Upcoming

September 9, Wednesday
WELCOME FOR FRESHMAN FAMILIES, by the Alumni Association
8:30–10:00 a.m., Eakins Lounge
OPENING EXERCISES OF THOMAS JEFFERSON UNIVERSITY, 8:00 p.m., McClellan Hall

September 15, Tuesday, 6:00 p.m., Washington, D.C.
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN ACADEMY OF OTOLARYNGOLOGY
RAMADA REnaissance TECHworld Hotel

September 17, Thursday, in Bethesda, Maryland
RECEPTION AND DINNER IN HONOR OF UNIVERSITY PRESIDENT PAUL C. BRUCKER, M.D.
6:30 p.m., Bethesda Marriott Hotel

September 24, Thursday
ALUMNI ASSOCIATION EXECUTIVE COMMITTEE Reception at 5:15, Dinner at 6:20, in the Faculty Club; Meeting at 7:30, Room 139, Alumni Hall

September 30, Wednesday, in Wilkes-Barre, Pa.
RECEPTION AND DINNER IN HONOR OF UNIVERSITY PRESIDENT PAUL C. BRUCKER, M.D.
6:30 p.m., Westmoreland Club

October 1, Thursday, in Clarks Summit, Pa.
RECEPTION AND DINNER IN HONOR OF UNIVERSITY PRESIDENT PAUL C. BRUCKER, M.D.
6:30 p.m., Scranton Country Club

October 13, Tuesday, 6:00 p.m., New Orleans
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN COLLEGE OF SURGEONS
Omni Royal Hotel, 621 St. Louis Street

October 15, Thursday
Lecture in MEDICAL HUMANITIES AND SOCIAL SCIENCES: Literature and Medicine, by Emile Passow, Ph.D. of Swarthmore College, 4:30 p.m., Room 139, Alumni Hall

In San Diego: ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS
5:30 p.m., Marriott Hotel, 333 West Harbor Drive

October 16, Friday
NOBEL SYMPOSIUM, "The Challenge for Medical Science and Education: Maintaining the Competitive Edge in the Twenty-First Century," hosted by Thomas Jefferson University as part of a weekend of events cosponsored by the Nobel Foundation of Sweden, the Alfred Nobel Museum in Sweden, and the American Swedish Historical Museum. Among the speakers will be Robert Q. Marsten, M.D., former Director of the National Institutes of Health, and Chairman of the Robert Wood Johnson Foundation Commission on Medical Science and Education; Michael Sollman, Director of the Nobel Foundation; Baruch S. Blumberg, M.D., Ph.D., Nobel Prize laureate and Master of Balliol College, Oxford University; and past Nobel Prize winner Glenn T. Seaborg, Ph.D.

October 17, Saturday, 6:00 p.m., New Orleans
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS
Marriott Hotel, 555 Canal Street

October 22, Thursday
ALUMNI ASSOCIATION EXECUTIVE COMMITTEE Reception at 5:15, Dinner at 6:20, in the Eakins Lounge; Meeting at 7:30, Room 139, Alumni Hall

October 30, Friday
PRESIDENT'S CLUB DINNER
November 6–8, Friday through Sunday
"MEDICINE AND THE ARTS" ALUMNI WEEKEND IN PHILADELPHIA (see page 44)

November 10, Tuesday, 6:00 p.m., Dallas
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN SOCIETY OF OPHTHALMOLOGY
Hyatt Regency Hotel

November 13, Friday, 4:00 p.m., Connelly Conference Hall, Drexel University, Science Building The ERSLEV LECTURE (open to the public): "From Erythropoietin to Steel Factor: Molecular Regulation of the Hematopoietic Stem Cell Hierarchy," by Alan Bernstein, Ph.D., Professor of Medical Genetics and of Medical Biophysics, University of Toronto, and Associate Director, Lumenfeld Research Institute of Mount Sinai Hospital

November 19, Thursday
ALUMNI ASSOCIATION EXECUTIVE COMMITTEE Reception at 5:15, Dinner at 6:20, in the Faculty Club; Meeting at 7:30, Room 139, Alumni Hall

December 1, Tuesday, 5:00 p.m., Chicago
ALUMNI RECEPTION AT THE MEETING OF THE RADIOLOGICAL SOCIETY OF NORTH AMERICA
McCormick Hotel

December 2, Wednesday
CAREER DAY, sponsored by the Alumni Association

December 3, Thursday, 4:30 p.m., Room 139, Alumni Hall
LECTURE IN MEDICAL HUMANITIES AND SOCIAL SCIENCES: History of Medicine: "Stark Images: Three Centuries of Body Work," by John Raymond Shea, Ph.D., Associate Professor of Orthopaedic Surgery

December 7, Monday, 6:00 p.m., San Francisco
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN ACADEMY OF DERMATOLOGY
ANA Hotel

January 21, 1993, Thursday, 4:30 p.m.
Room 145, Alumni Hall
LECTURE IN MEDICAL HUMANITIES AND SOCIAL SCIENCES: Alternative Views in Primary Care Research, by Tony Kuzel, M.D., Associate Professor of Family Practice at the Medical College of Virginia

January 28, Thursday
ALUMNI RECEPTION FOR FRESHMEN, 5:00 p.m., Eakins Lounge
ALUMNI ASSOCIATION EXECUTIVE COMMITTEE Dinner at 6:20, in the Faculty Club; Meeting at 7:30, Room 139, Alumni Hall

February 19, Friday, 6:00 p.m., San Francisco
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
Stanford Court Hotel

February 25, Thursday
ALUMNI ASSOCIATION ANNUAL BUSINESS MEETING
Reception at 6:00, Room 145, Alumni Hall
Dinner at 7:00, Eakins Lounge

March 3, Wednesday, 10:30–12:00
Herbert Auditorium, 1025 Walnut Street building
ALBERT M. BIELE, M.D. MEMORIAL LECTURE IN PSYCHIATRY (open to the public), to be delivered by Arnold M. Cooper, M.D., Professor of Psychiatry at The New York Hospital-Cornell University Medical Center

March 12, Friday
PARENTS' DAY, sponsored by the Alumni Association

March 25, Thursday
ALUMNI ASSOCIATION EXECUTIVE COMMITTEE Reception at 5:15, Dinner at 6:20, in the Faculty Club; Meeting at 7:30, Room 139, Alumni Hall

April 2, Friday, 6:00 p.m., Washington, D.C.
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS
Cosmos Club

April 22, Thursday
ALUMNI ASSOCIATION EXECUTIVE COMMITTEE Reception at 5:15, Dinner at 6:20, in the Faculty Club; Meeting at 7:30, Room 139, Alumni Hall

April 27, Tuesday, in Atlanta
ALUMNI RECEPTION AT THE AMERICAN OCCUPATIONAL HEALTH CONFERENCE

May 3, Monday, Washington, D.C.
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

May 25, Tuesday, San Francisco
ALUMNI RECEPTION AT THE MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

June 3, Thursday
PARTY FOR THE CLASS OF '93, sponsored by the Alumni Association, at the Port of History Museum

Reunion Weekend '93

June 4, Friday
ALUMNI BANQUET

June 5, Saturday
WOMEN'S FORUM, CLINIC PRESENTATIONS, DEAN'S LUNCHEON, CAMPUS TOURS, REUNION PARTIES

June 6, Sunday
FAREWELL BRUNCH
On the front cover
Jefferson commencement have been held at the glorious Academy of Music since the 1870s. The Medical College has used this theater even longer than the Philadelphia Orchestra, the Academy's well-known tenant.

photo by Robert Neroni

From the Clinic Presentations

Excerpts From Talks at Reunion Weekend

Malignant Bone Tumors
Developing at Sites of Benign Preexisting Bone Disease

An Experience With a Small Rural Hospital

The Prevention of Tourista and the Enjoyment of Foreign Travel

The Nemours Children's Clinic

The Shoulder Revisited

Jeff's Trauma Program

The Biochemical Basis for Diabetic Nephropathy

Dealing with the Media

Space Motion Sickness

Total Joint Replacement

Decision Making and the Doctor-Patient Relationship

New Endowed Chair

Inaugural Grandon Lecture

The Young Investigator

On Campus

Class Notes

Books by Alumni

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Mary B. Monteith

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On the back cover
The newest alumni.

photo by Don Walker
Alfred G. Knudson, Jr., M.D., Ph.D. was awarded an honorary degree of Doctor of Science for his work in oncology, particularly the "two hit" hypothesis of the origin of cancer.

An honorary degree of Doctor of Letters was conferred upon Michael N. Castle, Governor of Delaware, in recognition of his efforts to broaden the delivery of health care.

Looking to the future: Bonnie L. Wright, '92 gets some help carrying her diploma from son Ben.

Stanton N. Smullens, '61, Clinical Professor of Surgery, received the Leon A. Peris, '55 Award, presented to a member of the volunteer faculty for excellence in clinical teaching and superior patient care.

Diane G. Portman, '92 received the Alumni Prize for the highest cumulative record.
A Standard of Caring
Excerpts from Remarks to the Class of '92 at Class Day
by Edward H. McGehee, '45

Now you are legally physicians—M.D.'s. A narrow pathway of long-term work, study, and deliberation is ahead to reach the level of competence that you intend for yourselves.

Don't allow the standards that dance in your heads to decay as time rolls along. You represent medicine. Slowly but inevitably we are handing you the responsibility not for maintaining but for improving medicine's effectiveness and our national and international health.

You must have:
• Integritу.
• Kindness.
• Generosity—giving yourselves even more than money.
• Effort—toward knowledge and skills, on behalf of your patients.
• Patience, especially with those at each end of the age span (those in the middle will be even more frustrating!).
• Enthusiasm—don't lose it.
• Curiosity.
• Good cheer.
• Tact—knowing when to be quiet.
• Humility. Never, never forget how little we really know, and to how many people thanks are owed for what knowledge we do have.

Physicians must avoid the errors that some of them have been guilty of: over-charging, not being available, not showing respect, not caring or showing that we care, cheating and charging insurance companies or governments for procedures and care we did not deliver, even contributing to drug abuse.

Your struggle will be lifelong. It will require your time and you may gain fewer dollars over the years. But you will be happier. You will sleep better. You will find esteem, cooperation, and respect which will be beneficial to your family, your hospital, and your specialty.

Patients will not really understand the certificates on your walls beyond your Jefferson diploma or your state license. Mostly, they approach the trivia of wall decor appropriately. What they will know with remarkable accuracy is whether you care.

Caring is an emotional sensation—you can feel it but not really learn it as you learned anatomy or physiology or pharmacology. No logic to it. But think for a moment each day: "Am I caring about these folks?" Practice caring every week just as you will practice tying little knots inside match boxes and looking at funny lines on special paper. Work at caring. Take a minute to find out a bit about a patient's work, family, or background. What we hear frequently generates admiration and understanding, and builds a lasting bridge.

Part of most physicians' jobs is tending the seriously ill. Never think, "I can't do anything for him so I won't go by to see him." The doctor is as important as the remedy. Visit the sick. Smallpox, the Black Plague, Yellow Fever, and tuberculosis each involved physicians closely; the repeated contact and examinations eventually led to creative solutions. Leprosy was the AIDS of the Greco-Roman era. Tending the seriously ill is our hallowed background.

Show concern, not just equanimity. The most insecure patients I've had have been doctors. The most frightened, if a procedure was being considered, have been surgeons. They have told me, "To hell with Osler's equanimity. Tell me exactly what's going on and that you'll be there to watch it and then come back and tell me about it." This should be applied with any patient. Equanimity should not interfere with the perception of the physician's or surgeon's caring. We can be levelheaded without being cold fish.

If a surgery is involved, draw a picture or diagram to explain what you're about to do or have done. And don't expect your anesthesia team to show all the kindness that the patient expects and needs from you.

Patients deserve our time even when we've transferred them to another service. Call them on the phone after they've been discharged. "Are you getting better?"

Share a little of your own life, your family, your kid, your own illness or that of someone in your family if it is somewhat related to your patient's problem. This evidence of humanity in the doctor reassures patients, and improves their view of the whole medical profession. Similarly, doctors can shed a tear at the death of a patient without loss of esteem. Go to funerals and speak a few appropriate words at memorial services for your patients. You will have seen them suffer and know how they handled the most trying of experiences. Your words will be helpful to family and friends.

All these things you must practice. In the words of one of the greatest Jeffersonians, John Chalmers DaCosta, Class of 1885, "Each of us, however old, is still an undergraduate in the school of experience. When a man thinks he has graduated, he becomes a public menace."
A Class with Wide Interests

The Class of '92 is a remarkable group, ranging from Patricia F. Buttitta, whose son James is in the Class of '94, to Michael I. Goldberger, who even before graduation had co-authored “What’s New in Surgery ’92: Orthopaedic Surgery” in the Bulletin of the American College of Surgeons, vol. 77, no. 1 ... to Lilly KC, who is one of the first women to leave Nepal to study ... to Edgar R. Miller III, who had earned his Ph.D. and done research in marine ecology before coming to Jefferson ... to the many students who are relatives of alumni.

Dr. and Mrs. Thomas L. Carter, '56 with David L., '92 and (standing) Dr. and Mrs. W. Bradford Carter, '86 (Janie Huff Carter, B.S.N., '88; Thomas L., Jr., '84; and Stephen L., '90

Edward R. Hagopian, '56 and his daughter Ellen J. Hagopian, '92

Jeff Relationships

CLASS OF '92

Amrick, Christopher J. Thomas Amrick, M.D. Brother '85
Anwar, Iqbal A. Haroon P. Anwar Brother '95
Barbarevich, Christopher Gaetano Capone, M.D. Cousin '76
Bauer, Thomas L., II Albert Belardi, M.D. Cousin '88
Boyer, John W. Thomas Bauer, M.D. Father '65
Brian, Christopher M. Boyer, Carl W., Jr., M.D. Father '55
Brown, Christine F. David A. Brian, M.D. Father '64
Brown, Steven H. Richard DiDonato, M.D. Uncle '64
Burns, Erin E. Louis Brown, M.D. Father '61
Buttitta, Patricia F. Leo Burns, M.D. Brother '91
Carter, David L. James Buttitta Son '94

Cicilioni, Orlando, J., Jr. Gregory Halenda, M.D. Brother '56
Clewell, Karen M. J. Jerome Clewell Brother '84
Cohen, David J. William H. Annesley, M.D. Brother '86
Coats, Thomas D. William H. Annesley, Jr., M.D. Sister-in-Law '88
Crowell, Michael T. Janie Huff Carter, B.S.N. Brother '90
Danyo, J. Joseph, Jr. Stephen L. Carter, M.D. Uncle '55
Feagans-Dunston, L. Kyrian Gregory Halenda, M.D. Brother-in-law '84
Fitzpatrick, Michael H. Kathy M. Clewell Sister '93
Fox, David S. J. Jerome Cohen, M.D. Father '61
Friedman, Michael A. William H. Annesley, M.D. Grandfather '11
Hagopian, Ellen J. William H. Annesley, Jr., M.D. Uncle '48
Hneleski, Ignatius S., III Joy Aguas Crowelio, M.D. Wife '90
Hneleski, Karen A. J. Joseph Danyo, Sr., M.D. Father '59
Hneleski, Karen B. Sally Danyo, R.N. Mother '59
Feagans-Dunston, L. Kyrian John Hume Miller, M.D. Brother '93
Fitzpatrick, Michael H. James J. Fitzpatrick, M.D. Brother '91
Fox, David S. J. Jerome Cohen, M.D. Cousin '92
Hagopian, Ellen J. Richard Fox, M.D. Uncle '67
Hagopian, Ellen J. Robert G. Kirschner, M.D. Uncle '47
Hagopian, Ellen J. M. Joyce Hagopian, R.N. Sister '85
Hagopian, Ellen J. Edward R. Hagopian, M.D. Brother '85
Hagopian, Ellen J. Ignatius Hneleski, Jr., M.D. Brother '85
Hagopian, Ellen J. Edna Hneleski, R.N. Mother '58
Hagopian, Ellen J. Andrea Jordan, M.D. Sister '85
Hagopian, Ellen J. G. Edward Kienzle, M.D. Brother '81
Hagopian, Ellen J. Jack Jonathan Klein, M.D. Father '62
Kolecki, Paul F. Richard Kolecki, M.D. Father '57
Koletic, Paul F. Richard Kolecki, M.D. Brother '88
Kostelniak, Keith E. Robert Kolecki, M.D. Brother '89
Kostelniak, Keith E. Donna Kostelniak, M.D. Sister '89
Lasota, Jon F. Francis V. Kostelniak, M.D. Father '58
Lasota, Jon F. George L. Lasota, M.D. Father '62
Lasota, Jon F. Jeanne M. Lasota Sister '94

Five siblings in the Yavorek family have graduated from Jefferson Medical College.
Left to right: Henry G., '85; Vincent M., '91; their mother, Gertrude; Trudy A., '92; Amy, '88; and George A., '87.

Dr. and wife, J. Yavorek, with their children.
The Women’s Forum on Saturday morning of Reunion Weekend drew lively participation.

Barbara G. Frieman, ’80 led the Women’s Forum in serious issues and some lighter moments.

Levinson, Mark E.
William O. Levinson, M.D. Father ’45
Louis Levinson, M.D. Cousin ’62
Li, Sheryl G.
Gail G. Li, M.D. Father ’47
Min Hin Li, M.D. Grandfather ’22
Ben Luka Li, M.D. Great-Uncle ’29
Gaylyn Li-Ma, M.D. Sister ’78
Mann, Thomas A.
Lowell D. Mann, M.D. Father ’57
Martin, Amy E.
Alfred J. Martin, Jr., M.D. Father ’64
Amita S. Rothhammer, M.D. Mother ’65
Maylock, John V.
John Maylock, M.D. Uncle ’64
McGehee, Ann Marie
John T. McGehee, M.D. Father ’44
Paul A. McGehee, M.D. Brother ’82
Miller, Edgar R.
Tyria L. Jenkins Hiller, M.D. Cousin ’80
W. Douglas B. Hiller, M.D. Cousin-in-Law ’81
Montgomery, Matthew L.
Ernest Montgomery, M.D. Father ’61
Susan Edwards, O.T. Wife ’89
Mulkern, Ann V.
Daniel L. Mulkern, M.D. Husband ’92
Mulkern, Daniel L.
Charles Tullius, M.D. Cousin ’89
Ann V. Mulkern, M.D. Wife ’92
O’Donoghue, Michael J., Jr.
Herbert A. Luscombe, M.D. Great-Uncle ’40
Pharr, Tarrenk A.
William F. Pharr, M.D. Father ’65
Sailer, Jane Pisarchick
Jay G. Sailer, M.D. Husband ’92
Sailer, Jay G.
Jane Pisarchick Sailer, M.D. Wife ’92
Sava, Helen K.
James T. Fitzpatrick, M.D. Cousin ’91
Silver, David F.
Michael H. Fitzpatrick, M.D. Cousin ’92
Lawrence B. Silver, M.D. Father ’66
I. O. Silver, M.D. Grandfather ’34
Stephen Silver, M.D. Cousin ’70
Silver, Lynne J.
Barry A. Silver, M.D. Father ’67
Stambaugh, Michele D.
John E. Stambaugh, M.D., Ph.D. Father ’66
Michael Stambaugh Brother ’94
Stec, Eugene E.
Eugene O. Stec, M.D. Father ’54
Michael J. Stec, M.D. Grandfather ’25
Sweterlitsch, Louis H., III
Louis H. Sweterlitsch, Jr., M.D. Father ’60
Louis H. Sweterlitsch, Sr., M.D. Grandfather ’27
Paul Sweterlitsch, M.D. Uncle ’61
Weidner, Mark H.
Eric Sweterlitsch, M.D. Cousin ’89
Richard Pierotti, M.D. Cousin ’76
Weisman, Evan B.
Barrie Weisman, M.D. Father ’64
Woloshin, James
J. A. Slezak, M.D. Cousin ’63
Woloshin, James
Jeffrey Woloshin, M.D. Brother ’87
Yavorek, Trudy A.
Henry G. Yavorek, Jr., M.D. Brother ’85
George A. Yavorek, M.D. Brother ’87
Amy Yavorek, M.D. Sister ’88
Vincent M. Yavorek, M.D. Brother ’91

University President Paul C. Brucker, M.D. (right) talks with James E. Bowman, ’27.
The Big Weekend '92

Reunion Weekend 1992 began with the Alumni Banquet, held this year on Friday, June 5 at the Union League. A large and enthusiastic group of alumni and their spouses attended the festivities in the Lincoln Room. President Paul C. Brucker, M.D., Dean Joseph S. Connella, M.D., Chairman of the Board of Trustees James W. Stratton, and Alumni Association President William E. Delaney III, '53 addressed the audience. Edward H. McGeehe, '45 introduced his classmate Leonard Apt, '45, the recipient of the Alumni Achievement Award.

The Clinic Presentations, held on Saturday morning and covering a wide variety of topics, were moderated by Jack W. Fink, '54 and Elmer H. Funk, Jr., '47.

This year's class reunions were attended by a record number of alumni and their guests. The Class of '32 gathered during the Dean's Luncheon. Reunion chairman Nathan S. Schlezinger greeted his classmates and their guests. The reunion committee for the Class of '37, chaired by Paul A. Bowers and including Maurice Abranson, Bernard B. Zamostien, John F. Wilson, Irvin F. Hermann, and Joseph J. Blanch, chose the Eakins Lounge of Jefferson Alumni Hall for its fifty-fifth reunion. Members of the class and their guests were presented with boutonnieres and corsages as they arrived on Saturday evening.

Four classes held their reunions at the Hotel Atop the Bellevue. The Class of '42, with J. Wallace Davis as chairman, enjoyed a large turnout for its fiftieth reunion, held in the Cliveden Room. James E. Clark and Jerome M. Cotler hosted the Class of '52's dinner dance in the Conservatory. The class souvenir was a large button made of the alumnus's yearbook photograph without an identifying name. Arriving guests were asked to "find themselves" at the registration table. A memorial banner, sewn by Ginna (Mrs. James E.) Clark, with photo buttons of deceased alumni was displayed on a table in the Conservatory.
President of the Alumni Association William E. Delaney III, '53 (center) and Mrs. Delaney with J. Wallace Davis, '42

Sunday brunch provided a good send-off after an active weekend.

The Class of '57 held a dinner dance in the Clover Room. John R. Prehatny was chairman of the reunion committee, which included Associate Dean Joseph F. Rodgers, Phillip J. Marone, John T. Magee, and Robert H. Schwab. The twenty-fifth reunion of the Class of '67 took place in the traditional Rose Garden. Anthony M. Padula served as reunion chairman.

William V. Harrer and Joseph W. Sokolowski, Jr. chaired the Class of '62's traditional dual celebration. On Thursday evening, members of the class and their guests attended an evening of “heavy hors d’oeuvres” at the home of Dr. Sokolowski and cohosted by Dr. Harrer and Dr. Stephen G. Vasso. On Saturday, the group reassembled at DiLullo Centro for a thirtieth anniversary dinner party.

Anna Marie D’Amico led the Class of ’72 in a lively evening of dining and dancing in the Washington Room at the Four Seasons Hotel. The Class of ’77 held its fifteenth reunion in the Grand Salon at the Rittenhouse Hotel. After dinner, reunion cochairmen Robert S. Boova and Francis X. DeLone gave a slide presentation of the class’s history.

The fifth and tenth reunion classes met near Independence Hall. The Class of ’82 initiated a new reunion site, the Omni Hotel’s Azalea restaurant, overlooking Carpenter’s Hall. Chairman Walter M. Dearolf hosted a large and lively crowd. The Class of ’87 held their fifth reunion in the Grille Room of the Downtown Club. Bertram T. Chinn served as reunion chairman.

Reunion Weekend concluded with the Farewell Brunch, held Sunday morning in the Alumni Hall Courtyard and Cafeteria. Alumni young and old joined together to say goodbye to Jefferson and their classmates, promising to meet again no later than 1997. □
Tenth Reunion

Helen A. Leibowitz, '72 (standing) catches up with Dr. and Mrs. Philip C. Hoffman, '72

Dr. and Mrs. Elmer H. Funk, Jr., '47 (right) chat with classmates.

The Class of '37 at their Fifty-Fifth Reunion

Dr. and Mrs. George E. McCarthy, Jr., '62 and William V. Harrer, '62 enjoy the Thursday night party hosted by Joseph W. Sokolowski, Jr., '62.

Thirty-Fifth Reunion of the Class of '57
Charles A. Sym, Jr., ’52 and Alcin Merkin, ’52 enjoy the Fortieth Reunion.

Sharing a laugh are James P. Bagian, ’77, Dr. and Mrs. John D. Bartges, ’77, and Dr. and Mrs. David C. Bauman, ’77.

Parties

The Twenty-Fifth Reunion: Class of ’67

At the Fifth Reunion: Martin J. O’Riordan, ’87 and John F. Henzes III, ’87

Joseph W. Sokolowski, Jr., ’62 displayed the Jeff banner on his house, where he hosted a party for his class on Thursday night.

The Fiftieth
Alumni Achievement Award Winners

Year Presented

1964  LOUIS H. CLERF, '12  Chairman of Laryngology and Bronchoesophagology, President of the Alumni Association  (presented at the Annual Business Meeting)
1964  HENRY L. BOCKUS, '17  Emeritus Professor of Medicine at the University of Pennsylvania—Bockus Society for gastroenterologists is named for him
1965  PERCIVAL E. FOERDERER  Chairman of the Board, Jefferson Medical College and Hospital
1966  HAROLD STEWART, '26  Chief of the Laboratory of Pathology at the National Cancer Institute, and Chief of the Department of Pathologic Anatomy, Clinical Center, National Institutes of Health
1967  FRANCIS J. BRACELAND, '30  Psychiatrist-in-Chief at the Institute for Living, Hartford, Connecticut
1968  VICTOR HEISER, M.D. 1997  distinguished career in public health, Commissioner of Health in the Philippines  (presented at the New York Chapter Dinner)
1968  ABRAHAM CANROW, '24  Chairman of Biochemistry, President of the Alumni Association
1969  LEROY A. SCHALL, '17  Professor of Otolaryngology, Harvard Medical School  (presented at the Annual Business Meeting)
1969  GEORGE C. GRIFFITH, '26  Professor of Medicine at the University of California, cardiologist of international renown
1970  JOHN H. GIBSON, JR., '27  The Samuel D. Gross Professor and Chairman of Surgery, inventor of the heart-lung machine, President of the Alumni Association
1970  A. J. ORENSTEIN, '05  Physician for the mines in South Africa
1970  THADDEUS L. MONTGOMERY, '20  Chairman of Obstetrics and Gynecology, President of the Alumni Association
1971  BALDWIN L. KEYES, '17  Chairman of Psychiatry, President of the Alumni Association
1972  GEORGE J. WILLAUER, '23  Professor of Surgery, Alumni Trustee, President of the Alumni Association
1973  WILLIAM W. L. GLENN, '38  Professor of Thoracic Surgery at Yale University
1974  DANIEL BAKER, JR., '33  Professor of Otolaryngology at the College of Physicians and Surgeons of Columbia University  (presented posthumously)
1975  ANTHONY F. DEPALMA, '29  Chairman of Orthopaedic Surgery, President of the Alumni Association
1976  JO ONO, '25  Internationally known otolaryngologist from Tokyo
1977  J. EDWARD BERK, '36  Distinguished Professor of Medicine, University of California, Irvine
1978  GEORGE M. NORWOOD  Vice-President and Acting President of Thomas Jefferson University
1978  BENJAMIN F. HASKELL, '23  Professor of Surgery, President of the Alumni Association
1979  JOHN B. MONTGOMERY, '26  Chairman of Obstetrics and Gynecology, President of the Alumni Association
1980  WARREN W. NICHOLS, '54, PH.D  Professor of Human Genetics and of Pediatrics at the University of Pennsylvania; investigated how viruses cause cancer by affecting genetic material
1981  JOHN Y. TEMPLETON III, '41  Professor of Cardiovascular Surgery, President of the Alumni Association
1981  WILLIAM F. KELLOW, M.D.  Dean and Vice-President of Jefferson Medical College (presented at home)
1982  JOE HENRY COLEY, '34  Professor of Obstetrics and Gynecology at the University of Oklahoma, Alumni Trustee
1983  FRANCIS J. SWEENEY, JR., '51  Vice-President for Health Services and Director of Thomas Jefferson University Hospital, Professor of Medicine
1984  ABRAHAM E. RAKOFF, '37  Emeritus Professor of Obstetrics and Gynecology and Medicine (awarded posthumously)
1985  CHARLEY J. SMYTH, '35  Professor of Medicine at the University of Colorado, President of the American Rheumatism Association, President of the National Society of Clinical Rheumatology
1986  GERALD D. DODD, '47  Chief of the Department of Diagnostic Radiology, University of Texas and M. D. Anderson Hospital and Tumor Institute, Houston
1987  WILLIAM R. FAIR, '60  Chief of the Urologic Surgery Service and Professor, Memorial Sloan-Kettering Cancer Center
1988  SHELDON GILGORE, '56  Chairman and CEO of G. D. Searle and Company, President of Pfizer Pharmaceuticals, Jeffrey Trustee
1989  JOHN J. GARTLAND, '44  The James Edwards Professor and Chairman of Orthopaedic Surgery, President of the American Academy of Orthopaedic Surgeons, President of the Council of Medical Specialty Societies, author of Fundamentals of Orthopaedics
1990  JOHN H. HODGES, '39  The Ludwig A. Kind Professor Emeritus of Medicine, Trustee Emeritus of Thomas Jefferson University
1990  FREDERICK B. WAGNER, JR., '41  The Grace Revere Osler Professor Emeritus of Surgery, Alumni Trustee, University Historian
1991  J. WALLACE DAVIS, '42  Clinical Associate Professor of Surgery, Chairman of Annual Giving since 1964
1992  LEONARD APT, '45  Professor of Ophthalmology at the Jules Stein Eye Institute, University of California at Los Angeles, author of Diagnostic Procedures in Pediatric Ophthalmology, developer of Apt test
Leonard Apt, ’45, A Pediatric Ophthalmologist, Receives Alumni Achievement Award

Leonard Apt, ’45, Professor of Ophthalmology at the Jules Stein Eye Institute of the University of California, Los Angeles, School of Medicine, is the 1992 recipient of the Alumni Achievement Award. He is the first ophthalmologist to receive the honor.

Dr. Apt established the first full-time division of pediatric ophthalmology at a medical school in the United States at UCLA in 1961. He is the first physician to be board-certified in both pediatrics and ophthalmology, and his book, Diagnostic Procedures in Pediatric Ophthalmology, published in 1963, was one of the first texts devoted to the new subspecialty.

Dr. Apt is a pediatrician who has concentrated on diseases of the eye, in contrast to many pediatric ophthalmologists who have trained primarily in ophthalmology and then specialized in the treatment of children. He feels it is important to consider the whole patient, taking into account the condition of other organs, such as the liver, rather than approaching eye conditions as isolated phenomena.

He has authored or coauthored nearly 200 professional articles and book chapters in the areas of pediatric pathology, pharmacology, surgery, and ocular motility, and his interest has also extended to publications on the emotional aspects of hospitalization of children.

In his early career in pediatrics at Harvard Dr. Apt described his now well-recognized clinical test (the Apt test) that identifies ingestion of maternal blood during delivery as a spurious cause of gastrointestinal bleeding in newborns. He identified mothball (naphthalene) ingestion as a cause of some cases of severe acute hemolytic anemia in toddlers. Working with Drs. Carl Walter and Louis K. Diamond of Harvard, he introduced the use of plastic bags for blood transfusions in infants and children. Dr. Apt also reported, along with colleagues, the first cases of congenital deficiency of gamma globulin in children.

Dr. Apt’s pioneering work on allergy to catgut and collagen sutures contributed to the development of present-day...
nonallergenic absorbable sutures. His originate idea of using a skin test to prove the existence of allergy to catgut and collagen sutures is the basis for the now commonly used skin test carried out by plastic surgeons before proceeding with collagen injections.

Dr. Apt’s detailed anatomical studies on the extraocular muscles in humans established new insertion site measurements and muscle dimensions which have proven useful to surgeons performing eye muscle surgery. He has also developed new surgical instruments for use in pediatric eye surgery. His preoperative method of chemical preparation of the skin and eye is now widely used in the United States and abroad.

When eyes are removed during infancy because of disease or injury, facial deformities in the affected eye area are likely to appear later in childhood. In animal studies, Dr. Apt demonstrated that the presence of the globe itself during early life is critical for normal development of the orbital and surrounding facial bones. The information is of practical importance to the clinician faced with the question of enucleation in an infant.

Dr. Apt has also studied the bacterial flora of newborn eyes. He and an associate have developed a new, nonantibiotic, inexpensive, topical eye medication that in initial studies has proved to be nonirritating and highly effective against microorganisms which cause ophthalmia neonatorum—a potentially blinding disease, especially when due to the gonococcus. The project has been extended to Kenya, East Africa, where the incidence of maternal sexually transmitted diseases, and of neonatal conjunctivitis, is relatively high.

In a recently completed study, Dr. Apt and a coworker found a surprisingly high incidence of unsuspected latex glove perforations during eye surgery (22 percent). The observation is of particular concern to eye surgeons because of the rising frequency of acquired human immunodeficiency and hepatitis virus infections.

After graduation with honors from Jefferson and internship at Jefferson Medical College Hospital, Dr. Apt took fellowship and residency training at the Children’s Hospitals of Detroit and Cincinnati, and at the Children’s Medical Center in Boston, where he served as Chief Medical Resident in 1952–53. He then joined the full-time faculty of the Department of Pediatrics at Harvard Medical School.

Later he was a resident surgeon at Wills Eye Hospital. He then became the first Special Fellow in Pediatric Ophthalmology of the National Institute of Neurological Diseases and Blindness, serving at the NIH, the Children’s Hospital of Washington, D.C., and the Armed Forces Institute of Pathology. In 1960 he returned to the Wills Eye Hospital to do research in pediatric ophthalmology.

Dr. Apt joined the University of California as an Assistant Professor and Assistant Research Ophthalmologist in 1961, rising through the ranks to become a full professor there in 1971. He was one of the founding members of the Jules Stein Eye Institute, dedicated in 1966. Dr. Apt is Director Emeritus of the Division of Pediatric Ophthalmology, and continues to be an active member of the medical school faculty.

He also holds appointments at Cedars-Sinai Medical Center, in Los Angeles, and at Saint John’s Hospital, Santa Monica, and has been an active participant in numerous advisory groups, among them the State of California Bureau of Maternal and Child Health, the Los Angeles City Health Department, the National Eye Institute, the National Society for the Prevention of Blindness, and the Board of Directors of the National Aid to the Visually Handicapped.

A Fellow of the College of Physicians of Philadelphia, Dr. Apt’s many other professional memberships include the Society for Pediatric Research, the American Association of Pediatric Ophthalmology and Strabismus, and the American Ophthalmological Society. An authority on ocular drug therapy in children, he has been a panel member of the U.S. Pharmacopeia on ophthalmic drugs. He is also a charter fellow of the American Medical Writers Association, and serves on the editorial boards of a number of medical journals.

Despite his far-reaching professional commitments, Dr. Apt maintains an active interest in sports, and is a devoted patron of civic and cultural activities, particularly the Los Angeles Philharmonic Association, and the Los Angeles County Museum of Art. He also is a member of the Steering Committee of the UCLA Center for the Performing Arts, and the Advisory Board of the UCLA Graphic Arts Center. —Cynthia J. T. Clendenin
Malignant Bone Tumors Developing at Sites of Benign Preexisting Bone Disease
by Daniel Wilner, ’37

Malignant changes associated with benign processes of bone are well recognized:

**BENIGN TUMORS COMPLICATED BY MALIGNANT TRANSFORMATION**
- Osteoblastoma
- Osteochondroma
- Enchondroma
- Maffucci’s Syndrome
- Juxtacortical Chondroma
- Chondroblastoma
- Chondromyxoid Fibroma
- Giant Cell Tumor

**DISORDERS OF BONE PRODUCING BENIGN OR MALIGNANT NEOPLASMS**
- Paget’s Disease
- Fibrous Dysplasia
- Neurofibromatosis
- Simple Bone Cyst
- Epidermoid Cyst
- Bone Infarct
- Chronic Osteomyelitis
- Myositis Ossificans
- Osteopoikilosis
- Osteopetrosis
- Osteogenesis Imperfecta
- Gaucher’s Disease
- Tropical Ulcer
- Irradiated Bone

Certain benign disorders have a higher malignant potential than others, and the incidence of malignancy is much greater in patients in whom many bones are affected:

<table>
<thead>
<tr>
<th>BENIGN TUMOR</th>
<th>MALIGNANT TRANSFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solitary osteocartilaginous exostosis</td>
<td>1–5%</td>
</tr>
<tr>
<td>Hereditary multiple exostosis</td>
<td>10–15%</td>
</tr>
<tr>
<td>Solitary enchondroma</td>
<td>occasional</td>
</tr>
<tr>
<td>Multiple enchondromatosis</td>
<td>20–40%</td>
</tr>
<tr>
<td>Paget’s disease (general)</td>
<td>less than 1%</td>
</tr>
<tr>
<td>Paget’s disease (florid)</td>
<td>10–25%</td>
</tr>
<tr>
<td>Fibrous dysplasia (solitary)</td>
<td>0.5%</td>
</tr>
<tr>
<td>Fibrous dysplasia (polystotic)</td>
<td>much higher</td>
</tr>
</tbody>
</table>

Osteoblastoma is an uncommon, solitary benign osteoid and bone-forming tumor which shows a wide spectrum of activity. When sarcomatous transformation occurs, there is sudden dissemination with extension of the tumor into the soft tissues and even distant metastases.

Osteochondroma (osteocartilaginous exostosis) is a cartilage-capped bony protuberance which projects from the surface of an affected bone. Multiple osteochondromata is an anomaly of skeletal development forming multiple cartilaginous exostoses. Two-thirds of cases have a hereditary background. Malignant transformation is usually slow and insidious. It begins on the surface of the bone and requires many years for evolution. It is seen later in life and is slow to metastasize.

Solitary enchondroma is a benign cartilaginous tumor occurring centrally in bone. It occurs mainly in the short tubular bones of the hands and feet but is also common in the major long bones. Multiple enchondromatosis is a rare developmental anomaly occurring at multiple skeletal sites. There is a tendency towards unilateral distribution when it is known as Ollier’s disease. Malignant transformation is usually slow and insidious.

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Dr. Wilner is a Visiting Clinical Professor of Radiology at Cornell University Medical College, and the author of the four-volume textbook Radiology of Bone Tumors and Allied Disorders published by Saunders (currently being readied for a second edition).
Maffucci's syndrome is a congenital non-hereditary mesodermal dysplasia characterized by multiple enchondromas and subcutaneous hemangiomas. Chondrosarcomatous transformation has been reported in 15 percent of cases.

Juxtacortical chondroma is a rare, slow-growing benign cartilaginous tumor, of comparatively small size, developing from the periosteal connective tissue and occurring at the ends of the long or short tubular bones. Juxtacortical chondrosarcomatous transformation is rare.

Chondroblastoma is an uncommon, benign, cartilaginous tumor with a proclivity for the epiphysis but may extend into the metaphysis. Only occasional cases of sarcomatous transformation have been reported. They are more often seen after radiation therapy has been administered.

Chondromyxoid fibroma is a rare, slow-growing tumor showing chondroid and myxoid traits. It predilects the metaphysis of long bones, particularly the proximal tibia. Malignant transformation is rare. (One such case was shown in the proximal fibula.)

Giant cell tumor is primarily a tumor derived from skeletal connective tissue occurring in the epiphysial, metaphysial part of a long bone, usually in the age group of 20 to 40 years. The complication is giant cell sarcoma, which at first appears to be benign, but later becomes increasingly aggressive, destroying the cortex and invading the soft tissues.

Paget's disease of bone is a fairly common bone disorder of unknown pathogenesis affecting three percent of patients over 40 years of age. It features simultaneous or alternative phases of bone re-sorption and regeneration. It may be complicated by a giant cell tumor which is curable and has to be differentiated from a sarcoma which is invariably fatal. An interesting case was presented in an accountant who had Paget's disease of the humerus (monostotic) and was followed annually for 13 years, after which he developed a minor cortical change. Although the lesion appeared to be the earliest evidence of malignant change, he was dead six months later with pulmonary metastases.

Fibrous dysplasia of bone is a skeletal developmental anomaly characterized by an abnormal proliferation of fibrous tissue in the medullary cavity. Monostotic or polyostotic forms may occur. Malignant transformation is unusual.

Neurofibromatosis is a congenital family disorder affecting mesodermal and neuroectodermal tissues and is associated with abnormalities of the skin, nervous system, bone, and soft tissues. Sarcomatous transformation occurs in only a small percentage of cases.

Simple bone cyst is a common non-neoplastic disorder occurring in childhood or early adolescence and affecting the metaphysis of long bones especially the proximal humerus and femur. Sarcomatous transformation is rare and only five cases have been reported in the literature.

Epidermoid cyst is an implantation or inclusion cyst which occurs in the calvarium and terminal phalangeal tuft of the fingers. The squamous epithelial lining may rarely undergo malignant metaplasia and become manifest as a squamous cell carcinoma.

A bone infarct is the death of bone tissue due to a sudden incomplete obstruction of the arterial supply. Infarcts occur at either end of a long bone and more than one bone may be involved. Malignant transformation into a fibrosarcoma or malignant fibrous histiocytoma is rare. Only a dozen cases have been reported.

Chronic osteomyelitis may develop in a chronic draining sinus, usually of more than 20 years duration. Three-fourths of the cases occur in the lower extremity. A sarcomatous development may occur in the epithelialized lining of the bone cavity.

Myositis ossificans is a condition characterized by a heterotrophic formation of non-neoplastic bone and cartilage in the soft tissues. Two types are recognized: the posttraumatic type, the result of acute or chronic injury with the formation of a localized soft tissue mass containing bone and periosteum; and the progressive form, which is genetic or metabolic and is found in children. It affects the striated muscles, especially the paravertebral muscles. The complication in either form is osteosarcoma. A dozen cases have been reported in the literature.

Osteopoikilosis is a rare hereditary bone disorder characterized by numerous small ovoid or short linear radiopacities in the spongiosa of the metaphyses and epiphyses, occurring mainly in the appendicular skeleton, pelvis, carpal, and tarsal bones. In two reported cases, the osteoblasts have undergone active osteogenesis resulting in an osteosarcoma.

Osteogenesis imperfecta is an inherited, generalized, mesenchymal disorder in which the basic bone defect is a failure of adequate osteogenesis. Osteoid formation is deficient and there is diminished osteoblastic formation. Osteosarcomatous transformation is rare and only a few cases have been reported in the literature.

Tropical ulcer is a chronic ulcer that occurs usually on the anterolateral aspects of the distal lower limbs. The perioskeletal reaction that results blends with the cortex to produce an ivory ulcer osteoma. The condition is commonly observed in Central Africa. Malignancy develops in two percent of cases, occurring in chronic lesions of 10 years' or more duration.

Irradiated bone produces sequelae in the skeleton and bone marrow which depend on a variety of conditions. The complications in growing bone are retardation of bone growth, osteocartilaginous exostosis, and sarcoma. The complications in mature bone are radiation osteitis and necrosis and sarcoma.

[At the Clinic Presentation, roentgenograms, gross operative specimens, and histologic sections were presented showing the earliest bone changes from the time of onset of the disorder to the stage of malignant transformation.]

The high incidence of malignant transformation of cartilage tumors and giant cell tumors has been well recognized. I have presented a variety of other benign disorders of bone associated with active osteogenesis that may also undergo malignant transformation. Many of these occurrences are not well recognized.
From the Clinic Presentations

My Experience With a Small Rural Hospital

by Joseph W. Stayman, Jr., '42

St. Luke's Hospital is a 75-bed community hospital in Folk County, North Carolina, in the southwestern portion of the state close to the South Carolina line. The hospital serves four small towns in the surrounding area—a population of approximately 25,000. It is 25 miles from Spartanburg, South Carolina, and 30 miles from Greenville, South Carolina. Asheville, North Carolina is 40 miles away. All these cities have tertiary care hospitals.

My wife and I were no strangers to that area. We had always planned to move there when it came time for me to retire. When people asked, “Where’s Dr. Stayman going?” the woman who worked for us here in Philadelphia for 25 years replied, “He’s going down there to Carolina and get retarded.”

I immediately became involved with St. Luke’s Hospital. I was appointed consulting surgeon, which involved giving opinions and assisting in the operating room with the more difficult cases. I soon found myself on the board of trustees and on numerous committees. Upon my arrival and shortly thereafter, the hospital was a thriving institution. The occupancy rate was high, we had three general surgeons, three internists (one a pediatrician), an orthopaedist, a urologist, an ophthalmologist, eight family practitioners, a good x-ray department with a CAT scan, a good laboratory, good nursing, good community spirit, and many volunteers.

We took care of two types of people: retired Yankees and local folks. Nearly 80 percent of the patients are on Medicare. I have always gotten along well with the local folks partly because of my background. Once I was asked to see a man with lung cancer who needed surgery. I explained the situation to him; he just stared at me and didn’t say a word. When I had finished he said, “You’re a Yankee, ain’t ye.” I replied, “No, I came out of the hills of West Virginia and my great-grandfather was a captain in the Army of Northern Virginia under Lee.” He said, “Then you’re okay.”

Our troubles began in 1983 when the federal government began practicing medicine with the Prospective Pricing System and DRGs. Because of our high Medicare population, the financial impact on the hospital and the staff was severe.

Things began to fall apart. The obstetrician/gynecologist resigned. Obstetrics closed mainly because the family practitioners could not afford the high malpractice premiums. One general surgeon died, one general surgeon retired, the internist/pediatrician resigned, and two family practitioners resigned. The staff became demoralized. Patients sought medical care outside the area, which is a national trend, not just at St. Luke’s. The physicians referred patients outside the area because they did not care to trace “inpatients.” As a result, the hospital occupancy rate fell and the hospital began to lose money. Our losses have continued to increase and net operating revenue has decreased. Many small rural hospitals are closing due to financial reasons.

Since 1989 there has been a continued decrease in inpatient days. Of course, inpatient admissions have declined nationwide because more patients, particularly surgical ones, are being handled on an outpatient basis. But while all hospital admissions have fallen off, those at rural hospitals have fallen off much more.

What are we doing about the problems at St. Luke’s Hospital? We employed an outside consulting firm to analyze the situation. We did receive help from the federal government when they equalized payments to urban and rural hospitals. The Omnibus Budget Reconciliation Act (OBRA) went into effect April 1, 1990 and will continue until 1993. It includes rural hospitals with 100 beds or less and at least 60 percent Medicare patients. From this source we will probably receive somewhere between $300,000 and $600,000, which we badly need. But it will expire next year so we can’t depend on it for the future. In addition to assistance from the federal government, we hope to get help from the state government and the local community.

We have been advised to recruit a general surgeon and an internist. This is proving difficult because those interviewed are not happy about the future of the hospital and their ability to generate adequate income. Also, many physicians are reluctant to practice in rural areas. If we cannot maintain our present state as a primary care hospital we may have to eliminate some services and lean more toward chronic care—becoming a nursing home type of facility. We are also looking into a possible affiliation with one or more of the surrounding tertiary care hospitals. Until we find the final answer, I’m reminded of the words of that famous philosopher, Yogi Berra: “If you don’t know where you’re going you may end up somewhere else.”

Dr. Stayman served as Director of Surgery at Chestnut Hill Hospital from 1960 to 1980.
From the Clinic Presentations

The Prevention of Turista and the Enjoyment of Foreign Travel

by James T. Helser, '47

In 1965, I owned a share of a Debonair airplane and took my older son and brother on a flying trip to Baja, California. We were aware of the possibility of traveler's diarrhea in those days and planned to take the usual precautions of avoiding the tap water and fresh fruits and vegetables. However, when we landed, a waiter was there with a tray of margaritas which were hard to resist. We obeyed all the dietary rules except for avoiding ice.

We saw a fish storm on the Sea of Cortez, which occurs when a school of tuna runs into a school of sardines and an area 1,000 yards long becomes agitated with the rolling and tossing of fish. Heading home, flying at ten thousand feet, I developed cramps so severe that I had to hand over the controls to my 10-year-old son and crawl into the back of the plane. I evacuated into the emptied brain bag that all pilots carry and became sweaty and nauseated, but did not vomit. Finally being relieved, I was able to take back the controls and we landed. This brought into sharp focus the need to control traveler's diarrhea.

I researched the subject and found it was extremely common. Even when drinking water and fruits were avoided, the incidence was about 65 percent in people staying more than one week in countries where it was endemic. In 1967, I noted the first significant medical presentation. To prepare Mexico City to host the summer Olympics, a double-blind study was done using Sulfasuccidine in 2g doses each day and a placebo. This drug reduced the incidence to 15 percent. More recently, Cipro has been pointed out as 95 percent effective in dosages of 400mg per day.\(^1\) Once the disease occurs, of course, Lomotil or Imodium usually controls it, but there are two to three days of relative discomfort. Cipro is also effective in greater than the prophylactic dosages in controlling the symptoms more quickly. Also, a recent report showed Aztreonam 100mgm t.i.d. for five days reduced the time from 68 hours in the placebo-treated patients, to 33 hours in those receiving the active drug.\(^4\) The best treatment at this time is 100mgm of vibramycin taken every day while traveling.

Studies have shown that the culprit is a variation of E coli and there appears to be an enterogenic type of toxin that is both heat labile or heat stable, but in general, it is a variation of our own E coli. When Mexicans come to the United States, they frequently develop turista also. Prophylaxis is seemed by far the best method and as I checked the literature, I learned that prophylactic treatments other than antibiotics had been found much less effective than the prophylactic antibiotic.\(^5,6,7\)

There are so many interesting places to visit, you don't want to be held up by turista. In 1855 a San Francisco whaling captain, Charles M. Scammon, sailed down to the mouth of what is now known as Scammon's Lagoon (Mexicans call it Laguna Ojo de Liebre—"eye of the wild rabbit"). He noticed that whales seemed to be disappearing into the beach. Finally he spotted a small opening, less than one-half mile across, through which he could follow the whales into what was a huge lagoon filled with literally thousands of whales.

They are a unique type of baleen whale known as the California gray, which each year swim 6,000 miles to their summer feeding area in the Chukchi Sea, north of the Bering Strait. Most of their weight is gained up there, where huge numbers of worms grow on the sea floor, waving like grass and growing to six feet in length. The whales take huge mouthfuls of the worms. When ice floes begin to appear in the fall, the whales swim south, following the coast at about five knots, less than 25 miles out to sea. There they fed only on krill strained from the water by their baleen. They swim to three major lagoons. The largest was Scammon's Lagoon, part of which became known

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Dr. Helser is an Associate Clinical Professor of Surgery at the University of Southern California, and Head of the Melanoma Site Team at the USC Comprehensive Cancer Center.
as “the nursery” because many are born
there. The second was about 120 miles
further south, known as St. Ignacio
Lagoon, and the third was a more open
area, known as Magdalena Bay, another
175 miles further south.

In Scammon’s day, it was estimated that
there were at least 25,000 gray whales,
but within a few years, they were reduced
to the point where they were no longer
worth searching for. A second attack on
the whales began in about 1930 and was
finally stopped in 1941 by an agreement
among nations to no longer take whales.
This has allowed them to recover to the
point where there are now estimated to
be at least 18,000 gray whales each winter
in the lagoons.

Now the major enemy of California grays
is the much smaller orca or killer whale.
Swimming in pods, they wait at the
mouth of a lagoon and attack stragglers,
slapping them with their tails, and then
baiting their tongues out. I have watched
this from the air.

The characteristic appearance of the Cali-
ifornia grays is due mostly to multiple par-
asites, which cause permanent scars and
allow each one to be identified year after
year from its pattern of scars. They live
approximately 50 years and grow to a
length of 50 feet, weighing as much as 33
tons. They have amazing navigation abili-
ties to find the small lagoon entrances.

Whale milk is up to 60 percent butterfat
and comes out like a three-inch-round
paste. Baby whales take 50 pounds of
milk per day and gain weight at prodig-
ous rates.

We have watched them being born in the
“nursery.” You notice a whale remaining
constantly on the surface, failing to dive
after a few minutes as they usually do.
Finally, a tail flaps near her midriff and
a whale is delivered.

To be able to enjoy such experiences, it is
wise to prevent turista, rather than allow
it to occur and then have to treat it.

From the Clinic Presentations
The Nemours Children’s Clinic
by Albert H. Wilkinson, Jr., ’52

I believe Janice E. Nevin, ’87 explains
very well the challenging job that we all
have in lowering the cost of medical care
(see page 26). Access to health care for all
citizens has become a priority in the Unit-
eed States. Health care for children is cer-
tainly at the forefront of this challenge.
Previous decades have seen competition
as a significant factor in the delivery of
health care but in the nineties and
beyond, it is clear that collaboration must
be a strong element. Using this concept
in Jacksonville, a unique collaboration
between previously competing entities
has allowed the development of a chil-
dren’s health center to coordinate care
in this large metropolitan area. A new
regional children’s hospital and the
Nemours Children’s Clinic, which is a
privately funded ambulatory pediatric
specialty clinic, have joined together to
maximize resources for children’s health
care, pediatric education, and clinical and
laboratory research.

In addition to this larger regional medical
center, Nemours has laid the groundwork
for the development of a statewide system
of care for children. Primary care centers
are being established in underserved rural
and inner city locations. Nemours has
subscribed to the principle that health
care should be available to children
regardless of economic status or geo-
graphic location.

Jefferson has established an affiliation
with the Alfred I. duPont Institute and
Children’s Hospital in Wilmington,
Delaware (see the Alumni Bulletin, Spring
1991). The Alfred I. duPont Institute and
the Nemours Children’s Clinic in Jack-
sonville also operate out of the Alfred I.
duPont and Edward Ball Testamentary
Trusts. What we are doing in Jacksonville
and the state of Florida will be happening
in Delaware as well.

We are a tertiary referral center, not a
hospital, seeing approximately 60,000
children a year though that number is
growing very rapidly. We serve predomin-
antly northeast Florida, but our referral
base is growing, including much of sou-
thern Georgia as well as northern and cen-
tral Florida. The satellites are up and
running and four more are in the pipeline
with a target of 20 to 60 statewide. These
are primary pediatric clinics located in
rural underserved areas of Florida where
a pediatrician has never been seen before.

We see all children without regard to
their ability to pay. There is one standard
of care regardless of the patient’s financial
circumstances; we run our business like a
business and our charity like a charity.

The Nemours Children’s Clinic is a
multispecialty outpatient medical center
serving children and youth with major ill-
nesses and medical disorders. The clinic
plays a major role in recruiting and train-
ing new pediatric subspecialists and in
developing research programs. The
clinic’s new home is a $35 million,
180,000-square-foot facility in Jacksonville located on the south bank of the St. John’s River next to interstate 95. Our new children’s hospital will be a 185-bed facility at the Baptist Medical Center in Jacksonville right across the expressway from the clinic. Nemours has also developed a group of pediatric satellite clinics for rural northern Florida. These will place pediatricians in remote areas of the state, where children do not have access to adequate primary care. To date, seven satellite clinics are in operation and an eighth has been constructed.

All these activities are designed to carry out the wills of two businessmen, Alfred I. duPont and his brother-in-law Edward Ball, who moved to Florida in the late 1920s. Mr. duPont came from Delaware, where his family had manufactured gunpowder in the Brandywine Valley. The two men participated in many successful business ventures which continue today. When Mr. duPont died in 1935, his will established the Nemours Foundation. The foundation was to receive earnings from holdings of the duPont Trust. These funds were to pay for care of the elderly in Delaware and crippled children in Delaware and Florida. Mr. Ball spent his life building the trust and upon his death in 1981 left the greatest portion of his personal estate to Nemours to care for handicapped children in Florida.

In addition to its activities in Florida, the foundation operates the Alfred I. duPont Institute, a 120-bed pediatric hospital in Wilmington, Delaware, one of the outstanding children’s hospitals in the country. Wilmington is also the home of the Nemours Health Clinic, which provides outpatient services such as discount prescriptions, plus free eye, ear, and dental care for the elderly in Delaware. Fewer patients now stay in hospitals and those who do are more seriously ill. These changes in health care practice prompted the Nemours Foundation Board of Directors to develop the new clinic into a cutting-edge outpatient facility, similar to the system pioneered at the Mayo Clinics. Nemours serves as a referral center for primary care pediatricians and family practitioners. It is the only major clinic in the United States devoted to subspecialty care for children. The nursing staff provides care for Nemours patients in the clinic, in the children’s hospital, and at home. Nemours sees mostly privately insured patients but provides one high standard of care for all children regardless of their financial status.

Across northern Florida, stretching into the panhandle, is a vast region of evergreen timberland, pocketed by small towns. In this rural environment, lack of access to pediatric specialty care poses long-term health problems to many of Florida’s children. Access is limited since few pediatricians practice outside of urban centers. Families in remote areas of Florida may be 40 to 50 miles from a physician, and many do not have money or insurance to cover medical treatment.

In 1988, the Nemours Foundation established the Satellite Clinic Program to improve access to pediatric care in rural areas covering 41 counties in northern Florida. As the satellite program began, the foundation’s board members faced a sobering set of statistics. Distribution of

continues on page 32
The way we think about the anatomy of the shoulder has changed greatly in recent years.

In the shoulder girdle, do the deltoid and the rotator cuff really work alone as we thought? We didn't know that arteries and veins could be trapped and cause problems in and about the shoulder. We didn't know the reason for bursal openings. And the so-called "chronic arch syndrome" is now termed impingement syndrome.

Biomechanics, a product of recent years, revealed that there are several joints and articulations which comprise shoulder motion. They are the sternoclavicular joint, the acromioclavicular joint, the glenohumeral joint, the suprorneral or subacromial articulation, and the scapulothoracic articulation. If any one of these areas becomes diseased or damaged, shoulder motion will not be normal.

When we were in medical school, it was thought that a complete tear of the rotator cuff required surgery. This is not true, as approximately 40 percent of such tears will heal on their own as long as they are not complete avulsions of the entire cuff. It was also thought that a complete displacement of the clavicle from the acromion had to be operated upon. Time and patience have shown us that this is not true, for example in baseball players who have this problem. It has been shown that when these are not operated upon, there is still no loss of muscle power.

Once it was thought that the supraspinatus muscle, a part of the rotator cuff, existed merely to give compression of the humeral head in the glenoid. A few years ago we performed a study in which we paralyzed the supraclavicular nerve and the axillary nerve. When both nerves are paralyzed the person cannot raise his arm. If only the suprascapular nerve, which affects the supraspinatus and the infraspinatus, is paralyzed, the torque produced by the supraspinatus is equal to the torque produced by the deltoid. In essence, the deltoid functions without the supraspinatus or the supraspinatus could function without the deltoid in order to get back to forward flexion and abduction.

As for the containment mechanism of the shoulder joint itself, we wondered why we had so many problems with the shoulder. Was it just the musculature, or the ligaments, or both? We discovered that the articular glenoid, the labrum, and the glenohumeral ligaments all combined to create a socket of finite depth, approximately five millimeters. This is basically analogous to the meniscus in the knee which is necessary to give the knee stability. Once the meniscus is removed, arthritis sets in. The same thing happens in the shoulder. The musculature about the shoulder combines with the ligaments to precisely center the humeral head in the glenoid. If the humeral head slips forward or backward excessively, a shearing reaction occurs. This causes a wearing of the articular cartilage of the humeral head and glenoid fossa. Once the glenoid labrum and glenohumeral ligaments are disrupted, the muscular forces can no longer center the head, leading to problems within the joint.

The middle glenohumeral ligament is absent in approximately 25 percent of individuals. The inferior glenohumeral ligament is made up of two portions, anterior and posterior. The anterior portion is the most important in shoulder stability. The instabilities which occur are termed either anterior, posterior, or multidirectional. Most dislocations or subluxations are anterior and not posterior. In working with people who are in the business of throwing baseballs, I have realized that posterior subluxation, that is partial dislocation, happens all too often and is a major problem for them.

What have we done in recent years to improve our knowledge of the shoulder? MRI has been a very important diagnostic aid. It has replaced arthrograms which used to be the gold standard for cuff tears. CT scanning has been another important diagnostic aid as conventional x-ray may miss either fractures or tumors. Bone scans have aided us in telling whether or not there is infection, tumor, or fracture. Ultrasound has been utilized to ascertain the thickness of the rotator cuff and whether tears are present. Electromyography has helped us immeasurably, especially when looking for entrapments of nerves in and about the shoulder. It can demonstrate entrapments of the suprascapular nerve, the axillary nerve, or the musculocutaneous nerve, as well as brachial plexus injuries.

Arthroscopic surgery of the shoulder represents the greatest advance that we have had in recent years. It has enabled us to explore the inside of the joint when diagnostic studies have failed to disclose the problem. It is also utilized to perform intraarticular surgery such as repair of a Bankart lesion, which is an important component in anterior dislocation or subluxation of the shoulder. And it is used for other procedures such as removal of loose bodies and/or removal of glenoid labral tears.
From the Clinic Presentations

Jeff's Trauma Program

by Jerome J. Vernick, '62

I think everybody who has been away from Jefferson for a while and come back has to be very impressed with the emergency facility.

Across the nation, trauma finally has reached the status of a real disease. It’s hard to realize how much of a problem it is. In 1985, 12 percent of all inpatients were in the hospital as a result of a traumatic injury either at that time or in the recent past. Approximately 60 percent of all medical expenses are related to trauma. There were 142,000 deaths per year from trauma from 1985 through 1989, and about 62 million injuries were treated per year in emergency rooms. During this period the cost, including such aspects as lost wages, was $133 billion.

Jefferson is accredited as a Level I Trauma Center, the highest of three levels, under the criteria set by the Pennsylvania Trauma Systems Foundation. We undergo an on-site survey every two years by the foundation, which is probably the toughest accreditation survey in the country.

We have a registry and track every patient and we credential every doctor who takes care of trauma patients. We have over 40,000 emergency room visits per year and of those, over 1000 qualify for the trauma registry. Last year there were approximately 1180, which puts us ahead of other trauma centers in Philadelphia such as the University of Pennsylvania, the Medical College of Pennsylvania, or Hahnemann University, and behind Temple University which admits over 2000 patients, almost all of them with penetrating injuries due to violence.

Everybody wants to know who pays for the sophisticated equipment. We have a fair number of patients with Blue Cross/Blue Shield, commercial insurance, Medicare, or managed care, and the hospital is coming out well in the black on the trauma program. A trauma center brings some financial advantages to the hospital, for example exemption from the insurance cap for motor vehicle accidents.

We have avoided the pitfall of having a discrete hospital trauma unit. All of the doctors also do general surgery, but we have protected time reserved for trauma, and we don’t have other overriding responsibilities. There are seven who share the call load and three full-timers who are pretty much committed to trauma, although they also earn their salary with general surgery. We don’t have our own intensive care unit; all the facilities involved with trauma in the hospital are also utilized in other ways by the hospital, which makes for efficiency. If we aren’t using it somebody else is, but we can have it when we need it.

Trauma work cuts across disciplines, from social service to psychiatry to obstetrics and gynecology. Establishing the program had a positive impact on the rest of the hospital. For example, I don’t think anybody would want to have CAT scan availability only during daylight hours on weekdays. To qualify as a Level I Trauma Center, you have to have 24-hour availability of everything, including CAT scanners, doctors, nurses, operating rooms, and more. Now we have the ability to get people organized in an emergency situation such as a ruptured aneurysm, or bleeding in the operating room at another hospital. Before we had an organized trauma program, mobilizing forces for such a situation was impossible.

Jefferson’s new emergency area contains an operating room for the worst cases that can’t be moved. We haven’t saved anyone from cardiac wounds due to gunshots but we’ve saved a lot of stab wounds. In the first few months we had five unexpected survivors from penetrating thoracic trauma. The zero lag time due to having the operating room in the trauma center, has made a real difference.

As far as the kind of injuries, we are getting things now that I used to see in Vietnam. Fairly high-velocity weapons are in use which do terrible damage. Our house staff is getting much experience in the care of major soft-tissue injuries. The orthopaedics house staff is seeing many major orthopaedic injuries, and we have many combined injuries with the Regional Spinal Cord Injury Center of the Delaware Valley, located at Jefferson. We have over 200 spinal cord injuries a year, a big part of our trauma program.

The factor in whether a trauma center is going to survive financially is the number of penetrating injuries. Temple University’s center, for example, has about 90 percent penetrating injuries and loses roughly one million dollars each month. The warning point nationally is about 30 percent penetrating injuries, and we have leveled off in the 20 percent range. If we continue to have a fiscally viable case mix of patients, we can keep doing the kind of work that we have been doing and not break the bank.

How do patients get to a trauma center?
Most come by fire rescue with trained paramedics. We also have our own ground transport unit with a critical care nurse and paramedics to transport a very ill patient from another hospital. We have access to a helicopter which is eight

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From the Clinic Presentations

The Biochemical Basis for Diabetic Nephropathy

by Elliot J. Rayfield, '67

The complications of diabetes generally evolve over a period of 10 to 20 years despite the best efforts at normalizing plasma glucose levels. The discovery of insulin was not the answer for preventing complications although it certainly was the answer for preventing death of the patient with insulin-dependent or insulin-requiring diabetes.

Target glucose levels that we strive for in our patients are preprandially anywhere from 80 to 120, and one hour after a meal 60 milligrams per deciliter above that. But with oral hypoglycemic agents, insulin, or even insulin pump therapy, we cannot achieve as good control of glucose levels as we would like, and our patients still wind up with end stage renal disease, heart attacks, blindness, and other complications that this disease insidiously bestows.

There are three main theories as to the causes of diabetic nephropathy. The first deals with hemodynamic factors and hypertension. There is a controversy among nephrologists as to whether angiotensin converting enzyme (ACE) inhibitors are the preferred antihypertensive agent in the diabetic patient with hypertension, or whether any class of antihypertensive drugs is equally effective as long as the blood pressure is reduced to an acceptable range.

The second mechanism for diabetic nephropathy is the polyol pathway. However, when drugs have been used to block the polyol pathway in diabetic neuropathy—such as the aldose reductase inhibitors—the results have not been convincingly positive. Therefore, it is not likely that these drugs will help to prevent diabetic nephropathy.

I would like to discuss nonenzymatic glycosylation (glycation) as a mechanism for diabetic renal disease, diabetic vascular disease, and in fact the aging process itself. The studies presented here were performed in collaboration with Drs. Tony Cerami and Helen Vlassara over the last four years, initially at The Rockefeller University and more recently at the Pick-over Institute for Medical Research in Manhasset, New York.

There are several stages in the formation of protein-bound, nonenzymatic glycosylation products. Glucose combines with an amino group of a protein over a period of several hours to form an unstable, reversible Schiff base. The Schiff base then forms a more stable Amadori product over a time frame of days. At least 20 Amadori products have been described; the most well-known is glyated hemoglobin or hemoglobin A1c which is used as a clinical marker of glucose control in the diabetic patient over a two-month period.

A blood sample is obtained at the time of an outpatient visit and reveals the level of glucose control over the previous six to eight weeks. Through a series of rearrangements and dehydrations, the Amadori products (which are not pathogenic and do not cause any diabetic complications) progress over weeks to months to form advanced glycosylation end products (AGEs), such as FFI and pentosidine, which are the culprits believed to cause the damage in diabetic complications.

If two collagen molecules are in close proximity, cross linking will occur when an AGE on one of the molecules is poised to snap shut on a free amino group of the second molecule. This cross linking of structural proteins in addition to increased vascular permeability results in the thickening of the basement membrane and provides the biochemical basis for the complications observed in diabetic nephropathy as well as diabetic vascular disease. These structural alterations are irreversible.

Our research group has found that circulating macrophages have specific AGE receptors on their surface which do not bind to Amadori products and are distinct from other scavenger receptors. The AGE receptor system allows the body to identify senescent proteins for removal and destruction. Thus, the body is continuously removing AGE proteins as they are formed. Unfortunately, due to diabetes and with advancing age, the macrophages cannot keep the removal equal to the continued synthesis and the AGE's accumulate on long-lived proteins.

Dr. Peter Ulrich, an organic chemist in our laboratory, sought a few years ago to come up with a compound that could block AGE's from forming. He tried a hydrazine compound called aminoguanidine. If aminoguanidine is added either in vivo or in vitro it will bind to the carbonyl group of the Amadori product to form an inactive molecule, thereby preventing the usual progression to AGE formation.

Dr. Rayfield is a Clinical Professor of Medicine and Director of the Diabetes Research Laboratory at Mount Sinai School of Medicine, and Investigator at the Pickower Institute for Medical Research in Manhasset, New York.
Aminoguanidine is just beginning to be used in Phase II FDA-approved studies in humans and has very little known toxicity. So we now have a drug that can be administered to diabetic patients, who despite having high blood sugar levels will be prevented from forming these AGE's.

We believe that AGE formation is responsible for the chronic complications of diabetes, small vessel, neuropathic, and large vessel, in addition to the manifestations we note in the aging process—cataracts, vascular disease, stiffness of joints, and changes in skin elasticity. Diabetes is really a model for premature aging.

Two factors largely account for AGE accumulation in vivo. First, AGE production can be increased in a quantitative fashion in direct proportion to ambient glucose levels in patients with diabetes since AGE is originally derived from the attachment of glucose to structural proteins.

This mechanism accounts for AGE deposition in arteries, causing large vessel disease, and in kidneys leading to renal failure. The second factor which results in the accumulation of AGE's is the decreased clearance from the kidneys of these molecules once renal disease actually develops. A vicious cycle ensues since AGE peptides recirculate and attach to vessel walls and lipoproteins resulting in accelerated atherogenesis. It is this accelerated atherogenesis which kills both diabetic and nondiabetic patients with end stage renal disease, and which we conjecture is a direct consequence of AGE accumulation.

Thus there are two processes, increased production and decreased excretion of the advanced glycation end products which in concert lead to the vascular disease. And the molecular weight of AGE-peptides, which we can measure by ELISA methodology, is in the range of 1350 to 6000. This is the size of the "middle molecular weight uremic toxic substances" which are not removed effectively by current hemodialysis methods.

In all the AGE's that we measure, serum samples are passed through an ultrafiltration device (centrifrep 10) to separate a high molecular weight (>10Kd) AGE-protein fraction from a low molecular weight (<10Kd) AGE-peptide fraction. AGE peptide levels are now measured routinely since they more rapidly reflect changes in metabolic pools. To compare the efficacy of different treatment modalities used to improve renal function and remove AGE-peptides, we used conventional and high-flux dialyzers, continuous ambulatory peritoneal dialysis (CAPD), and renal transplantation. In those patients with end stage renal disease (ESRD), AGE peptide levels decreased more after high-flux dialysis than after conventional dialysis. However, AGE peptide levels returned to more than 70 percent of predialysis levels three hours after hemodialysis in the high-flux dialysis group. CAPD patients did not fare any better. Renal transplantation was the only treatment modality to normalize completely the serum AGE-peptide levels.

However, not all ESRD patients can receive a renal transplant. Some have severe macrovascular complications which preclude them from being suitable candidates, and there is a serious shortage of available kidneys. Thus, the role for aminoguanidine treatment earlier in the course of diabetic nephropathy becomes an important consideration. If given prior to a critical point, as yet to be defined, aminoguanidine has the potential to prevent nephropathy. In vitro, AGE-peptide binds to collagen within days, indicating its putative toxic effect, and in concurrent studies, this binding can be prevented by the addition of aminoguanidine to the samples.

Among the different therapeutic modalities which are used, only renal transplantation completely normalizes AGE peptide clearance. It is therefore tempting to speculate that aminoguanidine treatment may be an effective method of preventing AGE accumulation in the kidneys, in arterial walls, and in the circulation, which could prevent the ravages of diabetic nephropathy and indeed those of the aging process itself.


Dr. Vernick, from page 20

minutes from here, and can bring us victims straight from accident scenes when necessary, though this is unusual.

Before starting the trauma program, we had to send our surgery residents to other medical centers to get trauma experience, which was expensive. Now we can take residents from other places and train them here.

To be accredited as a trauma center, you have to educate both physicians and the public in the care of trauma patients. We conduct advanced trauma life support courses about six times a year. We also have a community education program with a full-time outreach person who has made presentations on prevention to about 70,000 school kids, starting with basics such as wearing seat belts.

Research is required in a trauma program, to minimize the damage that injuries produce. Our research has grown very rapidly. Areas of investigation include shock mediators, platelet activating factor, tumor necrosis factor, and the interleukins. We have residents now in our laboratory. In a year and a half the laboratory has produced 19 publications and several major presentations.

Through its various activities, Jefferson's trauma program has been able to help many people, and has improved the hospital in significant ways.
From the Clinic Presentations

Dealing with the Media

by Martin Weisberg, '72

It will probably happen to you. I found a television camera in my face and was asked a question that I didn’t know the answer to. After that experience, I decided to get an education in dealing with the media. The media learned how to interview; we never learned how to be interviewed.

The first thing to find out is why they want to talk to you. Do they want information for an evening news type of broadcast? Do they want you to counter some quack who’s trying to sell peanut butter for hair growth? Do they want you because they are doing a piece on how miserable and rotten doctors are and they want to show an example of one? If you don’t know the show, if you don’t know the host, if you don’t know the interviewer, refuse, find out, then you can decide.

Rule number two. Plant your flag. You have a message that you want to get out and you had better get that message out early and not wait for them to ask for it. There is a study showing that women who are shaped like apples have more breast cancer than women who are shaped like pears. It was all over the media. It was cute, every reporter loved it. It is true; we all knew it. But the reporters missed the point, which is that one out of nine women get breast cancer, period. All women need to be vigilant and get mammographies and do breast self-exams. I had a patient who refused a mammogram the week after that study hit the news. I said, “You’ve been getting one every year. Why are you refusing one now?” She said it was because she was shaped like a pear. She didn’t think she needed it.

Suppose you work in a trauma unit and a city council member has been in an accident. Give the reporter the facts but also get your seat belt message out. If you are caring for somebody with lung disease, get your smoking message out. Forget trying to make the show exciting. That’s for the interviewer to worry about. Remember your message. Sometimes that’s a problem, even for the pros: during a speech a politician will forget which campaign promises his opponent hasn’t been able to keep.

Let’s say you’re invited to appear on a television show. What do you wear? A tie. If you’re a woman, don’t wear jangling jewelry. It’s distracting. Dark suits are better than light suits. Brown can lose an election. Wear a light (not white) shirt and usually some kind of “up” tie. Make sure your socks are long enough; it is silly to watch somebody cross his legs and see a little band of white. Little details: comb your hair.

Be forewarned that is very easy to get distracted in a television studio, because all sorts of things are happening off-camera while the cameras are rolling.

Never under any circumstances say “this is off the record” because it is not. It is on the record, on tape. Never say “no comment” without explaining why. “I can’t give you that information because the family has asked me not to” or “I can’t give you that information because the information is not available,” but “no comment” means you know something but you’re not saying what.

Even if you don’t understand a question, or you’re upset by a question, never say, “Stop the interview.” You need to expect the unexpected. An interviewer will use a word that you don’t know, and it’s easy to become disconcerted and ask that the interview be stopped. But usually it won’t be stopped: the tape will show you getting flustered.

Don’t let anybody push you around. A TV interviewer will seem friendly and receptive before going on the air, but then in the middle of a televised interview may needle you or twist your words, to make the show seem controversial or amusing.

There are some techniques for controlling the dialog. One is the bridge. A bridge answers a question that is asked, but then takes you to where you want to go. For example, let’s say you are being interviewed about a study you are conducting and the first question is, “Isn’t it true that they are wasting billions and billions of dollars on this type of research?” You can say, “Well, of course, it is very expensive to accomplish what we’ve accomplished, but one of the things we have learned is that you can give such-and-such drug for such-and-such condition.” Then you can start talking about that drug or that condition. That’s the bridge: take them from where they are to where you want to go.

A second technique is the hook: a response like, “Well, that’s true but that’s the second most important thing we do at our hospital.” Now every reporter has to wonder, “What’s the first?” and then you get to plant your flag. You swing them around to what you want to say.

And remember, you are on the air as a doctor. You can have amazing influence over people. I practice gynecology. For four years I was on the radio two hours a day on a medical talk show in Philadelphia. I had one patient who really needed hormone replacement therapy. She was afraid to undergo it, and miserable. I did a show on it. Shortly afterward she called me and said, “A doctor on the radio says it’s okay for me to take hormone re-placement therapy.” And she took it. So make sure you get your message out.

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Dr. Weisberg is a Clinical Associate Professor of Obstetrics and Gynecology at Jefferson.
Space Motion Sickness
by James P Bagian, '77

Slightly more than two-thirds of those who fly in space are afflicted with space motion sickness, which is a subset of Space Adaptation Syndrome. The symptoms, with the exception of “stuffy head,” are basically what you would see with ground-based motion sickness and for years people have tried to determine its etiology. It’s quite unpleasant, as anyone knows who has been severely motion sick on a fishing trip or even air sick. It can affect your performance of your work. We were trying to find the cause and then come up with a solution.

We observed that the components of the symptom constellation varied between individuals. Many times people experienced vomiting without nausea or other premonitory symptoms, which is similar to what you might see in people who have sustained a head injury. One theory is that an elevation of intracranial pressure may be the factor responsible. Transcranial Doppler (TCD) is a way to measure that indirectly. We looked at the middle cerebral artery blood flow velocity. You can’t measure flow per se with TCD but you can measure the velocity of the red blood cells in the artery. There are many studies that show that the diameter of the middle cerebral artery does not vary. Therefore you can infer that the velocity is proportional to flow changes. If it’s marked enough you can infer some increased intracranial pressure.

Conducting a study involves complications beyond those here on Earth. You have to figure out what kind of equipment you can take with you. There are many safety regulations concerning what you can fly on board. We had to remake the plastic case out of aluminum so it wouldn’t be flammable, and rebuild the electronics so that they wouldn’t create electronic noise and interfere with the spacecraft’s instrumentation.

Next we planned our procedures. We set up a mock-up of one side of the Space Shuttle’s mid-deck, where the unit would be used, and where people and equipment would be strapped down so they wouldn’t float around in the weightless environment. We made sure we had the choreography down pat. Our most precious commodity on orbit is time. You have to make every minute count. If you misplace your sensor for a moment or can’t find your conductive gel, and thus waste time, you lose the data you were to obtain during that period.

We practice working in a weightless environment in a KC135, the military version of a Boeing 707. The inside is gutted and lined with Ensolite® pad, similar to a ground pad you use when you go camping. We fly the plane through a parabolic trajectory, like a roller coaster, so that as you come over the top, you get about 20 to 30 seconds of weightlessness followed by the pullout which is 2 G’s, when you weigh twice as much as you normally do. Then you do the roller coaster again, maybe 40 in a row. That in itself is a motion sickness stress test.

That done we were ready for orbit. But the best-laid plans often go astray. The people who stowed equipment in the cabin had put all the data tapes in one bin, and as long as they were all in the bin it was fine, but when you took the first one out, the rest floated out also. A small problem, but it shows that even with all the preliminary work you still can get fooled now and then.

We correlated symptoms of motion sickness with changes in our TCD observations. Looking at mean velocities, we saw a difference where the sick population showed no change in their mean velocities in the middle cerebral artery, and the well population showed a significant decrease. It appears that the sick do not vasocompress as much cerebrally; that is, they do not increase their intracranial resistance as much as the well individuals.

We plan to use TCD to study the problem that we have with orthostatic hypo-tension when you come back to Earth. With TCD you can measure noninvasively whether cerebral blood flow falls off as G’s increase corresponding to becoming orthostatic.

Until a recent flight we had never had an effective treatment for motion sickness. On that particular flight we had somebody who was severely ill and I gave him 50 mg of Phenergan or Promethazine in his right deltoid, and within 20 minutes his color was back, he felt subjectively normal, his appetite was back, and he had no recurrence. Since then we have used it numerous times with similar success.

One issue we had always worried about when using Phenergan was sedation. Here on Earth, sedation is a big problem, especially with 25 to 50 mg of Phenergan intramuscularly, but our experience was much different. Ground base studies show 60 to 73 percent experiencing significant drowsiness and sedation, but we showed less than five percent. We are now trying to understand why.

Presently we use Promethazine to control motion sickness. It is not intellectually satisfying, in the sense that we don’t really know the etiology of space motion sickness, but we have a symptomatic cure at least, which is half the battle for an operational organization.

From the Clinic Presentations

Dr. Bagian, an astronaut, was the principal member of NASA’s first biomedical mission in the Space Shuttle program. At Jefferson’s Opening Exercises on September 9, he will be awarded the Dean’s Medal.
From the Clinic Presentations

Total Joint Replacement

by Joseph V. Vernace, ’82

Total joint replacement has been touted as one of the most significant surgical contributions to the quality of life of the elderly population, perhaps rivalled only by coronary artery bypass surgery. Pain relief, improved motion of the affected joint, and a return to independent living are the major goals of joint replacement surgery. In this country more than 300,000 total joint replacements are performed each year, most of them hip and knee replacement surgeries. This number has increased each year since its inception and will continue to do so as life expectancy increases and as the overall number of elderly individuals in the United States rises over the next 30 years.

The number of people over age 50 is expected to rise from 25 percent of the population in 1987 to 37 percent in the year 2020. The increasing number of total joint replacement surgeries will have a great impact on the overall cost of health care.

Hip replacement surgery was developed in the late 1950s and 1960s by Sir John Charnley in England. His initial results were quite discouraging. His early hip replacement implants were composed of stainless steel femoral components and teflon acetabular components or sockets. The teflon failed to hold up under the stress of ambulation and completely disintegrated causing proximal loss of bone, pain, synovitis, and the need for revision surgery. In addition, the stainless steel was often inadequate for the loads placed upon it and fractured, again causing pain and secondary surgical procedures. Perhaps most disheartening was an overall infection rate approaching 10 percent.

By modifying his surgical technique and choice of materials, Charnley eventually developed an extremely functional and long-lasting total hip implant system.

For total hip arthroplasties, Charnley borrowed a cement from dental colleagues in order to secure fixation of the implants. Unfortunately, this material which initially made total hip replacements possible has been found over the years to be the so-called “weak link” in the system. It is relatively brittle and unforgiving and eventually breaks down causing loosening of the implant. As the interface between the cement (polymethylmethacrylate) and bone loosens, the interface between the implant and the cement also loosens, causing pain and the need for revision surgery.

Recent technological advances have allowed us to improve on Charnley’s system. Improved alloys such as cobalt, chrome, and titanium alloys have greater strength, so that metal fatigue is quite rare at this time. Improved plastics engineering with the development of better high-molecular-weight polyethylenes, as opposed to teflons, for the articulations in the joints, has greatly reduced wear and loosening. Improvements in our techniques of surgical approach and of cementing have greatly reduced overall loosening and revision rates.

Perhaps the most significant advance in hip surgery over the past 10 years has been the development of porous or biologic ingrowth prostheses. In this system the patient’s bone will grow into pores in the metallic implant, securing it and obviating the need for bone cement.

Thousands and thousands of small beads are bound with a heat process to the implant. Between these beads are pores ranging from 50 to 400 microns which allow ingrowth of bone into the implant surface.

The tight fit that we achieve initially on the femoral side and on the acetabular side, sometimes aided initially with screw fixation, coupled with the ingrowth of bone into the implant at six months to a year, secures the implant so that no cement is needed. This is the current approach for most total hip implant systems.

Advances in surgical techniques such as the use of so-called space suits or body exhaust systems, laminar air flow operating rooms, and the routine use of prophylactic antibiotics have decreased the infection rate to less than two-tenths of one percent from Charnley’s original 10 percent. Newer surgical approaches with less blood loss and a more rapid approach to the hip joint have shortened the surgical procedure, so that an uncemented total hip replacement can be performed routinely in less than one and one-half hours.

Recent advances in transfusion technology allow us to perform joint replacement surgery routinely without the use of blood products other than the patient’s own. Pre-donation several weeks prior to surgery has been a routine part of preoperative surgical preparation for a number of years. More recent advances in intraoperative salvage, using the cell saver during total hip replacements, and

Dr. Vernace is an
Attending Orthopaedic Surgeon at Bryn Mawr Hospital and Havercord Community Hospital.
postoperative reinfusion with specialized surgical drain systems in knee replacement surgery, have allowed us to perform joint replacements at Bryn Mawr Hospital without the need for preoperative patient donation.

Through a comprehensive team approach, utilizing preoperative teaching classes for patients, specially trained operating room personnel, a specialized floor dedicated to the care of orthopaedic patients, and on-floor physical therapists, we have been able to provide patients with better care while streamlining the entire preoperative, perioperative, and postoperative patient rehabilitation program. The average hospital stay has been reduced to six to seven days with most patients being admitted the morning of surgery and some patients leaving as early as four to five days postoperatively.

With cost control and cost justification constantly in the forefront of consideration for developing technologies, this team approach is of significant importance in total joint replacement in the 1990s. Shorter intraoperative time, shorter hospital stays, more aggressive rehabilitation, and a shorter period of time to return the patient to independent living all contribute to a favorable outlook in long-term outcome studies.

With the cost of the implant alone contributing to 20 to 25 percent of the cost of the surgical procedure including the patient’s hospital stay, high-volume joint replacement centers which receive discounts from implant manufacturing companies due to their volume, will look more favorable in Medicare outcome studies. For this and other reasons, a trend toward centralization of total joint replacement surgery to large joint replacement centers in the near future, is likely.

With changes in surgical technique, implant design, and implant technology, total joint replacement surgery has become one of the most reliable major surgical procedures available today. Total hip and total knee replacement surgery both demonstrate an overall 90 to 95 percent satisfactory result at 10-year follow-up. We expect that we will be able to improve these already impressive results over the next 30 years.

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From the Clinic Presentations

Decision Making and the Doctor-Patient Relationship

by Janice E. Nevin, ’87

I spent the last two years completing a Family Medicine Faculty Development Fellowship at St. Margaret’s Hospital in Pittsburgh, and a Master’s of Public Health in Community Health Services at the University of Pittsburgh. But I have been and still am a family physician. The fellowship gave me the opportunity to develop research and teaching skills, but also afforded me time to better understand the discipline of family medicine.

One of the aspects of practicing that continues to fascinate me is that of medical decision making, not only in the context of the patient/physician relationship but in the greater sphere of health policy and its implications for teaching. 1992 has become the year of choice in many ways. Women’s constitutional right to reproductive choice is being challenged, and the

and forms the crux of the patient/physician relationship.

Although it is unpopular and perhaps unfavorable to regulate physician behavior, clearly the decisions we physicians make with our patients greatly impact the cost of health care. Indeed, there is evidence presented in the March 25 Journal of the American Medical Association that when physicians of different specialties care for patients with similar illness profiles, resource utilization and costs are different. Despite the explanations for these differences are certainly complex and unclear, education and training regarding decision making must play a role. Now variation in clinical practice is inevitable. And uncertainty is an avoidable part of every decision. Clinical decision making is a complex enterprise that

“To explore and feel comfortable with patients’ values, and our own, aids the clinical decision making process and perhaps also helps reduce costs.”

political choices we will make at all levels in the coming months will reflect how we as a nation will deal with the social and economic turmoil so vividly displayed recently in Los Angeles. For health care this is also a time for choice. For months we have heard and read of proposed solutions to the crises of service and cost. We’ve arrived at a time when we need to make decisions and start to act.

I have been told that there are four kinds of decision makers: the ulceroidal type who worries about everything, the adenoidal type who shouts about everything, the thyroidal type who rushes around with purposeless pep, and the hemorrhoidal type who just sits and sits on a situation, waiting for it to clear up! Decision making is at the core of health policy encompasses various factors and requires diverse skills, such as application of knowledge, problem analysis, and assessment of benefit and risk. Nevertheless, clinical decisions are influenced by our values and those of our patients. Learning to explore and feel comfortable with patients’ values, and our own, aids the clinical decision making process and relieves some of the burden of uncertainty. Perhaps it also helps reduce costs. An example will help illustrate this point.

Marie is an 87-year-old Italian immigrant, whose care I assumed this winter toward the end of a hospitalization for stroke that left her with little neurologic deficit. She was also treated for end stage congestive heart failure that was mostly responsible for her limited activity tolerance. She
lived with her son and his family close to my practice, so I arranged to see her at home. The first visit after her hospital stay found her doing well, but two weeks later I received a panicked call saying that she was having another stroke. She couldn’t move her right side. Fortunately, I was able to stop by the house immediately.

Sure enough, she was having some right-sided weakness and was less alert than usual. I sat with her and her family in the living room, and later around the kitchen table drinking coffee. We talked with and about Marie. We discussed her values and those of her family. It was a very open, occasionally tearful discussion, as she and her family decided, with my support, to keep her at home and let nature take its course. As this was not the first time we had talked about these problems, our discussion took only about 20 minutes. Part of a continuum.

For me, this experience lay at the very heart of being a family doctor. I was deeply moved by the family’s honesty as I asked them to think about the many issues confronting someone at the end of her life. I saw Marie later that week. She had improved and by the following week, she was back to making meatballs. I continue to see her every six to eight weeks, usually on Thursdays when I am inevitably treated to coffee, the best Italian bread, and various other delicacies. In the course of our relationship, I have shared with the family some of my values. It has become a very comfortable relationship.

Out of curiosity I inquired how much hospitalization might have cost. The DRG reimbursement for uncomplicated stroke is about $2500 in our hospital. The three home visits I made cost $120. Quite a difference. Not only in cost, but perhaps more importantly in benefits to the patient and her family, and to me as we developed comfort in dealing with and preparing for the uncertainty of health and disease.

I presented this case at a resident conference where clearly some folks were uncomfortable with this approach, as I would expect. They asked, “Where did you learn that?” My answer then and now is that I’m not sure. I learned the importance of home visits from my experience with the Family Medicine Department here at Jefferson. Learning to listen to patients, and develop a mutual understanding of cultural values, was part of my Jefferson education as a medical student and resident.

Such behavior can be taught during the process of medical education. One of my concerns both as a practitioner and as an educator is that most proposed changes in the health system pay only minimal attention to educational matters. It seems only logical that any comprehensive health policy would have to address not only the cost but also the manner of educating physicians. Indeed my own preference when it comes to patient care is to be educated rather than regulated. One of my goals as a teacher is to help students understand the process of practicing medicine as well as the content—a process that stresses the importance of culture and values in patient care.

A patient wrote in the journal Hippocrates that physicians have been taught in medical school that “they must keep the patient at a distance because there isn’t time to accommodate his personality or because if the doctor becomes involved in the patient’s predicament, the emotional burden will be too great.” The writer went on to say that a doctor’s job would be much more interesting and satisfying if he “simply let himself plunge into the patient, if he could lose his own fear of falling.” I contend that not only would value seeking and the development of a mutual relationship benefit the physician, but also the decisions made as a result of this partnership would ultimately provide better health care for the patient at a cost savings both to individuals and to society.


Edward B. Christian, Ph.D. Appointed Assistant Dean

Edward B. Christian, Ph.D. has been appointed Assistant Dean of Student Affairs and Special Programs. He is responsible for medical students in such areas as the Accelerated Program with Pennsylvania State University, the Physician Shortage Area Program, the M.D./Ph.D. tracks, the joint program with the University of Delaware and the Delaware Institute of Medical Education and Research, and the Minority Program. He works with the Associate Dean for Admissions to screen applicants for these segments of the class.

Dr. Christian is a member of the University Office of Minority Affairs and the Committee on Student Promotions. He is at work on programs in study skills and stress management for medical students.

A graduate of Lincoln University, Dr. Christian earned an M.S.W. from Carleton University in Ottawa, and a Ph.D. from Temple University. He has experience in adjustment counseling, and has developed workshops on cultural awareness, substance abuse, and stress management.

With Dr. Callahan are Portrait Selection Committee member Amy E. Martin, '92, Committee Chair James J. McKeith, '92 (far right), and artist Stephen S. Kennedy. In an interesting tradition, Amy's mother, Ami/II S. Rothhammer, '65, had served on the portrait committee back when she was a senior at Jefferson.

Class of '92 Selects Dr. Callahan for Portrait

Each year the graduating class honors a member of the faculty by commissioning his or her portrait. This year's seniors accorded that tribute to Clara A. Callahan, M.D., who in July was promoted from Assistant Dean to Associate Dean for Student Affairs, as well as Clinical Associate Professor of Pediatrics.

Amy E. Martin, '92, who served on the class's Portrait Selection Committee, said at the presentation that for the students, Dr. Callahan had always been "a big sister—part of the family. We were comforted to have her in our corner."

"Her infectious laugh puts everyone at ease," remarked Carla E. Goepp, M.D., Associate Dean for Student Affairs. "She is full of joy and spontaneity." Senior Associate Dean Robert S. Blacklow, M.D. praised her "optimistic and breezy disposition—willing to tackle any task. She is an excellent role model for students."

Senior Vice-President and Dean Joseph S. Gonnella, M.D. pointed out that "Often students think administrators are policemen. But they've chosen to give Dr. Callahan this thank-you. She's managed to tread the line between helping students overcome problems, and maintaining the guidelines of the society they must work within."

Although she spends half of each week in the Dean's Office, Dr. Callahan also shoulders a large teaching and clinical load in the Department of Pediatrics. Among the many committees to which she contributes are the Ethics Committee, the Pediatric Bioethics Committee, which she chairs, and the Task Force for the joint program with the University of Delaware.

In the painting, Dr. Callahan holds the pediatric stethoscope given to her by her late father-in-law, David H. Goodman, '35, and wears the pin she received from the 1987 Student Council for her interest in their activities.

It is the first Jefferson portrait to be painted by Stephen S. Kennedy, and quite striking, with piercing blues and greens in the fabric and stethoscope, and a delineation of the sitter's forthright, resourceful personality.

The portrait of Dr. Callahan currently hangs in the lobby of Alumni Hall.
One of Thomas Jefferson University’s major leaders over the past two decades was recognized by the presentation of his portrait on June 18. Edward C. Driscoll, a Trustee since 1974 and Chairman of the Board from 1984 to 1990, was given this honor by friends and colleagues.

Mr. Driscoll is the longtime Chairman of the Board and Chief Executive Officer of the L. F. Driscoll Co., a well-known construction firm which undertook such Jefferson buildings as the Medical Office Building and the Bluemle Life Sciences Building.

A Director of Provident National Bank, he is a past Chapter Chairman of the Young Presidents’ Organization and an Arbitrator for the American Arbitration Association. His community service has extended beyond Jefferson; he has served as an Advisory Council member for Wills Eye Hospital, Trustee of Children’s Rehabilitation Hospital, and Director of The Library Company of Philadelphia and International House.

Prior to becoming Chairman of Jefferson’s Board, Mr. Driscoll had chaired its Finance Committee and Health Affairs Committee, and served on the Capital Projects Committee that was responsible for the construction of the Gibbon Building and renovations to Foerderer Pavilion and the Thompson Building. He was a member of the Search Committee in 1977 that recommended Lewis W. Bluemle, Jr., M.D. for University President.

At the portrait presentation, Dr. Bluemle credited Mr. Driscoll with being able to “cut through the nonsense surrounding a complex issue and get to the heart of the matter” during the years they worked together as President and Chairman.

“He was used to looking not only at the forest not the trees, but also at many different forests.

“In advising me on administrative conundrums,” Dr. Bluemle continued with a medical metaphor, “he was a skilled therapist as well as a good diagnostician.”

Three years ago, Mr. Driscoll appointed another Search Committee, the one that recommended Paul C. Brucker, M.D. to be Dr. Bluemle’s successor.

Mr. Driscoll said he felt his most important duty had been to encourage the participation of many new members of the board. Two Trustees spoke at the presentation, Brian G. Harrison and Jack Farber, whom Mr. Driscoll had originally recruited. Mr. Farber credited the former chairman with ensuring the success of the Decade Fund. Mr. Harrison said Mr. Driscoll had made the university “a better place in all senses of the word.”

The painting by Dean Paules has strong verticals, starting at the head very near the top edge of the canvas and extending in resolute lines to the bottom, where Mr. Driscoll’s hand is braced on a book. The subject modestly declared it “flattering—it’s unbelievable I’d ever look like that.”

Dr. Bluemle recalled Mr. Driscoll’s profession and his community service by saying, “When people look at this portrait in the future, they will see a builder par excellence.”

The portrait of Mr. Driscoll currently hangs in the lobby of Alumni Hall.

At the reception: Senior Vice-President and Dean Joseph S. Gonella, M.D.; Cardeza Professor and Director of the Cardeza Foundation Sandor S. Shapiro, M.D.; Trustee Emeritus and The Kind Professor Emeritus of Medicine John H. Hodges, ’39
A New Endowed Chair Honors An Outstanding Career and Ensures Excellence at Jefferson

by Malcolm Clendenin

Professor and Director of the Division of Colorectal Surgery Gerald J. Marks, '49 has been honored by the establishment of the Marks Chair in Colorectal Surgery at Jefferson.

It is a most unusual event—only the second chair of colorectal surgery in the world, and the only one named for a surgeon. Virtually no other chair at Jefferson has been established to honor a practicing alumnus and faculty member. The Marks Chair carries one of the largest endowments of any professorship here.

The professorship was made possible through the generosity of numerous patients and friends of Dr. Marks, in particular Mr. and Mrs. Merrill Seidman, Mr. and Mrs. Jacob Seidman, and the estate of Francis W. Sullivan, Esq.

Dr. Marks says, "The chair came about through the vision of Senior Vice-President and Dean Joseph S. Gonnella, M.D., who realized that clinicians sometimes have contact with patients who have reason to show their appreciation, and the ability to do so on a large scale."

"The establishment of the Marks Professorship," according to Dr. Gonnella, "will allow the medical college to attract an outstanding clinical and research leader to follow in Dr. Marks’s footsteps."

The new Marks Professor will direct the Division of Colorectal Surgery and its residency training program, and will report to Francis E. Rosato, M.D., the Gross Professor and Chairman of Surgery. Dr. Marks will continue to direct the Comprehensive Rectal Cancer Center and the program of rectal cancer management that he initiated in 1976.

That program has matured to comprise over 250 patients, the largest of its kind in the world. Dr. Marks's approach, combining high-dose preoperative radiation and special sphincter-preservation surgical techniques, combats two critical problems: the high incidence of tumor recurrence and the frequent need for a permanent colostomy that results in the loss of normal anal sphincter function. Results have indicated that his methods allow normal function to be preserved in treatment of cancers of the distal rectum, with enhanced local control of disease and enhanced survival rates. His protocol has become standard in many medical centers around the world.

The Division of Colorectal Surgery has undertaken collaborations with other Jefferson departments, including Radiation Oncology, Medical Oncology, Genetics, Pathology, and basic scientists in the Jefferson Cancer Institute. Funding from the National Institutes of Health is actively sought.

Research projects in the division also include one undertaken by a medical student, Jossalyn T. Emslie of the Class of '95, who has received a grant from the American Cancer Society to study prognostic indicators of rectal cancer.

Dr. Marks has a new role as Founding President of the International Federation of Societies of Endoscopic Surgeons. Twelve years ago he had served as Founding President of the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), and this has been the keystone for the development of similar societies around the globe. The federation will provide a framework of interaction for these groups. "The current societies in North America, Europe, and Asia represent roughly 4000 members," Dr. Marks points out, "and with new societies forming in Latin America, Australia, and India, the representation will rise considerably. The federation has an important role in linking surgeons around the world, and ensuring that the evolution of new surgical methods is orderly."

Future challenges for Dr. Marks include ensuring the success of the fourth World Congress of Surgical Endoscopy in Kyoto, Japan in 1994. His hope is that the fifth congress, in 1996, will be held in Philadelphia.

continues on next page
Falk Trust’s $1.5 Million Grant Will Spur Leukemia and Lymphoma Research

Jefferson has received a three-year, $1.5 million grant from the Dr. Ralph and Marian C. Falk Medical Research Trust established by Marian Falk. Ralph Falk, M.D. was a member of the Class of 1907.

Ralph Falk, ’07 Made Intravenous Therapy Safe and Practical

Surgeon Ralph Falk, ’07 transformed the administration of intravenous fluids. At the same time, he probably kindled his wife’s interest in supporting medical research because she witnessed the impact his achievement had on the entire world, said Jefferson President Emeritus Lewis W. Bluemle, Jr., M.D.

Earlier in this century, patients who received intravenous therapy developed chills and high fevers. At that time, ordinary rubber tubing was used to carry fluids from the bottle to the needle in the patient’s arm. It was Dr. Falk who proved that the rubber tubing, not the fluids, was at fault: the chemical impurities in the rubber seeped from the tubing into the fluids, producing the side effects.

After years spent tracking down the answer, Dr. Falk began commercial development of the right kinds of systems with the right kind of tubing, and from this came Baxter Travenol Laboratories.

Dr. Marks’s work has been a spark plug for internationalism at Jefferson. It led to the multidisciplinary scientific exchange that the university has established with the University of Rome. An Italian surgeon has just returned home after gaining new expertise in Jefferson’s Colorectal Surgery Division. Currently the division is host to a Japanese doctor, and a surgeon from Nanjing who won a competitive grant from the Chinese government to undertake further study at Jeff.

Dr. Marks was Jefferson’s first board-certified colorectal surgeon, joining the faculty upon completing internship and residency here. In 1969 he procured the first production-model colonoscope in the country, which gave him the opportunity to be a pioneer in colonoscopy and polypectomy. The world’s first symposium on colonoscopy was sponsored by Jefferson in 1974, and repeated two years later, with extraordinary success.

Dr. Marks also developed the earliest colonoscopy teaching model, made of latex. And he put together the first multi-institution clinical evaluation proving the value of the flexible sigmoidoscope.
The earliest evidence that radiation in high dosages could affect the growth of rectal cancer had been provided in the 1950s by Jefferson’s Simon Kramer, M.D., now the Distinguished Professor Emeritus of Radiation Oncology and Nuclear Medicine. These findings ultimately led to Dr. Marks’s establishment of the present rectal cancer program with Dr. Kramer and Mohammed Mohiuddin, M.B.B.S., Professor of Radiation Oncology and Nuclear Medicine, in 1976.

Dr. Marks established Jefferson’s colorectal surgery residency program, which was the first such residency to be on-site in the primary academic hospital, rather than an affiliated institution.

Dr. Marks is a member of the Executive Committee of the Alumni Association, and founding Secretary and past President of Jefferson’s Volunteer Faculty Association.

Among his honors are an annual lectureship named after him in the Society of American Gastrointestinal Endoscopic Surgeons. He served as an Associate Editor of Diseases of the Colon and Rectum and Editorial Consultant for the New England Journal of Medicine, and is Senior Editor of Surgical Endoscopy, Ultrasound, and Interventional Techniques. His numerous past posts include Vice-President of the American Society of Colon and Rectal Surgeons and President of the Pennsylvania Society of Colon and Rectal Surgery. He chaired the Publications Committee and the Public Affairs Committee, and served as Vice-President, of the Philadelphia County Medical Society.

When not involved in medicine, Dr. Marks plays tennis and paints in watercolors. He has had shows in the United States and abroad. In his waiting room are his landscape paintings of far-flung countries to which he has traveled. Dr. Marks and his wife, Barbara, live in Penn Valley and have three sons, including Richard M. Marks, ’88 and John H. Marks, ’89.

The endowment fund remains open for the Gerald J. Marks Professorship. For further information, please contact the Development Office.

### Nobel Prizewinner Baruch S. Blumberg, M.D., Ph.D., Master of Balliol College, Oxford University, gave a seminar for Jefferson students during a recent visit to campus.

### Dr. Wilkinson, from page 18

Pediatricians in private practice is concentrated in major cities: Pensacola, Panama City, Tallahassee, Gainesville, and Jacksonville. Over 25 percent of those under age 18 in the region are supported by incomes below the federal poverty level, yet most private physicians who practice in the area do not accept Medicaid for indigent patients. Teenage pregnancy rates are well above the state average and teenage mothers who do not receive adequate prenatal care are more likely to have low-birth-weight babies. Fifteen of the 41 counties with over 51,000 children did not have a pediatrician. In 35 of the counties the ratio of pediatricians to children was below the recommended ratio set by the American Academy of Pediatrics, which is one to 2500.

The clinics are private, freestanding operations, funded by a private foundation. Each consists at a minimum of a pediatrician, a pediatric nurse practitioner, and an administrative support person, who work in a modern, computerized office linked to the clinic in Jacksonville and its staff of pediatric subspecialists. To prepare clinic buildings, either vacant storefront properties or existing office spaces were leased. Each is equipped to handle most pediatric emergencies, and has an office laboratory and equipment for vision screening. Approximately 1800 square feet of space are designed to accommodate a pediatrician and pediatric nurse practitioner seeing 30 to 40 patients per day.

During recruitment a satellite physician profile evolved. Three of the current physicians are female and all seven have a strong altruistic side to their personalities. They enjoy small-town life, often because of their childhood experiences. Most of their spouses also come from rural areas. Pediatricians at the satellite clinics have greater autonomy than a single member of a group practice, coupled with Nemours support for their freedom of action. The Nemours program addresses many social problems that result from high rates of poverty and illiteracy. When the physician and nurse practitioner cannot address these problems directly, they are committed to networking and acting as child advocates with other community agencies.

Will we make a difference? In the next three years, certain health care and social parameters will be measured for outcomes, such as infant mortality, teenage pregnancy, child abuse, and physician and nurse practitioner retention. Immunization rates, clinical protocol outcomes, emergency room visits, hospital admissions, and cost effectiveness will also be studied. The goal of the Nemours Foundation is to establish a model that can be duplicated for rural children on a national basis. With this philosophy and the successes in Florida, the Nemours board announced in 1991 that it would replicate the model in rural Delaware by providing care for children in underserved areas. Each satellite clinic physician is proof that one doctor can make a difference.
Inaugural Grandon Lecture Brings to Campus Dr. Todd of the AMA
by Malcolm Clendenin

James S. Todd, M.D., Executive Vice-President (and chief executive officer) of the American Medical Association, delivered the first of the annual lectures on health policy established by Dr. and Mrs. Raymond C. Grandon, '45. Dr. Todd said he was "very pleased to be speaking at Jefferson, which has some marvelous alumni and marvelous activities."

One of the benefits of the new lecture-ship is that it brings to campus distinguished physicians who talk informally with students. While Dr. Todd was here, he also met with some of Jefferson's senior residents.

Since his appointment to his new AMA post in 1990, Dr. Todd has been able to steer the agenda nationally toward discussion of health policy. He has made the "Journal of the American Medical Association" a vehicle for health policy ideas. A top priority has been formulating and promoting the AMA's program to ensure that the more than 30 million Americans who are uninsured or underinsured will have access to affordable, quality health care.

"Managing medical progress," he said in his lecture, "is becoming more and more difficult with exploding medical technology, because we are uncovering vast information that we don't fully understand yet."

The intelligent rationing of care, Dr. Todd believes, may be necessary to avoid focusing the nation's limited health care resources on a few individuals. Five percent of U.S. citizens consume 50 percent of the country's health care, and half of all health care dollars are spent on patients very near the end of their lives, while at the same time basic care is unavailable to many of the poor and a growing part of the middle class.

Physicians must not use technology just because it exists, Dr. Todd emphasized. They must only perform procedures and tests that according to outcome studies are likely to be beneficial. They must constantly ask, is there a more cost-effective way to achieve the same result?

Attention should be paid to the healthiness of every individual's social environment, he said. "We in the United States have done a good job providing for physical well-being, but not always for moral and spiritual health, though these are in the definition put forth by the World Health Organization. Our shortfalls can be seen in events such as the violence that breaks out periodically in this country."

More attention must be given to medical education. "As they learn more, physicians have an obligation to reach back to their medical schools. Schools should maintain the sense of collegiality and tap this huge resource, their graduates." The practitioners in the field will benefit. "Doctors need an umbilical cord to the medical school. Primary care physicians, especially in rural areas, are too often cut off from new ideas."

Dr. Todd called for more self-governance by physicians. "Everyone must be involved in the affairs of the profession as well as be a good doctor. Standards of conduct should be determined from within the profession, not from outside. Physicians have begun to lose this right because they haven't exercised it."

Dr. and Mrs. Grandon's establishment of the new lectureship at Jefferson is promoting the discussion of these important issues. □
The Young Investigator

Jefferson Faculty Make Significant Discoveries About HIV

In research that they describe as an example of clinicians and basic scientists working together, Jeff faculty members have made significant findings about AIDS.

In the May 21 issue of the New England Journal of Medicine, Omar Bagasra, M.D., Ph.D., Research Associate Professor of Medicine, and Roger J. Pomerantz, M.D., Associate Professor of Medicine, demonstrate that the actual number of virus-infected cells in patients who test positive for HIV may be up to tenfold greater than previously thought.

"It has been difficult to understand why AIDS has such devastating consequences," Pomerantz comments, "because the virus has been reported to infect only one percent of its target blood cells (T4 lymphocytes, monocytes, and macrophages). This led us to develop a new laboratory technique to discover the true incidence of infected cells in AIDS patients." Measuring the total amount of virus within the patient is a way of evaluating potential treatments.

Bagasra and Pomerantz, in their own words, "piloted a new, more sensitive variation of the PCR (polymerase chain reaction) test that is commonly employed in HIV testing and research. With HIV, the amount of virus in each cell is so small that it is difficult to measure directly, so the virus DNA must be amplified. In traditional PCR, the cell is destroyed, and the DNA is removed and amplified in a test tube.

In the researchers' in situ PCR, the chance of detecting existing virus is much greater, because the amplification procedure is actually performed within the cell without destroying it. In this way, there is less potentially destructive manipulation of the DNA, leading to a much more sensitive and accurate test result. Furthermore, since the investigator is working within the cells themselves, it is possible to pinpoint more precisely which cells are infected with the virus.

In this study, Bagasra, Pomerantz, and their associates studied 56 adults known to be infected with HIV and 11 noninfected individuals. None of the noninfected individuals tested positive for HIV using this technique, which validates the test as very specific. All 56 infected patients tested positive, showing that the test is very sensitive.

In the 19 HIV-infected patients who showed no symptoms, the number of infected cells ranged from 0.1 percent to 3.6 percent. In those who showed symptoms of AIDS, the proportion of involved cells ranged from 1.2 percent to 13.3 percent. This is much greater than was indicated by previous studies, which generally have suggested that only one percent of circulating cells were infected with the virus.

Pomerantz also feels that the new technique is more sensitive because it detects latent virus that is not actively reproducing within cells. "From this study, it is evident that most HIV-infected cells are dormant," he says. "This knowledge is important, because drugs such as AZT inhibit only the actively reproducing virus. This study demonstrates that there is still a huge reservoir of cells that can pump out virus. We must deal with latently infected cells if we want to cure AIDS."

The new technique could become a useful research and diagnostic tool, since one can detect various genetic disorders, aberrant genes, cancer genes, and infectious agents more accurately and rapidly.

Bagasra and Pomerantz have also recently discovered a way to keep HIV type 1 in an inactive, dormant state in cultured cells. Their findings appear in the July 15 issue of Proceedings of the National Academy of Sciences.

"This is an important step in understanding the infectivity and latency of HIV," says Pomerantz. "Our goal is to help turn HIV into a chronic disease, such as diabetes or heart disease. By maintaining HIV in a dormant state, we may be able to help people who are infected with the virus live longer, healthier, and more productive lives."

The study provides new information that helps explain how certain infections may accelerate the disease process. The authors also identify cofactors necessary for viral production in certain cell types, and suggest practical ways of blocking viral replication in cells and thus slowing the disease process.

It was initially thought that HIV was harbored only in lymphocytes. It has since been found that the virus infects other cell types, including monocytes, which may be found in either blood or solid tissue such as the liver and the brain. In monocytes, small amounts of HIV may lie dormant, causing no active disease in the patient.

However, Bagasra and Pomerantz and their coworkers found that when monocytes in culture are exposed to endotoxin, a product of certain bacteria that often cause human infections, the HIV within the monocytes begins to multiply and can thus exacerbate a patient's disease. The researchers found that only monocytes with a specific protein, CD14, present on their surface were stimulated by endotoxin. This led them to attempt to use an antibody directed against CD14 to prevent viral replication. When they exposed cells in culture to such an antibody, and then to endotoxin, the HIV in the cells did not multiply.

"Our team is pleased to demonstrate that this monoclonal antibody against CD14 is so effective against viral replication," Pomerantz declares. "Although these findings have so far been confirmed only in cultured cells, we hope that this theory can be applied to humans infected with the virus. If so, it will be the first technique for maintaining the virus in an inactive state in an infected individual." □
Researchers Here “Design” Bacteria That Can Identify Anti-AIDS Agents

Jefferson researchers have developed a promising assay that uses “designer” bacteria to screen for anti-AIDS compounds and to isolate mutant bacteria that may also produce such compounds.

Designer bacteria are bacteria the genetic structure of which has been altered in the laboratory.

The new assay is “safer, faster, and more suitable for mass screening than existing cell-culture and biochemical assays,” says Timothy M. Block, Ph.D., Associate Professor of Microbiology and Immunology and principal investigator in the study.

This line of research has the potential for broad application. “We’ve designed it for the AIDS protease, but the bacteria can be designed to screen a host of other agents aimed at other viruses and medically important targets,” he states.

“Standard means of developing antiviral agents involve growing live viruses in tissue culture—a process that may involve some hazard to researchers from the virus itself. Moreover, many of these assays are very complex and demand a high degree of technical sophistication, which makes them time-consuming and costly.”

One benefit of the new assay is that instead of using the AIDS virus itself, the assay uses the AIDS virus protease, which, although harmless, is necessary for the AIDS virus’s growth.

For the assay, Block’s team has designed bacteria that can’t grow in the presence of the AIDS protease.

“To test a compound’s ability to inhibit the growth of the AIDS protease, we mix the compound with the specially designed bacteria, which can grow only if the AIDS protease is prevented from functioning,” he explains.

“Preliminary findings indicate that we can determine in a matter of hours whether or not the bacteria are growing. If they do grow, the compound being tested may be effective against the virus. If not, the compound is ineffective.”

Only further testing, Block states, would reveal whether the compound effective against the AIDS protease would be effective against the AIDS virus itself.

The scientists have noted that under certain conditions, mutant bacteria emerge. Block says, “The beauty of this system, besides its simplicity and lower cost, is that it allows us to identify the mutant bacteria, which are potentially capable of producing as-yet-unknown inhibitors of the AIDS virus protease.”

Adapted by permission from JeffNEWS, June 8, 1992

Major Conference on the Molecular Biology of Matrix

The fourth international Conference on the Molecular Biology and Pathology of Matrix, sponsored by Jefferson’s Institute of Molecular Medicine, attracted more than 250 experts from all over the world. Renowned researcher Steven L. McKnight, Ph.D., of the Howard Hughes Medical Institute and the Carnegie Institute of Washington, delivered the keynote lecture, “C/EBP—A Regulatory Protein That Catalyzes Terminal Cell Differentiation.” Among the other speakers were Klaus Kuhn, Sherrill Adams, Richard Mayne, and Benoit de Crombrugghe. Topics included osteoporosis, osteoarthritis, liver cirrhosis, pulmonary fibrosis, and blood vessel diseases such as aneurysms.

Darwin J. Prockop, M.D., Ph.D. (below), Chairman of Biochemistry and Molecular Biology, chaired the session at the Matrix Conference on “Mutations in Collagen Genes and Their Consequences.” Dr. Prockop was recently named a member of the Institute of Medicine of the National Academy of Sciences. He also has been selected to serve the Federation of State Medical Boards as a committee member for the United States Medical Licensing Examination.

Honors for the Liver Transplant Program

Michael J. Moritz, M.D., Associate Professor of Surgery and Director of the Division of Transplantation, and Santiago Muñoz, M.D., Associate Professor of Medicine and Medical Director of the Liver Transplantation Program, have been honored by the American Liver Foundation. Dr. Moritz was named Physician of the Year. Dr. Muñoz is the first, along with Christopher O’Brien, M.D. of the University of Pennsylvania, to receive the foundation’s Young Investigator of the Year award.
On Campus

Jefferson has established the Lennox K. Black International Prize in Medicine through a $1 million grant from Mr. Black, a trustee. The objective of the prize is to identify leading medical scholars around the world, and strengthen their links to Jefferson. Each year an individual under 50 years of age will be invited to Jefferson for a three-month visit.

Robert S. Blacklow, M.D. has stepped down as Senior Associate Dean in order to become President and Dean of Northeastern Ohio Universities College of Medicine. The university will miss his many talents, yet Jefferson is honored by this former administrator's attainment of such a leadership post.

Dr. Blacklow has published extensively on medical education and medical ethics. He made many innovations in Jefferson's educational programs. Before joining the university in 1985, he had served in top positions at Rush Medical College and Rush-Presbyterian-St. Luke's Medical Center, and previously had been a faculty member and administrator at Harvard Medical School.

The twenty-first annual Symposium on Care of the Professional Voice was cochaired by Robert T. Sataloff, M.D. '75, D.M.A., Professor of Otolaryngology and Director of the Arts Medicine Center. During the six-day program, researchers from around the world discussed topics ranging from anatomy of the voice, to treatment of spasmodic dysphonia, to results of laser surgery.

Chairman of Pediatrics Robert L. Brent, M.D., Ph.D. received special honors in April from Western China University of Medical Sciences and Bethune University of Medical Sciences, also in China.

Professor of Anesthesiology Rudolph de Jong, M.D. received the annual Nils Lofgren Award of the American Society of Regional Anesthesia for outstanding contributions to the field. Dr. de Jong is widely recognized for his research on regional and local anesthesia, and pain management. The award is named for the Swedish pharmacologist who discovered lidocaine and was involved in studies that led to the introduction of xylcaine.

Assistant Professor Adam E. Flanders, M.D. is one of only six radiologists nationwide to be designated a Scholar of the Radiological Society of North America. This comprises a two-year, $90,000 award which Flanders will use to study "Uses of Magnetic Resonance Imaging in Assessing Severity and Forecasting Outcomes of Spinal Cord Injury."

Professor of Radiology Barry B. Goldberg, M.D. has received the Joseph H. Holmes Clinical Pioneer Award from the American Institute of Ultrasound in Medicine. This year, more presentations at the annual meeting of the AIUM were made by Jefferson faculty than by any other institution.

Senior Vice-President and Dean Joseph S. Gonnella, M.D. presented "The Challenges in Measuring Educational Outcomes" at the Fiftieth Anniversary Conference of the Liaison Committee on Medical Education, sponsored by the Association of American Medical Colleges and the American Medical Association.

Clinical Assistant Professor of Medicine Mark G. Graham, M.D. has been elected President of the Philadelphia Occupational and Environmental Medical Society for a two-year term. The society is the second-largest component of the American College of Occupational and Environmental Medicine.

Directors of Health Policy and Clinical Outcomes David B. Nash, M.D., M.B.A. has been appointed to the Users Advisory Group of the Joint Commission on Accreditation of Health Care Organizations.

Among the ways that Jefferson house staff receive recognition to their mentors is the Robert Waelder Award for "outstanding teaching in psychiatry." This year's graduating residency class conferred it upon Clinical Professor Harvey J. Schwartz, M.D.

Chairman of the Department of Ophthalmology William S. Tasman, M.D. is currently chairing the American Board of Ophthalmology.

Honorary Clinical Professor of Medicine F. William Sunderman, M.D., Ph.D. has had a seminar room named after him at the Bermuda Biological Station for Research.

Clinical Assistant Professor of Medicine David S. Prince, M.D., Instructor in Surgery Gordon S. Clement, M.D., and Adjunct Instructor in Medicine Ronald B. Barnett, M.D. have published "Pulmonary Changes After Laparoscopic Cholecystectomy" in Surgical Laparoscopy and Endoscopy, vol. 2 no. 2.
Class Notes

Faculty

John E. Deitrick, M.D., former Magee Professor and Chairman of Medicine, was regretfully in an auto accident this past year, but his condition has improved. Alumni can contact him at Nottingham Village, Strawberry Rd., Northumberland, PA 17857.

Gabriel E. deCicco has been appointed to the board of RSVP, the Retired Senior Volunteer Program in Youngstown, Ohio.

Victor P. Satinsky has received his black belt in the martial art of aikido at age 79.

Abraham G. Eisner has been named “Man of the Year” by the Jewish Community Center of Scranton, Pennsylvania.

John A. Pfister was recently presented with the “Fifty Years of Medical Service Award” from the Pennsylvania Medical Society.

Harry M. Burros, having retired as Chairman of Urology at The Graduate Hospital in Philadelphia, is now Medical Director of Utilization Management there.

David G. Simons just returned from Kazan, Russia where he attended the Second International Congress of Vertebroneurology. There he met the noted Russian neurologist, Georgy Ivanichev, “who has spent many years studying myofascial trigger points and has made remarkable progress in understanding them.” Dr. Simons was gratified to see that the Russian edition of the text he co-authored, The Trigger Point Manual, has had a wide circulation.

Richard A. Ellis, “instead of retiring, is adding more activity” by opening another office, this one in Bala Cynwyd, Pennsylvania.

L. Roy Newman has been active on the Physicians’ Steering Committee of the Albert Einstein Society, which supports research projects and diagnostic and treatment facilities at Albert Einstein Medical Center in Philadelphia.

Robert E. T. Stark wrote the article on obesity for Conn’s Current Therapy, 1992, and continues to chair the American Society of Bariatric Physicians.

William B. Holman has retired from private practice but still serves as Health Commissioner and Coroner for Huron County, Ohio.

Simón Piovanetti hosted Jefferson’s Chairman of Pediatrics Robert L. Brent, M.D., Ph.D. when Dr. Brent spoke recently at Puerto Rico’s Ashford Presbyterian Community Hospital. Dr. Piovanetti is a former Director of Pediatrics, and President of the Continuing Medical Education Committee at the hospital.

Dr. Piovanetti and his daughter Ivette, also a pediatrician, welcome Dr. and Mrs. Brent.

Arthur N. Avella has retired after 11 years as Chief Executive Officer and Medical Director of Essex County Hospital Center in New Jersey, but continues as a consultant to the state Board of Medical Examiners.

Joseph Hodge’s book Surgical Anatomy, which he coauthored with the late John E. Healey, M.D., has been translated into Indian and Korean and is being sold in 24 countries outside of North America.

John M. Levinson weighed anchor in July serving as ship’s surgeon on an expedition to the North Pole on a Russian nuclear icebreaker. Closer to his Delaware home, Dr. Levinson has coauthored Shorebirds: The Birds, the Hunters, the Decoys, published by Cornell Maritime Press.

Joseph F. Centrone has been elected Chief of Staff for the Voorhees, Camden, and Berlin Hospitals of West Jersey Health System.

An Alumni Directory is in the Works

Look for a questionnaire this fall to verify information for a new Jefferson Medical College alumni directory. It will be produced by the Harris Publishing Company, which has a remarkable tradition of producing directories for numerous well-known schools. The new guide will be a handy way to look up fellow Jeffersonians’ addresses, phone numbers, and more. Harris promises that information will be kept confidential except for use in the directory, which will be available only to alumni who order one.

Leonard J. Graziani has been named by Philadelphia Magazine as one of the most highly regarded pediatricians in the Philadelphia area, as has J. Ronald Halenda, ’57.

Benjamin Bacharach was mistakenly described in the Spring Alumni Bulletin as having been inducted into Muhlenberg College’s Alumni Physicians Hall of Fame. In fact, he was among those who helped to select the first Hall of Fame members, among whom were Kenneth N. Beers. In other matters, Dr. Beers writes that he married Cecil Mae Mutter last December 26.

C. Robert Jackson was honored at a Farewell Open House in April at the medical group where he has practiced in Madison, Wisconsin. He had served for several years on its Board of Directors and on the Peer Review Council for the Board of Governors of the State Liability Insurance Plan.

Patrick S. Pasquariello, Jr. has been honored by the establishment of the Pasquariello Chair in General Pediatrics at the Children’s Hospital of Philadelphia. Dr. Pasquariello has served that hospital for more than 30 years, serving as Director of its Diagnostic Center, a resource for community physicians who wish to refer patients to Children’s Hospital for complex conditions or hard-to-diagnose disorders. He also led the hospital’s continuing education program for 10 years. His other activities have included two terms as President of the Philadelphia Pediatric Society. Dr. Pasquariello is a second-generation Jeffersonian, following in the footsteps of his father, Patrick S. Pasquariello, ’29.
"Every Person Deserves and Needs Someone to Call ‘My Doctor’"

Tall, with a warm smile that puts people at ease, Max J. Stierstorfer, Jr., ’53 is a man of hard work and few hobbies. Bird watching in his yard and at his seaside cottage near a bird sanctuary tops the list.

Dr. Stierstorfer has been a fixture for almost 40 years in Midway Manor, Pennsylvania, where the residents are vocal in their praise of him. He endeared himself to the community treating people without charge when they were out of work.

In recognition of Stierstorfer’s community service, the Community Association renamed its newly equipped playground for him at a dedication June 14.

Stierstorfer calls medicine “one of the most intriguing ways to spend your days,” but warns that it can become a “seductive mistress” if one succumbs to greed. He feels the profession has an obligation to the poor. He’d like all physicians to share in caring for the indigent as “private patients on a long-term basis. Every person deserves and needs someone to call ‘my doctor.’”

His experiences at Jefferson, when he lived near a poor section of Philadelphia, taught him this.

Stierstorfer recalls that John H. Gibbon, Jr., ’27, the Gross Professor and Chairman of Surgery, emphasized the need of the people to his students. He would bring in poor patients as examples. “When they took their shirts off, the lice would fall off. But Gibbon treated them like royalty. It gave us a sense of caring. At Jefferson our teachers preached, ‘Treat the people at a price they can afford.’”

Stierstorfer worked his way through medical school, spending summers on a construction crew building the New Jersey Turnpike. After internship, he worked in an area of “ramshackle shacks. Those people were not really getting their share of anything. They were overwhelmed by poverty and malnutrition, yet were always extremely grateful.”

Nowadays even his favorite pastimes, like sitting in on lectures at major medical centers, are an extension of work. “I hope I’ll always maintain a position treating a few people.”

Adapted by permission from the Allentown Morning Call, June 25, 1992

Drawing Attention to the Health Effects of Air Pollution

Robert M. Zweig, ’52 has had an increasing interest in health effects of air pollution since 1971, when he was elected President of the Riverside County, California Medical Association, and began to learn about the results of smog, which was steadily increasing in the South Coast Air Basin. His research into the components of smog even brought him to the makeup of fossil fuels and tailpipe emissions.

In 1974, attending the first meeting of the International Association of Hydrogen Energy, he found that although many countries are developing the use of hydrogen, few are interested in using it as an automotive fuel to combat air pollution. Ever since then he has been teaching about the health effects of pollution. He has appeared on the television program Nova on the subject of alternate fuels, and has been invited to speak as far afield as Beijing, Zurich, Vienna, and Moscow. He brought a prototype hydrogen-powered bus to his own community for a year.

A Director of the American Lung Association of California, Zweig received the Clean Air Award in 1991 from the South Coast Air Quality Management District. And he’s not about to slow down. In June he presented papers in Florence, Italy and in Paris at the annual meeting of the International Association of Hydrogen Energy.

Richard T. Price received the first annual Health Professional Exemplar Award from the Bucks County unit of the American Cancer Society.

‘59

Kenneth P. Johnson, Jr. continues to chair the Department of Neurology at the University of Maryland School of Medicine.

‘60

Herbert D. Kleber is serving as Executive Vice-President of a policy center in New York City, the Center on Addiction and Substance Abuse (CASA), which he founded with former U.S. Secretary of Health, Education, and Welfare Joseph A. Califano, Jr.

Mrs. Ulysses E. Watson, widow of Dr. Watson, is pleased to report that four of their children are now doctors, their daughter June having just graduated from the University of Cincinnati College of Medicine. Daughter Maria J. Watson, ’90 will be returning to Jefferson in July 1993 for a fellowship in rheumatology.

‘63 Thirtieth Reunion June 4–6, 1993

Charles Markosi, Jr. has joined the staff of Wernersville State Hospital.

‘64

Eli O. Meltzer has been designated “Master in Allergy” by the American College of Allergy and Immunology. This included being featured in the publication Masters in Allergy, which is published in cooperation with the ACAI. Among the 12 physicians who have previously been honored in this way is Herbert C. Mansmann, Jr., ’51. Dr. Meltzer is currently a Clinical Professor of Pediatrics at the University of California at San Diego, Chief of Allergy and Immunology at Children’s Hospital of San Diego, and President of the Joint Council of Allergy and Immunology.

‘67

George E. Cimochowski will present his video on selective cerebral perfusion in dissecting aneurysms at the meeting of the European Association for Cardiothoracic Surgery in Geneva in September. The video demonstrates a technique in which the brain is perfused separately from the heart, using a warm solution to preserve the heart while replacing the diseased aorta. Dr. Cimochowski will also present the video at the American College of Surgeons annual meeting in New Orleans in October.

Paul P. Slawek received a J.D. degree from Widener University Law School in June, and took the Pennsylvania Bar Examination in July.

‘68 Twenty-fifth Reunion June 4–6, 1993

Marcia A. Fitzpatrick has been promoted to Clinical Assistant Professor of Surgery at Jefferson.
Mark Nissenbaum has been appointed a Clinical Professor of Orthopaedic Surgery at Temple University, and continues as Chief of Hand and Microsurgery at Abington Memorial Hospital.

William D. Bloomer has been appointed Professor of Radiology at Northwestern University Medical School, Chairman of Radiation Medicine at Evanston Hospital, and President of the Radiation Medicine Institute. At the institute, Dr. Bloomer is developing a major research program on new methods to diagnose tumors more quickly and new drugs to improve patient responsiveness to both radiation and chemotherapy treatment.

Allan P. Freedman continues in a pulmonary group practice at Presbyterian Medical Center in Philadelphia and Jeane’s Hospital, with a special interest in occupational lung disease. At Presbyterian he directs the Pulmonary Function, Exercise, and Research Laboratories.


Frederick B. Wagner, Jr., ’41 and J. Woodrow Savacool, ’38 have edited Thomas Jefferson University: A Chronological History and Alumni Directory, a second volume that complements their Thomas Jefferson University: Tradition and Heritage, published in 1989. The new book lists every graduate of the university between 1824 (Jefferson’s founding) and 1990, including those who came here for residencies and fellowships. The 1,300 pages contain more than 1,200 illustrations from the Archives. The book is available for $70 (including postage and handling) from the Jefferson bookstore, 224 S. Eleventh St., Philadelphia, PA 19107, (215) 955-7922.

Available at the Jeff Bookstore: Second Volume of Jeff History

A Biography of Dr. Gibbon


One of the most important new chapters is “Confidentiality,” written by David Joseph, a clinical psychiatrist, and Joseph Onek, an attorney with the firm that represents the American Psychiatric Association. Confidentiality is one of the most important ethical issues in the treatment of patients, especially in psychiatry. Most of the other chapters have subheadings relating to the problems of confidentiality in their particular areas: child psychiatry, geriatric psychiatry, sex therapy, involuntary commitment, and psychiatric research. Break of confidentiality may lead to a malpractice lawsuit. Psychiatrists are especially concerned about protecting the confidentiality of the doctor-patient relationship. Nonpsychiatric physicians should pay particular attention to this very delicate and sensitive aspect of general medical treatment.

Robert L. Sadoff, M.D., University of Pennsylvania School of Medicine

When I reviewed the first edition of Psychiatric Ethics for JAMA a decade ago, I referred to it as “a most important book in psychiatry” and recommended it be read by every serious student of the field “wishing to provide the highest quality of care within the highest principles of medical ethics.”

I am pleased to note that the second edition is an even finer compilation of readings in psychiatric ethics. The book has grown from 365 to 556 pages and has added six new chapters. In addition to the original series of excellent presentations, the second edition has added the chapters “Psychiatry as a Profession,” “The Concept of Disease” (which should be of interest to all physicians), “The Ethics of Deinstitutionalization,” “Ethics and Psychogeriatrics,” “Psychiatry in the Nazi Era,” and “Ethical Issues in the Delivery of Mental Health Services: Abuses in Japan.”

Structurally, the original chapters have been left fairly much intact but have been appropriately updated by their original authors for the most part. Some new authors have replaced others. Most notably, Robert Miller presents his chapter “The Ethics of Involuntary Commitment to Mental Health Treatment,” which replaces one by the late Louis McCarr and Paul Chodoff, “The Ethics of Involuntary Hospitalization.” The difference in the title is not merely semantic but reflects the major changes that have occurred in the involuntary commitment of patients, not only to hospitals, but to other mental health facilities or to outpatient treatment.

That chapter is followed by Roger Peele’s “The Ethics of Deinstitutionalization,” another very important change in the treatment of the mentally ill that has affected all segments of our society.

Journal of the American Medical Association. 1991;266:3350. Copyright American Medical Association
Thomas Mullins has been named Clinician of the Year by the Fallon Clinic in Worcester, Massachusetts.

Dr. Mullins

Theodore Zukoski has received an award for service to children and families from the Council for Exceptional Children, Chapter 416. Dr. Zukoski has been active in such organizations as Help Stop Environmental Lead Pollution (HELP) and Citizens' Alert Regarding the Environment (CARE).

Thomas F. Mullins has been named Clinician of the Year by the Fallon Clinic in Worcester, Massachusetts.

Arthur Sitelman has been active in the College of American Pathologists, serving as a Laboratory Accreditation Inspector, as Chairman of the AIDS Task Force and the Infection Control Committee, and as Vice-Chairman of the Career Services Committee.

Gary B. Barnett has been appointed Chief of Service in the Gerontology Section at Delaware County Memorial Hospital.

W. Edward Jordan III has joined the hematology and oncology staff at Berwick Hospital Center.

Frederic B. Kremer has been cited by Drexel University as one of its "Top 100 Graduates" among the 65,000 who have received degrees from the college. Dr. Kremer has made many innovations in eye surgery.

Paul R. Long and his wife, Peggy, are delighted at the birth of Timothy Matthew on May 22.

Gary B. Barnett

William C. Konchar has opened an office in Spring Grove, Pennsylvania.

Dr. Konchar

June 4, Friday
Alumni Banquet

June 5, Saturday
Women's Forum, Clinic Presentations, Dean's Luncheon, Campus Tours, Reunion Parties

June 6, Sunday
Farewell Brunch

‘72

‘73 Twentieth Reunion June 4–6, 1993

Eric W. Blomain has been elected Vice-President of the Pennsylvania Plastic Surgery Society, known as the Ivy Society.

Charles L. Liggott, Jr. has earned an M.B.A. from the University of South Florida "in order to make my professional career more efficient and satisfying." He wrote his thesis on the advanced automation of a general and vascular surgery practice, and continued to practice while working on this degree.

Joseph W. Sassani has been elected President of the Pennsylvania Academy of Ophthalmology.

Dr. Sassani

‘75

Mark L. Dembert is serving as a Captain in the Navy Medical Corps and a staff psychiatrist at the National Naval Medical Center in Bethesda, Maryland.

Robert T. Sataloff and his wife, Dahlia, are the proud parents of twins born January 28 and named Benjamin and Johnathan (with a unique spelling).

Dr. Sataloff

Warren L. Robinson, Jr. and his wife, Lee, are the proud parents of Paige, now nearly one year old, and is Cally Donnan Rosenberg, daughter of Kenneth C. Rosenberg and his wife, Frances.

Frank J. Yohe is serving as Medical Staff President at Meadville Medical Center.

‘79

Robert S. Djergaian has received the Distinguished Alumnus Award from Marple Newtown High School in Delaware County, Pennsylvania.

Catherine Z. Hayward has been appointed a Clinical Assistant Professor of Surgery at Jefferson.

‘80

Thaddous S. Nowinski and his wife, Mary, are the proud parents of Olivia Anne, now one year old.

‘81

Scott M. Kennedy is working in Nairobi for the U.S. State Department as medical attaché for East Africa.

David M. Mannino III is now working in Atlanta at the Centers for Disease Control, in the National Center for Environmental Health and Injury Control. He and his wife, Brenda, were thrilled at the arrival of Olivia Sewell Mannino last September 26.

Kevin A. Mansmann has joined the staff of Paoli Memorial Hospital.

‘82

David B. Massey and his wife, Wendy, are the proud parents of Daniel, born February 10.

John A. Wilson, Jr. has joined the staff of Canonsburg General Hospital.

‘83 Tenth Reunion June 4–6, 1993

Aaron D. Bleznak has been appointed a Clinical Assistant Professor of Surgery at Jefferson.

Thomas Carnevale has joined the Clearfield Hospital medical staff in Clearfield, Pennsylvania.

Jeffrey A. Freed will be joining the pathology department at Foothill Presbyterian Hospital in Glendora, California.

Paul F. Mansfield has been appointed an Assistant Professor of Surgery at the University of Texas at Houston and M.D. Anderson Cancer Center.

Samuel H. Markind and his wife, Dina, are the proud parents of Simeon, now nearly one year old, as is Alison Blair Sailer, daughter of Dale W. Sailer and his wife, Jeanine.

‘84

Angela M. DeAntonio has been board certified in critical care medicine.
Named Editor of the AMA’s New Journal

Marjorie A. Bowman, ’76 has been appointed Editor of the American Medical Association’s new journal Archives of Family Medicine, which begins publication in September with a pilot issue. A second issue is scheduled for November and monthly publication begins next January.

Dr. Bowman chairs the Department of Family and Community Medicine at Bowman Gray School of Medicine in Winston-Salem, North Carolina, and is the current President of the Society of Teachers of Family Medicine.

She is a product of Jefferson’s five-year accelerated program with Pennsylvania State University, from which she received her B.S. After a family medicine residency at Duke University came a master’s degree in public administration at the University of Southern California’s Public Affairs Center in Washington, D.C. Prior to her appointment at Bowman Gray, Dr. Bowman taught at Georgetown University School of Medicine, becoming Director of its Division of Family Medicine.

She has served as Reviewer or Editorial Board member for numerous journals, including American Family Physician and the Journal of the American Board of Family Practice. Dr. Bowman has received grants to establish training in family medicine, and has served as Co-Principal Investigator on a large grant to study “Physician’s Prevention of STD/HIV Infection.”

Appointed to an Endowed Chair at Sloan-Kettering

William R. Fair, ’60 has been named to a newly endowed chair at Memorial Sloan-Kettering Cancer Center, the Florence and Theodore Baumraver/Enid Auncell Chair of Urologic Oncology. Dr. Fair, the Chief of the center’s Urology Service, is a leader in the application of new surgical techniques, including one that uses a section of a patient’s small intestine to fashion an internal replacement for a removed cancerous bladder, thereby allowing the patient to void normally without the use of catheters.

Dr. Fair’s research focuses on factors influencing the growth of prostatic tumors, and is aimed at discovering how the body often limits the growth of these tumors while they are still very small. He is also working to develop new combined-modalitity treatments that ease surgery by first shrinking tumors of the prostate or bladder. And he is overseeing the establishment of Sloan-Kettering’s new Prostate Cancer Diagnostic Center, which will track individuals at high risk of this cancer.

Working with Washington Leaders to Increase Awareness of Prostate Cancer

This past April 9, approximately 200 prostate cancer patients, spouses, physicians, staff, and members of the United States Congress met at the Capitol in Washington for the quarterly meeting of the US TOO group from Walter Reed Army Medical Center. Staff leader of the group as usual was Judd W. Moul, ’82, a urologic oncologist at Walter Reed. Two well-known new members of the group, Senators Robert Dole of Kansas and Ted Stevens of Alaska, had opened their offices for the meeting. With many members of the national press in attendance, the session served to increase public awareness and encourage research support for prostate cancer, now the most frequent cancer in men in the United States.

Other Congress members present included Senators Alan Cranston of California and Strom Thurmond of South Carolina. Patients had come from as far away as Arizona.

Administrators from the National Cancer Institute, including NCI Deputy Director Daniel Ihde, M.D., were present along with Arthur Keeney, Executive Director of the American Foundation for Urologic Disease.

Senator Stevens spoke about the need for more research into the cause of prostate cancer. Senator Dole talked about his efforts to advance awareness of the disease. Edward Kaps, founder of US TOO, traced its progress from humble beginnings less than three years ago in Chicago to this highly touted Capitol meeting.

During a question-and-answer session, Dr. Moul and other guest experts fielded a variety of queries from the patients and senators.

At the meeting, Moul was made a National Advisor for US TOO, and Senators Dole and Stevens were named Honorary Cochairmen of the organization.

Dr. Moul comments, “The meeting provided two main benefits: support groups are extremely beneficial to patients and their families as evidenced by the explosive growth of US TOO; and this particular meeting had national exposure which will serve to increase public awareness of men’s health issues, prostate cancer, and the need for additional research support.”

Judd W. Moul, ’82 (second from left) with Senator Ted Stevens, Senator Robert Dole, and Edward Kaps, cofounder of the national US TOO group. photo by Louise Noakes, American Medical News.
Peter A. DeMaria, Jr. has been promoted to Assistant Professor of Psychiatry and Human Behavior at Jefferson, where Michael J. Rupp has been appointed an Assistant Professor of Pathology and Cell Biology.

Terry L. Edwards has joined the staff of Eastern Long Island Hospital.

'85

Alan S. Baseman has joined the medical staff of Grand View Hospital.

Larry J. Dashow, M.D. '85, Ph.D. has been appointed an Instructor in Surgery at Jefferson.

Gayle A. Hopper and her husband, Steve Weisberg, are thrilled at the birth of Rebecca Hopper-Weisberg on July 8. Dr. Hopper is serving as an Assistant Professor of Family Medicine at the University of Maryland.

Henry G. Yavorek, Jr. has joined the medical staff of Evangelical Community Hospital.

Robert H. Zuch has been elected to partnership with Southern California Permanente Medical Group.

'86

Virginia Graziani has been promoted to Assistant Professor of Rehabilitation Medicine at Jefferson, where James D. Knox, Jr. has been appointed an Instructor in Family Medicine.

'87

Mark A. Brzezinski has begun a two-year fellowship in plastic and reconstructive surgery at Albany Medical Center.

Gregory Przybylski has received a doctoral fellowship award in biomedical engineering from the Whitaker Foundation. Dr. Przybylski is a sixth-year neurosurgery resident and doctoral student in bioengineering at the University of Pittsburgh. The grant will provide him approximately $27,000 annually for up to five years for graduate tuition and professional development. The award also includes a stipend. He will conduct research under the direction of Savio Lau-Yuen Woo, Ph.D., Professor of Orthopaedic Surgery and Mechanical Engineering at the University of Pittsburgh. Dr. Przybylski’s primary interest is in the biomechanics of the spine.

Suzanne W. VanDerwerken has joined a family practice in Centerton, New Jersey.

'88

Fifth Reunion June 4–6, 1993

Greg F. Burke has joined the Geisinger Clinic in Danville in the Department of General Internal Medicine.

Edward Kim has been appointed an Instructor in Psychiatry and Human Behavior at Jefferson.

Carolyn S. Langer has received her J.D. and M.F.H. from Harvard University, where she will remain to complete a residency in occupational medicine.

George A. Macones has been appointed an Instructor in Obstetrics and Gynecology at Jefferson.

Jeanne M. Marrazzo has completed her stint as Chief Resident in Internal Medicine at Yale-New Haven Hospital, and begun a combined fellowship in infectious diseases and M.P.H. program at the University of Washington in Seattle.

Gregory T. Narzikul has joined the family medicine staff at Paoli Memorial Hospital.

Philip H. O'Donnell has joined Eye Surgeons Associates in Defiance, Ohio.

Suzanne P. Olivieri, having finished her residency at Children's Hospital of Philadelphia, is "busier than ever" now that she has joined a private pediatric practice in Ambler, Pennsylvania.

Kevin M. Zakrzewski has joined the practice of Internal Medicine Associates of The Graduate Hospital in Philadelphia.

'89

Dale S. Birenbaum has been appointed an Instructor in Surgery at Jefferson, where David T. Sawyer has begun a cardiology fellowship.

Jeffrey S. Gosin and his wife, Kate (Kate Burt, B.S.N. '87), are thrilled at the birth of Julia on May 1, as are Marla Triano-Rodgers and John C. Rodgers at the arrival of Sarah Josephine on July 12. Dr. Triano-Rodgers has begun a neonatology fellowship at St. Christopher's Hospital for Children in Philadelphia.

Jonathan M. Wilson has joined the medical staff of LATROBE Area Hospital. He is based at the Saltsburg Family Health Center.

Christopher F. Huntington is beginning his second year of orthopaedic surgery residency at the State University of New York at Stony Brook.

Michael G. Katlan has begun an allergy and clinical immunology fellowship at the National Jewish Center for Immunology and Respiratory Medicine in Denver.

John J. Monroe, Jr. and his wife, Kathleen, are delighted at the birth of John J. III on December 13, as are Mark J. Sangimino and Ursula R. Sangimino at the birth of Joseph on June 29.

Bret A. Rosenblum has been named Chief Resident in Family Practice at LATROBE Area Hospital.

Since your diploma is from Jefferson Medical College of Thomas Jefferson University, please refer to your degree as being from Jefferson Medical College.

Obituaries

Harold C. Atkinson, '26 died May 11 at age 89. Dr. Atkinson had practiced internal medicine in Macon, Georgia for many years and served as President of the Georgia Diabetes Association and the Bibb County Medical Society. He is survived by his wife, Lilly, two daughters, and two sons.

Philip B. Davis, '26 died January 27 at age 89. A surgeon in High Point, North Carolina, Dr. Davis was a past President of the Guilford County Medical Society and the American Business Club. Survivors include his wife, Betsey, a daughter, and two sons.

Robert E. Allen, '27 died April 7 at age 93. A family practitioner in Mount Carmel, Pennsylvania, Dr. Allen had served as President of the Northumberland County Medical Society, and General Chairman of Mount Carmel's centennial celebration. He was a longtime member of the National Guard, eventually promoted to Brigadier General. His wife, Myrl, survives him.

Cecil B. Van Sciver, '27 died May 23, 1991 at age 87. A resident of Tollhouse, California at the time of his death, Dr. Van Sciver is survived by his wife, Eva.

Joseph Kalett, '28 died November 13. Dr. Kalett had practiced cardiology at New Britain General Hospital in Connecticut for nearly 40 years. He was a resident of Pompano Beach, Florida at the time of his death.

Yen Pui Chang, '29 died May 29, 1992 at age 86. Dr. Chang—known as “Y.P.”—was a true general practitioner, for which he credited his Jefferson education. He was an outstanding student, earning many honors including membership in Alpha Omega Alpha. After graduation he practiced on Kauai, renting a house for an office, infirmary, and hospital. He became Chief of Staff at Wilcox Hospital, the first private hospital on Kauai. During the Second World War, Dr. Chang went to Honolulu, maintaining a family practice there for many years until his retirement in 1974. He is survived by his wife, Anne, a daughter, and two sons, one of whom...
became an anesthesiologist. Dr. Chang’s brother Hon C. Chang, ’37, nephew Walter K. Y. Young, ’60, nephew Bernard W. D. Fong, ’52, and great-nephew Jeffrey S. Fong, ’80 also survive him.

Richard B. Nicholls, ’30 died March 19 at age 87. Dr. Nicholls did not retire from the practice of obstetrics and gynecology till he was 81. He was a founder and former President of the Virginia Obstetrical and Gynecological Society, and former President of the Norfolk General Hospital staff. Survivors include his wife, Sylvia, a daughter, and two sons.

Charles F. Williams, ’34 died December 3. Dr. Williams had practiced pediatrics in Raleigh, North Carolina for many years. He is survived by his wife.

Harry B. McCluskey, ’35 died June 12 at age 83. Dr. McCluskey had specialized in internal medicine in Short Hills and East Orange, New Jersey until moving his practice to Pompano Beach, Florida in 1977. His wife, Madeline, a daughter, and two sons survive him.

Norman W. Henry, ’38 died May 24 at age 79. Dr. Henry had served as Pathologist and Director of Laboratories at St. Joseph’s Hospital in Philadelphia, as Treasurer of its medical staff, and as an Assistant Professor of Pathology at Jefferson. He was a resident of Stone Harbor, New Jersey at the time of his death. His wife, Ethel, two daughters, and three sons survive him.

Lindsay R. Riddle, ’40 died April 13 at age 77. A retired Navy captain and former Chief of Surgery at the Naval Hospital in Pensacola, Florida, Dr. Riddle had won national sailing races such as the Soverel 33 National Championship One-Design Regatta in Newport, Rhode Island. He is survived by two daughters and two sons.

Edward A. Troncelliti, ’42 died April 13 at age 76. Dr. Troncelliti was a much-loved pediatrician at Bryn Mawr Hospital for 46 years. Survivors include his wife, Jeanne, three daughters, and three sons.

Harry E. Carman, ’43 died November 15 at age 73. A family practitioner, Dr. Carman had been a Director of Holy Name Hospital in Teaneck, New Jersey.

Charles L. Putzel, Jr., J’44 died April 17 at age 72. A specialist in internal medicine, Dr. Putzel had served as Director of Medical Services at West Central Rehabilitation Facility in Selma, Alabama. He was a board member of the Alabama Heart Association. His wife, Ann, a daughter, and a son survive him.

Jerome J. Froelich, S’44 died April 11 at age 72. Medical Director of the John Knox Village Community in Fort Lauderdale, Dr. Froelich had also practiced family medicine in Newark, New Jersey. He is survived by his wife, Marie, two daughters, and five sons.

Frederick A. Resch, S’44 died June 23 at age 74. Dr. Resch had practiced in Canfield, Ohio and served as Associate Director of Western Reserve Care System’s Family Practice Center. He was a past President of the Mahoning County Medical Society. His wife, Carolyn, and three sons survive him.

E. Allan Casey, ’45 died June 6 at age 71. Dr. Casey had maintained a general practice in Cranston, Rhode Island. He is survived by his wife, Frances, two daughters, and a son.

James G. Marnie, ’45 died June 24 at age 74. Dr. Marnie had served as Chief of General Practice at Queen’s Medical Center in Honolulu, and as a member of its Medical Executive Committee. For many years, he volunteered as team physician to the University of Hawaii football team. After his retirement, he served on the State Medical Conciliation Panel and the American Arbitration Association. He is survived by his wife, Dorothy, a daughter, and three sons, including Timothy E., Class of ’93. Memorial donations may be made to Jefferson Medical College, c/o the Alumni Office.

Robert J. Sullivan, ’46 died June 6 at age 71. Dr. Sullivan was a family practitioner in Fall River, Massachusetts, and chief medical officer for the Lathrop Home.

William T. Sallee, ’49 died January 13, 1991 at age 67. A resident of Santa Fe at the time of his death, Dr. Sallee had practiced ophthalmology in Michigan. His wife, Bette, survives him.

Robert J. Bower, ’51 died March 13, 1992 at age 71. Dr. Bower had served as Senior Director of Clinical Research at Merck, Sharp and Dohme Research Laboratories, and previously as Director of Clinical Research for Wyeth Laboratories. A resident of Punta Gorda, Florida at the time of his death, Dr. Bower is survived by his wife, Mary, three daughters, and two sons.

John J. Kelly, Jr., ’54 died May 10 at age 63. Dr. Kelly was Chief of the Division of Internal Medicine at Lankenau Hospital, as well as Codirector of the Cardiac Rehabilitation Center, past President of the Medical Staff, and a member of the Board of Trustees. He held an appointment as Clinical Professor of Medicine at Jefferson and was a member of the Alumni Association Executive Committee. Dr. Kelly served on the Council on Clinical Cardiology of the American Heart Association. He is survived by his wife, Sharon, two daughters, and two sons, including John J. Kelly III, ’84.

Delbert L. Long, Jr., ’55 died June 19 at age 68. Dr. Long had served as director of the emergency room at All Souls Hospital in Morristown, New Jersey, at Dover General Hospital, and at St. Clare’s-Riverside Medical Center in Denville. He had also been Associate Medical Director of the Knoll Pharmaceutical Company, and Assistant Director of Medical Products Research at CIBA Pharmaceutical Company. He volunteered for 25 years as physician to the sports teams at Bayley-Ellard High School. Survivors include his wife, Betty, three daughters, and six sons.

Francis J. Caulfield, ’58 died April 22. A family practitioner, Dr. Caulfield had worked for Kaiser Permanente Medical Group in California. A daughter survives him.

Guy W. McLaughlin, Jr., ’59 died May 24 at age 63. Dr. McLaughlin had served as Chairman of Pediatrics at Nazareth and Holy Redeemer Hospitals in Philadelphia. Survivors include his wife, Elgie, a son, and two daughters, including Elgie R. McLaughlin, ’85, who practiced with him.

John L. Loder, ’68 died in March 1991 at age 48. A family practitioner, Dr. Loder had served as Chief of Staff at Simi Valley Doctors Hospital in California. He is survived by his wife, Leslie, a daughter, and a son.
THE JEFFERSON MEDICAL COLLEGE ALUMNI ASSOCIATION
CORDIALLY INVITES YOU TO

Medicine and the Arts
NOVEMBER 6–8, 1992

A Weekend to Take Advantage of Philadelphia’s Extraordinary Offerings in Music, Painting, Sculpture, and Crafts

The Committee: WILLIAM E. DELANEY III, ’53, President of the Alumni Association
RALPH A. CARABASI, JR., ’46, Committee Chairman • MRS. RALPH A. CARABASI, JR.
JAMES E. CLARK, ’52 • MRS. PAUL POINSARD • RUSSELL W. SCHAEDLER, ’53 • MRS. F. THEODOS

Friday, November 6
6:00 P.M. RECEPTION AND DINNER
TOUR OF THE UNION LEAGUE ART COLLECTION
The Union League, Broad and Sansom Streets

Saturday, November 7
10:00 A.M.—4:00 P.M. TOURS OF THE PHILADELPHIA CRAFT SHOW,
THE PHILADELPHIA MUSEUM OF ART,
AND THE RODIN MUSEUM, WITH CURATOR TALKS
(all transportation and tickets included • lunch on your own)
6:00 P.M. RECEPTION AND DINNER
The Cosmopolitan Club, 1616 Latimer Street
8:00 P.M. THE PHILADELPHIA ORCHESTRA
at the Academy of Music, Broad and Locust Streets
WORKS BY MUSSORGSKY, PROKOFIEV, AND SHOSTAKOVICH
MARK WIGGLESWORTH, CONDUCTOR • ANNE AKIKO MEYERS, VIOLIN

Sunday, November 8
11:00 A.M. BRUNCH AND EAKINS GALLERY DIALOGUE
"THE THOMAS EAKINS-JEFFERSON MEDICAL COLLEGE CONNECTION"
with University Art Historian Julie S. Berkowitz

For hotel accommodations call The Ritz-Carlton Hotel, (215) 563-1600 or (800) 241-3333

Reservation Deadline October 5

Mail this form to the Jefferson Medical College Alumni Office, Room M-41, 1020 Locust St., Philadelphia, PA 19107-6799

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<th>Number of persons</th>
<th>Total amount</th>
<th>Name</th>
<th>Guest Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
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Is this address ☐ home or ☐ office?
**Egypt & The Nile**

**AN EXCLUSIVE JEFFERSON TRAVEL OPPORTUNITY**

Sponsored by:  
Jefferson Medical College Alumni Association

Hosted by:  
William V. Harrer, M.D., '62  
Professor of Pathology and Cell Biology  
Jefferson Medical College  
Chairman, Seminar Travel Committee  
Joseph W. Sokolowski, Jr., M.D., Co-Chairman  
Mary B. Montelth, Executive Director  
Jefferson Medical College Alumni Association

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**JANUARY 17—FEBRUARY 1, 1993**

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<th>$4799 Per Person, Double Occupancy</th>
<th>$5799 Single Occupancy</th>
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<tr>
<td>Prices include a $200 per person contribution to the Jefferson Medical College Alumni Association.</td>
<td>For Further Information and Complete Brochure, Write or Call: Ana del Loreto Troncoso, Travel Consultant, 812 East Moyer St., Philadelphia, PA 19125 (215) 291-0239.</td>
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### INCLUDED:

- Welcome cocktail party in London  
- Festive farewell dinner in Cairo  
- Comprehensive sightseeing with specially-selected English-speaking guides, and all entrance fees  
- Medical enrichment program  
- Porterage  
- Service charges and taxes on included items  
- Customized trip preparation kit with readings, maps, bag tags, name badges and flight bag  
- Services of professional tour director throughout

**RESERVATION REQUEST**

Reservation Requests must be accompanied by a $500 per person deposit. Please make checks payable to Ana del Loreto Troncoso, Travel Consultant.

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<th>Class Year:</th>
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<th>Accommodations:</th>
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<td>Twin, please assign roommate</td>
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<td>(We will attempt to find compatible roommates, but cannot guarantee it. In the event that a roommate is not available by the final payment date, a single supplement fee will be charged.)</td>
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<th>Accommodations:</th>
<th>Single. (Limited number available, assigned on first-come, first-served basis).</th>
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<th>Aircraft Seating:</th>
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<th>Domestic Flights:</th>
<th>I need roundtrip flights to connect with the international flight to/from Philadelphia from ________ (departure city airport).</th>
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<td>I will get to Philadelphia on my own for the international departure flight.</td>
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**Deposit Deadline: September 30, 1992.** (Reservations accepted on a space-available basis after this date. A surcharge may apply.)

**Final Payment Deadline: October 15, 1992.**

Please Send Reservations And Deposits To:  
Ana del Loreto Troncoso, Travel Consultant,  

**Cancellations and Refunds:** Full refund minus $200 per person administrative fee will be made for cancellations received prior to October 15, 1992. Cancellations received thereafter will incur a $300 per person cancellation charge to which will be added any applicable non-recoverable air/land/cruise expenses. THE PURCHASE OF TRIP CANCELLATION INSURANCE IS STRONGLY ADVISED. INFORMATION WILL BE SENT TO ALL REGISTRANTS.