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Letters to the editor: These will be posted on the SOM Alumni Web site. Submit letters at somalumni@hsc.utah.edu
Alumni President’s Message

I recently attended a conference at Princeton University, just a week after our national elections. Their “Center for Health and Wellbeing” [part of the Woodrow Wilson School of Public and International Affairs] convened a group of well-known academics, economists and health policy experts to discuss a range of issues related to implementation of the Affordable Care Act (ACA) and the portent of our nation’s budget deficit on health care. Their job seemed a bit easier than it might have been just a few months ago, with the Supreme Court letting the law stand, President Obama being re-elected and the Democrats retaining control of the U.S. Senate.

The “experts” at this conference reiterated that the ACA is the law of the land and that repeal is very unlikely. However, the Court threw a wrench in the works by making the law’s required expansions of Medicaid an option for states, stating it would be “coercive” for the federal government to require states to take on an estimated 16 million more low income individuals if eligibility were increased to an income of 133% of the federal poverty level. The consensus at this conference was that provisions of the law will gradually be implemented and over time change the way health care is provided and paid for in the U.S.

So, what are the implications for our school of medicine? How will it change the way we educate future doctors? Not a lot in the short term, but significant changes will be required over time. Our state’s legislature is likely to be reluctant to expand Medicaid eligibility, but with other reforms of health insurance regulation being implemented, and functioning health insurance “exchanges”, many more people are likely to have coverage in the coming years. Even prior to the ACA, Utah was on its way to changing how health care was paid for, by enacting our own version of Medicaid reform. Starting in January of 2013, the University Hospital (and others along the Wasatch Front) will be paid a set amount of money per Medicaid patient enrollee, called “capitated managed care”. This will put downward pressure on reimbursements, and require documentation of specified quality measures and outcomes of care. The primary goal is to contain costs, while also improving the quality and value of health care [see University of Utah Health Care Transformation: The Video at http://www.youtube.com/UofUHealthCare]

This will be an enormous challenge to our academic health center, which serves as a substantial part of our state’s “safety net”, caring for a significant percentage of Medicaid patients. Teaching how to deliver care economically, efficiently, and safely will need to be top priorities in medical education, in addition to learning the art and science of medicine, which is ever expanding.

The inevitable economic pressures on our school make it essential that we receive more funding from our state legislature to support our mission (state funding for our public medical school is among the lowest in the nation). Dr. Vivian Lee, our Vice President of Health Sciences, has committed to do just that, by seeking sufficient funding from the state legislature during the 2013 session to allow restoration of the class size to 102 students, (the level it was from 1975 - 2009). Furthermore, she hopes to increase the class size to 122 as soon as it is feasible. More state funding is essential as we absorb all the changes required by both state and federal “health reforms.”

The SOM Alumni Association is committed to carry this message to our elected officials and to make the case for increased funding. Having a high quality medical school is essential for our state - for our economy and for the health of our population - and it is well worth investing in. As the provisions of ACA are implemented more of our citizens will likely have health insurance coverage, but it will be of little use if they do not have access to qualified physicians. The University of Utah School of Medicine has a proud record of training capable doctors, and strengthening state support will ensure our capacity to do so during these strenuous times of change. The beneficiaries will be the public, and the public’s health.

David N. Sundwall M.D.
As an educator, I’m equally inspired when I have the chance to watch students make their own discoveries. It may be a first-year medical student discovering she finally understands a concept in biochemistry or a resident discovering that a complex diagnosis he made was correct.

These moments are a reminder of the important role academic medicine plays in society, and the role our students will play in sustaining our country’s health care and research infrastructure in the decades ahead.

Utah medical school graduates have a long history of leading health care innovation and discovery in this country. Over the past 18 months I’ve had the pleasure of meeting and introducing some of these leaders to our current medical students as part of my Dean’s Roundtable series. These noontime sessions have given students the chance to hear from prominent alumni like Drs. James W. Freston, Marsden Blanch, Cecil Samuelson, William DeVries, Homer Warner, Thomas Rees, and Greg Critchfield.

These remarkable Utah graduates have helped transform health care and I’m grateful to each of them for taking time to engage with our current students.

I encourage you to watch their interviews online at the alumni homepage at http://medicine.utah.edu/alumni. More interviews are planned in the coming months and I invite your feedback and suggestions for future guests.

Despite the tremendous contributions of these notable alumni and the numerous academic accomplishments of our faculty, the University of Utah School of Medicine is still undiscovered in many ways – including by many in our own state.

It’s our job to make sure the citizens of Utah understand the role we fill in advancing science, in training physicians and other health care providers, as well as in providing the depth and breadth of high quality clinical services needed to care for the citizens of the Intermountain West. To that end, you’ll be seeing, and hearing, a lot more about the University’s health sciences in the coming years through a sustained communication effort.

The first part of that initiative was the publishing and distribution of our *Algorithms for Innovation* report to local and national health care and community leaders. We’ve also established a corresponding website at www.algorithmsforinnovation.org where we are sharing videos and ideas featuring voices from across the health care, higher education, and research community. I encourage you to visit the site and share your thoughts and ideas with us.

In addition, we’ve started sharing the stories of our medical students with local media outlets across the state. We are grateful to the community for sending us their best and brightest students and plan to do a better job making sure Utahns know we appreciate their continued support of our school.

Finally, as I’ve written in the past my top priority as dean is restoring and growing the class size of our medical school. While we weren’t able to secure funding last year, we made significant progress with state lawmakers and I’m pleased to report that our class size initiative is the University’s top priority for the upcoming legislative session.

As physicians and scientists we all share a passion for discovery. Whether it’s observing something in the lab for the first time or connecting data to make a clinical diagnosis – the opportunity for discovery is one of the great gifts of our profession.

*By Vivian S. Lee, M.D., Ph.D., M.B.A.*
Our plan is transparent, straightforward, and supported by solid data:

- To expand our class size from 82 to 122 students per year it will cost us $12.2 million per year.
- Our School of Medicine clinical departments will participate in cost sharing so that the requested state appropriation is reduced to $10 million.
- In 2013 we would grow the class size to 102, and by 2015 the incoming class size would be 122.
- Utah has a strong applicant pool with a current applicant to acceptance ratio of nearly 20:1. Every year very qualified applicants are turned away. Increasing the class size will enable us to keep more of Utah's top students in Utah.

This plan is good for our school and good for our state. It represents a true partnership and is a key element in a broader strategy to help Utah address its ongoing physician shortage.

I encourage you to support our efforts by contacting your local legislators and helping them discover the University of Utah School of Medicine. We remain committed to providing high quality medical education at a reasonable cost to Utah students and ensuring that all Utahns have access to high quality health care. For more information visit the SOM Alumni Association Web site: www.medicine.utah.edu/alumni.

Discovering Your Medical School

A Commitment to Utah Students

- At least 75 percent of each incoming class are Utah residents.
- Eight students are from Idaho (funded by the State of Idaho).
- All out-of-state students must show strong Utah ties, enter the M.D./Ph.D. program, or be specifically recognized as a member of a population group underrepresented in the physician workforce.

Serving Utah

- Our medical students provided 14,404 hours of service to Utah communities during the 2011-2012 academic year. Activities included work in free clinics, at health fairs, in community settings, and with K-12 educational programs.
- Our medical students interacted and taught more than 10,000 students in 29 Utah school districts through the Office of Inclusion and Outreach, including the Utah Rural Outreach Project.
Medical school has been a dream for me since I first stepped into my human anatomy and physiology course in high school. I knew it would be hard work but the importance of an education was instilled in me early on in my life. I still remember my mother working two shifts daily to put my father through college and make ends meet. Because of this experience, I have always viewed education as a privilege. When I first started at the U of U as an undergrad, I could not believe how expensive tuition was. Once I found out about how much it actually cost to attend medical school, it was like being hit with a brick. How was I going to pay for this? While working part time in undergrad I had never made more than ten thousand dollars per year and the idea of having hundreds of thousands of dollars in debt was mind-boggling.

The most humbling day of my life was when I found out that I was selected as a Ballard Scholar. In fact, I was in shock. I felt joyful, overwhelmed, lucky and grateful all at the same time. Just think back to how you felt while watching the ending (all three!) of the last Utah-BYU football games. To this day I still cannot believe that I was chosen for such an unbelievable honor. Becoming a Ballard Scholar was one of the most motivational and inspirational experiences in my life.

I remember sitting in this exact room four years ago at my first scholar-ship luncheon. After coming to this luncheon, talking to Dr. Ballard and hearing students speak about their experiences, I was motivated to do as well as I could. I wanted to do well so that I could convince myself that I deserved this scholarship. To this day, I continue to be motivated by it.

The generosity of Dr. Ballard was in itself, inspirational, but who was Dr. Robert H. Ballard? Was I to remember him as a generous man who has a rehab center and an ICU named after him? Was I to remember him as someone who had provided an unprecedented amount of support to our medical school? Definitely yes, but in my mind, I knew Dr. Ballard best as the history buff. The first time I met Dr. Ballard, I was getting quizzed on American history right from the get go. I was afraid he would retract my scholarship right there because I could not answer a single question he posed. Afterwards I wised up, and whenever I would visit him at his house, I would always try and read up on a history topic. That way, I could steer our conversations towards an event I knew about and hope that he would only ask me questions about that topic. It never worked.

The best memory of visiting Dr. Ballard was seeing pictures of the Ballard Scholars on his wall. He told me that he was so proud of all of us and was happy that he was able to support our education. He was always asking about school and what else I was doing for fun besides school. At first, I told him nothing and that I was studying hard to do well on exams. He promptly corrected me right there. “Sometimes it matters more what you do outside the classroom,” he said. I took his advice to heart, began volunteering at the 4th street homeless clinic and eventually worked as a student-manager there.

Even now as I apply for residency I reflect upon my experience as a Ballard Scholar. The great thing about the scholarship was that I knew I could select a specialty free of financial influence. I have decided on a career as a radiologist as the study of anatomy has not only influenced my decision to become a doctor but has continued to fascinate me. Often I get asked about the possibility of the declining compensation within the field and whether it has played into my decision at all. I can answer honestly that it has not.

The experience of being a Ballard Scholar is one that is lifelong and will always continue to motivate me. I am forever grateful for the support that Dr. Ballard has provided. I do not think that I could ever thank him enough. The only thing I can do is to aspire to be like him. Self-less. Inspirational. An excellent mentor and friend. He has done more for me than he will ever know. ☺

The Power of Scholarship

In 2006, Dr. Robert H. Ballard, an orthopedic surgeon from the class of 1944, established the Dr. Robert H. Ballard and Dorothy Cannon Ballard Endowed Scholarship. This generous gift now provides full-ride scholarships for eight medical students (two in each class). Gifts like this give our school a powerful tool in helping convince our best and brightest students to remain in Utah for their medical training. Our ultimate goal is to provide every student with scholarship support. Tony Trinh is a fourth-year student and Ballard Scholar who spoke at our annual scholarship luncheon. He is a Utah native and graduate of Bingham High School in South Jordan. Below is a transcript of his remarks from the event.

– Vivian S. Lee
Some of you may have seen an old man walking through the University of Utah campus this summer. He traverses the campus, goes up to the Bonneville Shoreline trail, and back to his house near Second South and Thirteenth East. You could recognize him by his bandana sweatband, his faded beige baseball cap, short pants and the sun block that covers his face and neck. I am that old man… or as I kid myself, just sort of old.

I always think while I walk. One recent day, as I moved upward through the President’s Circle and by Orson Spencer Hall, my mind journeyed back to 1944 and Mrs. Thomas’ fifth grade class at Madison Elementary School in Ogden, Utah. She began that year by pinning a miniature ladder on her tack board and told us that school progress is like a ladder; each year forward moves students up the education ladder toward completion of college and that symbolized success for Mrs. Thomas.

I think as I walk by the Huntsman Center, over Mario Capecchi Drive and through Fort Douglas, of the scholarships that helped me up that ladder: in 1951 to 1953 at Weber College, two years at twenty-five dollars a quarter—my, how that’s changed—then in 1956 to 1958 at the University of Maryland School of Medicine each of the last two years, five hundred dollars that was almost full out-of-state tuition in those days. That scholarship money came from benefactors like you.

As I walk by the Red Butte Garden outdoor amphitheater into the foothills and up to the rocky Shoreline Trail, I look west and then south, over the city and then down to the expanse of the Health Sciences Complex and its satellites in Research Park. I reminisce that in 1963, while at the Salt Lake County Hospital on 21st South and State Street, during my last year of Radiology residency, this vista was a dry sagebrush field with the exception of early construction of buildings to become the University of Utah Hospital and Medical School in the mid 1960’s. The change from a sagebrush field to this expansive Health Sciences Complex can be compared to the change in yearly cost of tuition then and now: a few hundred dollars then and many thousands now.

As I slither down the steep descent from the shoreline trail to the Jewish Community Center and on to the new hospital cafeteria for water, I think how important benefactors are to these aspirants with dreams, benefactors who will give lifeblood to the heart of health care as these students morph from the likes of day laborers to health care professionals. It is an honor for all of us to be part of a student’s dreams in small or large ways. I personally salute you for all you do and all you have done and all that you will do for our students. The education they gain will enrich their lives, empower their communities, and enhance the health of the people of this great land.

Dr. Richard Keller is a retired radiologist who did his residency training at the University of Utah School of Medicine. He is currently the chair of the SOM Alumni Board Programs Committee and sits on the School of Medicine Admissions Committee. From 2008-2012 Dr. Keller donated a full-tuition four-year scholarship to a U of U medical student. In 2013 he endowed a scholarship in the SOM for a female medical student from an underserved background. This is the talk he gave at the Health Sciences Scholarship Luncheon in September 2012.
Then & Now

By Kristin Wann Gorang, M.S. and James T. Roth, M.D., ’89

Changes in Obstetrics and Gynecology in the Past Half Century

Recently OB/Gyn physician James T. Roth, M.D., Class of 1989 and Kristin Wann Gorang, School of Medicine Alumni Relations Director, sat down with Howard C. Sharp, M.D., a retired OB/Gyn doctor, Class of 1947 and Howard T. Sharp, M.D., his son, an Associate Professor and Division Chief in the U of U Obstetrics and Gynecology department and a 1994 house staff alum, to discuss the changes they’ve seen in their specialty over the years. It was interesting to notice the difference in their respective responses to the same questions.

Kristin: What do you think is one of the most significant differences over the past fifty years in the practice of obstetrics and gynecology?

Howard C: The improvement of medical training. In my day many doctors would finish their medical school training and have one additional internship year and hang out their shingle and start their practice, including doing obstetrics. The specialization in the field has greatly improved care for women.

Howard T: Now only about 50% of our residents go into a straight obstetrics/gynecology practice, the other 50% complete an additional three-year fellowship in one of four sub-specialty areas, urogynecology, gynecologic oncology, maternal fetal medicine or reproductive endocrinology and infertility.

Kristin: What are some other changes you have seen?

Howard C: My goodness, it would have been great to have had ultrasound! Ultrasound technology changed everything. When I first started practicing the diagnosis of pregnancy depended on physical signs and symptoms. Animal tests with mice, rabbits and frogs were used to confirm questionable cases. This is where the term, “the rabbit died” came from. We’d inject the rabbit, mouse or frog with the woman’s serum to see if its corpus luteum burst, confirming a pregnancy. It took four days to find out if a woman was pregnant or not! We often weren’t sure if a woman was pregnant or just had fibroid tumors growing in her uterus until we could take a fetal skeletal x-ray at around four months along. Now we can confirm within seven weeks from the last menstrual period and catch many problems early with ultrasound technology and other tests such as amniocentesis, chorionic villus sampling and maternal alpha-fetal protein sampling.

Howard T: Laparoscopic surgery has made a big difference in our ability to treat many gynecological problems without having to cut a woman open. And now robotic surgery in the pelvic area has improved technique and become even more accurate and exacting.
Howard C: The increasing rate of cesarean section. Sixty years ago the incidence of C-section was about 5%, it has now risen to 30% nationally, largely due to medico-legal concerns for injury to the mother or fetus. In my day we used forceps a lot to rotate and extract the fetal head; this rarely occurs anymore. Also the availability of anti-D immune globulin (RhoGAM) for Rh negative women whose partners are Rh positive has virtually eliminated the need for intrauterine fetal transfusion. When it is occasionally needed, ultrasound has greatly facilitated the procedure.

Howard T: One of my greatest difficulties in practice is that technology is expanding so quickly and rapidly it’s hard to know which wave to ride. Some technologies approved by the FDA have ended up hurting patients. For example some of the mesh kits that were approved earlier, plus some of the endometrial ablation devices ended up not being so good. It’s hard to determine when to jump in and start using a new technique or technology and when to wait. It’s not always a good idea as an Ob/Gyn doctor to be an early adopter but one also doesn’t want to ignore new, better technology that improves patient safety and care.

Jim: How has the 80-hour work week for residents impacted their training?

Howard T: Well, there’s not as much time for attending doctors to do surgeries with residents as in the past. When I trained 50% of my time was spent in the OR, now probably 25% of training time is spent there. They have to rotate through so many different areas and also spend a significant amount of time in clinic. Some residents are still really gung-ho to do surgery, and that is still possible, but some residents shy away from surgery and would rather do a straight office clinical practice. I think this also may be part of the increase in more fellowship training, as the scope of practice has expanded and the training hours have become more limited, some residents feel they need more training and specialization before they go into practice.

Howard T: That is pretty much not an option anymore due to the insurance companies.

Howard T: During my training we still drew all our patients’ blood work on our own. It’s much better now both error-wise and cost-wise not to have medical students or residents drawing blood. Too much risk for mislabeling and it’s not the most efficient use of their training time.

Jim: Malpractice rates have also significantly changed. OB has the second highest rate of malpractice insurance after medicine.

Howard C: In my day we offered a lot of professional courtesy, to nurses, physician’s wives, medical students and others. It was a privilege to take care of a colleague or his or her family member.

Howard T: What about relationships with mid-wives? How has that evolved?

Howard C: We didn’t have many mid-wives practicing early on in my practice, so it wasn’t much of an issue.

Howard T: I think the midwives who practiced thirty, forty years ago are fundamentally different than many of the mid-wives who practice today. There has been an evolution in midwifery and in OB/Gyn doctors’ perception of midwives. In the past it wasn’t always the friendliest of relationships, but now many physicians use midwives as physician extenders and midwives have become more mainstream, working alongside physicians as opposed to being totally separate from doctors. In my practice we have two midwives and one nurse practitioner and they all contribute a lot to the practice and are well-accepted by the doctors.

Jim: Working with the SOM Alumni Association Board there has been a concern about medical students being able to afford medical insurance while they’re in school. When we were in training many physicians saw medical students and colleagues as a professional courtesy. That seems to have gone by the wayside due to insurance companies claiming that providing professional courtesy equals “insurance fraud.”

Howard C: It was $125 a quarter, $375 a year. We didn’t come out of school with the kind of debt students do now, but then we also were only paid $25 a month during residency…and we even covered the night lab along with the wards for that pay! Fortunately our malpractice insurance was pretty nominal when I first started practice, not like it is today.

Howard T: During my training we were in the Bryner Clinic in the 1960’s.
Increased use of antibiotics changed the treatment of sexually transmitted diseases and other genito-urinary infections. The use of prophylactic antibiotics has been instituted for many procedures.

Widespread use of cervical cancer screening has greatly reduced deaths from cancer of the cervix. Human papilloma virus (HPV) has been shown to be the cause of almost all squamous cell carcinomas of the cervix. Vaccines are now available to decrease the risk of cervical cancer.

Medical treatment with progestational drugs and more definitive laparoscopic procedures to treat endometriosis.

Treatments for premenstrual tension and dysmenorrhea have greatly improved.

Increased use of embolization procedures to treat fibroid tumors of the uterus and control postpartum bleeding.

Discovery of the BRCA gene has made it possible for women with a strong history of breast and ovarian cancer to determine whether they are at greater risk and should consider having prophylactic surgeries at an early age.

Medical and laparoscopic treatment of ectopic pregnancy has become safer and less invasive.

Treatment with endometrial ablation for certain heavy bleeding problems.

The use of urethral slings for stress incontinence.

Howard C. Sharp’s additional notes on other changes he’s witnessed in the practice of obstetrics and gynecology over the past sixty years:

OBSTETRICS

Electronic fetal monitoring has saved many fetal lives, but has also contributed to the increased rate of cesarean sections.

Greatly improved methods of anesthesiology offered during labor and delivery.

The use of prostaglandins for post-partum uterine hemorrhage and also for cervical ripening where induction is necessary.

Use of antibiotics for treating pelvic infections during pregnancy and postpartum recovery. Much more testing and treatment for infections is now available for mothers when they are admitted for labor.

In-vitro fertilization, many infertility diagnostics tests and treatments and cryopreservation of sperm are all fairly recent occurrences.

GYNECOLOGY

Jim: Since I began practicing 20-years ago a lot more women have entered the field of Ob/Gyn. How do you feel that has changed the practice?

Howard T: When I was in residency the residents were fairly evenly split between male and female. Currently at the U the majority of Ob/Gyn residents are women, five or six women to every one man in most of the years. I think many women are very receptive to seeing a female physician for their obstetric and gynecological needs.

Jim: It seems to me that women physicians tend to pay more attention to work-life balance, especially once they start a family, so we’re seeing more OB/Gyn docs giving up obstetrics earlier than in the past.

Howard T: Yes, I think the average age to quit practicing obstetrics now, according to the American College of Obstetrics and Gynecology is fifty, which is younger than in the past. Another change I’ve seen is in our office staffing. Just in the last two years with switching over to an electronic medical records (EMR) system our office has almost doubled the medical assistant staff so they can type in all the history and other data on patients required by EMR. I used to do more of the input, but now it’s more involved so medical assistants do all of it.

Jim: What was or is your greatest disappointment or frustration in your years of practicing obstetrics and gynecology?

Howard T: I think my largest frustration is treating uninsured patients and trying to get them the care they need. We see quite a few uninsured individuals at the U and since I think the heart of an enjoyable practice is meeting the needs of patients, it’s hard when you can’t always do that as well as you’d like to.

Howard C: I really can’t think of any major disappointments looking back at my career. I really enjoyed my practice at Bryner Clinic for the 25 years I practiced there and also my last 12 years up at the U, where I got to do a lot of things I hadn’t done while in straight clinical practice. It was a great learning experience and a lot of fun.

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Medical and laparoscopic treatment of ectopic pregnancy has become safer and less invasive.

Treatment with endometrial ablation for certain heavy bleeding problems.

The use of urethral slings for stress incontinence.
For the thousands of children with cancer and their families, improved treatments—and a cure—can’t come soon enough. Researchers and physicians at Huntsman Cancer Institute (HCI) and throughout the University of Utah Health Sciences Center (UUHSC) agree.

“We’re looking for really impactful research that will help make the lives of cancer patients better,” says Stephen Lessnick, M.D., Ph.D., director of the Center for Children’s Cancer Research (C3R) at HCI and a professor in the Division of Pediatric Hematology/Oncology at the University of Utah. Combining the strengths of UUHSC’s exceptional basic science and genetics research with the excellent pediatric treatment facilities at Primary Children’s Medical Center, physicians and scientists are making breakthroughs toward that longed-for cure.

Working Together to Find a Cure

“We have an incredibly strong cancer center and an incredibly strong pediatric hospital,” says Lessnick. But until the formation of the C3R, he says, “we really didn’t have an effective way to cross that gap from a research perspective. The C3R serves as the bridge to help organize all the pediatric cancer research on campus.”

The collaboration has paid off. Lessnick points to a recent example involving a protein his lab has studied for years. The protein, EWS/FLI, plays an important role in the development of the pediatric cancer Ewing sarcoma. The Lessnick Lab found that EWS/FLI functions by binding to a particular protein that had not been linked to EWS/FLI before. A discussion during a C3R meeting revealed that HCI investigator Sunil Sharma, MD, and others from HCI’s Center for Investigational Therapeutics were working to develop drugs that block this particular protein.

“We all looked at each other across the table and said, ‘This is a huge opportunity to link our two projects together,’” says Lessnick. “It turns out that their drug blocks the function of EWS/FLI, as predicted, but more importantly, the drug kills Ewing sarcoma cells in the laboratory very efficiently.”

Lessnick says without working with his colleagues, it might have taken years before the drug could benefit Ewing sarcoma patients. “That’s the best possible outcome of a collaboration—to bypass those years and years of waiting and bring new cutting-edge agents to these young kids as quickly as possible.” This research has been accepted for publication by a cancer journal.

Another research project brings Lessnick together with cell biologist, Mary Beckerle, Ph.D., HCI’s CEO and director, and breast cancer researcher, Alana Welm, Ph.D., to look at how Ewing sarcoma metastasizes. In this disease, says Lessnick, “It’s usually not the primary tumor that kills the patient—it’s the metastases. If we can understand what that process is and how to block it, that would be a major discovery.”

Lessnick says some of the most exciting pediatric cancer therapies involve molecularly targeted agents. “In recent years, a number of companies have developed these molecularly targeted agents that specifically block some of the enzymes and pathways that cancers use to develop.” He points to a recent study of an agent called an ALK inhibitor. “A couple of pediatric cancers rely on the ALK enzyme to develop—a particular kind of lymphoma and a type of solid tumor called a neuroblastoma. This study showed in a very preliminary fashion if you give patients this ALK inhibitor, you can actually get these lymphomas and neuroblastomas to regress.”

Pioneering the Field of Pediatric Cancer Genetics

UUHSC’s strength in genetics research is leading to important discoveries about how pediatric cancers develop. Joshua Schiffman, M.D., is a pediatric oncologist who studies pediatric hereditary cancer syndromes and genetic susceptibility to childhood cancers. He is an HCI cancer investigator, an associate professor in the Department of Pediatrics, and an adjunct associate professor in the Department of Oncological Sciences.

“We’re working hard and advancing the field of pediatric cancer genetics here at the University of Utah,” says Schiffman, noting UUHSC’s leadership in the relatively young field.

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According to a recent editorial he wrote for *Pediatric Blood & Cancer*, Schiffman believes if you look for hereditary cancer syndromes, you will find them—even when it is commonly believed they don’t exist for a particular cancer.

As part of his translational genomic laboratory at HCI, Schiffman currently studies the genes of children with Ewing sarcoma and their parents to look for genetic risk factors. “Ewing sarcoma is really the only tumor that has not been associated with an underlying hereditary cancer syndrome. We are trying to understand if there is a genetic risk, and we think there is. Understanding this genetic risk may one day lead to novel prevention and treatment strategies for this deadly sarcoma.”

Since beginning the study, Schiffman has been alerted to unusual cases of familial Ewing sarcoma, such as two siblings or a parent and child who both have the disease. Physicians and clinics from around the world have sent these patients’ blood samples to Schiffman for molecular analysis. “With these really precious, unique resources—these clinical samples—we can study the genomics in the lab and see if we can find any clues about why they developed cancer.”

Schiffman speculates pediatric cancer is more likely to have an underlying inherited cause than adult cancer, as tumors in adults more often can be attributed to environmental exposures over a longer period of time or a lowered capacity to repair DNA as the body ages. He points to a recent study at Cincinnati Children’s Hospital Medical Center in which 370 pediatric cancer survivors met with a genetic counselor to determine if they were eligible for further genetic workup. Of the 370, 29% were determined eligible. This rate is much higher than the 5-10% of adult cancers attributed to inherited mutations. This is important information, says Schiffman, because “if we can figure out where cancer comes from, we can try to prevent it. Moreover, we can think of new treatment strategies for children and adolescents who develop cancer that target inherited genetic mutations, even if they don’t have a hereditary cancer syndrome. This is because many tumors contain the same mutated genes regardless of whether they occur as part of a familial cancer syndrome. Therefore the same treatment strategies would work for patients with hereditary cancer and patients with spontaneous cancer.”

Schiffman says pediatric genetic testing has been rare until recently because not much could be done if a mutation was found. Cancer. LFS is characterized by mutations in a tumor suppressor gene; those with the syndrome have a 70-80% chance of developing cancer or multiple cancers in their lifetime.

Schiffman says pediatric genetic testing has been rare until recently because not much could be done if a mutation was found. But FCAC took part in one of the first North American trials to determine whether cancers could be detected early in children. Using rapid sequence MRI scans, the study found cancers in patients who underwent an early cancer surveillance program and had their cancer detected by full-body MRIs or by lab

**Using Genetics Research for Early Detection and Prevention**

The genetic research at UUHSC not only leads to better treatments but also helps oncologists detect cancer at its earliest stages. Schiffman is Medical Director of the High Risk Pediatric Cancer Clinic at HCI’s Family Cancer Assessment Clinic (FCAC). One of the nation’s only dedicated pediatric cancer genetics clinics, its goal “is to see children and their families who are at risk for hereditary cancer syndromes so that we can offer novel early cancer surveillance approaches,” says Schiffman. “We know that if you detect the cancer early, you have a much better outcome.”

One particular family can attest to that. After losing his wife to breast cancer when she was only 29 years old and seeing many in-laws diagnosed with cancer, the family’s father, Von, looked into genetic testing at HCI for his three kids, Tony, Lindsey, and Andrew. All three tested positive for Li-Fraumeni syndrome (LFS), an inherited genetic disorder that greatly increases the risk of
work, 100% were still alive after three years, as opposed to those with LFS that didn’t want to receive the screening,” says Schiffman. “When those who weren’t screened presented with symptoms of cancer, only 21% were alive after three years. So we now encourage and offer full-body MRI screening for all of our LFS patients.”

Now adults, Tony, Lindsey, and Andrew all have annual MRIs in addition to blood work, colonoscopies, mole mapping, and other cancer screenings. And it has proved to be lifesaving.

“Had we not followed the screening regimen, I believe Tony wouldn’t be alive today,” says Von. The first MRI Tony underwent revealed a brain tumor. Tony hadn’t experienced any symptoms other than headaches, which weren’t alarming because he’d had a long history of them. “The tumor would have gone undetected until it became symptomatic,” says Von.

As Tony explains, that would have been too late. “Three of my cousins also had brain cancer. By the time they found one cousin’s tumor, it was the size of a grapefruit,” he says. “Another cousin’s tumor was the size and shape of a banana that wrapped around his brain.” None of the cousins survived their cancer. Tony’s brain tumor, however, was detected early enough through the early cancer surveillance program to be removed successfully.

With her mom’s history of breast cancer at such a young age, Lindsey started having regular mammograms even before she underwent genetic testing. A few years ago, she began considering a preventive mastectomy.

“It took a lot of thought and contemplation,” she says. At a conference about LFS, Lindsey heard a physician give a presentation about the high risk for breast cancer in LFS families. She spoke to the physician afterward, who said based on Lindsey’s LFS and family history, she was almost certain Lindsey would get breast cancer within the next five years.

“That did it for me,” says Lindsey. “I came home and talked with Dr. Schiffman, and he got me a consult with an HCI oncologist, plastic surgeon, and breast surgeon. They decided I would qualify for a double mastectomy because I am high risk enough. After talking with my family, we decided it would be the best option to go ahead with it.”

Schiffman’s involvement with this family illustrates his approach to the High Risk Pediatric Cancer Clinic. “We have a really strong relationship with our patients and their families—making sure the families are comfortable and that we can follow them closely.” The clinic assumes responsibility for ordering scans and following up with the results. In addition, the clinic schedules yearly physical exams, where Schiffman can talk with his patients and discuss any new cancer screenings or prevention suggestions. Von says he and his family “would probably be completely lost” without the High Risk Pediatric Cancer Clinic coordinating all the screenings and following up with the family. Tony calls Schiffman a “godsend. He really cares. He checks up on us. When I was in the hospital [for the brain tumor surgery], he visited me multiple times even though he was not my primary physician. I know he has a genuine interest in us and our lives. I feel very safe in his hands.”

Research articles mentioned can be found in:
Class of 1962:

Back Row, Left to Right: Thomas J. Green, Robert H. Crist, Wendell Bart Christenson, Jr., Theodore G. Obenchain, Leo M. Stevenson, Elbert M. Dansie

Front Row, Left to Right: Rodney V. Hoyle, Eric F. Holt, Michael S. Pecora, J. Ronald Shaffer, Conrad Knowles, George C. Pingree, Joseph R. Armstrong, Reed E. Fogg

Class of 1967:

Left to Right: Lee Malan, Gordon Brown, Kent Rasmussen, Dennis Russell, Michael Vincent, Robert Wray, John Holbrook, Elizabeth Hammond, Gary Halversen, Thomas Coppin, David Feil, Keith Ritchie

Class of 1972:

Left to Right: Richard Lambert, Willard Maughan, Doug Miner, Steven Kammeyer, Hugh Voorhees, Daniel Christensen, Dennis Peterson, Walter Reichert

Class of 1982:
Left to Right: Gwen Cannon, Kent Jex, Ed Hildebrand, Nick Mamalis, Steven Simper, Brent Black, Gary Snider, David Ryser, Kim Rigby

Class of 1987:
Back Row, Left to right: Lamar Bushnell, Tim Pingree, Ron Anderson, John Edwards, Lawrence Grandy, Clark Sheffield, Brian Waterfall, William Stewart, Jim Stringham, Cherie Brunker

Front Row, Left to right: Kevin Tolton, Susan Rydz, Kathleen DiVincenzo, Steven Heath, Michael Daun, Robin Ohls, Letitia Archuleta, Stewart Landau, Jeff McClellan

Class of 1992:
From Left: Clarisa Borrego, William Sheffield
Classes of 1997 and 2002

Class of 1997:
From Left: Jennifer Allen, Viet-Dung Nguyen, Dan Kinikini, Kirsten Novak, Alisa Knowlton

Class of 2002:
Left to right: Elizabeth Huff, Lisa Giles, Angelica Putnam-Elizondo, Craig Hughes, Jeffrey Anderson, Brandon Ferney, Josh Bradley, Scott Samuelson, Clint Christensen, Rene Valles, Khizer Khaderi, Angela Krull, Joshua Hall, April Larson, Trever Burnett

Awards Banquet

Distinguished Service Award winner Dr. Richard Middleton with family members

Dr. Thomas Rees accepting the Distinguished Humanitarian Award
Fourteen members of the Class of 1962 gathered first at the Thursday evening Awards Banquet and then on Friday for their class reunion. Some class members had not seen each other in fifty years, but there was an immediate sense of camaraderie. It seems that memory makes the heart grow fonder—or that was the feeling as reminiscences of medical school were recalled with warmth and amusement. Memories included Dr. Hashimoto’s anatomy class, Emma, one member’s first year team’s cadaver, delivering Max Wintrobe’s daughter’s baby, and pathology department doctors “trash talking” to Max Wintrobe’s internists for failing to diagnose diphtheria in a patient who had died. Appreciation for the privileges their education afforded them to serve as physicians was frequently expressed.
Continuing Medical Education

C.M.E.

This year the series, Updates in Science, Practice and Policy, featured guest speaker, Paul Grundy, M.D., M.P.H., IBM Corporation’s Global Director. Dr. Grundy addressed what changes are needed for health care reform to be successful, including modifying the delivery system from fee for service to employer sponsored primary care medical home clinics. Other speakers and topics included Greg Poulsen, Sr. Vice President at Intermountain Healthcare who clearly delineated our country’s current medical emergency, with Medicare debt accelerating at an unsustainable rate, and shared some new models of care to alleviate the crisis. Margaret DeAngelis, Ph.D. addressed new treatment for macular degeneration, Howard Weeks, M.D., shared the latest treatments for difficult to treat depression, Dean Y. Li, M.D., Ph.D. excited the audience with his vision of the future for personalized medicine and Kirtly Parker Jones, M.D. explained what’s new in family planning from contraception methods to advanced reproductive technology.

James Mason, M.D. ‘58 and Joe Nelson, M.D. ‘58

Greg Poulsen presents

Kirtly Parker Jones, M.D., Ron Anderson, M.D., ‘87 and daughter, Kiem, discussing the presentations

Homecoming Pre-Game

Tailgating

Vice president of health sciences and medical school dean, Vivian Lee, opened her home up to many School of Medicine alumni for a tailgate party before the homecoming football game against BYU. Sixty-three individuals attended, enjoying a barbeque, the pool and relaxed conversation. The evening was capped off by a nail biting victory in double overtime: Utah 24, BYU 21.

Tom Rees and daughter Liz with cousin Beverly Johnson, her husband Dale and Don Pedersen

Mary Ellen and Tom Caine catch up with Ann and Lorris Betz
Dean’s Roundtable: 
features William DeVries, M.D. and Homer Warner, M.D.
By Peta Owens Liston

This fall, Vivian S. Lee, Dean of the School of Medicine, invited two University of Utah legends back to campus to share their stories and insights with a packed room of medical students.

On September 14, cardiothoracic surgeon William DeVries, M.D., ’70 regaled students with stories about his journey to successfully implant the first artificial heart, the Jarvik-7, into patient Barney Clark in 1982.

On November 9, 90-year-old Homer Warner, M.D., ’49, shared stories about pioneering one of the most modern fields today—biomedical informatics, the use of computers to help make decisions about patient care. We were all very grateful to have one last opportunity to hear Warner’s stories firsthand, as he passed away three weeks later on November 30, 2012.

You can watch both interviews in their entirety at http://medicine.utah.edu/alumni/deans_roundtable/

William DeVries, M.D., ’70

Thirty years ago on Dec. 2, 1982, while a blizzard swirled outside University of Utah Hospital, cardiothoracic surgeon William DeVries, M.D., carefully removed the ravaged heart of Barney Clark—a heart that tore like tissue paper due to years of treatment with steroids—and replaced it with the world’s first permanent artificial heart. Known as the Jarvik-7 (named after former U of U physician and inventor Robert Jarvik, M.D.), this aluminum and polyurethane device was connected to a 400-pound air compressor that would accompany Clark for the rest of his life—all 112 days of it. During the seven-hour operation, reporters from around the world set up their press headquarters in the hospital cafeteria, and the entire world held their breath as the team of surgeons led by DeVries, pioneered a new frontier of medicine involving the most symbolic of all our organs, the heart.

A dentist and “tough old guy” from Seattle, the 62-year-old Clark was hailed as a hero as the world watched him for the next 112 days. The willingness of both DeVries and Clark to pioneer this new device infused life into mechanical heart device research.

“With all the eyes of the world looking at me in 1982, I was very glad to have someone like Barney Clark and his wife in my corner,” says DeVries. “He really did give his life to thousands of people. All medicine is like that—it came from someone who dared to do something like this.

Did you think the Jarvik-7 heart would work? I absolutely believed that the implantation was going to work; otherwise I would not have done it. As a matter of fact, the original Utah Artificial Heart [Jarvik-7] is almost exactly the same as the Total Artificial Heart being used today. I had personally already implanted about 200 artificial hearts in calves and they did really well. Plus, we had a strong team at the University of Utah.

How was success defined? According to the Utah IRB [Institutional Review Board], success was defined as Clark coming out of surgery alive. That shocked me. My idea of success was to give Barney some quality of life, get him up and moving around, and living a bit longer.

Why Barney Clark? We had spent quite a while looking for the right patient and Barney fit the criteria for the kind of patient we were looking for. He was over 50, had chronic heart disease, and had no other options available for him. The other systems in his body were working moderately well, and he had a strong support system, primarily his family. By the time I saw him, he was facing the last few weeks of his life and death was imminent.

Barney was a tough guy, and as a successful dentist knew something about medicine. I had him watch me put an artificial heart into a cow. He saw the cow wake up and walk around. I really wanted him to understand what he might be signing up for. Barney said “I have some problems that this cow doesn’t have—it’s healthy going into this, I’m not.” He decided not to go through with it. I admit, I was a bit disappointed but accepted his decision.

Dr. Devries with Barny Clark.
What changed his mind? He changed his mind on Thanksgiving. He was so sick that day his son had to carry him to the head of the dinner table. Going to bed that night, he told his wife, he was going to go through with it. He said, “I’ve been kept alive for the last four years through all kinds of medicine and therapies that other people have given their lives to help discover; now, it is my time to pay them back.” That comment has really stayed with me. Barney’s reason was to contribute, to move science forward and to help others in the future. Once he made up his mind, he was quite determined to go through with it.

What was Barney’s reaction when he awoke from the surgery? When he woke up and started looking around, I asked Barney, ‘how do you feel, do you have any pain?’ He said ‘no pain’ but that he was aware of a strong heart beat in his body for the first time in a long time. Then he looked at his wife, Una Loy, and said, “I want to tell you even though I have no heart, I still love you.” He really became a hero for everyone, hospital staff and the 350 reporters camped out in the hospital cafeteria.

What was the last day like? On that 112th day, in which I had only left the hospital once, I had just checked on Barney and he was up reading the newspaper. An hour later, he was unconscious and his blood pressure had plummeted down to zero. At that time, declaring death was based on one’s heart stopping not on whether one was brain dead. His wife was with him, when we agreed to turn off the heart-pump machine. It was over. The easiest thing for Barney to do would have been to go home and die, but he chose not to; he was a pioneer who truly did give his life for something important.

What did you learn from the experience? We did a lot of trouble-shooting over those 112 days. We’d never had a person on this device before, so we faced a lot of new issues ranging from dealing with anti-coagulation measures to how best to deter infection. We worried about whether he should be on antibiotics the whole time. We had huge, collaborative meetings with people representing specialties from throughout the U, all helping us decide how best to care for Barney. In the end, we probably treated him with too many antibiotics and he got an infection—pseudomembranous colitis.

What was the most meaningful result of that experience? The favorability of this type of new technology jumped. If it had not worked, it may very well have slowed down the progression in this area. Instead, within the next ten years, 236 Utah Artificial Heart implants had been implanted around the world. Today, artificial implants [LVADs] are being used primarily as a bridge to transplants—securing people time until a heart is available.

What did this mean for you personally? That whole experience really defined my life and career. I’ve learned, above all, that the patient is the most important person and that relationship needs to be the focus. That was a key lesson for me as a doctor; developing a strong communication bond with the patient was a source to vital information and more likely meant success. This meant that spending time with my patients, really listening, and reciprocating with openness and honesty was key.

Today, researchers at the University of Utah continue to push the boundaries of what’s possible for patients like Barney Clark. “Our Division of Cardiothoracic Surgery remains the only program in the region actively studying novel devices to support the failing heart,” says Dr. Craig H. Selzman, Surgical Director of the University of Utah’s Cardiac Mechanical Support and Heart Transplant program and the Lung and Heart/Lung Transplant program. During the Barney Clark era, the field was so young (the U didn’t even have a heart surgery program), that transformative leaps such as implanting the first artificial heart could be made. Today, research in this field is more about incremental advances, smaller steps forward.

“What we are trying to do now, just like all of medicine, is to become more biologically based,” explains Selzman. “Engineering is important, but the devices we use are now very refined.” Today, patients suffering from heart failure can extend their lives with the implantation of a Left Ventricular Assist Device (LVAD) that weighs only ten ounces and has a diameter of 2.5 inches.

The next transformative advance is going to be in manipulating the biology of the patient and using heart pumps to assist patients in getting their heart. For example, while a patient is using an LVAD, we can learn about what makes a heart fail and how to make it stronger.”
Homer Warner, M.D, Ph.D., ‘49
Based on a 2011 interview with Dr. Homer Warner by Peta Owens-Liston

Homer Warner, M.D. Ph.D. is downloading yet another app onto his iPhone. This latest app allows him to view current snow conditions at all the world’s prominent ski resorts. Never mind that he hasn’t skied for years. “This little thing here,” says a 90-year-old Warner, flashing his iPhone, “has a thousand times more memory than the first digital computer we used, which took up space twice the size of this room.”

“I think he had the first iPhone in Utah,” confides his son Stephen Warner. “The minute he reads about some new technology, he’s downloading it or down at the Apple Store.”

Pioneer of Biomedical Informatics

Warner’s research in the 1950s fueled the idea that computers could be used to improve patient care. The use of electronic medical records (EMRs) today is merely the tip of the iceberg perched upon years of Warner’s cerebral sweat and passion-driven analysis.

Warner’s imprint is not only found in today’s medical technology, but also on the hundreds of students he taught in his labs and in classrooms throughout his long career. As the chair and founder of the world’s first degree-granting Department of Biomedical Informatics (1962), he helped guide more than 200 students through their Ph.D.s. “He was a hands-on teacher who for some reason never really intimidated us,” recalls Reed Gardner, a former student who became second chair of the department. “He’d say, ‘well if you’ve got an idea, go and try it,’ giving us remarkable freedom in terms of helping us gather data from real clinical situations.”

Solving Equations by Becoming a Student Again

The turning point for Warner was in 1956 when he enrolled in an advanced engineering math class and learned about a math concept called Fourier Analysis. He stayed up all night using a 3-foot slide rule to analyze one heartbeat. “I got so excited because it was such an interesting way to look at things,” recalls Warner. “It led me to the whole concept of using computers in medicine.” Another mathematical concept, Transfer Function, prompted Warner and his colleagues to build their first analog computer. “I wasn’t a mathematician, but with this machine I could solve equations,” says Warner.

When the University purchased their first digital computer in 1960, Warner saw the Holy Grail. “I knew there were things we could do with this that we could never do without it.” Working with graduate students late at night when the computer was available, they proved that it could diagnose as well as or better than cardiologists. When they presented their findings at an American Heart Association meeting, it raised quite a stir among physicians, who felt it was ridiculous that a computer could “diagnose and think.” The study resulted in a NIH grant for a digital computer at LDS Hospital.

“I realized that that’s where the future lay for me,” explained Warner. “All of a sudden I had something like a microscope that no one else had that let me look at things in a completely different way and get insights I wouldn’t have without this tool.”

From the Heart to HELP, Computers in the ICU

Warner developed computers to analyze pressure waveforms, eventually moving them from the lab to the operating room and then to the Intensive Care Unit (ICU).

Reed Gardner and Warner collaborated to set up a system for ICU heart patients that would flash red, yellow, or green, signifying different readings. One day, Warner walked into that ICU and watched a nurse become confused about what to do after a yellow light went on.

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“The venous pressure was rising, the arterial pressure was going down, and the cardiac output was dropping, and she didn’t know what to do,” recalled Warner. “She was overloaded with information.” The nurse only needed some guidance, perhaps from the computer itself, thought Warner, whose mind began pursuing a solution.

In 1968, during what Warner calls the most productive week of his academic life, he wrote the first version of the software program for the HELP system (Health Evaluation thru Logical Processing). This was the first computer-based medical record in which medical logic evaluates patient data in order to give the care provider assistance. It would generate alerts, reminders, and messages in accordance with best care standards, develop differential diagnoses, and provide critiques or suggestions for interventions. As it became more and more refined, it was populated by information from the pharmacy, clinical laboratory, infectious disease, cardiology, pulmonary function testing and diagnosis from history data. HELP was probably Warner’s most significant contribution to the field, being one of the first operational systems to have a separate knowledge base in the 1970s.

“He was always thinking of new applications and solutions” recalls Charles Sorenson M.D., who worked in Warner’s labs while he was in medical school and is now the CEO of Intermountain Health Care. “He wasn’t the sort of person who got enamored with one success and didn’t move on to other things. He was always asking, ‘How can we make this better and work more effectively?’”

Sorenson recalls Warner calling the lab late one night to check with the night lab technician about rebooting the computer (he had a connection to it at home). He asked Sorenson why he was at the lab so late to which Sorenson answered that he was really interested in what he was doing and having a lot of fun with it. Sorenson then asked why Warner was calling at 2 a.m. “For the same reasons,” responded Warner.

Founder of the First Department of Medical Informatics

By 1962, Warner’s research was attracting more and more students. Henry Eyring, Ph.D., Dean of the Graduate School commented, “It’s a shame, Homer, that your students can’t get a label that will tell people what kind of training they’ve had. You really ought to have a department.” With Eyring’s help, the Department of Biophysics and Bioengineering was established in the engineering school. Later it would move into the medical school and eventually become the world’s first Department of Biomedical Informatics. Almost fifty years later, the department has educated more Ph.D. students than any other department.

Warner was always more interested in the research than in the accolades. You have to do your own digging to find out that Warner received the prestigious NIH Research Career Award, was president of the American College of Medical Informatics (where an award has been created in his honor), founder and editor of the field’s academic journal for 26 years, among many other tributes.

A Balanced Life

Throughout his career, Warner was as committed to his wife, Kay, and their six children as he was to his career. He attended his children’s dance recitals and was a Boy Scout leader. He wrote letters to his grandchildren sharing his excitement for what they were experiencing. “Work in spurts” was his advice, when asked how he accomplished so much.

An avid and self taught sailor, Warner took a six month sabbatical in 1982 with family and sailed his 40-ft sailboat, Daisy, in the Victoria to Maui Race. He wrote a book while on his sabbatical sail, Computer-Assisted Medical Decision-Making, which he dedicated as follows, “To Kay who conceived it, to Daisy who carried it, and to Dorothy, who delivered it—my wife, sailboat, and secretary respectively.”

Homer Warner continuously moved into new frontiers, both personally and professionally. Whether as a sailor, a Navy pilot, a researcher, or as a father, grandfather and great-grandfather, he was always looking forward to the next endeavor. In referring to Warner, Reed Gardner said, “He was always a free spirit, adventurous in everything he did.”
Physical inactivity is bad for one’s health. A recent publication in *The Lancet* estimates that 1 in 10 deaths worldwide can be directly attributable to physical inactivity. Sitting is now considered an independent risk factor for all-cause mortality. We have successfully engineered physical activity out of our lifestyles with a clicker for everything, and moving sidewalks, to name only a few. Now we must re-engineer physical activity back into our world.

One such strategy is through the implementation of walking workstations. Developed by Dr. Jim Levine, an endocrinologist at the Mayo Clinic, the treadmill desk allows the user to walk at a slow pace of 1-3 miles per hour promoting physical activity throughout the day, while avoiding sitting. It is important to point out that this is not exercise, which would typically be performed at a much higher intensity, but is physical activity which along with exercise is beneficial for health. Research has shown that 30 minutes of moderate to vigorous intensity physical activity cannot undo the harms of eight hours of sitting! When it comes to physical activity, none is bad, some is good and more is better.

Physicians and other health care providers can play a significant role in promoting physical activity with their patients. A recent report from the U.S. Preventive Services Task Force found that physician counseling for physical activity was associated with increases in patient physical activity along with reductions in multiple cardiac risk factors. However, only one-third of patients receive counseling from their physician regarding physical activity; and the strongest predictor of physician physical activity counseling is in fact a physician’s own physical activity level. Simply put, it is not enough for physicians to “talk the talk” with regard to physical activity, they must also “walk the walk” to be credible and effective advocates.

Through the generous support of the University of Utah Educational Resource Development Council, along with the Department of Family and Preventive Medicine, we have placed six treadmill workstations in the Health Sciences Education Building and Eccles Health Sciences Library. Two of the workstations are located in the Medical Student Lounge, two are in the combined Health Sciences Student Lounge, and two are on the first floor of the Eccles Library. The treadmills go from 1 to 4 miles per hour and the desks are height adjustable to accommodate multiple users.

First and second year medical students completed a web-based questionnaire regarding their own personal activity and their attitudes about physical activity counseling at the start of the academic year and will be invited to complete a follow-up questionnaire at the end of the Fall and Spring semesters. Utilization of the treadmill workstations by the students is also being tracked. Integrating the questionnaire and utilization data, we will evaluate the impact of this environmental change on the attitudes and behaviors of medical students regarding their own physical activity.

Physicians and other health care providers can play a significant role in promoting physical activity with their patients.

The overarching goal of this study is to raise awareness and encourage physical activity as part of a healthy lifestyle among medical students with the hope this will translate into healthier doctors and healthier patients.
The Medical Student Wellness Program (MSWP) at the University of Utah School of Medicine was established in the summer of 2010 in an effort to help medical students maintain their emotional and physical well-being as they undergo the inevitable stress and rigors of a medical education. The MSWP addresses this issue through the provision of educational and counseling services for all students, their families, and children.

Medical students (like resident and attending physicians) are a high risk group for the development of mental health issues and are less likely to request assistance than the general population. Nationally, nearly 50% of students report burnout, around 20% endorse significant depressive symptoms, and between 6%-12% report suicidal ideation during their medical school years. Untreated mental health problems often lead to further impairment in their professional careers. This is most starkly represented by the fact that male physicians are 40% more likely to complete suicide than the general population, and alarmingly, female physicians have 130% higher rate of completed suicide.

To counter these trends, our educational efforts aim to teach healthy and adaptive stress management techniques. This year, thanks to the efforts of faculty, volunteers, and students alike, we will be introducing a weekly series of noontime discussions and activities on most Wednesdays throughout the academic year. Discussion topics will be on a variety of wellness themes; the activities will focus on teaching mindfulness-based stress management skills.
Josh Bonkowsky, M.D., Ph.D., assistant professor of pediatrics at the University of Utah, was awarded a prestigious Director’s New Innovator Award from the National Institutes of Health (NIH).

The NIH awards the honor to 50 researchers across the country who pursue visionary work that exhibit the potential to transform scientific fields and speed the translation of research into improved health.

The grant is a 5-year, $1.5 million study for a novel method to understand the nervous system. Established in 2007 and awarded annually by the NIH, the New Innovator Award is intended to support exceptionally creative new investigators who propose highly innovative projects that have the potential for unusually high impact. Dr. Bonkowsky was named as a New Innovator Award recipient at the Eighth Annual NIH Director’s Pioneer Award Symposium in Bethesda, Md.

The Common Fund High Risk High Reward Program provides opportunities for innovative investigators in any area of health research to take risks when the potential impact in biomedical and behavioral science is high,” said NIH Director Francis S. Collins, M.D., Ph.D.

As a clinician, Dr. Bonkowsky treats children with neurodevelopmental disorders such as epilepsy and brain injury in preterm birth and it has been his on-going clinical interactions that drive his research. Dr. Bonkowsky’s project focuses on a novel genetic approach for understanding how the brain circuitry develops and functions. The research uses an innovative technology that activates gene expression when cells make contact. His team of researchers is using this innovation to map neural circuits, and characterizing nervous system reorganization following injury.

“Patients throughout the world are benefiting from his work,” says Ed Clark, chair of the Department of Pediatrics at University of Utah School of Medicine. ©
The past year has seen tremendous growth for the Pediatric Research in Inpatient Settings (PRIS) network (pronounced ‘prize’). The PRIS network membership now exceeds 700 hospitalists representing over 85 hospitals, 43 states, and 3 Canadian provinces. Hospitalists are generalist physicians who care for hospitalized patients, and are the largest growing specialty in the United States.

The network is diverse, including small community hospitals and large free standing children’s hospitals. “We believe that collaborative research and implementation efforts are the key to transforming our healthcare system and improving outcomes for children,” says Chair of the PRIS network Executive Council, Raj Srivastava, M.D., FRCP(C), M.P.H., an associate professor of pediatrics at the University of Utah in the Division of Pediatric Inpatient Medicine and a Fellow with Intermountain Healthcare’s Institute for Healthcare Delivery Research.

The mission of PRIS is to improve the health of and healthcare delivery to hospitalized children and their families. The mission is accomplished by conducting multi-institutional studies in areas of inpatient pediatric care to support clinical decision making about everyday clinical practice questions that are relevant when caring for children and their families. Currently, PRIS research is supported by nearly $13 million in private and federal funds.

Since 2009, the University of Utah has housed the network’s administrative core. “The U houses a lot of highly-productive research networks,” says Srivastava. “We have a long history of supporting multi-center research that will answer questions in a rigorous manner so that we may help care for our patients using the best available, up-to-date information. PRIS is happy to join a long list of these other established networks that have a home at the U.”

Utah-managed Pediatric Research Network Hits Membership Milestone

In July of 2012, Nicholas Whipple, M.D., a 3rd year pediatric resident at the University of Utah was standing in a hot, humid room in a rural health clinic in West Africa. Behind him was a projector screen and in front of him were 14 public health nurses and midwives from the Atwima Nwabeagya sub-District Ministry of Health in central Ghana. “We know that pneumonia, diarrhea, malaria and malnutrition are by far the most common causes of death for children in rural areas. We also know that health workers such as you can learn to effectively identify and treat these conditions in the community setting,” Whipple told his audience. Over the next six days, Dr. Whipple introduced the health workers to a program conceived by the World Health Organization and UNICEF designed to improve the recognition and management of common childhood killers in low-resource community settings. Each of these trainees would serve in turn as trainers for other community health workers.

Dr. Whipple found himself in front of this audience through participation in a unique educational program in the Department of Pediatrics. The Global, Rural and Underserved Child Health Certificate Program provides participating residents with the structure and resources to study, discuss and experience various aspects of child health in resource-limited or rural settings. Through lectures, readings, on-line education and peer-to-peer education sessions, residents explore child health through a global lens. While a few residents have found themselves in rural Africa, others have completed electives in rural or underserved settings in the Intermountain West.

Dr. Whipple, upon return from his work in West Africa, said “After such an eye-opening medical experience in Ghana, I have little choice but to make furthering the cause of global health one of my career aims. More than ever, I see how medical progress on a global scale, particularly in impoverished areas, is often an unglamorous exercise and quite taxing at times to
To address the growing need for quality and accessible eye care, on July 4, 2012 the John A. Moran Eye Center signed a Memorandum of Understanding (MOU) with the San Fernando General Hospital in Trinidad and Tobago in conjunction with their Ministry of Health.

With a population of 1.2 million, Trinidad and Tobago (located in the southern Caribbean) has 30 ophthalmologists with a strong private practice base. Due to poverty, 70 percent of cataract surgeries go through the public sector, frequently leaving patients waiting for four years to get the procedure. Because of the long wait time, many people use the private sector, which charges more for the surgery than in the U.S.

“Last year, the major public clinic in Trinidad and Tobago performed just 300 cataract surgeries between their seven ophthalmologists. That’s less than one per week per physician,” says Randall J Olson, M.D., CEO of JMEC. The MOU outlines plans to make San Fernando Hospital a center of excellence for the Caribbean and Central American region. This includes increasing the number of sub-specialists (currently they only have a retinal specialist and a pediatric ophthalmologist), modernizing the residency program, dramatically changing their surgical efficiency, and increasing the number of patients treated.

“The work has already begun. Physicians from Moran have visited Trinidad and Tobago on two separate occasions and one of their physicians recently received training at our facility. With ongoing training, we hope to increase the number of cataract surgeries from 1000 in 2012 to 2000 in 2013,” said Olson.

To begin this process, Ronnie Bhola, M.D., a representative from the Ministry of Health in Trinidad and Tobago visited the Moran Eye Center September 1 – 15, 2012. His time in Salt Lake was spent working with the Moran’s retina team on the latest surgical techniques and planning with administrators how to improve operations at San Fernando General Hospital.

This project expands JMEC’s international outreach to the Caribbean region. Currently, the JMEC and its partners provide clinical support and training all over the world including regions in Africa, Asia and central and South America. The JMEC International Outreach division aims to not only provide the best surgical care, but to train and mentor local physicians and medical staff, so they can continue quality care long after the JMEC team departs.

Formally integrating global, rural and underserved child health training opportunities into the University of Utah Pediatrics Residency Program will prepare pediatricians like Nick for the ever-globalizing world, whether they care for the children of immigrants living in Utah or underserved children elsewhere.

For decades, the John A. Moran Eye Center’s (JMEC) International Division has provided medical training and performed charitable surgeries throughout the world. It is now expanding its scope of services to the Caribbean. With an unprecedented partnership, JMEC has committed to provide medical training, operational and strategic support to create a center of excellence in the area.

John A. Moran Eye Center Assists in Creation of Caribbean Center of Excellence
U Professor and Alum Displays His Paintings:
“Homelessness in Our City”

Don Pedersen, P.A. (’78) Ph.D. (’88) displayed two of his 3’ x 3’ paintings depicting homelessness in our city and made fine art prints available of the paintings to participants at the 8th annual Street Medicine Conference held in Alumni Hall at the Spencer F. and Cleone P. Eccles Health Sciences Building in September.

The paintings are a collage of images of individuals and agencies active in support of the population of homeless individuals in Salt Lake City. The signed and numbered prints were given to those conference participants donating $100 or more to the Street Medicine Institute. Street Medicine is the provision of medical care directly to those living and sleeping on the streets through mobile services such as walking teams, medical vans and outdoor clinics. Street Medicine is the first essential step in achieving higher levels of care through assertive, coordinated and collaborative medical management.

The Street Medicine Institute facilitates and enhances the direct provision of health care to the homeless where they live. Efforts in cities worldwide have led to a global awareness of Street Medicine that embodies compassionate, accessible and cost effective care to a population that otherwise would be universally ignored. Those communities that provide Street Medicine look to the Street Medicine Institute for support and guidance as the field of practice continues to develop.

Salt Lake City was specifically chosen to host this year’s symposium because of the exemplary model of collaborative and coordinated care practiced by its core group of homeless outreach organizations including the Fourth Street Clinic, University of Utah Global Health Initiative, and Volunteers of America-Utah. Their creatively-networked resources, strong community partnerships, and shared ideological vision have helped them work together seamlessly to meet the health needs of a diverse street homeless population.

Over a decade ago U of U physician assistant alumnus Peter Chapa, ’95 and Pamela Atkinson (for whom the Fourth Street Homeless Services Center is named) pioneered the first major outreach to those in need on Salt Lake City streets with a mobile van, bringing clothing, food and other assistance to the homeless.

Then, two years ago School of Medicine alumnus and physician assistant, Joel Hunt, ’08 began working with the Fourth Street Clinic to establish a bond of trust with chronically homeless individuals who refused to come in off the streets for health care by bringing medical care to them in the form of physician, nurse and physician assistant staffed medical vans. The effort is proving to be successful in decreasing ER visits for street people with debilitating health care problems.

The many agencies involved in the homeless outreach effort are depicted in Dr. Pedersen’s paintings. These agencies are literally a lifeline for those in need of care.

If you are interested in purchasing a print to support medical outreach to the homeless in Salt Lake City contact Donald Pedersen at dpedersen@upap.utah.edu.
Dr. Orville Nielsen was born on May 8, 1916 in Huntsville, Utah. He attended school in Huntsville through the ninth grade and Weber High School in Ogden. He attended what was then Weber College for two years, then transferred to the U of U in 1939, earning a degree in bacteriology in 1941.

He entered the medical school at the U in September of 1941, a member of the first four-year class. After the bombing of Pearl Harbor in December, representatives from the Army and Navy visited all U.S. medical schools to sign up students so they wouldn’t be drafted. Orville passed the Navy physical and finished medical school as a cadet. During the war years the medical school went year round and classes graduated in three years instead of four. All graduates were then allowed a nine-month internship, which Orville served at Graduate Hospital at the University of Pennsylvania. Upon completion of his internship he received orders to the Marine Corps. He was at Camp Pendleton in basic training when the bomb was dropped on Hiroshima and Nagasaki, ending the war. Shortly after he was sent to occupied Japan where he was involved in finding and destroying weapons of warfare.

Upon his discharge from active duty in the Navy he trained in internal medicine at LDS Hospital in Salt Lake, the Graduate School Hospital at the University of Pennsylvania and the VA medical training program in Memphis, Tennessee.

In 1950 he began to practice medicine in Provo, but was recalled to active duty in the Navy in 1952, stationed first in Boston and then in So. California. It was while working at the Navel Hospital at Camp Pendleton that a doctor from the Navel Bureau of Medicine and Surgery visited and asked Orville if he was interested in obtaining more training in gastroenterology, which he was. After training in gastroenterology at Graduate Hospital in Philadelphia for a year he was ordered to the Navel Hospital of Philadelphia where he worked as the first board certified gastroenterologist in the Navy. He oversaw two 30-bed wards for gastroenterology and started the first Navy training program for gastroenterology.

From 1966-1967 he served on the hospital ship, the USS Sanctuary, where he was the Executive Officer and Chief of Medicine. From there he was transferred to the Bureau of Medicine and Surgery in Washington, DC. In 1969 he was transferred to the Navel Hospital in Newport, Rhode Island where he was once again the Executive Officer and Chief of Medicine. Upon retiring from the Navy in 1972 he moved to Binghamton, NY where he practiced gastroenterology until he retired in 1975. There he and his wife, Emily Abbott Nielsen, served on various community boards and kept up the old family home that was established by Emily’s grandfather in 1905.

Dr. Nielsen continued to keep up with his specialty and was proud of his medical training at the University of Utah and his ties to Utah and hoped his gift would further both his specialty and strengthen the Gastroenterology Division at the School of Medicine.
Camille Collett, M.D.’83
Dr. Collett was raised in Colorado, and came to Utah to attend Westminster College, her medical training was at the University of Utah, and the Family Medicine Residency at Holy Cross Hospital. She completed a Family Medicine Fellowship and was on the faculty at the University of Utah Department of Family and Preventive Medicine from 1986 to 1990. She worked at St. Mark’s Hospital from 1990 to 2000 and was involved in the development of the Family Medicine Residency program located there. For ten years she was a family physician at the Salt Lake Community Health Centers, where she cared for all ages including obstetrical patients. She delivered babies for 27 years until Labor Day, 2010. She was in a clinic-based practice for a year and then transitioned back to join the faculty at the St. Mark’s Family Medicine Residency in September 2011. She is married, and has one adult son who lives in Montana.

Thomas D. Coppin, M.D., ’67
Dr. Coppin was born in Salt Lake City, and raised in Provo and Brigham City. He graduated from Utah State University and the University of Utah School of Medicine. A distinguished military graduate of ROTC, he had a 30-year Army career with a rotating internship and residency in pathology, served in Germany, was an exchange officer as consultant pathologist at the Royal Army Medical College in London, and was Chief of Pathology and Residency Program Director for 15 years at Madigan Army Medical Center, Tacoma, Washington. For three years he was also Pathology Consultant to the Army Surgeon General. He returned to Utah in 1993, worked for FHP and Paracelsus Hospital, and worked nine years as a pathologist at Lakeview Hospital in Bountiful. He is a past president of the Utah Society of Pathologists and for four years was the state commissioner for laboratory accreditation for the College of American Pathologists. In 2007 Dr. Coppin organized and became project director for Pathologists Overseas to restore surgical pathology to a 1,000-bed teaching hospital in Kumasi, Ghana, recruiting and managing rotating volunteers for the next three years. He and his wife currently serve at the Family History Library in Salt Lake City.

Elizabeth Hammond, M.D., ’67
Dr. Hammond was born and educated in Salt Lake City. She received her BS and MD degrees from the University of Utah. She did an internship at the University of Utah Medical Center, and then went to Stockholm, Sweden on an NIH postdoctoral fellowship in tumor biology. Her residency was in anatomic pathology and immunopathology at Massachusetts General Hospital. She served as an associate pathologist at Mass General Hospital and assistant professor of Pathology at Harvard Medical School until 1977. While in Boston, she and her husband Jack became the parents of three children.

Dr. Hammond returned to Utah where she developed the Electron Microscopy Laboratory at LDS Hospital, a specialized pathology service providing special pathologic examinations of cancer, transplant and cardiac and kidney tissue specimens. Her husband Jack founded his own architecture firm in Salt Lake City. Together they raised their children and had great fun mixing professional lives, soccer games, swimming and tennis meets, CDT performances, and ski adventures. As the children left home, Dr. Hammond became more involved in professional activities, chairing her department at LDS Hospital, becoming a tenured professor of pathology at the University of Utah School of Medicine and serving on the Board of Intermountain Healthcare, as well as the College of American Pathologists and the National Cancer Institute. She retired from her pathology group in 2011 but continues to pursue her research interests related to predictive cancer testing and cardiac transplantation research. For her, research beats playing golf!
Scott Hopkins, M.D., ’94
Dr. Hopkins was born and raised in Salt Lake City, Utah. He graduated with a B.A. in history from the University of Utah in 1990 before proceeding to the University of Utah Medical School where he graduated in 1994. He then pursued two years of general surgery training and four years of urology residency at Indiana University. In 2000, he returned to Salt Lake City and joined Western Urological Clinic where he practices general urology at St. Mark’s and Alta View Hospitals. He is married with 5 children aged 4-18. He enjoys biking, skiing, reading and almost any outdoor activity with his family. He has enjoyed hosting medical students and their significant others in his home as part of the SOM Alumni’s Dinner With a Doc program and is looking forward to working on the Student Program and Awards Committee on the board.

Dale B. Hull MD, ’85 M.P.A.
Dr. Hull is a Utah native from Roy City. He attended Snow Jr. College and completed his undergraduate degree at Weber State University. After a year and half of graduate work at BYU in physiology he entered the University of Utah School of Medicine graduating in 1985. He completed his residency in Obstetrics and Gynecology at the University of Utah Medical Center and Affiliated Hospitals in 1989. He practiced general obstetrics and gynecology for ten years in the south Salt Lake Valley.

In 1999 he experienced a spinal cord injury resulting in paralysis from the neck down. This life-altering event, which prevented him from returning to active practice, required him to devote approximately three and half years to his rehabilitation. He was fortunate to have an early return of neurological function. With the expert guidance of physical therapist Jan Black, he was able to take advantage of that return to make significant progress.

Realizing there was an unmet need to provide access to the extraordinary rehabilitation he had experienced, Dr. Hull partnered with Black to form a non-profit organization to help others facing paralysis. In 2004 they opened Neuroworx, a physical therapy clinic providing aggressive, innovative neurological rehabilitation. He serves as the executive director of Neuroworx.

Dr. Hull completed a Master of Public Administration degree from BYU in 2012 to improve his ability to direct the Neuroworx organization. He lives in South Jordan and is currently president of the South Jordan Rotary Club. He is married to Renee Heileson and has four sons.

Amasa Mason Redd, M.D., ’63
Dr. Redd was raised in Monticello, Utah, where he attended elementary through high school, all in one building. He started his college education in premed at Brigham Young University. After two years he was drafted into the United States Army. After his basic training and additional schooling in photo-interpretation he spent a year in the Far East mostly in South Korea. After discharge from the Army he returned to BYU for one year. Again his college education was interrupted, this time to serve as a missionary for three years in Switzerland.

Finally, after nine years he completed premed and began medical school at the University of Utah. He never considered being a teacher, but after his residency in psychiatry, C. H. Hardin Branch, M.D., chairman of the psychiatry department, invited him to stay on as a member of the faculty. He loved his experience at the U, working with patients and colleagues in psychiatry and teaching and working with medical students and residents.

He formally retired in 1999 but continued to work in consultation psychiatry at the University Hospital until 2001 when he and his wife, Karen, left to serve a mission for the LDS church in the Far East. He currently serves as a volunteer for the LDS Missionary Department as Chairman of the Psychiatry Committee and covers for colleagues on the University of Utah inpatient psychiatric units about a week a month. He and his wife Karen have seven children and eighteen grandchildren.
Alumni News

Class of 1962

Joseph R. Armstrong, M.D.
Dr. Armstrong and his wife JoAnne have five children, twenty-four grandchildren, and four great-grandchildren. He enjoys doing church service, yard and garden work, duck hunting, sports, and salmon fishing in Alaska. He decided to become a physician at the age of 12 years old and is still happy with that decision.

I. Laurence Gee, M.D.
Dr. Gee and his wife Alice live in North Salt Lake City. He specialized in pediatrics until retiring in 1996. His hobbies include researching his family history, working with computer and web-based medical records, pediatrics, and obstetrics.

Wendell Bart Christenson, Jr., M.D.
Dr. Christenson specialized in urology and practiced medicine for many years until he retired in 1998. His hobbies include family history research, traveling, and missionary work. He is currently serving an 18-month mission with his wife at the Oakland Temple Visitors Center in Oakland, California.

Elbert M. Dansie, M.D.
Dr. Dansie and his wife Shanna have been married for 51 years; they have six children and sixteen grandchildren. His interests include cycling yearly in the Salt Lake Century and participating in the MS150. He has traveled around the Cape of South Africa and is planning a trip to Antarctica. His hobbies include fly fishing and reading history books, especially on the adventures of Lewis and Clark.

Eric F. Holt, M.D.
Dr. Holt and his wife Marlene have been married for 58 years. They have “four marvelous and intelligent children, seven grandchildren, and three great-grandchildren and all are really close to being perfect.” His interests include being with family and friends at their home on the shores of Payette Lake in Idaho.

Rodney Hoyle, M.D.
Dr. Hoyle is on the Board of Directors of the Everett Philharmonic Orchestra, associated with the School of Music and Art, and is active in the National Guild for Community Arts Education. His hobbies include playing the violin for the Mukilteo Community Orchestra and rebuilding violins.

Klint H. Stander, M.D.
He enjoys building model sailing ships and recently donated 13 of his models to Huntsman Cancer Center where they are on display.

Mark Nicklanovich, M.D.
Dr. Nicklanovich specialized in gastroenterology. While in medical school, a resident told him “You might as well pack your bags because no one talks to Dr. Burdett (surgeon) like that!” Somehow he survived! His best memory of medical school is getting to know everyone at the senior banquet.

Theodore G. Obenchain, M.D.
Dr. Obenchain’s significant achievements include publishing a book, The Great Viession Debate: France, Power Cabot, Experimental Science and the Claims of Brutes. In addition to medicine, he enjoys traveling, reading, exercise, and completed a two year master’s degree program in creative writing in Cambridge, Massachusetts.

George C. Pingree, M.D.
Dr. Pingree specialized in ophthalmology until retiring in 2006. He is a proud father of five children and nine precious grandchildren. His hobbies include swimming, traveling, and going on family trips and activities. His professional interest is helping third-world ophthalmologists receive surgical training and serving as an ophthalmologist consultant for LDS missionaries worldwide.

J. Ronald Shaffer, M.D.
Dr. Shaffer is still practicing internal medicine in Sacramento, California. He is one of the 22 physicians who founded a medical group which later evolved into Sutter Medical Group, which now has 650 providers in the greater Sacramento region.

Class of 1967

David G. Feil, M.D.
Dr. Feil has been practicing ophthalmology in his in-office surgery center since 1983 which then expanded into the Visalia Eye Center in 1995 (www.visaliaeyecenter.com). He has three sons who are also physicians.

Dennis D. Russell, M.D.
Dr. Russell specializes in dermatology, practicing in Salt Lake City, Utah. He retired in 2007, unretired in 2009, and retired in 2010. He enjoys spending time with his family, friends, and his patients.

Klint H. Stander, M.D.
Dr. Stander specializes in cardiovascular surgery and works part time at a Federal Prison Medical Department. His significant achievements include starting an open heart surgery program in 1982 at the Utah Valley Regional Medical Center in Provo, Utah. He has seven children: one MD, two lawyers, one PhD, one artist, and two free thinkers.

Robert B. Wray, M.D.
Dr. Wray specialized in cardiology. His significant achievements include balancing a career in patient care, teaching and administration during a period in which the discipline of cardiology exploded in terms of pharmacy, technology, and in the delivery of cardiac care.
Class of 1975

Daniel Cummings, M.D.
Dr. Cummings is a family medicine doctor practicing in Casper, Wyoming. He was nominated in 2012 by the Wyoming Constitution Party as its candidate for the United States House of Representatives for its only district.

Class of 1979

Earl Leeman, M.D.
Dr. Leeman lives in Farmington, Utah and specializes in anesthesiology.

Class of 1982

Mark Chittum, M.D.
Dr. Chittum specializes in ophthalmology and practices at Retina Consultants of Southern Colorado in Colorado Springs, Colorado.

Douglas C. Fuller, M.D.
Dr. Fuller lives in Kaysville, Utah. He specializes in occupational medicine and is the medical director at Hill AFB, Utah. His significant achievements include participating as a fellow in the American Academy of Family Physicians, a fellow in the American College of Occupational and Environmental Medicine, and is a member of the American Optometric Association.

R. Kent Jex, M.D.
Dr. Jex practices cardiothoracic surgery at the Nebraska Heart Institute in Lincoln, Nebraska. He and his wife Terri are currently building a retirement home in the Heber Valley area of Utah. They hope to move there within a couple years.

David Ryser, M.D.
Dr. Ryser practices at the Intermountain Medical Center where he specializes in physical medicine and rehabilitation. His significant achievements include medical director for Neurological Rehabilitation in the Intermountain Healthcare’s flagship hospital since 1989. He is also the author/contributor to 18 peer-reviewed publications.

Class of 1983

Lori Fraiser, M.D.
Dr. Fraiser is chair of the sub-board of Child Abuse Pediatrics of the American Board of Pediatrics, was a member of the sub-board developing the first certification examination in Child Abuse Pediatrics and sits on the Board of Director of the American Professional Society on the Abuse of Children and the Governing Board of the National Center on Shaken Baby Syndrome. She remains clinically active on the faculty at the U of U department of pediatrics in the evaluation and treatment of abused and neglected children and is a leading national and international expert on the subject. She and her husband Michael live in Salt Lake City and enjoy the company of their adult children.

Class of 1985

Richard Allen, M.D.
Dr. Allen practiced family medicine for some years in rural Canada. He then went back to school for his Masters in Public Health and was offered a faculty job at St. Mark’s Family Residency where he became the program director in 2011. He also practices home health and hospice medicine. He has six girls (three born during medical school) who keep things hopping outside of work.

Class of 1987

Thomas Lloyd Gardner, M.D.
Dr. Gardner lives in Lindon, Utah with his wife Malisalei and enjoys spending time and creating memories with his four children: Calen, Josh, Brooklyn, and Beerea.

Class of 1993

Mark Chittum, M.D.
Dr. Chittum specializes in ophthalmology and practices at Retina Consultants of Southern Colorado in Colorado Springs, Colorado.

Douglas C. Fuller, M.D.
Dr. Fuller lives in Kaysville, Utah. He specializes in occupational medicine and is the medical director at Hill AFB, Utah. His significant achievements include participating as a fellow in the American Academy of Family Physicians, a fellow in the American College of Occupational and Environmental Medicine, and is a member of the American Optometric Association.

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Dr. Ryser practices at the Intermountain Medical Center where he specializes in physical medicine and rehabilitation. His significant achievements include medical director for Neurological Rehabilitation in the Intermountain Healthcare’s flagship hospital since 1989. He is also the author/contributor to 18 peer-reviewed publications.

Class of 1995

James Schouten, M.D.
Dr. Schouten practices family medicine and is the hospice medical director in Payson, Arizona. He has four daughters.

Class of 1997

Richard Allen, M.D.
Dr. Allen practiced family medicine for some years in rural Canada. He then went back to school for his Masters in Public Health and was offered a faculty job at St. Mark’s Family Residency where he became the program director in 2011. He also practices home health and hospice medicine. He has six girls (three born during medical school) who keep things hopping outside of work.

Class of 1999

Kevin Gardner, M.D.
Dr. Gardner owns a private practice, Wasatch Peak Family Practice, which expanded from 3,000 sq. ft. to over 8,000 sq. ft., offering rooms for 120 providers. It is the only family practice that still admits to Davis Hospital and serves as a back-up for all other hospitals. He and his wife of 25 years have two children.

Class of 2005

Richard Gurgel, M.D.
Dr. Gurgel finished his residency training at the University of Iowa in 2010 and then completed a fellowship in neuro-otology and skull base surgery at Stanford University. While at Stanford, he was awarded Fellow Teacher of the Year for two consecutive years. He is now an assistant professor in otolaryngology at the University of Utah. He and his family are happy to be “home” at the U!

Class of 2007

Brandon Park, M.D.
After completing one year at the University of Utah for general surgery, Dr. Park went on to the University of Nebraska Medical Center where he just completed his residency in diagnostic radiology.

Megan Freestone-Bernd, M.D.
Dr. Freestone-Bernd just completed her pediatric anesthesiology fellowship at the Penn State Milton S. Hershey Medical Center and is now an assistant professor of anesthesiology there. Her family has been staying busy. She and her husband, Kerry, are the lucky parents of a wonderful two year-old boy named Asher who is a joy!
Patrick F. O’Leary, M.D., HS 1969 Receives Lifetime Achievement Award from New York City’s Hospital for Special Surgery

Patrick F. O’Leary, M.D., received the Lifetime Achievement Award at Hospital for Special Surgery’s 29th Annual Tribute Dinner at the Waldorf-Astoria in New York City.

More than 1,000 people attended the June event, which raised 2.6 million dollars for education, research and patient care at Hospital for Special Surgery.

Dr. O’Leary, a former chief of the Spine Service at Hospital for Special Surgery, has focused on the fundamental principles and evolving techniques of spine surgery over the past 35 years. He specializes in the surgical management of disorders of the cervical, thoracic and lumbar spine, including revision surgery. He helped co-develop the Spine Section in Biomechanics in 1990 and establish the Biomechanics Fellowship at Hospital for Special Surgery in 1991.

Professional athletes, including members of the New York Mets, New York Knicks, New York Jets and New York Rangers are among those Dr. O’Leary has treated.

Dr. O’Leary is a fellow of the American Academy of Orthopaedic Surgeons, the International College of Surgeons and the American College of Surgeons. Dr. O’Leary is also a member of the New York Academy of Medicine, Cervical Spine Research Society, the Scoliosis Research Society and the North American Spine Society.

Dr. O’Leary (left) receives Lifetime Achievement Award.

Do you have an idea for an article in Illuminations?

A story you’d like to share about your personal experience in the world of healing?

A humorous or moving incident you think other medical personnel would enjoy reading?

Know of an alumnus/a who has done something remarkable in their life?

Submit your ideas or manuscripts (subject to editing and no longer than 1200 words) on line at http://app.medicine.utah.edu/SOMAlumni/index.htm by attaching them to the image link, email your submission to Kristin.gorang@hsc.utah.edu or mail to Illuminations, SOM Alumni Relations, 540 Arapeen Drive, Ste. 120, Salt Lake City, UT 84108.
## In Memoriam

<table>
<thead>
<tr>
<th>Name</th>
<th>Degree</th>
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<tbody>
<tr>
<td>Carlo C. Davis, M.D.</td>
<td>HS*</td>
<td>13 Aug 2012</td>
<td>M. Paul Southwick, M.D.</td>
<td>MD 1945</td>
<td>02 Oct 2012</td>
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<tr>
<td>Donald Kassebaum, M.D.</td>
<td>HS*</td>
<td>19 Oct 2012</td>
<td>Russell V. Young, M.D.</td>
<td>MD 1978</td>
<td>06 Jul 2012</td>
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*HS designates House Staff alumni

## Call for Nominations

### School of Medicine Distinguished Alumni, Service and Humanitarian Awards 2013 Submission Criteria

The following categories are used to describe the nominee’s qualifications for receiving the award. The nominator will be requested to describe how their nominee contributes to any or all of the categories listed, plus any other pertinent information he or she feels is valuable to the nomination:

<table>
<thead>
<tr>
<th>Distinguished Alumni Award</th>
<th>Distinguished Service Award</th>
<th>Distinguished Humanitarian Award</th>
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<tbody>
<tr>
<td>• Exelled in Clinical Practice</td>
<td>• Service to the School of Medicine</td>
<td>• Outstanding Commitment to the Health of the Community</td>
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<tr>
<td>• Extensive Academic Activities</td>
<td>• Contribution to the Field of Medicine</td>
<td>• Service to Underserved Populations or in Challenging Situations</td>
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<tr>
<td>• Research Accomplishments</td>
<td>• Demonstrated Commitment to Enhancing Medical Education</td>
<td>• Community Service</td>
</tr>
</tbody>
</table>

### Curriculum Vitae:
A CV should be included with the submissions for the Distinguished Alumni Award. A CV is recommended, but not required for the Service and the Humanitarian nomination. The recipient or organization of the Distinguished Service Award and Distinguished Humanitarian Award do not need to be U of U School of Medicine Alumni.

### Letters of Support:
A minimum of two letters of recommendation are required for each nominee; one of which can be the nomination letter.

### Deadline: March 1, 2013

Send completed nominations to:
540 Arapeen Drive, Ste. 120, Salt Lake City, Utah 84108, faxed to (801) 585-2613, or emailed to kristin.gorang@hsc.utah.edu

To view previous recipients, please view our Web site: http://medicine.utah.edu/alumni/awards/past_recipients.php
An application form is available online at: http://medicine.utah.edu/alumni/awards/nominations.php

### Announcement of Awards:
Awards will be announced in May of each year and printed in the June edition of Illuminations magazine. Recipients will receive their awards at the October 10 Alumni Association School of Medicine Awards Banquet.
Class of 1962 at September School of Medicine Awards Banquet

Please visit our Web site at http://medicine.utah.edu/alumni