagnosis but nonetheless may be finding that their food is not going down as smoothly as it once did.

In addition to over 150 recipes, the book includes information on the mechanics of swallowing, ways to swallow safely and easily, and hints on tailoring food textures to make swallowing easier. It also offers suggestions on approaches to dealing with specific problems, such as extremely dry or sore mouth, limited range of motion of the tongue and food that seems to get stuck.

The book, published by John Wiley & Sons, is available at most bookstores.

UW's Ralph M. Waters, MD

Founder of modern anesthesiology

By Moira Urich

Someone with enough passion and vision can change a field of study. This is what Ralph Waters, MD, of University of Wisconsin Medical School, did for anesthesiology.

When Waters began his medical practice in 1913, all physicians who specialized were self-taught. Anesthesia was not included in the medical school curriculum, and there were very few physicians who, like Waters, chose to limit their practice to anesthesiology. By the time he came to UW 75 years ago, Waters recognized that the way to transform anesthesiology from an occasionally haphazard practice to a profession was to establish a course of study in a medical school. At Wisconsin, he founded the world's first academic center for anesthesiology.

"Madison became the mecca for anesthesiology," says Lucien Morris, MD (PG), who was a resident under Waters from 1946 to 1948. "Physicians came for standard residencies, and there was a steady stream of visitors staying for shorter periods," says Morris, now an emeritus professor of anesthesiology at the Medical College of Ohio in Toledo. "He was ahead of his time, and he influenced the way anesthesiology is practiced worldwide."

As early as 1918, Waters was presenting case reports to medical societies. The following year, he called for a major change in practice: that anesthesia be delivered by a physician specialist. At the time, it was customary to allow a medical student, nurse or other less experienced assistant to administer anesthesia. While acknowledging the convenience of that practice, Waters wrote in an article for *Lancet* titled "Why the Professional Anesthetist?" that a husband can sometimes deliver a baby too, but "that is no argument that we do not need . . . obstetricians."

Thus he began his advocacy for the physician anesthetist. "To be thinking in those terms in 1919 shows how innovative he was," says Morris. "This became his mission in life."

Waters embarked on a key component of his mission when he began teaching anesthesiology courses at UW. "These were at first offered through the surgery department," according to Mark Schroeder, MD '79, UW Medical School associate professor of anesthesiology. "He took the then-unique approach of cross-departmental collaboration, primarily with the departments of pharmacology and physiology."

Waters was fortunate to have the support not only of basic science faculty, but also Erwin Schmidt, MD, a UW professor of surgery, and

Charles Bardeen, MD, dean of the school. The UW Medical School catalog began listing courses in anesthesiology in 1937.

Schroeder says that Waters continued his practice of making keen observations and compiling data about various anesthetic agents. "This sort of study wasn't being done elsewhere, probably because anesthesia had been relegated to an assistant's job," he says. "I think he had a very good mind for research, for asking questions and seeking solutions."

Waters was a pioneer in the use of the anesthetic cyclopropane. "The introduction of cyclopropane was important because, unlike ether, it could anesthetize patients very quickly," says Schroeder.

Adds Morris, "His clinical evaluation of that new drug established a model for subsequent studies. In addition, Dr. Waters originated the cuffed endotracheal tube to seal the airway and prevent aspiration of foreign material."

Another of Waters' contributions was the introduction of a closed system for respiration, allowing the re-breathing of exhaled air. He designed the volume and shape of the so-called "Waters canister" to achieve the most efficient removal of carbon dioxide from expired air. "This allowed anesthesiologists to conserve on anesthetic agents during a procedure," Schroeder explains. "With soda lime to absorb the carbon dioxide, and with the addition of oxygen, patients could re-breathe their exhaled air."

Morris points out that, in earlier times, if there was a respiratory complication, including airway obstruction, the fire department was often called in to try to resuscitate the patient while physicians stood by. "Dr. Waters put a stop to that," he says. "With simple demonstrations of the bag and mask, he showed that the anesthesiologist was the best person to perform resuscitation and ensure adequate ventilation."

According to Susan Goelzer, MD '81, the first Ralph M. Waters Distinguished Chair of Anesthesiology at UW Medical School, Waters' most important contribution was his unique focus on teaching and inspiring others to become educators.

"Our faculty consider themselves fortunate to have the opportunity to 'teach doctors to teach,' the tradition established by Dr. Waters when he began training others to establish anesthesiology as a separate medical specialty," she explains. "Now most of the leaders in our specialty can trace their roots back to Dr. Waters and the University of Wisconsin."

Waters trained 60 residents over two decades at UW, a large number for the time. Of the 60, 40 went on to long-term professorships at other universities, and many founded anesthesiology departments.

Their impact has been magnified many times over. "In 1980, Dr. Waters' students—or students of his students—were anesthesiology department chairs in 80 of the 120 medical schools," says Morris, who prepared a professional genealogy of anesthesiology chairs who had been Waters' students. The students were called "aqualumni," in a word play on his name.

Morris describes his former teacher as a humble and retiring person. "Yet I know of no other professor who has had that degree of influence in a field of medicine," he says.

After retiring from UW in 1949, Waters lived in Florida until his death in 1979. An international conference hosted this summer by the UW anesthesiology department (see sidebar on page 20), which highlighted Waters' contributions, is not the only event at which he is remembered. "Each time the Anesthesia History Association convenes their annual meetings," says Schroeder, "they pay tribute to Dr. Waters by toasting him—with water."

"Now most of the leaders in our specialty can trace their roots back to Dr. Waters and the University of Wisconsin," says Susan Goelzer, MD '81, UW's first Ralph M. Waters Distinguished Chair of Anesthesiology.

At the recent commemorative conference, Drs. Lucien Morris (right) and Carlos Parsloe, both of whom were UW residents under Waters, pay tribute with a toast—of water.

Conference commemorates Waters and his legacy

In 1964, Ralph Waters, MD, addressed a conference of anesthesiologists saying, "I have always felt that it would be fun to meet and talk with some of the old chaps who...in their own way, did contribute a lot to the development of ways of relieving pain."

At a conference this summer, the University of Wisconsin Department of Anesthesiology hosted anesthesiologists from around the world to recognize Waters' contributions. No doubt they would have loved a chance to talk with the man who led the way for all of them.

The conference, held June 6–8, observed the 75th anniversary of Waters' arrival at UW and his establishment of the first academic center for anesthesiology. Conference organizer Mark Schroeder, MD '79, UW associate professor of anesthesiology, reports, "It was a great success. We had roughly 200 attendees from the United States and 11 other countries."

According to Lucien Morris, MD (PG), a former UW resident who studied under Waters, the international tenor of the conference "exemplifies the high regard in which Dr. Waters is held worldwide."

Within a few years of his arrival at UW in 1927, Waters had sufficient international acclaim that "visitors from all parts of the world came to Wisconsin to learn from his innovative educational approach to anesthesiology." Morris, who addressed the conference, is an emeritus professor of anesthesiology at the Medical College of Ohio in Toledo.

Among the invited speakers were other former students of Waters', such as Torsten Gordh, MD, former chief of anesthesiology at the Karolinska Institute in Stockholm, Sweden, and Carlos Parsloe, MD, of São Paulo, Brazil, who is the past president of the World Federation of the Societies of Anesthesiologists.

Other former residents of Waters sent video greetings. "Dr. Jone Wu, who is regarded as the father of modern anesthesiology in China, expressed how pleased and honored he was to have been trained by Dr. Waters," says Schroeder. "It was clear that Dr. Waters' influence was truly valued."

Conference organizer Mark Schroeder, MD '79, greeted Ingrid Bardeen-Henschel, daughter of anesthesiologist Ann Bardeen-Henschel, MD '45 (center).

Susan Goelzer, MD '81, the first Ralph M. Waters Distinguished Chair of Anesthesiology at UW Medical School, spoke with Dr. John Steinhaus, former Waters resident and Emory University anesthesiology department chair.

Susan Goelzer, MD '81, the Ralph M. Waters Distinguished Chair of Anesthesiology at UW Medical School, says that it was both a professional and a personal honor to host the 75th anniversary celebration. "The espoused principles of Dr. Waters—superior patient care, teaching and research—continue to guide the UW Department of Anesthesiology," she notes. "In addition, I consider it a privilege to have trained in this department, to have been part of its history and to have had the opportunity to meet many of its honored alumni who were part of the celebration."

M.U.

Hospital ranks high in 10 specialties

University of Wisconsin Hospital and Clinics ranks among the top 50 of the nation's nearly 2,000 major medical centers in 10 medical specialties, according to the latest "America's Best Hospitals" guide in *U.S. News and World Report*. The guide analyzes and ranks hospital care in 17 specialties among 1,958 U.S. teaching hospitals.

UW Hospital was ranked among the nation's top 50 hospitals in the following categories:

- cancer
- digestive disorders
- geriatrics
- hormonal disorders
- kidney disease
- orthopedics
- urology
- eye care
- otolaryngology
- gynecology

"It's always an honor to be recognized as a national leader in healthcare," says **Donna Sollenberger,** UW Hospital chief executive officer. "While we are pleased with this recognition, every ranking of this type has both strengths and limitations. Therefore, it's important for consumers to look at a number of rankings over time to get an accurate picture of overall quality."

Of the 6,045 hospitals, *U. S. News* analyzed care at 1,958 major teaching institutions that are at the forefront of sophisticated patient care. Four categories—pediatrics, psychiatry, eye care and rehabilitation—are ranked based on a reputational score alone. The other 13 categories are assessed based on reputation, mortality rates and a mix of other data.

The magazine listed the top 50 hospitals in 13 of the 17 categories and various numbers of hospitals in the four categories ranked only by reputation. UW Hospital and Clinics has been ranked in several medical specialties every year since the first *U.S. News* ranking in 1993.

UW hospital board elects new leadership

Attorney **George K. Steil, Sr.,** from Janesville, Wisconsin, has been elected chair of the University of Wisconsin Hospital and Clinics Authority Board of Directors. Former UW–Extension chancellor, **Patrick G. Boyle,** has been elected vice chair.

The board, which governs the UW Hospital and Clinics Authority, elected Steil and Boyle at its meeting July 10. Former board chair, Frank (Jack) Pelisek, recently died.

Steil, president of the firm Brennan, Steil, Basting & MacDougall, S.C., has a long history of service to UW and to civic and business organizations in Wisconsin. A former president of the State Bar of Wisconsin, he was named to the UW System Board of Regents by former Governor Tommy Thompson in 1990 and served as regent president from 1992 until 1994. He also served, from 1995 to 1999, as chair of UW Medical Foundation, the clinical practice group of the UW Medical School faculty.

Boyle, one of three regents appointed to the hospital board, retired in 1993 after 13 years as UW–Extension chancellor. He joined the UW faculty in 1957 and was a professor until his retirement. He and Steil both have served on the Authority

The Health Sciences Learning Center continues to take shape immediately adjacent to UW Hospital and Clinics, with work proceeding on the building's foundation system. At left, the foundation for the lower-level garage is being completed, while on the right of the photograph the formwork for the ceiling of the garage is being finished. Both areas comprise what will be the Education Wing. Just north of this area, excavation for the lower level of the Library Wing is beginning.

board since its creation in 1996.

UW Hospital and Clinics Authority board was established by the Wisconsin legislature when the hospital ended its status as part of the University of Wisconsin and became a public authority.

Transplant program remains among best

Newly released national statistics for 2001 place the University of Wisconsin Hospital and Clinics transplant program among the best in the country—once again.

The United Network for Organ Sharing (UNOS) compiles and releases performance data for all 270 transplant centers in the nation. The report shows that patients receiving transplants at UW Hospital are living longer, and the transplanted organs are lasting longer than expected.

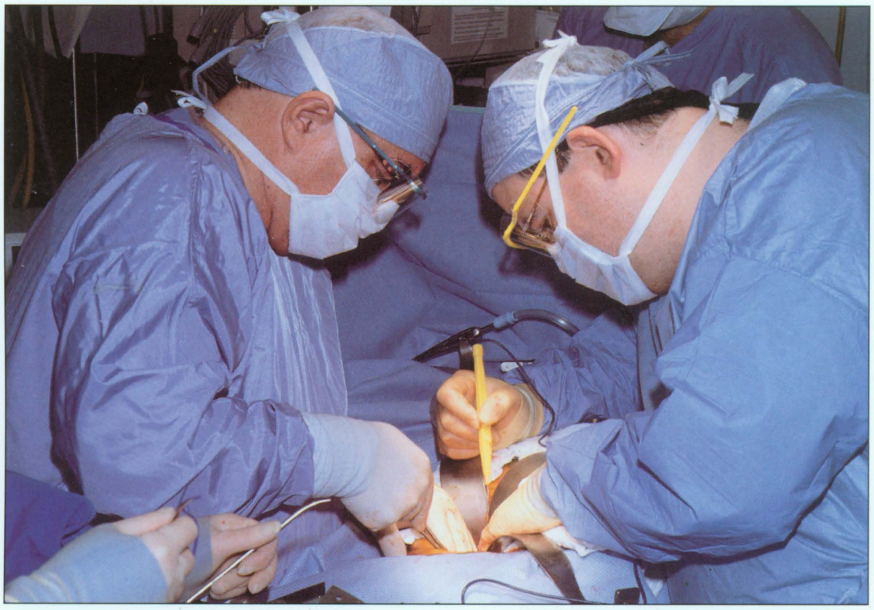
UNOS presents patient outcome data in several ways: patient survival and graft survival at one year and patient survival at three years post-transplant. The UW program shows patient and transplant organ survival rates above expected survival rates in adult kidney and kidney-pancreas transplants and it continues to excel in other categories.

In adult kidney transplantation, UW was the only hospital in the Midwest with a statistically significant better graft survival rate at both one- and three-years post transplant.

UW ranks third in volume of all centers nationwide for kidney and kidney-pancreas transplants, totaling 667. UW's average waiting time for kidneys is significantly less than that at many centers.

For adult liver transplantation, UW exceeds expected patient survival rate after one year post-transplant. At one year, 89.29 percent of liver transplant patients survived, compared with a national survival rate of 86.33 percent.

"What we are seeing now is the payoff of having a transplant team that has been working together for the past 20 years," says **Hans Sollinger, MD, PhD,** chair of organ transplantation at UW Hospital. "And, of course, credit must be given to the expertise of our individual surgeons as well as staff."



"What we are seeing now is the payoff of having a transplant team that has been working together for the past 20 years," says Hans Sollinger (left), MD, PhD, chair of organ transplantation at UW Hospital.

Medical School hosts international heart meeting

Approximately 500 physicians and research scientists from around the world came to campus in July to learn about new advances in cardiovascular disease, research and treatment. Stem cells, gene therapy and personalized drug prescriptions were key topics at the 24th annual meeting of the International Society for Heart Research (ISHR), North American Section.

The meeting, held July 24–27, was preceded by a special conference on women and heart disease, titled "Sex Differences in Cardiovascular Health and Disease."

"Hosting this meeting was a tremendous opportunity for the University, the Medical School and our UW Cardiovascular Research Center," says **Richard Moss, PhD,** chair of the local organizing committee and professor and chair of physiology at UW Medical School. "Some of the world's top experts in heart research presented the very latest developments in cardiovascular research."

The conference's first keynote speaker, Eduardo Marban, MD, discussed the use of gene therapy for heart arrhythmias. Marban, of the Johns Hopkins University, conducts research on vectors used to deliver healthy genes into heart tissue to correct genetic defects. The second keynoter, Dan Roden, MD, of Vanderbilt University, talked on the use of genetic information to tailor drug therapy to the specific needs of each patient. Other topics included congestive heart failure, proteomics and

repair of cardiac tissue after myocardial infarction.

Several sessions during the meeting also focused on mechanisms of cardiac arrhythmias and honored the contributions of a pioneer in this field, Harry Fozzard, MD, of the University of Chicago.

Zdeblick named chair of orthopedics and rehabilitaion

Thomas A. Zdeblick, MD, professor of orthopedics and neurosurgery at University of Wisconsin Medical School and medical director of UW Hospital and Clinics Comprehensive Spine Center, has been named chair of the recently established Department of Orthopedics and Rehabilitation.

In his new role, Zdeblick will lead strategic planning initiatives aimed at maintaining the department's position as one of the best orthopedic programs in the country. His plans include further development of the joint reconstruction clinic, the pediatric and adult spine centers and the hand center, as well as expansion of the sports medicine and rehabilitation medicine divisions.

Zdeblick joined the UW faculty as assistant professor of surgery in 1989 and was subsequently promoted to professor of surgery in the division of orthopedics. He was named interim head of the orthopedics division in the surgery department in April 2000.

Zdeblick aims to maintain the department's position as one of the best orthopedic programs in the country.

"We are very pleased that Tom Zdeblick will assume leadership of the orthopedics and rehabilitation department," says Philip Farrell, MD, PhD, dean of the Medical School. "His reputation, both as an orthopedic surgeon and as a leader in research, is stellar."

Certified by the American Board of Orthopedic Surgeons, Zdeblick is widely known for his pioneering research in minimally invasive spinal fusion techniques. His clinical specialties include endoscopic and micro-surgery of the spine, cervical spine disorders and spinal tumors.

"We are consistently ranked among the best orthopedic programs in the country," says Zdeblick. "My goal is to maintain that pre-eminence by infusing the department with additional research, teaching and clinical resources."

Zdeblick earned his medical degree from Tufts University School of Medicine in 1982. He completed his general surgery internship, a surgical research fellowship in microsurgery and an orthopedic residency at Case Western Reserve University in Cleveland. In 1988, he finished a fellowship in spine surgery at the Johns Hopkins University departments of orthopedics and neurosurgery, division of spine reconstructive surgery.

Orthopedics and rehabilitation became a department of the UW Medical School in January 2002. Prior to that, it was a division of the Department of Surgery. Zdeblick succeeds Andrew McBeath, MD '61, who chaired the division of orthopedics for 25 years (see "In Memoriam" on page 41 for more on McBeath).

Grants support research to prevent blindness

The Medical School's Department of Ophthalmology and Visual Sciences has been given an unrestricted award of $110,000 by Research to Prevent Blindness (RPB). In addition, two faculty members have been given individual RPB grants. RPB, which supports research into the causes, treatment and prevention of blinding diseases, has provided the department more than $3 million over the years.

Associate professor **Robert W. Nickells, PhD,** won a $50,000 Robert E. McCormick Scholar Award to support his research in glaucoma. The award is part of RPB's Special Scholar program designed to support outstanding young scientists who are conducting research of unusual significance and promise.

Assistant professor **Nader Sheibani, PhD,** won a $200,000 Career Development Award to support his research on angiogenesis in conditions such as diabetic retinopathy, macular degeneration and ocular tumors.

"Our ultimate goal is to eliminate vision loss and cure eye diseases," says **Daniel M. Albert, MD, MS,** chair of the department. "Every dollar we can put toward that goal moves us a little closer to this achievement."

Oversight and advisory committee members selected and appointed

BY DIAN LAND

The Blue Cross & Blue Shield (BC/BS) program moved another step forward on August 22, 2002, when the University of Wisconsin System Board of Regents selected and appointed eight members to serve on the UW Medical School's Public and Community Health Oversight and Advisory Committee.

According to regent Patrick Boyle, "This was one of the most comprehensive processes of screening and selecting in which I've participated. Consequently, the Board of Regents had the opportunity to review and select outstanding individuals for the committee."

"This is an important milestone. We are fortunate to have recruited such accomplished and diverse individuals for this committee," says Philip Farrell, MD, PhD, dean of UW Medical School. "Regent Boyle, who interviewed all candidates, deserves a great deal of credit for the ideal composition of the committee. He showed excellent judgment."

The appointments complete and implement one of the first requirements in the state insurance commissioner's order for disbursing proceeds from the sale of stock from Cobalt Corporation, the for-profit successor of Blue Cross & Blue Shield United of Wisconsin, to the two state medical schools. The stock has not yet been sold.

The oversight and advisory committees will plan for and oversee the use of funds allocated for public health purposes. They also will review and monitor funds the schools will be using for medical research and healthcare provider education.

Each committee consists of four public members, four university members and one member appointed by the insurance commissioner.

The four public members selected and appointed by the UW regents are Margaret MacLeod Brahm, MA; Nancy Miller-Forth, RN, MSN; Douglas N. Mormann, MS; and Gregory Nycz, BS. The four university members include Philip Farrell, MD, PhD; Patricia Kokotailo, MD, MPH; Patrick E. McBride, MD, MPH; and Patrick L. Remington, MD, MPH.

The regents appointed Farrell initial chair of the committee, charging him with presiding over the election of a permanent chair.

"All of these individuals have very strong backgrounds in public health," says Eileen Smith, who leads the BC/BS initiative for UW Medical School. "They have been engaged in all aspects of public health as practitioners, policy makers, researchers, educators and advocates."

In screening for the public members, a committee comprised of Boyle, UW Medical School administrators and faculty, and Wisconsin Division of Health administrator John Chapin reviewed resumes and references. Of 36 nominees, 14 were interviewed and four ultimately were recommended to the entire board of regents for its approval.

An *ad hoc* committee led by Boyle screened the 19 university nominations. Eight were interviewed and four of them were recommended to the regents.

"In the next few months, we will be working with the committee to develop operating principles and guidelines," Smith says. "Most importantly, members will be participating in developing a five-year expenditure plan for the public health proceeds."

According to the plan, 35 percent of funds generated by the stock conversion must be directed toward improving public health in the state. The schools may use the remaining 65 percent for research and healthcare provider education.

"We hope that by the end of 2002, a final plan for use of the funds will be approved by the oversight and advisory committee, the regents and the Wisconsin United for Health Foundation," says Smith. "When money from the stock sale becomes available, the committee will be ready to make decisions on distribution of the proceeds designated for public health."

Members of the UW Medical School Oversight and Advisory Committee

The four public members include:

Margaret MacLeod Brahm has been with the American Lung Association of Wisconsin since 1997, serving as president and chief executive officer since 1999. Previously, she was executive director at the Literacy Services of Wisconsin, where she gained first-hand experience with the challenges facing the disadvantaged. In her current position, she is active in teen smoking cessation programs and is developing a policy for regional expansion of the lung association's services. She was involved in forming Smoke-free Wisconsin, Inc., a non-profit agency devoted to tobacco control advocacy, and is now completing a two-year term as president of that organization.

Nancy Miller-Korth has served in the area of tribal health programming for over 20 years, providing the 10 tribes in Wisconsin assistance with program evaluation, public health needs assessment and planning. Since 1994, she has been the nursing consultant for the Great Lakes Inter-Tribal Council. As a captain in the U. S. Public Health Service, she has assisted the tribes in analyzing local health data, identifying priority health areas and setting goals and objectives. She has facilitated the establishment of collaborative public health initiatives involving governmental, university and tribal entities in Wisconsin, Minnesota and Michigan.

A health officer in Wisconsin the past 20 years, **Douglas N. Mormann** has been the health officer of La Crosse County the past 17 years. In this capacity, he administers approximately 30 different public health programs, from public health nursing to communicable disease control. He has played a key role in many of the decisions the state has made concerning the future direction of health in Wisconsin, including chairing the first statewide public health planning group in 1989. He participated in the development of Wisconsin's health plan for 2010, and has served on the boards of the Wisconsin Public Health Association and Wisconsin Health Officers Association.

Gregory Nycz has had 30 years of experience in rural health advocacy in various capacities with the Marshfield Clinic, and the Marshfield Medical Research and Education Foundation. He has extensive knowledge of rural health issues and a broad understanding of the uninsured and other population health issues, particularly in northern Wisconsin. Nycz helped develop the state health plan for 2010. Recently he was given the 2000 Rural Health Achievement Award by the Wisconsin Rural Health Association. He has worked effectively with the Northern Wisconsin Area Health Education Center to build community/health profession school partnerships that address the shortage of health professionals and the quality of services available in Wisconsin rural areas.

The oversight and advisory committees will plan for and oversee the use of funds allocated for public health purposes. They also will review and monitor funds the schools will be using for medical research and healthcare provider education.

The four university members include:

Philip Farrell has been UW Medical School dean since 1994, and UW–Madison vice chancellor for medical affairs since 2000. He was chair of the Medical School's Department of Pediatrics from 1985–1994. In addition to earning MD and PhD degrees, he trained in epidemiology at the University of Michigan School of Public Health and the London School of Hygiene and Tropical Medicine. Farrell previously was an officer in the U.S. Public Health Service (USPHS) from 1972–1977 and currently is on active reserve duty in the USPHS Commissioned Corps. As dean, he has led innovative changes in the school's curriculum, created new research centers and overseen essential facilities development. Since the announcement of the BC/BS conversion

proposal in 1999, he has been actively involved in preparing the Medical School for the gift by effecting changes that enhance the school's education and research initiatives in public health.

Associate Professor of Pediatrics **Patricia Kokotailo** holds a master's degree in public health with an emphasis on maternal and child health. She also completed a training program in alcohol and drug issues at the National Institute of Alcohol and Drug Abuse. She is director of adolescent medicine and medical director of the Adolescent Alcohol and Drug Assessment and Intervention Program in the UW Department of Pediatrics. She has been involved in the development of numerous assessment and treatment programs. She also has been director of the pediatric medical education program, covering all student teaching in pediatrics, and of the post-graduate fellowship program in sports medicine and adolescent medicine.

"All of these individuals have very strong backgrounds in public health," says Eileen Smith, who leads the BC/BS initiative for UW Medical School. "They have been engaged in all aspects of public health as practitioners, policy makers, researchers, educators and advocates."

Patrick E. McBride is a professor in the UW Medical School's Department of Medicine, section of cardiovascular medicine, and the Department of Family Medicine. He also is director of preventive cardiology and medical director of health promotions and fitness at University of Wisconsin Hospital and Clinics. McBride holds a master's degree in public health. Currently an investigator on several National Institutes of Health grants, his research has focused on the management of cholesterol disorders and the quality of cardiovascular disease prevention. He is a leader in developing and implementing statewide teaching programs on screening and prevention of heart disease and on smoking cessation.

Patrick L. Remington is associate professor in the Department of Population Health Sciences and associate director for outreach and population studies at the UW Comprehensive Cancer Center. His research centers on public health approaches to tobacco and cancer control and on methods used to measure the health of communities. He is the director of the Wisconsin Public Health and Health Policy Institute, whose mission is to stimulate and communicate useful population health research. Remington was the state chronic disease and injury epidemiologist and the chief medical officer for chronic disease and injury prevention in the Wisconsin Division of Health. In addition to earning a master's degree in public health, he completed an epidemiology fellowship at the Centers for Disease Control.

VIEWPOINT

It's not the VA you trained in anymore!

By Dean D. Krahn, MD '80, MS

During the last 20 years—roughly the span of my career—remarkable changes have occurred in the practice of medicine and psychiatry. Yet, when other physicians learn that I am the chief of the Mental Health Service Line at the William S. Middleton Memorial Veterans Hospital, they often regale me with a training-related story of VA inefficiency or lack of coordination. Usually, I take these comments in the jovial spirit in which they were intended. But I always realize how little most MDs know about the new VA. Following are a few of the changes that have been made.

Computerized Patient Record System. I think the first big shock most clinicians would have at the VA today would be to see how well the CPRS functions. With a few keystrokes, I have easy access to virtually all inpatient and outpatient notes, summaries and reports from the last several years at our hospital and other network hospitals. I can check labs and radiology or pathology results, and I can order medications without leaving the computer. I also can forward my notes for co-signature to any clinician with whom I want to coordinate care. Without leaving CPRS, I can search through Medline and many medical texts. We never have a lost or illegible note. And those huge multi-volume VA charts you may remember so fondly from your training? They're gone!

Mental Health Service Line. The VA has undergone remarkable changes in management during the last 10 years. Not long ago, most VA medical centers were divided into discipline-related "silos," which made coordinated decision-making very cumbersome. Now, many VAs have created mental health and other service lines for coordinating the work of clinicians. The groups can make decisions about how best to distribute medical, nursing and other resources across inpatient, outpatient, community support and other services. Unlike most situations in the private sector, the VA can plan its services for a population that has well-known characteristics and needs. Thus, rather than remaining in the reactive mode experienced by most private MDs in today's healthcare market, VA clinical leaders can become proactive.

A Continuum of Services. While some of you may remember the emphasis on inpatient care as well as the unusually-named Mental Hygiene Clinic as characteristics of VA psychiatric services, VA care now encompasses much more. Newer feature include long-term and acute inpatient mental health services, community support services, residential and intensive outpatient treatment, specialized post traumatic stress disorder treatment, and outpatient care. Moreover, housing and support for homeless veterans, vocational rehabilitation services, and specialized gero-psychiatric services are available at many sites.

Care Available in the Community. The former VA provided inpatient and outpatient care only at its widely scattered institutional settings. Given that a major factor in compliance with mental health, substance abuse and other treatment is distance to the treatment site, it has been a real step forward to deliver services at community-based outpatient sites scattered around the state. These sites and others are likely to expand over the next 10 years.

New Directions. Our VA and others in the system now are routinely providing significant amounts of care via telepsychiatry. The availability of such specialists in areas where it is hard to find these services is much appreciated by patients. Patient satisfaction measures for these video services are equivalent to those obtained for in-person services. The VA has funded our participation in a study comparing the effectiveness and cost of the integrated delivery of mental health and primary care services for elderly patients with that of the traditional referral system. Funding for addiction and mental health research has also increased as the VA tries to match more closely the clinical needs of the veteran population.

Hard to believe, isn't it? The VA, as I experience it every day, is now an integrated, high-tech, efficient, modern and innovative system. Obviously, I am a biased reporter. But you can visit me to see for yourself.

In addition to being chief of the Mental Health Service Line at the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin, Dean D. Krahn is an associate professor in the UW Medical School Department of Psychiatry. He earned his MD and an MS in administrative medicine from UW Medical School. He can be reached at Dean.krahn@med.va.gov or (608) 280–7015.

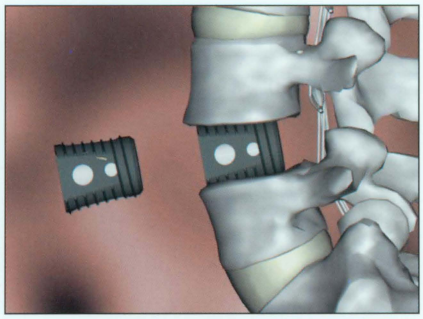
New bone graft for spinal fusion reduces pain and recovery time

The U. S. Food and Drug Administration recently approved the use of INFUSE Bone Graft—a new treatment that promises to reduce pain and recovery time for the more than 190,000 Americans who undergo lumbar spinal fusion surgery each year.

"The availability of INFUSE Bone Graft could completely change the way surgeons perform spinal fusions for the treatment of low back pain," says **Thomas Zdeblick, MD,** chair of University of Wisconsin Medical School's Department of Orthopedics and Rehabilitation and one of the main investigators in clinical studies of the bone graft. "We'll be able to eliminate the second surgery necessary to harvest the patient's bone and still achieve equal, if not better, results compared with the current standard procedure."

In the new procedure, protein-saturated sponges are placed in the patient's spine to replace the disc removed during fusion surgery. The sponges contain bone growth factor, which produces bone to complete the fusion.

Low back pain affects an estimated 65 million Americans, and treatment options include pain medications, physical therapy and spine surgery. Spinal fusions, the most common type of spine surgery, essentially "weld" two or more vertebrae together to eliminate pain caused by movement of the problematic vertebra.



Growth-factor-soaked sponges placed in titanium cages are implanted between vertebrae, stabilizing the back while the discs fuse.

Lumbar spinal fusion surgery currently requires two surgeries—the first to remove small pieces of bone from the patient's hip, called an "autograft," and the second to implant them in the spine. Numerous studies have shown that patients experience considerably more pain from the hip surgery than they do from the fusion procedure itself.

The new bone graft replaces the use of autograft bone because it contains a recombinant human bone morpho-genetic protein, or rhBMP–2, which causes the body to grow its own bone where needed. When surgeons use INFUSE, rhBMP–2 powder is reconstituted with sterile water and then applied to a collagen sponge. The sponge is placed inside a thimble-like titanium device called an LT-CAGE and implanted between the vertebrae. The LT-CAGE keeps the INFUSE bone graft at the fusion site, maintains the proper height between the vertebrae and stabilizes the spine while it is fusing.

A large-scale, randomized, two-year study including patients from UW was conducted to evaluate the safety and therapeutic benefits of the new system. Approximately half of the patients received autograft bone, and the other half received INFUSE Bone Graft. Study results indicated that patients who underwent spine surgery using the new system showed a trend toward having higher fusion rates when compared with autograft patients at 24 months (94.5 percent fused vs. 88.7 percent).

Zdeblick, who is also medical director for the UW Comprehensive Spine Center, says that INFUSE Bone Graft—which has rhBMP–2 as its active ingredient—is the only product statistically proven to produce results at least equivalent to transplanted bone.

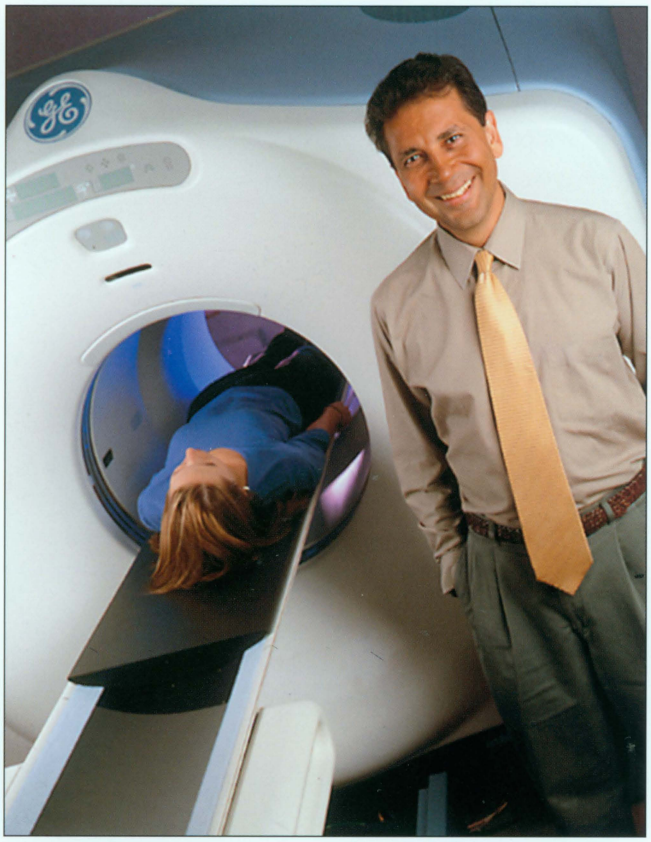
New scanner fuses PET/CT technology

A new device that fuses information gathered from positron emission tomography (PET) and computed tomography (CT) has been installed at University of Wisconsin Hospital and Clinics Comprehensive Cancer Center.

Known as the GE Discovery LS imaging scanner, the device helps radiation oncologists more effectively target tumors by fusing two images into one. The result is better diagnosis and more precise treatment of certain cancers.

"PET scans help pinpoint cancer cells by showing us changes in cellular function, such as the rate at which cells use nutrients," says **Minesh Mehta, MD,** head of radiation oncology at the cancer center. "CT scans provide the best view of the body's anatomical structures, which helps us pinpoint the location of the tumor."

Continues Mehta, "Now, instead of looking at the two scans side by side as we have in the past, we can use the new device to see the two scans fused into a single image. For patients who require both scans, we can more precisely treat their tumor—sparing normal tissue—as we customize their individual cancer care plan."



The new PET/CT scanner enhances the physician's diagnostic confidence and reduces patients' exam time, according to Minesh Mehta, MD, head of radiation oncology at the cancer center.

Mehta says that the new PET/CT scanner not only enhances the physician's diagnostic confidence, but also reduces the patient's exam time.

"The entire exam with this machine takes about 30 minutes," Mehta says. "Accordingly, physicians have better information more quickly, and patients can have results within an hour as opposed to as long as a day when the two exams are performed separately."

Mehta says that "UW Hospital's acquisition of the scanner, which is manufactured by GE Medical Systems in Waukesha, Wisconsin, symbolizes an approach to cancer treatment that is never satisfied with the status quo.

"Embracing new technologies is one of the ways we express our commitment to excellent care for our patients," he says. "The PET/CT imaging scanner is one of several cutting-edge technologies we have in our repertoire. Used by our highly skilled clinicians to direct and monitor treatment, it will mean better quality of life and more people cured of their cancer."

Why the gender gap in cystic fibrosis care?

A new study examining the "gender gap" in cystic fibrosis (CF) has shown, for the first time, that females are diagnosed significantly later than males are—and that the discrepancy cannot be explained by gender differences in common CF symptoms, chest X-rays or the age at which youngsters are infected with *pseudomonas aeruginosa,* the bacterium implicated in up to 90 percent of CF deaths.

University of Wisconsin Medical School researchers point out, however, that it currently is impossible to know whether the delay in diagnosis causes the higher mortality rate seen in female CF patients.

CF is the most common potentially lethal genetic disease among Caucasians. It can cause gastrointestinal problems and serious lung disease. Newborn screening for the disease has been debated for years, and the Wisconsin CF Neonatal Screening Project began in 1985 to assess the benefits and risks to patients of the practice. The newest findings, published in *American Journal of Epidemiology,* are based in part on data from the Wisconsin study.

CF scientists and physicians have recognized for many years that females with CF do not live as long, on average, as males with the disease, but the reason why has never been clear. In the current study, the Wisconsin team examined the age and condition of CF patients at the time of diagnosis. The goal was to find out if there are significant differences in when males and females are diagnosed, and whether one gender has more serious disease than the other at the same age.

The team used CF Foundation Registry data on 11,275 patients diagnosed between 1986 and 1998. They found that, on average, females were diagnosed four months later than males were; the median age for females at diagnosis was 12.7 months, for males 8.7 months.

The researchers also found that the delay in diagnosis for girls was most pronounced for patients with respiratory symptoms only. In that group, girls were diagnosed a median of 18 months later than boys were.

Finally, the researchers compared the severity of symptoms, chest X-rays and the age at which the patient acquired a respiratory infection. They found no significant differences in such factors between males and females.

"When we discovered that females are diagnosed, on average, four months later than

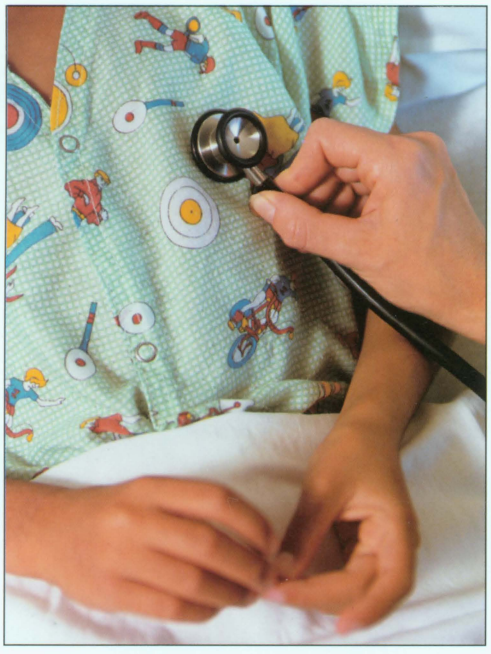
males are, we speculated that girls perhaps had less severe respiratory problems at diagnosis than boys did," says Hui-Chuan Lai, PhD, assistant professor in the nutritional sciences department at UW–Madison, and lead author. "But that isn't the case. There were no differences between boys and girls in terms of their cough, chest X-ray or the age when they got their first respiratory infection. We have to look elsewhere for an explanation."

Philip Farrell, MD, PhD, principal investigator of the Wisconsin Neonatal Screening Project and dean of UW Medical School, says that although a four-month delay in diagnosis may not seem significant, the period from six months of age to one year is a critical time for CF symptoms to appear and worsen. Patients can become very seriously ill in a matter of weeks.

The UW researchers suggest that both physicians and parents may have an "unconscious bias" that is producing this disparity. They note that the prevalence of recurrent wheezing is 1.5 times higher in males than in females and that boys under 10 are at higher risk for developing asthma than their female counterparts. Physicians may be relying on such perceptions in deciding whether to refer children with respiratory problems to diagnostic tests such as the sweat test for CF.

Furthermore, boys traditionally are encouraged to be more physically active than girls are, they say, and perhaps parents may notice breathing or stamina problems sooner in boys.

While there is no hard evidence proving that later diagnosis in girls is responsible for their higher CF mortality rate, Farrell says that some research is beginning to indicate that early diagnosis is associated with greater longevity. He suggests that neonatal screening—whose benefits are just now becoming clear—may be the only way to ensure consistently early diagnosis of both girls and boys with CF.



Girls are diagnosed with cystic fibrosis significantly later than boys are, UW Medical School researchers have found.

New option to radiation following breast lumpectomy

Brachytherapy is rapidly becoming a popular option for women who have had a lumpectomy for early-stage breast cancer. The procedure was pioneered by Robert R. Kuske, MD, University of Wisconsin Medical School professor of human oncology.

Breast brachytherapy offers at least three advantages over the standard external-beam radiation. It treats solely the breast tissue closest to the site of the surgically removed tumor, not the entire breast. The treatment is completed in one week, as compared with the standard six to seven weeks. And the radiation exposure of underlying lung, heart, ribs and muscle is markedly diminished, as is the dose to the overlying skin.

Kuske, who came to UW in 2000 after developing breast brachytherapy while at the Ochsner Clinic in New Orleans, says that, initially, his work was better known in Europe, but that word is rapidly catching on since his arrival in Madison.

"I treat about three patients a week at UW Hospital and Clinics, with half of them coming from out of state," he says.

Kuske developed the technique in 1991 while treating an oil company executive from Venezuela who refused to relinquish the time it would take to have her lump removed and then receive chemotherapy followed by six weeks of radiation. She also deemed the other remaining option, mastectomy, unacceptable.

Spurred by the challenge of finding a more acceptable form of treatment for this patient, Kuske successfully treated her with brachytherapy, which is actually a 100-year-old form of radiation therapy commonly used to treat prostate cancer. It previously was applied only as a "boost," or small portion of the overall radiation treatment for cancer.

The prefix "brachy," Greek for "short distance," is used because the radiation is delivered snuggly against only the tissues closest to the tumor site. Similar to the form of brachytherapy used to treat prostate cancer, breast brachytherapy delivers the treatment through a radioactive seed about the size of a thin grain of rice.

The seed travels through a series of 14 to 28 catheters that encircle two centimeters beyond the lumpectomy site. An alternative to the multiple-catheter method, recently approved by the Food and Drug Administration, is known as MammoSite. Manufactured by Proxima Therapeutics, MammoSite is a single catheter with a balloon at the end that is inflated in the lumpectomy cavity. Kuske has been the principal investigator on this national trial.

"Once the balloon is inflated," Kuske says, "we run the radioactive seed to the center of the balloon and treat one centimeter around the lumpectomy site. The balloon stays in place until the woman's week-long treatment is complete." The procedure is done on a completely outpatient basis.

Whether a woman receives the 20-catheter method or the single-catheter MammoSite depends on the size and shape of the treatment area, he says.

Despite initial skepticism from physicians who have preferred to stick to the "textbook" standard of irradiating the entire breast, evidence from recently completed and continuing clinical trials may convince doctors to give breast brachytherapy a long look.

"Breast brachytherapy is not for every woman," Kuske adds. "First, selection criteria need to be met. Second, it is invasive, and you need experienced and trained people to perform the procedure. But more and more doctors and their patients are finding it worth exploring."

To be considered, the tumor must be less than three centimeters, and spread to no more than three nearby lymph nodes.

"I have treated 278 women over 11 years," Kuske says. "In that time, there have been only two recurrences." In addition to Kuske's results, which have been published in the *American Journal of Surgery,* similar results have been published by clinicians at the William Beaumont Hospital near Detroit.

"Of the patients who qualify for breast brachytherapy, it proves especially appealing to women who either live far from a major cancer treatment center or who cannot take the six weeks off required by standard radiation," Kuske says. Large-breasted women also may consider breast brachytherapy, he says, because skin tolerance to external beam radiation is poor in contrast to treatment "from the inside out" with brachytherapy.

Call for nominations: WMAA Board of Directors

The board of directors is the governing body of the Wisconsin Medical Alumni Association (WMAA). There is balanced representation from each of the four districts of the state on the board. Each member holds a three-year term that can be renewed if the board member demonstrates continued and active interest and effective leadership.

At the WMAA annual meeting in May, 2003, the board will elect members to represent the following districts:

District 1 – represents the northwest and central areas of Wisconsin, including La Crosse.

District 2 – represents the northeast and eastern areas of Wisconsin, including Appleton, Green Bay and Sheboygan.

District 4 – represents the south-central and southwestern areas of Wisconsin, including greater Madison.

The WMAA invites you to nominate your colleagues and classmates from these districts for consideration as a member on the board of directors for the 2003–2006 period. Nominees must demonstrate an active interest and involvement in the WMAA.

Please submit your nominations by December 1, 2002, to Karen S. Peterson, Executive Director, WMAA, 4245 Medical Sciences Center, 1300 University Avenue, Madison, WI 53706–1532, or via email to *kspeters@facstaff.wisc.edu.*

Medical student program reaches out to high school girls

by Dian Land

When University of Wisconsin Medical School third-year students Cara Syth and Hisam Goueli began their clinical rotations this summer, they bid good-bye not just to classes, laboratories and late-night study sessions. Goueli and Syth also handed over leadership of a project that has been extremely close to their hearts for the past two years—a day-long seminar that they developed and held twice to introduce girls from Wisconsin high schools to careers in the healthcare professions.

Seven second-year UW Medical School students have volunteered to take over the project and will soon begin focusing on the dozens of details required to run the seminar, to be held again on a Saturday in February. Syth and Goueli say that they are somewhat sad to leave the project behind, but that they hope the seminar will become an annual student-run event.

Many UW medical students devote time and energy to any number of socially relevant projects, and school leaders support and encourage the extra-curricular activities.

"Physicians should give back to society and participate in their communities. This philosophy develops when students begin their medical studies," says Carolyn Bell, MD, associate dean for curriculum, adding that there are many student-run volunteer organizations in which to participate. "Cara and Hisam used remarkable creativity and resourcefulness in developing their seminar."

The effort required the combined talents of both students, but the idea for the seminar was forming in Goueli's imagination even before he reached medical school. "In a class on sociology of gender during my senior year at UW–Madison, I learned that women are systematically discouraged from pursuing professional degrees and that this begins as early as elementary school," he says.

Once Goueli was enrolled as a medical student, he attended a meeting of Women in Medicine (WIM), a student group that logically might include members who were interested in supporting a seminar addressing the problem. Syth, who is a WIM member, soon warmed up to her classmate's idea. And so the project began.

"Cara and Hisam (left and right) used remarkable creativity and resourcefulness in developing their seminar," says Carolyn Bell, MD, UW Medical School associate dean for curriculum.

A fruitful synergy immediately developed between the two students. They recognized that each brought unique strengths to the job. Broadly speaking, Syth is a details person while Goueli is an ideas person. It was just the combination needed to successfully pull off a bold, multi-faceted plan requiring careful attention at every step along the way.

The two wrote a proposal and got a campus grant to cover costs of lunches and snacks provided for the high school students. They asked local businesses for donations. They contacted and signed up students representing health professions programs on campus—medicine, nursing, pharmacy, physical therapy and occupational therapy—who would be available for the seminar. Letters were sent to administrators of school districts in a block of the state extending south to Illinois, west to Iowa, east to just west of Milwaukee and as far north as Wisconsin Dells.

Syth enlisted the assistance of her husband, middle-school teacher James Ivens, and together the three of them handled the numerous assignments that they gave themselves while still managing to attend to the other responsibilities of their busy lives. And the hard work paid off.

In February 2001, 43 juniors from 17 Wisconsin high schools attended the first seminar, held at the Medical Science Center. Molly Carnes, MD, MPH, director of the UW

The seminar included an activities fair, in which participants learned to take vital signs and tested gadgets such as otoscopes.

Center for Women's Health and Women's Health Research, delivered a keynote address. During a morning panel discussion, current health professions students provided practical tips on ways the high school students could increase their chances of getting into the college program of their choice. At an activities fair, participants visited Medical School anatomy laboratories, learned to take vital signs, tested gadgets and saw how prescriptions are filled. Later in the day, the girls chose two potential fields of interest and sat in on small group sessions led by professionals and soon-to-be professionals in those fields.

A survey revealed that the high school students were even more excited about the seminar than Goueli and Syth expected they would be. Gratified and encouraged, the two medical students began planning for the next year's seminar.

They won a competitive award from the medical honor society, Alpha Omega Alpha, to support the seminar a second year. They also parceled out the work by getting several first-year students involved, preparing them to assume responsibility for the program.

Syth and Goueli made a few changes in the 2002 seminar. They added physician assistants to the program, contacted high school guidance counselors and instituted a mentor-match, in which the girls could be paired with a person working or studying in a specific field.

Due to a snowstorm, attendance at the 2002 seminar was not as high as had been anticipated. Nevertheless, many of the 40 girls who did attend rated it highly. "It was great to be one-on-one, almost, with professionals and students," said one participant. "People really seemed to care about us being there," said another. And, "It really helped me in understanding different fields of medicine."

Goueli and Syth also ranked the project a first-rate personal experience. "At some point in your medical school experience, you ask yourself if aiming to get straight A's is really the best way to become a good, well-rounded doctor," says Syth. "I think we both decided that if we just learned and understood our coursework, and didn't feel that we needed to get top grades, we could gain so much from this experience."

"This experience has been absolutely wonderful, and we both have had a great time doing it," adds Goueli. "Maybe some day we'll be asked to participate as representatives of our profession."

Many of the high school girls rated the seminar highly. "It was great to be one-on-one, almost, with professionals and students," said one.

Classnotes

1952

Clyde H. Kratochvil lives in Portage, WI, where he practices pharmacology. He received the U.S. Air Force Legion of Merit in 1970, the Upjohn Award in 1985 and the U.S. Air Force Commendation Medal in 1963. He enjoys language and windsurfing. He and his wife, Janice, have five daughters, five grandchildren and one great granddaughter.

Living in Lake Oswego, OR, **Robert C. Watzke** is a professor of ophthalmology at the Casey Eye Institute at the Oregon Health Science University in Portland, where he specializes in retinal diseases. His favorite activities are hunting and fishing. He and his wife, Lorraine, have five children.

1962

Alan S. Bensman reports that he currently is experiencing the "best of both worlds." Fifty percent of his time, he practices physical medicine and rehabilitation in Minneapolis; the other 50 percent, he rides trails with his two horses near his home in Minnetonka, MN, and enjoys his peaceful family cabin. He and his wife, Carol, have three children and six grandchildren.

Richard A. Van Dreel is a pediatrician in Manitowoc, WI. He and his wife, Jean, have four children and three grandchildren. His time is largely spent doing community volunteer work with various boards and charitable organizations, while continuing to serve as a pediatric associate with Interfaith Services to Latin America in Jalapa, Nicaragua. He intends to expand his volunteer work by assisting Health Volunteers Overseas in some capacity.

1972

Edward P. Ehlinger and his wife, Sally, live in Minneapolis, where he practices public health. He is the current director of Boynton Health Service at the University of Minnesota, Twin Cities. The couple has two daughters and one granddaughter. His goal for the future—laudable, yet formidable—is to contribute to eliminating tobacco use by college students.

Bernard J. Mansheim resides in Reston, VA, where he practices internal medicine, while specializing in infectious diseases. Since 1990, he has been senior vice president and chief medical officer for Coventry Health Care. His activities include long-distance running (he's run 11 marathons), golf and reading. He and his wife, Denise, have three children—Christopher, Meera and Alison.

1977

Sheila K. Carlson and her husband, John T. Davenport, and children—Michael, Daniel and Lindsay—live in Madison, WI, where she practices anesthesiology at Davis Duehr Dean Clinic. She is chair of the Department of Anesthesia of Dean Health Systems and is a member of the Finance Committee at Edgewood High School.

After 15 years as program director of two emergency medicine residency programs and three years as associate director of Medical Education and Transitional Program Direction at Henry Ford Hospital in Detroit, MI, **Bruce M. Thompson** decided to take a sabbatical from his practice in order to care for his parents and three children—Adam, Andrew and Allison. He will continue to teach and staff the EM Residency Program. He and his family live in Walled Lake, MI.

1982

Living in Roscoe, IL, with his wife, Lisa, and their three children, **Russell D. Albert** practices obstetrics and gynecology at a multi-specialty group clinic in Beloit, WI. He also stays busy with church activities, choirs and Habitat for Humanity. He enjoys getting away to the family cabin in central Wisconsin, where he bikes and camps. Beyond these activities, he admits that "the golf game remains poor."

Charles (Bud) F. Brummitt II, specializes in infectious diseases at St. Luke's Medical Center in Milwaukee. He is also a clinical associate professor at UW–Madison. He pursues staying fit by biking and running. His professional interest lies in trying to do what he can locally for HIV prevention and care. He and his wife, Jane, live in Whitefish Bay, WI, with their three children—Sam, Charlie and Martha.

Donald B. Kohn practices medicine at Children's Hospital of Los Angeles, where he specializes in translational research (gene therapy). Also, he is professor in the Department of Pediatrics and Molecular Microbiology and Immunology at University of Southern California Keck School of Medicine. He is the recipient of numerous awards for pediatric research, including the Basil O'Connor Research Award from the March of Dimes Birth Defects Foundation, the Elizabeth Glaser Scientist Award from the Pediatric AIDS Foundation and the Distinguished Clinical Scientist Award from the Doris Duke Charitable Foundation. He currently is president-elect of the American Society of Gene Therapy. Recreational activities include skiing and daily visits to the gym. He and his wife, Sheryl Handler, who completed her residency in medicine and ophthalmology at UW, have two children—Lisa and Scott.

Mark A. Supiano resides in Ann Arbor, MI, where he specializes in geriatric medicine while also serving as director of the VA Geriatric Research, Education and Clinical Center. He is also a professor of internal medicine at the University of Michigan in Ann Arbor. His hobby is running marathons: he has run the Boston Marathon four times and the Marine Corps Marathon 11 times. He and his wife, Katherine, have two children—Rebecca and Andrew.

1994

Patrick S. Ramsey was one of the lead obstetricians who delivered the first set of sextuplets in the State of Alabama on July 7, 2002. A Rhinelander High School graduate, he completed an undergraduate degree from UW–Eau Claire in zoology and a medical degree from UW before embarking on residency training in obstetrics and gynecology at the Mayo Medical Center in Rochester, MN. Completing his residency in 1998, he then began subspecialty training in maternal-fetal medicine at the University of Alabama at Birmingham (UAB). He currently is an assistant professor in the division of maternal-fetal medicine at UAB.

"All in the family" in Fond du Lac, Wisconsin

by Shelly Haberman

When it comes to family traditions, not many people can top the McCulloughs of Fond du Lac, Wisconsin. After all, John (Jack) McCullough, Sr., MD '45, and John McCullough Jr., MD '76, are both local physicians, though Jack is now retired. Each chose family practice as his initial field of interest. And both went to the University of Wisconsin Medical School.

But that family tradition took on even more meaning earlier this year when John was named chief of St. Agnes Hospital medical staff, the same position his dad held 34 years ago.

Surprisingly, John almost did not follow in his father's footsteps and enter the field of medicine. When he first started his undergraduate studies, he chose geology as his major. "I went away from medicine at first. Geology, physics, paleontology—those were the topics that interested me. I really liked the sciences," says John. "But I came around and realized what interested me most was the human anatomy, and I decided to pursue a career in medicine."

For his father, the decision to become a doctor was a little more clear-cut. But he, too, was keeping a family tradition. "I had two uncles who were doctors, and I used to watch them work," says Jack. "That's what got me interested in medicine, plus I always liked the idea of helping people." Others in the family must have as well: Jack's brother, Jim, became a doctor, and they started their Fond du Lac practice in 1946 with uncles H.A. Devine, MD '58, and Joe Devine, Sr. Cousin Joe Devine, Jr., later joined the practice in the 1960s.

John McCullough, Jr., MD '76, became chief of the medical staff at St. Agnes Hospital this year. His father, John (Jack) McCullough, Sr., MD '45, held the same position 34 years ago.

Although Jack and his son entered the field of medicine for different reasons, they agreed on where to go to school. Jack graduated from UW Medical School in 1945; the ceremony was brief, and there were no caps or gowns due to the war. When John graduated in 1976, it was especially significant because he asked his dad to be his mentor. That meant that, after 31 years, Jack finally got to wear a cap and gown and be part of a graduation ceremony.

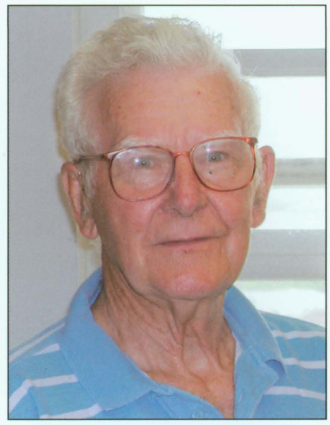
After John finished medical school, he completed a family practice residency at Ball Memorial Hospital in Indiana. He then spent two years working at the U.S. Public Health Service in California. But in 1981 the prospect of working in the family business enticed him back to Fond du Lac. "The idea of working with the family is what brought me back here. It was the opportunity to be together and carry on our family tradition," says John. So he set up shop as a family practice physician with his father, uncle and cousin.

In 1986 he changed his focus when a local emergency room group was looking to build a practice in the Fond du Lac area. John took advantage of the opportunity and switched to emergency medicine, which he has been practicing ever since.

Last year John was approached about becoming the chief of St. Agnes Hospital medical staff, and he didn't hesitate to accept. "I thought it was an honor to be asked to take on such a position of responsibility," he says. "This is also the first time that someone in emergency medicine was asked to be chief; I thought it would be good to bring that perspective to the table."

St. Agnes Hospital is a 161-bed facility offering, among other things, cancer treatment, cardiac care, home and hospice care, comprehensive women's health services and sports medicine. Founded by the Sisters of St. Agnes, the hospital has operated since 1896. It is part of Agnesian HealthCare of Fond du Lac.

Class Representatives



Robert F. Schilling, '43

Sylvia Griem, '53

Conrad L. Andringa, '63

Timothy M. Richer, '98

Robert F. Schilling
Class: 1943 (M)
Type of practice: Academic
Fondest memory of UW Medical School: Freshman physiology with Meek and Eyster.
Hobbies/interests: Hunting, fishing, travel/interface between medicine and society.
Other news: I am pleased and fortunate to be alive after an auto accident for which I was not in any way culpable.
Faculty member remembered the most and why: Ovid Meyer was a scholar, gentleman and a friend. After tutoring me in Madison, he sent me to Boston, where I had two exciting and stimulating years.
Message to classmates: Do come to Madison for our 60th.
Plans for reunion: Our 60th class reunion will be held in conjunction with Alumni Weekend, May 8–10, 2003. We will have a get-together and dinner on Thursday, May 8.

Sylvia Griem
Class: 1953
Type of practice: Professor of dermatology—retired, University of Chicago Medical School
Fondest memory of Medical School: Bill Acheson. He was my partner learning to draw blood and he produced a rather large hematoma in my left antecubital. I went to a big dance the following day sporting this large hematoma. Bill was very apologetic.
We (Mel and I) went to a rather large party at a classmate's apartment. There we found Bill Broadhead, a classmate, stirring a large volume of "purple passion" in the bathtub with his arm. This was a mixture of grape juice and lab alcohol. Unfrotunately both of these classmates are deceased.
Hobbies/interests: Sailing on Lake Michigan, reading and traveling, especially with Elder-Hostel.
Other news: Mel and I were classmates—married in 1951. We have two daughters, both physicians, both married to physicians. Katherine Griem, a Harvard graduate, is a radiation oncologist like her father. Melanie Griem, a University of Chicago graduate, is a dermatologist like her mother. Our son Robert Griem is a comptroller at Thurston, Inc., in Aspen, CO. He is married to the owner of an upscale jewelry store.
Faculty member remembered the most and why: P.P. Cohen who taught "P Chem" (physiological chemistry). He was a very good and sympathetic teacher, always patient with "knuckle-headed" students trying to learn things like the Krebs cycle.
Message to classmates: Come one and all to our 50th class reunion in May 2003.
Plans for a reunion: Our class reunion will be held in conjunction with Alumni Weekend, May 8–10, 2003. The class celebrating its 50th reunion gets all sorts of special recognition at receptions, luncheons and banquets. And what fun we will have reminiscing about our "Med School" days, and what we have done since.

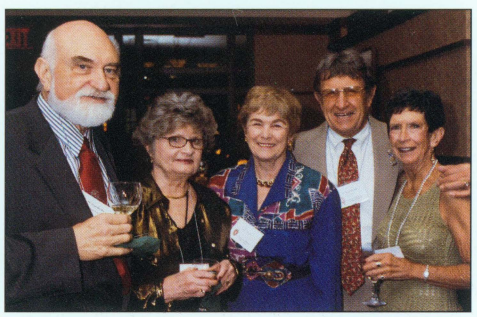
Conrad L. Andringa
Class: 1963
Type of practice: Pediatrics
Fondest memory of Medical School: The friends I made (some of them are my best friends today) and the experiences we shared.
Hobbies/interests: Downhill skiing, reading history and camping with my grandchildren every summer.
Other news: Madison Memorial High School, where I have been team physician for over 30 years, named their new field house after me and I'm not

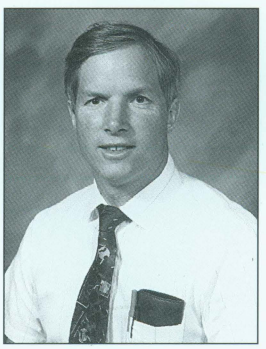
even dead yet! Also, I hope to practice five more years.
Faculty member remembered the most and why: Nate Smith, David Smith, Charles Lobeck—they influenced my medical choice and career the most.
Message to classmates: Come back to our reunion and see your friends and classmates; you'll never regret it.
Plans for a reunion: Our 40th class reunion will be held in conjunction with Alumni Weekend, May 8–10, 2003. We will have a get-together and dinner on Saturday, May 10.

Timothy M. Richer
Class: 1998
Type of practice: Pediatrics (private practice) in Milwaukee
Fondest memory of Medical School: I have many: TGIF's, my trip to Europe as a Med IV, Dr. Pettersen turning the tables (or should I say 'tanks') on me and my practical joke attempt in anatomy, pulling off that first Dean's Cup victory, the Field's CD release, or just a good 'ole beverage on the Terrace, to name a few. But I guess what all these had in common was that I had a chance to share them with great friends.
Hobbies/interests: Still love music, but unfortunately I'm not getting to play it much these days. While I was in Philadelphia, I got into the Broadway thing and the great restaurants. I'm still a big sports fan as well, though I was sidelined with a meniscus tear for a while. I also finally have a decent hockey team to follow (sorry Admirals) – Go Flyers!
Other news: I recently married a Philly girl, Syma, in March, spent a week in St. Lucia, moved back to Milwaukee (my home town) in July and bought a condo on the east side. I also joined my father in a local pediatric practice. That about sums up my last year, thus the short hobby/interest list! Lots of weddings for several good friends of our graduating class (and some babies as well) have recently given us opportunities to get together.
Faculty member remembered the most and why: There are several, but I guess I'll always remember Dr. Pettersen for his energy and sense of humor, and for making that first semester so much fun. I also thought my fourth-year externship in Dodgeville with Dr. Mark Bishop was incredible; he was an inspiring role model and I still use some of his sayings and techniques to this day with my own patients.
Message to classmates: I hope everyone is healthy, enjoying their careers, and hey, if you're back in Wisconsin, get in touch!
Plans for a reunion: I think autumn is a good time, and to work in a Badger game with a pre-game party (preferably organized by Dan "Digger" Schraith, the undisputed king of pre-game parties) would be simply ideal. The WMAA has reserved a block of football tickets for our reunion on September 20, 2003. Mark your calendars! We're all busy but if we planned far enough in advance, we could even make this an annual thing.

Corrections

In the summer issue of the *Quarterly*, we misidentified the people in the photo below, who celebrated during Alumni Weekend. They are (left to right): Hugh and Janice Riordan, Jane and Bruce Stoeher, and Anne Schierl. We also inadvertently switched reunion pictures for the classes of '42 and '49. We regret the errors.





In our summer story on UW Children's Hospital, we also printed the wrong picture of Michael J. MacDonald, MD. Our apologies to Dr. MacDonald, shown at left.

Thirty-one, thirty-two, thirty-three and counting

The University of Wisconsin Medical School's Office of Continuing Medical Education now offers over 30 online CME programs. Our newest ones are: ***Hypertension Guidelines, A Sleep History Guide, Treating Tobacco Use and Dependence,*** and ***Fetal Alcohol Identification in Women*** in the ***Substance Abuse Series,*** and the ***Pediatric Grand Round Series*** (four new programs), a ***Pain Management Series*** (three programs), and a ***Radiology Series*** (four programs). All can be found at www.cme.wisc.edu/online/coursepage.html.

On the average, thanks to the continued participation of many UW Medical School faculty, we are adding two to three new online programs a month. Maybe it's time for you to become involved. If you are willing to share a one- to five-hour educational activity, we will format it for the Internet. Innovative, instructional designs are selected to suit the course material provided. Often the material has already been created and only a couple of CME forms will need to be completed to offer this activity for CME credit. Hurry, currently there is no fee for this technical service.

Following is a list of most CME online programs:

Alzheimer's Disease: An Update – audio, 1 hour, FREE

Hand Hygiene – text, $20

Bioterrorism Series

- *Biological and Chemical Terrorism: Health Care Implications,* audio/slides, 2 hours, $25
- *Bioterrorism Questions and Answers*—audio, 1 hour, $20
- *Bioterrorism Symposium* (no CME credit)

Primary Care Screening Guidelines Using Evidence-based Medicine—slides, 1.5 hours, $20*

Cardiovascular Series

- *Coronary Artery Stent Infections*—slides, 1/2 hour, $20*
- *Dyslipidemias Guidelines Update*—text, 2 hours, FREE*
- *ECG - A Primary Care Approach*—5 hours, $30*
- *Endovascular Treatment of Aortic Disease*—slides, 1.5 hours $20*
- *Hypertension Guidelines: Recognizing and Treating*—text, 1 hour, FREE*
- *Peripheral Arterial Occlusive Disease*—1 hour, $20*

Pediatric Grand Rounds

- *The Female Athlete*—audio/video, 1 hour, $20*
- *Helping Kids Kick Butts*—audio/video, 1 hour, $20*
- *Wisconsin Newborn Screening*—audio/video, 1 hour, $20*

Infectious Disease Series

- *Novel Anti-fungal Therapeutics*—audio/video, 1 hour, $20
- *Upper Respiratory Tract Infections*—slides, 1 hour, $20*

Pain Management Series

- *Pain Management in the Opioid-naive Adult*—audio/video, 1 hour, $20
- *Acute Pain Treatment in the Trauma Patient*—audio/video, 1 hour, $20
- *Acute Pain In Patients with Chemical Dependencies*—audio/video, 1.5 hours, $20
- *Legal and Ethical Issues Affecting Pain Management* – audio, 2.5 hours, FREE

Psychiatry Series

- *Premenstrual Dysphoric Disorder*—2 hours, FREE
- *Depression in Primary Care Treatment*—1/2 hour, $20
- *Post-traumatic Stress Disorder*—1 hour, FREE

Radiology Series

- *How to Optimize Your Contrast-enhanced MRA*—text w/flash plugin, 1 hour, $20
- *3D Contrast-enhanced MR Angiography of the Renal Arteries*—text with flash plugin, 1 hour, $20
- *MRA of the Thoracic Aorta, Aortic Arch, and Carotid*—text w/flash plugin, 2 hours, $20
- *MRA of Aortoiliac and Periperal Vascular Disease*—text w/flash plugin, 1 hour, $20

Substance Abuse Series

- *Drug Diversion and Abuse: The Facts*—audio, 2.5 hours, FREE
- *Treating Tobacco Use & Dependence*—text, 1 hour, FREE
- *Fetal Alcohol Identification in Women*—audio/video, 1 hour, FREE

Women's Health Series

- *Alternatives for Menopausal Symptoms*—slides, 1 hour, $20*
- *Phytoestrogens for Perimenopausal and Postmenopausal Women*—slides, 1 hour, $20

Sleep Disorders Series *

- *Sleep History Guide*, text, 1/2 hour, $20*

These educational activities have varying degrees of interactivity. The programs with an asterisk (*) are text based or have text alternatives available and require only Internet connection—no extra computer programs or plugins. The others use an audio/video format like Quicktime, RealMedia or Flash. These free programs or plugins can be found on links supplied in each CME program. All but one of the *Bioterrorism* educational programs can be viewed for FREE, if no credit is required.

A simplified two-step registration system is now available with the new portal. In addition, a one time "Account Sign-up" is required to set up a password; then you can access all the courses by logging in and registering. For your added convenience, credit card payment can now be made on our secure server, automatic feedback is given for the short quiz at the end of the course, and, upon successful course completion, a credit letter can automatically be printed. When you're ready, the course is ready. . . no more waiting for emails that provide information before you begin.

If you would like more information about an online short course, the process or how to develop a CME program, contact Rhonda Dix at rkdix@facstaff.wisc.edu or phone (608) 265–5221.

CME Courses

October 25
Alzheimer's Conference
Madison, Wisconsin

October 26
Pediatric & Adolescent Back Pain
Lake Geneva, Wisconsin

November 3–5
Fecal Incontinence
Milwaukee, Wisconsin

November 8–9
Fall 2002 Psychiatric Update
Madison, Wisconsin

November 15–16
Thrombosis & Hemastasis Problems in Hospitalized Patients
Madison, Wisconsin

November 16
Peripheral Vascular Diseases
Milwaukee, Wisconsin

November 16
Airway Conference
Madison, Wisconsin

November 18–22, and December 2–6
Grant Funded Faculty Training in Addiction
West Palm Beach, Florida

November 21–22
Primary Care Conference
Madison, Wisconsin

December 5–6
Nosocomial Infection Control
Madison, Wisconsin

Call for Nominations for 2003 WMAA Awards

The Wisconsin Medical Alumni Association (WMAA) Awards Committee invites you to nominate your colleagues and classmates for consideration for the 2003 WMAA awards listed below. Medical School alumni, faculty and staff, as well as other professional colleagues, may submit nominations. Complete nominations should include the following:

- A letter stating the award for which the nomination is submitted, outlining in detail the nominee's qualifications
- The nominee's curriculum vitae, including current address and phone number
- Secondary letters or materials in support of the nomination, if available

Medical Alumni Citation Award

The award honors a Medical School alumnus who has achieved distinction in medicine. Achievement is recognized through excellence in medical practice, academic activities and research accomplishment.

Medical Alumni Service Award

The award recognizes outstanding service to the WMAA. It is offered to an alumnus who has exhibited exceptional commitment to the association over a period of years.

Ralph Hawley Distinguished Service Award

The award is conferred on an alumnus who has made outstanding contributions to the local community through medical practice, teaching, research or other humanitarian activities.

Medical Alumni Association Honorary Life Membership

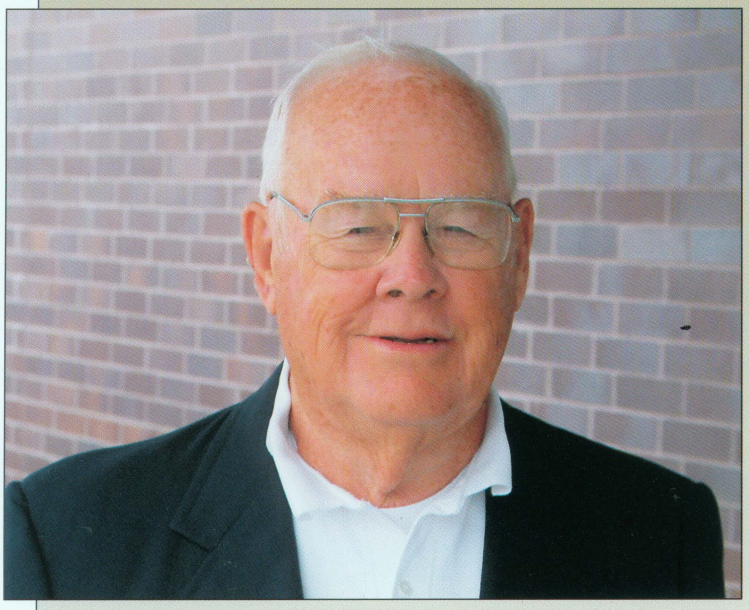
The award honors a UW Medical School or UW Hospital and Clinics employee who has been particularly supportive of and helpful to students and alumni.

Submit nominations to Executive Director Karen S. Peterson, Wisconsin Medical Alumni Association, 4245 Medical Sciences Center, 1300 University Avenue, Madison, WI 53706-1532.

RUSS LEWIS WRITES

A sermon on death with dignity

Those of you who are old enough to remember Dr. William S. Middleton will recall that he often had private nicknames for his students. His name for me was "Parson." At that point in my life, I was not a church-goer and had not even read the Bible, so I felt Dr. Milddleton must have made a bad diagnosis, which was almost unheard of. Today, however, I plan to deliver a sermon.



Almost all of you know that my wife Ellen died recently of ALS. She went through six months of misery, but not because of pain. The misery came because her brilliant mind found itself trapped in a body that soon could not stand or walk. Then she could not raise her arms to write or even feed herself, and finally she could not talk, so communication became impossible. Neither she nor we could do a thing about it.

Two years earlier Ellen was diagnosed with lung cancer, for which she received chemotherapy in 2001. She worried about a painful end and we often talked about Oregon's law concerning assisted suicide. The "Death with Dignity Act" allows terminally ill Oregon residents to obtain lethal medications from a physician and then voluntarily self-administer them. The act specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another's life.

As a devout Catholic, Ellen was adamantly opposed to the idea. She never faltered during her illness, and I was proud of her for her belief. She had every right to make and keep to that decision. But I felt—and still feel—that the Oregon law is a step forward. And it is only the beginning.

In fact, I also take a positive stance on euthanasia, a subject that is even more taboo. This has no bearing on Ellen's problems, but relates to my mother, an equally intelligent lady who had what was then called senile dementia, probably what is known today as Alzheimer's.

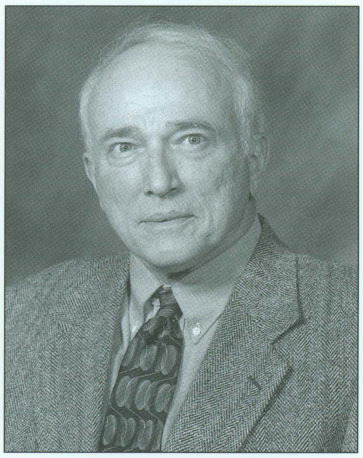
Mother was in a nursing home for the last four years of her life. For almost all of that time, she knew nobody—not my dad, myself, my brothers or other family members. She was a burden to the family in many ways, something this proud person never would have allowed if she were able to control the circumstances. Fortunately, we were able to handle the situation financially.

But my sermon is this: Why should Ellen or my mother or the attorney general or anybody else make such a decision for *me*. It seems to me that having the right to die, since it does not hurt any other person, should be legal. For those who are suffering, it should be an option for them to obtain relief.

Today with more money going to the military, we are seeing fewer dollars for many of the vital needs of our country's people. In my opinion, we are wasting—and I mean wasting—billions of dollars on prolonging life in many people who might rather not live, such as those with advanced Alzheimer's disease. With the increasing cost of medical care for these patients, no country will be able to afford to take care of them in the future. We should start paying attention to what is happening in Oregon and the Netherlands, where euthanasia is practiced, and learn from their experiences.

I feel we should face up to priorities and make children number one. Let's put our resources into better education, improved housing and healthcare for everyone, especially the young. Why wait? Human rights has become an important movement in recent years. I would hope that in addition to strongly pushing for policies allowing all people to live with dignity, human-rights proponents would also seriously add the right to die with dignity.

In Memoriam



Andrew McBeath

University of Wisconsin Medical School lost a valued colleague on June 2, 2002, when Andrew McBeath, MD '61, died following a long illness. He was 66.

Four days after his death, the University's Board of Regents approved the "Andrew McBeath Distinguished Professorship," an endowment to provide ongoing support for a residency training program and to help expand orthopedic research. Thomas Zdeblick, MD, chair of the newly formed Department of Orthopedics and Rehabilitation Medicine, was appointed the McBeath Professor.

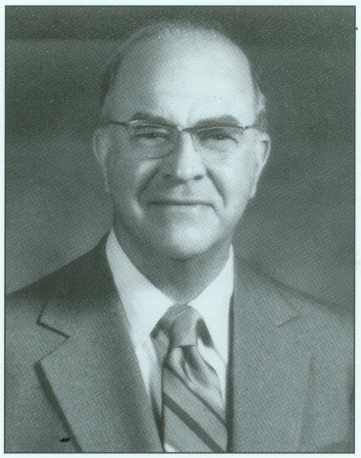
"I am honored to be named the first McBeath Professor," said Zdeblick. "I'll never forget Andy's style, generosity or dedication. He left a rich legacy as a teacher, clinician and leader here at the university."

McBeath devoted more than three decades to the study of total joint reconstruction, focusing specifically on the hip and knee. He contributed to the design of the Wisconsin Hip, a prosthesis that has helped improve mobility and quality of life for thousands of Americans.

Following graduation from University of Wisconsin Medical School in 1961, he spent two years in Connecticut at Hartford Hospital, first as an intern, then as a general surgery resident. He completed his orthopedic residency at the University of Iowa. In 1966, he joined the U. S. Air Force, where he earned a Commendation Medal, then returned to Madison to begin his career at the Medical School.

Under his direction, the orthopedics division grew considerably, branching into several new subspecialties. When McBeath began his tenure as chair, the division consisted of four members. Today, it has 13 internationally recognized faculty who specialize in a variety of areas, including hand surgery, spine surgery, oncology, pediatrics, trauma and sports medicine. McBeath was named the Frederick J. Gaenslen Professor of Orthopedic Surgery in 1980.

He was a member of numerous professional societies, including the American Academy of Orthopedic Surgeons, American Orthopedic Association, American Medical Association and Orthopedic Research Society. He was a reviewer for *The Journal of Bone and Joint Surgery* and *Clinical Orthopedics and Related Research.*



Frederic Mohs

Frederic E. Mohs, MD, the University of Wisconsin Medical School surgeon who developed the technique for treating skin cancer that bears his name, died July 1, 2002, at age 93.

In the 1930s, Mohs pioneered the surgery that helps rid patients of external tumors such as lip and skin cancers. The technique relies on extremely precise dissections of tumors instead of the gross removal of tumor masses.

Also called chemosurgery, the technique initially used a chemical paste containing zinc chloride to destroy cancerous tissue layer by layer under delicate microscopic control. By the 1950s the approach continued to rely on microscopic analysis but involved less use of chemicals.

As a UW–Madison student in the early 1930s, Mohs began experimenting with procedures and compounds that came to be known as "microscopically controlled surgery." Once it gained popularity, the process became known worldwide by the name it still carries: Mohs surgery. It typically results in a significantly smaller surgical defect and less noticeable scarring, as compared to other methods of skin cancer treatment.

Mohs' method is still in widespread use. Over time, Mohs surgery training programs were established at a number of the nation's leading medical schools and clinics, including the University of Michigan, the University of Iowa, New York University and the University of California-San Francisco. UW Medical School has trained the largest number of Mohs surgeons. The American Society for Mohs Surgery was founded in 1990 to further the practice.

Samuel G. Perlson

Samuel G. Perlson, MD '51, a devoted friend of University of Wisconsin Medical School and a dedicated member of the Wisconsin Medical Alumni Association (WMAA), died in Milwaukee, Wisconsin, on June 13, 2002.

"As a member of the WMAA board of directors, a committee member and a tireless contributor to the programs that benefit medical students, Dr. Sam Perlson set a very high standard for all alumni to follow," said Christopher Larson, MD '75, WMAA president. "His gentle, caring nature was visible and ever-present. His willingness to give of himself—his time and thoughts—has been invaluable to me throughout my years with the alumni association. Sam will be missed."

During his tenure as WMAA president, which began in 1988, Perlson initiated many projects to support medical students and alumni. He took his interest to new levels in 1990, when he conceptualized and began the Low-Interest Student Loan program. The fund, which has helped more than 100 medical students over the years, was renamed in his honor in 2001.

"Sam's concern for the financial hardships of medical students spawned the Low-Interest Student Loan program, which continues to grow and attract alumni contributions," said Larson. "His understanding of our role as mentors to UW medical students has created a legacy of commitment among those who worked closely with him."

Following graduation from UW Medical School, Perlson completed an internship at Mt. Sinai Hospital (now Aurora Sinai Medical Center) in Milwaukee. He began a residency in obstetrics and gynecology at Beth Israel Hospital, New York City, but was called into military service for two years during the Korean War. In 1959, he returned to Madison to complete his obstetrics/gynecology residency with Benjamin Peckham, MD, professor and chairman of the department at UW Medical School.

In 1985, Perlson had a heart attack that required him to retire from medical practice. Through excellent self-care, the care of his physicians, and the care and support of his family and friends, he developed a new lifestyle. He added a regular exercise and swimming program. He audited dozens of courses at UW Milwaukee and encouraged colleagues to do likewise. He maintained his position as a teacher of interns and residents in the UW Medical School program in Milwaukee, and he played an active role in providing care to the poor in clinics operated by local hospitals.

Perlson was also the WMAA Class of '51 representative. "In this role, Sam was instrumental in maintaining cohesiveness in his class. He faithfully wrote to classmates on an annual basis, called them and kept them informed of class news," said Karen Peterson, WMAA executive director. "He led many very successful class reunions. The WMAA will experience his contributions for years to come."

Andrew McBeath '61
June 2, 2002

Raymond A. McMahon '37
May 20, 2002
Portland, Oregon

Frederic Mohs
July 1, 2002

Samuel G. Perlson '51
June 13, 2002
Milwaukee, Wisconsin

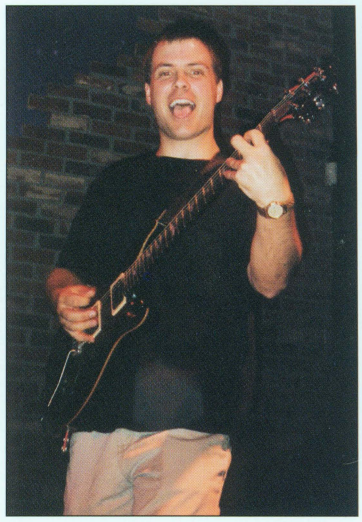
Bernard Schwam '50
May 14, 2002
Boynton Beach, Florida

10th Anniversary

ARRHYTHMIAS

The University of Wisconsin Medical School

And the beat goes on



"And the beat goes on"

The Wisconsin Medical Alumni Association (WMAA) invites you to celebrate the tenth anniversary of the creation of "The Arrhythmias."

This student band began as an activity that busy medical students—who also happened to be good musicians—took up for fun. Subsequent students have carried on the tradition for a decade, and the band has been a source of excellent entertainment for students and alumni at social gatherings and formal events over the years

The celebration will be held Saturday, October 19, 2002, immediately following the homecoming football game at Union South, 227 N. Randall Avenue. Tickets, which are $10 for alumni, faculty, family and friends, include buffet and beverages. A cash bar will be available. Anniversary t-shirts will be on sale at the party.

Advanced tickets required. For ticket information, please contact the WMAA at (608) 263–4915 or bjlukes@facstaff.wisc.edu.

Wedding sparks "mini-reunion" for Class of '98

Nearly a dozen members of the Class of 1998 were among the guests who attended the LaCrosse wedding of classmate Ann Fjelstad. The gathering was a mini-reunion for the class. In fall 2003, the Wisconsin Medical Alumni Association will begin hosting reunions for recently graduated classes. An official reunion marking the fifth anniversary of the Class of '98 will be held September 20, 2003, in conjunction with the UW versus North Carolina football game. Tenth, fifteenth and twentieth reunions will also be held in fall 2003. Look for details soon!

Classmates seated with bride and groom are (left to right) Xuan Thy Thi Tran, Abe Liebeskind (groom), Ann Fjelstad (bride), Sara Meinz, Tara Dall and her baby, Paxton Larson. Standing (left to right)are Anish Desai, Suzanne Davidowitz, Amy Moschell, Tim Richer, Alice Farrell and Dean Philip Farrell, Dan Schraith (class of '99), Conrad Yu and James Haine.

Coming Events
Wisconsin Medical Alumni Association

Alpha Omega Alpha Dinner
Friday, October 11, Monona Terrace

Homecoming 2002

Friday, October 18

10:00-11:30 a.m.	Editorial Board meeting, Waisman Center
12:00 – 1:00	WMAA Executive Committee meeting
1:30-4:00 p.m.	WMAA Board of Directors fall meeting, Waisman Center
6:00 p.m.	Homecoming Dinner for board of directors, past presidents and class representatives, Fluno Center

Saturday, October 19
WMAA football tailgate, Union South

10th anniversary celebration for "The *Arrhythmias*"
post game, Union South

2003 Winter Board Meeting
Thursday, February 27, Milwaukee

2003 Winter event
Thursday, February 27, Milwaukee

Alumni Weekend 2003, May 8–10

May 8	Dean's reception Class reunions 1943 – 1958
May 9	Editorial Board meeting, Pyle Center Board of Directors spring meeting, Pyle Center Class of 1953 recognition luncheon, Pyle Center Awards banquet, Concourse Hotel
May 10	Continuing Medical Education program Class reunions 1963 – 1983

Graduation 2003
Friday, May 16

Continuing Medical Education Conference
"From DNA to Molecular Medicine"
May 20–23, 2003, Memorial Union and the Pyle Center

Middleton Society Dinner
May 22, 2003, Monona Terrace

For additional information, visit the WMAA website at www.med.wisc.edu/alumni/ or call (608) 263–4915.

OBSERVATIONS

Sailors and strollers enjoy a warm fall day before winter arrives and Lake Mendota begins to freeze. Photo by Bob Rashid.

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