Senate Testimony

by

Joseph S. Gonnella, M.D. and Daniel Z. Louis

The prospective payment system was designed to correct some of the inefficiencies in the health care system. We believe that the system should be pressured to correct these inefficiencies without sacrificing high quality medical care. A prospective (i.e. pre-determined) level of hospital reimbursement for specific types of patients makes sense. However, there are problems with the DRG classification used to implement this approach.

The principal problems with the DRG classification result from a lack of clinical homogeneity in many of the DRG definitions. Patients with different diagnoses, undergoing different surgical procedures, with different levels of severity of their underlying disease entities, and with a variety of other unrelated diseases in addition to their underlying disease entity, are often classified—and therefore reimbursed—on the basis of the same DRG. A disease should be classified according to three elements: cause of the problem (etiology), organ(s) affected by the problem (location) and extent of the damage (stage of the disease). Almost none of the DRGs reflect all three elements. Therefore, it is difficult to use the DRG system to appropriately compare one hospital to another, to compare physician performance or to evaluate the quality of patient care.

A few examples can be used to illustrate the types of problems involved. There is only one DRG for patients with Diabetes Mellitus (age 36 or over). No differentiation is made by the DRG system based on the stage of the diabetes in a particular patient. The same DRG is assigned a diabetic with acidosis and coma, as a diabetic without those complications, despite the fact that these two patients are clinically very different and require very different resources for effective treatment.

Not only do the DRGs frequently include patients with different severity levels of the same disease, but in many cases patients with different principal diagnoses are classified in a single DRG. For example, DRG #1 is defined as craniotomy (age greater than or equal to 18 except trauma). A craniotomy may be performed on patients with a number of different diagnoses. The nature of the procedure, the cost of care and the patient’s prognosis may vary significantly from patient to patient.

In an analysis of patients at one hospital we found that patients classified in DRG #1 (craniotomy, age greater than or equal to 18, except trauma) were admitted with a variety of different diagnoses—cerebral tumors, defects of the central nervous system, aneurysm of cerebral vessels and complications of essential hypertension. The cost of care among these patients varied from $4,094 to $42,165. Despite these clinical and cost differences, the hospital is reimbursed for all of these patients under the same DRG.

Diseases are dynamic, not static. A disease should therefore be thought of as a process which can be identified in patients. A system which classifies patients at only one point in time is clearly not sufficient to capture the nature of the disease process. In order to adequately evaluate effectiveness and quality of medical care, it is necessary to analyze patient data at multiple points in time. At a minimum, medical status should be measured at the time of hospital admission, during the hospital stay and at the time of discharge.

Another serious flaw in the implementation of the DRG system results from the fact that both the definitions of the DRGs themselves and the calibration of the DRGs for use in prospective payment are based on historical utilization data. In essence, this approach assures that the DRGs are likely to perpetuate what they were intended to control. For example, surgery currently accounts for a large portion of hospital expenses. The DRG system assures that this situation will continue by classifying illness on the basis of how resources have been expended, rather than on the basis of how resources should be expended.

These problems with the DRG system represent serious implications in terms of the

continued on back inside cover
Members of the Alumni Trustee Committee of the Executive Committee recommend to its membership the reelection of Sheldon G. Gilgore, M.D. as its 1986 candidate for Alumni Trustee. He would serve his second term until June of 1989.

Dr. Gilgore, class of 1956, assumed in February the position of President and Chief Executive Officer of G. D. Searle & Company, a subsidiary of Monsanto Company. In announcing his appointment, the President of Monsanto stated that Dr. Gilgore brings to Searle the capability of producing leadership to develop the company into one of the major pharmaceutical houses in the world.

Dr. Gilgore previously was President of Pfizer Pharmaceuticals in New York, where he continues as a member of the Board of Directors. He joined Pfizer in 1963 as Associate Director of Clinical Research and subsequently was Director of Clinical Pharmacology, Director of Clinical Research and Vice President and Medical Director. He was named President in 1971.

While serving on the TJU Board of Trustees he was a member of the Scientific and Academic Affairs Committee from 1984 to 1986 and the Finance Committee from 1983 to 1985. He also was a member of the Joint Conference Committee of the Hospital.

The Alumni Trustee is a member of the American Diabetes Association and the American Federation for Clinical Research among others. He serves on the Boards of Brooklyn Union Gas Company and Clark University, is Chairman of the Board of the Connecticut Grand Opera Company and is a member of the Connecticut Commission of the Arts.

Serving with Dr. Gilgore as Alumni Trustees on the Thomas Jefferson University Board are Paul A. Bowers, M.D. '37 and Frederick B. Wagner, M.D. '41.

DETACHABLE BALLOT—BACK COVER
Alumni Trustee Committee

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Commentary
Dean Joseph S. Gonnella and Daniel Z. Louis, Director of the Center for Research in Medical Education and Health Care, explain inadequacies in the DRG system at the request of the Honorable John Heinz (R-Pa.) during Senate hearings on the aging.

Cardiac Catheterization 1986
Laboratory Director Sheldon Goldberg, M.D., discusses percutaneous transluminal coronary angioplasty (PTCA), advances and successes.

The Heart Has A Wisdom That Can't Be Duplicated
Bartley P. Griffith, M.D. '74, has invented a devise which keeps heart and lungs viable for transplantation.

Impotence: A Mystery No Longer
The Sexual Function Center, directed by Stanley N. Cohen, M.D., has made significant progress in helping men deal with this historically undisussed subject.

Climb To End World Hunger
Alex Levin, M.D. '82, participated in the climb to the peak of Mount Kilimanjaro last November.

Jefferson Scene
A new Alumni President and two new department chairmen highlight this section.
CARDIAC CATHETERIZATION 1986

A Jefferson Specialist Discusses Percutaneous Transluminal Coronary Angioplasty Advances and Successes

by Sheldon Goldberg, M.D.
During the past decade, some of the most important and innovative concepts in cardiovascular medicine have been developed by clinical investigators working in the cardiac catheterization laboratories. As a result, the treatment of patients suffering with ischemic heart disease has been revolutionized and improved.

In 1977, Andreas Gruentzig, M.D. at the University Hospital in Zurich, Switzerland, relieved an obstruction in the left anterior descending artery of a 37 year old man with severe angina pectoris by means of a cardiac catheter with an inflatable balloon. For the first time, direct myocardial revascularization was performed without the need for general anesthesia, a median sternotomy or cardiopulmonary bypass. This result was achieved after a meticulous series of experiments in cadavers, the animal laboratory and the cardiac surgical suite. In an understated and straightforward report, Gruentzig documented the results of percutaneous transluminal coronary angioplasty (PTCA) in the initial 50 consecutive patients. He developed guidelines for careful patient selection for PTCA, and helped establish the National Heart Lung and Blood Institute registry for PTCA. The early results were only moderately encouraging: of 3079 patients enrolled from more than 100 different centers, the primary success rate was 62% with a mortality of 1% and a complication rate of 19%. It was estimated that only 5% of patients who were candidates for coronary artery bypass surgery could be treated with angioplasty.

In an unprecedented series of live demonstration courses held in Zurich and later at Emory University in Atlanta, Georgia, Dr. Gruentzig trained many of us in proper patient selection and subtleties of technique; he stimulated clinician-scientists to advance the state of the art. In recent reports, the primary success rate for PTCA has risen to over 90%, with mortality as low as 0.1% and myocardial infarction rates of approximately 2.5%. This has been the result of several factors including greater physician experience and technologic improvements in catheter equipment design and imaging systems. Because of these advances, the number of patients who can be treated with PTCA has increased to approximately 25% of those who are candidates for bypass surgery.

Here at Thomas Jefferson University Hospital we have focused on research aimed at making PTCA safer, and more widely applicable in addition to improving long term results. To make PTCA a safer method of myocardial revascularization, we have attempted to protect the heart muscle during the procedure. This concept is similar to administering cardioplegia during open heart surgery. We reasoned that if it were possible to slow down the local metabolism of the heart during inflation of a balloon in the coronary artery, the patient would be protected from myocardial ischemia with its attendant anginal pain, electrocardiographic changes and dangerous arrhythmias. Using the information derived from an experimental model of myocardial ischemia, we administered the beta adrenergic blocking agent propranolol directly into the coronary arteries of patients during balloon inflation, and we found an important protective effect on the heart muscle, which enabled us to perform the procedure with greater safety and less discomfort to the patient.

These findings were presented by Andrew P. Zalewski, M.D., Assistant Professor of Medicine, at the American College of Cardiology meeting in 1985, and will be published in Circulation in April 1986. This idea of cardiac protection during PTCA is one we hope to extend and improve by both pharmacologic and mechanical means. In order to work out optimal methods of myocardial protection, we are actively working in a recently established research facility under the direction of Dr. Zalewski, an attending physician in the Cardiac Catheterization Laboratory. We will shortly begin a series of experiments on myocardial perfusion during balloon inflation in an attempt to further reduce ischemic injury. Our goal is to extend the indications for PTCA to higher risk groups such as those patients with multivessel disease, previous myocardial infarction and prior coronary bypass surgery. Our preliminary data for high risk angio-plasty will be presented by Michael P. Savage, M.D. '80, third year cardiac fellow, at the Scientific Sessions of the American College of Cardiology this spring. Our group previously reported on the efficacy of PTCA in patients who had undergone prior bypass surgery and developed recurrent angina or myocardial infarction.

Another endeavor we are undertaking is an attempt to reduce the incidence of restenoses following successful balloon angioplasty. At present, approximately 25% of patients who have had successful coronary dilatation have a recurrence within six months following the procedure. As part of our efforts to reduce this rate, we are participating in a multicenter, randomized trial of adjunctive pharmacotherapy to deal with the problem of restenosis. Patients who enter the study receive either placebo or one dose of methylprednisolone prior to the PTCA procedure. The end point will be the rate of restenosis at the six month follow-up.

Dr. Goldberg, Professor of Medicine and Director of the Cardiac Catheterization Laboratory, joined the Jefferson faculty in 1980.
angiogram. Our hypothesis is that by inhibiting the inflammatory response, pretreatment with the pulsed steroid dose will reduce the rate of restenosis. We plan to enroll approximately 800 patients in this phase of the trial. Hopefully, the treated group will show a statistical reduction in the restenosis rate. If there is no important difference between the treatment and placebo groups, then we will proceed to systematically test other interventions.

**Acute Myocardial Infarction**

In 1980, Marcus A. DeWood, M.D. and the group in Spokane, Washington, showed that nearly 90% of patients with acute myocardial infarction catheterized within six hours of symptom onset had complete obstruction of the infarct related vessel by coronary thrombus. In the next year, Peter Rentrop, M.D., working in Germany, documented that the intracoronary administration of the thrombolytic agent streptokinase could dissolve thrombi, and restore antegrade coronary flow in roughly 75% of the patients treated. These two observations encouraged us to begin an acute myocardial infarction program at Thomas Jefferson University Hospital in 1981. Our goal was to relieve the acute coronary obstruction during evolving infarction, and thereby interrupt the process of myocardial cell death and loss of contractile function. This represented a major departure from traditional therapy for acute myocardial infarction, which previously had been limited to supportive measures and treatment of arrhythmias. In contrast, this new approach was designed to reduce heart muscle damage, and decrease postinfarction mortality and heart failure. We were aided in these clinical studies by an open, cooperative attitude on the part of our volunteer faculty physicians who referred patients for this controversial, experimental treatment. I will never forget the first patient, a 73 year old man hospitalized in our coronary care unit at Jefferson who was evolving an acute anterior myocardial infarction. The attending physician encouraged us to go ahead with this new approach.

The patient was taken to the cardiac catheterization laboratory where we documented the thrombotic occlusion of the left anterior descending artery. We began the intracoronary streptokinase infusion and rechecked the flow in the coronary artery by frequent repeated dye injection. After approximately 20 minutes we were amazed to see a trickle of dye passing through the prior total occlusion. Ten minutes later, there was brisk flow past an atherosclerotic plaque which had apparently served as the nidus for thrombus formation. At the moment of opening, the patient developed a brief episode of "slow ventricular tachycardia." We noted dramatic relief of pain and resolution of the injury pattern on the electrocardiogram. In addition, left ventricular function improved as documented on the angiogram. Nineteen days later, the patient had recurrent angina which necessitated coronary bypass surgery from which he completely recovered. This index case demonstrated several important findings which we were able to extend and confirm in our subsequent studies.

First, it was possible to safely perform cardiac catheterization on a patient in the early hours of an acute myocardial infarction and restore antegrade coronary flow by intracoronary streptokinase. Second, successful clot lysis was associated with specific arrhythmias which serve as useful noninvasive markers for successful restoration of coronary flow. Third, the clinical, electrocardiographic and angiographic indices of acute ischemic injury could be improved after reperfusion, and fourth, recurrent ischemic events due to residual coronary stenosis are common and the underlying ischemic events need to be treated. We were fortunate in being one of the first groups to document the efficacy of combined thrombolytic therapy and subsequent PTCA to prevent recurrent post infarction ischemia.

The demonstration that intracoronary streptokinase was useful for coronary reperfusion during acute myocardial infarction led investigators to seek a more practical approach to emergency treatment. Several centers tested the efficacy of intravenous streptokinase. The idea was to try to achieve

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*Left coronary angiogram from a patient with a four-hour old anterior myocardial infarction. There is total obstruction of the left anterior descending artery (LAD) (arrow).*

*After intracoronary streptokinase administration, the LAD flow has been restored, and a high grade atherosclerotic plaque is evident (arrow).*
coronary reflow at the earliest possible moment—without the logistic delays necessitated by intracoronary drug infusion. This is important since the earlier the reperfusion the more complete the myocardial salvage. Unfortunately intravenous streptokinase was only about half as effective as intracoronary streptokinase in coronary recanalization. This led to a search for a more ideal thrombolytic agent—one that could be administered intravenously in the emergency department, was clot specific, and could lyse thrombi in an acceptable percentage of cases. The second generation agent currently under investigation is tissue plasminogen activator or t-PA, a substance being produced utilizing recombinant DNA technology.

Using lessons we learned during our prior experience with acute myocardial infarction, we will shortly begin a study using intravenous tissue plasminogen activator (t-PA) to perform earlier reperfusion, followed by PTCA. In a joint protocol with our colleague at Methodist Hospital, Salvatore P. Girardo, M.D. '69, our catheterization group will offer the possibility of early clot lysis by means of intravenous t-PA which has a similar chance of reperfusion as intracoronary streptokinase. This approach has enormous appeal because the earlier we can achieve reperfusion, the greater the likelihood of myocardial salvage.

It is my hope that someday we could organize a way to make t-PA available to patients in the community via a trained “myocardial infarction team” which would be sent out to administer the drug at the earliest possible time. Follow-up PTCA could then be performed after transfer to the University Hospital to prevent recurrent ischemic events.

The Role Of TJUH Catheterization Laboratory

I don’t know who first said “experience doesn’t mean much unless you learn from it,” but it expresses my feelings about our three interrelated goals: patient care, research and teaching.

We need to continue to have the highest standards of diagnosis and treatment in our daily practice. Our endeavor has been aided by the Hospital administration which recently helped us construct our new $1.3 million biplane, digital subtraction cardiac catheterization suite. This has made for improved diagnostic and therapeutic catheterization. Furthermore, we have the responsibility to accurately document our data as we approach the cutting edge of newer therapy. This necessitates computerization of our facility for data storage and retrieval so that we can monitor and modify our clinical practice according to our results. This effort is currently underway. We need to develop more effective treatment and this requires intensive basic and clinical investigation. In this endeavor, we were aided by Albert N. Brest, M.D., The James C. Wilson Professor of Medicine and Director of the Division of Cardiology; Dean Joseph S. Gonnella and Willis C. Maddrey, M.D., The Magee Professor of Medicine and Chairman of the Department, in establishing a research facility so that today’s experimental intervention is tomorrow’s practical treatment. Our commitment to high quality training must continue. There is no doubt that our accomplishments depend on the eagerness, dedication and skill of our cardiac fellows. They serve as an important stimulus to the faculty for continued growth.

As we look to the future, I see changes in our patient care delivery by means of outpatient catheterization. I expect our ability to image the heart and coronary arteries will improve substantially. In this regard, noninvasive visualization of the coronary bed may be within our grasp. Changes in PTCA technique will include the use of lasers and angioscopes. I am gratified that David C. Levin, M.D. will be joining our faculty as Chairman of the Department of Radiology. Dr. Levin, a world recognized leader in cardiovascular radiology, has much to offer us in strengthening our program. (see p. 20) I welcome this distinguished teacher and colleague to join our efforts.

Finally, our ability to improve patient care rests on our continued training and research efforts—goals that are increasingly recognized and supported at Thomas Jefferson University.

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**PTCA (percutaneous transluminal coronary angioplasty) of residual stenosis. The balloon is inflated in the area of the plaque.**

**Final result after PTCA shows improvement in arterial caliber. The patient completely recovered and is leading an active life practicing medicine.**
The Heart Has A Wisdom That Can't be Duplicated

Through investigation and research, Bartley Griffith '74, has devised a system whereby heart and lungs are kept viable for transplantation

by Judy Passmore McNeal

Hospitals across the country are making news as transplant procedures become more commonplace—and more successful—every day. Since cyclosporine has come into use as a new immunosuppressant, patients whose bodies would have rejected new organs before are surviving transplantation; increasing numbers of organ recipients are living normal lives with new kidneys, livers, hearts and lungs.

Jefferson alumnus, Bartley P. Griffith, M.D., '74, has been at the forefront of cardiac transplantation and has led the initial trials of combined heart and lung transplantation at Presbyterian-University Hospital at the University of Pittsburgh, one of only three institutions in the country performing a combined heart-lung transplant procedure. He heads the surgical team. Since 1980, more than 230 heart and 34 combined heart-lung transplant procedures have been performed. When Thomas E. Starzl, M.D., eminent transplant surgeon, came to Pittsburgh in 1980, the cardiac transplant program had already begun, but with his presence, according to Griffith, "came the ability for us to experiment with the new immunosuppressive drug cyclosporine." This drug, combined with other conventional immunosuppressants, such as azathioprine and corticosteroids, has helped

Dr. Griffith with the Jarvik-7 total artificial heart used by him to sustain the patient until an organ donor is found.
scrubbed, observing. Because of this individual, we have been able to flourish. It's rare,” he commented, “We clearly couldn’t have accomplished anything here over the past four years without his guidance of the team approach.

Heart transplantation surgery was performed at Presbyterian-University Hospital in 1968. Dr. Bahnsen’s patient lived a year and one half, but the program fell off. At the Department Chairman’s request, the program started up again in 1980. “Six months later Thomas Starzl, M.D., arrived with his ‘magic drug,’ cyclosporine, and things just took off. The multiple organ transplant program began with 30 to 40 livers in 1980 and 12 heart transplants. In 1985, more than 300 livers and 80 hearts were transplanted. When added to the 200 kidney transplants, the pancreas, and the heart-lung transplants, the volume at times is overwhelming. All this happened in part because of Dr. Starzl’s impact but also because of Dr. Bahnsen’s unique ability to blend productive individuals into the environment,” said the surgeon.

Dr. Griffith has a Hobie Cat which he takes to Stone Harbor, New Jersey, for a week each August. This past summer he and his oldest son entered their first regatta. His nirvana would be lots of work, a little sailing, and more time with his family. Dr. Griffith and the former Denise C. Cannon have been married since medical school days when they lived in a converted boarding house at 2nd and Spruce, and she worked in the admissions office at Rosemont College.

“As we grew together, we knew that life with a cardiac surgeon would not come without a great deal of work. Later she said, “You can take the job as Chief Cardiac Resident, but I’m not going to make it easy.” And she’s been true to her word,” he laughed. “My wife sees me as obsessed,” he said, “but happy in spite of it. She has been able to share in some other good fortune, such as a recent trip to Australia and to Dallas for a Texas Heart Institute testimonial for Dr. Cooley. I believe we both understand the personal sacrifices necessary if contributions are to be made.”

Top: The team at Pittsburgh performs more heart and lung transplantations than any other in the country. Dr. Griffith (right) heads the team. Above: When the organs are removed they are placed in three polyethylene bags and set within a sterile lucite box which resembles an aquarium. The organs are immersed in a solution which is heated to body temperature to maintain the functional status of the heart-lung bloc.
Impotence: A Mystery No Longer

The Sexual Function Center has made significant progress in helping men deal with this historically closed subject.

by Stanley N. Cohen, M.D.

Impotence has long been a matter of mythology and folklore. Even in medical school it was a mystery for most of us because we had no sure direction and were unfamiliar with the diverse etiological roads that it could take. Much of this, however, has changed over the past decade or two, and today impotence rests on a strong scientific foundation. This message has not gotten through to many of our colleagues, although there has been a noticeable change in the past ten years. Patients initially informed us of the lack of concern, even derision, on the part of personal physicians. Today we hear fewer such stories.

Impotence always has been an enigma to patients. The media rarely mentioned the subject; hence many patients felt they had a singular and unique problem. They often were too discouraged and intimidated to discuss the subject with their physicians. Today, there has been a veritable explosion of publicity in the popular press and television and impotent men are seeking answers and treatment. However, a measure of the continuing reluctance to seek counsel is the large number of men seen in the past three years, who carry the tattered remains of articles on the Sexual Function Center featured in the now defunct Bulletin in 1981 and in the Inquirer in 1983. It has taken them several years to make the decision to be examined! The sexual revolution also has released women from their restraints and they have played a prominent role in referring their partners.

The fact is that at least ten million American men are impotent and this may be only the tip of the iceberg. One of the great problems is that physicians do not specifically ask their male patients whether they are having problems with their sex lives. If the question is not asked, then the patient is unlikely to bring up the subject when it does exist. Therefore, it is extremely important that students and house staff be taught and practicing physicians reminded that an integral part of any interview in an adult male is the question, “How is your sex life?” Obviously, this must be asked discreetly, at the proper time and in an appropriate manner. I have found it most proper to include it on a check-off list of systems review and to refer to it when the genitals are being examined.

The Sexual Function Center at Jefferson has evolved as a multidisciplinary program, including psychiatrists, urologists, an endocrinologist, a physiatrist and a psychologist. It was in 1978 that Miguel Ficher, Ph.D., then a new member of the Psychiatry Department and a steroid biochemist,

Dr. Cohen, Clinical Associate Professor of Medicine, was appointed to the faculty in 1959 and serves on the staff in the Division of Endocrinology.
contacted me regarding new areas of research.

Knowing of the strength of his department in the field of sexuality, I suggested the association of impotence and diabetes mellitus as an area of mutual interest. From this association grew the multidisciplinary team and receipt of a three year grant from The National Institutes of Health. Working together on this problem, we have published a number of papers.

Two years into our research I suggested to S. Grant Mulholland, M.D., the Nathan Lewis Hatfield Professor of Urology and Chairman of the Department, that the team stay together as a clinical group and that we expand our interest to impotence in males generally. It was at this time that the Center became a reality.

Aware that a patient's time is valuable and that a complex study such as ours is lengthy, the Sexual Function Center has been designed to completely evaluate the patient in one day, usually from 9:00 a.m. to 4:00 p.m. This can be a logistical problem in our large university setting; hence, the patient is provided with a map and careful directions to the office of each of the participating team members.

The patient initially completes a comprehensive sexual history with questions directed at all phases of his sex life. He also describes his problem in his own words. We are anxious to know, quite specifically, the duration of his erectile problem, whether it was sudden or progressive, and the status of his situation to date. Since a 75% erection is necessary for vaginal penetration, much attention is directed to this issue. Many clues become apparent simply on the basis of this historical review. If the onset is sudden, the problem is more likely psychogenic. If the patient is able to attain nearly complete erection with masturbation, but not with foreplay, then the problem is less likely to be organic. If there is a problem with libido, then the problem might be psychogenic, hormonal or medication induced. If the problem is organic, there is still a psychogenic factor in many patients since the fear of failure plays a prominent role.

A significant question always is the drug history of the patient since various drugs, notably psychotrophic and anti-hypertensive medications, may significantly affect libido, erectile function, ejaculation and orgasm. We must continue to be alert to newer medications and their effect on sexual function. One, cimetidine, has been found to be particularly culpable in causing impotence.

The patient undergoes an interview with either our psychiatrist, Ralph E. Fishkin, D.O. or Karl Doghramji, M.D. '80, or our psychologist, Arlene Goldman, M.A. A careful evaluation of the patient's emotional life is obtained in order to reveal factors which may be playing a role in impotence. The sexual sophistication of each patient is assessed since many men have an incomplete or distorted fund of sexual knowledge. Some have had premature ejaculation, often for the entire duration of their sex life. Others have developed this symptom as a consequence of their fear of failure. All of these factors and many more are revealed in the initial interview.

An extremely important finding at the Center pertains to the many widowers that we have examined. While their stories vary, it is interesting to note that most fall into a category that we have called the "widower's syndrome." Almost invariably, they have had happy marriages which terminated in the illness and death of their mates. Sexual relations usually have not been possible during the last six months to
two years. Months and even years after the death of the wife, sexual relations may prove to be impossible. This impotence has a psychogenic etiology and may respond to appropriate psychiatric therapy.

Next, our patients see the endocrinologist who again reviews the sexual history but also takes a careful medical history. Numerous medical problems may play a role in the patient's impotence with particular emphasis on those hormonal states that are associated with sexual dysfunction. Primarily, this includes diabetes mellitus, which is present in perhaps ten to 20 percent of the patients seen in our Center. These patients always have a progressive form of impotence. Interestingly, their libido is nearly always intact. The duration of the disease is significant and we have seen both newly diagnosed diabetics and those diagnosed diabetic for several years. It is well documented that nearly 50% of diabetic men over the age of 50 are impotent. Our experience attests to the correctness of this figure.

Other hormonal states are associated with hypogonadism in which the testes may be small and extremely soft. Such patients may have either a deficiency in gonadotrophic hormones resulting in hypogonadotrophic hypogonadism or primary failure of the testes resulting in hypergonadotrophic hypogonadism. Obviously, these conditions are diagnosed ultimately through laboratory studies including luteinizing hormone (LH), follicle-stimulating hormone (FSH), total testosterone and free testosterone. In previous years only total testosterone was measured. However, it also is essential to know the free testosterone since it is the functioning hormone. When the total testosterone is normal but the free testosterone is low, patients may respond to the injection of testosterone. However, a word of caution is due regarding the significance of testosterone values in that this hormone, like many, is secreted in a pulsatile fashion. The values may change from one hour to the next and we are not always entirely certain of the significance of testosterone values. Therefore, we frequently will check a patient's testosterone values on several occasions in order to arrive at an appropriate diagnosis.

Our urologists include Demetrius H. Bagley, Jr., M.D. and Irvin Hirsch, M.D. Urological examination again consists of a review of the patient's sexual history and an in-depth urogenital history. The latter is significant in that previous injuries to the pelvis or operations including prostatectomy and abdominal surgery may result in impotence. While examination of the penis, scrotal sac and contents is important, the evaluation of penile blood pressure by the Doppler method has great value. Diminution or absence of the penile sounds by the Doppler method are significant; however, their presence does not necessarily imply that the vasculature is completely functional to allow penile erection. Pelvic activity during the sexual act may itself decrease the vascular flow through the penis. Nevertheless, Doppler is a significant approach to the overall functional ability of the penis to perform.

Two members of the urology house staff, Thomas P. Lehman, M.D. '80 and David J. Ellis, M.D. '81, are involved with the program. Ellis, particularly, is helpful in entering statistics into a computer.

Edward A. Posuniak, Jr., D.O. a physiatrist, brings a knowledge of the nervous system to our group which is indispensable. The pudendal nerve latency test has become an important tool in the investigation of impotence when the pelvic and peripheral nervous systems may be involved. Obviously, the greatest yield occurs in diabetic patients where neuropathy is so frequently the cause of impotence. In those instances, a measurement of the function of the peripheral nervous system is also important and frequently gives a hint to involvement of the nerves directly affecting the penis.

Finally, the Sleep Disorders Center directed by Dr. Doghamji is utilized in those instances where it is difficult to
make a distinction between functional and organic impotence. The patient sleeps for three evenings in this laboratory while measurements are made of cerebral, cardiac, eye and muscle activity. In normal men, during REM (rapid eye movement) sleep, there is penile erection for long periods with decreasing periods of erection as man ages. The measurement of this erectile ability offers a significant aid in delineating the type of impotence present. In addition, sleep apnea, frequently associated with impotence, can be diagnosed in the laboratory by a different methodology than that for determining nocturnal penile tumescence.

In our analysis of 518 patients, aged 17 to 85, 55% have a primary diagnosis of psychogenic impotence while 50% are organic. The latter consists of patients with vascular, neuropathic and endocrine disorders. There is an overlap since it has not been uncommon to find two or more entities in the same individual. Eighty percent of our younger patients had a psychogenic problem with 35% of our older patients following in this category. The psychogenic and the organic etiologies may meet in the middle-aged category, half being psychogenic and the other half organic. While not surprised at these findings, it is extremely critical to be analytical and to individualize each patient's problem. Thus, while we expect to see vascular or neuropathic disease in impotent diabetic patients, we also find that a percentage of these patients have a primary hormonal problem that one would expect in the non-diabetic population.

Most patients come to us for treatment, but there is a significant small minority who simply want to know what is wrong and are not interested in therapy. Psychogenic impotence is treated by the psychiatrist or psychologist and this therapy may take several forms. Sex therapy or marital therapy may be needed where both patient and partner are seen together. Individual psychotherapy is applicable in a significant number of patients.

Patients who have impotence on an hormonal basis, usually hypogonadism, may respond to monthly injections of testosterone enanthate mg 300 administered intramuscularly. In carefully selected cases, approximately 75% will respond. Patients who fail are usually studied in the Sleep Disorders Center. We have seen relatively few prolactinomas, perhaps 20, most of whom can be treated with bromocriptine therapy. Interestingly enough, this treatment is appropriate for large, as well as small tumors. Evidence exists that it may be more appropriate in the larger tumors than in the small, although occasionally surgical extirpation of the tumor by the transphenoidal route is necessary.

Implantation of a penile prosthesis has become a popular procedure in this country. We feel that it should be reserved for patients who, following careful diagnosis, have been found to have an organic disorder. Rarely, it may be used for psychogenic impotence when psychotherapy has failed. There are basically two types of prosthesis, the semi-rigid and the inflatable. Recently, a totally intracorporeal inflatable prosthesis has become available which offers the convenience of surgical placement and excellent penile rigidity.

As mentioned previously, many drugs are associated with impotence. While all drugs affect patients differently, and some patients have no impotence whatever with culpable medications, there are many drugs that are more likely to cause impotence. These include reserpine and alpha methyl-dopa among the anti-hypertensive agents. However, nearly all anti-hypertensive medications can be at risk, and we simply make suggestions for substitutions when it can be done appropriately.

Our Center is both exciting and provocative. It is extremely rewarding to the team when we have been successful in treating a man's sexual dysfunction. Marriages have been enhanced, saved or entered into as a result of careful diagnosis and treatment. However, six years and 1500 patients later, we are aware that these are very difficult decisions. We await new methods of diagnosis and treatment as the natural results of renewed interest in the field.

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**A Success Story**

Our first patient that December morning in 1982 was a physician working for the United States Government in Mexico City. He was 57 years old and had been impotent for 17 years. We were curious as to why he had traveled such a long distance to see us. "Well," he said, "I read about your Center in a medical journal and I was impressed with your program. A well known medical center in New Orleans has a similar program. Upon questioning them, I was told I would be interviewed by a psychiatrist but if my impotence was organic I would be given a penile prosthesis. This sounded somewhat incomplete to me and I decided to come here."

The physician's visit to Jefferson proved to be extremely beneficial. At the end of our examinations and tests, we made a diagnosis of a prolactinoma on the basis of a serum prolactin greater than 2000 ng/dl. We called Mexico City and advised him to return here for a CT scan of the brain to verify the diagnosis. Since he worked for the government he preferred going to Fort Sam Houston for further tests and treatment. Several weeks later he called to inform us that he had been operated upon for a prolactinoma and three days later had his first penile erection.

This case study certainly is not commonplace among patients seen in the Center over the past six years, but it does tell a story and emphasizes the importance of the multidisciplinary approach the Center fosters in the field of impotence.
The Climb to End World Hunger

Area professionals, including Alex Levin '82, want to change our attitude on the world's hungry

by Judy Passmore McNeal

“IT felt so good to us. The problem is giant, but the resources are there. We know we made a difference.”

The speaker, Alex Levin, M.D. '82, is referring to the climb to the peak of Mt. Kilimanjaro in Tanzania, Africa, that he and 14 other Philadelphia area residents completed in November, part of their determination to extinguish hunger by the end of the century.

Aside from raising money and receiving extensive media coverage, Levin, a pediatrician on the staff at Children’s Hospital of Philadelphia (CHOP), stresses the importance of the number of people his group reached, informing citizens about world hunger. The subjects of their concern are the 24 human beings, 18 of them children under the age of five, who die as a consequence of hunger every minute of every hour of every day—13 to 18 million a year.

Socrates said, “Nobody is qualified to become a statesman who is entirely ignorant of the problems of wheat.” Hunger destroys culture and family structure, threatens the peace and security of our world and makes a mockery of our moral values, according to The Hunger Project, one of the two organizations benefiting from the climb in Tanzania. Save the Children is the other.

The reason Dr. Levin’s group has associated itself with these particular organizations among the hundreds formed throughout the world, is because they are U.S.-based, Save the Children in Westport, Connecticut, and The Hunger Project in San Francisco and New York City. Both organizations are at work in the United States and abroad, The Hunger Project with educational projects and Save the Children with community projects from inner cities to Native American Indian homelands.

Statistics state that the world population is 4.8 billion people. If, for example, there were just 100 of us in the world, 58 would reside in Asia, 11 in Africa, 10 in Europe, six in North America. The current estimate for world population in the year 2000 is 6.1 billion, with the rate of increase lower where hunger has ended as a basic issue.

“Treating the symptoms of the persistence of hunger costs us more than would the elimination of hunger,” said Levin. For instance, by contributing $30 million to the campaign that eliminated smallpox worldwide, the U.S. now saves $100 million annually in what it would have spent on immunization and quarantine facilities, vaccinations and surveillance.

Politically, it’s necessary to persuade governments to cooperate. “It’s very easy to govern hungry people,” said Levin; “they’re too weak to resist.” Then he related the incredible fact that the Ethiopian government is exporting food.

“We need to educate the world so that large groups can put pressure on governments. Ethiopia had enough pressure applied that they finally opened up their northern border to some relief agencies,” he said.

Although it would be easy enough for the United States to feed the world, it shouldn’t be the only country doing so. It’s a complex issue, the answer to which is not a giveaway. According to Levin, the regions of Zambia, Zaire and Zanzibar, if adequately farmed with a supported agricultural program, could provide enough food to feed Africa.

Save the Children exists on a special premise: What is it about this city/community/country that allows hunger to persist? Is there not a good job structure? Not enough land for animals to graze on? “They don’t try to bring Philadelphia to Tanzania,” said Levin;
A scent to the summit, day eight. The 19,340 foot peak of this mountain was chosen partly for its location — Africa, the site of the most publicized deprivation on the globe. It was the seemingly impossible feat which attracted these questors.

"they try to solve the problem where the problem exists, teach the people so they can become self-sufficient."

Many countries have become self-sufficient since 1960 by creating a system, whereby they could, despite disaster, provide food for their families.

"We know there's enough food in the world," Levin stated. "Every single panel and commission attests to this, both scientific and political. We have the resources to feed the world."

Dr. Levin and his colleagues from CHOP were joined by teachers, writers and other professionals in the area, to spread this message. He feels that they personally made a difference because their efforts brought the subject to the attention of thousands of people. "We were ordinary people doing something extraordinary," he said. "And although there were only 15 of us at the summit, each person who donated was symbolically on the banner we placed at the top of Kilimanjaro."

The 19,340-foot peak of this mountain was chosen partly for its location — Africa, site of the most publicized deprivation on the globe. It was the seemingly impossible dual feat that attracted these questors. Wasn't "World hunger" too big a bite to chew? Did they have to climb THAT mountain? The answers were "No" and "Yes." Somebody had to take on the hungry of the world. Their climb was planned before the Live Aid concert last summer, but all the publicity generated by the gathering of rock stars was the best kind of PR for them. Live Aid put the Africa tragedy on T-shirts, on television and on the consciences of the world. The musicians wanted to send food to the starving. Save the Children and The Hunger Project want to do more. "I can guarantee that not one cent raised will be used for food to sit on a dock somewhere," said Levin.

When the Hunger Project was introduced in India over 35,000 people enrolled in one day, the first time in history that more people took a stand against hunger than died because of it. Education is the answer to all the problems related to hunger — slowed brain growth, undernutrition, delayed development. "We know that kids make wonderful strides once nutrition is present. The amazing reparative ability of a child's body allows him to recover. We don't know at what point it becomes irreversible." states Levin.

Levin deals with abused children at CHOP but sees no contradiction in caring for distant people when others within walking distance of his hospital need his time. "Hunger is a form of child abuse. I wasn't walking away but towards something far greater, a more pervasive problem."

Although he says he will always maintain his interest in abused children, Levin plans to begin a residency in pediatric ophthalmology this summer at Wills Eye Hospital. He hopes to join another climbing team in 1987 if it materializes. The experience in Africa heightened an awareness in him and his conversation always returns to the climb. Walking through the villages in the foothills of Kilimanjaro Levin spoke with the natives about hunger, the value of nutrition, methods
of tilling the soil, cattle care and the creation of the economic structure for their communities.

All of the climbing group reached the Kilimanjaro summit of 19,340 feet. Between the mountain’s two volcanic peaks, Kibo and Mawenzie, runs a “saddle” at 14,000 feet. “Tourists usually just walk across the saddle,” says Levin, proud that his group had gone further.

“We took the seven-day route to the summit which was both difficult and dangerous. We could have fallen 1000 feet from some of the cliffs and ledges.” A tropical rain forest lies at 7000 feet, where they1 hit the first two days. The third day found them above the clouds in a sparsely vegetated, rocky terrain. At the summit there was snow and volcanic ash.

“Really quite remarkable,” said Levin. “It looks like the moon.” They camped in this outer crater on a glacier at the peak, 15 people plus a support team of 11.

The team tried “no-impact” camping for the most part, making no fires and leaving no debris. They carried 10-18 pound packs. They knew it would be difficult climbing, “but until you get there and have to take four breaths for every step, endure tortuous eight-hour hikes each day, whether you’ve slept the night before or not, whether you had mountain sickness or not—you can’t fathom it before you go. We wouldn’t be able to feel our toes for the first two hours of the day. There was no way to keep our feet warm, with no fires; we had to put our damp socks between our bodies and clothing or they wouldn’t dry. We dug for fresh water at 18,000 feet.

“Every single day someone thought about turning back,” said Levin. “But we were there for a reason; we knew we couldn’t.” Nobody did, and at the summit, posing with their banner and reveling in their victory, they wanted it to last forever. Admittedly, they couldn’t wait to get off the mountain, “but those moments at the top were utter joy—a disappointment to no one,” recalled Levin.

“We were there to make the world a better place,” said Levin. “That drove us. It’s hard to put into words. One woman on the climb looked over a ledge and became frightened; she froze for a moment. It came to her in the minute of fear that 24 people had just died of hunger. She couldn’t afford to be frightened.

“The 11 support people were not involved with our project initially, but they became highly motivated, stimulated; they wanted so much for us to succeed. They wanted to wear the T-shirts. There was that kind of spirit. There was no turning back; we all knew we had to make it, and the native porters shared this enthusiasm because our cause had special meaning to them.” Kilimanjaro: Philadelphia’s Climb to End World Hunger raised $80,000 through vast media coverage and the personal efforts of these climbers and hundreds of supporters.

“It put the concept of hunger in the minds of countless people who hadn’t given it much thought six months ago,” said Levin, in whose mind it is ever present.

"We were ordinary people doing something extraordinary," said Levin (top right). "And although there were only 15 of us at the summit, each person who donated was symbolically on the banner we placed at the top of Kilimanjaro."
alumni president

In his long association with Jefferson Medical College, Samuel S. Conly, Jr., M.D. 'S44 has worn many hats. "Let Sam do it," seemed to be the philosophy. And because of his wide variety of experiences, acquired over a period of 36 years, he is uniquely qualified to assume the position of President of the JMC Alumni Association.

Dr. Conly, Honorary Associate Professor of Physiology, may be the first President who taught students in the basic sciences, but he is definitely the first to have spent nearly 30 years in the Dean's office, 16 of them as Director of Admissions. You name it and Sam Conly has done it.

It was in his capacity of Assistant to the Dean that he received so much experience, treading where others either feared to tread or had never thought of treading.

"Let Sam do it." Let Sam chair the Housing Committee, the Disaster Planning Committee; let him Chair the committee evaluating the Jefferson-Penn State Program in 1976 and again in 1982. Let him coordinate the first pension plan, Chair the Pension Committee, co-Chair the first Hospital and College Personnel Committee, Chair the Philadelphia medical school MEND coordinators.

The versatile Emeritus Associate Dean and former Director of Admissions was Faculty Advisor to Student Council, the first Student Financial Aid Officer, organizer of the First Aid courses, co-Editor of the Jefferson Newsletter, member of the special faculty Committee on Student Problems.

Perhaps his most interesting venture concerned MEND—Medical Education, for National Defense. This program extended his interest in aviation physiology, which later became aerospace physiology, and provided annual trips to the School of Aerospace Medicine in San Antonio. Conly has kept, since 1961, a British newspaper showing Russia's Yuri Gogaran, the first man in space, waving to reporters after his victorious flight. Coincidentally, the very day of that premier space adventure, Conly had delivered a paper of his own on space medicine while on a Jefferson postgraduate trip to London.

Indeed, a high point in his Dean's Office-cum-Admissions Director career was organizing alumni trips abroad. These were in the days before CME credits; on all of these early trips, a second plane had to be chartered to accommodate the crowds.

On a more serious note, Sam Conly has been instrumental in forming many of Jefferson's important policies: Jefferson-Penn State Program, University status, DIMER (Delaware Institute for Medical Education and Research), plans for health care in underserved areas, student housing, student affairs, Faculty Advisory System, graduate education and postgraduate medical education. It is this kind of diversified experience that will lend a unique aspect to his Presidency.

According to Conly, "a demoninator among Jefferson alumni is pride in their Alma Mater and the fine medical education they've received. While still in school, they see how well they do in national medical examinations. In internships and residencies they quickly recognize their competency among peers from other medical schools, and Jefferson's longitudinal study, which follows students all the way into the practice of medicine, objectively confirms the favorable impressions. A look at the professional accomplishments and leadership roles of Jefferson alumni throughout the 50 states further intensifies this pride.

"The loyalty of Jefferson alumni is remarkable and well known," he said; "it is a reflection of the pride they feel for their medical school and is manifested, not only in record-breaking annual giving, but also in the warmth they feel and express widely. Graduates of Jefferson immediately become members of the Alumni Association," said the new President. "The objective of this association, as expressed in its by-laws, is: to promote the general welfare of Jefferson Medical College; to cultivate good feelings among the Alumni; and, above all, to advance the interest of medical education and the diffusion of sound medical knowledge.

"As I see it, the prime thrust is to perpetuate and strengthen this object. Lines of communication are wide open and must be maintained, improved. Our institution is in good shape and good hands."

Upon receiving honors in biology at Lafayette College in 1941, and election to Phi Beta Kappa, Conly embarked on his medical career. World War II interfered with a regular four-year education; he and his Jefferson classmates were accelerated in their schedules, graduating in September, 1944, instead of June, 1945. A year's internship interrupted his stint in the Army, where he rose to Captain. Buying a row house in South Philadelphia, he joined the faculty at Jefferson in the Department of Physiology as Assistant Demonstrator. "The lowest rank was Demonstrator," he laughs.

In order to keep the wolf from the door—he and wife Marjorie had two of their four children by then—he opened
a general practice in his home in the evenings. He had patients immediately, and before long he was coming home to find them lining the front steps and street. "I'd grab something to eat," he said, "attend to office hours, then start house calls at 12:00 or 1 a.m. Then back to Jeff the next day." He managed this hectic schedule for three years, but could not continue. He left Jefferson and practiced full time for three years before deciding to return as Assistant and later Associate Professor in the Department of Physiology. That was 1953; in 1956 he joined the Dean's office.

produced 11 grandchildren. Firstborn Carol lives in Puerto Rico with her attorney-husband and their two children; Forester Samuel S. Conly III and his wife live in White Sulphur Springs, West Virginia. They also have two children. Daughter Bobbi and her husband live outside of Ottawa, Canada, with their four children. Last but not least, "Our son the Doctor" Larry (Frank L. Conly, M.D. '80), who followed in his father's footsteps through Lafayette, Jefferson and residency at Bryn Mawr Hospital. Then he ventured off the prescribed route and set up practice in Renova, Pennsylvania, an underserved area in the center of the state. He and his wife have three daughters.

At one time or another, all of the above visited the Conlys over the Christmas holidays. "When people wonder how I keep myself busy in retirement I first look astonished, then I give them our four categories of activity," said Conly in the family room added onto the pre-revolutionary farmhouse. "First of all are all these children, spread out from Puerto Rico to Canada." The grandparents like to visit each household at least once a year, but haven't honored their threat of staying with each family three months. They enjoy their grandchildren, the bilingual Spanish speakers in San Juan, the bilingual French speakers in Canada and everyone in between.

The next activity is obvious to anyone who lives in an old house. As Marge said, "He spends half his time in the cellar holding it up!" Part of their house dates back to 1704. Dr. Conly is handy with tools, and has needed every bit of his expertise over the years. He has two workshops, including one in the garage, and does woodworking as well, having built two boats and several pieces of furniture.

Which brings to mind the third important activity—a small cabin in Canada where he and Marge spend time in all kinds of weather. Not a domicile for the faint-hearted, the cabin has heat but no hot water. Still, they have 300 feet of waterfront and a tranquility and beauty that can't be matched by modern conveniences. It is here they have launched their homemade boats, here their children and grandchildren have learned to swim and fish.

One more activity the Conly's enjoy that takes time, but little planning, is their spur of the moment daytripping. "Let's go walking on the boardwalk," they'll say, and off they go. "I feel like driving down to the DelMarVa Peninsula," one will say. "OK, let's do it." And they do. And they have in the backs of their minds that this might be where they want to live when they REALLY retire.

His favorite activities at Jefferson always centered around the students. It was this dimension that made his tenure as Director of Admissions particularly appealing. Young people are still his prime interest; now, however, they are directly related to him and to Marge.

Their four children, all of whom grew up in the Wallingford farmhouse the Conly's moved to in 1950, have
Association President, Robert Poole '53 the President-elect and Rudolph T. DePersia '48, replaces David R. Brewer, Jr. 'S44 as Vice President. Dr. Brewer has moved to his new home in Florida. Other officers of the Alumni Association are Vice Presidents Leopold S. Loewenberg '56, Jerome J. Vernick '62 and John F. Wilson '37; Secretary Nancy S. Czarnecki '65 and Treasurer Leon A. Peris '55.

Honorary memberships in the Association were awarded to Louis L. Keeler, Clinical Associate Professor of Urology at Jefferson and Chief of the Department at Our lady of Lourdes Medical Center in Camden, New Jersey, where he also served as President of the staff; Francis X. Keeley, Clinical Professor of Medicine at Jefferson and Chief of the Division of Gastroenterology at Our Lady of Lourdes; and Louis D. Lowry, Professor of Otalaryngology and Chairman of the Department at Jefferson. These physicians are chosen for this honor because of their fine contributions to medical education at Jefferson and the affiliates.

Drs. Keeler and Keeley are each married to a daughter of the late Vincent T. McDermott '26, a past President of the Alumni Association. Young Lou Keeler, class of '86, also was present.

radiology chairman

David C. Levin, M.D., Professor of Radiology at Harvard Medical School and Acting Chairman of the Department of Radiology at Brigham and Women's Hospital in Boston, has been appointed Chairman of the Department of Radiology at Jefferson, effective July 1.

Dr. Levin's undergraduate education was taken at Cornell University, 1955, and in 1964 he received an M.D. from Johns Hopkins University; between these, he served in the Air Force as a jet fighter pilot with a rank of 1/Lt.

Since his radiology residency at UCLA, Dr. Levin has been Assistant Professor of Radiology at Cornell Medical School; Associate Professor of Radiology at SUNY-Downstate Medical Center; and Associate Professor at Harvard. He has served as Professor at Harvard since 1981.

The new Professor is Associate Editor of Cardiovascular and Interventional Radiology and is on the Editorial Board of Investigative Radiology. A member of the reviewer panel in both vascular and cardiac radiology of the American Journal of Roentgenology, he is an occasional reviewer for the New England Journal of Medicine, Catheterization and Cardiovascular Diagnosis and Radiology. He was formerly on the Editorial Board of the American Journal of Cardiology.

Dr. Levin serves on the Executive Committee of the Association of University Radiologists, and the Board of Trustees of the Society for Cardiac Angiography. He is a Fellow of the Council on Cardiovascular Radiology of the American Heart Association, having been elected Member-at-Large of the Executive Committee of this Council in 1978. He also is a Fellow of the American College of Cardiology, President-Elect of the New England Roentgen Ray Society and served as President of the New England Angiographic Society in 1978-79. He is also a member of the Society of Thoracic Radiology, the Radiological Society of North America, the American Roentgen Ray Society and the North Ameri-
Department, and with Jefferson's Liver Transplantation Program team. Since the 1960's, Dr. Rubin's research has also focused on the interaction of alcohol and drugs.

Principal investigator and scientific Director of the Alcohol Research Center, supported by the NIAAA, Dr. Rubin also holds a grant from the Joint-U.S.-Spain Commission on Science and Technology. He is Editor-in-Chief of Laboratory Investigation, the premier journal of experimental pathology and is Field Editor of Federation Proceedings and Quarterly Journal of Studies in Alcohol. He also serves on the editorial boards of several other scientific publications, has published 121 research papers and is the author of 13 book chapters, editorial reviews and lectures.

After receiving his M.D. degree from Harvard Medical School, Dr. Rubin interned at Boston City Hospital and completed a residency at Children's Hospital of Philadelphia. A research fellowship in Pathology at Mount Sinai Hospital in New York followed, and Dr. Rubin spent most of his career there, serving as Given Professor of Pathology and Chairman of the Department at Mount Sinai School of Medicine and at City Hospital.

Dr. Rubin is a Diplomate of the American Board of Pathology (Anatomical and Clinical Pathology) and a member of the American Association of Pathologists, the International Academy of Pathology, the American College of Physicians, the American Gastroenterological Association and the American College of Toxicology among many others.

**affiliations**

Jefferson is able to educate the more than 800 students matriculating here because of the network of affiliated hospitals and medical centers throughout Pennsylvania, Delaware and New Jersey that take groups of second, third and fourth-year students into their educational programs. This provides continuity of curriculum and experience with the varied sizes and settings in the network.

Because the affiliations program is so important to Jefferson, Joseph F. Rodgers, M.D. '57, Associate Dean for Affiliations and the Residency Program, has accepted the mission of forging stronger bonds between the Medical School and the 22 institutions that comprise the affiliation system.

"We depend on them to teach our students," says Dr. Rodgers. "We could not provide meaningful clinical experiences to all of our medical students and residents without the help of our affiliates. The relationship is mutually beneficial; we want to keep it strong and healthy."

Dr. Rodgers, Clinical Associate Professor of Medicine, feels that communication is the most important factor in this complementary relationship, and to that end he visits each affiliation several times a year, once with Dean Joseph S. Connella.

Faculty members at these hospitals and medical centers also come to Jefferson to confer with department chairmen on what should be taught and what steps might be taken to effect a stronger program. Each chairman establishes his goals and the faculty at the affiliates implements the educational programs. Feedback from the students and residents confirms that the affiliate faculties continue to provide an excellent learning experience. Input from those faculties is an essential part of the evaluation of both residents and students. This process is continually being refined and upgraded.

"The bottom line is education," says Rodgers. "Since we send over 50% of our students to these hospitals, it is our responsibility as the parent institution to involve them, stimulate spirit, enhance communication and appropriately reward efforts.

In Pennsylvania, those affiliates include Bryn Mawr Hospital and Bryn Mawr Rehabilitation Hospital; Chestnut Hill Hospital; Children's Rehabilitation Hospital (formerly Children's Heart Hospital); Crozier-Chester Medical Center; Elizabethtown Hospital and Rehabilitation Center; Franklin Regional Medical Center; Lankenau Hospital; Latrobe Area Hospital; Magee Rehabilitation Hospital; Mercy Catholic Medical Center; Methodist Hospital of Philadelphia; Northeastern Institute of Psychiatry; Veterans Administration Medical Center (Coatesville) and Wills Eye Hospital.

In Delaware are Delaware State Hospital, Medical Center of Delaware, Veterans Administration Medical Center (Wilmington) and Alfred I. duPont Institute; and in New Jersey Our Lady of Lourdes Medical Center, Underwood Memorial Hospital and the West Jersey Hospital System.

**faculty club**

What organization on campus boasts ambience, social activity and proximity and simultaneously provides an opportunity to obtain a grant in your field of research? According to informed sources the answer is the Faculty Club in Jefferson Alumni Hall.

Because he served as its first President and as Social Chairman for the first seven years, one of the most informed sources is Robert J. Mandle, Professor of Microbiology. He also is the cheerleader for the Faculty Club which, he states, "helps bring Jefferson together."

Mandle insists that the concept for the Faculty Club "came from the fertile mind of Andrew Ramsay, Professor Emeritus of Anatomy," who was instrumental in the design and layout of the Commons area, completed in the spring of 1968.

The following fall, with the rooms completed and the furniture in place, the club couldn't be chartered until 50 members had been recruited. When informed of the reason for the long delay, Mandle produced more than the required number in a few hours by enlisting his colleagues and friends. He now calls it a "major force in the life of this institution."

What is the secret of its success? "It allows the basic scientists and clinicians to discover each other," Mandle explains. It should be understood that before the late Dean, William F. Kellor, arrived on the Jefferson scene, there were few opportunities for these two groups to intermingle. "Everything was run by department chairmen," says Mandle, "and they were the only ones
who could serve on committees." Dean Kellow brought with him a democratic philosophy that opened communications between groups and factions; the Faculty Club was an extension of this.

"Look," says the Professor, craning his neck to see around a post, "there's an anatomist and a radiology biologist with the Librarian John Timour. Over there," he points, "neurologists are having a luncheon meeting and there's the Dean with Paul Brucker. At that table George Kalf is presiding with the basic scientists but the clinicians will be drifting in."

He continues, "It has given the faculty an opportunity to sit and meet each other, not necessarily to talk shop. There's time for jokes and gossip and all the things that go on in social groups.

"On the other hand, we basic scientists hear what the clinicians are interested in and what spills over into medicine. A lot of research grants have been submitted based on conversations started here at lunch," he says enthusiastically.

In the first years of the Faculty Club there were social functions almost every other week, but lifestyles have changed as has the regularity of activities. Still, there are two dances a year and a Christmas party and the daily luncheons delightfully served by a staff that has been here almost as long as the building.

On any given day there is a wide assortment of salads, sandwiches and soups, oven fresh breads and two entrees with accompanying vegetables. He recommends the Cobb salad from California and the pumpernickel bread liberally dotted with white raisins.

Barely able to contain his enthusiasm, Mandle rattles off a list of memorable parties and events centered around the Faculty Club, not the least of which were the Gourmet Dinners which he organized out of his love of good food. Soon, it became gastronomically evident that these could not continue.

"The faculty complained of too much food," he laughs. "They went home dying."

There were the square dances with Dean Kellow establishing the standards to which everyone aspired; the parties with James Hunter '53 and the Red Peppers providing the music; cruises down the Delaware; gambling nights with different departments manning various booths; horseracing films; wine and cheese parties. Richard Schmidt ran an art auction.

Mandle regards the success of the Faculty Club very high on his list of accomplishments. He is particularly pleased that he and his wife together have made so many lasting friendships through this association. "It's one of the best investments of time I've spent at Jefferson," he says proudly.

**honors, etcetera**

A grant of $554,000 from the estate of Etelka J. Greenfield to Thomas Jefferson University will be used to help support research fellowships in family medicine. Paul C. Brucker, M.D., Alumni Professor and Chairman of the Department, announced that the Research Division of the Family Medicine Department, established in 1983, has been renamed the Greenfield Research Center; the first two fellows began in September. Donald J. Balaban, M.D., M.P.H., Research Professor of Family Medicine, will direct the research division and fellowship program.

Orville H. Bullitt, Jr., Ph.D., has been appointed Chairman of the Board of Trustees of Children's Rehabilitation Hospital, according to Edward C. Driscoll, Chairman of Jefferson's Board of Trustees, of which Dr. Bullitt has been a member since 1971. Children's Rehabilitation Hospital is the new name for Children's Heart Hospital, Jefferson's affiliate at 3955 Conshohocken Avenue, Philadelphia.

Jerome M. Cotler, M.D., Professor of Orthopaedic Surgery, has been appointed Director of Orthopaedic Surgery at TJUH, with responsibility for the day-to-day management of clinical services. A grant of $750,000 from the William Penn Foundation will fund three years of research to develop "An integrated Service Delivery System for the Effects of Dementia on the Elderly and Their Families." The Center for the Study of Geropsychiatry, Department of Psychiatry and Human Behavior, will receive a considerable portion of the grant to expand the Dementia Evaluation Clinic at Jefferson, according to Edwin A. Cramer, Ed.D., Clinical Assistant Professor of Psychiatry and Human Behavior.

Stephen A. Feig, M.D., Professor and Vice Chairman, Department of Radiology, JMC, and a member of the National Council on Radiation Protection and Measurements Scientific Committee 72 on Radiation Protection in Mammography, is co-author of a monograph, *Mammography—A User's Guide*. The book, published by the NCRP, is intended as a practical guide to physicians and technologists who perform and interpret radiographic evaluation of the breast and to physicists and engineers who calibrate, monitor and maintain mammographic facilities and evaluate image quality factors.

Farid I. Haurani, M.D., Professor of Medicine, Cardeza Foundation for Hematologic Research, spent time as a Fulbright Scholar in Egypt, where he taught Clinical Hematology at the Medical School of the University of Cairo. In addition, Dr. Haurani spent seven months studying hematopathology at Hotel Dieu, the Sixth Medical School of the University of Paris, and did research on vitamin B12 and iron research at Hotel Dieu and two other hospitals affiliated with the University of Paris. He also attended the Eighth International Conference on Proteins of Iron Metabolism in Lille, France, where he presented a paper, "Transferrin Iron of the Macrophage."

Joseph S. Gonnella, M.D., Dean and Vice President, JMC, has accepted Dickinson College's invitation to become a member of the College's Board of Advisors.

Peter D. Pizzutillo, M.D. 70, Associate Professor of Orthopaedic Surgery, has been appointed Director of Pediatric Orthopaedic Surgery at TJUH. Dr. Pizzutillo served his residency in the Affiliated Program between 1971 and 1975, and in 1976 became a Diplomate
of the American Board of Orthopaedic Surgery. He is presently Director of Medical Education and Sports Medicine at Alfred I. DuPont Institute. He is a Fellow of the American Academy of Pediatrics, the American Academy of Orthopaedic Surgeons and the American College of Surgeons, a member of the American Orthopaedic Society for Sports Medicine and Vice President of the Jefferson Orthopaedic Society. Since 1978, he has been Pediatric Orthopaedic Consultant at the State Crippled Children’s Clinic in Georgetown, Delaware.

Thomas Jefferson University ranks in the top ten universities for patents issued, the only university within the Pennsylvania/New Jersey/New York/Delaware area to attain such high ranking. Jefferson’s 10 patents tied it for eighth place with The Johns Hopkins University and the University of Florida Board of Regents. Patents issued in 1984 include those to Jewel Osterholm, M.D., Professor of Neurosurgery and Chairman of the Department, for the invention of the system to treat stroke. Patent approval for the Jefferson artificial larynx was issued to Philip Katz, Ph.D., Associate Professor for Technology and Information Management and Louis D. Lowry, M.D., Professor of Otolaryngology and Chairman of the Department; Harold L. Schwartz, Ph.D., Clinical Engineer in the Department of Biomedical Instrumentation; and Henry S. Brennan, D.D.S., Associate Professor of Otolaryngology (oral surgery) and former Chairman of the Department of Dentistry. More patents were issued in 1985 for these inventions. Other results of the Intellectual Properties Program include the University’s receipt of $1.5 million in research dollars between 1980 and 1984, along with an additional $150,000 in royalties from licenses.

new jersey leader

On May 2, 1986, Edward A. Schauer, M.D. '49, became the 194th President of the Medical Society of New Jersey, the oldest medical society in the United States. As spokesman and representative for the 9,600 members of the organization, he feels that one individual can make a difference. His thrust, this year in office, is the preservation of the private practice of medicine.

"Since I’ve been in practice — 34 years — I’ve seen Medicare, Medicaid, PSRO, HSA, DRGs. I have a big problem with those,” said Schauer. "Philosophically, I am against government programs which cost tax payers money and leave bureaucrats fumbling with the programs. Physicians should practice good medicine, take good care of patients. The more that’s done by the individual, the less by government, the better it will be. I want to work toward preventing further governmental inroads into medicine.

"In addition, I have very strong feelings about citizenship,” Schauer continued. "We have the greatest country in the world, and I think if everyone tries to do a better job — no matter what that job is — the rest of the country will benefit.” The new President is also accepting the responsibility of working with the problem of medical liability. "One in three physicians is being sued,” he stated. "The populace is hurt by this as well as the physician.” Dr. Schauer insists that it’s becoming an overall social problem, and feels that this is where the medical community might find their support. "If schools can’t afford to buy insurance, as well as townships, restaurants and small businesses, changes will have to be made.”

Dr. Schauer cites the state of Indiana and its medical liability protocol. Otis Bowen, M.D., Secretary of Health and Human Services, was first a family practitioner. He was elected to the State Assembly, became Speaker of the Assembly and then Governor of the state for two terms before assuming his present Cabinet post. "He was instrumental in bringing medical liability legislation in his state to proper fruition,” said Schauer. "I consider that an example of how one person can make a difference.”

The Supreme Court has recently ruled that much needed liability reforms in California are constitutional. Nationally, there is bill S1804, sponsored by Senator Orrin G. Hatch (R-Ut) and HR3865, sponsored by Congressman Norman F. Lent (R-NY), to correct some of the inequities. The bill is being discussed in committee.

In New Jersey, the Medical Society is also encouraging legislation to change the medical liability situation. A public relations effort of MSNJ presently in effect has grown steadily over the past several years. "We want to bring our theme to the people of New Jersey: Care with Caring,” said Schauer, who admits he will have a busy year. "I still like the words ‘physician’ and ‘patient,’” he said, "rather than ‘provider’ and ‘client.’" He has always had a hand in medical politics, and enjoys the challenge. In his 34 years of family practice, Dr. Schauer has founded the Monmouth County Chapter of the New Jersey Academy of General Practice, serving as its first President. For 10 years he was on the Board of Directors of the New Jersey Academy of Family Practice, was President in 1967 and Chairman of its Board in 1968. He represented New Jersey in the American Academy of Family Physicians House of Delegates for 12 years, served on its Board for three years and was Vice President in 1979. Currently, he is an alternate delegate to the American Medical Association (six years) and has been a delegate from Monmouth County to the Medical Society of New Jersey for 27 years. He is a Charter Fellow of the American Academy of Family Physicians and a
Charter Diplomate of the American Board of Family Practice.

While a member of the Board of Directors of the American Academy of Family Physicians, he acted as Liaison to the National Society to Prevent Blindness and now serves as a member of the Medical Advisory Committee of the New Jersey Division. Presently an emeritus member of the Board of Trustees of the Monmouth County Heart Association, he has served as its President and Chaired its fund drives.

He was instrumental in founding the Family Practice Department at Jersey Shore Hospital, where he has been on the staff for 34 years, and served for five years as its Director. He has been Chief of Staff for three years.

The new President of the Medical Society lives in Farmingdale, a tiny town ten miles west of the ocean, where, "if everybody's home, we number about 1000 people." Dr. Schauer came to Farmingdale from the Navy, where he served in the Korea/ Japan theater. The young doctor bought the practice of his wife's physician, who wanted to specialize in obstetrics. The Schauers have raised four children and numerous large dogs in a house, with office attached, on the main street of town.

The house and office, built by the father of W. Paul Havens, Honorary Professor of Medicine and Honorary Clinical Professor of Microbiology at Jefferson, has been enlarged over the years to accommodate their children and a second physician. Dr. Schauer is pleased that in addition to his brother, Joseph W. Schauer, M.D. '55, joining him in practice, his nephew, Joseph III '81 is a member of the group. He feels that a three-man practice is better able to care for the community.

When he is away from his office, he and his wife, Alice, can be found at their Long Beach Island home, built by their son-in-law on property they have owned for 30 years. Their four children and four grandchildren are spread all over the coast, from Massachusetts to Florida; daughter Andrea is a student at Jefferson, class of 1988.

Although the Schauer Family Group does not deliver babies, the three physicians take care of newborns and children, as well as attending to general medicine, office gynecology and minor surgery. Emergencies are usually handled at Jersey Shore Hospital, eight miles to the east. Their territory covers most of Howell, Wall and Freehold Townships, south to Tom's River, east to Asbury Park. Farmingdale is directly off Route 195, which runs due east between Trenton and the Beaches.

Enrolling first at the University of Pennsylvania, and hearing about "those people across the river at Jefferson Medical College," Schauer transferred on the Navy V-12 plan to Colgate before entering Jefferson, where he heard about "those people across the river at Penn." He commuted to school from Bucks County, and remembers fondly his association with four other commuters with whom he spent a junior internship at Trenton State Hospital.

Outside activities that occupy Dr. Schauer's scant free time include singing and sports. He plays pick-up basketball and volleyball with the local firemen, and is an associate member of the Fire Department. He follows the local high school and college teams and is active in the Pop Warner Football Program. He and his brother share high school football team duties, although his main responsibility is to the seven grammar schools in the area. The group also handles medical examinations for small industries nearby and Brisbane, a Child Treatment Center.

Schauer brings his considerable experience in patient care and medical politics to the Presidency of the country's oldest medical society; his many years of service have earned him the respect and support of his colleagues and constituents.

**insurance program**

One of the most tangible and direct benefits of membership in the JMCAA is its Group Insurance Plans. A broad, comprehensive program is available and the savings that can be realized add up significantly.

Two new Plans were made available early in 1986. One is a $1,000,000 Excess Major Medical Plan with unique benefits. First, it is Guaranteed Issue. No member under 60 years of age can be turned down for this coverage because of health history. Second, cost is modest. A member at age 49 pays only $66 annually; member, spouse and children can have coverage for $174 annually. A $25,000 deductible makes Guaranteed Issue and low cost possible.

The other new Plan is an enhancement of the Group Term Life program that raises the ceiling on face value to $300,000 from the present limit of $250,000. In addition, a special 25% Benefit Bonus will apply on all new coverage amounts at no additional premium. This bonus can bring the benefit to your family as high as $375,000. This extra 25% of protection will remain until your 60th birthday.

The One Million Comprehensive Major Medical Plan offers a choice of three deductibles, either $500, $1,000 or $5,000. These deductibles plus a step rating of premium by age make some significant savings over Blue Cross and most other Major Medical programs. All members and their employees under age 65 may apply for this One Million protection. Coverage for spouse and single, dependent children is also available. This Plan pays in or out of hospital and provides for skilled nursing services. Then at age 65 premiums are reduced, the Plan converts to a Medicare Supplement filling in the gaps in Medicare and generally extending its hospital/skilled nursing services and out of hospital benefits.

The Disability Income Program pays up to $5,000 per month to protect against either sudden or long term loss of income. Two Plans are available. The Basic (short term) Plan provides up to $5,000 a month for up to one year. The Extended (long range) Plan provides benefits after one year. Should disability occur before age 50, it provides up to $5,000 a month for life. Together these plans can be tailored to your needs to provide complete coverage; used separately they supplement existing protection.

Alumni may call toll free in Pennsylvania (800) 562-5790; nationwide (800) 523-0211 or locally 646-1949.
1926

Philip B. Davis, 1125 Gatehouse Rd., High Point, N.C., writes, "We returned to High Point to our yearly residence to be near our own personal physicians and children. We closed our Delray Beach home in 1984. Mrs. Davis and I have established an endowment fund at the University of North Carolina for undergraduate study."

1928

C. Kenneth Schloss, 2000 Stoneybrook Tr., Fairborn, Oh., "just had 81st birthday and healthy."

1929

Mrs. Karl W. Hahn has sent word that she has established at St. Luke's Hospital in Bethlehem, Pennsylvania, the Hahn Memorial Fund to enhance education and study in the field of diabetes, because of her husband's long interest in the specialty. Dr. Hahn was a pioneer in the treatment of the disease in the Lehigh Valley. He died in June of 1980.

1931

Harry F. Suter, 49 W. Main St., Penns Grove, N.J., is still working part time. "Hope to get to the mid-winter alumni meetings."

1932

C. Earl Albrecht, Advance, N.C., was featured in a four column story in the Winston Salem Journal in December. It traced his early involvement in health care in Alaska, his position as Commissioner of Health and his work in organizing a health department for the territory.

Joseph Lomax, 610 San Servando Ave., Coral Gables, Fl., has been retired for 12 years.

1933

Nicholas F. Vincent, 2119 O'Hara Ct., Columbia, S.C., is enjoying his retirement. "I play tennis doubles three times a week. Have done a little part time medical duty; may do more."

1935

R. Marvel Keagy, 3510 Baker Blvd., Altoona, Pa., is "retired!"

1936

J. Edward Berk, University of California, Irvine, Distinguished Professor of Medicine, delivered the Augustin Liboro Memorial Lecture at the University of Santo Tomas, Manila, Philippines, on December 6. Dr. Berk also served as Visiting Professor at the University of Singapore and addressed the Philippine, the Singapore and the Hong Kong Gastroenterology Societies during the period December 3-12.

James F. Burke, 4 Wiltshire Rd., Philadelphia, writes that he is "looking forward to our 50th."

John P. Manges, P.O. Box 498, Chambersburg, Pa., hopes to be back on campus for his 50th reunion in June.

Stanley C. Suter, 204 Hathaway Park, Lebanon, Pa., was honored by his colleagues and friends at a dinner on February 14 at the Lebanon Country Club.

Robert F. Early '52, a neighbor and friend, brought greetings and congratulations from John R. Prehatny, President of the JMC Alumni Association. Dr. Suter is a urologist at the Good Samaritan Hospital there.

1937

Maurice Abramson, 7500 Manchester Rd., Melrose Park, Pa., is semi-retired. "Looking forward to our 50th in 1987; playing the violin with Doctor's Symphony."

Russell E. Allyn, 495 North 25th St., Camp Hill, Pa., represented Jefferson at the inauguration of Gerhard Ernst Spiegel as the twelfth President of Elizabethtown College on April 5.

Floyd C. Atwell, 1216 W. 68th Ter., Kansas City, Mo., retired from the practice of OB/GYN in June, 1983.

1938

A scholarship has been established at Susquehanna University, Selinsgrove, Pennsylvania, in memory of the late George B. Wentzel, M.D. '38, Founded by his son and daughter, the scholarship will be given next fall to a mathematics or science student who plans to enter a health-related profession. Dr. Wentzel established an ophthalmology practice in Sunbury and maintained the practice until his retirement in 1982. He died in September 1984.

1939

In ceremonies last June at Mercy Hospital in Pittsburgh Fred C. Brady was honored when the Fred C. Brady, M.D. Memorial Library was dedicated. Dr. Brady, who died in 1976, served as Chief of the Department of Surgery, Director of the Outpatient Department and Director of Surgical Training there. A Fellow at the Lahey Clinic in Boston, Dr. Brady was a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. During the June ceremonies a portrait of the honoree also was presented and now hangs in the library. In biographical remarks on the program Dr. Brady was lauded as "an outstanding and much beloved physician and teacher . . . whose legacy to us is one of compassion and dedication to excellence and service to people."

Lewis Lehrer, East Riding Dr., Cherry Hill, N.J., reports that his daughter, Luisa, graduates JMC this June.

Henry H. Stroud, 708 Ashford Rd., Wilmington, De., is "retired and enjoy­ing life."
1940

Henry L. Smith, 835 Lake Ridge Rd., Tallahassee, Fl., is “still enjoying practice as the senior member of a five-man urological group.”

1941

James A. Collins, P.O. Box 22, Riverside, Pa., continues to work with the AMA Internal Medicine Residing Review Committee. Dr. Collins is Chairman of the PMS Educational and Scientific Trust, and a member of the long-range strategy planning for PMS. “I’m still active in practice at Geisinger Clinic, but am planning to retire in 1996.”

Frederick A. Robinson, 160 Foxcatcher Ln., Media, Pa., is “completely retired and enjoying every minute of it including first grandchildren.”

1942

James A. Heckman, #2 Virginia Ct., Huntington, W. Va., is retired from active practice (orthopaedic surgery) as of September 30, 1985.

1943

Winslow J. Borkowski, 1324 Red Rambler Rd., Jenkintown, Pa., is Honorary Professor of Neurology. Dr. Borkowski’s daughter, Teresa A. Borkowski, M.D. ’85, will be a dermatology resident next year.

1944


Marion W. Young, 1630 Berkley Ci., Chattanooga, Tn., recently retired after 40 years in family practice, public health and psychiatry.

1945

Victor M. Ruby, 101 S. Montgomery Ave., Atlantic City, is moderator on two successful radio shows, “Your Doctor Speaks,” where listeners call in questions, and on which Jefferson graduates are frequent guest speakers, and “Sunday Concert Hall,” which presents classical music and celebrities each Sunday morning. The medical program has been on the air for 32 years, the musical program for 36.

1946

Thomas E. Patrick, W. Third St., Mifflinville, Pa., retired in April, 1985, due to illness.

Henry A. Seidenberg, 180 N. Michigan Ave., Chicago, has been elected President of the Chicago Psychoanalytical Society, beginning September, 1986.

1947

Frederick W. Bode, Jr., 35 Holland Rd., Pittsburgh, chaired the Pennsylvania Chapter of the American College of Utilization Review Physician’s seminar, “Changes in Quality Assurance and Utilization Review,” January 11 at Forbes Regional Health Center in Monroeville. Dr. Bode, a specialist in otolaryngology, is Medical Director of Utilization Review at Forbes Regional Health Center, and Medical Director of the Murray Manor Convalescent Home and Beverly Manor Convalescent Home. In addition, he is on the active staff of the Forbes Regional Health System, a consultant to the Veteran’s Administration Hospital and a private practitioner. Certified by the American Board of Quality Assurance and Utilization Review Physicians and the American Board of Otolaryngology, Dr. Bode is a member of the American Academy of Otolaryngology.

ALUMNUS HONORS ALUMNUS

Gerald J. Marks, M.D. ’49, delivered the first John Cheleden Memorial Lecture at Halifax Hospital Medical Center in Daytona Beach, Florida, on February 28. The lecture, “Personal Experiences with Pre-Op Radiation and Sphincter Preservation for Rectal Cancer,” was part of a three-day Rectocolon Cancer Conference. Dr. Marks was a friend and colleague of Dr. Cheleden and is a leader in the field of colon and rectal carcinoma surgery.

The late John Cheleden, M.D. ’32, was one of Jefferson’s earliest graduates with a colorectal specialty: a proctologist. He and his wife, Mary, were favorites of the medical community before their move to Florida. Friend and physician to Dr. Cheleden, Herbert D. Kerman, M.D., a radiation oncologist and Director of the Regional Oncology Center in Daytona Beach, remembered his colleague in the opening remarks of the lecture in Dr. Cheleden’s memory. Dr. Kerman referred to him as an “outstanding and active statesman for medicine.”

Dr. Cheleden was a Phi Beta Kappa graduate of Gettysburg College before entering Jefferson, where he was a member of AOA. His postgraduate work as an intern was at Jefferson. After serving an apprenticeship in proctology at the Graduate School of the University of Pennsylvania, he joined the Jefferson staff and remained for 16 years. During World War II he served with the 38th General Hospital (Jefferson’s unit) in the Middle East, Persia and India.

Relocating to Florida, Dr. Cheleden spent the next 31 years as a leader in medical affairs in Volusia County as well as the state of Florida, serving as a member and past President of the Volusia County Medical Society and a member of the Florida Medical Association. He was a Diplomat of the American Board of Proctology, a Fellow of the American Proctologic Society and a Fellow of the American College of Surgeons and the International College of Surgery. He was an active member of the American Society of Colon and Rectal Surgeons.

Dr. Cheleden died on November 8, 1983; Mary, four months later. “John and Mary were a delightful couple who had a shared interest in people and medicine,” said Dr. Kerman. “They both left their mark on this community and will be warmly remembered and missed.”

Dr. Marks is Professor of Surgery, Director of the Division of Colorectal Surgery at Jefferson, Director of the Section at the Pennsylvania Hospital and Adjunct Professor of Surgery at the University of Pennsylvania.
Ross S. Funch, 606 Fields Dr., Lafayette Hill, Pa., has retired from the practice of anesthesiology. Dr. Funch now works part time at a plasma collection station and has organized a "Stop-smoking" program.

Edgar C. Hanks, Hudson View Gardens, New York, is retiring as Professor Emeritus of Clinical Anesthesiology at the College of Physicians and Surgeons, Columbia University, and as Attending Anesthesiologist at Presbyterian Hospital, as of September 1986.

Paul H. Jernstrom, 1414 S. Hope St., Los Angeles, a pathologist at the California Hospital Medical Center Laboratory, ran his 35th marathon last October in Chicago, clocking in at 3 hours, 38 minutes, 5 seconds, or 8 minutes, 19 seconds per mile. "Advancing age is taking its toll."

Edward A. Kelly, State Rd. and Addingham Ave., Drexel Hill, Pa., reports that his son, Edward Jr., (73) practices in Downingtown. His son, Paul, also a physician, has joined his father in practice, while Mark ('85) is a surgical resident at Jefferson.

Charles J. Rodgers, 1434 Keller Ave., Williamsport, Pa., reports that his son, John C., is a freshman at Jefferson.

1948

Lee S. Serfas, 80 Gordon Dr., Easton, Pa., planned to retire at the end of 1985.

1949

Edward A. Schauer, 53 Main St., Farmingdale, N.J., will be inaugurated as President of the Medical Society of New Jersey on May 3 at the meetings at the Host Farm, in Lancaster, Pennsylvania. (see p. 19)

1950

Drew E. Courtney, Rt. 4, Myerstown, Pa., has just completed a term as President of the Pennsylvania Academy of Family Practice.

Leonard M. DelVecchio, 308 Old Airport Rd., Douglassville, Pa., is the newly elected President of the Berks County Medical Society. Dr. DelVecchio practices family medicine at the Birdsboro Medical Center. His son, Leonard M. DelVecchio, Jr., M.D., graduated with the class of 1973; daughter Marie Theresa received her BSN from the College of Allied Health Sciences in 1975. The late Mrs. DelVecchio was a graduate of Jefferson's School of Nursing in 1949.

1951

Simon C. Brumbaugh, Jr., 7337 Central Ave., Lemon Grove, Ca., says that his #5 daughter, Patti, is following her grandfather and him to Jefferson. "When is the reunion? I'll be there."

John W. Langley, 4960 Challen Ave., Riverside, Ca., planned to retire from Southern California Permanente Medical Group, after 27 years, January 31, 1986.

1952

Leo C. Partyka, 7439 Overton Dr., Leesburg, Fl., "has changed our address to warm Florida, but will maintain contacts in Pennsylvania, including Jefferson meetings, etc."

1953

Norman Gladsden, 200 SW 21 Rd., Miami, retired earlier this year from family practice "and am devoting my time to Hypnotherapy for Medical Problems — private practice, lecturing, teaching, writing, etc. Do I miss my old practice? Too busy to notice!"

James M. Hunter, 901 Walnut St., Philadelphia, is Professor of Orthopaedic Surgery, Chief of the Division of Hand Surgery of the Department of Orthopaedic Surgery and Director of the Hand Rehabilitation Center. In that capacity, Dr. Hunter and Evelyn J. Mackin, L.P.T., the Center's Administrator, spoke at the December meeting of the Societe Francaise de Chirurgie de la Main (G.E.M.) in Paris. Dr. Hunter discussed "A Functional Tendon Replacement."

1954

Norris B. Groves, 102 S. Maple Ave., Martinsburg, W. Va., was appointed by

"High-level study." Sidney Koretsky '46, tents on the rocky terrain of the Mount Everest Base Camp near Rongbuk, Tibet, at elevation 17,000 feet.

Paul A. Bowers '37, Professor Emeritus of Obstetrics and Gynecology at JMC, at the Annual District III American College of Obstetricians and Gynecologists meeting in Rome, Italy, in September. Surrounding "The General" are, from left, Eloise Bowers, Doris Krantz, Lola Riggs and, below, Susan Garra and Tish Colombi.
the Governor to the West Virginia State Board of Education until 1993. Dr. Groves is a former President of the County Board of Education and former President of the State School Boards Association.

Stanley R. Kern, 57 N. Wyoming Ave., S. Orange, N.J., was recently elected President-elect of the New Jersey Psychiatric Association. "In the past year we became grandparents, but do not feel that old."

Donald L. Minter, 309 Hackett Rd., Goshen, In., spent the better part of April and May, 1985, in the People's Republic of China, Sichman Province, in a medical exchange program. "An excellent educational experience."

1955

Edwin D. Arsht, 3909 State Rd., Drexel Hill, Pa., is Director of the Department of Family Practice and Director of Medical Education at Delaware County Memorial Hospital. Dr. Arsht is also Chairman of the Commission on Education of the Pennsylvania Academy of Family Practice, President of the Delaware County Academy of Family Practice, Chairman of the Committee on Aging of the Delaware County Medical Society and Alternate Delegate to the Pennsylvania Medical Society from Delaware County.

Robert E. Berry, 502 Audubon Rd., Roanoke, Va., is outgoing President of the Roanoke Academy of Medicine. Dr. Berry is also Chairman of the Planning Committee for the Virginia State American Cancer Society, whose annual meeting will be held in Roanoke. He is a member of the Executive Council of the Association of Program Directors in Surgery.

Joseph A. Heaney, 358 Hillcrest Dr., Willmar, Mn., is the psychiatrist at Willmar State Hospital. Dr. Heaney's son, Stephen, graduates from the University of Iowa School of Medicine in May.

Burton Schaffer, Park Towne Apts., Philadelphia, is Chairman of the Department of Radiology at Underwood Memorial Hospital in Woodbury, New Jersey and Elmer Community Hospital in Elmer.

1956

Joseph P. Bering, 12 Stoneleigh Dr., Lebanon, Pa., writes that his son, Tom, is an anesthesiologist at Lancaster General Hospital. His son, Joe, Jr., is a second-year student at Jefferson;

daughters Sue and Beth are industrial engineers and daughter, Ericka, is a nursing assistant at Leader Nursing Home. "Very proud father."

1957

Herbert G. Aaronson, 17 W. Norton Dr., Churchville, Pa., reports that his son, Gary, is completing his second year of internal medicine residency and daughter, Debbi, is in the first year of medical school at the University of Pennsylvania.

T. Clark Corson, Ten Penn St., Bloomsburg, Pa., represented Jefferson at the inauguration of Harry Auspitz as sixteenth President of Bloomsburg University on Saturday, April 5.

Howard S. Richter, 26 Suzanne Rd., Lexington, Mass., has been named Medical Director of the Medical East Community Health Plan, BRAINTREE Division. Dr. Richter will be leaving his Woburn practice in internal medicine, where he founded and managed Woburn Medical Associates, a five-physician group practice. He is certified by the American Board of Internal Medicine and is a Fellow of the American College of Physicians.

1958

Donald M. Dill, 171 C. Ave., Coronoado, Ca., will be serving his third term as Chief of the Medical Staff at his local hospital, the staff of which has grown from a dozen members to over 70 in the past 25 years. "My goal this year is to handle the local issues easily so we can turn our attention to more global projects. My intention then is to have us reconfirm our commitment to peoples' well-being and to contribute and promote such projects as eradicating polio from the planet, ending world hunger and preventing nuclear war—the work we do in many ways is the world's medical research."

"My son, James, is a freshman at Jefferson. I've traveled a bit lately from Manila to Vienna giving papers on chemonucleolysis and spinal stenosis, etc. I'm currently 'coping' with all the changes in medicine."

1959

Trevor D. Glenn, 5072 N. Van Ness, Fresno, Ca., reports that he is a Clinical Professor at the University of California, San Francisco, and Chief of the inpatient psychiatric unit at Veterans Hospital in Fresno. Dr. Glenn is in part-time private consultative practice in forensic psychiatry.

1961

Joseph J. Cirotti, 836 Tennis Ave., Ambler, Pa., is "practicing pediatrics at 298 Blair Mill Road, Horsham, and at Abington Memorial Hospital." Dr. Cirotti and his wife, Ethel, have five children and two grandchildren.

Frederic T. Huffnagle, 1234 Hyde Park Ave., Boston, is practicing orthopaedic surgery in Boston with a special interest in spine surgery and chemonucleolysis. "My son, James, is a freshman at Jefferson. I've traveled a bit lately from Manila to Vienna giving papers on chemonucleolysis and spinal stenosis, etc. I'm currently 'coping' with all the changes in medicine."

William D. McCann, Box 207 M.R.D. #1, Pequea, Pa., was installed as President of the Lancaster City/County Medical Society in January. Dr. McCann is a cardiologist with Cardiovascular Associates of Lancaster.
1962

Edward L. Cahn, 158 Clover Way, Los Gatos, Ca., reports that his son, David, is a first-year student at Jefferson.

William Gottfried, 10 Rustic Ct., Orinda, Ca., is Chairman of the Department of Pediatrics at Permanent Medical Group, and Chief in the Departments of Staff Education, Health Education and Quality Assurance at Kaiser Foundation Hospital in Walnut Creek.

Courtney M. Malarney, 591 Chews Landing Rd., Haddonfield, N.J., has become an ardent runner, competing last May in the Broad Street Run. He wrote in an article published for the Camden County Medical Society that he now has a drawer full of T-shirts designating all the runs he’s participated in, one of his favorites being Philadelphia’s Independence Marathon.

1964

William A. Freeman, P.O. Box 130, Shippensburg, Pa., is “pleased to have a son starting at Jefferson next year.”

Robert M. Steiner, Professor of Radiology and Associate Professor of Medicine, JMC, recently received the Governor’s Award of the American College of Cardiology for the exhibit entitled, “The Radiology of Cardiac Pacemakers,” at the 34th Annual Meeting of the ACC in Anaheim, California.

Harvey M. Tucker, 23700 Halburton Rd., Beachwood, Oh., has been elected Vice President of the Middle Section of the Triological Society for 1986. (The American Laryngological, Rhinological and Otological Society, Inc.) Dr. Tucker is Professor and Chairman of the Department of Otolaryngology and Communicative Disorders at the Cleveland Clinic Foundation.

1965

Richard W. Cohen, 1620 Mulkey Rd., Austell, Ga., is an orthopaedic surgeon with five daughters. Dr. Cohen is past-President of the Cobb County Medical Society. He Chairs the Department of Orthopaedic Surgery at Cobb General Hospital and is Director of the Medical Association of Georgia.

Nathan B. Hirsch, 5420 S.W. 95th Ter., Miami, reports that as of January 1, 1986, he assumed the duties of Chairman of the OB/GYN Department at South Miami Hospital. “Living the good life in ‘Miami Nice.’”

1966

William F. Pharr, RD3, Danville, Pa., reports that Audrey and classmate Ralph W. Crawford, Jr., M.D., have a new son, Matthew Andrew.

Harvey Slater, 1363 Shady Ave., Pittsburgh, is Director of the Burn Trauma Center at West Penn Hospital.

1967

Jane M. Breck, 415 Devonshire St., Pittsburgh, reports that she appeared on national television in November as the pediatrician on “Mr. Rodgers’ Neighborhood.” Dr. Breck (nee Mikuljak) examined a 35-year old child, explaining the components of the exam and the instruments used. She will also be appearing in a book, Visit to the Pediatrician. Dr. Breck, in private pediatric practice, is also consultant to programs for handicapped children and directs the PKU program for western Pennsylvania.

Robert J. Karp, 7205 Lincoln Dr., Philadelphia, has been appointed Clinical Associate Professor in the Department of Pediatrics at JMC.

1968

Stephen L. Hershey, 5826 Kennet Pk., Centreville, De., was elected President of the Board of Trustees of DIMER (Delaware Institute for Medical Education and Research.)

Garth A. Koniver, 103 Santomera Ln., Wilmington, De., writes “My wife, Ellen, children Mia, 17, Beth, 15, Craig, 11 and I wish you all a happy, healthy New Year.”

Jacquelyn J. Wilson, 536 Brotherton Rd., Escondido, Ca., is President of the American Institute of Homeopathy, founded in 1844, which makes it the oldest national professional organization for physicians. “I am still doing private family practice now but am traveling more.”

1969

Elizabeth S. Bussard, RD#1, Box 341, Ringoes, N.J., writes that “after seven years’ retirement” while the kids were little, I became a resident again, at Temple, and now have my old position back—anesthesiologist on the staff of Hunterdon Medical Center in Flemington, New Jersey.”

James D. Heckman, 9543 Burwick, San Antonio, Tx., was recently promoted to Professor and Deputy Chairman in the Department of Orthopaedics at the University of Texas Health Science Center in San Antonio.

Thomas E. Sullivan, 6 Brackenbury Ln., Beverly, Ma., took the position of Medical Director of an HMO in Peabody in 1985.

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1970

Allen B. Davis, 127 Brook Rd., Sharon, Ma., writes, "Massachusetts continues to have a repressive anti-physician attitude. A word to the wise: Unless the situation drastically changes, if you want to be happy practicing medicine, stay away from Massachusetts."

Louis A. Freeman, 7450 N. Valentine, Fresno, Ca., is continuing the practice of anesthesiology as Medical Director of the Fresno Surgery Center, a new physician-owned, free standing center. "Marge is anticipating sending the first of four off to college in the fall."

Norman C. Lobenant, Kibbutz Rosh Hanikra, Israel, writes, "Our youngest child has started first grade, our oldest is halfway through her army service, the middle two in seventh and eighth grades. I finished my basic training in October, then started a radiology residency (!). Waiting for visitors."

Fred A. Mettler, Jr., University of New Mexico, Lomas Blvd., Albuquerque, N.M., is Professor and Interim Chairman of the Department of Radiology there, according to classmate Norman C. Lobenant, who tracked down his former roommate after discovering two books on radiology he had written. Dr. Mettler and his wife, Gloria, have lived in New Mexico since 1977; their sons, Erik and Larsen, are 8 and 6 years old.

David R. Pashman, 80 McFadden Dr., Huntingdon Valley, Pa., is completing a term as President of the Medical Staff at Warmemore General Hospital. "Enjoying group orthopaedic practice."

Peter D. Pizzutillo, 5 Ravenwood Ct., Wilmington, De., has been appointed Director of Pediatric Orthopaedic Surgery at TJUH. (see p. 18)

Parker M. Seymour, 1035 Lombard St., Philadelphia, announces the birth of Peter Mclean on October 27, 1985. Dr. Seymour is practicing emergency medicine at Chestnut Hill Hospital (Jefferson affiliate).

Calvin L. Weisberger, 538 11th St., Santa Monica, Ca., writes that a new CCC is being built at Kaiser West L.A. Dr. Weisberger is still Chief of Cardiology and Director of Critical Care, and is Chairing both the Southern California Regional Internal Medicine and Cardiology Symposia this year. He is in his second year as President of Temple Beth Sholom in Santa Monica, and spent New Year's Eve with classmate Larry Miller and family.

1971

Robert E. Chandlee, 205 Sloan St., Roswell, Ga., is President of Cobb Radiology Associates, P.A., a seven-man group practicing all aspects of diagnostic radiology in two hospitals in Atlanta's western suburbs. "Please call if in town."

David R. Cooper, 475 Millington Rd., Shavertown, Pa., delivered a paper on "Conso-Bestplete Syndrome in Polish Ski Jumpers" at the 2nd Annual Warsaw Orthopaedic Association meeting. The paper won second prize—"an all-expense paid week touring Albania that my whole family enjoyed! Looking forward to the 15th reunion in June."

W. Buckley Ratchford, 36 Ladwood Dr., Holmdel, N.J., writes, "Mary Alice and I hope to see all of the class of '71 in June."

Barbara L. Tenney, 56-45 Main St., Flushing, N.Y., is in her third year as Chairman of the American Academy of Pediatrics Committee on Women in Pediatrics, and was recently elected Vice Chairman of the Medical Board at Booth Memorial Medical Center.

1972

Steven A. Ager, 809 N. 29th St., Philadelphia, is Chairman of the Advisory Committee for the Older Adult Unit at the Institute of Pennsylvania Hospital. "My 7-month-old son, Tyler, is a delight."

Paul M. Dainer, 4132 Stowe Run Ln., Jacksonville, Fl., has left the active Naval service and is now a staff hematologist-oncologist at the University Hospital of Jacksonville. "In addition to my position as an Assistant Professor of Medicine at the University of Florida, I retain my military rank of Commander in the Ready Reserve."

Alexander E. Ehrlich, 1900 Rittenhouse Sq., Philadelphia, has recently appeared on KYW-TV Channel 3's "Evening Magazine" as its dermatology expert.

Barry P. Skeist, 105 Chemung St., Waverly, N.Y., says, "My life has changed much this year. I left New York City and moved to the small rural New York village of Waverly (about 15 miles east of Elmira). I'm a member of a multispecialty group, The Cuthrie Clinic, and work in the radiology department of the adjacent Robert Packer Hospital in Sayre, Pennsylvania, just across the border from Waverly. I

married Destiny Kinal in October, a marketing consultant who has been working in Boston and flying to our 130-year-old home on weekends, but who is now home for awhile. For anyone in the area, we are right off Exit 60 of Route 17 (the Southern Tier Expressway). Two other classmates are here as well, Lou Blaum and Wayne Rensimer."

1973

Rodney A. Appell, 37 Colony Rd., Greenbush, N.Y., writes, that he traveled, lectured and operated in the People's Republic of China, at the request of the Chinese Medical Society during the month of September with five other urologists, including Demetrius H. Bagley, Jr., M.D., of Jefferson's Department of Urology.

Kathleen W. McNicholas, Medical Office Bldg., 51 N. 39th St., Philadelphia, has joined Gerald M. Lemole and Paschel M. Spagna in a practice of cardiothoracic surgery. She formerly was Director of Pediatric Cardiothoracic Surgery at Deborah Heart and Lung Center in Browns Mills, New Jersey.

1974

James W. Kessel, 415 Morris Street, Charlestown, W. Va., has been elected Chief of Staff at St. Francis Hospital there. He also has been named Medical Director of a newly formed Trauma Unit.

William I. Miller, 2112 Oakstream Ave., Pensacola, Fl., is a Commander in the Navy, presently in an aerospace medicine residency.

1975

Mark M. Dembert, 1315 Cornwall Place, Norfolk, Va., and his wife, Jane, have returned to the States after a tour of duty in the Philippines. Dr. Dembert, working as an epidemiologist and Head of the Infectious Disease Control and Immunization Division at the Navy Environmental Health Center, is responsible for writing infectious disease and immunization policy for the Navy. He was featured in a Sunday New York Times Magazine Christmas article entitled "On Being Santa Claus," describing the feelings and fun he has had playing Santa to elementary school kids, officers and wives and families, hospital patients, etc.
Bartley P. Griffith 74, and his family enjoying their Hobie Cat at Stone Harbor, New Jersey, last summer. From left, Denise Cannon Griffith, Bartley, 10, Cullen, 8, David, 6, and Dr. Griffith. An article on the young surgeon starts on page 6.

Richard S. Jackson, 22 John St., Shelburne, Vt., has been practicing cardiothoracic surgery at the Medical Center Hospital of Vermont since July, 1982, and is also an Assistant Professor at the University of Vermont Medical School.

Alexander R. Pedicino, 1650 Huntingdon Pk., Meadowbrook, Pa., welcomed the addition of Nicholas David last May to join Nicole, Michael and Matthew.

1976


Ira Brenner, 729 Oak Springs Rd., Rosemont, Pa., completed his psychoanalytic training and graduated from the Philadelphia Psychoanalytical Institute in December, 1985. Dr. Brenner is currently in practice at the Institute of Pennsylvania Hospital, where he is Psychiatrist-in-Charge of the North-3 Unit.

John R. Cohn, 518 Penn Valley Rd., Narberth, Pa., has been invited to be Course Director and speak at a daylong symposium on asthma to be given in April at Graduate Hospital. Dr. Cohn is Clinical Assistant Professor of Medicine and Instructor in Pediatrics at Jefferson, where he practices allergy and immunology and pulmonary medicine, with emphasis on the treatment of asthma.

Robert L. Goldberg, 7030 Walnut Woods Dr., Modesto, Ca., "was honored to become a Fellow of the American Academy of Family Physicians at the annual meeting in Anaheim. I have also been elected to the Board of Directors as Second Vice President of the Western Occupational Medicine Association."

Scott M. Goldman, 41 West Springfield, Philadelphia, has been promoted to Assistant Professor in the Department of Surgery at JMC. He is serving as 10th reunion chairman for the June 7 party at the Philadelphia College of Art.

Judith F. and Philip C. Grem, 1641 Potato Valley Rd., Harrisburg, announce the birth of a second son, Timothy Matthew, on September 4, 1985. Michael Jack is two and a half.

George J. Heymach III, 80 Dietrich Rd., Pittsburgh, is active as Clinical Assistant Professor of Medicine at the University of Pittsburgh and Adjunct Professor at Carnegie-Mellon University Biomedical Engineering Program. Dr. Heymach reports that he is in pulmonary practice; he, his wife, Barbara, and the three children are in good health.

Ted M. Parris, 205 David Dr., Havertown, Pa., maintains a "skeleton rheumatology practice in Bryn Mawr while entrenched in a second fellowship in cardiology at Hahnemann."

L. Martha Ann Thomas, 905 S. Beaver, York, Pa., is in the private practice of OB/GYN in York, where she lives with her husband, Jeff DiFebo, Emily, 7, and Bradley, 5.

David W. Willis, P.O. Box 25471, Portland, Or., is Head of the Division of Behavioral and Psychosocial Pediatrics at Emanuel Hospital in Portland. "I have been appointed to the American Academy of Pediatrics Committee on the Psychosocial Aspects of Child and Family Health."

Elizabeth H. Thilo and Eugene Wolfel, 5290 E. Dakota Ave., Denver, are "pleased to announce the birth of our first child, Zachary, born August 23, 1985. Zachary was delivered at Rose Medical Center in Denver where Liz is Assistant Director of Nurseries. (Robert E. Wall, M.D., '75, is Acting Chairman of the Department of OB/GYN there.) Gene is Assistant Professor of Medicine at the University of Colorado Health Services Center, and is a staff cardiologist at Denver General Hospital.

1977

Cynthia Altman Weinstein, 1989 Armstrong Dr., Lansdale, Pa., has recently been appointed to the newly-created position of Executive Director, Strategic Planning, at Grand View Hospital in Sellersville. Dr. Weinstein will coordinate Grand View's short- and long-range planning in such diverse areas as alternative health care systems, prospective payment systems and DRG's, hospital utilization review and precertification, marketing, interactions with pharmaceutical companies and the FDA, expansion of new clinical research via the Investigational Review Board and liaison with medical schools.

1978

Kimberly Best-Long, 1726 Naudain St., Philadelphia, is Visiting Instructor in the Department of Psychiatry and Human Behavior, JMC.

Loretta D. Bonanni and Thomas S. Metkus, 455 Cheshire Dr., Downingtown, Pa., write, "Hi! Tom has been made Director of the Cardiac Rehabilitation Unit at Brandywine Hospital. He has also been made a Fellow of the American College of Cardiology."

Gregg E. Cregan, 1325 Plaza Dr., Winston-Salem, N.C., has joined Salem Orthopaedic Associates with five other surgeons. "We're pleased to finish a residency and fellowship in hand and microvascular surgery at Duke University. Alexander (6) is burning up his
Mountain Medicine

A Recent Graduate

Extolles the Virtues and Beauties of Practicing in the Yosemite Valley

by Gary M. Flashner, M.D. '80

Most people are surprised to learn that a medical facility exists and operates in a National Park. There always seems to be interest and curiosity as to the life style and type of practice in such an environment, certainly the reason that I was requested to write about it for the Alumni Bulletin. After being here for approximately 18 months, I can understand an interest that goes beyond that of a more traditional area. Working and living here has been unique in a variety of ways.

Our federal government has set aside more than 100 acres around the country to be preserved, protected and made available for public use and recreation. These areas constitute the National Park Service system and include some of the most magnificent areas in the country and on this planet. The parks are visited by millions of people every year from all over the world, despite a large degree of geographic isolation and limited accessibility. It is interesting that only three parks have facilities for the delivery of definitive medical care: Grand Canyon, Yellowstone and Yosemite. As everyone knows very well, recreational areas seem to generate their own special set of needed medical services. The experience in Yosemite exemplifies this fact on a daily basis, occasionally in a rather dramatic fashion.

Yosemite National Park consists of 1200 square miles of land located far into the Sierra Nevada mountains in northern California, approximately 200 miles directly east of San Francisco and not far from the California-Nevada state line. It is best known for the area called "Yosemite Valley," a ten mile by half mile valley near the geographic center of the park that is surrounded by massive granite rock formations and vertical walls that were originally carved out by glaciers thousands of years ago. These walls rise above the valley floor anywhere from 2000 to 4000 feet and are the object of thousands of rock climbers who come from all over the world to scale them.

Most visitors are less adventurous and come to see, to marvel, photograph and "ooh" and "aah" at the sights. For those so inclined, there are myriad other outdoor activities: rafting, windsurfing, swimming, hiking, backpacking, horseback riding, bicycling, skiing and hang-gliding, just to name a few. A visitor can stay at a campground, cabin, lodge or even an elegant hotel; meals are eaten at your campsites, in your motor home or at one of several restaurants.

As one might imagine, a support staff of significant size is required to maintain such an array of services and activities. More than 95 percent of this support comes from two groups, the National Park Service and the Curry Company. The Park Service is responsible for maintaining and preserving the land in addition to providing guidance and protection for the public who visits here. The Curry Company, a division of MCA Corporation in Los
Angeles, owns, operates and staffs the restaurants, guest housing areas, the stores and shops, the ski area and several other commercial establishments operated in the Park.

The majority of Park Service and Curry Company employees are lodged in the Yosemite Valley in houses, dorms, cabins and tent cabins owned and operated by either of these organizations. The employee population ranges from about 1000 in the slowest seasons to 2500 in the busy summer season. As such, Yosemite exists not only as a National Park, but as a small community organized basically as a "company town." In our case, it's a two-company town.

With this background in mind, one might be able to imagine the types of medical care required and the character of the practice here. Approximately half of the practice involves all aspects of family medicine, outside of a hospital. The majority of this includes evaluation and management of common infectious disease (mostly respiratory and GU), health care maintenance (Pap smears, work and school physicals), minor injuries (mostly occupational) and ongoing management of diabetes, hypertension, seizure disorders, etc. This part of the practice applies not only to permanent and seasonal employees but also to a number of individuals and families who live just outside the park border and use our facility as their base of family medical care.

The other half of the practice is certainly of a much different character. The Park Service maintains an active EMS System and we are responsible as their base station. We also participate actively in ongoing education and certification for those involved. A fully equipped ambulance is stationed in Yosemite Valley and is kept busy during the summer months bringing us the gamut of what typically is seen in your local ER: lacerations, fractures — as many as nine in a single day — various cardiac, respiratory, renal, intestinal and endocrine pathology; an occasional emergency delivery; victims of minor and major bicycle, motorcycle and automobile accidents; climbers who fall anywhere from five to 500 feet (we see only the ones who survive); summertime drownings and near-drownings, etc. Even more memorable are some of the unusual problems and situations that arise on a rare occasion: rattlesnake envenomation, a case of acute malaria, intestinal parasites more often seen in tropical areas, a case of diabetic ketoacidosis complicated by high altitude pulmonary edema and occasional cases of severe hypothermia.

Accidents of greater interest this year included five individuals struck by lightning on the top of Half Dome and another incident where a 25-foot limb of an oak tree mysteriously broke off and landed on 15 people riding in an open air tram. The former incident killed two people, two other requiring extensive surgeries to their legs. The latter incident also claimed two victims and approximately 13 others were injured, most of them hospitalized.

Incidents such as these illustrate some of the challenging aspects of practicing medicine anywhere; it is particularly fascinating to reflect on providing emergency medical care in situations when you are out in the middle of nowhere. As one can imagine, if a special procedure must be done, you do it yourself. Unlike hospital emergency rooms, one cannot call upon the anesthesiologist to perform the intubation, the orthopaedic surgeon to reduce the fracture, the thoracic surgeon to place the chest tube or the general surgeon to place the central venous IV lines. The minimum distance to these specialties is 85 to 100 miles.

Life becomes even more interesting when one learn that the minimum time needed to transport a patient by ground to a well-equipped facility is approximately three hours, but usually requires four to five hours. Fortunately, several commercial helicopter/air ambulances with turnaround times of between one and three hours are willing to provide a service to the Park. Of course, these services become nonexistent at dusk, and we must live with the lengthy turnaround time of the ground services.

Logistical difficulties such as these become even more complicated when the patient is not in the Clinic, but is hanging from a wall anywhere from 500 to 2500 feet above ground level. Fortunately, this responsibility remains in the hands of Yosemite Search and Rescue which is maintained and operated by the National Park Service. During the spring, summer and fall, they are often called upon to reach and safely remove injured individuals from precarious places. The performance of many common EMS procedures (IV placement, airway management, control of bleeding and splinting of fractures) becomes unimaginably difficult or impossible in these situations, something that can be troublesome to grasp for the physician who is more acclimated to dealing with the environment of the city street.

Life aside from practicing medicine is probably very much like that in numerous other small company towns. Despite the fact that Yosemite is a National Park, many services exist that one might not expect: a grocery store, a deli, restaurants, a bank a gasoline station, a kindergarten through eighth grade school, gift shops, the Ansel Adams Photo Gallery, a post office (UPS makes deliveries to the Park five days a week), a ski area called Badger Pass, a barber shop, a dentist's office, a swimming pool, a weight room and much more.

As one might expect, the community obviously attracts those who desire a variety of outdoor activities, and this is reflected by the relatively young average age of those who live and work here. The sun shines most of the time, and the weather is generally very mild compared to the East. The community is generally an active one, and most people take full advantage of what the Park has to offer.

The variety of activities in an urban area certainly do not exist, but many individuals stay busy with group activities in the Park, including a yearly play production, movies and videos, community outings, the Lions and Rotary Clubs, etc. The air and water are clean, the roads are good, the people are friendly and the crime rate is low. My family and I plan to stay here for awhile. ☐
baseball league; Avery (3) is her 
mommy’s most enthusiastic helper. 
Nancy’s expecting our last delivery 
from the stork in May.”

Frederick G. Dalzell, 703 E. Grist Mill 
Way, Smithville, N.J., completed his 
orthopaedic residency at Yale and 
recently passed his boards. Dr. Dalzell 
is currently living and practicing in 
Atlantic City with his wife, Jane, and 
dughters, Devon, 3, and Allison, 1.

Susan M. Ginsberg, 10614 Pennypack 
Ln., Silver Spring, Md., is in internal 
medicine/nephrology practice in 
Washington, D.C.

Robert M. Lintz, 14 Morningside Ct., 
Little Falls, N.J., writes, “Bob and 
Carol continue to enjoy life in North 
Jersey. Bob is in the private practice of 
internal medicine and gastroenterology.

Little Falls, N.J., writes, “Bob and 
mommy’s most enthusiastic helper.

Rachel was two in October. Baby 
Barbara M. Matteucci, Apt. C-6, The 
Villages, Carrboro, N.C., has com­ 
pleted a year of research in rheumatol­ 
ogy/immunology in Chapel Hill and 
will be returning to the Philadelphia 
area to practice rheumatology.

Eric J. Michael, 951 Park Ave., Col­ 
lingswood, N.J., is now Clinical Assistant 
Professor of Pediatrics, JMC, and is 
practicing neonatology as a member of 
the full time staff at TJUH. Dr. 
Michael’s office address is Room 709 
College, Department of Pediatrics, 
Division of Neonatology.

Arthur J. Patterson, Jr., 223 E. High St., 
Waynesburg, Pa., writes, “Surgery is 
alive and well in Greene County.”

Robert H. Peters III, 1804 Tall Oaks 
Rd., Orwigsburg, Pa., is “out of the 
Army and enjoying private practice 
with two other gastroenterologists in 
Pottsville.”

David M. Reed, One Valley Rd., #209, 
Stamford, Ct., announces the birth of 
his daughter, Jessica Holliday Reed, on 
September 26, 1985. He and his wife, 
Janet, have recently moved from Buf­ 
falo, New York, where he completed a 
fellowship in surgical oncology at Ros­ 
well Park Memorial Institute, to Stam­ 
ford. Dr. Reed is now in the private 
practice of general, vascular and onco­ 
lologic surgery. He holds an appointment 
as Assistant Clinical Professor of 
Surgery at New York Medical College, 
where he is in charge of junior medical 
students during their clerkship at The 
Stamford Hospital. Their new home 
address is above; “visits by old Jeff­ 
erson friends would be most welcome.”

Harry M. Rosenblum, 1101 St. 
Andrews Rd., Hollywood, Fl., is certi­ 
fied in general surgery and has com­ 
pleted his cardiothoracic training at 
Columbia-Presbyterian Medical Center 
in New York. Dr. Rosenblum is pres­ 
ently in private practice in Hollywood. 
“Having the best time of my life. Come 
on down and visit.”

Nancy H. Sherman, 3600 Consho­ 
hacken Ave., Philadelphia, is Assistant 
Professor of Radiology at the Univer­ 
sity of Pennsylvania and a staff radiol­ 
ogist at Children’s Hospital of 
Philadelphia.

Neil H. Shusterman, 1419 Suffolk Ln., 
Penn Wynne, Pa., is Assistant Director of 
Dialysis Programs at the Hospital of 
the University of Pennsylvania.”My 
wife, Cheryl, and I had our third child, 
Danielle Hilary, on October 1, 1985.”

David W. Stepansky, 1960 Hemlock 
Rd., Norristown, Pa., and his wife, 
Debra, “brought our 9 lb. 10 oz. little 
bundle into the world last March. 
Adam, now 10 months old, brings con­ 
tinuous joy and havoc into our lives.” 
Dr. Stepansky practices internal med­ 
icine with a large group in Phoenixville. 
He is “busy and happy.”

Eric J. Werner, 4521 Rean Meadow 
Dr., Kettering, Oh., is in his third year of 
a four-year commitment to the Air 
Force at Wright-Patterson Air Force 
Base. Dr. Werner is practicing pediatric 
hematology/oncology.

1979

Deborah K. Childress, 10311 Perry 
Hghy., Wexford, Pa., participated in the 
1985 Hawaii Ironman World 
Championship, finishing 30th among 
200 female contenders. Dr. Childress 
swam 2.4 miles, biked 112 miles and 
rallied 26.2-mile marathon. Her total 
time was 11 hours and 45 minutes, just 
an hour and a quarter off the winner’s 
pace. She is a staff physician in the 
emergency room at Allegheny General 
Hospital in Pittsburgh, according to an 
article about her in Medical World 
News. “I compete for fun,” says Dr. 
Childress. “Training will always be a 
part of my life.”

Stephen S. Grubbs, 2700 Silverside Rd., 
Wilmington, De., has been appointed 
Instructor in the Department of Medi­ 
cine at Jefferson affiliate Medical Cen­ 
ter of Delaware.

Douglas R. Hough, 7355 Ireland Ct., El 
Paso, Tx., is Assistant Chief in the 
Rheumatic and Immunologic Disease 
Unit at William Beaumont Army Medi­ 
cal Center, El Paso.

1980

Barbara G. Frieman, 639 Montgomery 
School Ln., Wynnewood, Pa., has been 
appointed Instructor in the Depart­ 
ment of Orthopaedic Surgery at JMC.
where he was Chief of Primary Care, and is now at Griffiss AFB in Rome, New York. His new wife, Tammy, whom he married on August 18, 1985, will be attending Utica College. While in Hawaii, Dr. Laurence learned SCUBA diving and ran in the Honolulu Marathon.

Timothy S. Pilla, 8953 Ashton Rd., Philadelphia, is in his fourth year of surgical residency at Graduate Hospital.

Gregory T. Smith, 5C Springwood Sq., Harwick, Pa., married Helenkay Hutchison on April 27, 1985, and moved to the above address. "I will be the Chief Medical Resident at Allegheny General Hospital beginning in July, 1986."

1983

Peter R. Berghethon and Elcinda L. McCrone, 76 Brent St., Dorchester, Ma., write that Peter is completing his residency in internal medicine at Boston City Hospital and will begin a research fellowship in the Department of Biochemistry in July at Boston University. Cindy is also completing her residency in internal medicine at Boston City Hospital and will begin an infectious disease fellowship at Beth Israel and Brigham and Women's Hospitals.

Peter A. Cognetti, 2126 Main Blvd., Allentown, Pa., writes, "Marianne and I are blessed with a baby girl, Sarah."

Saul H. Helfing, 14800 NW Cornell Rd., Portland, Or., is "Getting my feet wet" in Oregon, mid-way through my psychiatry residency.

Frederick W. Ruthardt, Jr., 330 Arch St., Verona, Pa., is finishing a medical residency and will begin a two-year NHSC commitment in the Hill District of Pittsburgh in July.

1984

Jonathan S. Daitch, 2522 Woodhull Ave., Bronx, N.Y., is completing his anesthesiology residency at Albert Einstein College in the Bronx.

J. Christopher Daniel, Branch Medical Clinic, Box 7, FPO San Francisco, is engaged to Shauneen Murray, a Villanova graduate ('83) and Navy nurse. "We will be married July 4, 1987. I have been transferred to Cubi Point Naval Air Station in the Philippines where I will be working as a flight surgeon and be the Assistant Senior Medical Officer until mid-1988.

Robert L. Davoli, 301 Albina Way, Latrobe, Pa., a second-year resident at Latrobe (Jefferson affiliate), plans to marry Dawn Bulas in July.

Nathan B. Duer, 6 Dartmouth Ave., Bridgewater, N.J., married Lori Welborn on June 16, 1984. They are expecting their first child this July. Dr. Duer is in his second year family medicine residency at Somerset Medical Center in Somerville. He will be Chief Resident in July.

James K. Kavanagh, 1011 Melford Ave., Pearland, Tex., announces the birth of Jessica Christine in June, 1984. Dr. Kavanagh is in his second year of anesthesiology residency.

Paul M. Kiproff, 5813 Hobart St., Pittsburgh is "keeping busy in Pittsburgh! Renovating our house, radiology, and a baby coming this May. Any name suggestions? Please let me know."

Robert W. Meikle, 490 Pheasant Run Dr., Evans, Ga., is a second-year family medicine resident, "which is definitely cramping my partying style. I am still single, available, looking for the ultimate bag lady."

Larry H. Pastor, 1479 New Castle, Durham, N.C., is completing his second year of residency in psychiatry at Duke University Medical Center. "I traveled to Tel Aviv, Israel, in February to present a paper at the Second International Congress of Law and Ethics."

Gail A. Reedman, 46 Palmer Green, Baltimore, writes, "I'm happily finishing my second year of family medicine at the University of Maryland. I've been fortunate to have been chosen as Chief Resident for next year. It's nice to see other Jefferson graduates in the Baltimore area."

Michael S. Rosenblatt, 451 Park Dr., "made the cut in the Boston University/Boston City Hospital Surgery Program and will be starting my third year in June. Congrats to Guy and Carol."

Guy M. Stofman, 509 Mulberry Ln., Haverford, Pa., writes, "Carol and I just gave birth to Lily Ashly Stofman on January 9, 1986—5 lbs. 9 oz. She wants to be a neurosurgeon! I'll be starting ENT at Jefferson in July."

Mary B. White, 340 Centre St., Dorchester, Ma., is finishing her second year of internal medicine residency in Boston. Dr. White hopes to specialize in primary care.
Obituaries

Walter W. Werley, 1918
Died November 13, 1985 at the age of 90. Dr. Werley, a resident of Wyomissing, Pennsylvania, served as Chief of Radiology at St. Joseph Hospital in Reading.

Jacob J. Berman, 1919
Died September 5, 1985 at the age of 86. Dr. Berman was a general practitioner in New York City. His widow survives him.

Joseph R. Russo, 1924
Died November 28, 1985 at the age of 85. The retired general practitioner was a resident of Wilmington, Delaware.

James H. Landau, 1927
Died November 14, 1985 at the age of 83. Dr. Landau was a general practitioner in Sunbury, Pennsylvania.

Samuel M. Hauck, 1929
Died December 1, 1985 at the age of 81. Dr. Hauck was a general practitioner in Lancaster, Pennsylvania, and served on the medical staff of the Lancaster General Hospital. He was past President of the Lancaster City and County Medical Society and the Franklin and Marshall Alumni Association.

Eli J. Keller, 1931
Died November 15, 1985 at the age of 78. Dr. Keller was a general practitioner in Reading, Pennsylvania.

Carroll V. Willis, 1934
Died September 27, 1985 at the age of 76. Dr. Willis was a general practitioner in Vanceboro, North Carolina.

Woodrow W. Lindenmuth, 1938
Died August 2, 1985 at the age of 72. Dr. Lindenmuth was a general surgeon from Woodbridge, Connecticut. He was certified by the American Board of Surgery.

John M. Siegel, 1938
Died December 10, 1985 at the age of 72. Dr. Siegel, who was a resident of Newport Beach, California at the time of his death, had practiced general medicine in Butler, Pennsylvania. Later in his career he was certified in dermatology and practiced in Allentown where he was a member of the Allentown General and Sacred Heart Hospitals. Dr. Siegel was President of the Philadelphia Dermatological Society and a Fellow of the American Academy of Dermatology. In California he was an Associate Clinical Professor at the University at Irvine and taught at the Veterans Administration in Long Beach. His wife, Faye, and a daughter survive him.

John A. Kubek, 1941
Died January 1, 1986 at the age of 69. Dr. Kubek was a charter member and Fellow of the American Board of Family Practice. He maintained an office in Bethlehem, Pennsylvania and was a member of the staff at St. Luke’s Hospital. Dr. Kubek retired last June. Surviving are his wife, Betty, four sons and two daughters.

Rufus E. Palmer, III, 1941
Died January 18, 1986 at the age of 69. Dr. Palmer, a general surgeon, resided in Spring City, Pennsylvania. He was former Chief of Surgery at Montgomery Hospital in Norristown and had served as President of the surgery staff at Sacred Heart Hospital, also in Norristown. He was a member of the American College of Surgeons. Surviving are his wife, Elizabeth, a son and a daughter.

Edward B. McCabe, 1944
Died July 20, 1985 at the age of 67. Dr. McCabe, a radiologist, resided in Norfolk, Connecticut. He was Chief of Radiology at the Winsted Memorial Hospital there. He had served in a similar post at the Huron Road Hospital in Cleveland and the Mercy Hospital in Oklahoma City. Author of several publications he was a Diplomate of the American Board of Radiology and Nuclear Medicine. His wife, Mary, three sons and three daughters survive him.

Armand A. Wallack, 1951
Died on September 5, 1985 at the age of 58. Dr. Wallack, a resident of Cherry Hill, New Jersey, was certified by the American Board of Internal Medicine. At one time he served as Director of Medical Education at Philadelphia General Hospital. His widow survives him.

Joseph F. Malfara, 1956
Died January 30, 1986. Dr. Malfara was a general practitioner in Cherry Hill, New Jersey. His wife, Julia, and three sons survive him.

Albert N. Morgese, 1957
Died February 26, 1986 at the age of 61. Dr. Morgese, an orthopaedic surgeon, was residing in San Francisco at the time of his death. However his practice was located in Hanover Township, New Jersey, where he was associated with St. Clare’s Riverside and General Hospitals. Dr. Morgese was awarded the Order of St. Sylvester by Pope John Paul I at ceremonies in Rome. A member of the American Association of Orthopaedic Surgeons he was a Fellow of the American College of Surgeons and the International College of Surgeons. Surviving are his wife, Irma and three sons.

Donald F. Post, 1965
Died January 23, 1986 at the age of 47. Dr. Post, who resided in Camp Hill, Pennsylvania, was an obstetrician/gynecologist and served as senior associate in the Department at Holy Spirit and Harrisburg Hospitals. He was a Fellow of the American College of Obstetricians and Gynecologists. Surviving are his wife, Linda, two daughters and a son.

George W. Smith, 1965
Died January 19, 1986 at the age of 46. Dr. Smith was a psychiatrist who resided in New York City. His mother survives him.

Armando F. Goracci, Faculty
Died February 7, 1986 at the age of 69. Dr. Goracci, a Clinical Assistant Professor of Surgery, was Chief of Surgery and Chairman of the Department at Underwood Hospital in Woodbury, New Jersey. A Fellow of the American College of Surgeons he served as President of both the Gloucester County Medical Society and the Medical Society of New Jersey. Dr. Goracci was elected an honorary alumnus of the JMC Alumni Association in 1977 and was a member of the President’s Club. Surviving are his wife, Constance, his daughter Grace G. Slimak ’85, son-in-law Randall E. Slimak ’84 and brother-in-law William T. Lemmon, Jr. ’60, among others.
equitability of hospital reimbursement and the quality of care provided to Medicare beneficiaries. By not adequately differentiating patients based on the stage of their illness, the DRG system provides financial incentives for hospitals to provide care to the less sick patients and to avoid treating the sickest patients. Not surprisingly, hospitals are not only changing their behavior, but are also pressuring their medical staffs to modify their behavior which results in at least a potentially negative impact on the quality of care provided to Medicare beneficiaries. Of major concern is the poor patient who has a disease of a serious nature that will make him unattractive from a financial point of view because of the DRG applied to his disease. Who will admit the patient with staphylococcal pneumonia with complications which may include empyema, respiratory failure, meningitis? It will be more profitable for a hospital to admit a patient with staphylococcal pneumonia with atelectasis, since this patient will have the same DRG, but will consume fewer resources.

There are a number of important changes that we believe should be made in the DRG prospective payment system to increase the equitability of hospital reimbursement and improve the quality care provided to Medicare beneficiaries.

- In the short run, using existing data, the prospective payment system can and should be modified so that patient clusters are more specific as to diagnosis and specifically account for severity of illness. Neither the DRG system nor the “severity of illness” classification addresses this problem. In addition, the latter classification confuses response to treatment with the issue of whether or not the treatment was appropriate and timely. We believe that the “disease staging” approach has been demonstrated to meet the criteria of a clinically valid system in which the clusters are defined in terms of the patient’s specific disease entities.

- We believe that the data collection systems should be modified to collect data at different points in the process of care. In order to analyze the hospital stay, one needs to measure the patient’s condition at the time of admission to the hospital, at one or more key points during the course of the stay and at the time of hospital discharge. Only with these types of data will one be able to measure adequately the effectiveness and quality of medical care.

- The prospective payment system should be revised so that reimbursement is based on necessary care and not simply on historical average cost of treatment. This change may be the most fundamental of our recommendations. While the research should begin now, changes should not be implemented until the classification system has been modified to include the essential characteristics of disease (etiology, organ system(s) affected and stage) and the necessary systems have been put in place to accurately collect clinical data over the course of the patient’s stay. With these types of data one can begin to relate resource consumption to patient outcome and develop a more realistic reimbursement system based on what it should cost to provide quality care.

- The prospective payment system should be revised to address the issue of timeliness of hospitalization. A patient may be admitted to a hospital too early (i.e. when his condition does not require care in an acute hospital setting), on a timely basis, or too late (i.e. at a more advanced stage in the progression of his disease than desirable.) The PRO program is designed to monitor early admissions. Timely admissions can be reimbursed under the prospective payment system — hopefully revised to include our suggested changes. The issue of late hospital admissions, however, has not received adequate attention. With the support of the Kellogg Foundation, we are currently addressing issues related to costs of, and reasons for, late hospital admissions. We have found significantly greater costs for late hospital admissions than for patients admitted on a timely basis. For example, hospital costs for patients admitted with late stage cholecystitis were, on the average, more than $5,000 per patient higher than costs for those admitted on a timely basis. Costs for patients admitted for late stage cancer of the colon or rectum averaged more than $8,000 per patient higher than for those patients admitted at early stages. Even more important than these cost differences are the significantly higher morbidity and mortality resulting from late hospital admission. Identification of late stage hospital admissions and their cause should be made a high priority of the Medicare program.