Alumni Calendar

November 1 & 2
Eating Disorders Throughout the Life Span
Sponsored by the Department of Psychiatry and Human Behavior
Jefferson Medical College
The Hershey Hotel

November 13
Reception during the meetings of the American Academy of Ophthalmology
the Capital City Club
Atlanta

November 28
A reception to honor Emeritus Professor Philip J. Hodes during the meetings of the Radiological Society of North America
The Cosmos Club
Washington, D.C.

December 7 & 8
Use of the CO₂ Laser for Head and Neck Surgery
Sponsored by the Department of Otolaryngology at the College
(also offered February 22 & 23)

January 27
Reception during the meetings of the American Academy of Orthopaedic Surgeons
The Hilton Hotel
Las Vegas

January 25
Dinner for alumni and faculty in Delaware
Wilmington Country Club

February 6, 7 & 8
Dinners in Miami, Fort Lauderdale and Tampa areas for Florida alumni
Places to be announced

February 28
Annual Business Meeting
Alumni Association, JMC

Reunion Chairmen

Dates: June 4, 5, 6, 8, 1985

1930 55th
Patrick J. Kennedy, M.D.

1935 50th
Edmund L. Housel, M.D.
J. Edward Lynch, M.D.

1940 45th
Joseph R. Bigley, M.D.
Herbert A. Luscombe, M.D.

1945 40th
James H. Lee, Jr., M.D.
John S. Madara, M.D.
Edward H. McGehee, M.D.

1950 35th
William B. McNamee, M.D.

1955 30th
Herbert E. Cohn, M.D.

1960 25th
Sherman W. Everlof, M.D.
Richard R. Soricelli, M.D.
Leonard Vinnick, M.D.

1965 20th
Nancy S. Czarnecki, M.D.

1970 15th
Richard L. Nemiroff, M.D.

1975 10th
John E. Hocutt, Jr., M.D.

1980 5th
Marianne T. Ritchie, M.D.
Options For Hospital Funding 2
Jefferson's President addresses the problem of future funding for health care.

The Dunglison Grave Revisited 7
University Historian Frederick B. Wagner, Jr. '41, writes about this early Dean of the Medical College, whose tombstone was recently restored.

Jefferson Scene 11
An article on the varied uses of the computer, a Director for the new Toxicology Division, a profile on Gary G. Carpenter, '60, and Young Investigator, David H. Fischer, M.D., are featured.

Dinner at Longwood 22
Longwood Gardens' flowers and fountains set the scene for the annual President's Club Dinner, to honor and entertain Jefferson's generous alumni and friends.

Class Notes 26
Joseph Julian, Jr., '71, writes of his experiences in refugee rehabilitation along the Cambodian border, and George C. Godfrey, '52, tells what it's like to be a physician to the casinos in Atlantic City.

Editor
Nancy S. Groseclose

Assistant Editor
Judy Passmore McNeal

Publication Committee
Franz Goldstein, M.D. Chairman
Cynthia B. Altman, M.D.
William V. Harrer, M.D.
Warren R. Lang, M.D.
Fred D. Lublin, M.D.
Gerald Marks, M.D.
Philip Nimoityn, M.D.
Leon A. Peris, M.D.
J. Woodrow Savacool, M.D.
Stanton N. Smulens, M.D.

Credits:
Photos of the Longwood dinner, including cover, profile and computer story by Don Walker.

Published four times a year, Fall, Winter, Spring, Summer
Second Class Postage Paid at Philadelphia, Pa. ISSN-0021-5821

The Alumni Association of Jefferson Medical College
1020 Locust Street, Philadelphia, Pennsylvania 19107

POSTMASTER: Send address changes to the above address.
Options for Hospital Funding

An Economy Class of Health Care Delivery?

by Lewis W. Bluemle, Jr., M.D.

The care of the poor has been a traditional mission of American Hospitals ever since the first one was established in 1751. For example, the stated purpose of the Pennsylvania Hospital founded by Benjamin Franklin and Dr. Thomas Bond was to relieve "the distress of such distempered poor as from time to time came to Philadelphia" and was "for the relief of the sick poor and for the reception and cure of lunaticks."

This humanitarian purpose was echoed in the founding documents of many hospitals built over the ensuing 200 years. Indeed, during this more religious era of American History, a shared sense of responsibility to provide needed medical services to the less fortunate members of our society served as a source of great spiritual strength.

At the turn of the century, when medical education became more reliant on ample clinical experience, a symbiotic relationship developed between the sick poor and the teaching hospital which has served both well to the present day.

In the first half of this century, government and industry were minimally involved in health care financing.

Dr. Bluemle, President of Thomas Jefferson University since 1977, spoke on this subject during the national meetings of the Association of Academic Health Centers.
Hospital trustees, administrative officers, faculty and staff all prided themselves on being part of a largely one-class health care enterprise for rich and poor alike—and that class was first class.

and no one calculated how much of the gross national product was spent for this purpose. Nurses, hospital orderlies, kitchen and laundry workers settled for a hard life and low pay, content in the belief that a more rewarding life awaited them in heaven. Interns, also underpaid, expected only modest rewards, but somewhat sooner.

Infant mortality rates were high. Life expectancy was short. Infectious disease was a constant threat. The physician’s power to change the course of most morbid processes was very limited. Thus, medical charity didn’t cost very much and it also produced few miracles. But charity service became an integral part of the model, up through mid-century, laying the seeds for later scientific developments which now make medical miracles—indeed expensive miracles—not only possible but commonplace.

Along the way, charity as a motivating personal force in American medicine was somewhat modified. With the advent of Medicare and Medicaid, so-called “volunteer service” applied to a lesser number of doctors. Faculty members rejoiced as more clinical income became available. Deans rejoiced as medical colleges got their fair share through private plans and the difference between full-time and private physician incomes decreased.

Technology expanded. Hospital support personnel proliferated and many joined unions. Incidentally, some of these unions are now demanding unlimited health care for the poor as well as increased wages for themselves in their hospital contract negotiations. Accredited agencies, revised building codes and new consumer demands brought better standards for patient care, hospital food and hotel comforts, as well as safety. Hospital trustees, administrative officers, faculty and staff all prided themselves on being a part of a largely one-class health care enterprise for rich and poor alike, and that class was first class.

In summary, then, it would appear that by the early 1970’s academic medicine had finally achieved a level of care for the old and poor, as well as benefits for itself, that could only have been dreamed of 50 years before.

However, this dream is now being tempered by a realization that hospitals cannot afford it. A complex set of forces has driven our health care system to a point apparently beyond the ability of hospitals to control its costs, still rising much faster than the Consumer Price Index. Competition, not on quality of service but on price reduction, seems the country’s only answer.

The situation may also be looked at from a different point of view. If we must accommodate or compromise with the values of a competitive marketplace, we shall ultimately corrupt the academic enterprise.

What compromise should we adopt between the two extremes of maintaining the commitment of hospitals to the poor and possibly going broke on one hand, or reducing this commitment but at significant risk to our communities on the other?

If institutional solvency and social purpose become mutually exclusive because of reduced subidation for care of the poor and old, then we must make a choice. For the moment we can still shift some costs to self-pay patients and the private insurers, but Robin Hood’s burden is getting awfully heavy. Additionally, American industry’s aggressive search for lower priced health care for its workers will only further narrow the shrinking subsidy base for indigent care.

Each academic health care center must of course decide its own community role in the context of its own circumstances: historical, economic, geographic, legislative and otherwise. However, the collective posture of academic hospitals as a segment of the health care industry will generally reflect three facts.

The first fact is that the problem of caring for the poor is ours de facto if not de jure. That is, the kinds of hospitals with which most of our academic health centers are associated constitute some of the principle foci for indigent care in this country. This fact was reinforced by a recent Urban Institute study of all short-term, general, non-federal, non-profit hospitals of 100 beds or more in the nation’s 100 largest cities. There were 736 such
If institutional solvency and social purpose become mutually exclusive because of reduced subsidation for care of the poor and the old, then we must make a choice. For the moment we can shift some costs to self-pay patients and private insurers, but Robin Hood's burden is getting awfully heavy.

hospitals in 1980 and they provided over $7.5 billion of care to the poor. Of the 453 hospitals studied more intensively, those under private auspices provided about 70 percent of the Medicaid-financed care, while charity care was the overwhelming responsibility of the public institutions (charity care being defined as that provided to patients from whom no payment is expected because of inability to pay).

Not surprisingly, there was a strong correlation between indigent care and teaching function. The average non-teaching private hospital spent $4.3 million on indigent care, compared to $15.4 million for the average one with teaching commitments. The charity burden was even greater for public hospitals, averaging $26 million for each non-teaching institution and over $30 million for each teaching public hospital. These data add statistical credence to the assumption made for many years, namely, that the large inner-city hospital which is either a part of, or closely allied with, an academic health center constitutes the mainstay of our nation's medical safety net for the poor.

The data also showed that the best indicator of hospital financial stress is not poor management but rather the hospital's load of poor patients, particularly those under ambulatory care. Too much indigent care, it would appear, can make the hospital itself poor, and even before prospective payment comes into existence.

A second fact is that health care needs of the poor and the old, already of massive proportions, can be expected to increase sharply over the next few years. The age-adjusted death rate in the United States has been declining at over two percent per year since 1968. It is also falling sharply for the elderly, so that we now have not only more people over 65, but a lot more over 75. The health care needs of this growing segment of our older populations will undoubtedly continue to increase with time.

Similarly, the number of our citizens below the poverty line has been rising since 1978 and not just because of unemployment. The most alarming of the poverty trend lines is a sharp increase in poor children under 18 years of age. This in turn is the result of a dramatic increase in the number of households headed by a single parent, mostly women, which doubled from 1.7 million in 1966 to 3.4 million last year. Most of these households are located in our bigger cities. In these households are 6.7 million children, certainly some of whom were born in the obstetrical units of our academic health care hospitals. Many of them will probably return for delivery of their own children in the near future. As those who cannot escape the poverty cycle grow older, they will experience about twice the average prevalence of heart disease, arthritis, hypertension, asthma, diabetes and emphysema, according to data cited recently by David Jones, President of the Robert Wood Johnson Foundation.

In total, there are about 45 million Americans who now depend on free or subsidized health care. Their medical needs are directly related to age and poverty. They live primarily where most of our academic health centers are located and their numbers are growing.

A third fact is that few hospitals will be inclined to accept more indigent patients, or perhaps even maintain their present loads, in a more competitive environment. Certainly the growing for-profit institutions are not likely to. In the first place, most of them are not located where the poor people are, and the care of the sick poor is not in their charters. Also, it would appear from the studies, first by L.S. Lewin and more recently by R.V. Pattison and H.M. Katz, that the for-profits may be less cost-effective than their not-for-profit sister institutions anyway. So they may have no economic margin for community service in a competitive era even if the incentive were there. Incidentally, all 280 hospitals in the study groups, both for-profit and not-for-profit, were minimally involved in either charity care or teaching. These two functions seem to be mutually present or mutually absent.

It is highly doubtful that we will ever see an ambulance program in health care equivalent to the bussing program in education, and I for one would not
These data add statistical credence to the assumption made for many years...that the large inner city hospital...either part of, or closely allied with, an academic health center constitutes the mainstay of our nation’s medical safety net for the poor.

argue for it. However, the idea of redistributing the financial burden of indigent care among all hospitals is beginning to be heard. To quote Hadley et al: “It would occur on a voluntary basis—with a community’s institutions committing a fixed amount of their surplus to support other institutions’ care to the poor. Or government could mandate a redistribution—as has occurred in rate-setting programs that required all third parties to contribute to bad debt and free care in return for constraints on total payment increases.”

Even Clark Havighurst, Professor of Law at Duke University, a strong proponent of old-fashioned capitalism as the best treatment for our ailing health care system, acknowledges that, “Specifically, much of the squeeze caused by aggressive purchasing will be felt by indigent populations who cannot afford the services they need. These populations have long relied on the ability of hospitals to shift the cost of their care to others, an ability that cannot survive an awakening of hard bargainers on the demand side of the market. Here, then, is a community concern that should indeed give business leaders pause in their unilateral efforts to reduce fringe benefit costs. Business interests should not use their new-found bargaining power simply to escape their responsibility for contributing a fair share toward meeting recognized community obligations.”

Let us hope that his kind of concern will ultimately be reflected in the actions as well as the rhetoric of both government and industry. Until it is, however, it behooves the prudent manager of every academic health center hospital with a heavy indigent load to examine all options for containing this load as its financial base becomes less stable.

I would say there are basically only two options, reduction of costs and reduction of care.

In the old days at a hospital like Jefferson in Philadelphia a doctor could do both with a street car token. When that extra poor patient in the clinic needed to be hospitalized but the wards were full, the doctor could send him off to the Philadelphia General Hospital where the cost probably was less and the comforts were certainly not overdone. But now the old Philadelphia General Hospital where Sir William Osler made his early imprint in academic medicine, is gone.

How about reduction of care or rationing of medical services as an ultimate option? The very thought is repugnant, as anyone who has ever had to do it can testify. My personal experience came in the early days of the artificial kidney, when there were not enough resources, human, technical, or otherwise, to meet the demand. Aside from being demoralizing to both the doctor and the patient, outright denial of really necessary care is not publicly acceptable either before or after prospective payment. Furthermore, it may not be good business in two regards. First, the referring physician whose poor patient is rejected is unlikely to send the hospital his well-insured patients. Second, if the fixed costs for indigent care are very high and irreducible over the short term, money may not be saved by decreasing patient volume. In fact, it may be better to lose $2 per patient visit at 100 visits a day, than $10 per patient visit at 50 patients a day.

Nevertheless, prospective payment, corporate bargain seeking, and legislative proscription of cost shifting, all coming to bear simultaneously, could necessitate outright denial of care at the same institutions. At state institutions the stimulus may simply be a reduction in the state appropriation for hospital operation.

This happened in Nebraska in the late 1970’s at the University of Nebraska Medical Center. State support fell from $3.7 to $1.6 million.

To deal with the problem, a task force of faculty and administration was appointed which realized that indigent care would have to be limited. In consultation with the various branches of state government, a policy was adopted to restrict elective non-emergency admissions in the absence of adequate insurance coverage or ability to pay by requiring a 20 percent down payment of estimated costs at the time of admission, 50 percent for out-of-state residents.
In the first few years 88 patients were denied admission. By and large, the policy seems to be working, although some faculty members apparently consider it a major denigration of academic medicine's social responsibility. Extensive press coverage is said to have stimulated a rise in charitable care reported by other local hospitals.

Whether this approach would work in the Bronx or in North Philadelphia I'm not sure, but a telephone survey conducted by the University of Nebraska group indicated that many other university-owned institutions use a financial screening process, and half of them have formal policies for denying admission for non-emergency cases.

There is such a policy, for example, at Thomas Jefferson University Hospital, and it, too, works reasonably well, but as yet a suitable mechanism has not been found for restricting unreimbursed ambulatory care, a major economic problem in Pennsylvania. At present the University can still subsidize indigent ambulatory care from general hospital revenues.

While these techniques are holding the fort for the moment, one wonders whether they will be sufficient in 1986 when we begin to feel the full impact of prospective payment. There is reason to believe that by that time a significant number of poor patients may have to be turned away altogether, at least in the large economically disadvantaged cities.

Then how about the option of reducing costs as a way to solve the indigent care problem? It is apparent that all of our hospitals are now strengthening management methods to shorten length of stay, reduce unnecessary use of ancillary resources, and meet the demands of a diagnosis related groups (DRG)-based prospective payment system.

So far it would appear that these cost saving efforts are aimed at bringing about needed economy in the care of ALL patients, indigent and non-indigent alike. Having virtually achieved one-class hospital care over the past two decades, it is natural that we should now take it for granted. But I believe it is also time to ask whether any institution can continue to run a charity hospital and a sophisticated referral center under one roof with essentially one pricing structure. If we reduce costs across the board to the point where our teaching hospitals can afford to admit the poor, will they still attract the well-insured?

An alternative, in states without uniform payment systems for all payers, is to develop an economy class of care with modest amenities, low personnel to patient ratios, and more reliance on young men and women training for professional services. This would be a contemporary equivalent of the old medical ward. It could be available to indigent patients and to those seeking the lowest price. Patients who can afford more privacy, greater personal comforts, and less teaching atmosphere would still have access to a different setting but at a higher price.

The way such a modern ward or "shared caring" unit could be developed would be to have just one nursing station for 20 patients. This should still permit ample attention and observation. Social interaction among patients would be encouraged, as well as self-reliance for simple functions such as serving trays and housekeeping. Incentives for efficient operation could be engendered among house staff and nurses, possibly on a competitive basis with other units. What better way to teach young health care professionals about the importance of economy, its crucial balance with quality, and the ultimate risks if economy is carried too far?

I realize the idea of a "shared caring" unit is not likely to gain quick endorsement from hospital employees, residents, nurses, hospital administrators, or even most patients — so long as there is enough money around for everyone to go first class. But I believe the time is coming when we must test experimentally ways of tailoring acute hospital care to the consumer's need and ability to pay. We must learn where our costs for hospital care really lie. This may be the key to being able to provide indigent care in a competitive era.

To summarize, academic health centers have a heavy investment in the care of the poor. The operating costs of this investment are covered poorly at present and will be even more inadequate in the years ahead despite a growing demand.

To the extent that public policy covering this social need is inadequate or tardy, certain problems of indigent care would have to be left to our institutions to work out on their own. General cost reduction and rationing within reason would be the first line of defense. A third one, quite foreign to our ethic and our present reimbursement systems, is the adoption of a range of health care settings, comforts, and services comparable to those offered by airlines, banks and other deregulated providers of human service. What is needed is study of the feasibility and cost-saving potential of an economy class of hospital care.

In conclusion, there is no "right answer" to the question of indigent hospital care in a competitive environment. However, my feeling is that academic medicine has no choice but to accommodate to the values of a competitive marketplace. Indeed, I would submit that we must teach our students more than their predecessors learned about efficiency in health care, since efficiency itself may well become the hallmark of academic medicine in the post-Flexnerian era.

---

I submit that we must teach our students more than their predecessors learned about efficiency in health care, since efficiency itself may well become the hallmark of academic medicine in the post-Flexnerian era.
The Dunglison Grave Revisited

by Frederick B. Wagner, M.D. ’41

If you think visiting a cemetery is the last thing to do, why not go even further to avoid one that is largely deserted today. Contrary to this view, President Lewis W. Bluemle, Francis E. Rosato, M.D., the author and Philadelphia historian John Francis Marion established a priority regarding our Jefferson heritage to restore and highlight the grave of one of our nearly forgotten “greats,” Robley Dunglison, M.D. Uniquely, the circumstances were timely for the man, the cemetery and the idea.

Robley Dunglison (1798-1869) was an equal counterpart in medicine to Samuel D. Gross in surgery. Both were the intellectual giants of their era, not only at Jefferson but nationally. Gross, his fellow Professor, wrote as follows: “Of all the colleagues—nearly 40 in number—with whom I have been associated, Robley Dunglison was by far the most learned. His range of knowledge was almost encyclopedic. With his vast acquisitions he combined remarkable clearness of intellect and soundness of judgment. Even at the Green Row Academy, where he received most of his early classical education, he was distinguished for rapid progress in learning and for systematic habits. Whatever seemed to him to be of special importance he faithfully recorded in his notebooks, which were remarkable for their neatness and for the extent and variety of their contents. His after years were given up to literary toil.”

As one of the most prolific medical writers of all time he prepared eight volumes with supplementary notes of autobiography, personal recollections, letters, business accounts and sundry records that are preserved in the College of Physicians of Philadelphia. In 1963, Samuel X. Radbill, M.D., published this material as “The Autobiographical Ana of Robley Dunglison, M.D.” in the Transactions of the American Philosophical Society, the

Dr. Wagner, the Grace Revere Osler Emeritus Professor of Surgery, is serving as the University Historian.
oldest scholarly journal in the United States. It is the most authoritative account of the events, places and persons in his distinguished career, and especially rich in Jefferson lore. Among his many accomplishments were his roles as personal physician to Thomas Jefferson, his work in physiology and the deanship at Jefferson.

In 1824, while George McClellan (age 27) was occupied at Philadelphia in the founding of Jefferson Medical College, Thomas Jefferson (age 81) was equally occupied at Charlottesville in founding a medical school for the University of Virginia. In that same year Rобley Dunglison was recruited from London by Francis E. Gilmer, Esq., Jefferson’s representative to take the chair which comprised instruction in “Anatomy, Surgery, the History of the Progress and Theories of Medicine, Physiology, Materia Medica and Pharmacy.” The comprehensive nature of these duties did not deter Dunglison who had unlimited capacity for challenge.

Scarcely three months after Dunglison’s arrival with his bride Harriette, Jefferson on May 17, 1825, requested the personal medical attention of his new professor. The complaint was urinary frequency due to partial prostatic obstruction. Within the next two weeks Dunglison called eight times at Monticello, affording relief by passage of a bougie and teaching the ex-president to carry out the procedure himself. Jefferson, who formerly had distrusted physicians as doing more harm than good, quickly developed confidence and respect for Dunglison’s conservative belief that “nature assisted by rest, abstinence and good nursing would effect a cure in most cases.” Friendship with social visits that included Mrs. Dunglison developed.

Between May 27, 1825, and April 7, 1826, a historic series of letters were exchanged. These “Jefferson-Dunglison Letters” were among the last that the dying Jefferson wrote to anyone and extended to within three months of his demise on July 4, 1826. Published in 1960 by John Morris Dorsey, M.D., they contained a dialogue in which Jefferson expressed gratitude for the medical services with protests about not being billed and rebuttals by Dunglison for the privilege of treating the former president and current university rector. Diarrhea, becoming increasingly resistant to medication and probably due to colonic malignancy, brought an end to Jefferson’s life. During the last eight days Dunglison remained at the bedside and closed his famous patient’s eyes in death. As a token of esteem, Jefferson had directed that a grandfather clock in his bedroom, that Dunglison admired, be given to his physician. This Jefferson-Dunglison clock, still in perfect running order, may be viewed in the main exhibition hall of the Historical Society of Pennsylvania. Several years ago a replica of this clock was donated anonymously to Jefferson and stands in the Board of Trustees room in the Scott building.

While in Virginia, Dunglison was subsequently personal physician to James Madison, James Monroe, and called into consultation for treatment of Andrew Jackson. In 1833 he went to Baltimore to teach at the University of Maryland, and in 1836 came to Jefferson in the chair of Institutes of Medicine where he remained the rest of his career.

Dunglison’s textbook, Human Physiology, was printed in Boston in 1832. As the first comprehensive treatise on physiology by an American author it earned for him the title of “Father of American Physiology” and promptly became the leading class-book for students. It was periodically revised by Dunglison and at his death had reached the seventh edition. For a time he participated actively in the research of William Beaumont, M.D., surgeon in the U.S. Army, on the gastric juice obtained from the fistula of Alexis St. Martin. He personally performed some of the experiments on the juice and outlined some chemical examinations, which when aided by his chemist friend Emmet identified hydrochloric acid as a significant constituent. According to Radbill, of all the respectable scientists to whom Beaumont applied, Dunglison was the only one who came to his aid. Further, were it not for the pressure from his cousin Samuel Beaumont to publish his work alone, it is likely that Dunglison would have been an associate author. Above all else, Dunglison loved to teach and he never entered the classroom without due preparation. He spoke rapidly but concisely and with a British accent that added elegance to his diction.

On arrival at Jefferson Medical College in 1836, Dunglison encountered internal strife, the result mainly of jealousy and pettiness which was surprising among men of stature and repute. He was warned of this before coming but by nature and intent determined to remain non-partisan in the quarrels. He refused to take sides in the struggle between George McClellan and the Board of Trustees which refused to yield to attempted domination by the founder. His famous “letter of appeal” of March 9, 1839, to the Faculty established him as a peacemaker. Edward L. Bauer, M.D., appropriately reproduced this classic letter in the appendix of his book on Jefferson history, Doctors Made in America. When Dean Robert M. Huston retired in 1854, the Board of Trustees would consider no other faculty member but Dunglison to accede to the post. He was most loathe to accept but felt duty-bound to do so. During the last 14 years of his professional life he added these administrative chores to his arduous editorial duties. His name is on thousands of Jefferson diplomas.

Radbill credits Dunglison with an impressive number of innovative “firsts.” At the University of Virginia, Jefferson limited Dunglison’s practice to consultation only, thus making him the first full-time professor of medicine in the United States. His annual salary was $1,500, with supplementary tuition fees, and free rent in one of the University pavilions. A five-year covenant of $5,000 guaranteed the arrangement, which was an early example of academic tenure. Also at the University of Virginia he was the first in the country to give a formal series of lectures on medical history in the curriculum. His treatise on “Human Physiology” as the first of its kind in America
has already been mentioned. In 1833 his medical
dictionary was the first book of this type in our country and
went through 23 editions, earning him the sobriquet of
"walking dictionary." When appointed Professor of
Hygiene at the University of Maryland in 1833 he became
in fact the first professor of preventive medicine and public
health in our nation. By publishing his systematic lectures
he created the first formal textbook of hygiene on this side
of the Atlantic.

Dunglison received an LL.D. degree from Jefferson
College at Canonsburg in 1852 and the same degree from
Jefferson Medical College the following year. The list of
institutions to which he belonged, his writings, editorships,
honors and cultural activities is staggering. Thomas Sully
painted a portrait of Dunglison in 1868 for the Musical
Fund Society, of which he was the President, which now is
on display in the College of Physicians of Philadelphia. In
1876 Jefferson Medical College commissioned Samuel Bell
Waugh to do a posthumous portrait of the Dean.

Inquiry into the circumstances that led to Dunglison’s
burial in Laurel Hill Cemetery is interesting. This
cemetery, founded in 1836, is the second oldest rural one
in the United States. Mount Auburn, in Cambridge,
Massachusetts, created in 1831, was the first of significant
size to be detached from a church or parish and the first to
be non-sectarian. Laurel Hill Cemetery was formed by
union of a northern section, originally the county seat of
Joseph Sims, called “The Laurels;” a central portion,
previously owned by George Pepper, known as “Fairy
Hill;” and a southern area, the county seat of William
Rawle, called “Harleigh.” This 95 acres rises high along
the east bank of the Schuylkill River and adjoins
Fairmount Park. While only several miles from City Hall,
in those days it was considered beyond city limits and a
“strollers paradise.” Laurel Hill was the first rural
cemetery to be designed by an architect, John Notman
(1810-1865), and the natural landscaping was embellished
by the listed planting of 178 of the principal trees and
shrubs that would survive the Philadelphia climate.

Dunglison through his membership in the American
Philosophical Society as well as the Asylum for the Deaf
and Dumb and Asylum for the Blind became associated
with Benjamin W. Richards, formerly Mayor of Philadel-
phia and organizer of Laurel Hill Cemetery.

As editor for the “American Medical Intelligencer”
Dunglison wrote an article for the July 1, 1837, issue

---

The Osler Plaque

Revere, Gross, and Osler were the names that adorned
the life of Lady Osler from 1854 to 1928. She enhanced
their prestige over the bridge of two centuries and
on both sides of the Atlantic by her many benefactions.
Eulogized as the “ideal physician’s wife,” she extended
the legend of Sir William Osler, Regius Professor of
Medicine at Oxford University. Her first husband was
Dr. Samuel W. Gross who inherited the intellectual
superiority of his world-famous father and succeeded
him as a Professor of Surgery at Jefferson. Their happy
marriage ended by his premature death at age 53.
The “Widow Gross” married Dr. William Osler three
years later but never forgot her “first love” or
Jefferson Medical College. In her will of 1928 she
endowed a lectureship at Jefferson in memory of her
first husband for his interest in tumors. This subse-
quently became the Grace Revere Osler Professorship
of Surgery, first held by Dr. George P. Mueller, 1939
to 1946.

Dr. Frederick B. Wagner, Jr., ’41, Grace Revere Osler
Emeritus Professor of Surgery and University Historian,
presented a plaque, honoring the benefaction of Lady
Osler to Jefferson, at an Oslerfest at Oxford, England,
on September 25, 1984. It is presently hanging in
the Osler mansion. He also gave an illustrated talk on
the “Twilight Years of Lady Osler” before the Osler Club
of London on October 1st.
entitled “Rural Cemeteries.” A quotation reveals his sentiment and his flair for the literary style of that era: “How often has it happened in the progress of our own city to its present population, that places of worship have been disposed of; their cemeteries desecrated, and ashes, which, at the period when they were deposited there, it was presumed, would ever remain free from violation, been exhumed and scattered to the winds.

“These and other considerations have given rise to the beautiful cemeteries of Pere la Chaise, near Paris, of Mount Auburn, near Boston, and of Laurel Hill near this city. The preceding remarks have, indeed, been suggested by a recent visit to the last of these. Situated at a convenient distance from the city of Philadelphia, yet so far from it as to almost preclude the possibility of future molestation in the progressive improvement of the city or from other causes, on a sylvan eminence immediately skirting the Schuykill, and commanding a beautiful view of that romantic river; embellished in a manner most creditable to the taste and liberality of spirit of the respectable individuals under whose management it has been projected, and carried into successful execution, it is indeed a hallowed place where affection may delight to deposit the remains of those on whom it has doated; ’a part of rest from troublous toyle. The world’s sween In from paine and wearisome turmoyle.”

The proprietors of Laurel Hill Cemetery, with whom Dunglison enjoyed the warmest friendship, shortly thereafter made him the gift of a lot. It was not long without use, for in 1841 his 16-year-old daughter, Harriette Elizabeth, died of “endopericarditis” due to rheumatic fever. Twelve years later, when Robley was 55, he was destined to suffer the loss of another Harriette, his devoted wife of nearly 30 years of happy marriage. She likewise died of a cardiac complication of rheumatic fever which she had first experienced at the age of 13 in England. Dunglison believed in the hereditary predisposition to acute rheumatic fever and wrote that the cause of his daughter’s death “was laid in an organization derived from her progenitors, her mother having suffered from the same malady many years before we were married.”

The mother was buried to the side of her daughter, and Dunglison never remarried. Four sons and a daughter survived their distinguished father. Two sons, Richard J. and Thomas R. became physicians (Jefferson Medical College graduates, 1856 and 1859 respectively), William L., a merchant, and J. Robley an editor and reporter of the “Sunday Republic.” Richard J. was a subsequent editor of Gray’s Anatomy, and also continued the later editions of his father’s medical dictionary.

Robley kept residence with his physician sons at 1116 Girard Avenue in Philadelphia and died at age 71, April 1, 1869, in congestive heart failure. His burial site in Laurel Hill Cemetery is marked by a horizontal tombstone with slanting sides and a cross engraved at the head. Harriette’s name is inscribed on one side and Robley’s on the other, with their years of birth and death.

Happily, this is not the end of the account. The author’s interest in Laurel Hill Cemetery (now known as East Laurel Hill as opposed to West Laurel Hill truly beyond city limits in Bala Cynwyd) was initiated by finding the well-preserved grave of George McClellan, founder of Jefferson Medical College (cf. Jefferson Al. Bull., the winter 1980, p. 16). Around this time Mr. John Francis Marion, author of “Famous and Curious Cemeteries,” was conducting tours of Laurel Hill under the auspices of the Philadelphia Museum of Art, the University of Pennsylvania and the Friends of Laurel Hill Cemetery. His fascinating explanations of the monuments, temples, columns, urns, crosses, marble coffins, life-sized statues of animals, people and angels, suggested that the collection is actually an “outdoor museum” especially related to the Victorian era. An overview of the multi-faceted aspects—literary, artistic, political, military, medical, architectural, mercantile, horticultural, etc., required a programmed series of three visits. The tours were conducted in rain or shine. On one occasion in which the author was thoroughly drenched, Mr. Marion dryly remarked that “the Almighty is not wishing to cooperate.”

In 1977 East Laurel Hill was listed on the National Register of Historic Places. Restoration plans were developed and the outer portion of the pillared gateway was renovated. Mr. Marion stressed the need for foundations, relatives and friends to restore graves and volunteers to aid in the horticultural maintenance. He lamented the lack of even the simplest information that would enhance the visitors’ interest in many of the grave sites. The Dunglison grave seemed a case in point. After more than a century the foundation was sinking, the stone no longer level, and matted weeds were growing randomly over the slanting sides of the well-weathered granite. The lettering was distinguishable but dulled and dirty from dust and storm. Dunglison’s grave was not mentioned in the tour series, although conveniently located (Lot 106, Sect. B) near the cemetery entrance.

A project was conceived, with enthusiastic endorsement by everyone consulted, in which the foundation would be raised, the tombstone and ledger polished, and an informative headstone erected. It was essential that the tombstone and its inscription remain unaltered and that there be no legal objection by any Dunglison descendants. There were no traceable living descendants and the Cemetery Board gave approval at its October, 1983, meeting. Restoration was completed with a separate commemorative granite slant-faced headstone inscribed as seen on the photo on page 7.

President Bluemle graciously provided University financial support because Dunglison “had such a profound and beneficial impact on Jefferson Medical College during its formative years.” It is a recompense for absence of Dunglison’s name on Jefferson’s Winged Ox Column that he is again remembered in a historic site where visitors may hear a tidbit of our tradition through achievements of one of its “exemplary keepers of the faith.”
computer science

Cuban born Guillermo M. Alexander, an Assistant Professor of Neurology, has been at Jefferson since 1982. He utilizes computer imaging to do functional anatomy of the central nervous system of experimental animals. This induces measurement of cerebral blood flow and cerebral glucose metabolism and distribution of neurotransmitters. The following material on computers was prepared by him for the JAB.

Dr. Alexander received the Bachelor of Science degree from the University of Miami in 1968 and then entered the Air Force where he attained the rank of Captain. In 1973 he again enrolled at the University of Miami in the BioMedical Engineering Program receiving a master’s degree in 1975. Remaining at the University he became a Research Associate for the BioMedical Instrumentation Laboratory and later a Research Associate for the Department of Neurological Surgery. Dr. Alexander entered the graduate school of the University of Texas in 1978 and was awarded his Ph.D. in BioMedical Engineering in 1982.

The proliferation of microcomputers in the last decade has been extraordinary. Today’s personal computer not only has the computing power of yesterday’s large systems, it occupies much less space and comes at a fraction of the cost. Microcomputers are beginning to play a significant role in most academic institutions, Thomas Jefferson University being no exception.

The number of microcomputers at TJU has increased dramatically from 39 in October 1973 to nearly 200 systems as of June 1984 and growing rapidly. The University administration and, in particular Dean Joseph S. Connella, have encouraged this growth. The microcomputer systems at JMC vary in complexity from the small Radio Shack TRS-80’s and Commodore VIC-20’s to the relatively large PDP-11’s and DEC-20’s. In the middle range there are a large number of Apple II’s, Apple III’s and IBM personal computers (PC’s). These systems are used for a variety of tasks like word processing, patient data bases, medical practice plan record keeping, information searches from national data banks (MEDLINE), computer assisted instruction, graphics generation and more.

In the laboratories, data storage, statistical data analysis, activity monitoring of experimental animals and computerized image analysis, are just a few examples from the rapidly growing list of microcomputer uses. Microcomputers are tools like pocket calculators, screwdrivers and stethoscopes. Like any tool, they are well suited for some tasks and ill suited for others. Just like a big screwdriver will not do the job when a small one is needed, a small computer may be the best choice to perform a particular task.

The Department of Neurology is a good example of how microcomputers are currently being used at JMC. The department has ten microcomputer systems: four Apple II’s, four Apple III’s, a Compupro S-100 and a PDP-11/34 (technically a small minicomputer). All systems are used for a variety of general tasks, with each system being used mainly for a few specific jobs.

The general tasks are: (1) word processing of grants, manuscripts and correspondence; (2) statistical analysis of experimental data; and (3) generation of graphs.

The specific tasks vary with each investigator. Dr. Gregory T. Golden, Research Assistant Professor, uses a Columbus Instruments Corporation computerized animal activity monitor interfaced to an Apple II to monitor the behavior of rats. Professor Ruggerio G. Fariello uses his Apple III to store and retrieve information about seizure patients on an experimental drug study. Dr. John M. Bertoni, Associate Professor, has developed his own program to store and retrieve references used in his research. He also has automated some of his laboratory work by connecting the output of the Gilford spectrophotometer to an Apple II.

Dr. Fred D. Lublin, also Associate Professor, uses his Apple III to keep track of hundreds of mice in his experimental multiple sclerosis protocol. This enables him to review the progress of his experiments at a glance. Department members are also able to use Dr. Lublin’s Apple III to conduct information searches. The computer is connected through an audio-coupler (Modem) via the telephone to Knowledge Index. Knowledge Index contains data bases on medicine, psychology, agriculture, engineering, books, business, computer and electronics, corporate news, education, government publications, legal information, magazines and news.

Dr. Leopold J. Streletz, Associate Professor, used his PDP-11/34 minicomputer for the averaging and analysis of clinical evoked potentials and for compressed spectral analysis (CSA) of the routine EEG. The CSA modality gives comparative frequency-domain pictures of left and right side power. An attached graphics terminal gives a live cumulative display of the
CSA and similarly the build-up of the evoked potential summations. In addition to the live displays of the EP and CSA during data acquisition, the system has automated and comprehensive physician-interactive graphics analysis and report generation capabilities. The reports are finalized versions used in the patient's chart, minimizing clerical efforts.

The Apple II of Dr. Robert Schwartzman, Chairman of the Neurology Department, is interfaced to an optical densitometer and is programmed to read the optical density of X-ray film. Most of Dr. Schwartzman's experimental work involves the measurement of neural tissue radioisotope concentration by quantitative autoradiography in order to measure regional cerebral blood flow, local cerebral metabolic rate for glucose, and neurotransmitter receptor densities and affinities in experimental animals. This is done by taking thin dry sections of brain tissue containing radiolabelled compounds, and placing them against X-ray film in light-tight cassettes along with standards of known "equivalent" concentrations. After a suitable exposure time the film is removed and developed.

The tissue concentration is computed by comparing its optical density to that of the standards. Measuring radioisotope concentrations utilizing manual densitometry requires large numbers of readings and averaging of these readings in order to obtain regional maps. This is both cumbersome and time consuming. In order to alleviate our data analysis problem we designed and built a computerized image processing system (a full description of this system is in press in Neuroscience Methods). The heart of the computer imaging system is a charge-coupled-device digital camera. The digital image is stored in a Digital Graphics TKS-400 imaging computer system. This system consists of a Compumpro S-100 microcomputer and five additional printed circuit boards that insert directly into the microcomputer. Four of these boards are used to store and manipulate the image; the fifth, which we designed and built, is used to interface the camera to the microcomputer.

This system scans the X-ray film and stores the density values of over 128,000 image pixels. From the density value, it computes the experimental variable being measured (i.e. glucose metabolism, blood flow, etc.) and displays the image on a color TV monitor. Although this system is capable of displaying 256 different colors, a 20 color scheme was found to be optimal for our work. Pseudocolor coding is an image enhancement technique that takes advantage of the eyes greater ability to discriminate between colors than between shades of grey. This technique has been used extensively by NASA to enhance pictures from satellites and deep space probes.

This imaging system is currently being used in the study of Parkinson's disease. The recent description of several individuals who have become Parkinsonian inadvertently due to intravenous use of 1-methyl-4-phenyl-1, 2, 3, 6-tetrahydropyridine (MPTP). MPTP is a contaminant formed during the illicit synthesis of a Demerol-related compound. The subsequent demonstration that MPTP causes a Parkinsonian syndrome in primates has given us a good model for the study of the illness. We are currently studying the changes in brain metabolism and neurotransmitter densities and affinities in this model of Parkinson's disease. Our computerized imaging system has decreased considerably the time spent evaluating autoradiographic data, and has shown us changes in metabolic patterns that we would have otherwise missed.

The variety of microcomputer uses described here is just a small sample of what they can do. Microcomputers not only simplify many tasks but also allow you to perform some that were previously impossible. The aim of personal computer manufacturers is to have a computer at every desk. This may be overly ambitious, but those of us who use small computers in our work, find it hard to imagine doing our jobs without them.
toxicology director

Uniting the University's basic science and clinical capabilities to investigate and treat environmentally linked disorders, the Division of Occupational and Environmental Medicine and Toxicology was established in July, 1983 under the Department of Medicine. Willis C. Maddrey, M.D., Magee Professor of Medicine and Chairman of the Department, who has served as interim director, announces that a Director has been appointed. Lance L. Simpson, Ph.D., assumed the position in October as Professor of Medicine.

A graduate of Vanderbilt University, Dr. Simpson received his Ph.D. in physiology at the University of California and became a postdoctoral Fellow at Columbia University, where he has since served as Associate Professor of Pharmacology and, more recently, as Senior Research Associate and Research Scholar. A prolific writer, he has published dozens of papers and articles on toxicology and related topics.

Dr. Maddrey has expressed his personal commitment to respond to the needs of industry and society, and has defined the following objectives of this Division:

- An educational program that will teach Jefferson's medical students the principles of occupational and environmental medicine and familiarize them with methods medical centers can use to resolve such problems.
- Academic research focused on current toxicologic problems important to the community at large.
- Continuing education programs in occupational medicine, environmental medicine and toxicology to increase the diagnostic awareness and competence of community physicians.
- A resource where persons exposed to toxic hazards can come for treatment and advice.

The Division's eight-person staff will consist of the Director, a physician, a toxicologist, a Clinical or Research Fellow, a postdoctoral Fellow and three technicians. The Director will be assisted by an Advisory Board to work with corporations, labor and other academic institutions and government agencies to assess, clarify and predict the outcome of complex toxicological situations.

In addition to working with public and private organizations, the staff will collaborate with Jefferson's clinical and basic science departments. Members will seek assistance to devise better screening methods for toxic hazards; explain how toxins affect human cells, tissues and organ systems; and sort out the chemical, genetic and environmental factors that contribute to toxic insult. In these and other efforts, they can draw upon more than 30 experts from Jefferson's faculty. These include a large number of recently appointed physicians and scientists engaged in innovative neurological and cardio-pulmonary research relevant to occupational and environmental health.

opening exercises

Cool weather, pomp and circumstance marked the 1984-85 Opening Exercises for Jefferson Medical College, College of Graduate Studies and College of Allied Health Sciences. Joseph S. Gonnella, M.D., principal speaker, was invested as Dean and Vice President of JMC.

Held on Wednesday, September 5, in Jefferson Alumni Hall, the ceremony included a message from the new Dean and the distribution of prizes to outstanding students. University President Lewis W. Bluemel, Jr., M.D., noted that JMC would be starting its 161st year that night. "Academically speaking, then," he said, "Happy New Year."

After recognizing the faculty, the "Stewards of Academic Enterprise," and the trustees present, he told the students gathered to remember that they were among the brightest and the best. He introduced Dean Gonnella by saying that he was the first Dean in the College's history "to pay his own way," referring to Dr. Gonnella's three-year $750,000 grant from the Kellogg Foundation for his work on Disease Staging.

Dean Gonnella told the freshman there that they had been chosen from 4567 applications, and were representatives of 87 colleges and universities. Other statistics from the Class of 1988 show 223 members, 59 of whom are women, 38 of whom are children of alumni and 16 of whom are children of faculty. Of the 223 members, 125 come from Pennsylvania and 98 from other states.

He mentioned the "international flavor," with students from Bermuda, Brazil and Singapore, noting that Jefferson students not only receive high praise from their professors, but from program directors during their rotations, as well. He presented awards to seniors and underclassmen.

The Obstetrics and Gynecology Prize, given to the student who has demonstrated general excellence in Clinical Obstetrics and Gynecology during the third year, was awarded to Marlon T. Maus, Providence, Rhode Island, with honorable mention to Thomas J. Amrick, Allentown.

The Melvin I. Katzman Pathology Prize to a sophomore student for the most outstanding general performance in the pathology courses taken in the first two years of the medical curriculum was awarded to Patricia Anne McCormack, Scranton, Pennsylvania, with honorable mention to...
Steven P. Lawrence, Washington, Pennsylvania.

The William W. Bodine, Jr. Award to the medical student who has completed three years and has shown the greatest tenacity and dedication in research in pharmacology was awarded to Robert F. Crochelt, Jr., Rockaway Park, New York.

The Class of 1947 Scholarship Award, given in memory of the deceased classmates to the student who has achieved a high academic record in the first year, was awarded to Alexandra H. Simkovich, State College.

Three students received the Physiology Award, presented to the top first year medical students in the Physiology Department by its faculty: David B. Abrams, Cherry Hill, New Jersey; Michael R. Gallagher, Newtown Square, Pennsylvania; and Alexandra H. Simkovich.

Prizes were also given by Jussi J. Saukkonen, M.D., Dean of the College of Graduate Studies, and by Lawrence Abrams, Ed.D., Dean of the College of Allied Health Sciences. The CAHS conferred its Alumni Special Achievement Award upon Doris E. Bowman, R.N., B.S.N.Ed., M.S.Ed., former Director of the School of Nursing, in recognition of her contributions in the areas of education, research and community service.

Dean Gonella told the audience that his choice of topics for the evening was broad but that his time allotment wasn't. Instead of speaking to the well-worn issues of the high costs of medical education and care, time investment, curriculum and available resources, he chose "compassion" as his theme. His text appears below.

**compassion in medicine**

The medical profession is criticized for the lack of compassion of many of its members. It seems that for some individuals it is more important for physicians to be compassionate than it is for them to be technically competent. This is not your first exposure to the topic, and I assure you, it will not be your last. While I will focus my remarks on the manifestation of compassion by a physician, a similar analogy can be made for other health professionals.

Webster defines compassion as a "sympathetic consciousness of others' distress together with a desire to alleviate it." He also refers to the synonym, "pity." Therefore, in its strictest sense compassion involves more than a desire to alleviate the distress of others — it means being willing to bear some part of it. The fully compassionate physician, therefore, would be prepared to bear the distress of many individuals and would be quickly crushed by doing so. Too much compassion can clearly destroy the compassionate person. There must be limits. There must also be judgment about where and how and when to be compassionate. The physician, while willing to share the suffering of others, must be able to alleviate it without afflicting him — or herself inappropriately and excessively.

The first mark of a compassionate physician, in contrast to a compassionate lay person, is technical competence. This involves an ability to quickly and effectively determine the causes of patients' affictions. Competence consists of various elements including medical knowledge, a willingness to use that knowledge, judgment, and various psychomotor skills appropriate to managing medical problems. Acquiring such competence may itself be painful and one looks for a compassionate faculty in medical school to help students recognize the ultimate utility of what they are learning. Individuals who are unwilling to exert the effort and to experience the discomfort of acquiring professional competence are unlikely to be compassionate in their professional practice. Again, there must be a balance. One cannot learn what one needs to know in order to become a competent physician overnight (although there are some individuals who try, usually the night before an examination). The pain of learning must be felt over an extended period of time. Of course, one of the nice things about learning is that the pain of learning may itself be just as invigorating as the pain of competing in an athletic event.

The second aspect of compassion in physicians involves the willingness of the practitioner to give time to patients, and to their families. Those who are becoming restive during this presentation may have some difficulty in attending to others for prolonged periods of time. Perhaps the purpose of these opening exercise lectures is to test your stamina and afford you an opportunity to reconsider your choice of a career. Students who have difficulty in giving time to their studies may have difficulty in giving time to their patients. The time that a physician spends with a patient in this country has been estimated to be less than 15 minutes. By contrast, medicine men working with various Indian tribes in our Southwest may spend two or more continuous days with a patient going through rituals designed to produce a cure. For some conditions, the medicine men may be more effective than our modern physicians. A common synonym for physician in the current age is "busy." Physicians are busy. But when they are too busy to spend time with patients, issues relating to compassion inevitably arise. Moreover, patients rarely become ill when it is convenient for their physicians. They are most likely to experience the worst symptoms at night, on holidays, weekends, or when their physicians are burdened by multiple responsibilities.

A third aspect of competence, and closely related to the second, is the ability of the physician to listen. Some physicians may be willing to spend time with patients, provided that they don't have to listen to them. It has been suggested that a major reason for physicians' invariably taking their patients' temperatures is to keep them quiet. Or, the physician may communicate to the patient only innocuous messages and elicit the same in return. "Everything all right today?" may not really be a question but a way of telling the patient you don't want to hear about his or her complaints. Or, one may focus on the obviously trivial and provide no opportunity for the patient
to tell you what is really bothering him. Speaking is only one aspect of communication, and, perhaps, the least important one. The compassionate physician is thus one who listens, one who is sensitive to a wide range of his patient’s problems, one who knows when to be quiet and when and how to get the patient to talk.

If you agree with my description of the features of the compassionate physician, the question then arises: how should one incorporate these ideas into our educational program? There are implications for undergraduate, graduate and continuing medical education.

The first implication is that we should get rid of the dichotomy between compassion and competence. Competence is an integral part of compassion, and compassion is an integral part of competence. We must continue to stress that the students acquire the knowledge, attitudes and skills necessary for effective and efficient practice of medicine. The multiple roles of the physician as a clinician, as a researcher, as a teacher and as a manager must be acknowledged and integrated.

The second implication is that we should not expect medical education, or any education, to be stress free or pain free. We should help students to understand and cope with stress and pain. This involves being able to use our resources more effectively. Study cannot be put off until the night before an examination. The goal of learning is not merely to pass an examination. That which is important and valuable in life does not come easily. Medical school faculty and deans must present role models to students for them to emulate: students and physicians must in turn be role models for their patients to emulate. Attention must be given to efficiency as well as to effectiveness. We must learn that our resources are limited. We must learn how to be compassionate without bankrupting individuals and society. More technically competent physicians are likely to be less wasteful and thus more compassionate in a broader sense. We must recognize that technical competence ought not to be equated with ordering all possible laboratory tests. The discerning physician can make medical diagnoses and monitor patients with a minimum of tests, albeit, perhaps, needing additional time to talk and to observe his or her patients.

To fulfill your role as an effective manager, you will be called upon to utilize efficiently all resources at your disposal. You will be assisted in this task by a modern panacea, the computer, but you must recognize early on that the final clinical decisions—those that really make the difference—are yours.

Finally, I would like to point out the necessity for continuous evaluation. Those factors which contribute to producing compassionate physicians can be identified and should be strengthened. We are not seeking perfection in our physicians. We know that most physicians are competent as well as compassionate. While an evaluation of ourselves will help us to improve, the recognition of our deficiencies will bring with it a degree of pain. But we will cope!

In all such discussions, there is a notorious “bottom line.” Who will pay for physician compassion when an important manifestation of it is time? To some extent, one may think in terms of “trade-offs” whereby more time given upon the patient’s first visit will permit more accurate diagnosis and alleviation of patient anxiety and suffering. This will tend to reduce patients’ need for return visits and the likelihood of medical malpractice actions being instituted. What prompts more patients to sue physicians is not negligence, but what is perceived as an uncaring manner of the physicians, usually associated with limited time having been given to the patient. Proper management of time is likely to make more time available to the physician to handle more difficult patient problems and hopefully more patients.

If one accepts the argument above, there are also implications for medical education. The main function of a faculty is to evaluate student competence, rather than to impart information to the student which he might get from other sources more quickly and easily. This means that medical educators must be prepared to spend more time with individual students. They must help students to identify their own learning problems and needs. Here again, time is a bottom line. And, here again, it may be argued that if faculty time is used wisely, there will be a compensatory reduction in demands being placed upon faculty time later on. If medical students are to become compassionate physicians, they must be exposed to compassionate role models from the moment they enter the medical school. Most medical school faculty, I believe, are compassionate educators. It is my hope that during the period that I serve as Dean, it will be possible for priorities to be rearranged so that our faculty can demonstrate to our students the traits we expect from them. In this, I am prepared to offer my time to faculty and to students in the identification and correction of obstacles in providing the compassionate environment which I judge to be important.

carpenter profile

What do you know the most about, the pediatrician is asked. “How much I don’t know,” he answers. This is a typical response from Gary G. Carpenter, M.D. ’60, who inclines toward self-deprecation and wry humor. But, all modesty aside, there are certain subjects about which he knows more than most people, about which he is considered an expert: short-statured boys, in particular, and conditions in children caused by hormone malfunctions and genetic mistakes, in general. He has been searching for solutions since 1964.

Dr. Carpenter served in the U.S. Navy after The Haverford School, and then attended Rutgers University, graduating from Jefferson in 1960. He took his internship at Jefferson and his residency at St. Christopher’s Hospital for Children, where he was Assistant Chief Resident and a training fellow in metabolism and amino acids. After a year at Temple University Medical
School, he returned to Jefferson as
Associate Professor of Pediatrics and
Director of the Division of Pediatric
Metabolism and Endocrinology. He
consults at seven Pennsylvania and two
New Jersey hospitals; a pediatric
endocrinologist, he is a Fellow of the
American Academy of Pediatrics.

He sees fewer Downs Syndrome
cases than he used to, but figures
prominently in the book CARA,
written by the mother of a child so
diagnosed. He devotes much of his
time now to problems of short-statured
boys who, for reasons of genetics or
metabolism, don’t reach society’s
expectations or their own. They come
to him for treatment, which consists of
small doses of testosterone.

It’s an emotion-charged field, this
interfering with metabolic make-up,
but he’s convinced that the small
dosage he gives is safe. “If boys are
short by genetics, with no medical
cause,” he says, “I’ll intervene a little
bit if both he and his parents approve.
It all depends on how much suffering
he’s doing out there. These are normal
boys born into an abnormal world
inflamed with heightism, the 1984
perception of appropriate maleness.
The trick is to accelerate the growth
time without impinging on their final
height.”

Some of this comes out of a wave of
popularity for Human Growth Hor-
more, “where the real action is.” Since
it has been medically sanctioned, it has
been brought into widespread use.
“These boys may have some growth
hormone, but in measurably smaller
amounts than taller boys. Then, with
injections of HGH, they’re given a dash
of gigantism.” He shakes his head, “It’s
highly controversial.

“Testosterone,” he explains, “in
small doses, has few if any side effects
and ideally increases bone length
without increasing bone age. Human
Growth Hormone, on the other hand,
is different. It makes everything hum.
It increases everything a boy wants
increased, and keeps doing that. It’s
part of the body cosmetics of this
sensate age we live in.”

Although Dr. Carpenter himself is as
tall as any man would want to be, he
has genuine empathy for these boys
who want to be more than they are.
This is why he is particularly guarded
about the use of Human Growth
Hormone: it does exactly what the
boys want it to do, but it carries risks.
There are too many unknowns, he
feels.

“This growth hormone is human
material, supposedly sterile, which
adds strength and growth. But being
human material,” he says, “it can carry
infections. We are putting human brain
material —cadaver material— into
children, and that’s scary. Can’t you see
the anxiety there?

“So far, there have been no tumors,
no occurrence of hepatitis or AIDS or
multiple sclerosis.” Or kuru, the slow
virus that proved devastating to the
Fore tribe in New Guinea because the
women and children ate the brains of
the dead. A similar virus-like particle, that of Jakob-Creutzfeldt Disease, caused the death of ballet impresario, George Balanchine, in April 1983. “This slow virus caused withering deaths,” he says; “It takes its time, but wrecks its havoc. When you take or inject neurologic material, you don’t know what will happen 40 years down the road.”

He has thought of trying to solve this and other mysteries since 1964, when he studied disorders during his endocrine and metabolic fellowship. Most of what he knows now wasn’t available knowledge then. “But once a month,” he says, brightening, “I get to be a regular baby doctor.” He spends one week out of the month in the well baby nursery, “where I display some wisdom and tell young mothers not to put olive oil on their newborns’ dry skin as Cleopatra did.”

Is he a baby lover? “Absolutely not,” he exclaims, surprised at the question, although he admits that his four and a half year old daughter is delightful. Then why pediatrics? “Because it’s so fascinating,” he answers. Outside his office on the eighth floor of the New Hospital, dozens of babies and toddlers fill the clinic waiting room, some sleeping, some nursing, others howling. They are carefully separated from his babies and children, some of whom have serious and often obvious disorders.

“I was trained here as a GP with a rotating internship, so really what I’ve learned about many of these disorders I’ve learned somewhere else and brought here. I graduated to child neurology...actually it was neuroendocrinology, the brains and glands intertwined.” Jefferson provided a haven for his studies. “I would have perished in private practice. Honestly it’s only in the shelter of a University such as Jefferson that a subspecialty such as pediatric endocrinology can thrive. I came back here because they offered me the position of Associate Professor of Pediatrics and an opportunity to do what I wanted. And I tend to want things to go well here,” he adds, as close as he would come to admitting a sentimental attachment to his alma mater.

Dr. Carpenter had a youth of chronic illness, spent in and out of sanatoriums for tuberculosis of the right tibia. He was either in bed, or in a wheelchair or on crutches until he was nine, wearing braces until early high school. An only child, he was shuttled back and forth, coast to coast, “as my disease waxed and waned,” to parents who had been separated since he was a year old. His interest in art grew out of his hours alone, “to make up for the deficits.

“I want to gradually bring the two together,” he says of his passion for art and medicine, “possibly to draw a picture that would be so descriptive of a syndrome that I could not just recognize it myself as having the features and characteristics of that syndrome, but allow for recognition by others.

“This business of syndrome recognition is marvelously complex,” he says, warming perceptibly to the subject: “transmitting the ability to see visual images to other people. We would see that this child had this problem that separates him or her from all other problems. It would give specific diagnosis by sight. Just as you can tell it’s your child running the other direction two blocks down the street,” he says, “that’s how familiar would be this syndrome,” which he describes as “a collaboration of different physical signs that altogether mean something that none of them alone means. Like a constellation,” he says, pointing to an imaginary group of stars on the wall next to his desk. “All the stars put together.

“Syndrome recognition. There’s hardly a good way to teach that,” he admits. “We all have these gifts of insight more or less, but some have better recognition capabilities than others. If it’s intuition, we ought to know that. It may be an absolute science, as carefully worked out as biochemistry, but we haven’t arranged our chemicals right to find it. This study has been very motivating over the years,” he says, “and has amalgamated my tendency to want to draw pictures.”

While drawing pictures of his patients, he was convinced that there are these recognition capacities... image transferring, if you will. “I can describe patients’ features, and I can draw patients’ features, but so far I have not been able to make those two capacities say the same thing. I can’t transmit in visual imagery what can be told in words,” he says, asserting that he will keep on trying.

He attempted once to present his ideas in the form of an art show in the Jefferson Alumni Hall gallery, following a successful watercolor exhibition. “The first show was pleasing and decorative,” he says. “The second was a sincere attempt to add artistic attachment to what I do scientifically, showing syndromes through line drawings. It was depressing.”

He envisions his drawings (“Cartooning isn’t medically legitimate”) in textbooks or perhaps even computer video presentations. “This is my electronic fantasy,” he smiles, peering into his coffee cup, “tying together the loose ends of unusual disorders.”

Of his artistic ability, Dr. Carpenter says he has none whatsoever. “I’ve learned tricks, that’s all. Contrivances, only of value to me.” Anyone who has seen his paintings and drawings, and particularly the hinged miniature wooden sculpture of the Gross Clinic found in the Eakins Gallery, would disagree, but he is adamant. He changes the subject.

“The reason I’m here,” he says, “the sensible reason I’m here, is to have a medical student or a resident in town and work with them around a patient of high complexity, and perhaps evolve through them some method of improved teaching, understanding children’s disorders. This isn’t always achieved, but we try.

“I enjoy talking with students,” he says, “explaining something very complicated and having them understand it. I have a feeling that I teach well, but I never know whether I’ve done it as well as I could have. It takes constant work to make the ideas clearer; there always seem to be flaws. I used to be very structured in my teaching, but I’m a little more
Just want to clarify the concept of hinged miniature medicine. It's a particularly justified effort to make it clear to those students who are not going into pediatric medicine, for it may be their last chance to experience the pediatrician's concept before they are forever immersed in medicine's other specialties. Many will come upon children with medical and surgical problems and the self-evident differences of age are insufficient to direct the therapy in the best possible way.

"The child becomes a curiosity in the adult-care system—an entreatment but also distracting one at that," he says. "The students learn of the ordered disorder of pediatric care."

When Dr. Carpenter is away from the ordered disorder of pediatrics, he is in residence in Lansdale, with his wife and delightful daughter. Here, he relishes the activity of bicycle riding and mowing the lawn with his aging push reel mower. He has been known to relax by playing the accordion and mandolin for his own enjoyment.

Another of his abilities, and as absorbing as his art and music, is flying a German-built Schleicher sail-plane out of Beltzville Airport in southeast Carbon County. He owns the plane with two other pilots, and has been gliding since 1968. He says that soaring is therapy for him—nice and quiet, no phones. One day, as he was riding the thermals above Hawk Mountain, he was overheard to say on the radio that he was "flying formation with two hawks, one off each tip." J.P.M.

honors etcetera

Richard A. Baker, M.D., has been promoted to Clinical Professor in the Department of Obstetrics and Gynecology.

Richard G. Berry, M.D.'s title has been changed from Professor to Emeritus Professor of Neurology (Primary) and Honorary Professor of Pathology (Secondary).

Loretta P. Finnegan, M.D., Associate Professor of Pediatrics and Psychiatry and Human Behavior at Jefferson Medical College, has received the 1983 Galen Award from the Philadelphia College of Pharmacy and Science's Beta Galen Chapter of Rho Pi Phi International Pharmaceutical Fraternity. Dr. Finnegan, who is Director of Jefferson's Family Center Program, was recognized for her many contributions in the area of treating addicts, particularly those that are pregnant.

Christopher M. Frauenhoffer, M.D. '76, has been promoted to Clinical Professor in the Department of Pathology.

The first annual John J. Cartland Lecture honoring John J. Cartland, M.D. '44, the James Edwards Professor of Orthopaedic Surgery and Chairman of the Department, was given May 21 at the College of Physicians. The lectureship was sponsored by the Philadelphia Orthopaedic Society. Guest speaker Clement B. Sledge, M.D., Professor of Orthopaedic Surgery at Harvard Medical School and Chairman of Orthopaedic Surgery at Brigham and Women's Hospital in Boston, discussed the special complications of hip replacement surgery during his lecture, "Management of the Deficient Acetabulum in Hip Arthroplasty."

Dean Joseph S. Gonella, M.D., presented Staging of Disease: A Case-Mix at the Third International Conference on System Science in Health Care held in Munich, Germany, in July. Dr. Gonella has been appointed to a two-year term to the National Board of Medical Examiners Coordinating Committee for the FLEX Examination.

William V. Harrer, M.D. '62, has been promoted to Professor in the Department of Pathology.

Stephen Hauptman, D.O., has been promoted to Clinical Professor in the Department of Medicine.

Madhu P. Kalia, M.D. Ph.D, Professor of Pharmacology and Neurosurgery, has accepted an invitation from the United States Department of Health and Human Services to serve a four-
year term on the Alcohol Biomedical Research Review Committee of the National Institute on Alcohol Abuse and Alcoholism. This committee is responsible for the scientific and technical merit review of research grant applications, training grants, fellowships and contracts submitted to the Institute.

Mark T. Madsen, Ph.D., Clinical Assistant Professor of Radiation Therapy and Nuclear Medicine and Chan Lee Park, M.D., Professor of Radiation Therapy and Nuclear Medicine and Associate Professor of Radiology, received a bronze medal for their exhibit at the Society of Nuclear Medicine’s 31st annual meeting in Los Angeles in June. Their exhibit was titled “Enhancement of SPECT Images by Fourier Filtering of Projection Images.”

Steven R. Peikin, M.D. ’74, Associate Professor of Medicine and Pharmacology at JMC reported in the June 1984 issue of Physiology and Behavior that excessive intake by the obese may be caused by a biochemical defect that prevents the body from sensing fullness. Using genetically obese rats as a model, Dr. Peikin and his associate, Carol McLaughlin, Ph.D., conducted a series of studies of the hormone cholecystokinin, CCK, which is known to stimulate satiety in a number of animals and humans.

Dr. McLaughlin is a former post-doctoral fellow at TJU, now at Washington University, St. Louis.

Joseph F. Rodgers, M.D. ’57, Clinical Associate Professor of Medicine at JMC, has been appointed Associate Dean of Affiliations and Residency Program Coordination by the Board at TJU. Dr. Rodgers’ duties will include the evaluation and strengthening of the teaching programs for Jefferson’s medical students and residents at the more than 20 hospitals with which Jefferson is affiliated.

A past President of Jefferson’s Volunteer Faculty Association, Dr. Rodgers interned at Chester Hospital and subsequently took a residency in medicine at the Mary Fletcher Hospital of the University of Vermont Medical College. He returned to Jefferson in 1959 as a Fellow in infectious diseases and then served as resident and Chief Resident in medicine. From 1962 until 1966, Dr. Rodgers was Director of Jefferson’s Division of Home Care, a program to help medical students appreciate the various medical and social problems involved in the management of patients with chronic diseases in a home setting. In 1970, he was appointed Clinical Assistant Professor of Medicine at JMC, and in 1975 was promoted to his present faculty rank.

The Fourth Annual Housel Lectureship
In Hypertension

Presented By

Morton H. Maxwell, M.D.
Clinical Professor of Medicine
University of California,
Los Angeles
Director Hypertension
Services
Cedars Sinai & UCLA
Medical Centers

Wednesday,
November 28, 1984

students view

Freshman and seniors in two academic years, 1980-81 and 1982-83, responded to eight new questions on the Longitudinal Study given by the Center for Medical Education and Health Care, concerning economic aspects of the medical system. The students were asked to rate each problem as major, minor, or of little importance. Response rate was 90 percent.

Almost all the students considered the rising costs of medical care to be a major problem. The next most highly rated problems by freshman in 1980 were the costs of medical education, the failure of individuals to assume responsibility for their health, and medical malpractice claims, all of which were seen as major problems for more than half of the respondents. Only five percent of the freshman considered excessive numbers of physicians entering the profession a major problem, although 40 percent believed it was a minor problem; 25 percent had no opinion. The only problem for which there was a significant change in the distribution of freshman responses between 1980 and 1982 was the rising cost of medical education.

Freshmen considered the rising costs of medical care and the primary/specialty imbalance among physicians more serious than did seniors. The latter considered the supply of physicians, the costs of medical education and government influence on the financing of medical care more serious than did freshmen. In 1982-83, the seniors again considered the supply of physicians and government influence on financing more serious than did freshmen. In addition, they rated the proliferation of expensive technology and malpractice liability claims higher than did freshmen. As a rule, freshmen and seniors alike tended to consider more important those problems which directly affect medical students and physicians than those which affect the functioning of the health care system as a whole.
David H. Fischer, M.D., is Director of the Uveitis Unit of the Retina Service at Wills Eye Hospital, a member of the staff in the Ophthalmology Department at Lankenau Hospital and Clinical Assistant Professor at Jefferson. He attended Gettysburg College, assumed graduate courses at Temple Graduate School, and completed his M.D. degree at Temple University School of Medicine in 1974. He lives with his wife and two children in Wyndmoor.

Dr. Fischer interned at Lankenau, took his residency at Duke Eye Center in Durham, North Carolina, and was a Fellow at the Francis Eye Proctor Foundation at the University of California, San Francisco, in ocular immunology and uveitis. He also served a fellowship at the Institute of Ophthalmology and Moorfields’ Eye Hospital, London, England.

His research projects during these fellowships included a study of ocular antigens and their cross reactivity to various ocular tissues; auto-antibody production in different forms of uveitis, with emphasis on antinuclear antibody and its specific subtypes; and circulating immune complex formation in ocular vasculitis.

During his Vitreo-retinal Fellowship at Wills Eye Hospital he studied ocular oncology, retinal vascular disease, retinal inflammatory diseases, the medical and surgical treatment of diabetes, macular degeneration, retinal detachment and associated vitreo-retinal diseases. Following that, he became Director of the Uveitis Unit of the Retina Service and senior attending surgeon at Wills.

A Diplomat of the American Board of Ophthalmology since 1981, his most recent scientific investigation at Wills is described below.

uveitis research

My basic research interests involve uveitis and ocular inflammation in diagnostic, surgical treatment and therapy. Early studies in conjunction with Dr. Norman T. Felberg, Director of Molecular Biology at Wills Eye Hospital, were aimed at determining localized antibody production in intraocular tissues and fluids. This is quite useful in that many of the localized eye inflammations produce localized antibody, whereas systemic antibody may be at very low levels. Routine antibody blood tests may be negative, with often significant or severe ocular inflammations being present. An example of this is ocular toxoplasmosis or cytomegalovirus infection in which we found in anterior chamber paracenteses or vitrectomy specimens that localized antibody was markedly elevated over systemic antibody. With the use of the ELISA for toxoplasmosis in ocular fluids, we were thus able to diagnose atypical or difficult presentations of ocular toxoplasmosis, and therefore, institute the correct antimicrobial therapy. Previously, this diagnosis may have been difficult due to negative serologic findings and may have caused institution of improper therapy with worsening of the ocular condition.

As a result of our interest in difficult ocular diagnosis of difficult or previously unknown ocular conditions, through the help of Dr. Jay S. Federman, head of Research at Wills Eye Hospital, and Dr. Felberg, we developed a new technique for intraocular biopsy of tissues. As the sensitive tissues of the eye are quite difficult to biopsy as opposed to routine biopsies of the liver or kidney, our histologic and ongoing pathologic knowledge of inflammatory ocular disease is relatively unknown. With the use of new sophisticated surgical techniques, including pars plana vitrectomy, air-gas fluid exchange, we have developed the technique of removing in situ ocular specimens of the retina and choroid for study, both histologically, electron microscopically and immunochemically. We were the first to present this new material at the Academy of Ophthalmology in 1982.

The technique has been useful in delineating previously histologically unknown ocular diseases such as birdshot choroidopathy, and in obscure infectious diseases of the retina in which blindness was imminent if proper diagnosis was not immediately made. An example of this was a recent patient with the acquired immuno-
deficiency syndrome in which multiple biopsies of other organ systems disclosed abnormalities of the lymphoid tissues but no obvious infection. However, ocular inflammation, when sampled by an eyewall biopsy revealed evidence of ocular toxoplasmosis. After the eyewall biopsy was noted, pathologists reviewed their previous specimens and, indeed, found evidence for systemic toxoplasmosis.

The patient underwent intensive therapy and was cured of the ocular infection. The technique has also been useful in delineating ocular cancers such as the non-Hodgkins lymphomas (reticulum cell sarcoma). Recently a patient with chronic ocular inflammation in which a full neurologic evaluation disclosed no evidence of systemic disease was diagnosed by eyewall biopsy as RCS with rational and appropriate therapy.

In the course of our studies with the eyewall biopsy in conjunction with Dr. Felberg, we have been interested in examination of ocular fluids for lymphocyte subset populations using monoclonal antibody techniques. In a new ocular disease called the acute retinal necrosis syndrome, we were the first to evaluate systemic helper/suppressor cell ratios to intraocular fluid ratios. Our evaluation showed normal systemic ratios with reversal of the helper-suppressor subsets in vitreous fluid, suggesting local ocular immunosuppression in this disease. It is hoped that by studying the specific immunologic lymphocytic subset populations in the eye that we may better delineate the underlying immuno-pathologic mechanisms of disease in these new unknown ocular conditions.

Our future interests involve continuing diagnostic and basic science evaluations of the immune response in ocular inflammation. With new drugs such as cyclosporin, our interest will be in evaluating this new immunosuppressive agent for chronic ocular inflammatory diseases in which corticosteroids have not been useful. We are also setting up a protocol for the periocular injection of 5-fluorouracil in chronic inflammatory conditions involving the eye.

Hailed as a chess master, ski master, skeet shooter, Wizard of Wall Street and Smiling Jack the Aviator, Jack Edeiken, M.D. Professor of Radiology and Chairman of the Department, was honored when his portrait was presented to the University by his friends and colleagues on September 13.

Since the presentation coincided with the meeting of the International Skeletal Society, of which he is currently President, many of Dr. Edeiken's peers from the world over were able to attend. Introduced by Clinical Professor of Radiology, Morton G. Murdock, M.D., Chairman of the Portrait Committee, Dr. Edeiken also heard comments from his counterpart at Albert Einstein College of Medicine (Montefiore Medical Center) New York, Harold G. Jacobson, M.D.

Dr. Edeiken graduated from Villanova College in 1943, and the University of Pennsylvania School of Medicine in 1947. He served his internship at Mt. Sinai Hospital, (now called Albert Einstein Medical Center, Daroff Division,) and his residency in the Department of Radiology at the University of Pennsylvania. He was a Fellow of the National Cancer Institute from 1949 until 1951, after which he joined the Army and served as Chief of Radiology at the 34th General Hospital in Orleans, France. He came to Jefferson in 1958, and has been Professor since 1967 and Chairman since 1971.

Dr. Edeiken has written five books, six syllabi and over 70 articles, and was co-investigator of a multi-million dollar grant to study thermography. He enjoys an international reputation in the field of skeletal radiology, and is an expert in the fields of orthopaedic radiology and medical education. A trustee of the American Board of Radiology, he is also Chairman of the Commission of Diagnostic Radiology of the American College of Radiology.

Dr. Jacobson noted that his colleague is "a tremendously skilled clinical radiologist with dozens of scientific progeny." He added that the prerequisite for being Chairman of a Department was character. "Jack Edeiken has character."
Jefferson's 300 guests attending the President's Club Dinner at Longwood Gardens on October 19 questioned how it possibly could be topped? Situated in the conservatory surrounded by flowers and plants of every description and lifesized topiary animals, the dinner, to thank Jefferson's most magnanimous alumni and friends, combined elegance and ambience and climaxed with a lighted fountain display. High spirits characterized the black tie occasion. In addition, awards were presented to particularly generous Jefferson friends.

Receiving the Cornerstone Award this year was Joe Henry Coley, M.D. '34, who celebrated his 50th reunion with classmates last June. The ninth recipient of this prestigious award, Dr. Coley was cited as one of Jefferson's most distinguished benefactors, and was thanked by University President Lewis
W. Bluemle, Jr., M.D., for his faithful service as Class Agent, Alumni Chairman of the Sesquicentennial Fund and Alumni Trustee. In 1982, Dr. Coley received the Jefferson Medical College Alumni Achievement Award.

Dr. and Mrs. Coley recently executed an unusual bequest to Jefferson— their own house in Oklahoma City. In gratitude for this, Dr. Bluemle presented the Coleys with a painting of the home rendered by Philadelphia artist, Mr. Joseph Hassell. A resolution passed for this occasion stated that Dr. Coley "has thoughtfully, vigorously and generously supported the mission of Thomas Jefferson University and Jefferson Medical College and encouraged others to do the same."

Gold-headed canes, historically derived from the wand of Aesculapius and since then the traditional symbol of

Other guests at the October 19 dinner were (from left) Edward C. Driscoll, Chairman of the Board, Mrs. Ralph A. Carabasi, Mrs. Driscoll, Mrs. Samuel M. V. Hamilton, Trustee, and Dr. Carabasi '46 (top photo). (Bottom Photo) Mrs. Richard R. Soricelli is welcomed by Mrs. William P. Davis III (right) as Mrs. Bluemle, Dr. Soricelli '60 (center) and Mr. Davis look on. Mr. Davis is a Jefferson Trustee.
Left: Also attending the dinner were Mr. and Mrs. James W. Stratton (left) and Dr. and Mrs. Jussi J. Saukkonen. Mr. Stratton, a Trustee, is serving as Chairman of the Executive Committee of the Decade Fund; Dr. Saukkonen is Dean of the College of Graduate Studies. Below: Frederic L. Ballard (right) who was cited at the dinner for his seven years as Chairman of the Board, with Dr. Michael A. Naidoff.

Above: Dr. Willis C. Maddrey, the Magee Professor of Medicine and Chairman of the Department and Mrs. Maddrey (left) chat with Dr. and Mrs. Armando F. Goracci. Below: (from left) Dean Joseph S. Gonnella, Dr. Francis E. Rosato, the Samuel D. Gross Professor of Surgery, Professor Gianfranco Fegiz, a guest from the University of Rome, and Dr. Gerald Marks '49.
the healing arts, were presented to new Fellows Mr. and Mrs. Henry A. Brackman, Dr. and Mrs. Robert L. Brent, Mr. and Mrs. Edward C. Driscoll and Mrs. Grace Loeb. Others, unable to attend, included Dr. and Mrs. Carl M. Hadley, '25, Mrs. Sophie Koppelman, Dr. and Mrs. Lawson E. Miller, Jr., '34, and Mr. David Pincus.

Frederic L. Ballard Esq., who has stepped down as Chairman of the Board of Trustees, following seven years of service, received the Winged Ox Award for his many accomplishments during his tenure. A Board citation also was presented.

Dr. Bluemle announced the creation of a new professorship in rehabilitation medicine, which will be known as the Michie Professorship, established by a bequest from the late Miss Jesse Michie, a patient of J. Woodrow Savacool, M.D. '38 and the late George J. Willauer, M.D. '23.

After the dinner, presentations and socializing ended, and Jeffersonians were on their way home, the question remained: How could anything be better than 1984? One possibility was to return next year, but with a difference — drain the fern pond...and dance until dawn.

Top: Dr. Frank J. Sweeney '51. Above left: Dr. and Mrs. James E. Clark '52. Above right: Guests at the dinner included (from left) Mrs. Arthur C. Kaufmann, Mrs. Gustave G. Amsterdam and Dr. James M. Hunter '53. At right: Alumnus Joe Henry Coley '34 with Mrs. Coley receives from President Bluemle the Cornerstone Award for his leadership and generosity to the Medical College.
1930
The obstetrical unit at the Community Hospital of Springfield & Clark Company, Springfield, Ohio, was dedicated in honor of the late William DeFord Beasley, M.D. for the advancement he made in the practice of obstetrics. His picture has been presented to the hospital, and a plaque for the Beasley Memorial will be used to purchase a cardiac apnea monitor. Dr. Beasley died in October of 1983.

1932
C. Earl Albrecht, Drawer “L,” Bermuda Run, Advance, N.C., "has fulfilled a number of missions in his lifetime," says an article in American Medical News. He was physician for the Mananuska Valley colony, Surgeon-Administrator in the Army, and as Alaska’s first Health Commissioner, “under whose influence funds were allocated by the federal government to eradicate and control tuberculosis and later poliomyelitis in the state’s native population.” Dr. Albrecht later became a Professor at Jefferson, but returned to Alaska to develop a state health profession education plan. He is currently doing research on the problem of alcoholism in the state. Among his proudest accomplishments is the gathering of the international circumpolar health symposium, a week-long forum for the exchange of current research and trends among professionals living and working in cold-weather climates. Dr. Albrecht is credited with organizing the first symposium in 1967, held triennially since then in four countries including the United States.

1934
Edward Hoberman, 131 S. Fairview St., Lock Haven, Pa., was recently honored by the Clinton County Medical Society on the 50th anniversary of his graduation from medical school. There were many stories and anecdotes from fond friends on his football days, both as player and as team physician.
Arthur J. McSteen, 45 Thunderbird Ln., Pinehurst, N.C., regretted that he was unable to attend his 50th reunion in June because of ill health.

1937
Everett J. Gordon, 2916 Ellicott Ter. N.W., Washington, D.C., recently received a plaque dedicating a gymnasium to him in appreciation of 34 years service as Medical Director and member of the Executive Board of the Metropolitan Police Boys and Girls Clubs of Washington. It was estimated that Dr. Gordon had personally examined or supervised the examination of 75,000 children for their annual summer camping vacations. In July, the Exchange Club of Washington, D.C., selected Dr. Gordon as the 1984 recipient of the Exchange Club’s “Book of Golden Deeds Award,” recognizing his selfless work for public good with the Metropolitan Police Boys and Girls Clubs.

Milton H. Gordon, Ben Gurion International Airport, Israel, was awarded the John A. Tamisiea Award in San Diego, given by the Aerospace Medical Association “to an individual who has made an outstanding contribution to the art and science of aviation medicine in its application to general aviation.” Dr. Gordon, a Fellow in the association, moved to Israel in 1974 with his wife, Natalie, and since that time has served as Civil Air Surgeon for the State of Israel.

1938
G. Vernon Judson, 438 Euclid Ave., Haddonfield, New Jersey, following his September 1 retirement, will continue as Assistant Clinical Professor in the Department of Family Medicine at Cooper Hospital University Medical Center in Camden, which he writes will keep him abreast of the changing times. He adds "Jefferson has instilled something extra in its sons and daughters that prepares them for a rewarding life in medicine."

1939
George Evashwick, 204 Roswell, Long Beach, Ca., was honored with a special presentation of the Long Beach Medical Association, District Three, during its annual dinner dance. The proclamation by the mayor recognized Dr. Evashwick’s dedicated service since 1956 to the Medical Association including the Presidency in 1970. Dr. Evashwick was commended also for serving as President of the Visiting Nurse Service of Long Beach, and for donating hours to giving physicals to area high school athletes.

1941
Frederick B. Wagner, Jr., 800 Chauncey Rd., Narberth, Pa., University Historian, will write a history of Jefferson from its earliest roots beginning in 1824 to the present. His work will supplement that of George M. Gould who wrote The History of Jefferson Medical College 1826-1904, and he has appointed a 50-member Jefferson History Advisory Board to contribute material for the project. Dr. Wagner is writing another book entitled The Twilight Years of Lady Osler; he was appointed the Grace Revere Osler Professor of Surgery in 1978.

1942
Edmund K. Yantes, 711 Timber Ln., Wilmington, Oh., writes that he is still in practice, full time.

1944S
David W. Chase, 10135 Shasta Dr., Sun City, Az., writes that he regretted his inability to attend the 40th reunion, and hoped everyone had a great time.
John J. Gartland, James Edwards Professor of Orthopaedic Surgery and Chairman of the Department at
Celebrating his 50th reunion from Jefferson, giving a reunion clinic talk and being honored with a portrait presentation, have made 1984 an important year for Harold L. Israel, M.D. '34, Emeritus Professor of Medicine. His wife, Frances, their children and grandchildren, all helped him enjoy the festivities when his portrait was presented by colleagues and friends on September 14.

The ceremony, conducted in McClellan Hall, was attended by friends young and old, most staunchly by the Pulmonary Division where his expertise is legend. J. Denise Washburne, M.D., Clinical Assistant Professor of Medicine, served as Chairman of the Portrait Committee, with Rhoda Abrams, Co-Chairman.

William G. Figueroa, M.D., Professor of Pulmonary Medicine and Chairman of the Department at Lankenau Hospital, a former student of Dr. Israel's, hailed his mentor, saying how appropriate it was that the portrait be presented at the beginning of the new academic year. Dr. Israel has taught at every medical school in Philadelphia except Hahnemann.

“He had the largest of five residency services at Philadelphia General Hospital,” Dr. Figueroa recalled. He said Dr. Israel’s diagnoses were nearly 100 percent correct.

Michael L. Simenhoff, M.D., F.A.C.P., Professor of Medicine and Chief of the Nephrology Division at JMC, Gave a biographical sketch. A native of Fall River, Massachusetts, Dr. Israel graduated from Amherst College in 1930. He received his degree from Jefferson in 1934, and interned for two years at PGH, where he was awarded the Research Prize in 1936.

His primary interest was in sarcoidosis, which he studied at the Phipps Institute at the University of Pennsylvania as a Fellow, becoming an Associate in 1940. He received his Masters in Public Health in 1942, and was certified by the American Board of Internal Medicine. He came to Jefferson 25 years ago, became full Professor in 1972, and has held the rank of Emeritus Professor of Medicine since 1980.

Dr. Simenhoff called him “the primary physician’s primary physician.” He has always been in private practice, never a full time faculty member. He once wanted to be an architect, and still harbors interests in a wide variety of subjects, from art to music to flowers to gourmet dining. An inveterate traveler, he has circled the globe three times, and is one of the most faithful swimmers in Jefferson’s pool. “A constant source of inspiration among clinicians, a humble but remarkable doctor, the Billy Graham of sarcoidosis,” Dr. Simenhoff concluded.

Jussi J. Saukkonen, M.D., Dean of the College of Graduate studies, accepted the portrait for the Medical College in the absence of Dean Joseph S. Gonnella.

He congratulated Dr. Israel, saying that his was the “optimal role of clinician,” and that he combined the three models of teacher, researcher and clinician.

James E. Clark, M.D., '52, Alumni Trustee, accepted the portrait on behalf of President Lewis W. Blumle, Jr., for the University. After the artist, William A. Smith, was recognized, Dr. Israel spoke to the group. He expressed his feelings at the moment as “the exact opposite of being on a witness stand in a malpractice suit,” a quote which he attributed to John Y. Templeton, M.D. ’41.

Dr. Israel thanked Jefferson for providing the environment and support for him to do quality work, for the “long stream of young collaborators” who have enriched his years here, and finally, “for the biggest and best birthday party ever.”
Casino
Medicine

by Judy Passmore McNeal

George C. Godfrey, M.D. '52, is Chairman of the Department of Surgery at Shore Memorial Hospital in Somers Point, New Jersey, and Medical Manager for the Federal Aviation Administration Technical Center nearby. But for several hours each week he becomes PHYSICIAN TO THE CASINOS.

That very broad title is qualified by the modest Dr. Godfrey, who says that most of his work connected with the Atlantic City casinos involves Workman's Compensation. However, there are cases of illness, often stress-induced, that are brought to his attention.

Stress plays a large part in the health of both patrons and employees along the glittering boardwalk. The high-roller gambler, for example, with thousands of dollars at stake, is under enormous pressure. So are the regular gamblers who hit the jackpot...or just miss.

Dr. Godfrey says there are constant stress situations for employees, who are continually monitored while dealing and counting. Accuracy is essential, since they are personally responsible for miscalculations.

As the tension mounts, there is a significant lack of glee on the faces of gamblers and dealers alike; the patrons at the slot machines exhibit glazed expressions as they relentlessly deposit their quarters.

If the guests become ill, they either leave or make their problem known at the desk. In the case of the Golden Nugget, where Dr. Godfrey primarily involves himself, a physician is available at all times. His responsibility is to schedule their hours, making sure the office is covered whenever the casino is open, which is virtually 24 hours a day.

The most common complaints, he says, come from people who have confronted one or more machines for six hours at a time. Often over 65 years of age, they have boarded a bus for a day at the casinos, usually forgetting to eat breakfast. After investing so much money, they are loathe to leave for lunch, fearing that the next person will win "their" jackpot. They become hypoglycemic—the price they pay for the pace of the day.

Each casino has variations of medical programs, some with offices inside and others with offices nearby. At one time or another, Dr. Godfrey has been involved in the development of medical programs at all the casinos, but has now narrowed himself to the Nugget, The Sands and The Claridge.

Patterned after the medical clinic which handles 30 casinos in Las Vegas, Atlantic Industrial Medical Physicians helps stem the potential overloading of health facilities in Atlantic City, thus avoiding one of the major threats to the area.

While he admits that everyone does not share his optimism, he counters their criticism by pointing to obvious improvements. "The Atlantic City I knew was not only dying," he said, "it was dead. There were no movies, no supermarkets. The lawyers had moved out as had the insurance agents. There were no businesses. Nobody went out at night. On the boardwalk, storeowners would stagger their closing times every day to avoid robberies. Nobody walked on the boardwalk; now, five years later, it's crowded."

Although Dr. Godfrey says that most media accounts highlight the negative aspects of the casinos, such as eviction of citizens from their homes, and high unemployment, he thinks the best example of the prosperity the casinos brought to the area is the thickness of the newspaper. "It's just full of ads now," he says.

At one time the newspaper, then called the Atlantic City Press, moved to the mainland and excised Atlantic City from its name in an effort to disassociate itself from the town. The Press is now three times larger and very comparable, Dr. Godfrey thinks, to the Philadelphia papers.

The resurgence has been a gradual one, growing with the casinos, one by one, and he sees continued prosperity...
for the future. While the summer months are the busiest, winters now draw an almost equal share of visitors.

One potentially disastrous event during his tenure had state and government health officials converging on the casino strip following a hepatitis scare. A harried waitress, explaining why she was rushed, mentioned to a customer that they were shorthanded because another waitress had contracted hepatitis. This led to city-wide paranoia that took more than two weeks to subside.

Before they discovered that the waitress had jaundice, not hepatitis, and that there was no threat to the community, the casino physicians had gone through a whole series of crises and criticisms. One result of the furor was a bill from a Philadelphia doctor for a gamma globulin shot which the patient demanded be paid by the casinos. “There has been no epidemic here, to my knowledge, since the casinos arrived,” says Dr. Godfrey, “but that just shows you what a rumor can do.”

He states that not only are the dealers monitored for honesty, but that the employees are monitored, as well, for health and safety. “There is a major intent here to be very careful,” he says, pointing to the screening and visual acuity tests being given to all employees at that time. “And they’re very careful about who walks into the casinos carrying a black bag,” he adds. “We’re carefully screened, too.”

While he has not been asked to administer his medical or surgical skills to Frank Sinatra or Diana Ross, he has tended the sore throat of opera singer Enzo Stuarti. He cautioned the Italian baritone to avoid the very high notes, but Mr. Stuarti said that the audience came to hear him sing “Pagliacci” and they were not going to be disappointed. According to Dr. Godfrey, the entertainers take better than average care of themselves, and usually meet the physician on call as soon as they arrive at the casino. “There’s so much money resting on their good health,” he says.

As to the health of the 30,000 people who are assembled in the casino community at any given time, he remarks from his Somers Point office, “We’re giving a service over there, both in the casinos and in the off-site, control care facilities. It’s always available, and of known quality.”

Jefferson, was recently honored at the first annual John J. Garland Lecture given at the College of Physicians. (see p. 18)

1947

James T. Helsper, 635 E. Union St., Pasadena, Ca., reports that he has recently been elected Secretary of the Society of Head and Neck Surgeons, for a three year term. He would also like to report a new young son, Brian Harrison Helsper, now two and a half years old.

1949

Paul Hartstein, 3650 South St., Lakewood, Ca., recently assumed his duties as President of Long Beach District Three of the Los Angeles County Medical Association. Dr. Hartstein is a family practitioner.

Robert E. Stark, 444 W. Osburn Rd., Phoenix, Az., is President-elect of the American Society of Bariatric Physicians. He writes that he is involved in power-lifting, and has won three California Senior Olympics since turning 60. “I am still married to the lovely lady I met while at Jefferson. Four of my children are attorneys, one a school teacher, two have advanced degrees and two are still in college.”

1951

Leonard S. Girsh, 1401 Melrose Ave., Philadelphia, was the recipient for the third time of the Chapel of Four Chaplains Legion of Honor Award for outstanding service to the community. Dr. Girsh is Director of Allergy and Clinical Immunology at the Medical College of Pennsylvania and is in private practice in Jenkintown.

Herbert C. Mansmann, Jr., Professor of Pediatrics at Jefferson, was recently elected President of the Association for Care of Asthma. Dr. Mansmann has served on the Board of Directors since 1971. He also is Associate Professor of Medicine and Director of the Division of Allergy and Clinical Immunology, as well as serving as a member of the newly-appointed Jefferson History Advisory Board.

1954

Stanley R. Kern, 57 N. Wyoming Ave., South Orange, N.J., writes that classmate Robert B. Cahan and he were both appointed Directors of the American Board of Forensic Psychiatry. Dr. Kern was also appointed Adjunct Associate Professor of Law at Rutgers Law School.

Eugene G. Stec, RD#2, Dalton, Pa., has been named President-elect of the Pennsylvania Academy of Family Physicians. Dr. Stec previously served the board as one of its directors and as Vice-President. He is certified by the American Board of Family Practice.

1956

Paul J. Dugan, 305 Oak Ridge Dr., Roseville, Ca., has been promoted to Associate Clinical Professor in the Department of Family Practice at the University of California, Davis. Dr. Dugan has “stayed busy in the practice of medicine, being Chairman of Education of our Roseville Community Hospital, and the founder and Chairman of our community-wide ‘Start-a-Heart’ program with a goal of teaching and certifying every citizen in Roseville to know and to use CPR wherever indicated.”

Henry H. Sherk, 1210 Brace Rd., Cherry Hill, N.J., has recently been appointed Chief of the Division of Orthopaedic Surgery at the Medical College of Pennsylvania.

1957

Simon Kravitz, 681 Foxcroft Rd., Elkins Park, Pa., writes that his son, Daniel, graduated with the Class of ’84.

Joseph F. Rodgers, 1723 Sylvan La., Gladwyne, Pa., Clinical Associate Professor of Medicine, JMC, has been appointed Associate Dean of Affiliations and Residency Program Coordination by the Board of Trustees at TJU. (see p. 19)

Joseph M. Skutches, 830 Ostrum St., Bethlehem, Pa., has been appointed Chief of the Department of Obstetrics and Gynecology at St. Luke’s Hospital. He has been Program Director of Resident Education in the department since 1982, and is Clinical Associate Professor in OB/GYN at Temple University School of Medicine.

1959

Harris R. Clearfield, 720 Oxford, Bala Cynwyd, received the Lindback Foundation Award for Distinguished Teaching during 1984 commencement ceremonies at Hahnemann University, where he is Professor of Medicine.
1961
William A. Browne, IV, 6934 Kruckenberg Rd., Greenville, Oh., retired from the general practice of medicine last July and has assumed the position of Director of Student Health Services at Miami University in Oxford, Ohio. Dr. and Mrs. Browne look forward to moving to Oxford sometime soon, but for now are staying in Greenville; their sons, Mike and Bill, are recent graduates of Miami University, and their last son, Stewart, is a student at Colorado State.

Emilio A. Roncare, 136 Winding Way, Haddonfield, N.J., is President of the West Jersey Hospital Medical Staff. Dr. Roncare is Chief of the Section of Otolaryngology and Head and Neck Surgery at West Jersey.

Nathan Zankman, 3883 Sheffield Dr., Huntingdon Valley, Pa., has been appointed Director of Pediatrics at Lower Bucks Hospital in Bristol.

1962
William V. Harrer, 1600 Haddon Ave., Camden, N.J., has been promoted to Professor in the Department of Pathology at Jefferson.

Eugene W. Pelczar, 71 Tilbury Ave., W. Nanticoke, Pa., is pleased to say that his son, Brian, became a part of the Jefferson tradition in the fall. “I also have a daughter, Mary Ann, in the first physical therapy class in the College of Allied Health Sciences.”

1963
Robert C. Gallo, 8513 Thornden Ter., Bethesda, Md., received the Fourth Annual Alpha Therapeutic Award, presented during the 1984 Plasma Forum sponsored by the American Blood Resources Association. Dr. Gallo was chosen because of his recent work in discovering a member of the human T-cell leukemia virus family and identifying its close link to AIDS, and in particular for four articles which he co-authored.

Herbert C. Rader, 57-16 141st St., Flushing, N.Y., and his large family have moved to Flushing where he will serve as Administrator for Operating Services at Booth Memorial Medical Center. (Salvation Army) Major Rader recently attended the 98th Session of the International College of Officers in London and spent this past summer at the Overseas Ministries Study Center near Atlantic City.

1964
Robert B. Burns, Horizon Dr., Mendham, N.J., has been appointed Vice-President for Clinical Research at Ayerst Laboratories pharmaceutical division of American Home Products Corporation. Prior to this position, Dr. Burns was Director of Clinical Research at Sandoz Pharmaceuticals.

Robert M. Steiner, Professor of Radiology at Jefferson, has co-authored a guide for the identification and classification of cardiac pacemakers. A Guide to Cardiac Pacemakers has been hailed as “filling an information void felt by cardiologists and cardiac surgeons throughout the country.”

1965
Bruce W. Weissman, 333 Arthur Godfrey Rd., Miami Beach, has been elected Vice President of the Dade County Medical Association for the next year. He is currently Chief of Head and Neck Surgery at St. Francis Hospital and Assistant Chief of Surgery at Biscayne Medical Center in Miami Beach.

1966
Robert C. Vannucci, 252 E. Marion St., Lancaster, Pa., opened an office in July as pediatric specialist to newborns. Dr. Vannucci is one of about 30 pediatric neurologists practicing in Pennsylvania. Before moving to Lancaster, he was Director of Pediatric Neurology at the New York Hospital-Cornell Medical College and a researcher with grants from the National Institutes of Health and the New York Diabetics Association. Earlier, he was Chief of the Hershey Medical Center Pediatric Neurology Division.

1967
Neil C. Cutler, 13 Old Hickory Rd., Richboro, Pa., is practicing family medicine in the Franklin Town area of Philadelphia.

Barry C. Dorn, 41 Summit Rd., Lexington, Ma., is enjoying his practice of orthopaedic surgery and sports medicine. “I run six to eight miles daily. Our children are presently 14 and 17.”

Louis W. Schwartz, 1000 N. Broad St., Lansdale, Pa., has been promoted from Assistant Clinical Professor to Associate Clinical Professor in the Department of Ophthalmology at Jefferson.

1968
David A. Berd, 125 Heacock Ln., Wyncote, Pa., has been appointed Associate Professor in the Department of Medicine at Jefferson.

Jay B. Berger, 1371 Armstrong Rd., Bethlehem, Pa., has been elected President of the St. Luke’s Hospital Medical Staff. Dr. Berger is a specialist in internal medicine.

1970
James M. Gerson, Hemlock Farms, Hawley, Pa., has joined the staff of Wayne County Memorial Hospital in the Department of Pediatrics, with a subspecialty in Pediatric Hematology-Oncology. Dr. Gerson’s internship and residency in Pediatrics was taken at Children’s Hospital, and he served a three-year fellowship in Hematology-Oncology there. He has held teaching appointments at Hershey Medical Center, and is Board Certified in Pediatrics and Hematology-Oncology. His wife, Catherine Scholl-Gerson, M.D. 79, is on the staff also, with family practice privileges.

Peter D. Pizzutillo, Alfred E. duPont Institute, Wilmington, De., has been promoted from Clinical Assistant Professor to Clinical Associate Professor in the Department of Orthopaedic Surgery at Jefferson.

Jacquelyn M. Zavadnick, 543 Rock Glen Dr., Wynnewood, Pa., has been promoted to Clinical Associate Professor in the Department of Psychiatry and Human Behavior at Jefferson.

1971
Cora L. Christian, P.O. Box 1338, LaGrange Plot, Fredericksted, St. Croix, visited Jefferson last summer and gave a presentation for the Center for Research in Medical Education and Health Care on “The Virgin Islands Health Care System—An Integrated Comprehensive System.” Dr. Christian is Executive Director/Medical Director of the Virgin Islands Medical Institute.

Ervin S. Fleishman, P.O. Box 463, Narberth, Pa., has been promoted from Instructor to Clinical Assistant Professor in the Department of Medicine at Jefferson.

James G. McBride, R.D.D. #4 Old Mill Rd., Bethheim, Pa., is practicing solo ophthalmology at the Fairview Medical Building in Easton. “Carol, Patrick and I recently moved into our ‘new’ 200 year old stone farm house.”
1972

Joseph P. Horstmann, 395 Pepper Rd., Huntingdon Valley, Pa., has been promoted to Adjunct Clinical Assistant Professor in the Department of Pathology at Jefferson.

1973

Erick J. Bergquist, 2437 Garrett Rd., Drexel Hill, Pa., has been promoted to Clinical Associate Professor in the Department of Medicine at Jefferson.

Stephen P. Muller, Austin Regional Clinic, Austin, Tx., writes: "Retiring! from the U.S. Air Force." He is associated now as a staff otolaryngologist with the clinic.

Richard M. Sostowski, 60 N. Wyoming Ave., South Orange, N.J., has been promoted to Clinical Associate Professor of Psychiatry at the University of Medicine and Dentistry of New Jersey.

Mark D. Widome, 34 Woodbine Dr., Hershey, Pa., has been appointed Associate Professor in the Department of Pediatrics at the Milton S. Hershey Medical Center of The Pennsylvania State University. Dr. Widome has been Medical Director of Outpatient Services since 1982; he has a Master's Degree in Public Health from John Hopkins University and edits the Accident and Poison Prevention Newsletter, published quarterly by the American Academy of Pediatrics.

1974

Steven R. Peikin, 510 Lombard St., Philadelphia, published an article in Physiology and Behavior on obesity. (see p. 19)

Gary L. Shugar, 1508 Bern St., Reading, Pa., is the Medical Director for MDS Laboratories, a private medical lab in Reading.

1975

Alan H. Bierlein, 1206 Michigan Ave., LaPorte, In., is in solo family practice and is "proud to announce the addition of a daughter, Emily Jo, born on December 30, 1983. Brother Andrew is 5. I enjoy gardening, bicycling and fishing on Lake Michigan."

Donald L. Myers, 1500 Locust St., Philadelphia, is an Assistant Professor in the Department of Neurosurgery at Jefferson.

1976

Mark A. Clark, P.O. Box 346, Anderson, S.C., writes that he is "enjoying my solo practice in family medicine. We're expecting our second child any day now."

Christopher M. Frauenhoffer, 950 Walnut St., Philadelphia, has been promoted to Clinical Professor in the Department of Pathology.

John S. Liggett, Jr., University of Texas Health Center at Tyler, has been appointed Assistant Professor of Clinical Pulmonary Pediatrics there. Dr. Liggett previously served as a Clinical Assistant Professor at the South Dakota Medical School and was Director of the Sioux Falls Cystic Fibrosis Center and Clinic. He also served as a Clinical Instructor for flexible internship and family practice programs at Sioux Valley Hospital.

David E. Nutter, 8 N. Queen St., Lancaster, Pa., has been appointed to the Scientific Committee of the Eastern Region of the Society for the Scientific Study of Sex. Dr. Nutter will evaluate research and therapy concerning such diverse fields as child sexual abuse, treatment of sex offenders, and problems of sexual dysfunction. A psychiatrist, he is a member of the faculty at JMC and on the staff of St. Joseph's Hospital.

1977

Edward W. Bogner, 254 Front St., Northumberland, Pa., is "keeping very busy practicing family medicine here. I moved into my newly-built office last August. The solo practice is doing very well. We are enjoying the area as well as our two daughters, Emily and Lyndsey, and are expecting a third child in October."

James F. Burke, 701 Powder Mill Ln., Philadelphia, has been promoted to Clinical Assistant Professor in the Department of Medicine at Jef.

R. Anthony Carabasi, III, 1025 Walnut St., Department of Surgery, has been promoted to Assistant Professor in the Department of Surgery.

John J. Dulcey, 1501 Susan Dr., Lansdale, Pa., has been named to the consulting medical staff of North Penn Hospital in the specialty of internal medicine.

1978

Richard S. Buza, RD#1, New Ringgold, Pa., writes that he and his wife, Diane, are expecting their second child in November. "We will be moving to Huntingdon, Pennsylvania, where I will be working in an Emergency Room and opening a family practice."

Bruce C. Hall, 833 N. Sequoia, Lindsay, Ca., is currently in the private practice of internal medicine with Lawrence W. Ginsberg, '75, and Kathryn Hall (Ginsberg), '75. "I am also serving as Chief of Staff this year and was recently named to the Board of Directors of the Lindsay Hospital Medical Center."

Joseph M. Kmonicek, 28 Temple Ave., Stratford, N.J., is Instructor in the Department of Medicine at JMC.

Stephen I. Kramer, 3961 Seaton Rd., Winston-Salem, N.C., was recently certified by the American Board of Psychiatry and Neurology, and is on the faculty of the Bowman Gray School of Medicine, Department of Psychiatry.

Raymond B. Leidich, 2101 Shoreline Drive, Alameda, Ca., married the former Beth A. Beaman of San Diego on September 29, 1984, on Coronado Island, California.

Joseph A. Lombardo, 4340 Olive Ave., Long Beach, Ca., recently joined a multi-speciality group in Artesia, California. His wife, Joyce R. King, '78, is practicing pathology at Memorial Hospital Medical Center in Long Beach three days a week and practicing motherhood the remainder of the time. Their daughter, Sarah Ruth, was a year old on June 23.

Howard H. Weitz, 2016 Hopkinson House, Philadelphia, has been promoted to Clinical Assistant Professor in the Department of Medicine at JMC.

Linda C. Wilson, 107 Montgomery Dr., Coatesville, Pa., and her husband, Donald F. Wilson, '79, are partners in OB/GYN at Brandywine Hospital. They have two sons, Andrew, four, and Brian, 10 months, "and live a very busy life."

1979

Robert G. Bagian, 9742 Morefield Pl., Philadelphia, has joined the staff of the Allentown Hospital Emergency Center.

G. Alan Bridenbaugh, 1011 Lombard St., Philadelphia, is an Instructor in the Department of Medicine at JMC.

Ira W. Freilich, Baylor Medical Plaza, 3600 Gaston Ave., Dallas, Texas, writes
Rehabilitation for the Cambodians

by Joseph Julian, Jr., M.D. '71

One of the most visible and graphic reminders of the tragedy that has befallen the Khmer people is the presence among the refugee populations of significant numbers of the maimed and the seriously disabled. Among the victims of crippling illness and trauma there is a shocking predominance of children and young adults. The now long history of continuous armed conflict, deprivation and mass movements of Khmer refugees through or into inhospitable areas has resulted in the frequent occurrence of blunt trauma and serious wounds from bullets or larger projectiles. Perhaps unique to the Khmer situation is the dishearteningly large number of refugees who have lost one or both legs. The majority of these amputees had accidently stepped on one of the countless land mines which have been indiscriminately planted, by all of the fighting factions, along the whole length and breadth of the Thai-Kampuchean border.

Ynip and Sokhom are typical 10-year-old Khmer girls. They are quick to smile and as the mood strikes them they are alternatively vivacious or mischievous or even petulant. But always they are quite charming. Both had lived in encampments along the Thai-Kampuchean border; now they stay at the 30 bed inpatient rehabilitation ward in Khao I Dang, the largest of the Khmer refugee centers.

Ynip had lived at Nong Samet camp until the day she attempted to wash off her foot by dipping it into a depression filled with muddy water. The puddle hid a land mine. The explosion so badly mangled her left leg that the surgeons had to amputate it close to the hip.

Sokhom was playing with friends in the woods outside of Nong Chan camp. Her brother stepped on a larger mine, killing himself and three other children. Sokhom’s right leg was severed below the knee.

Ynip and Sokhom have become great friends. Each morning they put on their simple bamboo “peglegs” and then, books under arms, head off with the other camp children to Khmer grade school located near the hospital. In the afternoon they visit the workshop where a newer, more “sophisticated,” leg is being made for each of them. Ynip has never been very happy with the appearance of the temporary bamboo “training leg” but with its use she has acquired the skills necessary for her to walk safely and efficiently. Now she is ready for her new permanent leg with the moveable knee and artificial foot.

Ynip’s new leg is being made by Has Phan. He too is an amputee from Nong Samet. Six months ago he stepped on a land mine while gathering wood in the forest. He was brought to Khao I Dang Hospital and his shattered right leg was amputated below the knee. Within several days of surgery he was being seen by one of the ten Khmer physical therapy workers assigned to the surgery wards. Within two months he was transferred to the rehab ward. There he received further care for his stump and was instructed in strengthening exercises. He was fitted for a new limb and then completed gait training with the artificial leg. Has Phan volunteered to stay at Khao I Dang to train in the workshop to learn how to make the artificial legs. His training program completed, he returned to his family at Nong Samet. At that border camp he will work making and repairing artificial limbs at a small workshop. It is one of five such workshops run by Khmer workers trained at Khao I Dang. They continue to receive support, further training and supplies from the rehab station based there.

Ho Chom is a double mid-thigh amputee. He once had the bed next to Has Phan in the rehab ward but he has since moved out on his own. First he went to a special half-way house for the seriously disabled. Later, when he felt more comfortable with his handicap and was able to take care of his needs adequately, he moved into a regular house in the camp. He shares this house with four friends, two of whom are disabled themselves. In the morning Ho Chom studies typing. In the afternoon he usually visits his friends at the rehab ward or he goes to one of the rehab workshops where he watches Has Phan and the other 20
devices made in them were based on the principles that the aids to mobilization would be inexpensive to make and made exclusively from locally available materials. They would be simple in construction, durable and easy to maintain and repair. They would be made by the refugee workers themselves. There would be no dependency on outside sources of high-technology, expensive Western-style rehabilitation equipment. Thus more than 600 amputees have been given artificial legs of bamboo, steel, wood and leather. Scores of children with polio have received simple braces and shoes. More than 100 sturdy wheelchairs constructed of wood and bicycle wheels have been provided to paraplegics and other severely disabled refugees. Hundreds of bamboo and wooden crutches, canes, and walkers have been given to patients with painful bone and joint injuries and these patients have been instructed in their proper use.

Because of the very large numbers of patients requiring rehab services (200 to 250 seen daily) it would never have been possible to serve more than a fraction of the disabled if all the services had been performed solely by the expatriate staff. The primary work of the 10 volunteer rehab professionals was to train Khmer counterparts and then provide them with guidance and support. Programs were created to train refugee workers as physical and occupational therapists, rehab nurses, counselors and makers of braces, shoes, artificial limbs, wheelchairs and all the other varied rehab equipment. These training programs are ongoing not only in order to upgrade the skills of the various Khmer workers but also because relocation moves to other camps often suddenly and severely depleted the Khmer staff. Often with little or no advance warning, the expatriate staff was faced with training a whole new group of workers while simultaneously attempting to continue patient care activities.

Chhoueth is a pretty young woman; she is very shy, but captivates everyone with her disarming smile. When she was 27 years old, she and her husband were accused of stealing coconuts. They were beaten with steel rods. Her husband died and Chhoueth's spinal column was crushed, leaving her paralyzed in both legs. For more than three years she had lain immobile in

Khmer craftsmen making artificial limbs. Sometimes he entertains the staff and patients by playing the flute or guitar. Other times he tells them jokes and funny stories. Quite amazingly, he can even joke about the time in February, 1980, when he found himself trapped inside the camp hospital as it burned to the ground. In those days he had no artificial legs and no wheelchair. He had no means to escape the fire and was saved only because two Khmer nursing aides picked up his bed, with him in it, and rushed it out the door. He laughs about and makes light of his predicament but in his eyes the laughter fades and one can see the terror and utter helplessness of that moment.

In the uncertain and often dangerous world of the Khmer refuge, the greatest handicap is the loss of mobility. Programs to maximize the mobility of disabled refugees therefore received the earliest and highest priority. These programs and the equipment and
bed. When she was admitted to the rehab ward, her muscles were markedly wasted from lack of use. Her legs lay bent and lifeless; her bladder was infected and large deep bedsores had eaten away the flesh on her back.

Chhoueth’s Khmer nurse is Seang Heng. He is a gentle young man and he, too, seems quite shy. His right arm is missing and it is only now after working for a year with the severely disabled that he seems at ease with his own handicap. Under his care the bedsores slowly heal. Supervised by the expatriate rehabilitation nurse, he treats the bladder infection with antibiotics.

Her physical therapist is Yin Sotean. He is one of the most experienced and capable of the Khmer staff. He had trained with the original class of physical therapy workers more than two years before. All of the rest of the trainees in the first class (as well as scores of others trained since) have been relocated to other camps and then on to Europe, America or other countries. But Yin Sotean has not been so lucky; he has not been resettled. He remains at Khao I Dang, faithfully working six days a week without complaint and with no apparent bitterness for being the lone left behind. He is extremely dedicated and knows his job well. The expatriate physical therapist who supervises the ward has confidence in his evaluation of Chhoueth and allows him to devise and institute an appropriate plan of therapy. Over several months, his daily efforts slowly loosen her frozen joints and his exercises help her to increase in strength and endurance.

Chhoueth will never again be able to run and dance, but with the support of devices made for her by the Khmer rehab staff, she will learn to walk once again. Som Sari, a double amputee, makes her specially fitted shoes. Te Yo Hung, one of the bracemakers, measures her for stainless steel and leather braces that will support her weakened legs from ankle to hip. One of the carpenters constructs a bamboo walker to give her added support when, for the first time in years, she stands upright and takes the first halting steps.

While Chhoueth is in the midst of her physical rehabilitation program she is also being seen by Ngo Tieu Than, her rehab counselor. He too was once a patient in the rehab ward. An old paralytic illness has left him with diminished physical strength, but he is intelligent and articulate and good at problem solving. He is adept at using his wheelchair to move around the hospital wards and to the various social, educational and vocational programs in camp. He has enrolled Chhoueth in a Khmer literacy class and he has also been able to find someone who is willing to teach her how to knit.

Another one of Ngo Tieu Than’s counseling patients is Vuthen. At the age of 24 he attempted, along with group of friends, to sneak through the treacherous border area leading toward Thailand. He and 15 others were captured by soldiers and told to line up in single file. Then, one by one, without explanation or apparent reason, they were methodically dismembered. Vuthen had been placed at the end of the line and escaped death only because he was able to flee during the confusion caused by a surprise shelling. He continued toward the border but close to his destination he was captured by a different band of soldiers. He was beaten with a rifle and left paralyzed in both legs. A year later he was brought from the border to the rehab ward. He required treatment for the complications secondary to his paraplegia and he needed to be fitted for a wheelchair. Unlike most patients he was very uncooperative, moody and endlessly complaining about the total body pain, the food or about the other patients. He would not socialize, but preferred to sit alone, silently staring out the window. Ngo Tieu Than has talked with him daily and now after two months on the ward Vuthen is finally beginning to speak of his ordeal, his anger and his fears about an uncertain future. For the first time he has cried and grieved for his murdered friends and the senseless act that left him without the use of his legs. He has made some friends and has started a class in reading and writing Khmer.

The story of physical rehabilitation and the disabled Khmer refugees is essentially one of the enormous needs being met with limited resources in professional staff, equipment and other materials. That this large task is in some measure being accomplished is in most part a tribute to the fantastic courage, ability, dignity and compassion of the patients, their families and especially the Khmer staff.

Joseph Julian, Jr., M.D., graduated from Jefferson in 1971 and took his internship and residency in neurology in San Francisco. However, the more he traveled outside of the United States, in Europe, Asia, Africa and Central America, the more he became interested in rehabilitation, especially in the Third World countries. He is presently a Fellow in the Department of Physical Medicine and Rehabilitation at the Mayo Clinic, and recently presented a paper at the American Spinal Cord Injury Association Meeting, “Care of the Spinal Cord Injured in the Developing Countries.” In 1981, designated by the United Nations as “Year of the Disabled,” Dr. Julian was asked to coordinate and develop a large rehabilitation program for disabled Cambodian refugees at the Thai-Cambodian border. The program eventually had a staff of 70, including 10 expatriates and 60 trained refugee assistants. He served for one year as Rehabilitation Coordinator at Khao I Dang, the largest refugee camp in Thailand, and later spent five months with Operation Handicap International, a newly formed organization that makes simple but functional prostheses and orthoses from leather, wood, stainless steel, bamboo, etc.

Dr. Julian attributes the effectiveness of this program to the imagination and tenacity of the people themselves—many of whom learned from their own disabilities how to help others—who performed minor miracles every day with only the materials at hand. This, he feels, is the single most important characteristic of those villagers, and says that the same must hold true at the Mayo Clinic or at Jefferson; where resources in manpower and materials are greater, so must be the results.

The preceding is a chapter Dr. Julian wrote for a book on Cambodian refugee relief highlighting several cases and success stories from the more than 200 patients who came through the rehab program daily. He hopes to “become a rehab resource person and form a team of similarly interested rehab professionals who would be able to offer (from the national down to the village level, and from fairly sophisticated to low technology) assistance in developing a complete spectrum of rehabilitation programs—whatever would be appropriate to a community’s needs and its available resources.”
that he couldn't attend his class's 5th reunion last June because he was marrying Susan Miller, "generally regarded as the sweetest and prettiest nurse in Pittsburgh. She no longer holds that title, due to the fact that I have whisked her off to Dallas, where I have joined an established practice of dermatology and cutaneous surgery. By the way, J.R. and Miss Ellie send their regards."

Catherine Scholl Gerson, Hemlock Farms, Hawley, Pa., has joined the staff of Wayne County Memorial Hospital. Dr. Gerson will have family practice privileges. Her husband, James M. Gerson, M.D., '70, will practice pediatrics with a subspecialty in Pediatric Hematology-Oncology. Dr. Catherine Gerson received an R.N. degree and B.S.N. degree from Cornell, and an M.S. degree from the University of Scranton. Her residency in family practice was taken at Hershey Medical Center; she is certified by the American Board of Family Practice.

Victor J. Thomas, 2645 Timberglen Dr., Wexford, Pa., has just completed five years of residency at the Hospital of the University of Pennsylvania, where he served as Chief Resident this past year. Dr. Thomas has begun his practice of orthopaedic surgery, arthroscopic surgery and sports medicine with two other surgeons in an office in the Passavant Professional Building in Pittsburgh. At Jefferson, he was a life member of Alpha Omega Alpha. Married to the former Patricia Lynn Ewing, Dr. Thomas is the grandson of John P. Prioletti, '23.

1980

Donna M. Carr, 425 Orpheus Ave., Encinitas, Ca., is in private practice in internal medicine. Her husband is practicing cardiology at the same hospital. The Carrs have recently bought a new house.

Karl Doghramji, 240 David Dr., Havertown, Pa., is an Instructor in the Department of Psychiatry and Human Behavior at JMC.

Ronald N. Eister, 1001 First Ave., Williamsport, Pa., has completed his family practice residency at Williamsport Hospital and began his duties as physician at the Allenwood Prison Camp.

Arthur W. Mellen, IV, 177 Pearlcroft Rd., Cherry Hill, N.J., has gone into OB/GYN partnership with Richard L. Nemiroff, M.D., '70, at Pennsylvania Hospital.

David B. Nagel, 432 Highland Ter., Williamsport, Pa., has joined the staff of Divine Providence Hospital as a radiation- oncologist in the Cancer Treatment Center. Dr. Nagel completed his internship in internal medicine and his residency in radiation oncology at Jeff and was Chief Resident and an American Cancer Society Clinical Fellow during the last year of his residency.

Arthur H. Shedden, 900 N.W. 17th St., Miami, has completed his residency in ophthalmology at the University of Pittsburgh and has begun a fellowship in neuro-ophthalmology at the Bascom Palmer Eye Institute in Miami.

Robert J. Snyder, 610 N. 11th St., Allentown, Pa., completed a residency in OB/GYN and has begun private practice in Allentown. Dr. Snyder's special interests include infertility and microsurgery, and he is accomplished in laser therapy and high risk obstetrics (perinatology). He is a member of the American College of Obstetricians and Gynecologists and the-American Fertility Society.

1981

Kelly J. Acton, Indian Health Service, Crow Agency, Mt., writes that she is the only internist among eight doctors on the Crow Indian Reservation, "but that doesn't mean that I only practice internal medicine. I'm expected to deliver babies, treat children and handle trauma along with everybody else. Needless to say, I'm finding it a challenging (and fun) experience." Her husband, John Peterson, is Clinical Coordinator of Pharmacy at Deaconness Hospital in Billings; they invite Jefferson friends to visit them. "The fishing is great and the sights are incredible."

Daniel L. Diehl, 128 E. Clay St., Lancaster, Pa., is opening a practice of family medicine in Quarryville. Following a three-year residency at Lancaster General Hospital, Dr. Diehl chose to take an additional two-year residency at the Walter L. Aument Family Health Center in Quarryville.

Gordon M. Langston, 84 Sheppard Ave., Braintree, Ma., was a Clinical Fellow in cardiac and obstetrical anesthesia at Brigham and Women's Hospital in Boston, and is continuing his training there. Dr. Langston will be sharing the Chief Resident in Anesthesia position with classmate Paul D. Eckenbrecht, six months for each. He reports the birth of his first child, Gordon Edwin.

Stephen C. Marcum, 16 Airway Ct., Towson, Md., was married in June 1983 to Melinda Mickler. Classmate, Donald L. Kramer, was the best man. Dr. Marcum has finished an internal medicine residency at the Washington Hospital Center in Washington, D.C., and is starting a gastroenterology Fellowship at Baltimore City Hospitals and Johns Hopkins University.

James M. McWeeney, 2013 Hudson St., Charlottesville, W.Va., and his wife, Janet, announce the birth of their second child, James Michael McWeeney, Il.

George A. Winch, Jr., 60 San Andreas Way, San Francisco, announces his marriage to the former Brenda B. Leiker on June 16.

1982

Judd W. Moul, 1127 Fairview Ct., Silver Spring, Md., writes, "Ellen and I have purchased a new home here. I am starting my post-graduate year #3 in urology at Walter Reed."

1983

Thomas A. Cacciola, 25 Skyline Dr., Englewood Cliffs, N.J., is "alive and well and enjoying life very much. Congrats to new parents, especially Ken and Marie Sunnergren."

Richard J. Greco, 3019 Kent Rd., E., Folcroft, Pa., has accepted a position as Fellow in Hand Surgery at The Hand Rehabilitation Center at 9th and Walnut Streets, Philadelphia. His wife gave birth to their first daughter, April Evelyn, on July 2; they report that sons Richard, three, and Blake, 20 months, are doing well.

1984

Jonathan S. Daitch, Mercy Catholic Medical Center, Darby, Pa., has announced his engagement to Barbara Sue Rosenberg of Havertown. Dr. Daitch is in anesthesiology residency at Mercy Catholic.

Ian S. Grimm, Naval Hospital, Bethesda, Md., has married Theresa E. Raphael of Saddle River, New Jersey. Dr. Grimm is serving a one-year residency in internal medicine there.

Kathleen McAleese Hoerner, 400 W. Hortter St., Philadelphia, married Mr. Henry Rhodes Hoerner, 3rd, on May 5.
Obituaries

George K. Nutting, 1916
Died January 23, 1984 at the age of 89. Dr. Nutting was a general surgeon who was prominent in West Virginia and Washington, D.C. medical circles. He was a Director of the Ogden Newspapers, Inc., of which his wife was President prior to her death in 1970. Dr. Nutting, who lectured in surgery at Georgetown University Medical School, was a member of the Cosmos Club in Washington. His two sons survive him.

Frank O'Hanneson, 1918
Died March 15, 1984. The retired physician was a resident of Oceanside, California. His wife survives him.

Cecil R. Park, 1921
Died July 24, 1984. Dr. Park, a resident of Scranton, Pennsylvania, was Chief of Surgery at the former West Side Hospital and was a consulting orthopaedic surgeon to the former Towanda Hospital. He was a past President of both the Lackawanna County Medical Society and the Cancer Society. Dr. Park served on the Board of Directors of the YMCA and the advisory Board of the Salvation Army. He was a Life Member of Jefferson’s President’s Club. Surviving are his wife, Marion, two daughters and a son, Richard C. Park, ’62.

John W. Frazier, Jr., 1924
Died June 21, 1984, at the age of 82. Dr. Frazier, a urologist, practiced and resided in Salisbury, North Carolina. Certified by the American Board of Urology, he taught on the faculty at Bowman Gray School of Medicine. Dr. Frazier served as President of the North Carolina Urological Society, as Chairman of the Salisbury Housing Authority and served as urological consultant at the VA Medical Center and as Chief of Staff of Rowman Memorial Hospital. Surviving are his wife, Sara, and a daughter.

John T. Kiely, 1925
Died March 16, 1984. Dr. Kiely was a general practitioner who resided in Towanda, Pennsylvania.

Irving J. Stewart, 1925
Died March 19, 1984. Dr. Stewart was a general practitioner in Swedesboro, New Jersey. He had served as police surgeon, school physician and President of the Board of Health.

James E. Yarbrough, 1927
Died June 16, 1984. Dr. Yarbrough was a retired Colonel in the USA Medical Corps who resided in Columbus, Georgia. Surviving are his wife, Marcia, and a son.

William E. Hudson, 1930
Died February 8, 1984, at the age of 78. Dr. Hudson was a general practitioner in New Philadelphia, Ohio, for over 50 years. He was cited by his community numerous times including Physician of the Year by the Rotary and by the Ohio State Sports Medicine organization. Surviving are his wife, Mildred, and three daughters.

William M. Howell, 1932
Died May 15, 1984. Dr. Howell, a family practitioner in Scranton, Pennsylvania, was a resident of nearby Waverly. He served as President of the Lackawanna County Medical Society in 1964.

Thomas F. Murphy, 1933
Died August 7, 1984, at the age of 76. Dr. Murphy, a resident of West Hartford, Connecticut, had served as Chief of Pediatrics at St. Francis Hospital and was the founder and Director of the Cystic Fibrosis Clinic there. Surviving are his wife, Patricia, a son and a daughter.

N. Van Sant Myers, 1933
Died April 28, 1984 at the age of 75. Dr. Myers was a resident of Red Bank, New Jersey at the time of his death. He was a proctologist in Engelwood before his 1969 retirement and had served on the staff of Englewood Hospital. Dr. Myers served as President of the New Jersey Proctologic Society in 1958. His wife, Kathryn, survives him.

Edgar W. Meiser, 1935
Died July 17, 1984, at the age of 74. Dr. Meiser retired from the US Army after 21 years in 1959 and returned to his native Lancaster where he served as Medical Director at Wyeth Laboratories. He and his wife, Dr. Mary Ellen Smith Meiser, had a family practice there. In addition Dr. Meiser was most active in his community serving as Secretary and President of the Board of Health and as a volunteer with the Boy Scouts among others. Dr. Meiser was President of both the Lancaster City and County Medical Societies. In addition to his physician wife, he is survived by a son and a daughter.

Gilbert N. Clime, 1936
Died March 20, 1984 at the age of 74. Dr. Clime, a resident of Lancaster, Pennsylvania, had served there as county coroner, city physician, and physician to the county prison and Barnes Hall. His wife, Lillian, a daughter and son survive him.

Abraham Hurwitz, 1938
Died September 6, 1984 at the age of 75. Dr. Hurwitz was a general practitioner in Philadelphia. His wife, Cora, survives him.

George M. Longaker, 1938
Died July 29, 1984. Dr. Longaker was a general practitioner in Pottstown, Pennsylvania, where he had maintained offices for 45 years. He had served as President of the staff at Pottstown Memorial Hospital. Surviving are his wife, Helen, a son and daughter.

Stephen E. Matsko, 1940
Died August 1, 1984. Dr. Matsko, a resident of McAdoo, Pennsylvania, was Chief of Surgery at St. Joseph’s and Hazleton State General Hospitals. A past President of the Hazleton branch of the Luzerne County Medical Society, he was a Fellow of the American College of Surgeons and the American...
College of Emergency Physicians and a Diplomate of the American Board of Abdominal Surgery. Following his retirement in 1977 he was named Medical Director of Luzerne County Cancer Detection Clinic. Surviving are his wife, Ruth, a son and a daughter, Jane, a student at Jefferson.

**Joseph R. Little, 1942**
Died December 2, 1983, at the age of 66. Dr. Little, who was certified by the American Board of Otolaryngology, was a resident of Salisbury, North Carolina. In 1962 he served as President of the Rowan-Davie Medical Society.

**Ronald M. Bernardin, 1944**
Died July 19, 1984, at the age of 65. Dr. Bernardin, who practiced pediatrics in Cherry Hill and Collingswood, New Jersey, was a Clinical Professor at the New Jersey College of Medicine and Dentistry in Camden. He served on the staff of Cooper and Garden State Community Hospitals and was Chairman of the Department at Our Lady of Lourdes Hospital in Camden. A member of the American Academy of Pediatrics, he was Medical Director of the New Jersey Association for Children with Learning Disabilities. Surviving are his wife, Catherine, two sons and three daughters.

**Randolph A. Read, 1971**
Died April 18, 1984, at the age of 34. Dr. Read, a member of the Jefferson/Penn State program, was a board certified psychiatrist who had trained at the University of California at San Diego. A resident of that area, he taught at the University of San Diego Law School and Medical School. Dr. Read was a noted forensic psychiatrist in the area and was the author of numerous publications.

**Richard T. Cathcart, Faculty**
Died August 29, 1984, at the age of 72. Dr. Cathcart was Honorary Associate Professor of Medicine, and had served as Director of the Pulmonary Division of that department from 1963 until his retirement in 1978. Surviving are his wife, two sons and three daughters.

---

Robert C. Mackowiak, M.D.
1938-1984

The Jefferson community was saddened by the sudden death on September 23 of former Associate Dean Mackowiak, who at the time of his passing was Clinical Professor of Medicine.

A cum laude graduate of the University of Pennsylvania, Dr. Mackowiak graduated from JMC in 1964, and took his internship at Methodist Hospital and residency at Mercy Catholic Center before returning to Jefferson. He became Associate Professor of Physiology in 1971 and Clinical Associate Professor of Medicine in 1976. His academic achievements included membership in Phi Beta Kappa, Alpha Omega Alpha and Sigma Xi, and he had written over 50 articles on various subjects.

The medical students were always a major interest to Dr. Mackowiak, and they reciprocated by awarding him the Christian R. and Mary F. Lindback Award for Distinguished Teaching (just three years after joining the faculty), a citation as “the Outstanding Basic Science Lecturer” in 1969 and by painting his portrait in 1980. At the time of the portrait presentation, he received a standing ovation from the members of the class, and was commended for his accessibility to students and uncompromising commitment to total student welfare. As Associate Dean, his responsibilities had been in Student Affairs, Hospital Affiliations and Continuing Medical Education.

He was certified a Diplomate by both the American Board of Internal Medicine and its subspecialty Board of Cardiovascular Disease, and was a Fellow of the American College of Physicians and the American College of Cardiology. A charter member of the Bioengineering Society, he was also a founding member of the American Academy of Cardiology.

He leaves a wife, Elaine, and children Jeffrey, 15, and Lisa, 11.