The Evolution of Anatomy
<table>
<thead>
<tr>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
</tr>
<tr>
<td>The Evolution of Anatomy</td>
</tr>
<tr>
<td>Still the bedrock of medical practice, gross anatomy instruction at UW has changed. And so has the Department of Anatomy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Departments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
</tr>
<tr>
<td>Dean’s Message</td>
</tr>
</tbody>
</table>

| 10         |
| Alumni Profile: Thep Himathongkam, MD '69 |

| 14         |
| Health Literacy |
| How does communication “static” inhibit health literacy and cause a major national healthcare problem? David Kindig explains. |

| 18         |
| Secrets of Success |
| Hans Sollinger shares his thoughts on the UW organ transplantation program, one of the largest and most successful in the world. |

| 38         |
| WMAA Winter Event |
| Many busy people took time out to socialize and learn something new at the annual alumni event held in the heart of Wisconsin. |

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**On the Cover**
John Harting (center), anatomy department chair, is flanked by gross anatomy course directors Edward Schultz (current, left) and James Pettersen (former).
Thanks to a very generous gift from the Rennebohm Foundation, which you can read about in this issue of the Quarterly, we are moving forward with funding for the HealthStar Interdisciplinary Research Complex—the IRC. I'm happy to report that contractors will begin making utility connections to the IRC construction site north of the Health Sciences Learning Center and University of Wisconsin Hospital and Clinics in May. We hope to have our groundbreaking ceremony in August 2005. As you know, the IRC is the last piece in an amazing puzzle that finally will bring together UW Medical School faculty members—researchers, educators and clinicians—in one location on the west side of the UW-Madison campus.

The new gross anatomy laboratories, which also are featured in this Quarterly, will be built in space between the IRC and the hospital. Students will no longer need to travel to the Medical Science Center on central campus for gross anatomy instruction once the new labs are completed. This move also will be symbolic, as it will mean that students in all four years of the curriculum will be united on west campus for the first time. The completion of these projects will help make the UW health sciences campus one of the most vibrant and sophisticated in the nation.

In another exciting development, we now have close to 75 first-year students signed up for the student summer research program, most of which is funded by gifts from Herman and Gwenn Shapiro. I’m not aware of any other medical school that has such a well-developed, funded, mentored research program for young medical students. Ramo Naidu’s report of his student project with the World Health Organization in Denmark, which appears in this issue of the magazine, is a wonderful example of the places such a research program can take a student.

Match Day this year marked a clear change for our school, reflecting a larger pattern around the country: a shift away from primary care residencies. During my deanship, more than 50 percent of the graduating class each year usually has matched to primary care residencies. This year, however, only 40 percent chose primary care programs.

I believe this shift signals the emergence of a new kind of medical school graduate, a new generation of doctors. The new trend has physicians—women and men—engaging in more job sharing and shift work. People are looking for more manageable schedules. They want to pay off those large medical school loans as quickly as possible.

Janet Bickel, our visiting associate dean for faculty, discusses issues related to this phenomenon in a recent article on faculty development appearing in Academic Medicine. In it she talks about the differences between the Baby Boom generation (people born between 1945 and 1962) and Generation X (those born 1963 to 1981). Sociologists say that Baby Boomers tend to work hard out of loyalty, expect to hold their jobs for a long time, feel they have to “pay their dues,” believe self-sacrifice is a virtue and generally respect authority. Generation Xers, on the other hand, work hard if they are allowed to balance their jobs with the rest of their lives, expect to look for many jobs, don’t feel paying dues is relevant, believe self-sacrifice may have to be endured occasionally and generally question authority.

Bickel says that, for the most part, today’s department heads and senior faculty are Boomers, while junior faculty, residents and students are Generation Xers, a social situation that can lead to tension. She urges us to use a “generational lens” in evaluating the impact such differences can have.

In my 10 years as dean, I’ve come to see that much of this new way of thinking will positively influence our profession. There’s strong evidence that the shorter work week results in fewer medical errors. It gives women, who now number half of our graduates, the opportunity to devote the time they need to raise a family. It also allows men more freedom for personal activities that can contribute to a better balanced life. We must be flexible and accepting of these different values and attitudes. Physicians today are every bit as effective—and perhaps healthier and happier—as those of generations past.
PRESIDENT’S Message

William Nietert, MD ’78
WMAA President

There are 10,000 of youz guyz, 6,000 grads of the Medical School and 4,000 of the house staff programs. You live in 50 states and 30 countries. Approximately 10 percent of you support the Wisconsin Medical Alumni Association (WMAA) and the Medical School financially.

Many of us seem to be blessed with the ability of being incapable of storing negative memories. Thus far, in my reign as president (less than one year), I have heard from many of you who, like me, have positive memories of their medical school training and are very grateful.

However, I have had more than one response indicating that some of youz guyz do not suffer from this affliction. In fact, a few have told me that they have negative memories of medical school and have no intention of supporting the school—so don’t bother to ask!

To steal a line from Groucho Marx, “I would never belong to an organization that would have me as a member.” But the truth is, we’re all members of this organization, whether we like it or not, whether we support it or not. So, as long as we’re members of this club, we might as well know a little about it.

Now, I could regurgitate the WMAA mission statement and activities...yada, yada, yada...but it’s not my style. If you want that, please go to http://www.med.wisc.edu/alumni/.

Instead, I’ll sum it up by saying that the alumni association is affiliated with, but independent of, UW Medical School, and everything we do with your money (and mine) is to try to improve both the present and future of UW Medical School students, house staff and faculty.

We have sponsored many wonderful projects, including playing a significant role in building the new Medical School. But we all know a medical school is more than just bricks and mortar (or now spancrete and aluminum). The future generation of doctors will most likely face challenges that we can now only imagine. Many of these will likely have nothing to do with disease or its treatment. Our job is to allow students to, as the Army would say, “Be the best you can be.”

Here’s the way I see it:

a) If you share my positive memories of medical school and would like to help current medical students, then I urge you to support the WMAA in whatever way you choose.

b) Or, if your experiences were negative, and you do everything you can to suppress your memories of medical school, then I think you need to be involved so that future physicians won’t suffer from the same plight.

Our job, as I see it, is to make sure that present and future generations of students, house staff and faculty continue to be “Wisconsinized.” Which is something I can’t describe, but I know it when I see it.

Th-th-that’s all folks!
Nietert

P.S. We are planning a charity golf event in Wausau late summer or early fall, with more information to come. See youz guyz there, hey!
P.P.S. I look much better with a golf hat on.
Gross anatomy dissection has been a revered tradition at UW Medical School since before the school's inception at the turn of the last century. For many years, instruction took place in the attic of UW-Madison's Science Hall. Soon new labs will be built adjacent to the Interdisciplinary Research Complex.
For more than 20 centuries, anatomists with steady hands, sharp eyes and exquisite patience have studied the internal intricacies of the human body, skillfully teasing out new discoveries in their cadaver and animal dissections. Historical figures such as Herophilus, Galen, da Vinci, Mondino and Vesalius gradually expanded awareness and understanding of the thousands of visible, palpable structures contained in each body. Even as recently as the 1940s, when the bronchopulmonary segments of the lung were described, anatomists were refining this body of knowledge.

While additional significant anatomic finds are unlikely, anatomy as a discipline remains the bedrock of medical practice. Students must learn gross anatomy before they can comprehend the way those structures function or how pathologies render them dysfunctional. In most cases today, the setting for this learning is virtually the same as it always has been: a gathering of a few students and an instructor around a cadaver.

The first days of gross anatomy often are seen as a rite of passage for students, an invaluable, unforgettable introduction to life by means of a lifeless body. Students usually regard the experience as one of the most profound in their medical education.

Laura Bonneau, a first-year University of Wisconsin Medical School student, described her class' introduction to gross anatomy last fall.

"On the first day of gross lab, no dissection was scheduled. Rather, we reported to meet our tank mates, including the cadaver. We greeted each other, then raised our last member out of her fluid bath.

"Initially, everyone kept their distance from the tank, as when approaching something of which one is unsure. Will it hurt me? How will I react? What does it look like?"

"True to our student selves, curiosity won out, and each of us approached closer, only the head cloth left to remove. Absorbed in silence, we looked at her skin, its unique pallor, the embalming sites, the rigidity of the body, hair peeking out from under the cloth still covering her face.

"We took it all in—the scent of preservative, the sight of the body in front of us—and silently gauged our own reactions. We removed her face cloth, and therein lay the discomfort. We confronted what we then recognized as a fellow human being. Our own mortality right there: recognition of another human form and the life that used to reside there. Her dreams, her pain, her decision to become our teacher."

**Passionate instructors**

In addition to the cadavers, instructors are the other essential element in learning gross anatomy. At UW Medical School, students have revered their instructors for decades, often regarding them as their personal guides on journeys into unknown places.

Charles R. Bardeen, MD, the first dean of the school, was a gross anatomy instructor. He was very active in teaching the large classes held in Science Hall, but as a “big picture, bold ideas” man, he may have preferred to leave the details of dissection to others. Even before Bardeen’s arrival in 1904 and the school’s founding shortly thereafter, William Snow Miller, MD, who later became an esteemed medical historian, was recognized as a special anatomy teacher. In the 1920s, '30s and '40s, Walter Sullivan, PhD, was the star anatomist; he eventually earned the Wisconsin Medical Alumni Association’s Emeritus Faculty Award.

"Even though the Department of Anatomy has evolved significantly to include much more than pure teaching in its mission today, gross anatomy instruction is still a central activity for us,” says John Harting, PhD, chair of the department for the past 23 years. "We are very conscious of carrying on a strong tradition of anatomy teaching here at UW Medical School.”

As pressure intensified in the past two decades for faculty to conduct research and publish papers in order to get tenure, more and more of them found that they didn’t have the time to teach gross anatomy, explains Harting, who balances his own research on the organization of central visual pathways with 32 years of exceptional neuro-anatomy teaching, which has earned him more than two dozen awards.

The solution has been to hire outstanding PhDs to concentrate solely on teaching gross anatomy.
Karen Krabbenhoft, who is the gross anatomy course co-director (with anatomy professor Edward Schultz, PhD), and Carl Sievert, lecturer in anatomy, handle the assignment.

"Karen and Carl are two of the best educators in the Medical School and at the University," says Harting. "We are very fortunate to have them."

The time commitment Krabbenhoft and Sievert make also frees the department's 22 tenure-track faculty members to conduct their research (see sidebar on facing page) and share various aspects of it with students as they teach in programs such as Biocore, a popular option for top UW-Madison undergraduates interested in biology.

The current gross anatomy instructors follow in the footsteps of giants such as Otto Mortensen, MD, and James Pettersen, PhD.

"These past and present educators have inspired students with their passion for teaching and their willingness to share their deep understanding of anatomy," Harting says. "The sustained tradition of teaching excellence has helped make our gross anatomy program one of the most respected in the country."

The UW Medical School anatomy department of the past was a "classic," Harting adds. "In the time of Mortensen, who was chair from 1950 to 1966, every faculty member taught the same amount. The instruction focused on gross anatomy, neuroanatomy, histology (microanatomy) and embryology, and it was aimed almost exclusively at medical students."

Mortensen may have been the quintessential gross anatomy instructor at Wisconsin, says James Pettersen, PhD, now a professor emeritus who was director of gross anatomy from 1970 to 1995.

"I loved the way Mortensen taught," recalls Pettersen. "He was very approachable, thorough and fun. He used a Socratic method of teaching, which involves a lot of interaction between students and the instructor."

Mortensen required students to sign up for hour-long discussions on the dissections they had just completed. "These in-depth, rather scholarly talks around the cadaver allowed people to really get acquainted, to learn a lot about each other in addition to a lot about anatomy," says Pettersen, who calls Mortensen his role model.

**Ongoing course changes**

Pettersen used the same engaging teaching style as Mortensen when he took over as head of gross anatomy, but he had to do away with the formal discussions, which took too much study time from other subjects that students were taking. Instructors then began circulating more informally from cadaver to cadaver.

"I enjoyed that arrangement, because it gave me time to get to know all the students better and to do more dissections," he says, adding that it takes a seasoned instructor only minutes to complete a dissection that can involve students for an hour.

Also because of the demands of other courses, the Medical School's curriculum committee reduced the amount of overall time for gross anatomy instruction—from four-hour labs five days a week, plus Saturday morning lectures, to three-hour morning
Beyond the “classic” anatomy department

True to the era he lived in, Otto Mortensen, MD, chair of anatomy at UW Medical School from 1950 to 1966, led a “classic” department, one that consisted of an insulated, small group of faculty members who concentrated almost entirely on teaching medical students the topics of gross anatomy, neuro-anatomy, embryology and histology.

“If Mortensen were here today, he would be stunned at the changes that have occurred in the department,” says John Harting, PhD, department chair for the past 23 years.

Harting stresses that gross anatomy instruction remains a central element in his department’s mission. For him, teaching will always be a passion, and he expects nothing less than teaching excellence from his staff. But in the past two decades, the tenure-track system has forced all medical school anatomy departments to diversify and include research in their missions.

Research excellence now balances teaching excellence, says Harting, whose own research has been funded continuously by the National Institutes of Health.

“Our faculty conduct world-class research, and this has greatly expanded our sphere of influence—on campus, nationally and internationally.”

Anatomists of the past were very descriptive in their interests, drawn to the morphology of structures, Harting notes. “Now we’re very functional,” he says. “We want to know what the structures do.”

Furthermore, Harting has broadened the scope of the department even wider, aiming for research that has practical applications. “I want faculty to do research that really matters for people’s health,” he says.

The department’s research activity, centering on various aspects of development, breaks down into four groups.

The DEVELOPMENTAL BIOLOGY GROUP examines molecular control of pattern formation during embryonic development. The scientists use mice, fruit flies, chicks, nematodes and Zebrafish for their studies. Faculty include Grace Boekhoff-Falk, PhD, Karen Downs, PhD, John Fallon, PhD, Anne Griep, PhD, Timothy Gomez, PhD, Yevgenya Grinblat, PhD, Mary Halloran, PhD, Katherine Kalil, PhD, Youngsook Lee, PhD, Gary Lyons, PhD, Edward Schultz, PhD, and John White, PhD.

The IMAGING GROUP applies novel imaging and fluorescent-probe technologies to better understand early developmental events such as cytokinesis (changes that take place in the cytoplasm during cell division), pattern formation and axon development. Faculty include Grace Boekhoff-Falk, PhD, Timothy Gomez, PhD, Mary Halloran, PhD, Katherine Kalil, PhD, and John White, PhD.

The STEM CELL BIOLOGY GROUP aims to understand signals important in maintaining these immortal cells—the building blocks of all types of tissue—in an undifferentiated state. They also are studying factors that influence stem cells’ differentiation into specific tissues or tissue precursors. Faculty include Gary Lyons, PhD, Clive Svendsen, PhD, James Thomson, PhD, and Su-Chun Zhang, PhD.

The SYSTEMS NEUROSCIENCE GROUP addresses the organization and development of neural circuits to understand the function of the nervous system. Faculty include Ray Guillery, PhD, Lewis Haberly, PhD, John Harting, PhD, Luis Populin, PhD, Philip Smith, PhD, and Daniel Ulrich, PhD.

With many faculty having joint appointments, the reach of the department faculty today extends across campus, from the Primate Center to the Department of Zoology to the Biotechnology Center to the Waisman Center.

The anatomy department has also been a major player in “cluster hires,” the UW-Madison initiative created to attract and retain faculty members whose interests span departmental disciplines.
labs with afternoon, but no weekend, lectures.

Still, an enormous amount of material was covered in gross anatomy. This prompted Pettersen to write overall objectives for the course as well as individual objectives for each of the 36 dissections performed each semester.

"That was a monumental task, but it became our first course book, which really helped students know what they had to learn," he says.

Pettersen also instituted laboratory practicals as another helpful teaching tool. In addition to preparing written exams, he and his staff would tag structures on the cadavers for students to identify during testing.

"There must be a happy medium between actual bodies and digital teaching. The value of the cadaver is that students actually feel and see the human body in three-dimension. It's also critical that they observe the vast variations that occur—by gender, age and pathology—from body to body."

Incorporating histology into gross anatomy also was a big change begun on Pettersen's watch. "Combining the two ensured that students could view slides of microscopic specimens at the same time that they were learning the related gross anatomy," he says.

The integration of the two courses required the support and direction of Harting, the leadership of Pettersen, Schultz and Krabbenhoft and the cooperation of members of the histology teaching faculty.

"The undertaking was so time-demanding that Karen basically locked herself in her office until the course book was integrated," Harting recalls.

Pettersen's successor, Schultz, oversaw the final integration of the courses, which was done, ultimately, in order to continue to make gross anatomy learning as efficient as possible for students.

Another major advancement for Schultz and his staff was their creation of videos of all 27 dissections now featured in the 16-week course. Feedback on the videos, which are available to students online so that they can become familiar with the dissections before they even get to the lab, has been extremely positive.

"The videos have been a very important adjunct to the course, since we also just instituted a platoon teaching system. With this system, we split up the group of students at each tank and ask half of them to dissect and then teach what they learned to the other half at the next session," says Schultz. "Students who are not in lab are working on clinical case studies relating to the anatomy being dissected. They bring that knowledge to the next session."

The new system further reduces the amount of time students spend in dissection—labs now occur two or three days a week for three hours each day. Nevertheless, Schultz and many others firmly believe that cadavers are indispensable.

"There must be a happy medium between actual bodies and digital teaching," says Schultz, who has taught gross anatomy at UW every year since 1975. "The value of the cadaver is that students actually feel and see the human body in three-dimension. It's also critical that students observe the vast variations that can occur—by gender, age and pathology—from body to body."

After four months of delving inside every corner of their cadavers, students usually emerge from the experience wiser, humbled and grateful. To express their gratitude, they have begun their own tradition of holding a memorial ceremony at the end of the semester. They light candles, recite poems and play musical instruments to share their feelings.

Students also invite family members of those who donated their bodies to join them in the moving ceremony. "We were honored to have family members join us as we paused to reflect on the wonderful gifts we were given by people who chose to donate their bodies to the Medical School," says Anne Marsh, who helped organize the ceremony in 2003.

New settings

The Medical School's first gross anatomy classes were held in the attic of Science Hall on UW-Madison's Bascom Hill. Cadavers were hard to come by in those days, but instructors acquired as many unclaimed bodies as they could from local institutions, mostly mental hospitals. The embalmed bodies were carried up to the top floor and placed on wooden tables, where students gathered around to perform dissections, most of the time—but not always—under the supervision of their instructors.

The gross anatomy laboratories remained in Science Hall until 1958, when Bardeen Medical Laboratories were completed as an addition to the Medical Science Center (MSC) at Wisconsin General Hospital on central campus. Among other things, Bardeen also housed the anatomy department, which was brought into the main Medical School complex at the time.

By the end of the 1960s, as laws were passed allowing people to donate their bodies for teaching purposes, UW Medical School had a well-established body donation program. The school's mortician, Wayne Roohr, stayed busy, removing bodies from all parts of Wisconsin with the department's state-owned vehicle. He embalmed and stored the bodies in the basement morgue for future use by a variety of programs. Most of the cadavers were used to train future clinicians—including physicians, physician assistants and occupational and physical therapists.

By fall 1981, five new state-of-the-art labs had been completed in the basement and first floor of Service Memorial Institute (SMI), another wing
The school will construct new gross anatomy laboratories at the intersection of UW Hospital and Clinics and the planned Interdisciplinary Research Complex. The 7,200 square-foot anatomy facility will contain instructional labs for medical students as well as space for faculty clinical activities.

of the MSC. As the school grew—and additional space was needed for new scientific developments and related research—the gross labs were downsized. The present three labs on the first floor of SMI now serve as the main cadaver labs.

The arrangement worked well until the school moved all other classes for first- and second-year students into the new Health Sciences Learning Center (HSLC) last fall.

"With gross anatomy the only part of the Medical School curriculum still located in the MSC," says Harting, "it has been extremely inconvenient for first-year students to travel the mile back and forth between the two buildings."

To remedy the situation, the school will construct a gross anatomy instruction lab complex next to the HSLC at the intersection of UW Hospital and Clinics and the planned Interdisciplinary Research Complex (IRC). With a total of 7,200 square feet of space, the anatomy complex will house three instructional laboratories at 1,200 square feet each, an embalming room and a morgue.

"This will comfortably accommodate instruction for our medical students as well as other health sciences students," says Schultz, who is leading the planning for the project. "We also want to be sure that there's enough space for faculty in clinical departments—such as surgery, orthopedics, ophthalmology, obstetrics-gynecology—who may want to use our anatomical specimens for their programs. We are in dialog with these departments to see what they may need."

The new anatomy complex will have computers at each tank as a way to instantly access Power Point lectures, and sample examination questions and other electronic resources that can help clarify what is seen in dissection.

"We will be looking at the course to see how it should be modified to better utilize digital technology," says Schultz.

The new anatomy facilities will enhance an already stellar program, says Susan Skochelak, MD, MPH, UW Medical School's senior associate dean for academic affairs.

"The anatomy department has been one of UW Medical School's strongest teaching departments right from the beginning," she says. "John Harting's neuro-anatomy course is consistently rated the highest in the school. Through his example, he has inspired his teaching colleagues to be leaders and innovators in medical education. I expect that this tradition will continue for a long time."
Bringing medical prevention and treatment to Thailand

"Really, it was UW Medical School that pointed me in the direction I wanted to go. Thirty-five years later, I think I have found my way."

by M. Van Eyck

At 9:30 a.m. on December 26, 2004, Thep Himathongkam, MD '69, and his wife checked out of their hotel on Patong Beach in Phuket, Thailand, a little earlier than planned. They and four vacationing friends had decided to visit the beautiful resort at Khao Lak in Phang Nga, a one and a half hour drive from Patong, before returning home to Bangkok.

But police stopped their car on the main road before they reached the destroyed bridge crossing to Phang Nga. The first tsunami had hit, leaving the road wet and covered with debris. The group learned later that Patong had been struck around 10 a.m. and that Khao Lak was the most devastated area.

"Dr. Thep," as he is called (Thais address people by their first names), and his companions escaped the waves that killed thousands of people by what he calls "a narrow window." Had he and his party left Patong only 30 minutes later, they would have been hit by the first wave. Had they left only a little bit earlier, they already would have been in Khao Lak and would have faced the deadliest wave.

Addressing a medical conference on aging in Bangkok a few days later, Himathongkam said he took that window as a sign that his work in philanthropy and diabetes prevention and treatment was not yet finished. "I figure God wanted me to continue to talk with you instead of him," he joked with his audience.

Today Dr. Thep runs the Theptarin General Hospital that he created. It is an 80-bed facility located in Bangkok that also sees approximately 12,000 outpatients per month, a little over 2,000 of whom are diabetic or thyroid patients. The Theptarin diabetes team is the biggest and most comprehensive in Asia.

By the end of this year, he also will open the doors to the adjacent 20-story Theptarin Center for Quality of Life and Disease Prevention, an outpatient service that will educate both patients and healthcare providers in everything from diet and exercise to cardiovascular health to diabetes care and prevention.

Particularly exciting for Dr. Thep, the center will also focus on foot care and shoe fitting for diabetics. "This is so important because we don't have podiatrists in Thailand," he says.

The growing size and reach of Himathongkam's medical facilities mirror a relatively recent movement in Thailand to bring comprehensive, cutting-edge healthcare to its population. In fact, Prince Mahidol of Songkhla, the father of the present king, studied at Harvard Medical School and is credited with introducing Western medicine to Thailand. (His son, His Majesty King Bhumibol Adulyadej, was born in Boston during Mahidol's studies.) Regarded as "the father of Thai medicine," the prince was devoted to bringing comprehensive medical education, research and healthcare to all Thais.

But it wasn't until the 1970s that the country's economic circumstances began to allow for the kind of medical system Mahidol had envisioned. Now, with public health educators, volunteer health workers, public and private facilities and relatively low medical costs, Thailand's health system addresses everything from HIV and AIDS prevention in small villages to cosmetic surgery.
The diabetes team at Theptarin General Hospital, which Himathongkam created, is the biggest and most comprehensive in Asia. The doctor recently stood in front of his hospital.
Each year, scores of visitors tour Himathongkam's facilities, and his diabetes teamwork model is replicated in institutions around the world.

for foreigners who travel long distances for the lower rates and premiere care.

With his research, medical centers and, now, philanthropic work, Himathongkam has contributed to this evolution in myriad ways.

Leaving Bangkok in the early 1960s, Himathongkam attended the University of California-Berkeley on a scholarship from the Thai government. Initially he planned to return to Thailand with a doctorate degree in cellular physiology to conduct further research, as the scholarship dictated. But he soon realized that his research needs would be too advanced for Thailand’s facilities at the time.

“I decided to go to medical school because it would be more practical,” he says, noting that UW-Madison was one of the few universities that had a good reputation for accepting foreign students. “And now I can stand any kind of cold!” he says of his years in Wisconsin.

After completing a residency in medicine and a fellowship in endocrinology at Harvard in 1974, Himathongkam returned to Bangkok to teach medicine at Mahidol University, one of the primary universities in Thailand, only to find that his work still proved too demanding for local resources.

“When I moved back to Bangkok, there were no endocrine laboratories,” he explains, “so I could not practice any endocrinology.” Undeterred, Himathongkam set up a hormone laboratory at the medical school. It was one of only a handful of radio-immunoassay labs in Southeast Asia. He then started introducing the use of thyroid and pituitary function tests to the Thai medical community.

But another obstacle presented itself. “I taught my medical students to use these labs,” he continues, “but then they would graduate and there would be no other lab in Thailand to service them.”

And so Himathongkam established Lab PLUS (Professional Laboratory Ultimate Service), the first commercial lab in the country, and made its services available to all hospitals throughout Thailand.

“Lab PLUS continues to grow,” says Himathongkam. “We recently signed a...
contract with a courier service that will help us serve neighboring countries as well.”

Meanwhile, as Himathongkam observed the changing health concerns in his country, his focus shifted from thyroid and pituitary function to diabetes.

Medical advancements, it seems, weren’t the only western influence on the health of the Thai population. Due to the introduction of fast foods and sugary drinks, he says, today 9.6 percent of Thais over age 35 have diabetes, but only half know that they do. And the rate of obesity in children has reached 12 percent to 13 percent, nearing the alarming 15 percent of U.S. children.

“We even have our own Frito Lay factory,” he says.

To address these concerns, Himathongkam took an early retirement from teaching in 1985 and founded the Diabetes and Endocrine Center. He patterned his clinic after the model of diabetes care he had seen during his training at Harvard’s Joslin Diabetes Center. He also has founded diabetes educators, a group of medical personnel from various fields who pursue multidisciplinary approaches to educate the Thai population on diabetes and its prevention. Each year, scores of visitors tour his facilities, and his teamwork model is replicated in institutions and organizations around the world.

“Perhaps not surprisingly, Himathongkam believes strongly that physicians must master team management skills in order to be effective.

Accordingly, his center hosts learning activities through camps and diabetes clubs that encourage diabetes patients to learn from a team of healthcare providers how to live healthier lives—and to teach newer participants to take responsibility for their health.

“It took me six years to get patients to sit down in a class and learn,” he says. “But now it’s just a matter of getting patients to teach other patients.”

In 1993, Himathongkam expanded the center into the Theptarin General Hospital, which addresses a broader spectrum of family medicine issues.

Through the years, Himathongkam has worked closely with Thailand’s Ministry of Health and other government associations to improve the training and education of practitioners. He also has founded the Thai Association of Diabetes Educators, a group of medical personnel who pursue multidisciplinary approaches to educate the Thai population on diabetes and its prevention. Each year, scores of visitors tour his facilities, and his teamwork model is replicated in institutions and organizations around the world.

“You can take care of thousands instead of just hundreds of people that way,” he says.

In addition to relying heavily on dietitians and nurses, he takes advantage of the many volunteer health workers in villages who are trained to treat, for example, parasitic diseases, to assist in child delivery and to provide health, nutrition and family planning education at the local, “grassroots” level.

“We have a very good system in Thailand,” he says, “with about one volunteer for every 10 families, and there are 9,700 health stations throughout the country.”

Dr. Thep also has help closer to home. His son, Tarin, who holds an MBA, now serves as the chief financial officer of Theptarin General Hospital. In fact, the hospital shares their two names. He also works with his eldest daughter, Tanya, who holds an MBA and a master of public health from University of California at Berkeley. His youngest daughter will be graduating from Wesleyan University in the spring.

With a strong support system intact, Himathongkam has been able to turn his attention toward philanthropy, which he sees as a way to coordinate the resources of universities, the government, professional organizations and industries like pharmaceutical and medical device companies.

With the help of these organizations, he hopes to bring an even higher quality of diabetes care and prevention to the country at large and even to establish a regional standard for diabetes educators.

It’s a big vision for someone who graduated from UW Medical School in the late ‘60s with the much smaller goals of teaching and practicing endocrinology back home.

“Really, it was UW Medical School that pointed me in the direction I wanted to go,” says Dr. Thep. “Thirty-five years later, I think I have found my way.”

Himathongkam (in glasses) graduated from UW Medical School in 1969.
FROM COMMUNICATION "STATIC" COMES LOW HEALTH LITERACY LEADING TO MAJOR PROBLEMS

by Dian Land

A merican healthcare experts and providers have their hands full with many worrisome challenges, including controlling ever­rising costs, striving for better quality of care, addressing health disparities and being prepared for emerging diseases. As if that weren’t enough, the Institute of Medicine (IOM) recently focused national attention on another insidious problem, one that seriously inhibits the way our healthcare system meets the needs of patients. The problem is called low health literacy.

According to David Kindig, MD, PhD, University of Wisconsin Medical School professor emeritus of population health sciences, health literacy is “the degree to which healthy individuals have the capacity to obtain, process and understand basic information and services needed to make appropriate, effective decisions about their health.”

Two and a half years ago, the IOM tapped Kindig, an internationally respected health policy leader who once headed the U.S. Council on Graduate Medical Education, to chair a committee on health literacy. Kindig and 10 others representing a variety of academic disciplines and backgrounds met regularly over an 18-month period, analyzing hundreds of studies, listening to public testimony from dozens of ordinary people and evaluating the typical kinds of information patients receive.

Assessing the abundant evidence, Kindig and his colleagues on the IOM committee came to a startling conclusion: Nearly half of all American adults—90 million people—have difficulty understanding and acting upon health information. Forty million people have trouble connecting words with numerical concepts, the committee found.

“This is a big problem that has wide-ranging implications for our society. Limited health literacy can have a profound impact on individuals’ health and the healthcare system,” Kindig says. “Our efforts to reduce costs, improve quality and eliminate disparities cannot succeed without simultaneous improvements in health literacy.”

The problem is complex, Kindig says. “It’s not just about patients’ ability to understand. Health literacy also depends upon the communication skills of people who provide care—nurses, doctors and administrators —and the clarity of the health information supplied by the media, marketplace and government agencies,” he says.

Additional issues worsen the problem. These include the increasing complexity of the healthcare system, rapidly changing technology, time limitations placed on clinicians, the proliferation of consumer information from numerous and sometimes competing sources, and the expanded use of complicated medical procedures.

But communication “static,” or the distortion of information, appears to be one of the most critical factors limiting health literacy and leading to confusion.

“People rely heavily on the information that is available to them,” Kindig says. “This information is at the heart of the partnerships that patients and their families forge with today’s complex health systems.”

The IOM report resulting from the work of Kindig’s committee, called Health Literacy: A Prescription to End Confusion, lists numerous examples of the communication breakdown. Examples include post-
TAKE ONE TO TWO TABLETS BY MOUTH EVERY THREE TO FOUR HOURS AS NEEDED FOR PAIN. DISCARD AFTERTT 06/01/2005.

PRESERVED IN A TIGHT, DRY location away from heat.

Refill as needed according to your physician.
"Studies showed that people with low health literacy use expensive health services, such as emergency department care, more frequently than people with higher literacy. As a result, limited health literacy is leading to billions of dollars in avoidable health-care costs."

Surgical discharge information that was unclear, consent forms that were nearly incomprehensible due to arcane language, signs in hospitals that were too technical and medical dosing information that could be interpreted in several different ways.

"Limited health literacy can result in improper use of prescription drugs and failure to follow instructions," says Kindig. "Misunderstandings around some of these kinds of issues can lead to catastrophic outcomes."

From the point of view of the patient or family member, the IOM report revealed that much of the printed material distributed in medical settings is above the average reading ability of most Americans. But health literacy is about much more than simply a person’s reading ability or education level, Kindig says.

"Health literacy is a composite of a broad range of skills," he says. "It includes writing, numeracy, listening, speaking and conceptual knowledge. All of these influence peoples’ capacity to navigate a complex healthcare system and advocate for themselves within that system."

Kindig urges us not to succumb to stereotypic thinking. Even people who deal very effectively with other aspects of their lives may find health information hard to obtain, understand or use, he says. A surgeon may have difficulty helping a family member with Medicare forms; a science teacher may not understand information sent by a doctor about a brain function test; an accountant may not know when to get a mammogram.

Cultural issues also loom large in the health literacy equation. "Culture and ethnicity may influence the way patients perceive health, illness and the risks and benefits of treatments," Kindig says. "Such differences between a patient and provider can contribute to problems in the patient’s comprehension."

Low health literacy affects us all, he says, "but in particular, it impacts the poor, new immigrants and the elderly. As the American population continues to age, the challenge of low health literacy will become a bigger problem."

Making matters even worse, Kindig’s IOM report found that low health literacy has been woefully under-recognized.

"Several studies indicated that people may be ashamed to speak up about problems they encounter with the increasingly complex health system. This has resulted in what some experts perceive to be a silent epidemic," he says. "As a result, limited health literacy is leading to billions of dollars in avoidable healthcare costs."

Fortunately, research also shows that health literacy can be improved.

"This is a complex problem involving many systems—healthcare providers, public health communities, government agencies, the education system, advertisers, the media, health communicators and..."
marketers,” Kindig says. “There are opportunities for improvement in many areas.”

National organizations such as the U.S. Surgeon General’s Office, the Agency for Healthcare Research and Quality, the American Medical Association and the American Hospital Association have joined with the IOM in a broad campaign to raise awareness about the issue, with each group offering solutions. Strategies for improvement focus on several areas.

**The healthcare system**
- Encourage patients to become more involved in collaborative care
- Redesign the healthcare encounter to support effective communication
- Create simplified, more comprehensive educational materials
- Incorporate nurses, pharmacists and ancillary providers into the healthcare team to offer more points of contact for patient education
- Elevate the role of health educators in materials design and provider training
- Make health literacy assessment a responsibility of the Joint Commission on Accreditation of Healthcare Organizations

**Education systems**
- Incorporate health knowledge and skills into the curricula of kindergarten through 12th grade classes, adult education classes and community education programs
- Significantly increase the teaching of health literacy in medical, nursing and other public health schools
- Incorporate health literacy instruction into CME programs

**Specific suggestions for physicians and other clinicians**
- Listen better
- Speak more clearly
- Ask patients to repeat the instructions
- Become aware of cultural barriers that cause misunderstandings and mistakes

**Specific suggestions for patients**
- Ask questions if you have doubts or concerns
- Bring a list of all medications to appointments
- Get the results of any test
- Talk to your physician about what hospital is best for a particular procedure
- Make sure you understand what will happen if surgery is needed
- Ask family members and friends to serve as advocates

The IOM recommends that the U.S. Department of Health and Human Services take the lead in developing uniform standards for addressing health literacy. Clearly, much more research is needed, Kindig says.

“In addition to more basic research, we also need many more demonstration and evaluation projects so we can begin to figure out what works,” he says.

Kindig, now a champion for better health literacy, feels a sense of urgency. “We’ve got a big problem that will only get worse if we don’t do something about it right now,” he says.

As he wrote in the conclusion of his committee’s report, “We envision a society in which people have the skills needed to obtain, interpret and use health information effectively. And within which a wide variety of health systems and institutions take responsibility for providing clear communication and adequate support to facilitate health-promoting action.

“While achieving this vision is a profound challenge, we believe that significant progress can and must be made over the coming years so that the potential of optimal health affects all individuals and populations in the society.”

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Health literacy is a complex problem involving many systems, says David Kindig, who chaired the Institute of Medicine committee. “There are opportunities for improvement in many areas,” he says.
Secrets of a highly successful organ transplantation program

An interview with Hans Sollinger, MD, PhD, UW Transplant Program chairman

"In part, it's the favorable geography. In part, it's a very lucky mixture of very compatible faculty. In part, it's great support by the Department of Surgery and UW Hospital. And perhaps, at the end of the day, we should give Dr. Folkert Belzer credit for starting it all."

The first-ever organ transplant in the United States—a kidney transplant—took place in Boston just over 50 years ago. By 1966, surgeons at University of Wisconsin Hospital and Clinics—William Kiskan, MD, Arvin Weinstein, MD, and David Uehling, MD—had performed a dozen kidney transplants, effectively launching a program that would become an international phenomenon.

Today, the UW program is the second largest in the world. Last year alone, its surgeons transplanted 617 organs into 512 patients. Program faculty also have been pioneers in the area of islet-cell transplantation, a therapy many experts predict may eventually lead to a cure for diabetes, and plasmapheresis, a technique that reduces the chance of organ rejection by cleansing a patient's blood. New immunosuppressants also are being tested.

Program chairman Hans Sollinger, MD, PhD, the UW Medical School professor of surgery who has guided transplantation at Wisconsin into the modern era, recently sat down with Quarterly reporter Aaron Conklin to share his thoughts on the program's success.

Q: Does it amaze you to realize that your program, one of the largest in the world, has excelled for some four decades in Madison, Wisconsin?

A: When you look at the demographics of a typical transplant center, the success we've experienced shouldn't have happened. Large transplant centers usually are located in large metropolitan areas—in other words, you need a huge population to build up a large program. It's absolutely amazing to me that this could have happened in the relatively little community of Madison.

So, what's your secret?

First of all, I think it has to do with the fact that we always had our own organ procurement organization (OPO). We were never dependent on anybody else, nor did we have to share the organ donors in our region with anybody else, outside of an emergency situation. Our destiny was always in our own hands. We also have no competing center in our region. This has meant that we've never had to spend any time or energy in competing. All we've had to do was make sure that our results and volumes were strong.

Secondly, we have been extremely lucky with personnel. We have had only two chairmen: Dr. Folkert Belzer, who started the program, and myself, so there has not been a lot of leadership turnover. As for the faculty, over a 30-year time span, only two faculty members have left, and this was in the 1970s and '80s. Since I have been here, we've only added faculty members. And they have stayed, which is very unusual, despite the fact that two or three of them have received very attractive offers. One of them declined the chairmanship at Harvard.

Surgeons, in general, have fairly strong egos. Why do you think you were able to retain your faculty and head off turf wars?

Yes, surgeons do have strong egos. Surgeons also re-train once they reach a high level of competency and want to have their own area of responsibility. Often, the only way to achieve this is for them to leave the institution and start their own program or become chairs of other programs. Quite frankly, I expected that would happen. The only way I was able to prevent it was to create several areas of independent responsibility for individual faculty members and give
them an opportunity to excel in a particular area. For example, Dr. Tony D’Alessandro was appointed head of the OPO and has made that organization the most successful in the country. Similarly, Dr. Stuart Knechtle has established himself as an internationally recognized transplant biologist. Several factors likely have contributed to the fact that few faculty have had a strong urge to leave: my not being a micromanager, giving them the ability to excel in their own specific areas, and, of course, the wonderful support we get from the staff of our program.

Given the program’s huge success, why do you think so few centers have been able to emulate it?

A Chicago surgeon called us the New York Yankees of transplantation. I get a visitor at least once a month who says, “I want to see how you’re doing it. I want to copy your program.” In part, it’s the favorable geography. In part, it’s a very lucky mixture of very compatible faculty. In part, it’s great support from the Department of Surgery and UW Hospital. And perhaps, at the end of the day—and very importantly—we should give Dr. Folkert Belzer credit for starting it all.

You’ve hit a number of milestones over the years. What do you consider to be the greatest triumph?

For me, personally, it’s the development of mycophenolate mofetil, an immunosuppressive drug approved by the U.S. Food and Drug Administration in 1995. I started to do the first animal experiments in 1989; today, the drug sells for more than any other in the history of transplantation. More than 300,000 patients are taking it.
What changes have you seen in the transplant field during your years as a surgeon?

Clearly, times have changed. Transplantation has always been an experimental territory, but with new regulations and much stricter procedures by various committees, the spontaneity we experienced in the early days is obviously disappearing. One example was Dr. Belzer’s discovery of the UW Solution. We really had no evidence how this solution would work for human liver transplant. We couldn’t test it—you either had to do it in a human liver, or you didn’t know. But we didn’t yet have approval to do it in a patient. One day, a liver was donated, but it turned out that, for anatomical reasons, it was not usable for the patient. So Dr. Belzer preserved that liver for more than 20 hours in UW Solution and then transplanted it into a monkey. It turned out that the liver functioned perfectly well. Needless to say, Belzer got into huge trouble later with various university committees. While they were right to reprimand him, his experience helped make a discovery that saved thousands of lives.

What else has changed?

In general, surgery now is routine and associated with few complications. Last year, 100 percent of all live donor kidneys survived. Liver transplantation has seen the most profound changes over the past 25 years. When Dr. Muncu Kalayoglu performed the first liver transplant at UW in 1984, the operation involved a very complex bypass technique similar to a heart-lung bypass. Today, Dr. Kalayoglu and the liver transplant team use a much simpler technique and don’t need all the machinery. Blood loss and operative time are significantly less. As for kidneys, it’s just a matter of increased practice. When I was a young surgeon, it took me three to five hours to do a normal kidney transplant. Today, it might take me two.

What’s next?

Research and development is a vital component of our program and a big part of the reason we’ve remained at the top of our game so long. Currently, several transplant researchers are verging on breakthroughs that may transform the field yet again.

Dr. William Burlingham is working on a test that, if successful, will significantly reduce the amount of immunosuppressive medication a patient will have to take following a transplant.

Drs. Jon Odorico and Luis Fernandez, who successfully implanted islet cells in the pancreas of a Wisconsin man in 2003, effectively curing his type-1 diabetes, are working on refining the process to reduce the number of donor pancreases needed to obtain the cells. Right now, two or three pancreases are required to cure a patient. We want to get it down to one.

Dr. Debra Hullett is among a team of researchers testing a new immunosuppressant that may be even better than mycophenolate. Dr. Knechtle’s research team continues to work on immune tolerance, and clinically, he is the leader of the development of Campath-1H, an antibody to fight rejection. We are continuing with efforts spearheaded by Dr. Thomas Chin to improve plasmapheresis.

I also am particularly pleased that transplant faculty have taken a major role in the education of medical students. Dr. Yolanda Becker heads this initiative, serving as director of the surgery clerkship and of professionalism curriculum development at the school.

Finally, transplant patients require intensive follow-up. We estimate that currently 4,500 patients are being followed for post-surgical care. Dr. John Pirsch is responsible for this Herculean effort.
Rennebohm Foundation gift
supports the Interdisciplinary Research Complex

by Chris DuPre

The Oscar Rennebohm Foundation has given University of Wisconsin-Madison $15 million to help build UW Medical School’s planned Interdisciplinary Research Complex (IRC). The announcement was made at a press conference held in Rennebohm Hall on March 4, 2005.

“The Oscar Rennebohm Foundation has shown true vision with this generous gift to help fund the Interdisciplinary Research Complex,” said Gov. Jim Doyle, who attended the press conference. “This project is a key part of my program to boost Wisconsin’s position at the forefront of biomedical research.”

The IRC has a total estimated cost of $133.9 million. The complex will replace outdated research facilities and help to unify UW Medical School on the west end of the UW-Madison campus, where the new Health Sciences Learning Center houses the school’s administrative and educational programs.

Oscar Rennebohm established the Rennebohm Foundation in 1949 to support education, research, healthcare and recreation in the Madison metropolitan area. Until today, the largest grant from the foundation was $5 million for the School of Pharmacy, which bears the Rennebohm name.

“The IRC will be home to talented, dedicated researchers from many disciplines working together to find solutions to society’s most complex health problems,” said Steven F. Skolaski, president of the Oscar Rennebohm Foundation. “The Rennebohm Foundation is certainly proud to be a partner in this project, which will someday benefit all of us here and people literally around the world.”

The new building itself is not the sole focus of this Rennebohm Foundation gift, Skolaski added. “It is the work that will be done within this building that is most important,” he said. “Soon, in this area of the university, we will have a world-class health sciences campus for advancing innovative research, training the next generations of medical professionals and delivering healthcare that is superior technologically and sensitive to human needs.”

The IRC is part of the HealthStar initiative, which has built on a successful public-private partnership to fund high-priority projects in research and medicine.

“The Interdisciplinary Research Complex is the final and most ambitious component of the HealthStar plan,” said Philip Farrell, MD, UW Medical School dean. “The IRC will bring human and technological resources close to patient care services and teaching facilities. This dynamic synergy will result in better treatment and healthier living.

“By bringing together, in one of the finest facilities of its kind, some of the best research minds in the world and enabling rapid translation of discovery to therapy, the IRC will firmly establish UW-Madison as among the top echelon of our nation’s biomedical research enterprises,” Farrell added.

In addition to private gifts and grants, the IRC project, which is due to be completed in spring 2008, is expected to use $23.3 million in state general fund-supported borrowing. Among the funds pledged to the project are $18 million in grants from the National Institutes of Health.
Laessig wins trifecta of public health awards

by Jessica Burda

The Association of Public Health Laboratories (APHL) and March of Dimes Wisconsin Chapter have honored Wisconsin State Laboratory of Hygiene (WSLH) Director Ronald Laessig, PhD, for his continuing public health and environmental service with three awards.

A UW Medical School professor of population health sciences, Laessig received the APHL’s Gold Standard for Public Health Laboratory Excellence Award, which is given to a member for significant contributions toward advancing public health laboratory science and/or practice. The APHL also honored Laessig for his service as chairperson of its Environmental Health Committee.

Newton receives two health statistics awards

by Kris Whitman

Michael Newton, PhD, University of Wisconsin Medical School professor of biostatistics and medical informatics and UW-Madison professor of statistics, received the 2004 Presidents’ Award from the Committee of Presidents of Statistical Societies (COPSS). This organization presents the award to a young member of the statistical community in recognition of an outstanding contribution to the profession of statistics. The award, established in 1976, is jointly sponsored by the American Statistical Association, the Institute of Mathematical Statistics, the Biometric Society and the Statistics Society of Canada.

The Presidents’ Award recognizes Newton’s ingenious and wide-ranging contributions to statistical theory and methodology; applications of statistical methodology, especially in genetics and genomics; and outstanding training of graduate students. Winners receive a $1,000 honorarium.

In 2003, Newton also received the Spiegelman Award from the American Public Health Association. This award, established in 1969, is given annually to a young statistician for outstanding contributions in health statistics.

Newton received his doctorate degree in statistics from the University of Washington in Seattle. He joined the University of Wisconsin faculty in 1991.

Kurtycz earns cytopathology group honor

by Jessica Burda

The American Society of Cytopathology (ASC) bestowed upon Daniel Kurtycz, MD, the 2004 ASC President’s Award. Kurtycz is a professor of pathology at University of Wisconsin Medical School. He also is medical director of the Wisconsin State Laboratory of Hygiene (WSLH), and director of its School of Cytotechnology and Sections of Cytology, Cytogenetics and Newborn Screening.

Founded in 1951, the ASC is a distinguished national professional society of more than 3,000 physicians, cytotechnologists and scientists dedicated to the detection and early diagnosis of cancer. This annual award recognizes contributions to the ASC and includes a $500 honorarium.

Kurtycz received his medical degree from the University of Michigan, then performed his pathology residency and clinical chemistry fellowship at UW-Madison. He has served extensively on ASC committees, reviews several journals and is a long-term member of the American Society for Clinical Pathology Board of Registry for Cytology. ASC President Celeste Powers, MD, PhD, credits Kurtycz with being instrumental in bringing the organization ‘on-line’ by focusing on the ASC Web site, listserv and CD-ROM programs.
Busse wins Medical School’s Folkert Belzer award

William W. Busse, MD ‘66, University of Wisconsin Medical School’s Charles E. Reed Professor of Medicine and head of the allergy and immunology section, recently was given the Medical School’s Folkert Belzer Award.

The “lifetime achievement” award recognizes contributions made to the Medical School throughout an individual’s career. Other criteria taken into consideration include the quality and significance of the individual’s academic impact, demonstration of comprehensive excellence and value to the institution.

Busse currently is president of the American Academy of Allergy, Asthma and Immunology. His research interests include mechanisms of virus-induced asthma. In 2003, the National Institute of Allergy and Infectious Diseases, a division of the National Institutes of Health, awarded him a six-year, $55.8 million research contract, the largest in UW Medical School history. The study aims to solve the dire national problem of asthma in inner-city children (see Winter 2003 Quarterly).

Belzer, a UW Medical School transplant surgeon, was a pioneer in the field of organ transplantation. His work resulted in the discovery of the UW organ preservation solution.

Corden recognized as a leader in pediatric medicine

Timothy Corden, MD, was named the 2004 Wisconsin Pediatrician of the Year by the Wisconsin Chapter of the American Academy of Pediatrics (WIAAP). The award recognizes his advocacy on behalf of children, particularly regarding legislative healthcare policy issues, and his role in teaching medical students and residents about the importance of advocating for children in their communities.

Co-chair of the WIAAP’s Legislative Committee, Corden also is a representative of the American Academy of Pediatrics (AAP) to the Joint Commission on the Accreditation of Healthcare Organizations. He recently was chosen to be a U.S. Department of Health and Human Services “Primary Care Health Policy” fellow.

An assistant professor of pediatrics at UW Medical School, Corden also is the medical director of UW Children’s Hospital’s pediatric critical care unit.

After receiving his medical degree from Wayne State University School of Medicine, Corden was chief resident at Northwestern University Medical School and Children’s Memorial Hospital in Chicago. He completed a critical care fellowship at the University of California at San Francisco. His community service, teaching and research focus on how health policy decisions impact the environment in which children live.

Cleary honored for contributions to end-of-life care

James Cleary, MD, received the 2004 Excellence in End-of-Life Care Award from HospiceCare, Inc., a non-profit agency serving several southern Wisconsin counties. A medical oncologist at University of Wisconsin Comprehensive Cancer Center (UWCCC), Cleary is nationally known for his work in palliative care.

An associate professor of medicine in the section of medical oncology at UW Medical School, Cleary also is director of palliative care at UW Hospital and Clinics and academic medical director of HospiceCare, Inc. He completed his medical degree at the University of Adelaide Medical School, South Australia, and an internal medicine residency and oncology fellowship at Royal Adelaide Hospital.

Cleary was the 2004 president of the American Academy of Hospice and Palliative Medicine, a physician organization dedicated to the prevention and relief of suffering among patients and families. He is co-chair of the American Pain Society’s Cancer Pain Guideline panel, a master facilitator for the national Education of Physicians in End-of-Life Care Program and a program leader of the UWCCC’s Cancer Control Program.
Please join us! May 5-7, 2005

Medical Alumni Weekend

Weekend schedule of events

THURSDAY, MAY 5, 2005

Noon
CLASS OF 1947 LUNCHEON
Health Sciences Learning Center (HSLC)
750 Highland Avenue

5:30 - 7 p.m.
DEAN’S RECEPTION
HSRC

6:30 p.m.
HSRC TOURS (OPTIONAL)

7 p.m.
CLASS REUNIONS
Classes of ’50, ’55, ’60, ’70

9:45 a.m. - 3:30 p.m.
EDUCATION SEMINARS
Featuring UW’s most dynamic and distinguished faculty

Session I - 9:40 - 10:40 a.m.
Choose one topic for this session.
A. “Conspiracy” Victoria Pagan,
PhD, assistant professor of classics
B. “The Future of Care: What Nurses Can Do and Why It Matters” Dean Katharyn May,
PhD, UWSN of Nursing
C. “Sleep, Mood and Migration” Ruth Benca, MD, PhD,
professor of psychiatry

Session II - 11 a.m. - Noon
Choose one topic for this session.
D. “Why We Love Dogs”
Patricia McConnell, PhD, adjunct associate professor of zoology
E. “Political Advertising and American Democracy”
Kenneth Goldstein, PhD, professor of political science, director, the Wisconsin Advertising Project
F. “New Security Challenges Since 9/11 and the Role of the University” Jeremi A. Suri,
PhD, assistant professor of history

10 - 11:30 a.m.
WMAA QUARTERLY
EDITORIAL BOARD MEETING
Lowell Center, 610 Langdon St.

11:30 a.m.
CLASS OF 1955
RECOGNITION RECEPTION AND LUNCHEON
Lowell Center

2 - 4 p.m.
WMAA ANNUAL MEETING
WMAA Board of Directors
SPRING MEETING, HSRC

Session III - 2:30 - 3:30 p.m.
Choose one topic for this session.
Memorial Union
800 Langdon Street
G. “The Roadside Geology of Wisconsin” Robert H. Dott,
Jr, PhD, emeritus professor of geology and geophysics
H. “The UW Sports Medicine Experience” David T.
Bernhardt, MD ’89, associate professor of pediatrics and sports medicine
I. “Media, Terrorism and Civil Liberties After 9/11”
Dietram Scheufele, PhD, professor of journalism and mass communication

WMAA AWARDS BANQUET
6 p.m. Reception
7 p.m. Dinner and Program
(Black tie optional)
Concourse Hotel, 1 W. Dayton Street

SATURDAY, MAY 7

BRUNCH FOR CLASS OF 1945
Concourse Hotel

5 a.m. - 2 p.m.
DANE COUNTY FARMER'S MARKET, Capitol Square

2:30 p.m.
CAMPUS BUS TOUR
Departs from the Memorial Union on Langdon Street

6 p.m.
CLASS OF 1985 REUNION
Edgewater Hotel

For more information, please call the Wisconsin Medical Alumni Association at (608) 263-4915.

FRIDAY, MAY 6, 2005

9-9:30 am
DAY ON CAMPUS
Registration and Coffee
Pyle Center, Below Alumni Center
650 North Lake Street
As with every Match Day, emotions ran high on March 17 this year. Danita Tom (above left) appeared thrilled with her residency program match. George Fisher (top right), who retired in March after working with UW medical students for six years, received the "Regular Fellow Award" from the Class of 2005. Kathryn Rodigan (bottom right) also appeared pleased with the match she got.

As if St. Patrick’s Day weren't enough reason for a party, Match Day 2005 fell on the same day this year: March 17. This happy coincidence gave many University of Wisconsin Medical School fourth-year students—and those at medical schools across the country—an additional reason to celebrate.

At approximately the same time from coast to coast (11 a.m. in Wisconsin), anxious students opened their envelopes and learned where they will be spending the next several years in residency programs after they graduate in May.

This year, 40 percent (or 57 students) of the 140 UW Medical School students who matched will enter primary care programs. Twenty-two of those students will enter pediatrics, 17 will train in internal medicine and 15 will go to family medicine programs. Two will enter internal medicine/pediatrics and one will go into internal medicine/primary care.

Twelve UW students matched to emergency medicine programs, nine selected anesthesiology, eight will go to diagnostic radiology and six will head for psychiatry programs. A total of 16 students will enter surgery programs.

Nearly half of the 140 students who matched, 45, will enter residency programs in Wisconsin. Thirty-five of the programs are affiliated with UW Medical School.
The group of students at top hoped for extra luck on the occasion that marked both St. Patrick's Day and Match Day. More smiles were evident as Bryan Fisher (middle left) read his match to classmates. Fred Valles and his family shared their happiness (middle right). Anna Warpinski and Amy Slawter savored the moment (bottom left) and Matt Aren couldn't contain his joy (bottom right).
Founder of the first UW medical student organization

Eugene Weston, MD '55, looks back

by Dian Land

Flash back to the early 1950s, and it quickly becomes clear that the situation for students at University of Wisconsin Medical School and most other medical schools— in terms of amenities surrounding student life and students' ability to participate in their overall education— left something to be desired. Just ask Gene Weston, MD '55.

"We had no student lounge, lockers or a convenient place to eat our brown bag lunches," Weston recalls of his first years as a student at UW Medical School. "When we first mentioned to our professors that we had a few suggestions about the courses that were taught, we were politely told, 'That's our department and you are students.'"

But during a medical ROTC summer camp at Ft. Bragg, North Carolina, between his second and third years at UW Medical School, Weston met medical students who recently had organized student associations at their schools. Upon returning to Madison for the 1953 fall semester, he was convinced that a similar organization was needed at Wisconsin. But it was a relatively novel idea at the time.

"Wisconsin medical students were a bit subdued, just glad to be in school. Under Dean Middleton, our white coats had to be starched and our hair cut short—no pony tails. We felt pretty low on the totem pole and were afraid to speak our mind," he says. "I wasn't a rabble-rouser, but I thought we ought to have some input into a few things."

Students also felt the need for some social activities. "There has to be some fun and joy at medical school," Weston says. "You can't be a study hermit for four years and then expect to go into a community as a well-rounded physician."

Weston enlisted the help of several other medical students, including Wayne Munson, James Brauch, John Simpson, Berniece Vandenbeng, Diane Dahl, Edward Minor and Donald Fink, all of the Class of '56.

"Our first organizational meeting was with doctors Middleton, Schmidt, Meyer and Coon," Weston says. "We proposed several ambitious plans, but were put down a bit by Dr. Schmidt. However, Dr. Meyer encouraged us, and soon WISMA—the Wisconsin Student Medical Association—was born."

Members of the new group were enthusiastic. "We found a place to eat in the 'basement' of the Medical Science Center and soon created a newsletter," he says. "We organized forums on student loans, internships, family practice and obstetrics-gynecology. We also co-sponsored social events, including Field Day, a day-long program of student research paper presentations, awards, scientific exhibits, recreation—all culminating with the popular third-year student skits held at the Wisconsin Union Theater in the evening. The Medichoir, under the direction of 'Doc' Edmonson, often performed."

The students later dared to venture into course evaluations for the first time. "Our input definitely improved the curriculum," Weston says. "We ultimately brought clinical material into the first and second years, especially coordinating anatomy, neuro-anatomy and pathology."

Weston says that since he was "a little ambitious in trying to get the local student group going," he also worked with the national Student American Medical Association (SAMA), which had been founded a few years before in 1950. In fact, he served as a member of the SAMA council of trustees from 1954 to '55, and he chaired the SAMA Reference Committee on Miscellaneous Business.

After graduating from UW Medical School in 1955, Weston did his internship at St. Luke’s Hospital in Denver. He returned to Madison and completed a residency in general, thoracic and vascular surgery at UW Hospital and the William S. Middleton Memorial Veterans Hospital.

After an Air Force-sponsored residency, Weston served as chief of surgery for five years at the newly completed U.S. Air Force Academy in Colorado Springs. He then joined his brother-in-law, John Siebert, MD '55, in Baraboo, Wisconsin, where they built a clinic.

In 1971, Weston moved his family back to Denver in order to focus more on thoracic and vascular surgery. With Charles Mains, MD, he formed Colorado Surgical Services, which now consists of 13 surgeons. Weston also volunteered as an associate professor of surgery at the University of Colorado. He retired in 1990 and continues to do volunteer and mission surgery.
Student leaders past and present compare notes

Last fall, Eugene Weston, MD ’55, founder of the Wisconsin Student Medical Association, took a few moments to meet with Erin Henrich, the second-year student who is the current president of the group, now called the Medical Student Association (MSA). In comparing notes, the two realized that although the organization has evolved in some ways it continues to fulfill its main purpose of representing the interests of all UW medical students.

Made up of elected officers and representatives from each class, the MSA today, as in the past, is involved in many aspects of student life. It oversees the budgets for each student-run organization at the Medical School, coordinates service projects in the greater Madison area and organizes clothing and equipment sales. The group also recently re-vamped its Web site page (http://students.med.wisc.edu/studentorgs/MSA).

“We are involved in many social and entertainment events, things students can do to blow off steam and relax,” adds Henrich. Activities include the month-long Dean’s Cup competition, class parties, TGIFs, and ice skating and sledding parties.

Other events are oriented more toward community service projects, such as, most recently, a bone marrow drive in which 50 students signed up to be on the registry.

Unlike during Weston’s time, however, the MSA works very closely with the Wisconsin Medical Alumni Association but not with the national medical student organization, now called the American Medical Student Association.

The Wisconsin group also represents the student body to the administration. “We have a curriculum committee that works closely with Dean Susan Skochelak, the senior associate dean for academic affairs,” Henrich says. “We also were asked to be involved in planning for the Health Sciences Learning Center, as well as the new learning communities.”

While UW Medical School administrators during Weston’s time may have balked at the thought of student involvement in such school-specific activities, Henrich is happy to report that the current administration eagerly encourages student input.

Erin Henrich and Gene Weston, below, found some differences but mostly similarities in their student organizations. One of the first things Weston and his classmates did some 50 years ago was to publish the WISMA newsletter, seen on the facing page.
"Infections do not stop at border checks"

by Ramo Naidu

Hospital-acquired infections (HAI), or nosocomial infections, have been showcased in the media with headlines warning of the evolution of "the superbug" and flesh-eating bacteria. While these reports have fed the allure of alarmism, coordinated efforts can reduce the morbidity, mortality and economic costs associated with HAI.

The Communicable Disease, Surveillance and Response (CDS-CSR) unit of the World Health Organization European Regional Office (WHO EURO) has recently taken the initiative in creating policies for reducing the transmission of nosocomial infections in its hospitals. Based in Copenhagen, Denmark, WHO EURO works with 52 countries stretching geographically from Greenland to Kamchatka on the eastern edge of Russia.

The regional adviser for CDS-CSR of WHO EURO, Bernardus W.K. Ganter, MD, created a project proposal on HAI surveillance when I worked for the European regional office in the summer of 2003. Dr. Ganter, who left his country of the Netherlands to work with the Pan-American Health Organization in Brazil for nine years before coming to WHO EURO, was instrumental in bringing me to Copenhagen. We have enjoyed fruitful debates on issues related to infection control, and working with him has been a pleasure.

During that summer, as I read through publications I was acquiring through MEDLINE on nosocomial infections in Europe and the United States, I saw a gap in healthcare systems that could potentially be filled by WHO. I had no prior motivation to work on infection control until I became aware of this unique challenge to public health.

It became apparent to me that, while much has been said about the quandary of nosocomial infections, something simply needed to be done on a greater geographic level than divergent local initiatives. What was needed was a process of standardization.

I wanted to examine infections using a horizontal approach, examining the problem by place, issue and other factors, rather than the traditional vertical analysis of studying a specific infection, such as tuberculosis, malaria and HIV/AIDS. With the support of a Fulbright Scholarship and a Herman and Gwen Shapiro Grant from UW Medical School, I have been able to continue my work with WHO EURO over the 2004-05 annum.

Despite the recent attention given to HAI, around the world, they have existed throughout the history of medical science. The first major nosocomial infection surveillance program was developed in 1970 in the U.S., and it evolved with two esteemed University of Wisconsin Medical School faculty members: William Scheckler, MD, and Dennis Maki, MD '67. They worked with the Centers for Disease Control and Prevention (CDC) on development of the National Nosocomial Infection Surveillance System (NNIS), which is still running in a number of American hospitals today.

During the 1980s and '90s, various countries in Europe adopted definitions and guidelines from NNIS and added their own alterations. These decades produced a number of disparate surveillance systems...
with varied definitions, numerators and denominators for assessing HAI prevalence. While the majority of the data is incomparable, a European meta-analysis conducted by WHO suggested that 10 percent of patients admitted into non-psychiatric wards become infected with HAI.

In the spring of 2003, the issue of HAI reached deeper into the public awareness with the spread of SARS. In a May 2003 article in the Taiwan News, the Taiwanese Minister of Health claimed that 94 percent of those infected in his country acquired SARS via nosocomial transmission. Immediately, the WHO asked its regional offices to make HAI infection control and surveillance a priority.

We are currently in the midst of completing the study design and choosing parameters for a survey to be sent to hospitals across the region. The responses will provide baseline data on hospital infection control and surveillance. The European Union has funded a number of projects for HAI and antimicrobial-resistance surveillance (e.g., HELICS, EARSS, ESCMID); from these, we have already acquired considerable data. Beyond the 15 countries that make up the EU, we have information from the 10 expansion countries; however, there is still much to be gleaned in the CIS, or former Soviet states. The CIS is the region we hope to gain the most insight from with this survey.

The survey is designed to be simple yet comprehensive, and will ask questions in two targeted areas: 1) infection control and 2) antimicrobial resistance. The survey responses will help us better gauge the current prevalence rates, risk factors and methods of surveillance. From this baseline, future studies using a permutation of this survey will be able to detect improvement or regression in infection control practices.

Infection control protocols such as the implementation of Standard and Universal Precautions, hand hygiene, waste management, disinfection, isolation procedures and quality assurance must be reiterated, and behavioral changes should be checked. Similarly, medical professionals must cease the flagrant prescribing of antibiotics for unnecessary reasons. The problem of antimicrobial resistance extends beyond the physician to patients, the agricultural industry and pharmacists. In this new millennium, it is not uncommon to buy antibiotics without a prescription in many parts of the world.

The challenges in carrying out this project, beyond biomedical science, are rooted in the politics of the region. Each country must weigh its sovereignty against the goals of United Nations organizations such as the WHO. Communication due to myriad languages and circuitous exchange of information, though greatly improved with the advent of the Internet, is still beleaguered in some areas. Moreover, creating the appropriate legislation and acquiring funding is a time-consuming and knotty process. With its capacity to standardize methods, definitions and statistical variables, the WHO has the ability and respect needed to take a leadership role in reducing the burden imposed by HAI.

I have genuinely enjoyed my time in Copenhagen and the stimulation of my research on this foremost public health issue. Taking a year off of medical school was a welcome change to spending copious hours in a textbook; however, the break from school does not come without the pains of adjustment and challenges in this work.

This is my fourth time back to Copenhagen, and it is no surprise that I enjoy Danish culture, which puts a great emphasis on quality of life. My Danish friends and I meet at cafés after work, and I have met a number of people from all parts of the world at the WHO and in the city.

One of the attractions to the WHO is its diversity—a walk down the hallway offers posters in Russian, debates in Italian, phone conversations in Swedish. Having a language background in French, Italian and rudimentary Russian has helped me in communicating with others and in accomplishing my survey. While the work has been demanding, the stress of it has been lifted by knowing that the project affects millions of people. Those who work here have had fascinating experiences in healthcare, and all seem to be eager to contribute to the WHO atmosphere: a workplace that is a microcosm of the world’s cultures.

Whether I return to WHO in the future depends on many factors, some of which are out of my control. No matter what I plan to specialize in, I always have international health percolating in the back of my mind, so there is always the possibility of one day returning to Copenhagen.
Music to Munch By

“Music to Munch By” is co-sponsored each year by the Medical Students for the Arts (MFA) and the Wisconsin Medical Alumni Association (WMAA). The week-long series, held during lunch time, is an opportunity for medical students to enjoy the musical talents of their fellow students while munching on delicious treats provided by the WMAA.

The mission of MFA is to provide medical students an outlet to express their visual and/or performing artistic talents. MFA and the WMAA received many enthusiastic responses after the first event, held during the holiday season last semester, and have decided to make “Music to Munch By” a feature each semester.

Students, faculty and staff recently relaxed to tunes played by MFA students Lisa Williams and Kelly Mackin (flutes) and Luxme Hariharan and Jeffrey Phillips (piano). The grand piano is a focal point in the HSLC atrium. At left, William Scheckler (right) and his wife Rolliana led an effort to fund the piano with Gordon Tuffli, Class of ’64.
Major research awards
Several University of Wisconsin Medical School investigators won major new research awards between August and October 2004. A few highlights include the following:

Vampire bat saliva as a treatment for stroke

UW Medical School's George Newman, MD, PhD, professor of neurology and neuroradiology, and Ross Levine, MD, associate professor of radiology and kinesiology, are the principal investigators on “Desmoteplase in Ischemic Acute Stroke (DIAS-2),” sponsored by the pharmaceutical company PAION.

The DIAS-2 study is designed to identify the appropriate dosage and effectiveness of a genetically engineered version of a blood clot-dissolving protein derived from the saliva of the vampire bat, Desmodus rotundus. According to the results of an earlier trial, desmoteplase is effective in preventing brain damage from stroke if it is administered between three and nine hours after symptoms begin. Desmoteplase is able to dissolve a blood clot without affecting the rest of the body's clotting system and, apparently, without increasing the risk of intracranial bleeding.

An artificial disk for cervical back surgery

Thomas Zdeblick, MD, professor and chair of the UW Medical School Department of Orthopedics and Rehabilitation, is the principal investigator of “A Prospective, Randomized, Controlled Study of an Artificial Cervical Disc Versus Anterior Cervical Fusion at a Single Level for Symptomatic Cervical Disc Disease.”

In March 2003, Zdeblick and Gregory Trost, MD, assistant professor of neurological surgery, implanted the first PRESTIGE Artificial Cervical Disc System into a patient’s spine to alleviate a herniated disc. Designed by Zdeblick, the system mimics the movement of a real disc, takes pressure off of pinched nerves and preserves the patient’s range of motion. Consisting of two metallic components that are screwed to the vertebrae, the system offers a quicker recovery than traditional methods.

The researchers hope to enroll 20 patients in the trial, which should run for two years.

Tracking fungal infections in transplant patients

David Andes, MD, assistant professor of medicine in the infectious disease section at UW Medical School, is participating in a 25-site study titled “Surveillance of Invasive Fungal Infections in Bone Marrow/Stem Cell and Solid Organ Transplantation Recipients: A Prospective, Multicenter Study.” The Centers for Disease Control has funded the bulk of the six-year study, and 10 pharmaceutical companies have also provided funding.

Researchers in this study will analyze demographic and clinical data about transplant patients to determine what types of fungal infections occur in this population, as well as the frequency of infection, risk factors and treatment options.

This issue is clinically relevant because suppressing transplant patients’ immune systems to avoid rejection leaves them more susceptible to fungal and other infections. Fungal infections—such as candida, aspergillus and histoplasmosis—may range from mild to life-threatening.

New fungal organisms also have been discovered to be a threat because they may not respond to conventional therapies.

Publications

UW Medical School investigators authored 360 publications from August through October 2004. One, described below, appeared in the Proceedings of the National Academy of Sciences.

New tests to detect the deadliest toxin

In an article titled “Using Fluorescent Sensors to Detect Botulinum Neurotoxin Activity In Vitro and In Living Cells,” a team of UW-Madison scientists led by Edwin R. Chapman, PhD, professor of physiology at UW Medical School, described their development of two rapid-fire tests for botulinum toxin, one of the deadliest toxins known to humankind. The tests vastly improve on current technologies to detect the poison. This work could underpin new technologies to thwart bioterrorism and spur the development of agents to blunt the toxic action of the world’s most poisonous substance.

One of these assays can be conducted in real-time compared to days for the old test. It could be deployed to protect the food supply or soldiers on the battlefield, or used by emergency responders dealing with an unknown agent.

The second assay provides a glimpse of the toxin’s action in living cells. This promises a rapid screen for millions of chemicals to see which might inhibit the toxin’s paralyzing effects, potentially leading to the development of drugs that protect against botulinum poisoning.
Patents

UW Medical School faculty and staff submitted 31 patent disclosures between August and October 2004. In the same time period, the U.S. Patent Office also assigned two patents to WARF on behalf of UW Medical School faculty and staff. One of these is described below.

**Improved viewing of arteries and joints**

Walter F. Block, PhD, assistant professor of medical physics at UW Medical School and of biomedical engineering in the UW College of Engineering; Thomas M. Grist, MD, the Robert Turell Professor of Imaging Science at UW Medical School and professor of biomedical engineering; and Aiming Lu, PhD, former College of Engineering graduate student, received a patent for “Vastly Undersampled Isotropic Projection Reconstruction” (VIPR).

Most conventional magnetic resonance imaging (MRI) scanners acquire data on a three-dimensional rectangular grid. In a new strategy, UW researchers are acquiring the data in a series of radial lines within a sphere, as shown at right.

The technique, VIPR, was previously patented with Charles Mistretta, PhD, UW Medical School’s John Cameron Professor of Medical Physics, to image the vascular system following a contrast injection. VIPR generates high-resolution, three-dimensional images that allow a radiologist to visualize anatomy from any perspective—top, side or an oblique angle.

The new patent describes how to exploit VIPR for vascular imaging without a contrast injection or for imaging the musculoskeletal system. VIPR is particularly useful in providing contrast between joint fluid, cartilage, arteries and veins. It also suppresses unwanted information from fat, which often obscures anatomy of interest. This new technology doubles the amount of data that can be acquired during an imaging period.
Nearly $7 million awarded for medical education and research

As reported in the Winter 2005 Quarterly, the Oversight and Advisory Committee (OAC) of the Wisconsin Partnership Fund for a Healthy Future (the Blue Cross program at the University of Wisconsin Medical School) awarded just under $6 million in grants to 33 organizations across the state in 2004.

The overarching goal of the OAC implementation and planning grants is to forge and support community-academic partnerships that will advance the health of the people of Wisconsin.

On a parallel track, the Wisconsin Partnership Fund’s Medical Education and Research Committee (MERC), the other major decision-making committee for the program, also is making major progress. Since its inception in June 2004, the MERC has awarded approximately $7 million for medical education and research programs that also will significantly impact health in Wisconsin in far-reaching ways.

Under the leadership of Paul DeLuca, PhD, vice dean of the University of Wisconsin Medical School, the 19-member MERC is emphasizing five focus areas: innovations in medical education, disease genomics and regenerative medicine, molecular medicine and bioinformatics, emerging opportunities and the Wisconsin Population Health Research and Clinical Trials Network.

Funds disbursed by the MERC last year supported one implementation grant and three planning grants. In addition, with the advice and endorsement of the MERC, four strategic initiative grants were awarded by the Medical School dean. The strategic initiative allocation provides resources to quickly identify and respond to emerging opportunities aligned with the mission and vision of the Wisconsin Partnership program.

The awards include:

One implementation grant totaling approximately $1.25 million per year for three years for innovations in medical education.

This program has an expansive three-pronged mission: to create an innovative curriculum that will give future Wisconsin physicians breadth and depth in population health; to expand the capabilities of the school’s clinical skills teaching and assessment center; and to develop new Web-based and distance learning capabilities.

Three planning grants totaling $330,000

The Survey of the Health of Wisconsin (SHOW) program involving several thousand Wisconsin residents will be a resource providing important insights into the determinants of health in local communities. The Wisconsin Clinical Trials Network will facilitate access for patients across the state to UW Medical School clinical trials across many disciplines. By exploring the molecular basis for human health, the Human Proteomics Program will provide early screening—and improved treatment—for many diseases.

Four strategic initiative grants totaling approximately $3 million

One grant supports the creation of the Medical School’s new Master in Public Health degree program. The second, Making Wisconsin the Healthiest State, analyzes the health status of Wisconsin compared to other states, and will recommend strategies for improving population health. Another grant supports the Wisconsin Alzheimer’s Institute in its efforts to provide early diagnosis, treatment and support for Alzheimer’s patients and their families. The fourth grant, Improving Cancer Care in Wisconsin, will translate evidence-based practices to practitioners statewide with the goal of improving colorectal cancer screening, pain control and palliative care.

The MERC is now reviewing applications for the “New Investigator Program,” which provides support to newly appointed assistant professors with innovative projects promoting the goals and objectives of the Wisconsin Partnership program. Announcement of these awards will occur in late spring.
UW wins $14 million grant
to accelerate clinical research

by Lisa Brunette and Linda Dietrich

Next summer, seven young University of Wisconsin-Madison researchers will break new academic ground by participating in the University’s first multidisciplinary “living lab.” These talented scientists from disciplines across campus will learn how to conduct research outside traditional laboratory settings.

The program is part of the National Institutes of Health’s (NIH) “Roadmap Initiative,” a long-term plan to speed up the pace of new discoveries. One goal is to build a workforce prepared to test diagnostic and treatment approaches efficiently and to move them into healthcare practice as quickly as possible.

A related goal is to develop teams of investigators to bridge the health sciences disciplines.

In carrying out the initiative, the NIH has awarded UW-Madison a $14 million training grant encompassing a wide range of academic disciplines. The university is one of only seven sites that the NIH chose last fall to receive a grant.

Molly Carnes, MD, MS, UW Medical School professor of medicine, is the principal investigator for the program, called TEAM (Training and Education to Advance Multidisciplinary Clinical Research). It primarily involves the UW-Madison schools of medicine, nursing, pharmacy and engineering. Some College of Letters and Science and School of Education faculty also will participate.

“UW-Madison won this grant, amid intense competition, because we already have in place much of what the NIH wants to advance: several strong academic disciplines doing clinical research in one location, institutional efforts to promote different disciplines working together, strategies to involve more women and under-represented minorities in academic clinical research, and a thriving program to train new researchers,” notes Carnes, director of the Women’s Health Research Center and also an affiliate in the College of Engineering. “Our new Health Sciences Learning Center symbolizes the different professions working together more effectively.”

Members of the inaugural TEAM class at UW, who had to be approved by the NIH, will meet in July and will be immediately immersed in multidisciplinary activities. The group will likely be divided into two teams and will begin the summer discovering how to collect and analyze clinical research evidence and learning the fundamentals of clinical trials.

The main coursework starts in September when the teams, working with campus mentors, will learn to collaborate within their group, interact with staff, set timelines, identify projects and develop a focus for their research.

According to Christine Sorkness, PharmD, RPh, a UW School of Pharmacy professor and the program’s director of curriculum, the team approach has proven to be a most successful model.

“These are potential academic stars, but they need to know how to work on projects as part of a team,” Sorkness says.

The teams will have space within the School of Pharmacy’s Rennebohm Hall, in the heart of the west campus, close to the Health Sciences Learning Center and UW Hospital and Clinics.

The program will train clinical research scholars in 10 areas:
• Aging and Geriatrics
• Asthma
• Cancer
• Cardiovascular Disease
• Child and Adolescent Health
• Epilepsy
• Healthcare Environment, Technology and Communication
• Nutrition and Obesity
• Tobacco and Alcohol Intervention
• Women’s Health and Underserved Populations

The program involves 72 UW-Madison faculty mentors who already lead multidisciplinary research teams. Within each area, the program will emphasize research on health disparities and recruitment of under-represented minority trainees.

The five-year grant will support up to 24 research trainees by its third year. The goal of the program is to train these scholars to be competent clinical researchers who are well versed in biostatistics and study design, research ethics, research quality, effective presentation and leadership.

“The NIH Roadmap is one of the most progressive initiatives now under way in health research,” says Carnes. “When this project is completed, we will have trained a new generation of academic leaders who will be competent to design and carry out clinical research so that patient care can be based on sound scientific evidence.”
Tom Rice, representative for the Class of 1945, and WMAA Executive Director Karen Peterson shared the good cheer.

Andrew Braun chatted with Guy Gottschalk (center), member of the UW Board of Regents, and Dean Philip Farrell.

WMAA President Bill Nietert (2nd from left) greeted medical students (l to r) Katie Nixdorf, Sarah Endrizzi and Matt Aschbrenner. Sarah and Matt, Wausau natives, spoke to the audience about what life is like in medical school.
Approximately 70 people turned out on February 24, 2005, for the annual Winter Event sponsored by the Wisconsin Medical Alumni Association (WMAA). The event—which included a reception, dinner and continuing medical educational program—was held at the Westwood Conference Center in Wausau, Wisconsin, for the second year in a row.

"The evening was a great opportunity for alums, students and friends of UW Medical School to get together and socialize," says Karen Peterson, WMAA executive director. "And the educational program was most interesting."

Many alumni drove in from the surrounding areas, such as Tom Rice, MD, 1945 class representative, who traveled from Marshfield, along with guests from Steven’s Point, Rhinelander and Antigo. First-year students Sarah Endrizzi and Jordan Olson drove up from Madison with third-year student Matt Aschbrenner, who hails from the Wausau area. Katie Nixdorf and David Sommerfeld, both officers in the Medical Student Association, also made the trip from Madison.

Two members of the UW System Board of Regents—Guy Gottchalk of Wisconsin Rapids and Mark Bradley of Wausau—also attended, as did Wisconsin Senator Russell Decker and Chuck Sabino, chief medical officer of Aspirus, Inc.

"We were thrilled that these busy people took time out of their schedules to visit with us and learn more about the school and the WMAA," Peterson says.

Before dinner, Bill Nietert, MD '78, WMAA president, moderated a panel discussion titled “Alternative Medical Practice Opportunities.” Nietert had hand-picked the panelists, all graduates of the Wausau Family Practice Residency Program.

Kristin Schuchart, MD, talked about her 14 months at the Kijabe Medical Center in Kenya as a missionary physician. There she supervised Kenyan family practice interns, managed the pediatrics ward and nursery, and performed Caesarean-sections in an outpatient clinic.

James DeLine, MD, described his work with local Amish families. Approximately 16 to 18 percent of his patient visits are with Amish patients, he said. He also has a clinic-based birthing center for the Amish that he’s operated since 1993.

Jim Messerly, DO, works at the Bone & Joint Clinic in Wausau. With a certificate of added qualification in sports medicine, he focuses on low back pain, stress fractures and concussions in local athletes. He also talked about non-traditional family practice opportunities.

"The WMAA is making a big push to reach out to alumni across Badgerland," says Peterson. "We hope to build on our success in north central Wisconsin and hold similar events around the state."

—Continued on next page
WMAA Winter Event in Wausau

From left, Deb Nietert met with Liz Barr, Susan and Gary Zimbrick (both '78) and Ann Fullington at the reception.

Luz Balmadrid met with CME speakers Kristin Schuchart and Jim Messerly, and grad Vicky Baker ('93).

As the event got under way, Jody and Daniel Seybold ('80) visited with Steven and Peggy Nichols.
Paul Gohdes and his wife, Dolores, are enjoying retirement in Tucson, Ariz. They volunteer at a homeless agency and find enrichment in learning activities offered by the University of Arizona. They continue to visit Door County in Wisconsin every other year for family reunions. Visiting their five children and seven grandchildren literally means traveling across the country from Maryland to Oregon.

Mary Herman continues to work as a neuropathologist and senior staff scientist at the National Institute for Mental Health intramural program in Bethesda, Md. It is challenging, she reports, both in diagnostic work and in research in the areas of schizophrenia, bipolar disorder, major depressive illness and neurodegenerative disease. She lives in Montgomery Village, Md., where tennis dominates her free time.

Still practicing primary care internal medicine, but only half-time, Allan Kind lives with his wife, Betsy, in Minnetonka, Minn. “For whatever reason,” he says, “the practice of medicine remains a fascinating endeavor.” They both love traveling to their northern Wisconsin cabin.

Glenn Meyer is a professor of neurosurgery at the Medical College of Wisconsin in Milwaukee, specializing in ear, nose and throat disorders and orthopedics. He recently was awarded the Smallwood Prize by Froedtert Memorial Lutheran Hospital. He and his wife of 43 years, Tizza, live in Dousman, Wis., and are the proud owners of five Icelander horses. The couple has three children and six grandchildren.

Retired since 1995, Frank Murray and his wife, Ione, live in a quaint, small, mountain village on Big Bear Lake in California. He is a member of the board of directors of a large national HMO and currently is engaged in a project to build a large observatory for the U.S. Forest Service.

John Schowalter retired in 2003, but continues to teach five hours a week at Yale University School of Medicine. He and his wife, Ellen, live in New Haven, Conn., and have traveled extensively throughout the winter and early spring, visiting Singapore, Thailand, Cabo San Lucas, Peru and the Galapagos Islands.

Retiring in 2003, Herbert Simonson volunteers for a number of charitable activities in the Phoenix area. He is on the advisory committee of Hospice of the Valley, a tax aide who assists seniors with tax preparation and serves as a mentor at Southwestern University, an osteopathic medical school. He and his wife, Patricia, have four children and five grandchildren.

After practicing orthopedic surgery in the Denver area for many years, James Urban retired in 2000 and is now enjoying life in Rio Verde, Ariz., with wife Robbi. He is a volunteer horticulture aide at the Desert Botanical Garden in Phoenix and is president of the Rio Verde Community Association as well as the McDonald Park Association.

1968

After 32 years in the practice of dermatology, Norman Deffner of Wausau, Wis., retired in September 2004. He recently has made the distinguished lists of “Best Physicians” and “Who’s Who in Medicine.” He and his wife, Jan, are enjoying their family, pets, gardening, fishing and caring for family woodlands.

Michael Ebersold was a staff neurosurgeon at Mayo Clinic in Rochester, Minn., from 1979 to 2001. He now works at Mayo Regional Practice at the Eau Claire Midelfort Clinic and heads the Mayo Alumni Association. He and his wife, Janet, live in Babushka, Minn., and have three children and one grandchild. Michael’s hobbies are skiing, kayaking, biking and boating on the Mississippi.

Kenneth Feldman and his wife, Jane Ann, live in Seattle, Wash., where he is a clinical faculty member at the University of Washington and practices primary care at an inner city clinic. He continues to take pediatric house staff from the Cascade Mountains. He enjoys hiking, biking, and sea and white water kayaking.

After practicing for 22 years as chief of emergency medicine at St. Vincent Hospital in Worcester, Mass., Paul Gramling retired in 1999. Since then, he has written two novels. In 2000, he was diagnosed with Alzheimer’s disease. He is unable to write, but enjoys mail from old friends. He lives with his wife, Kathryn, who teaches nursing at the University of Massachusetts in Dartmouth since her husband was diagnosed. The couple has two children and two grandchildren.

Kay Heggestad lives in Madison with her husband, Paul Wertsch. She reports that she is still in the process of picking a career. She passed board certification in hospice and palliative medicine in 2004. She currently is learning Spanish at Madison Area Technical College (MATC) and will teach a course for certification in the medical assistant program also at MATC. She is on the Council
on Ethical and Judicial Affairs of the Wisconsin Medical Society. She taps dances and is fighting for civil unions for gays, lesbians and trans-gendered people. She and Paul are active in PFLAG (Parents, Families and Friends of Lesbians and Gays). The couple has two children and one granddaughter.

Having been a radiation oncologist, Marcia Stahmann Richards says she saw too many people “who put things off and then wished they had not.” This common regret made her decide not to wait to spend more time with family ... and she retired. Now, she and her husband, Donald Whitaker, travel on two big trips a year; they visit ski condo in Salt Lake six to eight weeks a year. She figure skates almost every day and competes in four to six skating competitions a year, including the Adult Nationals. “Yes, both feet leave the ice on jumps, and I do spin,” she reports, “but jumps are low and spins slow.” The couple lives in Elm Grove, Wis., and has a daughter, one grandson and two cats ... “with frequent flyer cards,” she adds.

Certified with the American College of Physician Executives in January 2003, Kirk Veit “downsized” from being a half-time medical director of Agnesian Healthcare and Fond du Lac Regional Clinic to a quarter-time position as medical director of Fond du Lac Regional Clinic. He is a lead physician in the implementation of Cerner IS System for Agnesian Healthcare, to go live in July 2005. His hobbies include repairing fence lines, enjoying Nautilus workouts at the YMCA and spoiling the grandson. He and his wife, Gloria, have four children.

Tuenis Zondag says that he is in his third career in medical practice. He first was in family practice, then occupational medicine and now pain medicine. He and Barbara, his spouse of 36 years, moved in 2002 from Eau Claire, Wis., to Casper, Wyo. He is learning to fly fish and to explore Wyoming’s vast majesty, such as Teton National Park and Yellowstone Park. The couple still maintains a Wisconsin home in Lake Pepin. Tuenis says that he looks forward to the day he returns to Wisconsin and, at that time, will start sailing.

1983

After completing four years’ medical service in rural Guatemala, Steven Hammer moved back to the United States in June 2004. His humanitarian efforts continued as he set up a clinic in an elementary school functioning under the Good Samaritan Association, a local non-profit organization in the Waukesha, Wis., area, where he lives. He currently is working in an urgent care clinic in Delafield, Wis.

1985

Christopher Patterson left Pennsylvania six years ago to relocate in Spartanburg, S.C., with his wife, Betsy. He currently is attending physician in the areas of long-term care and hospice at centers around Greenville and Spartanburg. In the last two years, he has become board certified in pain management, hospice and palliative medicine, as well as getting recertified in geriatric medicine. He also is serving on the board of the American Medical Directors Association Foundation, a not for profit organization formed to promote education and research in long-term care.

1996

Thomas McIlraith recently began the position of medical director for hospital medicine service at two Sacramento-area Mercy hospitals. Leading a service of 19 full-time and six part-time physicians, he and his staff provide inpatient medical needs at Mercy General and Mercy San Juan hospitals. He probably is best remembered, he notes, as one of the founders of “The Arrhythmias,” a medical school band that gave him his “first experience in physician leadership.”

1997

David Kiefer recently completed a fellowship in integrative medicine at the University of Arizona in Tucson. He currently holds an assistant clinical faculty position there and is editor of herbal medicine teaching modules. He concurrently is an adjunct faculty member at Bastyr University, located north of Seattle, Wash., and teaches a field ethno-botony class in Ecuador through Arizona State University in Tempe.

1999

Molly and Mark Herr currently live in Scottsdale, Ariz. After she finished a fellowship in pediatric anesthesiology and he finished a residency in orthopedic surgery, both from the Mayo Clinic in Rochester, Minn., in 2004, the couple moved to the Southwest. Molly currently practices at Valley Anesthesiology Consultants in Phoenix, where she works primarily at the Phoenix Children’s Hospital. Classmate-turned-husband Mark currently is a fellow in foot and ankle surgery at the Mayo Clinic in Scottsdale. They report that they enjoy the warm weather in Arizona, but are looking forward to returning to the Badger State once Mark’s fellowship is completed.

2000

After completing her psychiatry residency in 2004, Karen Weisensel joined the medical staff at Child and Adolescent Center at Rogers Memorial Hospital in Oconomowoc, Wis. The program offers adolescents an intensive care program of intervention and treatment to address child and adolescent psychiatric disorders.
Get Involved! Regularly Scheduled Conferences

RSCs – What are they?

Regularly scheduled conferences, or what the Continuing Medical Education (CME) world refers to as RSCs, are daily, weekly or monthly CME activities that are primarily planned by and presented to an institution's professional staff. Examples are grand rounds, tumor boards, mortality and morbidity conferences, journal clubs and case conferences.

Can I get CME credit?

Not all RSCs are approved for CME credit. For example, out of the 100 or so RSCs that take place at University of Wisconsin Hospital and Clinics on a daily, weekly, and monthly basis, 49 of them have been approved by the University of Wisconsin CME Office for American Medical Association PRA Category 1 Credit.

What does this mean for me?

If you are a participant in an RSC, you may want to ask the chair of that RSC if it is approved for CME credit. If so, then make sure you receive the certificate that verifies the amount of credit you have earned for attending the RSC sessions. If you are a chair or a participant of an RSC that is not approved, think about getting involved in approving it for CME credit! RSCs require a lot of planning and maintenance to assist educational quality and effectiveness in improving patient care. Check with your institution's CME department or the State Medical Society to find out the process.

Here at the UW Office of CME, we require an application for preliminary approval. Once an RSC is approved, we monitor it for compliance as mandated by the Accreditation Council for Continuing Medical Education (ACCME). This can entail corresponding frequently with the RSC chair and administrators regarding policies and procedures, requesting and reviewing pertinent documents relative to compliance and stopping by for site visits.

While this process seems like a lot of work, the UW Office of CME is willing to help, and in the end, the process will add even more to the educational quality of the RSC. In addition, participants earn credit for their involvement in improving themselves and improving patient care.

Learn more about RSCs and CME

To learn more about RSCs at UW, contact Beth Mullikin, (608) 262-5077, or send her an e-mail at earmullikin@wisc.edu. For more information on all programs, e-mail us at cme@med.wisc.edu or visit the CME Web site: www.cme.wisc.edu.

Conferences—Spring and Summer 2005

<table>
<thead>
<tr>
<th>May 5-6, 2005</th>
<th>June 2-4, 2005</th>
<th>July 23-29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sports Medicine, Madison</td>
<td>Clinical Decision Making in Vestibular and Balance Rehabilitation, Madison</td>
<td>Summer Update in Otolaryngology, Beaver Creek, Colo.</td>
</tr>
<tr>
<td>May 6, 2005</td>
<td>June 8-10, 2005</td>
<td>August 2-6</td>
</tr>
<tr>
<td>Childhood Asthma: Primary Care Update Conference, Madison</td>
<td>Emergency Care and Trauma Symposium, Wisconsin Dells</td>
<td>3rd Annual Comprehensive Pain Board Review Symposium, Madison</td>
</tr>
<tr>
<td>May 7, 2005</td>
<td>June 24, 2005</td>
<td>September 18-20</td>
</tr>
<tr>
<td>Advanced Skills in Airway Management for the Clinician, Madison</td>
<td>Osteoporosis: Answers to the Tough Clinical Questions, Madison</td>
<td>Seventh International Conference on Dose, Time and Fractionation, Madison</td>
</tr>
</tbody>
</table>

Spring 2005
Both Ralph Hawley (left) and Jim Crow, Medical School colleagues in the early 1960s, still attend monthly lunches of retired Medical School faculty.

Ralph Hawley

James Crow, PhD, distinguished geneticist, emeritus professor of genetics at University of Wisconsin Medical School and former acting dean of the school from 1963 to 1965, reflected recently on his experiences with colleague Ralph Hawley, former business manager at the school. Hawley, who also served as long-time executive director of the Wisconsin Medical Alumni Association (WMAA), currently is writing a decade-by-decade account of the WMAA, which celebrates its golden jubilee in 2006. The second installment of Hawley's history will appear in the next Quarterly.

The right person for a tumultuous time

by Jim Crow

Ralph Hawley was the first executive director of the Wisconsin Medical Alumni Association (WMAA), and a great job he did. But that was only a small part of a busy life.

Ralph was closely linked to John Z. Bowers, MD, who was appointed dean of the Medical School in 1955 and served until 1961. It was not a tranquil time. Although Bowers had some good ideas, he did not have the personality, the finesse or the persuasive ability to carry them out, nor was he given adequate financial support. The Medical School soon became embroiled in controversy, which lasted through the whole time he was here and only gradually abated after he left.

One of his first acts was to appoint Ralph Hawley as business manager. It is
one of the best things Bowers did. It was also just possibly the least controversial. Hawley was a university graduate, but he had no medical training. What he did have was a keen intellect, an unusual capacity to keep all sorts of details straight and the patience of Job. Above all, Hawley had absolute integrity. The faculty soon learned to trust him and to come to him with their problems. He soon became the conscience of the Medical School.

In those days the organization was simple enough that one person could handle all the details; at least Ralph Hawley could. He was in charge of finances and all the grants funneled through his office. What a contrast to the complexities of the present!

Ralph soon took on another job. He became the first executive director of the WMAA. The association started in 1956, and Hawley came aboard soon after.

He was always available, thoroughly reliable, highly respected and loved by all. He served for 35 years.

Over the years, as the organization became more complex, he acquired some assistance; yet he handled a large part of the work himself. The organization thrived under his guidance.

When Bowers arrived, he became controversial almost instantly. He thought he had a mandate to upgrade the research activity of the Medical School, and he proceeded quickly to make several appointments. These included a chairman of surgery, who had an excellent reputation, but was unacceptable to the department, which had its own candidate. The entire Medical School faculty became polarized, and feelings were strong.

In the midst of the strife and distrust, the one person who was universally trusted was Ralph Hawley.

Despite being greatly overburdened, he was always approachable. He never seemed too busy to take on another problem.

Ralph’s “office,” if I can so dignify it, was a room in an old wooden house at 418 North Randall. (The house is pictured on page 43 of the winter 2005 issue of the Quarterly.) It was about 100 yards from the Medical School administrative offices, at that time located in the old hospital at 1300 University Avenue. I don’t know how often he made the trip from his office to mine, frequently several times each day. This was always on the run, and always without a topcoat, even in February.

Ralph eventually was promoted to assistant vice chancellor and also associate dean. Now retired, he still enjoys the company of his many Medical School friends, who usually also are retired. He always attends the monthly lunch of retired faculty. He still enjoys a golf match or a poker game.

And he has an astonishing and large collection of jazz recordings, which he can discuss authoritatively. Just try to name a jazz musician he doesn’t know about! Only recently, Ralph sent me a tape with some of jazz trumpeter Bix Beiderbecke’s most inspired performances.

His desk and all other horizontal space in his small office were piled high with papers. In fact, at first entering the room, visitors would find him hidden behind the stack on his desk, but he would be there. He worked long hours, often until late in the evening.
Class Representatives

Eugene L. Weston
Class of 1955

TYPE OF PRACTICE: General, thoracic and vascular surgery.
HOBBIES/INTERESTS: Special interests include being a private pilot for 35 years. I also enjoy golf, computers, travel and medical missions to Bangladesh and Mexico City.

OTHER NEWS: I completed a general, thoracic and vascular surgical residency at UW and University of Virginia in 1960. From 1960-65, I was the first chief of surgery at the U.S. Air Force Academy. I practiced in Baraboo from 1965-71 with my brother-in-law, Dr. John T. Siebert, and built the Medical Associates Clinic there. In 1971, I began a surgical practice in Denver, which I developed with Dr. Charles Mains into Colorado Surgical Services, a 13-man surgical group. I was a clinical associate professor of surgery at the University of Colorado. I have been married to Marge (a former UW orthopedic nurse) for 50 years and we have four children and eight grandchildren.

FACULTY MEMBER REMEMBERED MOST: A single statement by Dr. Ben Lawton, my preceptor at Marshfield Clinic, changed my career. I had indicated that I would like a two-year surgical residency and then to practice in Baraboo. Dr. Lawton said, "If you want to be a surgeon, be a surgeon!"

PLANS FOR A REUNION: We hope to see all of our classmates from 1955 in May for our 50th reunion. You can e-mail me at pilot-gen@worldnet.att.net

Frank E. Murray
Class of 1960

TYPE OF PRACTICE: Internal medicine.
FONDEST MEMORY OF MEDICAL SCHOOL: Musical skits spoofing our professors and ourselves. We had some fine musical talent among us. They made up new words to songs from current Broadway plays such as "Music Man," "My Fair Lady" and "Westside Story."

HOBBIES/INTERESTS: My passions are observational astronomy, astrophotography and astrophysics. I am planning and building an observatory for the U.S. Forest Service.

OTHER NEWS: I am on the board of directors of our local hospital foundation, a substance abuse prevention and rehabilitation center, and a large national HMO.

FACULTY MEMBER REMEMBERED MOST: Dr. Gabrielle Zu Rhein from the Department of Pathology and Laboratory Medicine. She was my mentor in the clinical research I did during medical school.

MESSAGE TO YOUR CLASSMATES: I was one of the very few medical students who was married with children all four years, so I didn’t have the luxury of a social or academic interaction with my classmates. I believe my memories of this have become fonder with time.

PLANS FOR A REUNION: Our 45th reunion will be held in the new Health Sciences Learning Center on May 5. I’ve invited seven of our former faculty, and am hoping for a good turnout.

Sandy Osborn
Class of 1970

TYPE OF PRACTICE: Pediatrics, now I'm the J.D. Kabler Class Mentor for the Class of 2006.
FONDEST MEMORY OF MEDICAL SCHOOL: Week-ends when I could get some extra sleep; graduation, because of the local rioting, and National Guard at the Stadium; all the women in med school getting together at noon to share and encourage each other; some patients I still remember that I met during my clinical experiences.

HOBBIES/INTERESTS: Music: recorder, church choir, hand bells; running (in road races when there’s time); counted cross stitch; international food/American, too—both eating and cooking.

OTHER NEWS: I’ve kept busy with the Wisconsin Medical Society and more recently with the Wisconsin Medical Society Foundation. I look forward to increased activity with the WMMA as president-elect and in a year and a half as president.

FACULTY MEMBER REMEMBERED MOST: Dr. Mortensen in anatomy stands out. Drs. Meyer and Harris in internal medicine and obstetrics too. They were fine teachers with great personalities.

MESSAGE TO CLASSMATES: A brochure will be sent; I hope you can come. I’ll write you a letter.

PLANS FOR A REUNION: We will greet each other at the Dean’s Reception held in the new Health Sciences Learning Center. At that time, you will have the opportunity to tour this beautiful building. If you haven’t already. We will have dinner on Thursday night, get together on Friday during the day and then attend the banquet on Friday night. On Saturday morning we will have breakfast at the Concours Hotel.

Thomas J. Rice
Class of 1945

TYPE OF PRACTICE: Obstetrics-gynecology.
FONDEST MEMORY OF MEDICAL SCHOOL: The excellent teachers we had both in basic science and clinical years.

HOBBIES/INTERESTS: Trout fishing, fly tying and teaching the same. Golfing. I enjoy the woods. Hunting grouse, turkeys and deer with my two boys and grandson.

OTHER NEWS: I have a beautiful wife and we are much together as a family. I practiced ob-gyn for 35 years at Marshfield Clinic.

FACULTY MEMBERS REMEMBERED MOST: Dr. Mortensen in anatomy stands out. Drs. Meyer and Harris in internal medicine and obstetrics too. They were fine teachers with great personalities.

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For me, preparing to write about first-year anatomy class from an alumnus' perspective brought a flood of memories of the very beginning of medical school, 1971. No memory is more vivid than the first day of anatomy lab. Meeting and choosing tank mates was a self-directed process—one that challenged us early to judge compatibility, work ethic, friendship and other qualities in this, our first step in medical education.

Those early days were a mix of fear—of the cadaver and the anatomy classroom—and readiness to begin. I remember the white coats, the smell of alcohol formalin and the hours of preparation for quizzes and exams. Our tank group, like most, developed a technique of reading aloud, watching the designated student move through the text description and dissecting carefully.

Partners stooped over to see the detail of the revealed anatomy, frequently passing the textbook around to make this very much a shared experience. It would be years before I would realize that these collaborative techniques would become some of the most important skills of a practicing physician.

Dr. James Pettersen, emeritus director of gross anatomy, was a wonderful resource for me in writing this article. He recalls the early lecture he gave to each incoming class emphasizing respect for the cadaver as a person to whom we owed a debt of gratitude.

This, after all, was just as much an early indoctrination of doctors-to-be as professionals as it was an education of first-year medical students. Dr. Pettersen remembers the bonding and many long-term friendships that developed as a result of tank group interaction and recalls that several tank partners even got married.

Though it was not a formal activity of the course, some tank groups managed to learn about their cadaver from the hometown physician or from family members and were able to develop clinical correlates to the pathologic findings that they saw. Some even wrote letters of appreciation to family members.

The first day of each new class was a test of nerves—"overcoming edginess," as Dr. Pettersen put it—with remarkably few negative incidents. In Dr. Pettersen's entire career, he recalls only two students passing out at the sight of the cadaver, and one had an anxiety attack because of an approaching examination.

Those early days were a mix of fear—of the cadaver and the anatomy classroom—and readiness to begin.

The tank group's oral quizzes were an important part of discovering the personality of a medical school class. Faculty got to know students. We students got to know professors who were tolerant, patient and forgiving of our mistakes.

Our volunteering answers and helping each other in a daily intellectual exchange would become important learning skills that we could apply forever. I was sad to hear that the oral quizzes were de-emphasized and eventually dropped later in the 1970s.

Dr. Robert Schilling, emeritus professor, class mentor and active alumnus from the Class of 1943, recalled Dr. George Rowe, who became a memorable anatomy teacher after his retirement from cardiology. Dr. Anna Marie Carley, representative for the Class of 2002, recalls Dr. Rowe as being "awesome ... really sharp ... he knew us all by name." She describes how Dr. Rowe presented the material as a living science, with hands-off direction.

Dr. Carley reports that first year rumors portrayed Dr. Rowe as a "tough cookie" before he retired from cardiology, "but we really loved him." He brought his love of anatomy from Washington University in St. Louis, where he taught the subject prior to starting medical school. He served as class mentor for the classes of 1996 through 2002 and all the while continued to teach anatomy, including participation in the fourth-year clinical anatomy elective, until February 2000.

Indelible memories of anatomy labs and lectures and of the professors and my classmates are something I will continue to share with alumni for years to come. I'm excited to learn that the Wisconsin Medical Alumni Association plans to financially support relocating the anatomy labs to new facilities on west campus. I look forward to seeing the move.
One of the first signs of spring, newly sprouted tulips frame the statue of Abraham Lincoln overlooking Bascom Hill.