Summer 1984

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ONE MILLION FOR JEFFERSON
The change in the Charter, establishing “Term Trustees” of the Board of Trustees, increased the flexibility of the Board and facilitated the acceptance of “Alumni Trustees.” Thirteen alumni have served in this capacity since 1965, presently three at a time, each for a three year term with the right of each to be elected by the Alumni to succeed himself. The terms are staggered so that each year a term is ended and a new Trustee is elected. The Alumni Trusteeship was the outgrowth of the desire by the Alumni to have a voice in shaping the policies of the Medical College. Its forerunner was the Alumni Advisory Council made up of nine nonaffiliated Alumni, who were elected by vote of all the Alumni. The Council met twice a year, interviewed students, faculty and administration, met with board members and rendered a report. The Council disbanded following three years of activity when the Board agreed with its recommendation that there be Alumni representation. The establishment of University status in 1969 changed the title of the Board from Jefferson Medical College to Thomas Jefferson University with well-defined areas of governance including Jefferson Medical College (JMC), Thomas Jefferson University Hospital (TJUH), the College of Graduate Studies (CGS) and the College of Allied Health Sciences (CAHS). The present Alumni Trustees are James E. Clark, ’52, Sheldon Gilgore, ’56, and now my successor, Paul A. Bowers, ’37. (see p. 6)

The six years of my two terms as Alumni Trustee have permitted a working relationship with students, faculty, administration and board members. The members of the board are a very choice group of persons, selected, with a great variety of individuals, for their personal achievements, integrity and ability to serve. Each Trustee completes, yearly, a conflict of interest statement. Frederic L. Ballard, Esq., Chairman, Gustave G. Amsterdam, Esq. and Mr. Edward C. Driscoll, Vice-Chairmen, ably guided us. The administrative matters of the entire University are masterfully brought to fruition and presented to the Board by President Lewis W. Bluemle, Jr., with the capable assistance and regular reports of the Deans of the Medical College, by Dean Jussi Saukonen (CGS) and Dean Lawrence Abrams (CAHS).

Mr. Michael J. Bradley, Vice-President for Finance, and Mr. John F. D’Aprix, the recently appointed Vice-President, play very important roles. The Vice-President for Health Affairs and Hospital Director, Francis J. Sweeney, Jr., ’51, who managed all matters relating to health services with a strong and knowing capability, has recently accepted a similar position at Temple University. The President of the Hospital Staff, who was automatically a member of the Joint Conference Committee, was invited to attend the meetings of the Health Committee (Paul J. Poinsard, ’41). Subsequent to the disbandment of the Health and the Academic Committee the President of the Staff (John Y. Templeton, III, ’41, and presently Warren P. Goldburgh, ’52) was invited to attend the regular monthly meetings of the Board where the material of these former committees is presented.

It is impossible, in this short article, to cover all the important subjects which were reviewed by the Board in this six year period; however, the following will present some idea of the scope of the items which were considered.

A Task Force for Planning, made up of members from the board and faculty, accomplished a comprehensive report of plans for the future of the University with a resulting main theme: “Jefferson is an Academic Health Center and should not attempt to be a comprehensive university.”

The Medical College suffered the resignations of two deans due to health, Dean
Jefferson Scene
An interview with the new Dean, Joseph S. Gonnella, M.D., leads a series of news items including the Alumni Achievement Award recipient.

44x2+40=Reunion 1984
Two classes graduated in 1944; here, as they celebrate their 40th reunion, they reminisce.

Reunion Clinics
John J. Gartland, M.D. 'S44
Anthony V. Coletta, M.D. '79
John J. Brooks, M.D. '74
Harris R. Clearfield, M.D. '59
Anthony J. DelRossi, M.D. '69
Paul A. Kennedy, M.D. '39
John E. Riffe, M.D. '64
Edward J. Saltzman, M.D. '49
Appearing at bottom left is
Harold L. Israel, M.D. '34

Class Notes
Norman G. Loberant allows us to see a kibbutz from the inside in the Class Note Special.

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the new dean

By any standard, the selection of Joseph S. Gonnella, M.D., as Dean of the Medical College has been touted a success, and success, standards and evaluation are all terms which Dr. Gonnella uses when speaking of his fascination with medical education.

A member of the Jefferson faculty since 1967, he became Associate Dean of Academic Programs in 1969. That same year, he was appointed Director of the Office of Medical Education, now called the Center of Research in Medical Education and Health Care. Since 1970, he and his staff in the Center have statistically followed the students through Jefferson, their internships and residency programs.

"In medical education," he said in his office in the College, "links are important. When you know past events and future goals, you can begin to prepare for the final question. Are you preparing these people for the right mission?" "I don't think any school, and I include my alma mater, Harvard, should be more proud of their graduates than we at Jefferson. And we have the data to prove it," he continued. "We need to exhibit more pride in our programs and students."

Dr. Gonnella's interest in medical education began at the University of Illinois, where he served as Chief Resident in Internal Medicine and later earned an appointment as Instructor in Medicine in 1965. His early research interest dealt with the analysis of competence on examinations (capability) and competence in real life (performance).

When he came to Jefferson in 1967, Dr. Gonnella addressed the issue of how to monitor educational programs. Question: Do the students like Jefferson? Clue: How well do they perform? Schools do, in general, pay attention to clues, he says. Clues are gathered, first, by examination and observation of the students; second, determining the students' satisfaction with the environment; and third, by the National Board results and types of internships selected by students. Jefferson, he noted with pride, is the only medical school in the country which adds a fourth method of monitoring the educational process: a Longitudinal Study to determine how our graduates are rated in the clinical world of their internships/residencies. Since the National Board scores of Jeffersonians are consistently well above average, and they are given high grades by both program directors at other hospitals and by patients, the Dean feels it is safe to assume that Jefferson graduates are excellent clinicians.

Although the facts and figures to prove that Jefferson produces good physicians have been verified by the reputation of Jefferson's alumni who practice across the country, Dr. Gonnella wants more. "A physician should be a fine clinician," he told the audience at the Dean's luncheon in June, "but a physician must also be a teacher to the patient; he must give information and, somehow, enable that patient to understand the information. The physician must be a manager as well. He, or she, must ask the following questions of himself, is this effective, is it efficient, is it appropriate?" Dr. Gonnella sees the prospective reimbursement system as an opportunity for students to prepare themselves to become efficient managers. "A physician, as he progresses professionally, should address all of these issues," he stated. "Physicians, ideally, should develop managerial capabilities during the undergraduate, graduate, and postgraduate training periods. My primary responsibility is, of course, to the graduate (medical school years), but I also feel an obligation to the other areas. Therefore, changes in all phases of the educational system can be expected."

Dr. Gonnella views "communicating with machines" as a necessary tool which enables the physician to store and retrieve information of immeasurable value in the treatment of patients. "Wouldn't it be nice," he asked, "to be able to push a button and see a patient's complete record at a glance? To learn that she is not allergic to penicillin, as she thinks, but to erythromycin? To make sure that you don't order a test that has already been done?"

"Presently, the computer is used primarily for billing and maintaining records of payments. It can be used, however, to record social history, biological characteristics and, simultaneously, introduce a system which will rank the medical problems most likely causing a patient's manifestations." He admits that the development of adequate programs for diagnostic purposes will take years, but insists that communication with machines will be important to the physician as both a clinician and manager.

"Since I am now coordinating the residency program at TJUH, I want to place more emphasis on the development of the physician as a teacher and a manager. The closer one moves to that world beyond the hallowed halls of education, the better manager one must be."

He has always encouraged students
to "reach" for their residencies. Even though they may prefer to stay at TJUH, "the best way for us to be known is to export our best products. We want to infiltrate the medical field."

"It's always a mistake to exaggerate," he said, "but in the area of education, Jefferson is among the very best. The dilemma is that the outside world doesn't want to use more than one ruler to measure medical schools. We always want to look at the simple thing," he said. "H.L. Mencken once said that for every complex problem there is a simple solution, which is often wrong.

"Sociologists evaluate medical schools through the analysis of responses to mailed questionnaires. In these evaluations, the ruler used over the past 30 years has been research. Which school educates the Nobel Prize winner? Who writes the textbooks?" He feels it is unfair to compare apples to oranges.

"The primary obligation of a medical school is to graduate outstanding physicians, and if they do more, that is above and beyond their primary purpose."

"During my tenure as Dean, I would like to see Jefferson Medical College excel in research as well. To achieve this we must recognize and build on our strengths. Our strength lies in the fact that, year after year, we graduate physicians valued by both program directors and patients. That is a tradition that I am committed to follow."

Another of Jefferson's strengths is the physician on the faculty. "We have maintained the clinical model at Jefferson," he stated, "but every time a physician allows a student to participate in the examination and evaluation of a patient, the physician is slowed down. And this," he said, "is why we need to reward those who are willing to give this valuable time. We have to use our people wisely."

To review education in general, he uses an analogy. "I see education as a pill, and the teacher, like the physician, should be a good diagnostician. The physician doesn't just say, 'Take this pill,' but he says when it should be taken, how often, what are its side effects, and how does one know that it is working?"

"A good teacher, like a good clinician, makes a diagnosis before beginning treatment. Ideally, a student's capabilities should be evaluated prior to the beginning of a course. It is usually quite safe to assume that the first-year student doesn't know too much about anatomy, but as the student progresses, the assumption of the teachers should be tested at the start of educational programs (whether classroom or clinical clerkship activities). In addition, the best way for students to appreciate what the teacher has in mind is to become familiar with the kind of evaluation used in that particular course."

"After the original assessment, the teacher, like a good physician, might decide to change strategy. It may be decided that the class is so heterogeneous that one game plan will not suffice. What was thought to be a single class turned out to be, in fact, five different groups, each needing a different program."

"Unfortunately," Dr. Gonnella said, "a teacher is equated with an information clerk, while, in fact, he is there to clarify, to stimulate," he continues. He feels that the day of the teacher serving as a reader because he is the only one with a book should have gone out with the Middle Ages.

"Those responsible for planning a curriculum need a road map," Dr. Gonnella said. "Once you have a road map, you need to formulate hypotheses. If we want to graduate knowledgeable, skillful and compassionate physicians, we must provide them with certain knowledge, certain skills and encourage them to adopt proper attitudes. These are the promises we have made, and we must now ask ourselves, 'Are we delivering?'"

"Who judges?" he asks rhetorically.

"The faculty. They must ask themselves, 'Are our graduates being identified with those characteristics that should have been instilled in them during medical school?' In my opinion, the longitudinal study is the best way to document that we have, in fact, achieved what we set out to achieve. Are the students skillful? Are they knowledgeable? The only way, so far, to tell is from examination scores and from patient evaluations. We have documented the fact that the better the
clinician, the better the chance is that he or she will not abuse, by overuse, the laboratory. Four years of medical school is not enough time to observe and gather data, so it is important to continue monitoring the graduates through their residencies," he says. Another link.

Dr. Gonnella is pleased with the many contributions of the affiliated hospitals. He would, however, like to have the programs consolidated so that each clinical department has four major affiliates. He is also impressed with the results of the Penn State accelerated program and, because of the high cost of medical education, he will ask the faculty to consider expanding it and perhaps even initiate another such program with the University of Delaware.

Dr. Gonnella is looking forward to working on these programs as well as the other responsibilities and pleasures of the Dean's office. "I have been here for a long time; I know where the problems are, and I have the staff, both here in the Dean's office and also at the Center, who are accomplished in their own right. We identify the problems, analyze them from all points of view, and then we make compromises, which shows that there is no simple truth."

Of his decision to come to Jefferson in 1967, he says, "It was a serendipity, I suppose. What would have happened, had I gone to another medical school with my interest for evaluating medical programs? Suppose the graduates had not been found competent. Would I have been allowed to share that kind of longitudinal study data with the outside world? I think not."

Comments from the faculty, alumni and students have proved one simple truth: There has been much acclamation for the new Dean. "Good to know the reins of leadership are in such capable hands." "This decision has unified the volunteer and full time faculty as no other issue in my memory." "The task, the honor, the man, all worthy company." "The new Dean is the best teacher I ever had."

Perhaps the serendipity is Jefferson's. We think so

research

Robert C. Gallo, M.D. '63, Director of the National Cancer Institute's Laboratory of Tumor Biology at Bethesda's National Institutes of Health, headed a team of specialists from NCI and three eastern universities who have identified a virus thought to be the primary cause of AIDS.

The Department of Health and Human Services, which supported the research, said the discovery might also make control of AIDS feasible through the development of a simple test to detect infected blood.

A vaccine is expected in two to three years. First, researchers must mass produce the virus so that there are sufficient quantities of antibodies; then, they must begin human trials. Subjects would be vaccinated, not with the whole live virus, but with the envelope protein of the virus.

Treatment is the ultimate goal, says Gallo in an article in American Medical News. "By making an antibody to an antibody — basically a more effective antigen — we might induce the type of immune response that eliminates the virus. If we could knock out the virus early on, it is possible that someone with the disease could be benefited."

Edward Brandt, M.D., Assistant Secretary of Health in the Department of Health and Human Services says, "I would tell current AIDS patients that the discovery may not be of direct benefit to them. But it opens up for the first time, the real possibility that we will be able to develop an intervention system."

The discovery, according to an article in TIME magazine, will enable doctors to attack a disease that has resisted all attempts at treatment and prevention: 43 percent of AIDS patients die within a year of diagnosis; no one has been known to recover. "This is the step that everyone has been waiting for," proclaims NCI Director Vincent DeVita, Jr., M.D.

TIME said that researchers had spent decades trying to determine if viruses played a role in human cancers. By the 1970's, most had given up, but he persisted. From the beginning his interest lay in the world of viruses. He was helped by the discovery in 1970 of an enzyme that is unique to retroviruses, a kind of chemical fingerprint. By looking for this enzyme, Gallo was able to hunt down a retrovirus that causes a form of leukemia and lymphoma in humans. The discovery of this virus, called human T-cell leukemia/lymphoma virus, or HTLV, won Gallo a 1982 Albert Lasker Award, the top prize in American medicine.

The AIDS discovery occurred almost simultaneously with French scientists' announcement that they, too, had isolated the virus. Regardless of which came first, or whether they are the same virus, French immunologist Daniel Zagury of the University of Paris credits Gallo with initiating the first investigations into the disease.

alumni achievement award

For the first time in its 114 year history, the Alumni Association of Jefferson Medical College has conferred its most coveted award — the Alumni Achievement Award — posthumously. The alumnus who received this honor is Abraham E. Rakoff, M.D. '37 (1913-1981).

Burton L. Wellenbach, M.D. '44, Clinical Professor of Obstetrics and Gynecology, spoke of his teacher, mentor and friend at the annual Alumni Banquet June 7 at the Bellevue Stratford Hotel. He praised the selection committee for their "wisdom" in choosing Dr. Rakoff, "a great teacher who taught well."

"He loved to teach" began Dr. Wellenbach, "projecting the most complex infertility, endocrine and neuro-endocrine concepts in clear concise and understandable terms. Coupled with this outstanding ability was his warmth and empathy and his caring for the young medical student. His lectures were consistently well attended and enjoyed. He believed his role as educator was not only to convey knowledge but to act as a catalyst for the students, so that they, in their own way, would be more active scientifically and become more involved in
Abraham E. Rakoff, M.D. '37

clinical and laboratory research.”

Dr. Wellenbach cited the recipient for his original research on Trichomonas and Monilias and his knowledge in the fields of cytology reproductive endocrinology and infertility. With diligent work he became an outstanding cytologist following the publication of the monumental study by Dr. Papanicolaou.

Dr. Rakoff graduated in 1937 with honors and shortly after published the first paper on the combined use of the hormones estrogen and progesterone to help salvage threatened abortions. This was the beginning of his outstanding research which resulted in 150 articles, chapters in 22 books and co-authoring of two books.

His accomplishments and contributions in the area of medical education and administration are widely recognized. Dr. Rakoff served as President of the American Society of Cytology, the Philadelphia Endocrine Society and the Jefferson Alumni Association during its centennial anniversary year. The class of 1964 selected the Professor as its choice for the honor of the portrait presentation.

The endocrine residency in the Department of Obstetrics and Gynecology remains a most sought after appointment. Dr. Rakoff was its leader and founder. Presently there are over 60 physicians throughout the world who served as his residents. The Associate Dean of the University of South Carolina, the Emeritus Professor of Obstetrics and Gynecology at the University of Buffalo and the Director of the Division of Reproductive Medicine at the Medical College of Georgia are some of the outstanding residents taught and counseled by the Professor.

“In anyone’s lifetime,” continued Dr. Wellenbach, “there are many trials and tribulations. So it was with the Jefferson Medical College and its family. In those moments of crisis, be it the problem of town versus gown, or members of the staff having personal problems (The Impaired Physician) Abe Rakoff was the person chosen to either lead the group or personally intervene on someone’s behalf. This is best exemplified in that he was elected the first President of the Volunteer Faculty at a time when our University needed a respected, responsive and altruistic leader.”

Dr. Wellenbach concluded the presentation by saying “those of us who were fortunate enough to know him, work with him and have him as their mentor will remember him as a person with great sensitivity, great warmth and selflessness. In his quiet, humble manner, he offered leadership, inspiration and a sense of dedication. To his wife, Doris, his sons, Jan, Jed and Todd, and their wives and children, it is with warm, deep feelings and love that the Alumni Association of Jefferson Medical College bestows the honor of the Alumni Achievement Award of 1984 to Abraham E. Rakoff.”

Jed Saul Rakoff, son of the late Professor, accepted the silver tray for his family. He told the appreciative audience that the same qualities that were true of Abraham Rakoff as a teacher “carried over without change or diminishment into his family life. My father was the most faithful man I’ve ever met,” he said. “His loyalty, next to his family, went to Jefferson Medical College and to the Jefferson Community. What was true in 1937 I know was true in 1981.

“In my imagination, I still talk to my father every night,” he said. “When I talk to him tonight, I know he will be embarrassed but very, very grateful.”
alumni trustee

Paul Applegate Bowers, M.D. '37, is the new Alumni Trustee, elected by ballot last spring after recommendation of the Alumni Trustee Committee. Dr. Bowers, Emeritus Professor of Obstetrics and Gynecology, was first appointed to the faculty in 1946, and named full Professor in 1971. He was Chief of the Section at Philadelphia General Hospital and past President of its staff, but most of his career has been spent at Jefferson.

Dr. Bowers has served as President of the Obstetrical Society of Philadelphia and as Chairman of District III of the American College of Obstetricians and Gynecologists, of which he is a Fellow. He is also a Fellow of the American College of Surgeons.

He was President of the Jefferson Alumni Association in 1973, and has been a member of the Association's governing board since 1946. Dr. Bowers brings extensive knowledge of both the Medical College and the Alumni Association to the Board of Trustees.

Another new member of the Board of Trustees is Jerald L. Stevens, President and Chief Operating Officer of the Vanguard Group of Investment Companies. He is also a Trustee of Bryn Mawr College and the University City Science Center. A graduate of Yale University with a Master's Degree from Harvard Business School, Mr. Stevens served for six years as Vice President for Finance and Administration at Yale.

senior portrait

Teachers know that the most meaningful praise they can receive comes from their students. In presenting his portrait to the College, members of the senior class have paid Robert J. Mandle, Ph.D., the supreme compliment.

Friends, family, colleagues and students of Dr. Mandle filled McClellan Hall on June 1 for the presentation, and were welcomed by Guy M. Stofman, M.D. '84, Class Representative and Chairman of the Portrait Committee.

A creation of artist Beki Williams, the portrait depicts the Professor of Microbiology in front of a screen on which mushrooms are projected. Dr. Mandle may be Jefferson's greatest source of information on mushrooms and fleshy fungi, a subject of keen interest for him, as he demonstrated in the cover story in the Fall 1983 issue of JAB.

Miss Williams selected the kinds of mushrooms used in the portrait, as well as the color of Dr. Mandle's coat, so the portrait has a rosy glow that lends itself well to the brick wall in the lobby at Jefferson Alumni Hall, its temporary location.

Jussi J. Saukkonen, M.D., Dean of the College of Graduate Studies, accepted the portrait for the Medical College. He said that Dr. Mandle was the first person to introduce him to Philadelphia and to Jefferson. He called him the "conscience of the faculty," one who has been instrumental in solving or soothing "thorny" issues that have arisen over the years.

A full professor here since 1965, Dr. Mandle received the Christian R. and Mary F. Lindback Award for Distinguished Teaching in 1979. That same year, he served as President of the Eastern Pennsylvania Branch of the American Society for Microbiology. He has been active on the Admissions and Promotions Committees, and has served as Chairman of the University Committee on Art since Dr. Andrew Ramsay retired in 1972. During his short speech in which he thanked the class of '84 for the honor he also expressed gratitude to his department. "Teaching is not a one-man show," he says. "This is an award for teaching and interest in students. Our department has always had the philosophy that the reason we're here is to help in the education of medical students.

"We've maintained the small laboratories, in spite of the Jefferson and nation-wide diminution on the emphasis on laboratories. The reason is that it's one time when students get a chance to know at least one faculty member really well. With 19 or 20 in a section, if you teach two sections, as I do, you should know 40 students each year. By the same token, they also learn that teachers put their pants on one leg at a time and that we are not all demons.

"The department has a role in that they have allowed me to do what I've wanted to do. Certainly the Chairman (Russell W. Schaedler, M.D. '53) in the last 17 years has been very supportive of me."

Mandle also knows many students because he gives most of the pre-laboratory directions which includes about half of the class. Here, a closer relationship is possible than in the formal lectures where the entire class meets. It's an informal time, and he likes it, teaching them about the technical operations and trying to bring in background material.

According to Harry L. Smith, Jr., Ph.D., Professor of Microbiology, and one of Mandle's first students at Jefferson, Mandle has a great variety of interests, including plants, people, animals, art—an enormous scope. He brings this enthusiasm to the classroom and laboratory. Always the teacher, he was involved in scouting for years, and has seen 25 young men attain the rank of Eagle Scout under his tutelage.

Dr. Mandle's undergraduate work was accomplished at Lebanon Valley College, after which he went into the Navy. When he returned three years later, he worked as a technician in the laboratories of the Rockefeller Institute, then located in Princeton, New Jersey. There, he became interested in virology with the help of his two "scientific godfathers," Wendell Stanley and Armin Braun. "They taught me the philosophy of experimentation, the philosophy of science."

His doctoral thesis at the University of Pennsylvania was on the physiology of organisms that cause crown gall, a cancerlike disease in plants.

He spent a year at the University of Delaware, working with Dr. Henry Stempen; both men came to Jefferson 33 years ago. Twenty years ago, Dr. Stempen left to join the faculty at Rutgers University, and Dr. Mandle
took his place teaching mycology. Since then, he has taught virology and bacterial physiology, also, continuing his research on micro-organisms that cause disease.

Dr. Smith, who punctuated his commentary on Dr. Mandle with slides of his boyhood and college days, and with humorous remarks, maintains strong professional ties with his mentor as well as strong personal ties with the whole Mandle family. He told the audience that Mrs. Mandle, the former Barbara Converse, “is a beacon, who guides and supports the family,” which includes Henry C., Robert J. Jr., Paula and Mark M. “Their family is very close,” he says; “They enjoy each other’s company.”

Mrs. Mandle accompanied her husband to Quito, Ecuador, four years ago, where he taught diagnostic mycology at Catholic University on a Fulbright Scholarship. They learned the language well enough to be understood — “Spanglish,” he calls it — and traveled after his three courses were completed. The Mandles have been to the area before, visiting the Galapagos Islands, and have returned since then.

In accepting the portrait for the Board of Trustees, Lewis W. Bluemle, Jr., University President, said: “Every once in a while someone comes along who is so close to the institution that he becomes part of the image.” He said Dr. Mandle is that person, “a thoroughly nice man, and the steward of Jefferson’s culture.”

**CGS award**

“Eileen Randall is a nationally recognized authority on clinical microbiology, a delightful, dynamic person, and one who has continued her interest in Jefferson,” said Russell W. Schaedler, M.D. ’53. Dr. Schaedler had nominated his former colleague for the 1984 Distinguished Alumni Award of the College of Graduate Studies Alumni Association presented at the annual banquet on May 4.

Dr. Randall was a part of the Jefferson campus from 1950 until 1973, in the capacities of student, clinical microbiologist and Associate Professor. She still thinks fondly and often of her years here at Jefferson, recalling that during her last year she and Robert J. Mandle, Ph.D., Professor of Microbiology, were instrumental in developing the Clinical Microbiology Program in the College of Graduate Studies’ Department of Microbiology.

She began her teaching career at Jefferson as a graduate assistant, and when she left 23 years later was Associate Professor in the Departments of Microbiology and Pathology. From 1955 until 1973, she was also a clinical microbiologist at TJUH.

At the present time, Dr. Randall is Director of the Division of Microbiology in the Department of Pathology and Laboratory Medicine at Evanston Hospital in Illinois. She is also Associate Professor of Clinical Pathology at Northwestern University School of Medicine in Chicago.

**luscombe lectureship**

The First Annual Herbert A. Luscombe M.D. Visiting Lectureship was presented Friday, April 27, 1984, in the Solis-Cohen Auditorium of Jefferson Alumni Hall. Speaking on “Skin Signs of Systemic Disease, Update 1984,” was Irwin M. Braverman, M.D., Professor of Dermatology at Yale University School of Medicine.

Welcoming remarks by Lawrence C. Parish, M.D., Clinical Professor of Dermatology and Chairman of the Visiting Lectureship Committee, identi-
fied Dr. Luscombe as the obvious choice for this honor.

Some of the details revealed in a brief biography by Charles H. Greenbaum, M.D. '54, Clinical Professor of Dermatology, included the fact that Dr. Greenbaum's father taught Dr. Luscombe when he was in graduate school at University of Pennsylvania. This was after Dr. Luscombe graduated from Jefferson in 1940 and finished his term with the Army in 1946.

Returning to Jefferson in 1949, he was appointed Chairman of the Department of Dermatology ten years later. He served as President of the Medical Staff in 1973 and was presented with a portrait "from friends and colleagues" in 1977. Dr. Greenbaum credits Dr. Luscombe with bringing the best of dermatology to Jefferson.

honors etcetera

Salman Akhtar, M.D., has been promoted to Professor in the Department of Psychiatry and Human Behavior.

Juan J. Arentsen, M.D., has been promoted to Professor in the Department of Ophthalmology.

Samuel H. Ballam, III, has been appointed University Treasurer. He comes to Jefferson from IU International, where he was manager of cash and banking. Mr. Ballam will be responsible for all banking activities, including borrowing and investing, and will serve as the University budget officer.

Anatole Besarab, M.D., has been promoted to Professor in the Department of Medicine.

Lewis W. Blumenle, Jr., President of the University, has been elected to the Board of Directors of Telefex Incorporated.

Michael J. Bradley, C.P.A., Vice-President for Finance of TJU, has assumed the additional responsibility of Acting Director of TJUH assuming the responsibilities of Francis J. Sweeney, Jr., '51, former Vice-President for Health Services, and Hospital Director.

Mr. Bradley came to Jefferson in 1973 as Chief Financial Officer, and was promoted to Vice-President when he was 35, making him the youngest person in the University's history to serve as senior officer. He has recently been elected President of the 900-member Metropolitan Philadelphia chapter of the Healthcare Financial Management Association (HFMA).

Seung-Yull Cho, M.D., Ph.D., arrived at Jefferson in March to start his six-month fellowship with the Center for Research in Medical Education and Health Care. Dr. Cho is Associate Professor and Chairman of the Department of Parasitology of the College of Medicine, Chung-Ang University of Seoul. While at Jefferson, he plans to concentrate on undergraduate evaluation and the use of computers in medical education.

John J. Cox, M.D. '45, is Honorary Clinical Assistant Professor in the Department of Medicine.

John J. De'Tuerc, M.D. '38, is Honorary Clinical Professor in the Department of Surgery.

Richard E. Goldberg, M.D. '62, has been promoted to Clinical Professor in the Department of Ophthalmology.

Burgess Gordon, M.D. '19, is Honorary Professor in the Department of Medicine.

Allan M. Lefer, Ph.D., Professor and Chairman of the Department of Physiology, recently received a three-year Distinguished Scholar award from Ciba-Geigy Corporation, which he will use to fund his research in cardiovascular physiology. Dr. Lefer is one of four recipients nationwide.

Lawrence J. McStravog, M.D. '45, has been named Honorary Clinical Professor in the Department of Otolaryngology.

Sheila A. Murphey, M.D., Director of the Division of Infectious Diseases and Assistant Professor of Microbiology, was misidentified in the Curriculum article in the Spring issue of JAB. She is Clinical Associate Professor of Medicine, not Clinical Professor.

James A. Spath, Jr., Ph.D., has been promoted to Professor in the Department of Physiology.

Brendan P. Teehan, M.D., has been promoted to Clinical Professor in the Department of Medicine.

Paul Walinsky was promoted to Clinical Professor in the Department of Medicine.

reunion week

For five days in June, the classes ending in four and nine returned to Jefferson, to listen and learn and to enjoy their reunions in an atmosphere of friendship and comraderie.

Beginning Tuesday evening, the 5th, with a welcoming cocktail party, which was an even greater success than last year, class members renewed acquaintances in the flowering garden of Jefferson Alumni Hall.

The Clinic talks on Wednesday, 11 in all, began with a presentation by Dr. Anthony V. Coletta for his fifth reunion, ending with Dr. Harold L. Israel's talk for the 50th. Eight of these papers are printed in this issue. (see p. 19)

Immediately following the Clinic Program Dr. Joseph S. Gonnella hosted his first Dean's luncheon in Jefferson Hall cafeteria. It was his initial opportunity to address the alumni and to review with them his visions and plans for the Medical College. Reviewing the State of the College he presented the strengths of Jefferson as he perceives them and some of the problems. He shared the excitement of his office with the 350 guests.

Traditions are part of that afternoon. By special invitation 22 of Jefferson's Emeriti Professors were present to greet their former students. Also, the senior students and their alumni fathers were cited by John J. Dowling, M.D., President of the Alumni Association. This year there were 39 such relationships.

That evening nine of the classes had
individual parties throughout the city. The 25th was a black tie dinner dance in the ballroom of the Academy of Music and the 50th was a dinner at the Barclay Hotel. For the first time, Carpenter’s Hall, in Society Hill, set an unusual and elegant stage for the 35th. The 5th and 10th met on Saturday evening.

While the CME seminars were well attended a small but enthusiastic group of spouses and others traveled by bus to Longwood Gardens Thursday morning.

And finally on Thursday evening the traditional alumni banquet was held at the Bellevue Stratford Hotel. Following opening remarks by Alumni President Dowling, and the invocation by Reverend Edward C. Bradley, M.D., ’55, the class of 1984 was introduced, standing to acknowledge the applause of their new colleagues.

The Alumni Achievement Award was given posthumously to Abraham E. Rakoff, M.D. ’37, by Burton L. Wellenbach, M.D. ’44, and was accepted by Dr. Rakoff’s son, Jed Saul Rakoff. (see p. 4)

J. Wallace Davis, M.D. ’42, Chairman, announced the attainment of the million dollar goal for the Annual Giving Fund and expressed his gratitude, on behalf of the entire Alumni Association, for the work of the Alumni Office and Mrs. Joan E. Schott in particular.

Ronald S. Leopold, chosen speaker for ’84, masterfully took his class as a patient through the four years at Jefferson. Concluding his treatment program Dr. Leopold said, “National Board Testing was ordered for the patient following earlier treatments and clearly therapeutic levels were obtained. Successful treatment was assumed at that time and the patient was given the opportunity to receive elective procedures and treatments. After ten of these it was decided to discharge the patient. The patient’s chief complaint of: ‘I want to become a doctor’ was presumed cured.

“The patient is being discharged on June 8, 1984 with outstanding results. It is presumed that the patient will continue outpatient therapy and an internship has been arranged to care for the patient during the first year following discharge. Discharge instructions include routine Hippocratic Oath.”

The new physician concluded his remarks by saying, “I, all of us, recognize the gravity of this moment. I submit to you the Jefferson Medical College Class of 1984 for your approval. I hope that you will accept us openly into your Alumni Association. Though we are all too aware of the rigorous standards and formidable responsibility of membership I ask only for your unbiased consideration. I hope that you will find us worthy.”

Thus ended the 1984 program.

class day

For the past 20 years seniors have had a day separate from the Commencement Exercises in which to honor their own. This year Class Day for the awarding of honors and prizes was scheduled for June 7 in McClellan Hall.

Dean Joseph S. Gonnella, presiding, introduced the day’s speakers: Magee Professor and Chairman of the Department of Medicine, Willis C. Maddray, M.D., and Senior Speaker, Ronald S. Leopold. Both were chosen by the class.

Dean Gonnella stated that 212 graduating seniors had all received outstanding residencies. One hundred and thirty-one or 62% went into primary care programs: 75 into internal medicine, 36 into family medicine, 12 in pediatrics, eight in obstetrics and gynecology. Thirty-nine chose surgery as their specialty.

“This is hardly a solemn occasion,” he said, “but neither should it be taken lightly. You have too much invested here to avoid the serious and important implications of what you have done. Tomorrow you will walk up on that stage, and in a brief moment you will become physicians—not just graduates, physicians.

“Then suddenly,” he said, “it will come together. Everything you have learned at Jefferson will be meaningful, and you will be eternally grateful for the hours, the days, the weeks, the months and the years of studying. Suddenly,” he said, “it will all be worthwhile.”

Dr. Gonnella announced that starting July 1, Carla Goepp, M.D., assumed the title of Associate Dean of Student Affairs and Director of the Office of Counseling and Career Planning.

Later in the program, the Christian F. and Mary R. Lindback Awards for Distinguished Teaching were announced. The sophomore class chose Joye Faith Jones, Ph.D., Assistant Professor of Microbiology, for the Basic Sciences Award. The seniors voted for Joseph F. Majdan, M.D., Instructor in Medicine, for the Clinical Sciences Award.

The Alumni Prize, given to the student with the highest cumulative record was awarded to John W. Spurlock, AOA, who will be at Walter Reed Army Hospital next year. The William Potter Memorial Prize in Clinical Medicine for highest achievement was given to Newton E. Kendig II, AOA, who will go to Strong Memorial Hospital in Rochester, New York, for his residency. The Philip and Bella Medoff Memorial Prize for a member of the Hobart Hare Medical Society recommended by the Magee Professor of Medicine for excellence in internal medicine was awarded to Deirdre M. Collins, AOA, who will be a resident at Duke University Medical Center next year.

The Leopold Goldstein Memorial Prize in Obstetrics and Gynecology for the highest average in that discipline, went to Frederick J. Cook, AOA, who will stay at Jefferson next year. The Clinical Surgery Prize was awarded to Thomas L. Carter, Jr., who also will serve his residency at Jefferson. The Orthopaedic Surgery Prize, sponsored by John J. Gartland, M.D., was given to Charles F. Leinberry, Jr., who goes to Allentown Affiliated Hospitals next year.

The Obstetrics and Gynecology Prize was awarded to John W. Spurlock, and the Henry Keller Mohler Memorial Prize in Therapeutics to Francis R. Colangelo, AOA, who will
be at the University Health Center of Pittsburgh next year. The Arthur Krieger Memorial Prize in Family Medicine was awarded to Kyle L. Forsyth, who will serve his residency at The Bryn Mawr Hospital. The Hyman Menduke Research Prize to the student demonstrating excellence in research went to Raymond J. Petrillo, who will go to the University of Connecticut Health Center.

**commencement**

The Philadelphia weather continued to be hot and muggy, but the Academy of Music was nevertheless a comfortable and impressive setting for the 160th Commencement of Jefferson Medical College.

With Robert J. Mandle, Ph.D., as Grand Marshall, the seniors were led onto the stage and down to their seats. From there, they were able to see the full and colorful regalia of the department chairmen and faculty members who had taught and influenced them over the past four years.

They received their diplomas from Lewis W. Bluemle, Jr., M.D., President of the University, nodded their respect to the faculty, and shook hands with the new Dean, Joseph S. Gonnella, M.D. As they left the stage, they received their green hood, and walked back to their seats physicians, with a new set to their shoulders and a new perspective.

Gowned in bright yellow, complimenting Dr. Gonnella's crimson robes, Willis C. Maddrey, M.D., Magee Professor of Medicine and Chairman of the Department, administered the Hippocratic Oath, and the new doctors vowed their allegiance to it.

Parents, wives and families were asked to stand and be recognized, and were applauded vigorously by their graduates.

Three honorary degrees were conferred, including an Honorary Doctor of Humane Letters to John A.D. Cooper, M.D., Ph.D., President of the Association of American Medical Colleges, who gave the Commencement Address.
In his speech, "Where is the Future?" Dr. Cooper outlined some of the advantages and disadvantages of the medical profession. In answer to the critics who complained of the rising costs of medical and hospital care he blamed not greedy doctors or inefficient medical care centers, but rather the general inflation, the growing population of older citizens who require more care, and the higher costs associated with more effective medical care. In spite of the problems, he is optimistic for the future:

"You are entering a great profession, one in which an overwhelming majority of its members continue to assert that if they were starting over again they would choose the same career," he said. "This affirmation of their career choice is not found to nearly the same degree in any other profession or occupation. So you should feel reassured that you have made the proper selection of your life's work. Your opportunity to have a rewarding and meaningful life is assured.

"Today, you and I will receive a degree from a very distinguished university and medical school. Over its 160 years, this institution has been rich in history and in its contributions to American medical education and medicine," he said.

The Honorary Doctor of Science was conferred upon Sidney Weinhouse, Ph.D., internationally known scholar and cancer researcher, Emeritus Professor of Biochemistry and Former Director of the Fels Research Institute of the Temple University Medical School. Biochemistry Professor George F. Kalf presented the recipient.

The Honorary Doctor of Humane Letters was conferred upon Francis Clark Wood, M.D., Emeritus Professor of Medicine at the University of Pennsylvania, former President of the Research Committee of the American Heart Association, former President of the Association of American Physicians, and former President of The College of Physicians of Philadelphia.

Also graduating at the Academy of Music was the College of Graduate Studies. Ten members of the class were awarded the Doctor of Philosophy Degree, six members earned a Master of Science in Clinical Microbiology, and one member earned a Master of Science in Industrial and Environmental Toxicology.

**jefferson relationships**

Alumni father-graduate pairs included: Thomas L. Carter '56 and Thomas, Jr.; Charles E. Cole '56 and Daniel J.; Arthur N. DiNicola '57 and Maribeth M.; Robert F. Early '52 and Robert F.; Philip Escoll '52 and Andrew J.; John R. Evans '50 and Richard C.; Lawrence Flick '42 and Pamela; Joseph Robert A.; Harry L. Smith, Ph.D. '57 and David A.; Frederick W. Floyd '58 and Mary F.; Robert E. Stoner '53 and Richard S.; Charles T. Storn '55 and Randle H.; Raymond M. Wargovich '54 and James D.

Grandfather-father-graduate relationships include: Frank S. Bakewell '09, Frank S. '52, and Brock K.; Philip Clair '26, Henry S. '58, and David L.; Joseph M. Dolphin '15, J. Murray '46, and Basil; Franklyn C. Hill '15, David I. '57, and David W.; George C. Meikle '36, Charles E. '60, and Robert W.; Sidney Rosenblatt '18, Alfred '55, and Michael S.; Frank A. Wolf '10, Frank A. Jr. '53, and Lisa C.

Lincoln H. Snyder's great grandfather,
During the year between September 1943 and September 1944, medical students at Jefferson walked to classes and marched to drill practice in the full uniform of the Armed Forces. Most of them were in the Army, some in the Navy, and all could think of better ways to spend their time. But they gamely complied, parading up 10th Street early each morning to the cheers and applause of neighbors hanging out of their windows.

With so much on their minds, these recruits saw little appeal in the military regimen. However, the Army had taken charge. Uncle Sam wanted physicians, and was willing to pay their tuition and wait until they had finished medical school. If a student had refused, he would probably have been drafted anyway, so the best course of action was to follow the rules.

One graduate of S44 is John J. Gartland, James Edwards Professor of Orthopaedic Surgery and Chairman of the Department who was a speaker at the reunion clinics (see page 19). Dr. Gartland remembers the rules, the regimen and the rigamarole.

"Looking back, we had a lot of fun," he said, puffing on his pipe, "but at the time it seemed pretty silly." Talking in his office in the old Curtis Clinic, he said it was a good thing that the Army did take over, because if it had waited for volunteers it would have been disappointed. He remembers fondly the gentleman in charge, Lt. Colonel Frederick H. Mills, in whose office he and other students felt comfortable enough to lounge with their feet up. He said the Colonel was not nearly as unreasonable as the young officers assigned to Jefferson—"Pin-Brains," as he called them.

Some of the "Mickey Mouse" he remembers took place during the week they spent in New Cumberland, after the military had come to stay, but he can't forget the barracks at Carlisle, either.

Here, he says, they "learned how to boil water and use a Lister Bag. I don't think the Lister Bag had been used since the Civil War." Then they endured survival tests, and an obstacle course where the men had to cross an open field with bullets flying over their heads. "I guess they were using blanks," he says now, "but we sure stayed close to the ground."

Afterward, at Fort Meade, Maryland, he gave physicals, and worked his way up to Captain. Then, his responsibility was to oversee other Army personnel giving physicals. "They rolled them through just like an assembly line," he recalls, and was more than a little distressed that some of the Army personnel wore their stethoscopes behind their ears!

Of the years at Jeff four decades ago this September, he has mixed thoughts. "It wasn't a professionally stimulating experience," he said; "the ones graduating ahead of us got more." He paused for a moment and added: "I was on the shipping list for Japan. When they dropped the bomb on Hiroshima, I was packed to go."

As one who graduated ahead of him, and who did go to Japan, Burton L. Wellenbach, Clinical Professor of Obstetrics and Gynecology, was not overwhelmed, either. J44 graduated a semester ahead of schedule, while S44 graduated a full year early, both accelerating classes and losing vacations to satisfy requirements. He feels his education was lacking, because so many of the faculty had left for the Armed Forces.

He, too, remembers the kindly Colonel Mills and the Marches at 10th and Lombard. "It was a nuisance," he says, "but we figured we had to do it, so it was hilarious." Recalling that different students were chosen to lead the troops at those drills, he laughs at the choice of Bill Mills, "the most laid-back guy you'd ever want to meet," who marched them into the street or into walls.

Of the New Cumberland experience he has vivid memories. Apparently the theme of the week-long indoctrination
was to prepare these men for war, but there was a noticeable lack of interest on the part of the recruits. They wanted to show the men films on venereal disease and other basic medical films, said Dr. Wellenbach, but he chose instead to take a couple of books out into the sunny fields and read on his own.

One of the most amusing parts of being at New Cumberland was the departure. Classmate Sam Kron could not return to school with the others because of his feet. Everyone had to be in full Army-issue uniform, and Kron’s feet were too big for any of the boots. When he asked how long it would take them to find a pair in his size, 14AAA, he was told six weeks. Fortunately, he was able to persuade them to release him, three days later, wearing his own shoes.

Dr. Wellenbach served three consecutive nine-month hospital appointments and then went on to Fort Sam Houston in San Antonio, where he said they had excellent teachers. When they told the men they might go overseas, he thought to himself, “This is it. I’m never coming back!” He did not apply himself to his studies, hoping that if he failed the tests he wouldn’t be sent. Four weeks after being inducted, he was shipped to Japan.

There was not a great deal of medical activity for an OB/GYN man in Japan, so he was asked to do circumcisions, first on local newborn babies and then on paratroopers. When the wives of servicemen arrived, he was transferred to Yokohama for a year, where the practice of OB/GYN truly flourished. He proudly admits to delivering the first American baby of Army personnel in Japan, and still has the picture. While not permitted to fraternize with the Japanese people, he traveled to some of the rest areas, and learned to ski at what would have been the site of the 1940 Olympics if they had not been cancelled because of the war.

Several members of the two classes added comments to their questionnaires concerning the war years at Jefferson and the years since. William H. Gehron, Jr., J44, who practices urology in Williamsport, Pennsylvania, says: “I always felt that our classes in 1944 were a little closer than the average class. We endured the heat of the summer of 1943, and in spite of everything would get down to the Jersey Shore. We were all quite aware that we were going to be in a war! This was well borne out in my duty in the Pacific Theater where I often met men from September ’44, especially when I was attached to the base in Oahu, Hawaii.”

James T. Wong, J44, who is an obstetrician and gynecologist in Honolulu served with Dr. Wellenbach in Sendai, Japan. Also, they were residents together after the war. Of the years at Jefferson he wrote that he “had good comradeship” and he still has many friends from that period. “My experiences at Jefferson were outstanding and memorable. Our teachers were the best. Our futures during the war were very unstable, but later nearly all of J44 and S44 did very well.”

Unlike Dr. Gehron, Dr. Wellenbach did not think that the two classes were any closer than any other junior and senior class, but felt a particular closeness to his own class because of the small size. “I knew everyone’s first name, and last name, what school he went to and where he was from.”

One classmate he knew better than others was Dr. Kron, mentioned earlier, who is a general surgeon at Pennsylvania Hospital and Albert Einstein Medical Center—Daroff Division. During their senior year, they practiced the forerunner of the present “scribe” system at Jefferson, with one taking notes for the other when hospital schedules conflicted with classes.
After an internship and pathology residency, Dr. Kron was assigned to an Army transport bringing service men, patients and dependents to and from Japan, Okinawa and the Philippines. He said it took 18 days to make the crossing, and since he was the only doctor for 2500 passengers, a singular thought lodged itself in his brain: "Who's going to take out MY appendix?"

John A. Martin, a radiologist in Roanoke, and Clinical Professor at the University of Virginia, notices changes in the past four decades. "There's a gradual but very substantial improvement in quality control in the medical profession," he writes, "particularly in 'who does what to whom.' Truly amazing technological advancements, particularly in my own field of radiology, are seen, with the related need for the practitioner to be continually re-educated." Of the climate regarding the military services, he says there was "a willing acceptance of a need to be involved, tempered by a welcome relief from school expense." He adds, "Our experience was softened in the A.S.T.P. by Colonel Mills."

A letter from John C. Kelleher, a plastic surgeon in Toledo, and one of the speakers at the reunion clinics, included an anecdote concerning William H. Shull, and the time he was grounded for not saluting an officer. "It was a warm day, and Billy was standing at the entrance to the College waiting for a class. He wore his military cap tilted back on his head, his tie loosely unfastened, and the collar of his shirt open, with his fatigue jacket unbuttoned and hanging on his shoulders. He also had a cigarette dangling from the corner of his mouth. At that moment, a staff car pulled up at the curb in front of the Walnut Street entrance and a bird colonel stepped out. He went up to Billy and said, 'Soldier, where's the ROTC Office Building?' and Billy jerked his thumb saying, 'Up the stairs... second floor.' At that the colonel said to Billy, 'Do you realize what rank I am?' Billy said, 'Yes, sir,' and the colonel said, 'Then come to attention and salute, and put that cigarette out!' Billy promptly came to attention, put out his cigarette and saluted the officer. He was then asked by the officer to follow him up to Colonel Mills' office for the appropriate chastising and grounding. This kept Billy close by for several weeks!

"It was a great period of time with Julian Brantley, Hubert Turley, Scooter Gragg, Billy Shull, Bert Jacobson, myself and many others who went to Stone Harbor on weekends. We did have a great time down there, and enjoyed that final year at Jefferson a little more than we might have, because of the Army supplied spending money."

President of the Class of J44, Edward J. Murphy, an obstetrician and gynecologist at Bryn Mawr Hospital, could not, for the life of him, remember why he had chosen to serve in the Navy rather than the Army—he was one of only 30 to do so—but an explanation from John Gartland might provide a hint. According to Dr. Gartland, the reason more men didn't go into the Navy was because the physical was so rigorous. "The Army didn't turn down ANYBODY," he says. The reason those who selected the Navy did so, he opines, was because the uniforms were much better looking. "The girls in the bars were very impressed."

One thing Dr. Murphy remembers well, because it happened so often, was that when John Kelleher sat in the front row of "The Pit" he was passed up, hand over hand, to the back row. Apparently Dr. Kelleher didn't mind this, because he continued to sit on the
Dr. Murphy recalls that Kelleher won a football game at Notre Dame with a field goal.

He said that the summer of '43, when they were all in uniform, was not "the most academic of summers." It seems a great deal of time was spent at the 40's version of Doc Watson's, Chassey's — in the case of the Navymen, no doubt, impressing the local girls.

President of the Class of S44, T. Frederick Weiland, a radiologist in Grove City, Pennsylvania, particularly remembered the drills.

"After we all joined the armed forces and then returned to Jefferson in uniform there was a lucid interval during which life went on exactly as before. Before long, however, somebody in the Army decided that it would be best for us to practice marching. The time selected was almost before dawn at some South Philadelphia playground. We marched for months, but we were never worth a damn. Very few could keep in step, less than half remembered the commands, and few cared because nobody wanted to be there. Our skills at marching remained about the level of the first time out. A slight improvement one week almost always forecast regression the next.

Colonel Mills was a fine old gentleman, called out of retirement to head our unit. He never came to the drills, but frequently asked about our progress. His young officers had a very good thing going and knew it. They were sitting out the war in Philadelphia, performing the little housekeeping chores of the A.S.T.P. unit. They always told the Colonel that we were coming along just fine and were shaping up into a very fine unit. Without seeing us march, the Colonel scheduled a military review and invited the press. Some of us began to wonder if horrid marching could possibly merit court-martial.

"On the day of the review, we marched according to our usual standards, and perhaps slightly better — in a word, horrible. At all the practices we marched to the cadence of a sergeant yelling, 'hup, hup, hee, four.' But at the review we had music by a military band, played on a record player through a loud speaker. Fortunately, the record slipped constantly on the turntable, changing the pitch and tempo of the music continuously throughout our performance. Our audience did not consider it unusual, under the circumstances, for everybody to be out of step. Some even felt sorry for us. Nobody was court-martialed, but the junior officers saw to it that we never had another review."

Dr. Weiland remembered one freshman year incident more distinctly than others. "When we were freshmen at Jefferson, I was eager to witness the drama of expert medicine practiced by the renowned physicians at my medical school. I was impatient that I should have to go through two years of Basic Sciences before I could have an opportunity to participate in such a great experience. Our first exposure to something remotely clinical came in Dr. Randle C. Rosenberger's bacteriology lab. We all received a series of six intradermal tests with various allergens: our first exposure to needles and clinical testing.

"We went to the front of the room, one lab table at a time, got our shots, and then returned promptly to our work. All went well for about the first third of the group. Then I heard a terrible thud and looked around to see Milton Kite lying flat on his back, apparently unconscious. I was worried for Milton, because the sound made when his head struck the floor had convinced me that his injury must be
TRIVIAL PURSUIT QUIZ

1. Why are Merritte W. Ireland, Class of 1891, and James C. Magee, Class of 1905, important to Jefferson's wartime history?
2. Who said, "He who would become a surgeon should join the Army and follow it"?
3. What was S44's military unit?
4. What was Jefferson's unit in Cairo called?
5. Who was the Professor of Military Science and Tactics who replaced Colonel Strome?
6. Who led the clinical pathology discussions at The Pennsylvania Hospital?
7. What professors' names come immediately to mind when "Pine Street Chest" is mentioned?
8. What was the "Jefferson Dust Bowl"?
9. What were the exact dates of Jefferson's J44 and S44 graduations?
10. What was the tuition then, and what made it special?
11. What percentage of the two classes are Pennsylvania residents?
12. What member of the Class of J44 is Olympic ski material? (information provided by Dr. Wellenbach) Hint: He is a prolific writer.
13. Who has the most sons graduated from Jefferson?
14. What member of the Class of S44 likes to make latch hook rugs and dollhouse furniture?
15. Who managed to deliver 300 babies at home in his first town practice after leaving the service?
16. Who has the most children of anyone in either class?
17. How did some class members spend their $56 a month spending money from the Army during that last year at Jefferson?
18. Which class has the most similar-sounding names?
19. Who said this, and when? "The fact that we are in a gigantic war does not relieve physicians of a serious threat from Federal Legislative bodies."
20. How many members of the two classes returned to Jefferson for their 40th reunion?
missed some education due to our ‘tomorrow we may die’ attitude and lacking some outstanding professors who were in the military.

"However, I am the luckiest guy in the world. I’ve had a loving childhood, wonderful, warm parents, excellent education, successful family practice, respect in the community, wonderful daughters, healthy grandchildren, excellent health and happiness, marvelous friends, and the most loving wife in the world. Who could ask for a better life?"

Frederick A. Resch, who has retired from his practice of family medicine in Canfield, Ohio, couldn’t see any difference in the relationship between these two classes and any other two. “My memories of Jeff during the war would be that there was a sense of urgency to complete our studies and prepare for the military. There was a sort of euphoria in spite of the times; there was an esprit de corps that has always existed for Jeff students and graduates.”

C. Lee Liggett, obstetrician and gynecologist in Kerrville, Texas, says that “Medicine has changed considerably since we took the Hippocratic Oath in 1944. It does not necessarily reflect on the schooling nor the individuals participating in the schools since that time, as much as there seems to be a change in the way people live today compared to the 40s’. Only time will tell how effective our efforts to live the oath we took has been to add to the well-being of society. Whatever has been accomplished, I hope we can reflect and give credit to the institution which made our efforts possible.”

The compiled answers to the questionnaires reveal little difference in the two classes, except that J44 graduates have more children. They also have more varied specialties and more kinds of hobbies, while S44 members hold more faculty appointments. Forty-nine of the possible 111 members of the Class of J44 responded (44 percent), and 47 of the possible 115 members of the Class of S44 responded (40 percent).

Of these, in both classes, the majority of practitioners were in family medicine, with J44 having four retirees and S44, three. A little under half of

J44 classmates (from left) Irvin M. Gerson, William H. Gehron, Jr., and Robert W. Balin, catch up on news.
each class had overseas assignments during or after the war, and J44 held more variations of rank.

Close to 45 percent of J44’s respondents hold faculty appointments, almost 90 percent hold hospital appointments, 73 percent are Board Certified and 70 percent are, or have been, active in medical associations.

Sixty percent of S44’s respondents hold faculty appointments, 93 percent hold hospital appointments, 76 percent are Board Certified and 80 percent belong to medical associations.

The Class of J44’s 49 respondents have 184 children, compared to S44’s 163 for 47 respondents, 3.7 per graduate compared to 3.4 per graduate. Of these children, 16 of J44 fathers, and 14 of S44 fathers have either become physicians or are in medical school. For 10 of these in J44 and nine in S44, that medical school is Jefferson.

Although only seven members of both classes are completely retired, many others have hobbies and interests outside of their practice. Golf, fishing, skiing and tennis are the favorite sports, and photography, gardening and travel are the most popular leisure activities. J44’s John B. Movelle lists his hobbies as “everything,” and S44’s Charles E. Hough says his are “excessive.”

As a whole, the graduates of both classes have successfully fulfilled their aspirations. John Bland, presently an Associate Professor of Medicine at the University of Vermont, may have foreseen this in his class history note: “We leave Jefferson with a curious contentment and a great confidence in the future, knowing that we are capable and able men...and will serve our country and our profession to the utmost. Our future looks rather well planned for us and we leave mightily charged with tomorrow.”
It is not unusual these days to hear colleagues report that they are advising young people not to pursue a career in medicine. Is that gratuitous advice sound and valid, or is it not?

I propose to debate for you the proposition "The M.D. Degree, Would You Do It Today?" I shall present arguments favoring the negative side followed by arguments favoring the affirmative. At the end I shall give you my answer and ask you to consider yours. Arguments to support the negative side are quite easy to find and generally concern the economics of medicine. It should not be lost on you that the strength of the negative arguments resides in economic impact.

Our questioning young people must be told that there is no question that profound changes can be expected to occur in the medical care system over the next decade. These changes will be forced on medicine by society because it can no longer afford to pay the costs associated with the present system. As a result, this nation is now shifting its emphasis from access to care, quality of care and improved technology to cost limitation as the driving force in its attitude toward health.

Most people in the United States have their medical costs covered by some third party payor in full or in part. This is as true of the persons covered by Medicare or Medicaid as the individual covered by an employer's health insurance policy. If medical care costs nothing or very little, why be economical if you do not save any money for yourself? Few involved in this process, patient, hospital, insurer or doctor have given much serious thought to a day of reckoning, a day when the piper would request payment. As could, and should, have been predicted, the day of reckoning has arrived. The piper has presented his bill and is now awaiting payment.

The United States is now spending 13% of its federal budget on health care. This portion of our budget represents the third largest budget in the world, ranking just behind the total budgets of the United States and the Soviet Union. Who is believed responsible for health costs? As far as the public is concerned, hospitals and doctors are. Nineteen percent of the medical care dollar now goes to the doctor and the public sees physicians as doing better than them economically. It is no wonder, then, that health care costs are an issue the public is ready to attack.

I believe we must inform our questioning young people that the past in medicine, as we knew it, is gone and will not return. The next decade will be confusing and unhappy for many physicians. Primary considerations will be given to the reduction of medical care costs by methods that will infuse less money into the system. We will see decreased physician incomes and a variety of new and untried health delivery systems tied to a variety of payment schedules. The real losers in tomorrow's medical care system, however, may not be doctors but rather the poor and the aged.

The unique characteristics of our present medical care system are derived from the unusual nature of the doctor-patient relationship. The new and mostly untried alternate health delivery systems we can expect to see in the future carry with them the potential to seriously disrupt or alter this relationship and our young people must be told about them.

At the present time, physicians and hospital administrators are keenly aware that a vigorous plan is afoot to modify our health delivery system by means of a pricing mechanism known as D.R.G.'s. Up to now, doctors have controlled the majority of decisions affecting patient care. DRG's will impact on these traditional decisions by strengthening the hospital administrator's role in the system. Many unpleasant possibilities have been predicted to follow wide implementation of the DRG system. Because a comparatively large number of services
Dr. Garland, S44, with classmate C. Lee Liggett, M.D.

are used to treat patients in certain DRG's, the specter of "winners and losers" at the business office arise. The fear is there could be selective recruitment of "winners" accompanied by an attempt to restrict access of medical care for DRG "losers." Because of these changes in medicare payment rules, hospitals may grant exclusive privileges to those doctors who are efficient in recycling patients promptly and attempt to deny staff privileges to those doctors whose financial "report cards" are in the red.

To aggravate matters further, some federal legislators doubt that costs can be controlled unless both hospitals and doctors are part of the same economic package. It appears quite likely that, at some later date, DRG's will include the costs of the attending physician plus all hospital based physicians. Such a change will surely increase friction between doctors competing to obtain a share of the funds that are certain to be limited in amount.

It has been estimated that by 1990, 50 percent of all hospitals in this country will be of the for-profit variety. A real concern for all of us is the understanding that in for-profit hospi-

citals critical decisions affecting patients and communities must be made within the context of protecting the interests of stockholders. There is reason to believe that when monetary interest is formally thrust into the medical care system, the public interest suffers significantly.

A projected future surplus of physicians will make it easier for entrepreneurs to hire doctors to man various alternate medical care delivery systems such as Emergicenters, Urgicenters and Doc-in-a-Box. To the extent these employers are nonphysicians dedicated to a bottom line mentality, medical care can be expected to become less professional.

Some portions of industry are beginning to look upon health care as a golden opportunity to make money. In their view, they see health care as an acceptable business which is rapidly growing, is recession resistant and for which there is a universal and constant need. What we should note with alarm is that nothing is said in any of these entrepreneurial inspired health delivery systems about physician competence or quality of care.

What our young people may have to confront is a future of corporate financing for medical care controlled by conglomerates with a primary interest in return on their investment. These systems represent a clear move away from M.D. control and represent a wave of anti-professionalism which is promoting cheap fast ways of providing health care. If corporate control of medicine does materialize, our future doctors' ability to function as the patient's advocate will be seriously compromised.

Arguments to support the affirmative side continue to exist as before but their visibility has been clouded by the public attention given to the economically based negative arguments. Accepting to time limitations, I propose to present only two arguments in support of the affirmative side. The first, "The need to be a patient advocate," is an altruistic reason and the second, "For the sheer excitement of it," is a more personal reason.

Tomorrow's physicians, more than ever before, will have to be dedicated to becoming vigilant patient advocates in order to preserve the quality of care and the patient's right to access to care, particularly the poor and the aged. Constant vigilance will be required to prevent unwise cost containment policies from reducing the quality of medical education at all levels.

A recent study by the Brookings Institution states that any measureable reduction in the growing cost of health services can be accomplished only by rationing medical benefits. The authors of the report claim that only by denying medical benefits can expenditures be restrained. If society should choose budget limits, who will make the critical decisions if we are not actively involved as physicians?

Our questioning young people must be advised that physicians must look beyond their scientific boundaries from time to time to examine the world around them. The challenges promised for medicine in the coming decade will carry a new excitement. More than ever before medicine will need capable people to become participants in the debate and active patient advocates, not just spectators as so many of us have been in the past.

From a purely scientific and professional viewpoint, the next decade promises to be the most exciting time ever experienced by medicine and the best of our young people should be advised to come aboard for the sheer excitement of it. In spite of their preoccupation with the cost of health care, an overwhelming majority of the American public not only believes that scientific research is an effort worth supporting but that government funds for basic research should be increased by a sizable amount, even in this era of tight federal budgets and soaring deficits. There is an understanding between most of the public and thoughtful physicians that biomedical research today determines medical practice tomorrow. John Naisbitt reminds us in Megatrends, "Biology will be to the 21st century what physics and chemistry were to this century." This interaction between a solid funding base and expanding
Organ Transplantation: State of the Art at Jefferson

Anthony V. Coletta, M.D. '79

The science (and art) of organ transplantation is rapidly advancing upon a new era. Selective immunosuppression, advanced surgical technique and clinically applicable biotechnology are striking bold new paths in a field born in the innovative minds of men like Joseph Murray, David Hume and Thomas Starzl.

This article will briefly review the immunobiology of transplantation, and then discuss renal, hepatic and pancreatic transplantation, highlighting Jefferson's efforts to advance to the forefront of these exciting, expanding fields.

Immunobiology of Transplantation

The major histocompatibility complex of genes which codes for the HLA cell surface antigens, those antigens that distinguish "self" from "non-self," are located on the sixth human chromosome.

The Class I antigens, HLA — A, B, and C, are found on all nucleated cells and may be defined via specific antisera (hence the term "serologically defined" antigens). These are the ultimate targets of rejection. Matching for these Class I antigens, however, has not proven to be as beneficial in terms of cadaveric graft survival in the United States as was originally expected, perhaps due to the marked heterogeneity of the patient population here.

The Class II antigens, HLA — D and DR are found primarily on the surface of cells of the immune system. HLA — D may be identified only in mixed lymphocyte culture (hence the term "lymphocyte defined") over a period of several days. HLA — DR, however, may be serologically identified and has been associated with improved graft survival. Rather than being the primary targets of rejection, the Class II antigens appear to regulate the intensity of rejection against Class I antigens, a favorable Class II match minimizing the rejection response.

Determining the ABO blood type
and crossmatching between recipient's serum and donor target cells, in an attempt to identify pre-formed antibodies associated with accelerated rejection are the other integral steps in the preoperative immunologic evaluation of the transplant recipient.

Regardless of the HLA-antigen match, immunosuppression of the organ recipient is vital to graft survival. Ideally, this immunosuppression would be both non-toxic and highly specific, i.e. suppressing only the immune response to the antigens introduced by the foreign organ, leaving the remainder of the immune system intact. This minimizes such undesirable side effects as opportunistic infection or malignancy. As the science of immunosuppression has advanced, this goal of specificity is closer to being attained.

Azathioprine, an azo derivative of 6-mercaptopurine, introduced in 1961, interferes with nucleic acid synthesis, affecting all replicating cells, preferentially, though by no means specifically, inhibiting the rapidly proliferating cells of the lymphoid system in the transplant recipient. Prednisone, added to azathioprine immunosuppression in 1962, is felt to be lympholytic, amplifying the suppression of immunoreactive cells. As evidenced by its many known systemic side effects, this agent also lacks specificity.

Antilymphocyte Globulin, introduced in 1967, consists of antibodies which recognize lymphocytes and initiate complement-dependent lysis of these target cells. Use of ALG was an initial step towards specific immunosuppression.

Cyclosporine is a cyclic, 11 amino acid polypeptide synthesized by a fungus, first used as an immunosuppressant in 1978. The drug appears to specifically inhibit the induction of cytotoxic T lymphocytes, the cells principally responsible for transplant rejection. This action only affects antigens freshly challenging the immune system and thus the drug is most useful when given just prior to antigen presentation. Cyclosporine appears to either inhibit the production of, or block the receptors for inter-leukin II, a known lymphokine released from helper T cells that mediates the differentiation of T cells into their cytotoxic form. With such a specific mode of action, it has proven a powerful new immunosuppressant, heralding the "cyclosporine era" of organ transplantation.

In evaluation through numerous clinical series, using low dose steroids and making little attempt to obtain close tissue matches, cyclosporine showed at least an equivalent graft survival and in some cases improved survival when compared to conventional immunosuppression. Lower rates of opportunistic infection were also noted as well as substantially reduced side effects secondary to steroids. Side effects of the drug itself, however, in particular its nephro-toxicity, have proved difficult problems to manage. Differentiating graft rejection from cyclosporine nephrotoxicity may require graft biopsy.

Early experience at Jefferson indicates a considerably higher incidence of acute renal failure following implantation when compared to standard drug therapy. Also the rate of creatinine drop has been noted to be much slower in cyclosporine patients and the baseline creatinine values have been much higher. We are just becoming proficient with the use of this drug at Jefferson and undoubtedly have much to learn about its toxicity and other complications. In spite of these problems, it has already made, as indicated below, a noticeable improvement in graft survival.

Other means of manipulating the immune system beyond the scope of this presentation include donor specific blood transfusion and marrow transplantation, new monoclonal antibody technology, total lymphoid irradiation, splenectomy and thoracic duct drainage.

Kidney transplantation

More than a quarter of a century has passed since the first successful renal transplant was performed between identical twins at the Peter Bent Brigham Hospital in Boston. Since that time, 100,000 patients with end-stage renal disease have had their lives prolonged with a renal allograft.

Kidneys for transplantation are procured from either living relatives or cadaver donors. Both graft and recipient survival are unquestionably better following living related donor grafts than with unrelated cadaver grafts, one year graft survivals ranging among various transplant centers from 75% to 95% for related donors.

When no suitable related living donor is available, cadaveric renal transplantation is the alternative. The cadaveric donor is, in general, a brain dead patient with intact circulatory and renal function. The current worldwide shortage of cadaveric kidneys for transplantation is not due to an inadequate supply but to lack of referral of these vital potential donors by attending physicians. Once identified and consent for donation obtained, cardiorespiratory and renal function are supported until time of procurement. One year graft survivals range from 50%-80% for cadaver donors with conventional immunosuppression. As noted, cyclosporine suppression has improved these results.

Once procured, the kidney is preserved using either simple hypothermia or in vitro hypothermic perfusion prior to transplantation. At Jefferson, as at most transplant centers throughout the United States, the retroperitoneal approach to the iliac vessels has become standard procedure. The transplant renal artery and vein are most often anastomosed end-to-side with the external iliac artery and vein. The ureter is anastomosed directly to the mucosa of the bladder, and the muscular wall is then approximated over the anastomosis in order to minimize reflux.

At Jefferson, we have performed 25 living related transplants during the period from January 1980 to December 1983, achieving survival rates comparable to centers throughout the United States. Most notably, we have achieved 100% three year graft survival in those living related transplants matched for one haplotype who have undergone donor specific blood transfusions.

During that same period, we have
performed 71 cadaver transplants, again achieving comparable one year graft survivals. We have found here, however, 100% one year graft survivals in recipients matched for both DR antigens with donor organs.

Finally, since we first began to use cyclosporine, we have performed 24 cadaver transplants using this means of immunosuppression primarily along with low-dose steroids. These transplants all had negative crossmatches but were unmatched for HLA antigens. Overall graft survival at six months is 66% which is equivalent to our overall six month survival using conventional immunosuppression.

Liver Transplantation

Since the first successful attempts at orthotopic liver transplantation in man were performed by Starzl in 1963, approximately 700 liver transplants have been performed throughout the world. Since 1980, when cyclosporine replaced azathioprine as the primary immunosuppressive drug, results have dramatically improved with 70% of patients surviving at least one year and 60% surviving more than two years.

There are generally four main categories of indications for hepatic transplantation, the first being chronic, benign liver disease, including portal and primary biliary cirrhosis, chronic active hepatitis and biliary atresia. This category accounts for nearly two-thirds of all transplants and is by far the most important indication for liver transplantation. Hepatic malignancy including hepatocellular carcinoma, cholangiocarcinoma, hemangiendothelial sarcoma and, in a few cases, secondary liver metastasis constitutes the second category. Although this accounts for almost 30% of reported cases, results have been mixed with some centers reporting unacceptably high recurrence rates. Inborn errors of metabolism constitute the third category of indications with acute hepatic necrosis and hepatic coma being the fourth.

The decision to accept a patient for liver transplantation is a complex one, involving many considerations including cost-benefit ratio, timing of transplantation, age and presence of other systemic illness. Once a patient has been accepted as a recipient for a liver graft, however, a search is made for a suitable donor. When one is found and thoroughly evaluated, the operation is timed so that recipient hepatectomy and liver transplantation are synchronized with donor hepatectomy. For both donor and recipient operations, experienced teams of surgeons, anesthetists, nurses and technicians are required as well as large quantities of blood and suitable facilities for biochemical, hematologic and blood gas analysis. Telephone communication between donor and recipient teams is essential to be certain that the donor liver is in the operating room before the recipient reaches the anhepatic phase.

Both operations are formidable ones. Once the liver graft has been positioned within the abdominal cavity (most often orthotopically), the vascular anastomoses are carried out sequentially, the first being the suprahepatic vena cava, followed by the infrahepatic vena cava portal vein and hepatic artery. The final step is biliary drainage which may take several forms using either the gall bladder or the common duct. Starzl has recently described the use of a veno-venous bypass pump which returns blood from the inferior vena cava and portal vein to the right atrium during the anhepatic phase, maintaining venous return and diminishing the need for transfusions of large volumes of blood and glucose during this period.

In 1983, a Consensus Development Conference sponsored by the National Institute of Health concluded that liver transplantation was therapeutic and should be made much more available. Over the last year, Jefferson has become one of several medical centers throughout the United States to make a serious commitment to liver transplantation. Under the direction of Bruce E. Jarrell, M.D. '73, and Shu-Yang Yang, M.D., teams of surgeons, anesthesiologists and nurses have trained extensively in canine and porcine transplantation. On May 31, 1984, Jefferson successfully performed the first human liver transplantation in the Delaware Valley.

Pancreas Transplantation

Based on clinical and experimental observations supporting the hypothesis that perfect control of carbohydrate
metabolism will prevent the development of, halt the progression of or even reverse microangiopathic and other lesions affecting the insulin dependent diabetic, attempts at clinical pancreas transplantation have taken the form of whole or segmental organ transplant as well as transplantation of pancreatic Islets of Langerhans, the insulin producing portion of the pancreas.

This clinical pancreatic transplantation has been shown to create a normoglycemic, insulin independent state in the recipient with a fair amount of predictability. Substantial problems remain, however, primarily involving the exocrine pancreatic secretions. Whole organ grafting is a formidable undertaking which utilizes the donor duodenum as a conduit for exocrine secretions. Segmental pancreas grafts involve the body and tail of the pancreas, revascularized in the iliac fossa using donor splenic artery and vein with either ligation of the pancreatic duct or obliteration by injection of the duct with synthetic polymers as a means of dealing with exocrine secretions.

An attractive alternative is isolation and transplantation of the endocrine pancreas, the Islets of Langerhans, eliminating the technical problems associated with the exocrine pancreas. The technique, however, is associated with its own technical obstacles, among these being inadequate numbers of functioning islets available for transplantation, associated with low yields in the isolation process, as well as the observation that islets are perhaps more immunogenic than the whole or segmental organ graft.

This July at Jefferson we will begin to study a new method of islet transplantation designed to overcome some of these obstacles. Using a technique described by Franklin Lim in 1980, isolated islet cells are placed within semipermeable microcapsules composed of polyanionically bonded polylysine alginate. The technique is an all aqueous phase one and the islets thus survive and, in fact, flourish within these microcapsules. The pore size of the capsules is such that glucose and insulin and other products of metabolism can diffuse across, but molecules such as antibodies have been shown not to be able to enter the internal environment of the microcapsule. In this way, the islets are isolated from the recipient's immune response, while the capsule itself has been described as being non-immunogenic. Although many details and difficulties still need to be worked out, Lim's initial studies showed prolonged normoglycemia when encapsulated islets were transplanted intraperitoneally into diabetic, non-immunosuppressed rats. We feel the technique holds great promise and look forward to the day when Jefferson will begin human pancreatic islet cell transplantation.

Thus, particularly in the fields of renal, hepatic and pancreatic transplantation, Jefferson remains committed to both improving and refining current capabilities, as well as developing new and innovative ones. Organ transplantation is entering a new era, during which Jeff plans to play a vital role.

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Clinical Application of Immunohistochemistry

John J. Brooks, M.D. '74

Recent developments in immunohistochemistry (as performed in the pathology laboratory) have important significance to clinicians. Biochemical advances relating to human disease are now almost immediately translated into analyses available in the clinical laboratory. One need only to review any journal in any subspecialty to realize the immense impact immunologic methods have had on our understanding of human disease. For those unfamiliar with immunohistochemistry, it is one of the most rapidly growing applied technologies, and it refers to the use of antibodies to define antigenic expression in biopsy material. This field is certainly not new, dating back to the late 1950's with the birth of immunofluorescence. But the discovery of the immunoperoxidase method by

Dr. Brooks is Associate Professor of Pathology and Laboratory Medicine at the University of Pennsylvania School of Medicine.
by Sternberger in the early 70's, led directly to our ability to permanently stain either frozen or fixed paraffin embedded tissues, enabled us to analyze retrospectively antigens in tissues removed as long as 40 years ago, and thus, paved the way to the current immunohistochemical explosion of uses and applications.

There are many broad categories of antigens detectable by this method, and indeed, the usefulness of this technique is restricted only by the availability of the desired antisera. Many of the antibodies used are polyclonal which, by the way, still have certain definite advantages. Polyclonal antibodies, increasingly available, have yet other advantages but also have restricted immunoreactivity. Some of these antisera detect quantities present in serum in which case the methodology is complimentary or confirmatory to other studies on peripheral blood. However, most antisera detect cell-specific or tissue-specific surface, cytoplasmic, or nuclear antigens found only in biopsy material. Clearly, more new information can be gained from patient biopsies than ever before and the results are often critical to patient management. Therefore, the bottom line is, given the appropriate reagent, the guessing game surrounding biopsy material is over. Now, instead of the pathologist stating that the biopsy is somewhat non-specific, he can now ask and answer a fundamental question: What is the biochemical makeup of this particular lesion? He can now clearly state with certainty that this process is expressing this specific antigen and thus, this is the specific disease. This is undoubtedly a milestone in diagnostic ability and one which effects most clinicians, who now can confidently give specific therapy.

The most frequent use of immunohistochemistry has related to the field of oncology and pathologic diagnosis of tumors. Many are familiar with the expression of the oncofetal antigens—human chorionic gonadotropin, alpha fetoprotein, carcinoembryonic antigen; by germ cell tumors and GI tumors respectively. In reality, such treatable tumors are often tested and diagnosed in the pathology laboratory before serum markers are back from reference laboratories.

The classic and most difficult diagnostic dilemma in tumor pathology is the undifferentiated neoplasm. Immunohistochemistry has proven far more valuable and cost effective than electron microscopy in resolving such cases. Three antigens serve as group-specific markers for the corresponding three broad types of human malignancy: the intermediate filament, cyto-keratin, for all epithelial tumors; the intermediate filament, vimentin, for all mesenchymal tumors; and T200 Antigen for all hematopoietic neoplasms. After the tumor group is identified, other tests make a more specific diagnosis possible.

Concerning such cell-specific antigens, prostatic-specific acid phosphatase has been extremely useful in marking prostatic carcinoma whether primary or metastatic. An equivalent and more recently identified marker is prostatic specific antigen, in prostatic carcinoma. This antigen may be positive even when the serum acid phosphatase is negative and, thus, is quite valuable.

All neuroendocrine tumors can now be clearly identified using antisera against the various polypeptide hormones. For example, numerous normal gastric G cells are contained with immunoreactive gastrin. The study of neuroendocrine tumors (call them carcinoids or apudomas if you like) have shown that within each tumor, multiple hormones may be produced which may effect the clinical presentation and any attempts at therapy.

One very important serum marker has been calcitonin. To show you just how helpful tissue immunohistochemistry can be, not only can a tumor be typed as medullary carcinoma (and believe me thyroid neoplasia can be difficult for the pathologist), but analysis of the surrounding thyroid has definite clinical consequences. If C-cell hyperplasia is found, the lesion is definitely familial and other family members should be tested.

In a similar vein, many non-pathologists would be surprised to know just how many unusual looking tumors in unusual places turn out to be amelanotic melanoma. Often, these patients are biopsied before a primary site is identified. Using routine histology, we could only hint at this possibility before, but now neval melanocytes and virtually all melanomas express S100 antigen, a brain derived protein. This has proven to be an extremely useful antigen which also identifies many neural tumors.

Sarcomas have often been an extremely difficult area for pathologists. However, now that specific therapy is available for certain types of sarcomas such as rhabdomyosarcoma, it is extremely important to identify these with certainty. An antiserum against myoglobin helps to identify a rhabdomyoblast. This type of staining is now routine in many of the oncology study groups, and has resulted in therapy given to homogeneous patient populations.

One lesion currently receiving attention is the AIDS associated Kaposi's sarcoma which has a number of peculiar characteristics and may not be a true neoplasm. Be that as it may, this proliferation, unlike all other spindle

Dr. Brooks, '74
Intestinal Gas and Clinical Syndromes

Harris R. Clearfield, M.D. '59

Symptoms associated with intestinal gas are often viewed with benign amusement, but these disorders are among the most common problems encountered in an office practice. Tension and air swallowing are frequent, and convenient explanations may fail to correctly identify the cause, thus leading to ineffective therapy. Chronic gaseous symptoms, such as belching, flatulence, abdominal distention and crampy pain require a thorough investigation, including appropriate x-ray

dr. Clearfield is Professor of Medicine and Director of the Division of Gastroenterology at Hahnemann University.
The swallowing of food and saliva lead to the accumulation of atmospheric air (79% nitrogen, 21% oxygen) in the stomach. This gas may be belched or may travel through the small intestine where most of the oxygen is absorbed but the nitrogen persists to become the major gas in flatus. An additional contribution to small bowel gas content is derived from the neutralization of gastric acid by alkaline pancreatic and duodenal secretions, resulting in the release of considerable quantities of carbon dioxide, most of which is reabsorbed in the distal small intestine.

The nitrogen content of flatus is derived from swallowed air. The “transit time” for gas is quite rapid, approximately 12 minutes to the distal ileum and 30 minutes to the rectum. Hydrogen constitutes about 20% of flatus and is produced in the colon by anaerobic bacterial fermentation of unabsorbed carbohydrate. Unabsorbed lactose, bran, or the complex carbohydrates in beans may be poorly absorbed in the small bowel and stimulate significant hydrogen production. Approximately 15% of this gas is absorbed and excreted by the lungs, thus permitting its measurement by gas chromatographic analysis of expired air. Breath hydrogen studies have been a useful technic for the detection of lactase deficiency. Carbon dioxide is also released by bacterial fermentation of unabsorbed carbohydrate. It is simplistic to consider flatulence as only a function of swallowed air, since the total volume is also influenced by how much carbohydrate is presented to the colon and the volume of hydrogen and carbon dioxide generated. Thus air-swallowing may be the major cause for flatulence in some patients, while others generate excess gas because of dietary problems.

Approximately one-third of patients are methane producers. The generation of this gas is not diet related and ordinarily has little clinical significance; however, the use of cauterization technics during colonoscopic polypectomy raises the possibility of intra-colonic explosions if hydrogen or methane accumulate. Bowel cleansing is essential to rid the colon of gas as well as feces.

Belching is a normal response to excess gas accumulation in the stomach. It usually occurs after meals and affords relief from a sensation of upper abdominal discomfort. Excess belching is caused by increased air swallowing induced by rapid eating or inadequate dentures, post-nasal drip, chewing gum, sucking on hard candies, or “nervous swallowing.” Carbonated beverages can obviously distend the stomach. Occasional patients exhibit “repetitive belching,” a phenomenon resulting from frequent swallowing of air with accumulation in the esophagus rather than the stomach, much like esophageal speech. Identification of the cause is often more important than symptomatic medications.

The quantity of flatus passed daily varies considerably, from 400 cc's to 2400 cc's. The discomfort associated with flatulence depends upon the frequency of gas passages, odor and the fastidiousness of the patient. Elimination of carbohydrates likely to be presented to the colon for fermentation, such as beans, cabbage or lactose may prove helpful, as well as efforts to decrease air swallowing. Bran is a popular dietary therapy for constipation and air swallowing. Bran is a popular dietary therapy for constipation and irritable bowel syndromes, but the gaseousness resulting from large quantities can prove counter-productive. A low carbohydrate diet may prove useful in some patients, since even starches and sugars may be incompletely absorbed in the small intestine.

The magenblase refers to the stomach bubble, which can press under the diaphragm, if enlarged, and give rise to high epigastric or low substernal discomfort. This pressure sensation generally occurs after meals, is relieved by belching, and is not associated with exertion.

If gas traps in the splenic flexure, the distended colon may press under the diaphragm and generate left upper quadrant discomfort which radiates to the left chest or shoulder. The splenic flexure and magenblase syndromes may sufficiently simulate cardiac disease as to prompt a sequence of stress tests and invasive studies. The air trapping could be secondary to a motility disorder in the left colon. If a carbonated beverage is administered during an air-contrast barium enema examination, the distended stomach pressing against the distended splenic flexure occasionally reproduces the pain pattern.

Crampy abdominal pain associated with a bloating sensation has been ascribed to excess intestinal gas, yet there is little correlation between the measured intestinal gas content and clinical symptoms. “Gas pains” are likely to be a function of normal quantities of gas and a motility disorder of the bowel. Measures to decrease air swallowing plus an antispasmodic medication may prove useful. The use of strict and detailed diets should be discontinued since compliance is difficult, but avoidance of carbonated drinks, chewing gum and foods known to generate gas, such as cabbage, bran, beans and perhaps milk products is often helpful. Many patients complain of abdominal distension, often increasing as the day progresses. If the distension is present in the erect position and absent when recumbent, the possibility of weak rectus muscles resulting from previous pregnancies or muscular atrophy should be considered. Many such patients are treated with sedatives and antispasmodics, when a support garment or exercises directed towards strengthening of the rectus would be more appropriate.

Emotional features may contribute to gaseous symptoms, but the patient should be reassured that the discomfort is not “imaginary,” and that anxiety or tension is only part of the problem. The role of diet, bacterial action on unabsorbed carbohydrate, and motility factors should be explained in detail, since fear of cancer or other organic diseases often responds to a thorough evaluation and reassurance.
Cardiac Surgery—Horizons

Anthony J. DelRossi, M.D. ’69

In 1896, Stephen Paget stated, “Surgery of the heart has probably reached the limits set by nature to all surgery.” Yet 57 years later, Dr. John H. Gibbon used his heart-lung machine to bypass the circulation of a girl with an atrial septal defect thereby beginning the era of modern cardiac surgery. Today cardiac surgery is performed so regularly that the question of too much or unnecessary surgery is raised. Now one must ask, are there still limits set by nature?

Clearly, in 1984 the most common operation on the heart is coronary artery bypass grafting. Initiated by Favaloro and Johnson in 1968 and aided by Ebert and Gay’s high potassium myocardial protection solution in 1972, the operative mortality for bypass grafting has decreased to an astonishing 1%. Subtle changes in the last ten years related to myocardial protection and internal mammary artery use has contributed to the enormous success of this procedure. Approximately 125,000 open heart procedures are performed annually.

What surgery has achieved is to alleviate pain in 80% of patients undergoing operation and thereby dramatically improving the quality of life. Seventy-five percent no longer take medication and 50% of patients have an event free course up to seven years as contrasted to 12% with medical therapy.

The most important questions relate to graft patency, progression of coronary artery disease and whether life expectancy can be prolonged with surgery. Follow-up angiograms at one year revealed 80-90% patency and an attrition rate of one to three percent annually. Therefore if the graft is opened at one year it has a high probability of remaining open at seven years.

Unfortunately bypass grafting does not alter the progression of arteriosclerosis. Ten percent a year of ungrafted arteries develop significant coronary artery disease. However, distal progression in bypassed vessels was not accelerated if the graft remained patent.

Of note is the following subset of patients that have been shown to have increased life expectancy: 1) left main coronary disease particularly if left ventricular function is moderately impaired; 2) triple vessel disease; 3) angina at rest with ST depression plus any two of the following: a) New York Heart Association class three or four category; b) history of myocardial infarction or hypertension.

Recently it has been noted that patients undergoing acute infarction have fresh thrombi in the involved coronary artery. Therefore the infusion of streptokinase or urokinase, potent thrombolytic agents, might reverse myocardial ischemia and preserve muscle that would otherwise be lost. By either direct infusion in the coronary artery or IV infusion within the first four to six hours of ischemia approximately 70% of involved myocardium can be salvaged. Coronary artery bypass grafting or PTCA may then be tried to provide long term reperfusion. This procedure has raised many questions: will all this alter infarction size, prolong life or decrease the incidence of angina or re-infarction? Further investigation is needed.

Another area of intense interest is percutaneous transluminal coronary angioplasty (PTCA). As popularized by Gruntzig, non-elastic balloon tipped catheters are introduced into the obstructed segment of the coronary artery and inflated to disrupt the intima and split the atheromatous plaque. The success rate in select lesions, that is, ones that are concentric...
and noncalcified in patients with recent onset angina and good left ventricular function have approached 70%. Restenosis occurs immediately in 10% and long term results are in progress. Unfortunately only 10% of patients have lesions amenable to PTCA.

In keeping with space age technology, lasers have been developed to vaporize arteriosclerotic plaque in the cath lab and operating room. Lasers in conjunction with light transmitting fiber optics have been introduced into animal and cadaver hearts to attack these plaques. A four-watt Argon laser has been connected to a balloon catheter with a central light fiber and a channel for flushing with saline. Blood is an unsuitable environment for the use of the Argon laser because hemoglobin absorbs Argon laser energy. This energy is transmitted to the surrounding tissue and results in lateral damage. However, saline results in mild lateral damage. Therefore the balloon is occluded proximal to the laser beam and saline is used as the fluid medium. Presently living human hearts are being used with both Argon and CO₂ lasers and the results are eagerly awaited.

Aneurysms of the heart, while comprising a 10-15% complication of acute infarction, may lead to congestive heart failure, angina or tachyarrhythmia. The latter has a poor prognosis because of the inability to locate the sites of the re-entry loop which triggers ventricular tachycardia. Electrophysiologic mapping has helped localize the re-entry loop. However, surgical ablation can be extensive and can result in excessive myocardial damage especially if the focus is located at the base of the papillary muscles of the mitral valve. Gessman et al, has developed a cryo-probe which interrupts the re-entry loop while sparring the surrounding myocardium. The technique is simple and is used intraoperatively along with electrophysiologic mapping and endocardial resection. To date 13 patients have had this combined procedure with no recurrent tachyarrhythmias.

With the success of the first allograft as performed by Barnard in 1967, transplantation has enjoyed both initial enthusiasm and then subsequent abandonment in many institutions. However, due to the continued efforts of Dr. Shumway at Stanford University, cardiac transplantation has found a place for patients with otherwise fatal heart disease. Survival is currently averaging 70% at one year and 50% at five years at the California institution. Others have not achieved these results yet but the latest drug Cyclosporine A, a fungal metabolite similar to Penicillin may help achieve that end. Cyclosporine suppresses T-lymphocytes and decreases allograft rejection. Prednisone is also added to increase immuno-suppression.

Recipients must be less than 55 years old, have no evidence of pulmonary vascular disease, diabetes mellitus, systemic infection, active peptic ulcer disease, any major systemic organ dysfunction or psychiatric illness.

Donors usually sustain catastrophic neurologic damage and must be less than 35 years of age. The donor heart itself is arrested by hypothermic, hyperkalemic aortic root perfusion then excised and transferred in cold saline for periods up to four hours.

The three major problems in transplantation relate to: 1) infection 2) chronic rejection with coronary artery disease in the donor heart and 3) malignancy. The latter complication varies between eight and 33%. Chronic rejection can be detected early with the transvenous endomyocardial biopsy probe. This is the definitive test for graft rejection and is used often. Infection, however, remains a major obstacle to long term survival.

Following transplantation the quality of life greatly improves with 85% of patients returning to their previous occupation or similar activities.

In patients with severe pulmonary vascular disease and increased resistance, combined heart-lung transplantation has been used to circumvent this problem. Donor selection is much more difficult since the lung is predisposed to nosocomial pneumonia or tracheal bronchial infection. The actual surgery is relatively simple and Cyclosporine A is the agent of choice. To date only a few operations have been performed but initial success is encouraging. Normal pulmonary function at rest and at exercise has been noted at 10 months.

The newest and perhaps the final frontier is the development of a totally artificial heart. Although the technology for left ventricular assist devices has been available and used in the last 20 years, only the heroics of Dr. Barney Clark captured our imagination. The current left ventricular assist devices pump blood either from the left atrium or the left ventricular apex to the aorta with a roller pump or auxiliary ventricle placed in the extracorporeal circulation. Major problems include right ventricular failure, hemorrhage and infection leading to few long term survivors. These obstacles led the Utah group to implant the Jarvik-Seven artificial heart which consists of two pneumatically driven separate ventricles with air chambers and four pyrolic carion disc valves. Air is intermittently pulsed in and out of the air chambers activating the diaphragm. The two ventricles displace a total of 680cc with a stroke volume of 120cc. The Jarvik-Seven follows Starlings law with autoregulation of stroke volume. As inflow is increased stroke volume increases and the converse is likewise true. Drive lines are connected at the skin level with velour skin buttons and then to the drive system of compressed air and electricity. The entire drive system with back up air and electricity can be made portable and smaller drive systems are being tested and will be available soon.

Indications for the use of a total artificial heart include patients that can not be separated from cardiopulmonary bypass, patients in cardiogenic shock and those patients awaiting transplantation who would die in the interim.

The challenge of the future then is the development of small artificial hearts with totally implantable power packs. In conclusion, let it be said that the only limits set by nature are those within the imagination of man.
When Physicians Retire

Paul A. Kennedy, M.D. '45

The shorter edition of the Oxford English Dictionary gives as its first definition of the verb "retire, to withdraw into a place of seclusion, shelter, or security." That may have been all very well in 1533 when the word carried that connotation, but how does it fit into the life of today?

A more modern viewpoint states, "Retirement is a major event in the life of any person, requiring adjustments and changes in lifestyles," and, "Physicians probably have more serious problems in facing retirement than most other occupational groups, both from a financial and psycho-social viewpoint."

There is an abundance of material on the subject. Much of it is advice on planning: financial, physical, emotional and demographic. Although authors may differ in some ways, all seem to agree on one thing—the sooner plans are made the better. M. Jean Carette, a French gerontologist, goes so far as to say, "From the age of 20 everyone should watch what he eats, eliminate toxic substances, watch his weight and concern himself with his psychological condition. These are the things which make the difference between a successful old age and an unsuccessful one."

A group of retired Canadian physicians also advise starting the preparation for retirement as early as possible. The keys to their positive adjustment to the retiree role were: good habits acquired early in life, experience in human relationships, friendships, physical fitness, continued interest in professional activities, new interest in many societal activities and increased closeness to the family.

Dr. A. Smith Kinne, a retired urologist, says, "The physician who has nothing in life other than his practice is a sad sack in retirement."

Adherence to the foregoing recommendations might seem to insure to the retiring physician a life lived "happily ever after," as the old fairy tales always said. There are, however, problems and misapprehensions to be addressed. Consider the following quote from a retired general surgeon, "I retired to Florida four years ago at age 58, the envy of all my friends. As I write this I'm sitting on my terrace. A gentle breeze tinkles the wind chimes as if to compete with a mockingbird in a neighbor's hibiscus tree. It's paradise, and I'm so damned sick of it I could climb the walls!"

What went wrong? Although he thought he had made his retirement plans very carefully, he had forgotten one thing. He had been born and raised and had practiced for 20 years in a small, stable upper New York State community—a community in which he knew—and was known by everybody. He moved to the Florida community where he knew no one and no one knew him, an unexpected emotional jolt from which he is only now starting to recover by becoming involved in town affairs.

In marked contrast is the experience of a pediatrician who retired after years of practice in Madison, Wisconsin, but who stayed on in her community. She has many friends there and many hobbies and declares, "I've been so busy since I retired that I don't know how I ever found time to practice medicine." Even given the inevitable difference in personality, the contrast is obvious.

One of the most difficult and worrisome problems is the determination of when to retire or—its other face—how to get someone who is "past it" to quit. Unless a physician is associated with a group, hospital or university with an arbitrary cut-off age he may, presumably, continue in practice as long as he chooses and is physically able to do so.

Clyde T. Hardy, Jr., states the dilemma in an article entitled, "When a Senior Partner Stops Carrying His Weight." He says, "Often a young physician has told me how his early gratitude and respect were being eroded by his sense of being 'put-upon' and his uncertainty about 'the old boy's' plans. An equal number of seniors have voiced resentment against the younger men for their apparent lack of appreciation for the help given them in establishing the practice." The younger man complains that the older one has slowed down in everything except his equal share of the take-home pay. Dr. Hardy advocates drawing up a formal agreement at the beginning of the partnership covering all aspects of it including partial and, eventually, full retirement of the senior partner.

The medical center in Columbus, Georgia, devised a screening process which they reported working well in a report entitled, "Surgeons Operating Past Their Prime? Not Here!" A surgical privileges committee was set up to screen all surgeons over the age of 62 and to limit them to procedures they were mentally and physically
capable of handling. Each surgical senior had to fill out a special application for surgical privileges each year. This included a description of his current caseload, a summary of a recent physical examination and a detailed list of the surgical procedures for which he wanted approval.

Declared the Chief of Surgery, "The problem of the retirement-age surgeon is that it's not just his problem, it's the patient's problem, the hospital's problem and the other surgeon's problem."

Nine years later a check on this screening program, which seemed to work so well at its inception, reveals that it is not being enforced.

One of the most deeply rooted and widely held misconceptions is that retirement creates stress that results in death shortly thereafter. Everyone has at least one horror story of the business man or neighbor who retired one week and died the next. An investigation of morbidity records on a representative sample of retirees demonstrated that 37% showed no change and 40% an actual improvement in health status after retirement. A 1980 study indicated that retiring may, indeed, predispose one to a fatal heart attack. Closer analysis of the data, however, suggested that coronary heart disease was a factor in the decision to retire rather than vice-versa. Nor do studies support the concept that retirement, per se, represents a psychological crisis for a majority of retirees.

Many retirement planners advocate a gradual curtailment of hours and practice as a means of easing into retirement and reports show that it has worked very well. It should be pointed out, however, that this path is not open to all prospective retirees. In some areas (and California is one) punitive malpractice insurance rates prevent the gradual slowdown making no provision for lower rates for less work. We are all able, however, to follow the advice of Canadian psychologists, Cummings and Henry, with regard to our personal lives. They advocate progressive adaptation and acceptance of a "dissengagement" process. The point to realize is that just as the early part of life was characterized by a

progressive engagement in more and more activities so the latter part of life is best achieved by disengagement — by accepting withdrawal with tranquility and realization that there will be a greater psychological distance in many former relationships and decreased social interaction with people around us.

So much for the suggestions and experiences of others. It seemed worthwhile to give some study to a group who would fall into the category of the retired or soon-to-be retired. Accordingly, questionnaires were sent to all surviving members of the Jefferson Class of 1939 — our class. All were asked to identify their field of medicine and to say whether they were retired or not retired. Identification by name was not required and could be omitted if preferred. Retirees were questioned on their reasons for retirement and their satisfaction with it financially, physically and emotionally. They were asked about their hobbies and what they did with their free time as well as whether they had moved away or stayed where they had practiced. Those who had not retired were asked about possible retirement plans and date, their hobbies and reasons for continuing in practice.

Eighty questionnaires were sent out and 63 (better than three-quarters) were filled in and returned. Of the 63, 33 of those replying were retired, 19 were not retired, and 11 said they were "semi" or partially retired. Only two of the entire group, retired or not, had plans to move to an area unknown to them, all the others staying where they were or moving to places with which they were familiar from past experience.

Health dictated the retirement of 13 of the retirees, while age was a factor for 15. Medical school or group policy figured in the retirement of only six, while the cost of malpractice insurance influenced eight and the "hassle of practice" 11 persons. Ten named personal reasons. Of the 33 who had retired, all except two found their retirement financially satisfactory, while three felt their emotional and physical conditions were not satisfactory. Six claimed they had not made retirement plans while 19 said they had made plans.

When the information about hobbies and avocations came to light it was obvious that many had taken to heart the advice to expand their activities beyond the field of medicine. Travelling led all the rest with 17 claiming to be frequent travellers. Golf was next — there were 14 golfers giving credence to all the old wheezes about doctors and golf courses. There were eight readers, seven gardeners, four woodworkers, three fishermen, two clock repairmen and, one is tempted to
say, “a partridge in a pear tree.”
Other interests named were: tennis, painting, bird watching, ham and commercial radio, music, photography, writing, genealogy, pets, bridge, investing, sports, clubs, church, theatre, crossword puzzles, cultural activities, socializing, hunting, swimming, TV watching, numismatics and loafing. A diverse group indeed.

Equally interesting were the members of the class who had not retired. There are 19 of them and, not surprisingly, the majority, or 12, are in either general practice or internal medicine. Two surgeons are still working, one anesthesiologist, one psychiatrist, and three in ob-gyn.

There is an overlap of figures because of the “semi-retired” but 17 members of this group said that they had plans for eventual retirement while an even larger number (20) had financial plans. Out of the entire group, however, only three had set a retirement date. Eighteen claim an absorbing interest in medical practice or a lack of interest in fields other than medicine. Twenty will continue in practice as long as they are physically able to do so.

Of the “semi-retired” physicians, all have cut down and say they practice “three days a week,” “two to five hours a week,” have kept one hospital job, work in senior medical centers as volunteers, and like jobs.

Comment was solicited at the bottom of the questionnaire and many used the space for additional information about themselves. The resilience and perseverance of some of the members of our class is both amazing and heartening. Forced into retirement by circumstances beyond their control (catastrophic illness for the most part) they fought to regain health and strength and to move from “retired” back to “semi-retired” status.

Retired family practitioner Ralph Wicks may have summed it all up for us when he said, “We’re all trying to smell the roses, perhaps belatedly. Younger doctors aren’t keeping their noses to the grindstone as much as we did. Maybe they are doing a better job of getting ready for retirement.”

There is probably no other area in the field of ophthalmology in which there has been such a significant advance in our ability to understand the pathologic processes involved and to alter the course of the disease process through treatment with resultant preservation of vision than diabetic retinopathy.

In the U.S. diabetes mellitus occurs in roughly 1-2% of the population. Diabetic retinopathy is the leading cause of blindness in the country and affects 40% of all diabetics. In juvenile onset diabetes there is a 50% incidence of diabetic retinopathy after 15 years. This incidence rises to 90% after 25 years. Diabetic retinopathy develops earlier in relationship to the diagnosis of adult onset diabetes. Here, the incidence of diabetic retinopathy is approximately 30% five years after the onset of the disease and 50% after 10 years duration.

Diabetic retinopathy can be classified into background or nonproliferative retinopathy and proliferative diabetic retinopathy. Background diabetic retinopathy accounts for more than 90% of all diabetic retinopathy. The associated maculopathy of background diabetic retinopathy is the major cause of visual loss. The findings in simple background diabetic retinopathy consist of microaneurysms, hard waxy exudates, superficial and deep retinal hemorrhages and intraretinal edema. There is also a subcategory of non-proliferative diabetic retinopathy which is termed by many as pre-proliferative diabetic retinopathy and is felt to progress sooner to proliferative diabetic retinopathy. The additional findings here are cotton wool infarcts, venous beading, retinal ischemia and occlusion, and intraretinal microvascular abnormalities (IRMA).

Proliferative diabetic retinopathy occurs in approximately 6% of the cases. The findings here are neovascularization of the disc (NVD) or neovascularization elsewhere (NVE). The major complications are vitreous or pre-retinal hemorrhage, tractional retinal detachment and neovascular glaucoma.

A point noted over and over again is that “most blindness from diabetic retinopathy results from seeing the patient too late.”

Over the years since my graduation from Jefferson and even since the completion of my ophthalmology residency there have been significant advances in our ability to adequately diagnose and evaluate diabetic retinopathy. While the direct ophthalmology
scope remains the primary means of funduscopy examination for most practitioners, its value is limited by its small monocular field of view. The indirect ophthalmoscope was initially developed by Dr. Charles Schepens in Boston in the early 1950's but did not gain widespread use among practicing ophthalmologists until the 1970's. This instrument has the advantage of a much wider field of view. Also, its binocular viewing scope permits stereopsis which is very important in the evaluation of proliferative diabetic retinopathy and its complications. Additionally, with the use of the indirect we are able to frequently obtain good visualization of the fundus through moderate opacities of the media. Utilization of the Goldmann fundus contact lens at the slit lamp offers a stereoscopic magnified view of fundus details and is a valuable adjunct in our examination. The routine use of fundus photography to document and follow-up diabetic retinopathy is a valuable management tool. Many ophthalmologists now take fundus photographs at each examination for comparative purposes. Indeed it is sometimes very difficult to monitor subtle fundus changes without using pictures for reference.

The development of fluorescein angiography in the 1960's has proven a valuable tool in our understanding of the microvascular changes which occur in diabetic retinopathy. Use of this technique has proven essential in the evaluation and management of many of our retinopathy patients.

There is controversy in the medical treatment of diabetic retinopathy between the benefit of “tight control” of blood sugar versus “not too tight control.” To date there is no good study showing the benefit of tight control for either background diabetic retinopathy or proliferative diabetic retinopathy.

Good control of hypertension is visually important in patients with diabetic macular edema. Increased retinal edema may be associated with increased hydrostatic pressure in hypertensive patients. Lowering the blood pressure reduces arterial perfusion pressure and the lessened hydrostatic pressure will often lessen macular edema. Similarly, treating fluid retention due to cardiovascular or renal disease further reduces hemodynamic stress. Low serum protein associated with renal disease enhances retinal edema due to reduced plasma oncotic pressure. Also elevated serum lipids are felt to cause increased hard exudate deposition in the retina.

Over the past decade we have developed a fairly good understanding of the pathophysiology of proliferative diabetic retinopathy. Although the exact etiology is unknown, the presumed cause is due to an angiogenesis factor produced by hypoxic or ischemic retina. This angiogenic factor can cause a vasoproliferative response to adjacent retina, the optic disc and iris. Neovascularization of the disc and neovascularization elsewhere tend to proliferate along the posterior vitreous surface. Neovascularization of the disc occasionally invades the vitreous gel.

With proliferative diabetic retinopathy, secondary changes tend to occur in the vitreous gel. What is termed a posterior vitreous detachment occurs in which the cortical layer of vitreous separates from the retina. Typically the vitreous remain attached posteriorly to the margin of each area of fibrovascular proliferation. The amount of vitreous traction exerted at these areas varies and accounts for the differing clinical features, such as elevated neovascularization, vitreous hemorrhage and tractional retinal detachment.

The completion of NIH Diabetic Retinopathy study represents a great milestone in our knowledge of the management of diabetic retinopathy. This nationally controlled study concluded that panretinal photocoagulation (PRP) was effective in controlling visual loss secondary to proliferative diabetic retinopathy. It was found that scatter photocoagulation treatment reduces the two year risk of severe visual loss by more than 50% in all high risk cases. Four risk factors for severe visual loss were identified. These are the presence of new vessels, new vessels on or near the disc (NVD), moderate or severe neovascularization and pre-retinal or vitreous hemorrhage.

It was found that eyes with three or four risk factors are at “higher risk” and should receive panretinal photocoagulation. It is now felt that it is possible to control proliferative diabetic retinopathy in nearly 90% of the cases with laser photocoagulation treatment provided the patient is seen early enough.

Pituitary ablation as a treatment for diabetic retinopathy is for the most part no longer done. There are, however, a few retinal specialists who feel that this form of treatment is still useful for what is termed “florid diabetic retinopathy” unresponsive to laser treatment. Most retina specialists, however, feel that the best treatment in such cases is simply more laser treatment in incremental doses until the retinopathy shows signs of regression.

Panretinal cryotherapy is another adjunct in the treatment of diabetic retinopathy. Here the retinal cryoprobe is used to freeze retina and produce an effect similar to laser retinal ablation. This treatment modality is usually reserved for cases with cloudy media where laser cannot be given or in cases where the retina has been maximally treated by laser photocoagulation.

Panretinal photocoagulation is typically performed by administering combinations of 200, 500 and 750 microns spot size argon laser photocoagulation in a scattered method over the entire fundus, avoiding the macular area. Twelve hundred to 1600 500-micron spots is the usual PRP. Comparable spots of Xenon arc photocoagulation may be used, but this form of laser treatment is now rarely done.

It has not been proven how panretinal photocoagulation works. The theory is that biochemical products of ischemic or hypoxic retina, the so called angiogenesis factor, stimulate endothelial proliferation and cause neovascularization. It is presumed that the destruction of hypoxic retina by laser burns reduces the metabolic requirements of the retina for oxygen, thereby eliminating the toxic stimulus, the angiogenesis factor, with ensuing regression of the neovascularization.
Diabetic macular edema is the most common cause of decreased vision in diabetics. Macular edema may occur in both proliferative and non-proliferative diabetic retinopathy. However, the visual loss here, in the 20/40 to 20/200 range, is not as severe as the profound visual loss caused by vitreous hemorrhage and tractional retinal detachment, which are associated with proliferative diabetic retinopathy. The macular edema is due to leakage of fluid into the retina secondary to capillary damage. Fluorescein angiography may reveal focal or multifocal leaks, diffuse capillary leakage, capillary non-perfusion and adjacent leakage, or various combinations. Argon laser treatment of macular edema is not of consistent proven value. The treatment of focal retinal macular leaks away from the macular with fluid leaking into the macula is the most rewarding.

There is also the “Temporal-C” in which a C-shaped pattern of laser application is placed temporal to the macula. The rationale here is that treating ischemic retinal tissue may eliminate a so-called “Permeability Enhancing Factor.” More recently a “Gentle Grid” treatment has been advocated. Here a pattern of light, small laser burns is placed over the entire posterior pole, avoiding the foveal area. It has been theorized that this grid of laser treatment effects a photocoagulative debridement of the retinal pigment epithelium and re-establishes the outer blood retinal barrier.

By far the most significant advance in our ability to treat the blinding complications of proliferative diabetic retinopathy has been the development of vitreous surgery techniques. Pioneered by Dr. Robert Machemer, vitrectomy techniques have enabled the restoration of vision in many eyes which formerly would have been considered lost. The vitreous body serves as a “scaffold” upon which proliferative fibrovascular tissue can grow. The objective of vitrectomy surgery is to remove any significant vitreous opacities in the case of vitreous hemorrhage. In so doing, we excise most of the vitreous gel together with the posterior hyaloid of the vitreous. One also removes and or segments elevated preretinal and flat epiretinal fibrovascular tissue causing retinal traction. Divided system vitrectomy instrumentation is preferred to permit a bimanual approach. The most commonly used vitrectomy systems feature a separate pars plana infusion canula inferiorly while the vitrectomy probe and fiberoptic light source are introduced through separate sclerotomies superiorly.

Another more recent advance is the endophotocoagulator. This instrument allows argon laser pan retinal photocoagulation to be given intraoperatively after the media has been cleared by vitrectomy surgery. The use of endophotocoagulation has effected a significant decrease in the incidence of postoperative rubeosis iridis and subsequent neovascular glaucoma.

The ophthalmology community is presently awaiting the results of the Early Treatment Diabetic Retinopathy Study. This study is a cooperative controlled clinical trial to evaluate the medical and laser treatment of diabetic macular edema, pre-proliferative diabetic retinopathy, and early proliferative retinopathy. Included in this study is the medical treatment of early diabetic retinopathy patients with either 650 mgm of aspirin per day or with a placebo in case of the control group.

The early vitrectomy study also is now in progress in order to determine the efficacy of this treatment modality in patients with early proliferative diabetic retinopathy.

Overall the 1970’s and early 1980’s have been an exciting time to be an ophthalmologist and retinal specialist. I am eagerly looking forward to the continued progress which I am sure the future will bring.
Pediatrics:
Future Considerations and Concerns

Edward J. Saltzman, M.D. '49

The world has entered a new time frame, that of the mid nineteen eighties. It is a time that promises to pose a new set of challenges and goals for those concerned primarily with the welfare of children, adolescents and young adults.

Concerns—Fewer children will be born to Americans.

Concerns—There is a slowdown in national expenditures for social health programs. Programs, albeit not perfect, do provide some payment for over 75% of our disadvantaged children's medical care.

Concerns—The specialty of pediatrics is included in the predicted saturation of most medical specialties for the nineteen nineties.

Concerns—The health supervision schedules suggested by the American Academy of Pediatrics will continue to be criticized in an effort to keep medical costs under control, with little appreciation of how “preventive maintenance,” and properly structured anticipatory guidance, can alter present and future life styles.

Concerns—There will be continued dissatisfaction with the lack of third party recognition of the value of cognitive service in medical care, primarily affecting the non-surgical and non-laboratory specialties.

In the past, primary care pediatrics has been 50% hospital based. It is now 90-95% office based, because of our past successes. Infectious disease treatment is no longer the major part of primary care since there is usually a prompt response to therapy and life threatening complications are rare.

Concerns—practical—predictable—not necessarily insurmountable.

What of our past?

In the early decades, pediatricians primarily addressed the problems of infectious disease and nutrition. By the mid fifties improved nutrition and immunization practices were evident. The reduction in infant mortality rose to 50% between 1960 and 1978.

Infant deaths decreased from 26 to 13 per one thousand live births and became a monumental success story. This has continued, or slightly improved, to the present day. The highly effective prevention or elimination of diseases such as smallpox, polio, rubeola, rubella, mumps and some types of hepatitis were, and still are, sources of pride to both the private and public sector. Our training has afforded us skills in assessing and diagnosing disease at its onset. Scientific and technical advances have enabled us to treat successfully the previously untreatable. Public awareness, education and desire for improvement in life styles have resulted in parents seeking medical counsel in the early stages of illness, with obvious improvement in results and lessening in severity of illness seen.

What now? Days replete with diagnosing and treating contagious illness—severe dehydration—nutritional disorders, etc. are the atypical, not the usual.

To be sure, the skills in the aforementioned traditional areas must be maintained and improved. However, the new areas of concern, the new pediatric morbidity and mortality are the medical social problems today. These are accidents, homicides, suicides, drug abuse, child abuse, depression, school learning problems, problems of sexual identity and issues of sexual preference.

Modern pediatrics has evolved to a state where parents and children look to us for help in coping with modern life. If we pediatricians are to offer assistance to our patients, we need to change our emphasis and confront these new concerns.

The new “practice mode” will involve Health Care. Accident prevention, i.e. seat belt usage, smoke alarm usage, safety advice, poison control advice, accident proofing of homes, etc., are topics of medical importance not just for casual conversation and small talk. There will be new emphasis on socialization from infancy on. With the pediatricians support of the “family center,” there will be a new community facility for teaching families constructive play and socialization beginning in infancy. Child abuse, drug abuse, parent abuse, divorce, life style desires, adolescent care, young adult care, educational advice and support, and, in general, anticipatory guidance are but a few of the topics in the new “encyclopedia” of psychosocial pediatrics. School health is an enormous area of concern and pediatric involvement here can mitigate extreme or inappropriate responses to problems such as learning disabilities, attention deficits, emotional problems, mental retardation, sensory problems, sociocultural difficulties and orthopaedic problems. The pediatrician has a legitimate stake in the management of each of these problems and will play a stronger role than before.

Our style of primary care for pediatric practice will also change if we are to be available and survive as a useful specialty in medicine. We must be responsive to the pressures of changes in delivery of health care, life style changes, population shifts and

Dr. Saltzman, Clinical Professor of Pediatrics at the University of Miami School of Medicine, is in private practice in Hollywood.
consumer legal redress of grievances.

Alternate medical care delivery systems, now encompassing 18% of the population (health maintenance organizations, individual practice associations, preferred provider organizations) are here to stay, since government and major industry are joined in an effort to constructively decrease the spiraling costs of medical care. Pediatricians must be responsive to this social change and attempt to insure the highest level of medical care by cooperating with these providers and, when possible, being active in the policy making areas of the individual organizations.

Intellectual changes will include continued high quality efforts at continuing medical education, specialty certification offered for a specified time period (i.e. six years, not lifetime), and recertification on a routine basis may be coordinated with State re-licensure to practice our profession.

Pediatric education is changing and will continue to change, with training being provided by both academicians and practitioners. Each teacher or practice role model will be assigned the task for which he or she is best suited, either hospital based or office based. The student will thereby learn the real world of pediatrics and those areas that are rarely used will be deemphasized. Career satisfaction will be maintained.

We are beginning, through the American Academy of Pediatrics, to really look at ourselves to review what we do and how we do it. We seek ways to constantly improve our performance of services, both for the present and future needs of our society. We are changing. We are continuing with zeal, our idealistic approach to the care of children and young adults, but we also are looking at developing ways for the pediatrician to feel more secure in mastering the needed skills to deal with these "new issues."

We will respond.

The net result will be greater pride, more satisfaction and more productivity, all assuring the future of pediatrics as a specialty.
1930
Francis J. Braceland, 43 Ledyard Rd., W. Hartford, Ct., was presented the Founders Award at the convocation of Fellows during the meetings of the American Psychiatric Association in Los Angeles last May. It is the highest award of the Association. Dr. Braceland received Jefferson's Alumni Achievement Award in 1967. The APA Founders Award was established in 1976 to honor members who have made outstanding contributions as author, spokesperson, and advocate in the service of the mentally ill and disabled and to the art and science of helping them.

Charles Duffy, 607 Pollock St., New Bern, N.C., is still in active practice four mornings a week. He and his wife just celebrated their 50th wedding anniversary. "Daughter, Mary Mathilde, and I will attend next year's reunion—the third for her," he writes.

1931
George W. Paschal, Jr., 3334 Alamance Dr., Raleigh, N.C., spoke on "The Gross Clinic" at the 100th anniversary of the Watauga Club.

1932
Nathan S. Schlezinger, 8378 Glen Rd., Elkins Park, Pa., was visiting lecturer in the departments of Neurology at both the University of Virginia Medical School and Bowman Gray Medical School last winter. His topic: "Progressive Supranuclear Ophthalmoplegia."

1934
Joseph P. Robinson, Jr., 533 8th Ave., Bethlehem, Pa., has been honored for his 50 year membership in the Northampton County Medical Society.

1935
J. Edward Lynch, 1025 Waltz Ln., Penn Valley, Pa., retired from the practice of obstetrics and gynecology in June. He is Honorary Professor in the department at Jefferson, and is a former Chairman of the Department of OB/GYN at Mercy Catholic Medical Center.

1936
J. Edward Berk, 101 The City Drive, Orange, Ca., is the first recipient of the Maimonides Award presented by the Maimonides Society. Dr. Berk is the Distinguished Professor of Medicine at University of California, Irvine.

Gabriel E. DeCicco, 1028 Westport Dr., Youngstown, Oh., retired as physician advisor for Utilization Review, effective January 6. Dr. DeCicco retired from active practice in medicine five years ago. He and Barclay M. Brandmiller, M.D., plan to return to Jefferson for their 50th reunion in 1986.

Peter Lancione, 3609 Belmont St., Bellaire, Oh., was chosen the 1984 recipient of the Bellaire High School Association's annual alumni award, given to the graduate who has "a distinguished career which reflects credit on the graduate, the school and the community." Dr. Lancione is engaged in private practice, and was Public School Physician and also physician for the football team for 25 years. In 1977, he received the outstanding team physician award from the Ohio State Medical and Ohio High School Athletic Associations; the following year, at his 50th high school reunion, he was featured as the school's outstanding graduate. He has served as President of the Ohio State Medical Board, and is a fellow in the American Academy of Family Physicians with a 25-year pin and certificate.

1937
John F. Wilson, 2013 Delancey St., Philadelphia, and Mary E. Clark, were married on February 26 in Philadelphia.

1938
Robert J. Anzinger, 880 Rue de la Paix, Cincinnati, Oh., has retired.

1939
David D. Dunn, 140 W. 2nd St., Erie, Pa., writes "A son, Geoffrey P. Dunn, Jefferson, 79, completed his residency on the Harvard Surgical Service, Boston, in June. On his return to Erie, we are both joining a surgical service here. I continue in the active practice of surgery, and Geoff will be the fourth generation to do so in Erie."

1941
Paul J. Poinsard, 2123 Delancey St., Philadelphia, was elected by the Executive Committee of TJUH Medical Staff to represent the staff at the newly formed Hospital Medical Staff Section (HMSS) of the American Medical Association.

John Y. Templeton, III, 111 S. 11th St., Philadelphia, delivered the Fifth John J. DeTuerk, M.D. Lecture in Surgery on "The Medical Malpractice Liability Crisis and the Surgeon" on Wednesday, May 23, at Methodist Hospital. Dr. Templeton is Professor of Surgery at Jefferson and President of the Pennsylvania Medical Society. Dr. DeTuerk graduated from Jefferson in 1938.

1942
Edgar T. Gibson, Grandview Rd., Newagen, Me., finished a 30,000 mile round-the-world cruise by sailing non-stop from the Falkland Islands to Atlantic City. His 36-foot sloop, Globe Star, was not equipped with compass, sextant, clock or radio so that Dr. Gibson and the crew could utilize their primitive navigational methods. For a look
at his adventures in depth, read the account of a former voyage in the Winter 1981 JAB.

1944J

Bernard L. Braverman, 17900 Gulf Blvd., Redington Shores, Fl., is recovering from a coronary and by-pass surgery in January. His treatment at Morton Plant Hospital in Clearwater was "superb" he writes. His classmate, James B. Leonard, is Head of Pathology there, "and was most helpful. I played my first round of golf in May and it felt good to be back on the course. I retired in 1983 and love every minute of it."

Frank H. Butt, 506 S. State St., North Warren, Pa., retired from anesthesiology August 1, 1983.

1946

Joseph L. Melnick, 1222 Remington Rd., Wynnewood, Pa., is Co-Chief in Obstetrics and Gynecology at Delaware County Memorial Hospital in Drexel Hill. His son, Paul, graduated from Medical College of Pennsylvania in May, and began a residency in medicine at Cooper Hospital, Camden, New Jersey. In July 1985 he starts a residency in neurology at Temple University Hospital.

1948

Joseph P. Kenna, 902 Penn Valley Rd., Media, Pa., heads the Department of Occupational and Environmental Health at St. Joseph's Hospital in Lancaster. His daughter, Denise Kenna, JMC '82, starts a surgical residency at Rhode Island General Hospital this summer.

C. Jules Rominger, 320 Strathmore Dr., Rosemont, Pa., was chosen as the Pennsylvania Radiological Society's outstanding radiologist this year. He is Chairman of the Department of Radiation Therapy at Mercy Catholic Medical Center and Associate Professor of Radiology at Jefferson.

1949

R. Mark Vetto, 3330 S.W. Fairmount Blvd., Portland, Or., writes that his daughter, Anne, enters the internal medicine program at Jefferson this year.

1950

Eugene L. Childers, 5 Raleigh Rd., Edison, N.J., writes that he has passed his Boards in family medicine the third time and is anticipating a move to California. "Grandfather for the second time, a boy, last April."

Irwin N. Perr, 14 Liberty Bell Ct., East Brunswick, N.J., was elected Vice President of the American Psychiatric Association at the national meetings in Los Angeles in May.

1951

Francis J. Sweeney, Jr., 931 Cedar Grove Rd., Wynnewood, Pa., has been elected to serve a second term as Chairman of the Board of the American College of Physicians. Dr. Sweeney, a Vice-President for the Health Sciences Center of Temple University, was re-elected by the ACP's 28-member Board of Regents. He will direct the Board during the 1984-85 College year.

1953

Jack G. Watkins, 1075 Jadwin Ave., Richland, Wa., was elected Chief of Staff at Kadlec Medical Center. He continues his practice of pediatrics at Richland Clinic where he has been located since 1978, and finds the specialty very rewarding. The new position introduces him to "a different phase of medicine."

1954

W. Robert Jacobs, 224 Roseberry St., Phillipburg, N.J., is Associate Director of the Family Practice Residency Program at Warren Hospital and is also employed part time with the Medical Department of Exxon Engineering and Research Company's main research facility in Clinton. "Currently making plans for the marriage of daughter, Jill Eileen Jacobs, to Jeffrey Mark Jacobs (not related yet), both third year medical students at Jefferson."

Francis J. Nash, 18 Manning Ln., Milton, Ma., writes that his oldest son is married, and that the five remaining are all in college in Minnesota, Vermont, Rhode Island and Massachusetts (2).

1955

Rachel Cherner, Benson Manor, Township Line Rd. and Washington Lane, Jenkintown, Pa., is a consultant in endocrinology and metabolic diseases at Parkview Hospital. He practiced at Jefferson for many years, and recently has changed to Rolloing Hill Hospital in Elkins Park. Dr. Cherner's leisure time is spent as a carver, ceramics maker and illustrator of Judaica.

J. Philip Nolan, 265 Pepper Rd., Bethayres, Pa., has been appointed to serve on the Board of Directors of Holy Redeemer Hospital. Dr. Nolan is Director of the Department of Obstetrics and Gynecology and has served as President of the Medical Staff. He is a Fellow of the American College of Obstetricians and Gynecologists.

Guy Lacy Schless, 3926 Henry Ave., Philadelphia, was elected National President of the Victorian Society in America.

Paul M. Selfon, 13116 Foxhall Dr., Silver Spring, Md., received the Distinguished Achievement Award from the Veterans Administration Prisoners of War Advisory Committee.

1956

Warren M. Levin, 444 Park Ave. South, New York, has rebuilt the 12th floor of an office building to his specifications for treating chronic stress, circulatory disorders, allergies and general abuses of the body. He uses extensive laboratory testing, nutritional management and non-invasive techniques including plethysmography and Doppler Ultrasound. Dr. Levin and his wife, Susan, organized the World Health Medical Group in 1979 when they perceived a need for a comprehensive preventative medical program in the New York area.

Edward L. Minier, 212 Grand Ave., Hackettstown, N.J., has recently celebrated 25 years in general practice. He sends the following abbreviated news: "Son, John, graduated from Dartmouth in June—plans to be a malpractice lawyer; daughter, Sarah, graduated from high school—in love; wife, job-hunting; husband, planning to retire, maybe."

1957

Robert A. Smith, 1420 Locust St., Philadelphia, writes that he is "finished paying tuitions." His wife, Elaine, who practices matrimonial law in Philadelphia has a new partner, daughter Donna, who received her J.D. in 1983. Daughter, Marcia, graduated in 1983 with a degree in economics and owns her own export business. Dr. Smith has offices in Delaware County and Center City; in addition to a practice in family medicine, he is involved in hair transplants and occupational and aviation medicine.
1959

Joseph A. Beseecker, 1209 Marietta Ave., Lancaster, Pa., is in a four-man pediatric practice which includes classmate Albert C. Price. His practice is very demanding and there's "very little time for leisure. Lynne is busy in local theater and is a vocalist with a small musical group," he writes.

Ronald E. Cohn, 2570 Haymaker Rd., Monroeville, Pa., has a new position: Executive Vice-President, Medical Services and Medical Director, Forbes Health System (address above).

Joseph W. Eshbach, 770 96th Ave., S.E., Bellevue, Wa., writes that "Mary Ann and I have enjoyed launching three children: Our oldest, Cheryl, is completing her Ph.D. in Political Science at Princeton; Annbeth graduated from Northwestern and is manager of a health club in New York City; and Joe graduated from Colorado College last year in economics, giving us another daughter, Deanne Raymond, when he married. Mary Ann earned her Master of Arts in Human Values and is converting her thesis into a book about creativity and women. I continue to enjoy the practice of internal medicine, specializing in nephrology, and continue to pursue my research into the anemia of chronic renal failure at the University of Washington. I am active in the King County Medical Society, The Northwest Kidney Center, my church and other community activities."

Trevor D. Glenn, 5072 N. Van Ness, Fresno, Ca., has been promoted to Clinical Professor of Psychiatry at the University of California, San Francisco.

Herbert G. Magenheim, 400 Melish Ave., Cincinnati, Oh., is President of the Medical Staff Executive Board of the Jewish Hospital of Cincinnati, where he practices internal medicine. The eldest of his three sons will be starting medical school in the fall.

Guy W. McLaughlin, Jr., 1111 Welsh Rd., Huntingdon Valley, Pa., writes that his daughter, Elgie, has completed her junior year at Jefferson.

1962

Irwin Becker, 1115 Morris Ave., Bryn Mawr, Pa., has been elected President of the Medical Staff of the Germantown Hospital and Medical Center. Dr. Becker is also Chairman of the Hospital's Family Practice Department. He is physician to the Philadelphia Stars football team and to LaSalle College. A graduate of Villanova University, Dr. Becker is a member of the faculty at Temple University Medical School.

Richard E. Goldberg, 948 Hunters Turn, Huntingdon Valley, Pa., has been promoted to Clinical Professor of Ophthalmology at Jefferson. He is associated with Wills Eye Hospital.

Paschal J. LaRuffa, 2300 Yardley Rd., Yardley, Pa., was elected President of the Delaware Valley Society for Adolescent Health.

1963

Matthew N. Boulis, 741 Riverton Rd., Moorestown, N.J., was appointed Clinical Professor of Pediatrics at the College of Medicine and Dentistry of New Jersey at the Rutgers/Cooper Medical Center.

John J. Taraska, 6520 Robinwood Dr., Peoria, Ill., recently returned from a short tour of duty in Montrouis, Haiti, where he worked at St. Vincent's Medical Clinic and in surrounding mountain villages.

1964

John E. Riffle, 3527 Carnoustie Dr., Augusta, Ga., announces the birth of "our third child and first son, Jonathan, in October, 1983. My wife, Barbara, and I have two older children — Lorraine, eight, and Christine, four. I am a Colonel in the U.S. Army Medical Corps and Chief of the Ophthalmology Service at the Dwight D. Eisenhower Army Medical Center, and an Assistant Clinical Professor of Ophthalmology at the Medical College of Georgia."

1965

Bernard S. Casel, 313 N. Frederickburg Ave., Ventnor, N.J., is practicing ENT in the Atlantic City area. He has two sons, "both able to play Little League baseball this summer."

Edwin E. Cohen, 125 Grampian Blvd., Williamsport, Pa., was recently appointed to the Board of the Pennsylvania Division of the American Cancer Society.

Franklin G. Maleson, 3815 Stokley St., Philadelphia, Clinical Associate Professor of Psychiatry and Human Behavior, has been appointed to the editorial board of the Journal of the American Psychoanalytical Association.

1967


F. Ardell Thomas, 15 Meade St., Wellboro, Pa., has been elected President of the Medical and Dental Staff at Soldiers and Sailors Memorial Hospital. In addition to this one-year term, he has been appointed an ex-officio voting member of the hospital's Board of Directors. An active member of the First Baptist Church of Wellboro, Dr. Thomas serves as Choir Director; he is also a member of the Board of Directors of Eastern College and Eastern Baptist Seminary.

1968

Sarah J. Richards, 16 Burroughs Rd., Lexington, Ma., continues to work full time as a pediatrician at Massachusetts General Hospital. "Am keeping very busy with four school-age children."

Ronald D. Serota, 523 Owen Rd., Wynnewood, Pa., has been promoted to Clinical Assistant Professor in the Department of Psychiatry and Human Behavior.

1969

Robert Abel, Jr., 1100 N. Grant Ave., Wilmington, De., of Delaware Ophthalmology Consultants, P.A., spoke on "Management of Contact Lens Complications" at an International Contact Lens Conference in Atlantic City in April; he spoke there in June on "Antiviral Use in Medicine." Dr. Abel is the YAG Laser Capsulotomy Monitor for Medical Lasers (formerly known as Meditec, Inc.).

Peter A. Gehret, 9311 E. Berry Ct., Englewood, Co., says, "All is well with the family and my orthopaedic practice."

Thomas M. Kain, III, 724 Hamilton Rd., Bryn Mawr, Pa., has been appointed Instructor in the Department of Orthopaedic Surgery.

Jonathan S. Kaplan, 85 Mayflower Dr., Tenafly, N.J., has left his private practice of neurology and is spending the year earning an MPH at Columbia. "I hope to start a new career in some aspect of health administration next year," he writes.
Dr. Loberant in the ER at Nahariya Hospital.

After a brief visit two years previously, many years of working for Israel and our local Jewish community, and months of psychological and physical preparation, we arrived for a "sabbatical year" in Israel in August, 1980. Our sabbatical year has extended to the present and shows no signs of ending in the near future.

Although there has been a Jewish community in Israel for thousands of years, modern Israel is primarily a nation of relatively recent immigrants from diverse backgrounds. For this reason there are organized absorption centers throughout the country that facilitate the new immigrants' entry into the social mainstream. Though we were not officially immigrants at the time we were allowed to study at the center. We selected a kibbutz absorption center because of what we had read and heard about these communal societies.

Kibbutz—the ideal: utopian, socialist, Jewish, rebuilding the land, strong community spirit, imparting the highest ideals to the next generation, sharing a cultural history, defending sometimes precarious borders.

Kibbutz—the reality: all of the above with the key phrase, HARD WORK. (and, of course, the human problems of any community)

My wife, Beth, and I spent the next six months in a rigorous schedule of half-day learning Hebrew and half-day working on the kibbutz, six days a week. We learned first hand about kibbutz agriculture, industry and communal services (kitchen, dining room, landscaping, etc.) and what day-to-day life is on kibbutz. Our children, Leslie, Joshua, Benjamin and Moshe, then 14, eight, seven and one year old respectively, spent their time learning Hebrew and receiving an introduction to perhaps the most important communal facility on the kibbutz, the children's house.

After our six months on the absorption center we moved to the kibbutz that we selected to finish our sabbatical year—the kibbutz to which we were elected as members a year later, Kibbutz Rosh Hanikra.

Kibbutz Rosh Hanikra was founded in 1949, following the Israeli War of Independence, by young Army veterans now in their early 50s. Our kibbutz is located at the intersection of Israel, Lebanon and the Mediterranean, the upper left-hand corner of Israel. We sit at the foot of a large hill, the other side of which is the Lebanese border. We're a short walk from the sea, and on a clear day can see across the bay to Haifa to the south, and across the plains to the hills of the Galilee to the east. Our first summer here was the summer of the rocket attacks on northern Israel. Though we were spared direct hits we would often hear rockets whistle over the kibbutz, and at times the ground shook and our windows rattled when they landed close by. Our children slept in bomb shelters intermittently for weeks. Since the expulsion of terrorists from southern Lebanon in the recent war, we've all slept above ground.

Kibbutz represents a pinnacle of participatory democracy. At our open
weekly meetings we discuss and vote on issues of principle and the more minor issues of daily life. We elect committees that oversee the various aspects of our community. Sometimes momentous decisions are made that affect kibbutz structure and philosophy. For instance, our children up to 7th grade will be sleeping in their family apartments instead of their children’s houses—a change in a 35-year-old tradition. This change has necessitated a multi-million dollar building program to build and enlarge housing. Another decision of principle was the introduction of private television into members’ homes; in the past, this had been opposed because of the possibility of distancing members from each other. When we decided to buy televisions, every family received one at the same time. We have decided this year to introduce private telephones into all members’ homes, an element of privacy unthinkable a few years ago, and another step in the evolution of our kibbutz.

Inflation in Israel is a well-publicized catastrophe, running at about 180 percent yearly. On kibbutz we are to a great extent shielded from this problem. We sign for purchases at the kibbutz store; phone calls, auto mileage charges and other incidentals are similarly automatically deducted from the members’ family budgets (for a family of six, about $1500 per year). Housing, food, laundry, children’s clothing, education, medical and dental care generally involve no expenditure of money. There are cultural activities on the kibbutz ranging from weekly movies, dances, lectures and celebrations of Jewish and Israeli holidays. There are also opportunities to attend activities in neighboring towns and kibbutzim—these have included concerts with Simon and Garfunkle and Leonard Cohen, and Broadway plays with Pat Carroll and James Earl Jones.

Evening activities also include meetings of the various committees concerned with kibbutz policy. Beth serves on the Secretariat (a real tribute to her recognized ability, since we’ve been members only a relatively short time) and the Education Committee. I am naturally enough on the Health Committee. Through this committee in the last year, our clinic has acquired an EKG machine, microscope, centrifuge and glucometer. We’ll have an incubator also, if I can find one for under $400. To foster the cause of public health we have had seminars on child health and started a serious anti-smoking campaign.

We are primarily an agricultural kibbutz, growing citrus, avocados and bananas. We also have a plant propagation laboratory involved in the cloning and export of specialty plants. In addition we have a cow barn (the children love to visit the section of newborn calves), large turkey run and even a tourist attraction—a cable car that runs down to the grottoes of Rosh Hanikra. Most members work in these production branches, or in the communal services. Some members, myself included, work off the kibbutz and their salaries are paid directly to the kibbutz. However, I got my chance to be a real kibbutznik also—I work my rotations in the kitchen and dining room like everyone; I work my five “extra days” in the bananas (everyone does that, no matter what branch he is in because the bananas are very labor intensive); and I worked several months in the orchard when there was a bureaucratic delay in my license renewal.

My primary work on the kibbutz, though, is in the clinic. What started out as a weekly voluntary pediatric clinic (I felt that our peds care was sub-optimal) has blossomed into a genuine family practice. Even though our Kupat Holim doctor still comes three times a week, most members and children see me in the mornings starting at 7 a.m. We have families of four generations on our kibbutz, fathers aged 50 with children and grandchildren, who have brought their parents, aged 75 to 85, to live here. Recently I was treating a great-grandma for her diabetes and her great-grandchildren for pneumonia at the same time. The doctor-patient relationship here can be complex and delicate—remember the old saw about not treating your family? Well here, we’re somewhat of an extended family, thus when my child’s teacher brings in her child, or herself, with psychosomatic symptoms, I find myself really having to choose my words.

To the kids I have two distinct identities. For instance, my wife’s group of six one-and-a-half year olds love me at home and in their children’s house, and happily hail me by my first name; in the clinic some of them look at me and burst into tears. And two of these children are my neighbors!

My full time job is as an emergency room physician at nearby Nahariya Hospital. I earn a glamorous salary of about $3 an hour (Wait! Before our notorious doctors strike I was making $1.80). In Israel patients arrive in the ER referred from a local Kupat Holim clinic physician, except for true emergency situations. The referring physician has no admission rights and does not generally participate in inpatient management. Hospital physicians feel little need to communicate with the LMD. This is an example of the over-compartmentalization of medicine here.

There is a similar attitude in the ER where each physician specialist takes care of his portion of the patient. Emergency medicine is not recognized as a specialty here; however, since my arrival we’ve had some consciousness-raising on this issue at Nahariya Hospital. I am additionally maintaining ongoing correspondence with the powers that be on the subject of Emergency Medicine as a formal specialty. It will be an uphill climb.

There is no shortage of problems here—economic, social, religious, defense, as well as medical. But despite all this it feels very right to be living, working, and raising our family in the special atmosphere of Israel and especially kibbutz. Part of this surely stems from the ideals of Zionism. Though my parents immigrated to the United States when I was only a few months old, they never lost their Zionist aspirations of someday settling in Israel. I feel that we’ve been privileged to fulfill that shared dream.

Shalom.
1970

Harvey B. Lefton, 559 Long Ln., Huntingdon Valley, Pa., recently lectured at a Philadelphia Gastrointestinal Group on colon cancer.

John R. McCloskey, 11 Seaview Dr., Longport, N.J., has been elected President of the Medical Staff at Shore Memorial Hospital, where he is Chief of Orthopaedic Surgery. Dr. McCloskey is certified by the American Board of Orthopaedic Surgery, and a Fellow in the American Academy of Orthopaedic Surgeons.

Michael B. Steinberg, 5005 Arabia Ave., Baltimore, is President of Maryland Health Management, an independent consulting firm specializing in the planning and management of hospital ambulatory programs, group practices and private affairs. "I am happily settled in Baltimore with my wife, Cathy, and children Kevin, 11, Kelly, 5, and Amanda, 4."

1971

James E. Barone, 36 Seventh Ave., New York, announces a third child, Pamela, born February 10. He was appointed to the Professional Medical Liability Insurance and Defense Board, a committee of the Medical Society of the State of New York.

Gregory P. Borkowski, 1642 Seven Oaks Dr., Lyndhurst, Ohio, was appointed Vice-chairman of the Division of Radiology, Cleveland Clinic Foundation, and Head of the Section of Abdominal Radiology.

William C. Davison, 3741 S. Mission Hills, Northbrook, Ill., says "I found Joe Julian! He is alive and well and a resident at the Mayo Clinic."

W. Buckley Ratchford, 36 Ladwood Dr. Holmdel, N.J., just brought in a partner to his pediatric practice. Things are going very well, he says, with his two sons, Jack, 10, and Buck, 12, and his wife, Mary Alice.

Ford F. Spechler, 1802 Haddonfield-Berlin Rd., Cherry Hill, N.J., is practicing ophthalmology there.

Barbara L. Tenney, 56-45 Main St., Flushing, N.Y., was married on October 22, 1983, to Michael A. Coté, an accountant. They reside in Brooklyn, but her office remains the same.

Mark B. Vizer, 920 Lawn Ave., Sellersville, Pa., writes that he was recently elected Chairman of Obstetrics and Gynecology at Grand View Hospital. "I am currently living in Lansdale with my wife, Susan, and two daughters, Honey, 12, and Sarah, 10."

1972

Mary F. Buechler (Janson), 410 Kentucky Ave., Whitesburg, Ky., has moved back to the mountains of eastern Kentucky with her husband. "I believe I am the only hematologist-oncologist in the eastern part of the state," she writes. "I see a lot of cancer among coal miners. My younger sister Elizabeth J. Buechler, 76, and her husband, Tom Sagu, have a second child, a daughter Samantha, born January 24."

Bruce L. Gewertz, 5812 S. Harper, Chicago, writes, "Joanne and I welcomed our third child, Alexis Jordon, in February. She joins Samantha (2) and Barton (1). In my spare time, I continue as Associate Professor of Cardiovascular Surgery at the University of Chicago."

Fred D. Lublin, 111 Overhill Rd., Bala Cynwyd, Pa., is Chairman of the Committee on Research at Jefferson which, on behalf of the faculty, recommends research policy and operates various college programs. The committee is responsible for formulating research policy and encouraging the development of research capabilities at Jefferson Medical College.

Arlen D. Meyers, 2005 Franklin St., Denver, has completed his Masters in Business Administration program at the University of Colorado. Dr. Meyers is a partner in Professional Management Services, Inc., a medical practice and financial management consulting firm.

George F. Speacce, 8 Church St., Wilkes-Barre, Pa., and his wife had a second child in June to join two-year-old Gillian. At an alumni chapter dinner there in May he was named Chairman for the area.

Robert E. Steward, Jr., Box 116, Wallackton, Pa., recently became a Fellow of the American College of Surgeons. Dr. Steward is a general surgeon associated with the Moshannon Valley Medical Group in Philipsburg; he is also an associate in surgery at Geisinger Medical Center.

1973

Michael H. Cohen, 1310 Sussex Rd., Wynnewood, Pa., is associated with the Dickinson Medical Group in the specialty of neurology. Dr. Cohen is certified by the American Board of Psychiatry and Neurology.

Lewis W. Gray, 67 High St., Newton, N.J., has been named Chief of the Department of Medicine and Vice-chief of Staff at Newton Memorial Hospital. Dr. Gray is Board Certified in both internal medicine and cardiology and also maintains a private practice in Newton. He and his wife, Carol, live in Hampton Township with their two daughters, Holly, 10 years, and Meredith, 10 weeks.

Joseph R. Thomas, 84 Myrick Ln., Harvard, Ma., is enjoying civilian life. "I've started cruising the area in my new Beech Bonanza," he writes.

1974

John S.J. Brooks, Jr., 15 Crest Lane, Swarthmore, Pa., has been promoted to Associate Professor at University of Pennsylvania. Dr. Brooks has been invited to give a course at the International Academy of Pathology meeting in Toronto in March, 1985, on Pathology and Immunohistochemistry. (see p.24)

Theresa A. Burt, 700 Ardmore Ave., Ardmore, Pa., is "busy practicing gastroenterology in Bryn Mawr."

Robert W. Gardner, 680 E. Cotati Ave., Cotati, Ca., is Medical Director at Santa Rosa General Alcohol and Drug Unit, and President-elect of the California Academy of Preventive Medicine. He's "happy and content."

Larry R. Leichter, 3419 N. 31st Terr., Hollywood, Fl., reports that his first novel, Epidemic, has sold over 41,300 copies. He is working on a second novel.

Michael H. LeWitt, Box 17142, Philadelphia, announces the birth of a baby girl, Mattea Beth, on March 29. "She is a joy to us," he writes. Dr. LeWitt is working at Chester County Hospital in West Chester, practicing emergency medicine.

William M. Schulman, 5 Prospect St., Lakewood, N.J., was honored with a fellowship in the American College of Surgeons. Dr. Schulman has been a member of the Medical/Dental staff at Kimball Medical Center for three years.
1975

Arthur C. Hayes, 375 Miles Dr., Ambler, Pa., is an Instructor in the Department of Medicine at Jefferson.

William J. Kitei, 1313 Center St., Bethlehem, Pa., and his wife, Susan Kitei, M.D., announce the birth of a son, Richard Samuel, on August 15, 1983.

Carol Morningstar Lamparter, Box 221, Danville, Pa., has joined the medical staff at Mount Union Area Medical Center. Dr. Lamparter is a certified family practitioner; her husband, Robert, '76, is Associate Pathologist at J.C. Blair Memorial Hospital, and they are the parents of a son, Matthew.

Ellis R. Levin, 223 Pacific St., Santa Monica, Ca., has been elected to Fellowship in the 60,000 member American College of Physicians. Dr. Levin, a specialist in internal medicine and endocrinology, is on the staff of the University of California Irvine College of Medicine.

1976

Gary B. Bernett, 141 E. Chelsea Sk., Newtown Square, Pa., and his wife, Bonnie, are the parents of a first child, Joshua Philip, born April 22, 1984.

Brad L. Hilaman, Newport Naval Hospital, Newport, R.I., Board certified in obstetrics and gynecology and a Fellow in the American College of Obstetricians and Gynecologists, is presently at the above address following two years of practice in Guam and Saipan. He has been accepted in law school and will work in the medical legal department of the Armed Forces Institute of Pathology where he will aid in the preparation of medical-legal cases for defense. “Our third child, Joseph, was born March 31.”


Paul R. Long, 116 Hawerford Dr., Wilkes-Barre, Pa., married the former Peggy J. Fuller on July 16, 1983.

1977

James P. Bagian, Johnson Space Center, Houston, returned to Danville, Pennsylvania, in March to participate in the dedication of the new Geisinger Life Flight Helicopter. Dr. Bagian spent a year at Geisinger Medical Center in postgraduate training. These days, he is training for the Fourth Spacelab Mission, scheduled for January, 1986.

Robert B. Doll, Jr., 2533 Walnut St., Allentown, Pa., is practicing endocrinology along with two other physicians.

William J. Herrmann, 30 Farmhouse Rd., Mountaintop, Pa., recently joined the Geisinger Medical Group in Wilkes-Barre. He was Board Certified in OB/GYN in December, 1983. “Does anyone know the whereabouts of Jim Folk?” he asks.

Thomas J. Loftus, 15310 Artesian Oaks, San Antonio, who will be at the above address for the next seven years, was the first doctor to finish in the 1984 Boston Marathon.

David M. Mintzer, 169 Cedarbrook Rd., Ardmore, Pa., writes: “David and Linda are moving back to Philadelphia after spending two years in New York. David has completed a fellowship at Memorial Sloan Kettering Cancer Center in clinical immunology/oncology, and will be joining a hematology/oncology practice at Pennsylvania Hospital.”

Brad S. Rogers, 501 Countess Dr., Yardley, Pa., writes, “I am now officially Board Certified by the American Board of Urology.”

1978

Frank Guillard, 306 Adams Ave., State College, Pa., writes that his father, Peter Guillard, M.D., ’51, is retiring from family medicine after 33 years in the Osceola Mills area. Dr. Frank Guillard is in internal medicine in State College and Paul Guillard, M.D., ’51, another son, is in internal medicine in Allentown, Pennsylvania. The senior Dr. Guillard and his wife, Cecelia, also have three daughters in the medical profession.

George R. Kenner, Jr., 48 Haines Dr., Sewell, N.J., has been appointed Instructor in the Department of Otolaryngology at Jefferson.

Michael P. Russo, 321 Blue Ridge Dr., York, Pa., is starting a private practice in obstetrics and gynecology.

David H. Trump, 7361 Kerry Hill Ct., Columbia, Md., has entered the M.P.H./General Preventive Medicine residency program at Johns Hopkins School of Hygiene and Public Health. He is a Board Certified family phys-

1979


Harry A. Hamburger, has completed a fellowship in neuro-ophthalmology at Bascom Palmer Eye Institute in Miami and has opened a private practice in West Palm Beach. In June he married Andrea Bender, M.D., who graduated this year from the University of Miami School of Medicine. She is taking a residency in neurology at Jackson Memorial Hospital.

Michael J. Kibelbek, 1027 Hastie Rd., Pittsburgh, completed his residency in anesthesiology at Mercy Hospital in June, after which he began a fellowship in pediatric anesthesia/intensive care at Children’s Hospital of Philadelphia. He will be there for one year.

Janet B. Leventhal, 2150 Lincoln Park West, Chicago, will join the Northwestern Anesthesia Department at Columbus Hospital in Chicago, following her fellowship in pediatric anesthesia.

L. Sandra Willingmyre, 2317 Hillcrest Ave., Pennsauken, N.J., is finishing her internal medicine residency at Cooper Hospital Medical Center in Camden, which is now the clinical campus for Rutgers University.

1980

Kevin M. Boyle, 122 Drummonds Way, Hampton, Va., writes, “My wife, Gerry, and I have two children now, Kevin, 4, and Sharon, 1. I am due to re-enter my internal medicine residency in July 1985 after fulfilling my commitment to the Air Force.”

Martin J. Carney, 1445 Broad St., Providence, R.I., started a two-year residency in plastics and reconstructive surgery at the Brigham and Women’s Hospital in Boston in July.

Ronald N. Eister, 604 Brandon Ave., Williamsport, Pa., is finishing a family practice residency at Williamsport Hospital and hopes to serve two years with the Federal Prison System to fulfill his public health requirement. “Cynde and I became the proud parents of a son, Ronald Jr., in July.”
Robert G. Hill, 504 Greenwood Ave., Bethlehem, Pa., began practice at St. Luke’s Hospital upon completion of an emergency medicine residency, and will be moving to this new address with his wife, Joy.

Shahab S. Minassian, Oak #4 1876 Woodland Rd., Abington, Pa., has been accepted as Jefferson’s 1984 Fellow in Reproductive Endocrinology and Infertility.

Raymond F. Nungesser, State and Walnut Sts., Millville, Pa., writes that Eric Longenback, ’81, is joining him in a family medicine practice.

Catherine T. Rommel, 3 Delwood Dr., Danville, Pa., and her husband, F. Michael Rommel, ’81, announce the birth of their first child, Bethany Marie, on February 9, 1984. “Mike is in his third year of residency at Geisinger Medical Center and I’m in my final year of ophthalmology residency at the same center,” she writes.

Nicholas A. Tepe, 275 Bryn Mawr Ave., Bryn Mawr, Pa., is Chief Resident in General Surgery at the Hospital of the University of Pennsylvania.

Carol A. Wheeler, 7400 Haverford Ave., Philadelphia, completed her residency in obstetrics and gynecology and returned to Philadelphia in July, 1984, to begin a fellowship in reproductive endocrinology at the University of Pennsylvania.

1981

Scott A. Brenman, 1213 Addison Walkway, Philadelphia, is continuing his general surgery residency at Pennsylvania Hospital, and will begin a fellowship in plastic surgery at Duke University in 1986. He and his wife, Susan, are expecting their first child in October.

Charles L. Bryner, Jr., 4596 Avery St., Oceanside, Ca., has been selected Assistant Chief Resident at the Naval Hospital, Camp Pendleton, for the coming year as he finishes his family practice residency. He and his wife, Jamie, are expecting their first child in October. “I hope everyone is having as good a year as I am,” he writes.

Victor A. Crosby, 1202 Westwood Dr., Valdosta, Ga., writes: “Medicine as a Flight Surgeon in the USAF is not too exciting, but flying in the back seat of

Married M.D.’s

Being married to a medical student would be hard for some people; being married to a medical student when you’re a medical student yourself would seem to be harder. “It’s easy,” say David and Kathleen Shander Guarnieri, both June graduates from Penn and Jefferson, respectively.

Living in Barringer Residence Hall, they say it’s much easier to be married than not, even though their schedules never meshed and even though their first vacation together since their marriage in October, 1981, was the summer of 1984, right after graduation.

In spite of frequent separations, life has been very good to them, and so have their families. “We couldn’t ask for better parents,” says Kathy, and they both remark on the help and support they have received. Kathy’s father, Ernest G. Shander, M.D. ’48, knows what they experienced as medical students, and maybe half of what they can expect with both of them in the profession. Although not doctors, David’s parents are just as supportive.

Kathy and David are planning careers in anesthesiology, and are signed up for residencies for the year July, 1985 to July, 1986. Kathy went through the Match and will spend her year of internship at Mercy Catholic Medical Center, completing her internal medicine requirement. She will serve her residency at Temple University Hospital. David’s residency will be at Penn, and he automatically takes the year of internal medicine there, too. Although Kathy would not have minded staying at Jefferson, she is pleased that her internship takes her out of the city.

But they might both end up in a city, and a large one at that, because positions in their specialties might only be found in big city hospitals. Kathy is interested in pediatric anesthesiology, and David in critical care anesthesiology; both like the concept of acute care in the OR. Kathy looks forward to the aspect of her position which will both educate and reassure her young patients before surgery. “It’s so important,” she says of being good at this job. “You have their lives literally in your hands.”

These two young people, who have both just finished rigorous courses of study at two very good, very different, medical schools, look forward to using what they’ve learned and what they love. Hearing their enthusiasm and seeing their obvious affection for each other is as refreshing as being welcomed into their cheery apartment after the long gray hallway. They leave no doubt as to why their parents are so supportive, and why their lives hold such promise.

David and Kathleen Shander Guarnieri.
the F-4 makes it worthwhile. Debbie and I have two big boys now, Colin, three, and Evan, one, and both are healthy blondes.”

Thomas R. Westphal, 1747 West Chester Pk., Havertown, Pa., began his orthopaedic residency at Jefferson in July, 1983. Dr. Westphal and his wife, Diane, and son, Andy, live in “Havermwood.”

George A. Winch, Jr., P.O. Box 212, Oyuhee, Nv., was married June 16 to Brenda Leiker in San Francisco. He is at the Indian Hospital in the Oyuhee Valley.

1982

Richard D. Bruehlman, St. Margaret Memorial Hospital, Pittsburgh, was among 20 recipients of a $1500 award from the AAFP to help finance his graduate training in family practice. Dr. Bruehlman was selected from a field of 142 candidates. He is currently a family practice resident at St. Margaret’s.

Richard L. Jahnle, Hopkinson House, Philadelphia, married Grace Ryan on September 17, 1983. Dr. Jahnle has finished his first year of ophthalmology residency at Wills Eye Hospital; his wife works in the Cardiac Catheterization Lab at Jefferson.

William J. Paronish, 301 Albina Way, Latrobe, Pa., “recently had our first child, a beautiful baby girl named Kelly Lynn.”

Jay A. Robinson, 2711 5th St., Altoona, Pa., and his wife, Diane, announce the birth of their first child, Kristen Lee, born on January 24, 1984.

Neal A. Schorr, 650 A, Kelly Ave., Pittsburgh, announces his engagement to Danielle Odom. Dr. Schorr is currently a resident in family practice at Shadyside Hospital.

1983

Mark Edwards, 665 Palomar Dr., Pensacola, Fl., will begin Naval Flight Surgeon training in August.

Leonardo S. Nasca, Jr., 115 Sunbury Rd., Riverside, Pa., was accepted for residency in emergency medicine (PGYII) at University Hospital of Jacksonville.

Obituaries

Robert T. Findlay, 1925
Died February 25, 1984 at the age of 82. The retired physician was a resident of St. Petersburg, Florida. Dr. Findlay was a general surgeon in New York City and later worked with the Veteran’s Administration. Surviving are his wife, Theresa, a son and a daughter.

William R. Bonner, 1927
Died January 23, 1984. Dr. Bonner, an ophthalmologist, was a resident of Summit Hill, Pennsylvania. Three of his five surviving daughters are married to Jefferson physicians.

John D. Ringwalt, 1928
Died March 8, 1984. Dr. Ringwalt, a cardiologist, was a resident of Lancaster, Pennsylvania.

John J. Penta, 1929
Died March 21, 1984 at the age of 78. Dr. Penta practiced ophthalmology and otolaryngology in Reading, Pennsylvania for 55 years. Surviving are his wife, Helen, a daughter and two sons, one of whom is John M. Penta ’69.

Morris Kesilman, 1930
Died May 22, 1984 at the age of 79. Dr. Kesilman was an internist and gastroenterologist in the Wyncote area of Philadelphia. In 1961 he joined the staff of Rolling Hill Hospital and in 1978 joined the staff of the Pennsylvania Health Department. Surviving are his wife, Dorothy, and a son.

John C. Urbaitis, 1930
Died April 23, 1984. Dr. Urbaitis was an administrator with the Warren State Hospital and was a resident of Kane, Pennsylvania, at the time of his death.

Philip Henstell, 1931
Died February 2, 1984. Dr. Henstell was a general practitioner in Forest City, Pennsylvania. He was a past President and Secretary/Treasurer at St. Joseph’s Hospital in nearby Carbondale. In 1978 he was named Pennsylvania Physician of the Year by the Governor’s Committee for the Handicapped and was the first recipient of the Forest City Distinguished Citizen Award. Surviving are his wife, Doreen, and a daughter.

Wylls Royce Hodges, 1931
Died January 31, 1984 at the age of 76. Dr. Hodges was an obstetrician in Cumberland, Maryland, where he had been in practice for 49 years. He was an early authority on continuous caudal anesthesia and pentothal intravenous anesthesia. A Fellow of the American College of Surgeons, Dr. Hodges traveled widely to medical meetings piloting his own plane. He served as agent for his class of 1931. Surviving are his wife, Elizabeth, and a son, W. Royce Hodges, III, ’66.

Kenneth H. Benson, 1932
Died April 20, 1984. The retired ophthalmologist was a resident of Phoenix, Arizona.

John E. Leach, 1933
Died April 7, 1984 at the age of 75. Dr. Leach, who was residing in Hummelstown, Pennsylvania, at the time of his death, had practiced medicine in Paterson, New Jersey. He was former Chief of the Department at Paterson General Hospital. Dr. Leach was a Diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians and a member of the American Society of Internal Medicine. Surviving are his wife, Katharine, a daughter and a son, Christopher L. Leach, ’73.

John V. Sutula, 1933
Died August 11, 1983 at the age of 77. Dr. Sutula was a general practitioner in West Hazleton, Pennsylvania.

Ransford J. Riddle, 1935
Died June 9, 1984 at the age of 75. The retired ophthalmologist was residing in Neavitt, Maryland. Dr. Riddle had practiced in Sharon, Pennsylvania, where he was on the staff of Sharon Hospital. He was a member of the
American Academy of Ophthalmology, a Fellow of the International College of Surgeons and a Diplomate of the American Board of Ophthalmology. Surviving are his wife, Mary Ellen, and two daughters.

John H. Donnelly, 1937
Died January 24, 1984 at the age of 73. Dr. Donnelly, a cardiologist with offices in East Orange and Newark, New Jersey, was an Associate Professor of Clinical Medicine at the New York University School of Medicine. He was associated with St. Mary’s Hospital, St. Michael’s Medical Center, New York University Hospital and Bellevue Hospital. Surviving are his wife, Emma, and two daughters.

Thomas S. Boyd, 1937
Died April 17, 1984 at the age of 73. A general practitioner in Midland, Pennsylvania, Dr. Boyd served as the physician for the Midland School and the Crucible Medical Department.

William F. Meehan, Jr., 1937
Died September 23, 1983. Dr. Meehan, an internist, was a resident of Eastchester, New York.

Earl E. Houck, Jr., 1938
Died November 26, 1983 at the age of 71. Dr. Houck was a general surgeon who practiced in DuBois, Pennsylvania. He was a member of the International College of Surgeons and the Board of Abdominal Surgeons. Surviving are his wife, Evelyn, a daughter and a son.

Eugene J. Malia, 1940
Died April 30, 1984. Dr. Malia was a radiologist in Pittsburgh, Pennsylvania.

Frank T. O’Brien, 1942
Died April 17, 1984. Dr. O’Brien was a thoracic surgeon in Wilmington, Delaware, and was an Honorary Clinical Assistant Professor of Surgery at Jefferson.

Edward V. Henson, 1943
Died November 1, 1983 at the age of 66. Dr. Henson, a resident of Wilmington, Ohio, at the time of his death, had been in occupational medicine since 1950. His last position was as Medical Director at Goodyear Atomic Corporation in Piketon. Dr. Henson was certified by the American Board of Preventive Medicine and was a member of the American Occupational Medical Association and the American Academy of Occupational Medicine. He is survived by his wife, Lois, and two sons.

Otto T. Boysen, 1944J
Died February 18, 1984 at the age of 64. Dr. Boysen served as Chief of Orthopaedic Surgery at Elmer Community Hospital in New Jersey and was on the staff of Cooper Hospital in Camden. He is survived by his wife, Anne, a son and three daughters.

George H. Jones, 1944J
Died in November of 1983. Dr. Jones was residing in Scottsdale, Arizona, at the time of his death. Prior to his retirement there in 1968, Dr. Jones was a urologist at Geisinger Medical Center in Danville, Pennsylvania. Surviving are his wife, Grace, and a daughter.

Glenn W. Tymeson, 1944J
Died May 5, 1984 at the age of 65 suddenly of a heart attack while on a fishing trip. Dr. Tymeson, Clinical Assistant Professor of Family Medicine at Upstate Medical Center, Syracuse University, practiced his specialty in Whitney Point, New York. In addition he had served as a Deputy Coroner of Broome County and Whitney Point school physician for 36 years. He had been named Doctor of the Year by the New York State Medical Society. Surviving are his wife, June, three daughters and three sons.

Robert H. Stockdale, 1945
Died March 5, 1984 at the age of 62. Dr. Stockdale, a resident of Natrona Heights, Pennsylvania, was associated with Allegheny Valley Hospital there. First trained as an internist, Dr. Stockdale later changed his specialty to radiology. He served as a President of the medical staff. Surviving are his wife, Norma, and three daughters.

Larrey B. Gale, 1948
Died March 20, 1984. Dr. Gale was a general surgeon in Newport, Ohio.

Marshall L. Clevenger, 1950
Died May 12, 1984. Dr. Clevenger, a general surgeon, was a resident of Albuquerque, New Mexico. He served as Vice President for the Alumni Association for the state. Surviving are his wife, a daughter and a son.

Leonard Seidenberg, 1950
Died December 23, 1983 following a long illness. He was the brother of Henry A. Seidenberg 46.

Nicholas P. Kitronos, 1951
Died January 1, 1984 at the age of 60. Dr. Kitronos, a neurosurgeon by training, was a retired captain in the US Navy and a former Commander of the Naval Hospital at Annapolis. He had retired in 1976. Dr. Kitronos had served in China, Korea and Vietnam and had received, among many awards, the Navy Commendation Medal and the Cross of Gallantry with gold star. A member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, he was a Fellow of the American College of Surgeons. Surviving are his wife, Lorene, and three sons.

John G. Aspiote, 1955
Died February 29, 1984 at the age of 64. Dr. Aspiote, a general practitioner in Pittsburgh, was associated with Allegheny General Hospital. He was a member of the American Academy of Family Physicians. Surviving are his wife, Freda, a son and a daughter.

Harvey Lozman, 1962
Died April 17, 1984. Dr. Lozman was a vascular surgeon at Beth Israel Hospital in New York. He served as President of the Doctors Alumni Association there in 1977. Surviving are his wife, Ann, and two daughters.

Helga M. Suld, Faculty
Died April 23, 1984 in an automobile crash. Dr. Suld, Assistant Professor of Pathology and Biochemistry, was chosen in 1962 by the late Dr. Peter A. Herbut to be his Research Associate in the Department of Pathology. She received her Ph.D. in biochemistry from the University of Pennsylvania. Surviving is her husband, George.
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Inquiries for orders may be made through the Alumni Office, 1020 Locust Street, Philadelphia, or 215-928-7750. The prices quoted do not reflect shipping charges which vary from state to state. Please allow two to three months for delivery from the plant in Gardner, Massachusetts.

Name ___________________________________________ Class ____________

Address ____________________________________________

__________________________________________________ Phone (____) ________
Class of 1984 Appointments

James E. Allen (AOA)
The Mercy Hospital
Pittsburgh

Vincent L. Angeloni
Brooke Army Medical Center
San Antonio

Brock K. Bakewell
The Mercy Hospital
Pittsburgh

William F. Bartlow
The Williamsport Hospital
Williamsport, PA

Barbara A. Bartman
George Washington University Hospital
Washington, DC

Michael H. Basista
Akron City Hospital
Akron, OH

Richard A. Beers (AOA)
Strong Memorial Hospital
Rochester, NY

Daniel A. Beneski
Mercy Catholic Medical Center
Darby, PA

Claudia G. Berman
Mercy Catholic Medical Center
Darby, PA

Bruce I. Blatt
Lankenau Hospital
Philadelphia

Sean P. Boyle
St. Vincent’s Health Center
Erie, PA

Roberto E. Briggs
Eastern Virginia Graduate Medical School
Portsmouth, VA

Thomas L. Carter, Jr.
Thomas Jefferson University Hospital

Gerald T. Celestine
The Washington Hospital
Washington, PA

Steve T. Chen
Walter Reed Army Medical Center
Washington, DC

Joseph W. Chow
University of Kansas Medical Center
Kansas City

Catherine M. Christie
University of Tennessee College of Medicine
Memphis, TN

David L. Clair
New Britain General Hospital
New Britain, CT

Maureen D. Clark
William Beaumont Army Medical Center
El Paso, TX

Herbert T. Cohen
Rush-Presbyterian-St. Luke’s Medical Center
Chicago

Francis R. Colangelo (AOA)
University Health Center of Pittsburgh
Pittsburgh

Daniel J. Cole (AOA)
The Mercy Hospital
Pittsburgh

William E. Collier (AOA)
Wilford Hall USAF Medical Center
San Antonio

Deirdre M. Collins (AOA)
Duke University Medical Center
Durham, NC

Frederick J. Cook (AOA)
Thomas Jefferson University Hospital

James A. Cook
University of Virginia Medical Center
Charlottesville, VA

Richard T. Cook, Jr.
Thomas Jefferson University Hospital

Susan L. Cooley
Morristown Memorial Hospital
Morristown, NJ

John F. Cox
The Bryn Mawr Hospital
Bryn Mawr, PA

Kirk W. Daaney
Thomas Jefferson University Hospital

Jonathan S. Daitch
Mercy Catholic Medical Center
Darby, PA

John C. Daniel
Naval Regional Medical Center
San Diego

James P. Daubert (AOA)
Duke University Medical Center
Durham, NC

Robert L. Davoli
Latrobe Area Hospital
Latrobe, PA

Angela M. DeAntonio
Geisinger Medical Center
Danville, PA

Francis X. DeCandis
Geisinger Medical Center
Danville, PA

Joseph M. DellaCroce
The Graduate Hospital
Philadelphia

Peter A. DeMaria, Jr.
Thomas Jefferson University Hospital

Timothy J. Denne
The Williamsport Hospital
Williamsport, PA

Charlie W. Devlin
Medical University of South Carolina
Charleston, SC

Bernhard E. Dietz
USAF Regional Hospital
Eglin AFB, FL

Maribeth M. DiNicola
Bayshore Medical Center
Springfield, MA

Michael J. Doherty
Wilmington Medical Center
Wilmington, DE

Basil Dolphin
New Rochelle Hospital Medical Center
New Rochelle, NY

Nathan B. Duer
Somerset Medical Center
Somerville, NJ

Jay S. Duker (AOA)
Beth Israel Hospital
Boston

Robert F. Early, Jr. (AOA)
The Mercy Hospital
Pittsburgh

Paul M. Eberts, II
Thomas Jefferson University Hospital

Karen A. Edwards
Hahnemann University Hospital
Philadelphia

Terry L. Edwards (AOA)
Walter Reed Army Medical Center
Washington, DC

Richard J. Egan, Jr.
Forbes Health System
Monroeville, PA

Jesse H. Eisenman
St. Louis University Hospital
St. Louis, MO

Christina E. Ellis
Lankenau Hospital
Philadelphia

Andrew J. Escoll
University of Cincinnati Hospital
Cincinnati

Richard C. Evans
University of Utah Medical Center
Salt Lake City

Pamela A. Flick
The Graduate Hospital
Philadelphia

Robert A. Martin  
Lankenau Hospital  
Philadelphia

Mary C. Martini  
McGaw Medical Center of Northwestern University  
Chicago

Joel N. Maslow  
Thomas Jefferson University Hospital

Michael J. McGee  
York Hospital  
York, PA

Daniel G. Megivern  
Geisinger Medical Center  
Danville, PA

Robert W. Meikle  
Dwight D. Eisenhower  
Army Medical Center  
Fort Gordon, GA

Herman J. Michael, Jr. (AOA)  
Thomas Jefferson University Hospital

Randolph J. Miller  
Geisinger Medical Center  
Danville, PA

Craig B. Mizes  
Cedars-Sinai Medical Center  
Los Angeles

Gregory D. Mock  
Conemaugh Valley Memorial Hospital  
Johnstown, PA

James M. Monihan (AOA)  
Dwight D. Eisenhower  
Army Medical Center  
Fort Gordon, GA

Joseph M. Montella (AOA)  
Thomas Jefferson University Hospital

Robert A. Moore, II  
Naval Regional Medical Center  
Portsmouth, VA

Robert A. Moyer  
Geisinger Medical Center  
Danville, PA

Suresh G. Nair  
Geisinger Medical Center  
Danville, PA

James A. Nard, III (AOA)  
University Health Center of Pittsburgh  
Pittsburgh

Hoa T. Nguyenpho  
The Graduate Hospital  
Philadelphia

John C. Oberholtzer  
Hospital of University of Pennsylvania  
Philadelphia

Martin E. Orlick (AOA)  
Jackson Memorial Hospital  
Miami

Ernest P. Osei-Tutu  
Cooper Hospital Univ. Medical Center  
Camden, NJ

Francis A. Palermo  
Wilmington Medical Center  
Wilmington, DE

Deborah Panitch  
Thomas Jefferson University Hospital

Larry H. Pastor  
Thomas Jefferson University Hospital

John C. Pedrotty  
Highland General Hospital  
Oakland, CA

Stephen F. Penny  
Naval Regional Medical Center  
Portsmouth, VA

Raymond J. Petrillo  
University of Connecticut Health Center  
Farmington, CT

Eric D. Phillips  
University of Maryland Hospital  
Baltimore

Clifford Pickett, Jr.  
Mercy Catholic Medical Center  
Darby, PA

Catherine M. Pihoker  
Charleston Area Medical Center  
Charleston, WV

David G. Polin  
New York University Medical Center  
New York

Carl J. Possanza (AOA)  
Scranton-Temple Residency Program  
Scranton, PA

Aldo J. Prosperi  
Latrobe Area Hospital  
Latrobe, PA

Steven H. Rappaport  
V.A. Medical Center  
Fresno, CA

Gail A. Reedman  
University of Maryland Hospital  
Baltimore

Kathleen L. Rehfuss  
Harrisburg Hospital  
Harrisburg, PA

Bradley P. Reynolds  
Reading Hospital and Medical Center  
Reading, PA

V. Karen A. Reynolds  
St. Joseph's Hospital  
Denver, CO

John W. Rhee  
Buffalo General Hospital  
Buffalo, NY

David A. Rivas  
The Medical College of Pennsylvania  
Philadelphia

Cynthia Rogalski  
Thomas Jefferson University Hospital

Michael S. Rosenblatt  
Boston University School of Medicine  
Boston

Benjamin A. Rosenblum (AOA)  
St. Christopher's Hospital for Children  
Philadelphia

Ellen I. Ross  
Thomas Jefferson University Hospital

Robert A. Ruffini  
Lankenau Hospital  
Philadelphia

Michael J. Rupp (AOA)  
University of Maryland Hospital  
Baltimore

John A. Ruth, Jr.  
The Union Memorial Hospital  
Baltimore
John C. Pedrotty (left) and fellow classmate Richard T. Cook, Jr. on their way from Commencement Exercises in the trolley bus.
Continued from inside front cover

William F. Kellow and Dean Leah M. Lowenstein, but has visions of renewed vigor with the recent appointment of Dean Joseph S. Gonzalez. The College’s finances were strained with the loss of the Federal Capitation Grant. It was forced to make raises in tuition, over the six-year period, from $7,800 to $13,175. Fortunately, for the students, Jefferson has one of the most extensive Student Loan Funds in the country. Somewhat similar tuition raises occurred in the other two Colleges of the University.

The dissolution of the Department of Community Health and Preventive Medicine was somewhat counterbalanced by the establishment of a Division of Environmental and Occupational Medicine and Toxicology in the Department of Medicine. Other additions included a Tri-State Hemophilia Center in the Hospital, the formation of a Division of Emergency Medicine in the Department of Surgery and the establishment of Departments of Occupational Therapy and Physical Therapy (CAHS). The dedication of the new site of the Wills Eye Hospital at Ninth and Walnut Streets reaffirmed Wills close affiliation with Jefferson. The Ophthalmologist-in-Chief of Wills, Robert D. Reinecke, was named the Chairman of Jefferson’s Department of Ophthalmology. The creation of new professorships has strengthened the faculty: the Peter A. Herbut Professorship; the Gonzalo E. Aponte (’52) Professorship in Pathology (first recipient, Warren R. Lang, ’43); the Daniel Baugh Professorship in Anatomy (first recipient, Andrew J. Ramsay); the Ellen M. and Dale W. Garber Chair in Family Medicine (first recipient, Edward H. McGehee, ’45); and Rohrer Chair in Medicine and a Distinguished Professor category which may be University-wide. The faculty has been further enhanced by the approval of excellent new Departmental Chairmen: Louis D. Lowry, otolaryngology; Francis E. Rosato, surgery; S. Grant Mulholland, urology; Willis C. Maddrey, medicine; Robert J. Schwartzman, neurology; Carl M. Mansfield, radiation therapy and nuclear medicine; Joseph L. Seltzer, ’71, anesthesiology and Warren R. Lang, ’43, pathology. The appointment of Benjamin Bacharach, ’56, to succeed Samuel S. Conly, Jr., ’64, as Director of Admissions for the Medical College, insures the maintenance of the excellent caliber of this division of the Dean’s office.

Regular reports and constant expert care of financial matters has kept the University in fiscal good health. A stimulus to the University’s resources has been the appointment of Kenneth Moore as Director of Development. The Decade Fund (1980-1990) has a goal of obtaining $65 million dollars for endowment and other programs. The half-way mark in this endeavor was achieved early this year. There is a continual updating of salaries, benefits packages and the practice plan, the last being an increasing source of Departmental and University income.

Patents and patent rights have been clarified with the establishment of a policy that “Researchers who make discoveries will receive guidance in patent policies and they, their Department and the University will share in the royalties.”

The myriad of activities of the Women’s Board of the Hospital, many of which resulted in generous donations for hospital projects and equipment, is a constant source of amazement and appreciation by the members of the Board.

The advancing role of nurses in Health Care and the increasing demands for nurses in health education, recognized locally as well as nationally, has led to changes in nursing education at Jefferson. The schools of Diploma Nursing and Licensed Practical Nursing have been phased out. The Diploma School has been replaced by a Baccalaureate program named Department of Nursing with Dr. Mary D. Naylor, Chairman and Associate Professor (CAHS).

Separate Commencement Exercises have been established, one combining the Medical College and the College of Graduate Studies, the other for the College of Allied Health Sciences. The newly created position, “University Historian,” has a fitting first occupant, Frederick B. Wagner, Jr., ’41, the Grace Revere Osler Emeritus Professor of Surgery, who plans to write the history of Jefferson starting at its founding in 1824.

A grand setting for The Gross Clinic, and other paintings by Eakins, was built in Jefferson Alumni Hall through the beneficence of the Connolly Fund and other donors. The gates at the entrance to the suite were supplied by the Alumni Association.

Structural changes on the campus have included renovations of the Medical College building, the Curtis building and the Foerderer-Thompson hospital complex. A new site for the Radiation Therapy Department has been established in the New Hospital building. The area at the southwest corner of Eleventh and Walnut Streets has been acquired and consideration is underway for the construction of a building to house outpatient services and additional physicians’ offices.

The Hospital (TJUH) functions efficiently and is renowned for its quality of care and financial productivity. The Childrens Heart Hospital is reviewing an in-depth study concerning its present and future goals.

It would seem appropriate that an accounting be given of my stewardship of the past six years. It has encompassed membership in the University Board, the Board of Childrens Heart Hospital, the Health Committee, the Nominating Committee, the Joint Conference Committee and the Capital Projects Committee. Chairmanship of one, and membership in many Search Committees; Board representative for the Hospital (TJUH), and Childrens Heart Hospital, to the Hospital Trustees Association of Pennsylvania and the Delaware Valley Health, Research and Education Committee. It was a gratifying experience, as a Trustee, to present my opinions, to aid in decisions and to experience the constant cooperation and assistance of all those involved.

My sincere appreciation to you, my fellow Alumni, for the honor, the privilege and the pleasure of having served as your Alumni Trustee.
A Million for Jefferson

This is an accomplishment for which we all must take great pride! For the past year each of you has been asked to support your Medical College with gifts to put us over the million dollar goal. Your response to our 36th annual appeal has been remarkable, with a final figure of $1,057,210. Not only have we shattered our goal we have increased over last year’s record high of $916,000 by $140,553. This represents an increase of 16%, well above the 10% challenge we accepted as the Association’s participation in the Decade Fund. Sincerest thanks to each of you who supported Jefferson during the 1983-1984 campaign.

Dollars, most certainly, bring much needed financial support to the College but it also is heartening to note that over 46% of our graduates gave to their school, that the average gift climbed to $287., and that over 1400 alumni increased their donations during the drive.

The Class of 1984 with Norman J. Quinn as agent established a record high for class performance with $69,000. The class of 1971 repeated its first place performance with 109 donations and the class of 1956 is number one with the highest percentage of participation, 65.6%.

Our congratulations to these agents and to the workers who helped with this success. Jefferson is deeply grateful for this fine support.

J. Wallace Davis, M.D.
Chairman
Fall Alumni Calendar

October 3
Class Agents’ Dinner
Union League of Philadelphia

October 9
Reception during the Meetings of the
American Academy of Family Physicians
Crown Center
Kansas City

October 19
President’s Club Dinner
Longwood Gardens
Kennett Square, Pennsylvania

October 23
Reception during the meetings of the
American College of Surgeons
Stanford Court
San Francisco

October
Dinners California Alumni
San Francisco, Wednesday, 24th
Stanford Court
San Diego, Thursday, 25th
Hotel del Coronado
Los Angeles, Friday, 26th
California Club

October 29
Reception during the meetings of The
American Society of Clinical Pathologists
Royal Orleans
New Orleans

November 13
Reception during meetings of The
American Academy of Ophthalmology
The Capitol City Club
Atlanta

November 17
Dinner for Central Pennsylvania Alumni
Hotel Hershey

November 28
Reception to honor Philip Hodes, M.D.
during the meetings of the Radiological
Society of North America
Cosmos Club
Washington, D.C.