Illuminations
The Magazine for the University of Utah School of Medicine Alumni and Friends

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Greetings for the New Year from your School of Medicine Alumni Board!

Looking back over the past year I am proud of the work we have done representing you, our alumni, and supporting our current medical students. It has been a year of growth and progress for the School of Medicine Alumni Association. Along with celebrating the restoration of our class size to 102 students in 2013 and increasing by another 20 in 2015 (from 82 to 122 students) we are proud of many other accomplishments.

When Dean Vivian Lee called upon us to assist in funding 3rd and 4th year students’ housing during their rural primary care rotations (federal funding for this program was cut in 2013) our Half Century Society members stepped up, funding this year’s program with a $25,000 gift. We then worked with philanthropists Zeke and Kay Dumke to set-up an endowed fund to ensure annual funding for this important program in the future.

We worked with current and past board members and current students to review our 2008-2013 Strategic Plan, and developed the 2014-2019 Strategic Plan. In doing so we realized how important it is for our medical students to make a meaningful alumni connection. As part of the effort to accomplish this goal we continued to work with the Dean’s office to assist in hosting five Dean’s Roundtables, bringing distinguished graduates of the School of Medicine together with students to discuss their careers and share insights. This is a favorite activity of our students and Dean Vivian Lee. We highlight two of the Roundtables in this edition of Illuminations and all of the interviews can be found on our web site at http://medicine.utah.edu/alumni/deans_roundtable/index.php. We encourage alumni to listen to what some of your classmates have been up to during their careers!

Speaking of careers, it was once again wonderful to welcome the 28 surviving members of the Class of 1963 into our Half Century Society. Twenty-one members made it back to the annual awards banquet and their class reunion in October. It was enjoyable and inspiring to hear what they have done during the fifty years since graduating from medical school. Watching them reconnect and have such a wonderful time together made us all realize what an extraordinary opportunity and experience going to medical school and practicing medicine can be!

With the class size increase there is a more pressing need for scholarship funding. This year, thanks to your generosity, we were able to give 25 $5,000 scholarships from our Alumni Scholarship Fund, plus we now have 13 alums/friends of the school that have made five-year “named” scholarship pledges. It was rewarding to see 100+ students gather in Alumni Hall in November to write thank-you cards to their scholarship donors, to the legislators who helped with supporting the class-size increase, and to other significant donors to the School of Medicine. We continue to work with our medical student representatives on the Alumni Board to ensure that current students know of the support available to them through the Alumni Association. The students are a wealth of information and we value their advice as we work to improve our programming.

On another note, our annual CME Symposium once again addressed the changes coming with the full implementation of the “Patient Protection and Affordability Care Act [PPACA], or the ACA for short. The uncertainty created by this new law imposes extraordinary challenges on our School of Medicine, and the entire academic health center. It has been said that “change brings opportunity,” so I am hopeful that with great effort and flexibility on the part of our institution’s leaders, we will continue in our tradition of excellence in education, research, and service. However, it will take the good will and support of all of us – including alumni – to ensure this happens.

We appreciate the support of all SOM alumni and welcome your suggestions on how the Alumni Association might better serve our school, the students, and your interests and needs.

David N. Sundwall, MD, ’69
This year’s alumni weekend and awards banquet, which gave us the opportunity to look back at the many accomplishments of our graduates, was phenomenal. It is such a pleasure for me to participate, to connect and reconnect with you, as the entire School of Medicine comes together to celebrate the accomplishments and careers of University of Utah trained physicians.

As you’ll find in the following pages, we recognized and awarded several of our own with titles earned by a lifetime of service and dedication. Notably, we presented the Distinguished Alumni award to Alan Crandall ’73, the Distinguished Service award to Kay and Zeke Dumke, the Distinguished Humanitarian award to Karen Buchi ’84, and the Golden Anniversary Prize in Clinical Investigation to Matthew Rondina, ’03.

As we train the next generations of distinguished honorees, I know we are bound to witness some remarkable accomplishments. This year, more students than ever accepted our invitation to become a Utah medical student, choosing the University of Utah against some very stiff competition. In fact, of the Utah residents admitted, 88 percent chose the University of Utah over other top medical schools in the country. Moreover, we have been able to attract many of our Utah residents attending college out-of-state to come back “home” for medical school. As undergraduates, our current medical students graduated from institutions such as University of Pennsylvania, Wellesley College, Stanford, and Harvard.

Along with recruiting this great caliber of student, we have also been focused on building a remarkable team of faculty and leadership. Most recently, we were very pleased to welcome Wendy Chapman, Ph.D., ’00, our new chair of Biomedical Informatics (BMI), who returns to us by way of University of Pittsburgh and University of California, San Diego. Dr. Chapman’s research focuses on developing and disseminating resources for modeling and understanding information described in narrative clinical reports, and she is sure to bring a wealth of BMI knowledge to our students.

As the new guard of teachers and students arrive, it is also important for us to recognize those who paved the way. This year we experienced the sad loss of a dear friend and alumnus, Dr. Thomas Rees, ’48. From aesthetic surgery on Park Avenue in New York to saving lives in Tanzania, Dr. Rees lived a life about which most of us could only read in books. He used his knowledge, skills and compassion to touch countless lives around the globe. In addition to a better world, Dr. Rees left us with the generosity of two endowed chairs and the model of a life we should all strive to reflect. He will be missed. Please read more about Dr. Thomas Rees at http://healthsciences.utah.edu/notes.

The circle of life often plays out like a finely tuned symphony. I would like to leave you with a short update from Dr. Peter Crane, ’08, who is a family physician in Montpelier, Idaho. Dr. Crane reports that he is, “finally doing what he dreamed of doing nine years ago when he started at the University of Utah School of Medicine.” He currently enjoys delivering a broad spectrum of care in primary medicine, emergency services, endoscopy, and obstetrics. In addition to working in rural Idaho, Dr. Crane enjoys participating in and organizing international medical service trips. But what is most remarkable about his story, and the reason I want to share it with you, is that upon his return to rural Idaho, Dr. Crane replaced the very physician who delivered him. If that does not illuminate how things are supposed to work, I don’t know what does.

On behalf of all of us at the School of Medicine, please keep in touch and be well.

Sincerely,

Vivian S. Lee, MD, PhD, MBA

Our Unique Mission

There’s one unique role of academic medical centers in the landscape of health delivery systems, which is our role as scientists and as educators. One of the things that we all have to keep in mind as we confront the daily challenges of preparing for health care reform is how important it is to train the next generations of providers. It is this challenge that also serves as one of our greatest assets: the pipeline for the future.
Learning Empathy the Hard Way

By Terry Box, MD, HS 1983 as told to Kristin Wann Gorang

I have a great life.
But there was a time it wasn’t quite so great.

I am a hepatologist (liver specialist) for the University of Utah Liver Transplant Program, where I am involved with a great multidisciplinary team of physicians, surgeons, anesthesiologists, radiologists, pharmacists, social workers, dieticians and financial advisors. We work together to help save and vastly improve lives of individuals through liver transplantation. I am a liver transplant recipient myself. I received the gift of life from a young man who died tragically in the prime of his life. I want to share with you a little bit of my journey as a liver transplant recipient and my experiences with the Liver Transplant Team.

My liver transplant story begins in 1998, when as a healthy and very physically active 47 year old, I finally decided to have a routine check-up. My last exam was 25 years prior when I was entering medical school. It is true that we physicians often live by the motto, “do as I say, not as I do.” In the midst of the exam my internist, Roy Gandolfi paused mid-sentence and said, “Did you know your liver is huge?” Of course I had no idea, though I’d noticed my abdomen was getting bigger and attributed it to middle age, despite the fact that I was 6’ 2” tall, 140 lbs. and ran and cycled seriously five days a week. Isn’t denial great?

A few days later, after a scare that it was primary or metastatic cancer, a CT scan revealed that my liver was 90% replaced by a giant and atypical, but nevertheless benign, cavernous hemangioma. Being a hepatologist, I know about these things, or so I figured. Although my clothes were fitting a bit differently and I was having some reflux as a consequence of the enlarging liver compressing my stomach, I felt that there were no major consequences of the cavernous hemangioma, right? Well, probably…. I consulted with Dr. Legrand Belnap, who was the senior transplant surgeon at the Intermountain Liver Transplant program, where I was working at the time. His initial comment was, “That thing is going to have to come out. Let’s just go ahead and put you on the transplant list so we can eventually get it done.” But I was feeling fine, was not about to do the surgery before I had to, and felt there were many really sick people who desperately needed to be transplanted before me, so settled on tracking the growth with serial CT exams. This might not have been such a bad idea since my first CT scan six months later in 1999 showed no major changes. I was still feeling fine and decided to wait for a year before repeating the exam. However, as might be predicted, now that I had the perspective of a patient, I began to behave as a patient. The one-year follow-up exam became a one-year plus exam. In fact, if not for a serious bicycle accident, I don’t know when I would have had evaluation number three.

In February of 2001, in the process of unzipping my jacket while riding my bike, I managed to hit a bump and launched myself over the handlebars. What resulted was a mild concussion, and three fractures in my pelvis. However, the ER doctors were most astonished by the CT appearance of my liver, which I found out later showed a significant increase in the size of the vascular mass when compared to the 1999 study. I recovered from my injuries, continued to ignore the liver issue and took up biking again, feeling none the worse for wear.

By the fall of 2002 things were beginning to change for me. My sleep was being interrupted by terrible night sweats and I wasn’t feeling as energetic as usual. In my typical fashion, I felt there was nothing wrong that a good dose of exercise wouldn’t cure. In that mode,
After hours of tedious and challenging surgery the monster liver was removed and my wonderful new liver was implanted without difficulty.

I took on a challenge with some of my 50-year old biking friends to ride with some very buff 30-somethings with the intent of riding them into the ground. It didn’t take more than a few blocks for me to realize I was in serious trouble. I felt I was riding on two flat tires and after 45 minutes of struggling to keep them in sight I had to drop out. Little did I realize I wouldn’t be on my bike again for eight months!

My lower legs and ankles swelled easily, I was soaking two or three sets of pajamas nightly, and due to high-output heart failure owing to the vast amount of blood going to the mass in my liver, I could hardly do any sustained exercise. A new workup showed more growth of the mass and extraordinary displacement of all abdominal organs. Moreover, the qualities of the mass had become very atypical and there was concern that there was a malignant transformation of the infiltrating vascular process. It was determined that I most likely had a malignant hemangioendothelioma.

Because of the malignant nature of the tumor and the point system developed for rating transplant necessity, which gave me 20 extra points due to the seriousness of my diagnosis, I was soon assigned a high priority on the liver transplant list. While waiting, I continued to work and found myself putting myself in the patient’s position each time I saw a transplant patient in clinic. A definite transformation in my approach was beginning to take place.

On October 18, 2002, I was at the hospital on the transplant hepatology service when the liver transplant coordinator informed me, “We have your liver.” I drove home to pack and prepared to return to the hospital as a patient. It was a beautiful Indian summer day in Salt Lake, and to me everything had more intensity; colors were more vibrant, images more vivid, thoughts were more focused. I considered that this might be the last time I would be making the drive. Yet I hoped it would be made again under different, and hopefully much better circumstances.

It was a long wait through a good part of the night in the intensive care unit while it was determined if the liver was “a go.” My wife Lee Anne and my good friend Ray Thomason, MD, another hepatologist I’d known for over thirty years, kept me company and gave me encouragement and support. At 1:30 a.m. the call came and the news was good, so off to surgery I went.

Suffice it to say the magnitude of the liver enlargement had been underestimated by the radiology imaging and the removal of my diseased liver was extremely challenging and dicey. After hours of tedious and challenging surgery the monster liver was removed and my wonderful new liver was implanted without difficulty. My recovery of 20-days in the hospital was three times longer than most liver transplant patients due to a few problems, but overall the news was excellent, and the pathologist reported that no malignancy was found in the explanted liver.

I found being a patient a very challenging experience, partially because I knew too much (e.g. what would happen if this transplant failed?) and because hospitals and sleep are not synonymous words for me. I was overwhelmed and humbled by all the well-wishes coming in from everywhere and felt there was nothing I could do to justify this wonderful gift I’d received at the extreme cost to many others. I think of my transplant experience as a wonderful and terrible experience, or a terribly wonderful experience. I would not want to go through it again, but I have new empathy and an unspoken bond with fellow transplant patients. This empathy leads me to the next part of my tale, the formation of the University of Utah’s Liver Transplant Program and the team I currently work with.

The U’s Liver Transplant Program was started in late 2005 for many reasons. It complemented the existing transplant programs at the U in heart, kidney, lungs, pancreas and bone marrow, making the U the only transplant program in the state covering all solid organs and bone marrow transplantation. The ability to offer complete evaluation and treatment for patients with advanced liver disease and liver failure was another compelling reason, plus the program would bring additional opportunities for research and training to the hospital and the medical school.

We began by recruiting providers with skill in managing liver failure, liver transplant and post-transplant care. Dr. John Sorensen was the founding surgeon and Dr. William Hutson the first transplant hepatologist. Alana Edwards, RN, was the first transplant nurse coordinator. All disciplines that come into contact with the liver transplant patient had to be in place before the first patient could be put on the transplant waiting list.

Priority on the liver transplant list determines the likelihood of transplant. Creating a list of waiting patients and having enough patients on the waiting list with high MELD (Model of End-stage Liver Disease) to secure donor livers is the key to success of any transplant program. Starting from a list of zero patients, in a highly competitive environment, was a stiff challenge for the University team. Since the first transplant in 2006, there has been steady growth. As of November 2013, we have performed 154 transplants with 31 performed in 2013 alone. As the demand
Alumni Association has increased the team has grown and now is made up of three liver transplant surgeons, three liver transplant hepatologists, four liver transplant coordinators and three advanced practice clinicians, along with more pharmacists, social workers, financial assistants and administrative personnel to support the effort.

Because of my experience as a transplant patient I work hard with my teammates to make our team approach very patient friendly.

Despite our successes there have been losses and disappointments. Ten to fifteen percent of patients die awaiting a donor organ that never comes. The issue of organ donor shortage is worsening rather than improving in spite of considerable effort in public awareness education programs. Our team continues to make changes in procedures to better utilize more organs that were turned down in the past. The possibility of initiating a living donor liver transplant program is being seriously evaluated as the program continues to succeed and grow.

The Liver Transplant team now functions as a single, cohesive unit in its approach to assessing and managing patients in organ failure, as well as in the peri-operative period during and after liver transplantation. This approach includes daily multidisciplinary rounds on all liver failure and liver transplant patients. Such practice spreads ownership and accountability, improves communication, increases efficiency and reduces redundancies.

As for me, I am proud of the work we do at the U. I find the demands of Patient Selection Conference more challenging than ever. Even when it is the right thing, it is difficult to say no to another when I have been given so much. I am blessed because I now have insight and experience my patients’ “second chances” from two perspectives rather than only one. The synergy of generosity and love of donors and their families combined with the determination of recipients and their families, and the skill of the transplant team creates this wonderful phenomenon of transplantation and the renewal of life. I have profited from this synergy as a transplant physician in the past; I now profit from it as a transplant recipient and a transplant physician.

Like the synergy in organ transplantation, the daily synergy between patient and caregiver in all aspects of our profession has the potential to vastly improve our delivery of health care. Our empathetic understanding of the total patient experience plays a very important role in helping make for the best experience possible.

Save the Date

Half Century Society Luncheon and Program
June 4, 2014 University Guest House – Speaker: Devon Hale, MD, ’69

Global Health Care Education In Today’s World: Why is it important?

Medical Alumni and Community Weekend
October 9 -11, 2014

Thursday, October 9
Awards Banquet and 50-Year Class Celebration (Class of 1964)

Friday, October 10
School of Medicine Departmental Continuing Medical Education Programs
Dean’s State of the School Address

Saturday, October 11
Continuing Medical Education Symposium

Get in touch with classmates and see who is coming to your class reunion by posting on the School of Medicine Alumni Association Facebook page!
The Lessons of My Medical Internship

Richard H. Keller, M.D., F.A.C.R.

(The young realize) “…the world is difficult and dangerous…with monumental decisions (as if he/she) has come through this storm, but it is borne in on me, suddenly, that it is a storm, a storm, moreover, that not everyone survives and through which no one comes unscathed.” James Baldwin from “They Can’t Turn Back”.

The black clouds disgorged their marble sized hail as I pulled onto a side road of U.S. Highway 30 to wait out the deluge. It was June 1958. To the west, beyond Kimball, Nebraska lay Salt Lake City and my new life; seventeen hundred miles east lay Baltimore and four years of medical school. Those four years had transformed me from day laborer to young doctor as evidenced by the parchment framed and riding in the seat beside me. Backward was the darkening night of my four year adventure learning doctoring and being introduced to the many faces of Baltimore: its teaming slums, its decadent seaport red light district and its diverse cultures challenging and expanding my Utah-bred worldview. Forward beyond the storm clouds and hail lay an adventure with new challenges as I moved up the seemingly endless ladder of medical training to become a competent physician.

Strange faces, with names familiar through their medical writing, would confront me in my straight medical internship at the University of Utah School of Medicine. Maxwell M. Wintrobe from Johns Hopkins Medical School was the chief of medicine, coming to Utah during the school’s transition to a four-year institution in 1944, as did Louis S. Goodman from Vermont in pharmacology. Both were famous for their research discoveries and their widely used textbooks each bearing their names (Goodman’s co-author was Alfred Gilman).

The hospital campus at State Street and 21st South was a rag tag assortment of old brick buildings and converted military barracks housing the hospital, research laboratories and offices dating back to earlier in the century. For many, the fledgling school’s centerpiece department was internal medicine due to Dr. Wintrobe’s fame. Make-do ancient facilities required something like a military procurement officer’s skills of innovation, patience and creativity to squeeze in the best teaching, patient care and research results from the old until the new east bench school emerged twenty-two years later. One of Wintrobe’s early residents who later became a department chair, an excellent physician writer and critic of the profession, Herb Fred, described the poor condition of the hospital in 1944:

“…The clinical facility was the Salt Lake County General Hospital, a dilapidated, neglected, and badly run structure with no blood bank, hardly a laboratory, and filthy accommodations for patients. Nevertheless, against tremendous odds and with little financial support, (Dr. Wintrobe) was able to recruit a small but truly outstanding faculty, each member an excellent teacher, clinical investigator, and physician.”
I would learn hematology from Dr. Wintrobe and Dr. George Cartwright, endocrinology from Drs. Frank Tyler and Gerald Perkoff, rheumatology from Dr. John Ward, and pulmonology from Dr. William (Bill) Harris; each a veteran in their subspecialties; many bringing with them to their new home in Utah the bedside philosophy of Sir William Ostler also formerly of Johns Hopkins.

Some staff physicians and residents were memorable, including Alexander (Mack) Schmidt, from my hometown of Ogden, Utah. His good humor elevated patient care and teaching to an empathetic level. He would soon become a crusading Commissioner of the Food and Drug Administration under President Nixon, then later a dean at the University of Illinois Medical School in Chicago. Then there was George Cartwright who would follow Dr. Wintrobe as department chair in 1978, but in 1958 exuded superb teaching skills as he taught a course on the cellular components of bone marrow and its diseases to interns and residents. Pulmonary disease internist, Bill Harris, taught me the dangers of smoking and allowed me to fluoroscope VA patients with lung cancer and emphysema; a practice not permitted today. Hilmon Castle, a cardiology fellow, soon to be the first head of Family and Preventive Medicine, on occasion, cornered me so students could auscultate my aortic insufficiency murmur.

We rotated every month through the medical wards: a resident and two interns supervised by a senior physician. Work shifts could span a night and two days, with little time for sleep, followed by a night or weekend off. There was no vacation for interns.

On a patient’s admission, following Dr. Wintrobe’s policy, a history, a physical and laboratory work were performed by the intern and added to the patient’s new chart. Students watched simple procedures like lumbar punctures and bone marrow aspirations; interns did them following the old medical axiom: see one, do one, teach one. Soon I would be the teacher for the next intern.

Late one night, a febrile, confused, forty year old woman was admitted with suspected meningitis. I struggled to insert a three and a half inch needle for a lumbar puncture. After two unsuccessful attempts, I finally, on the third try, observed a turbid, viscid spinal fluid coming from the needle’s end. Microscopic examination demonstrated pus and bacteria establishing meningitis that required antibiotics. That struggle taught me to seek help for cases that stretched beyond my experience.

At the County, the male house staff slept, when possible, in a single large room with drab, pinkish pastel walls, no pictures, one telephone and about six standard military style cots, all too short to contain the last six inches of my extended legs. Still, I was doing challenging, exciting, rewarding but fatiguing work with no tuition; meals while working and monthly pay of fifty dollars at the County and two hundred at the two VA hospitals.

Hospital food was barely edible. I used it mostly to stave off hunger and maintain energy for work. The County featured the worst menu of all the hospitals consisting of boiled beef, potatoes, canned vegetables, hot dogs, hamburgers, and fried fish. Most dishes were under salted, and soggy—especially the vegetables and potatoes; but the boiled beef could have been on loan from the county jail, barely edible if fortified by salt and catsup. At the VA hospital, the night shift charge nurses offered their kitchen passkey to residents and interns, allowing nighttime raids on the plentifully stocked refrigerator; the resulting Dagwood sandwiches were the best I have consumed.

During my internship year, Larry Thatcher, a resident, was admitted to my ward with recurrent Hodgkin’s disease that he, himself, had detected when a sophomore medical student. Larry was treated by liquid nitrogen mustard, a chemotherapeutic agent that was one of Dr. Wintrobe’s pioneering research projects. (Its gas variant killed my uncle, Harold Keller, in World War I.) This
research originated when pharmacologists Goodman and Gilman serendipitously found nitrogen mustard suppressed the myeloid and lymphoid tissue in mice models and later found similar effects in humans that were accidentally gassed during WWII, initiating the research study that followed. Response initially was dramatic as the tumors seemingly evaporated; but sadly, the cancers always returned. Larry’s cancer returned; he died the next year. Years later, chemotherapy in more complicated formulations became an important addition to surgery and radiation therapy in cancer treatment. Dr. Wintrobe’s teams were pioneers in its development.

Here are some of Herb Fred’s comments of Max Wintrobe as a leader:

“He demanded much of those around him, but never more than he demanded of himself. He abhorred excuses, expected top effort, and praised only those whose performance was exceptional. He was firm but fair. He had the rare ability to criticize someone’s work without making the individual feel personally attacked. He listened perceptively and spoke authoritatively, never leaving his audience in doubt as to where he and they stood, and why.”

Fred quotes Wintrobe: “If I do my job well...I’ll never win a popularity contest...I’d rather be respected than loved.”

I would add: bedside medical care emphasizes the use of the best science to treat the patient’s disease and to communicate empathetically the treatment results to the patient and the patient’s family. In the late nineteenth century, Sir William Ostler instilled this approach into his students and others he influenced at Johns Hopkins. This philosophy migrated to Utah with Max Wintrobe and his associates.

Some feel this bedside approach has been marginalized by replacement of personalized patient care by an emphasis of the body as a machine instead of humanistic concern for the anxiety, fear and discomfort brought on by illness. New technologies such as laboratory tests or MRIs are tools to improve patient care but cannot replace empathetic doctor/patient communication; listening and the hands on connections of the doctor with the patient.

Presentation of cases occurred every day. The senior residents scrutinized the most challenging diagnostic and therapeutic puzzles on the ward for interns or residents to present. The most challenging presentations were to Dr. Wintrobe. His precise, questioning, analytic mind, his intolerance of mediocrity and his ability to hone in on the central problem, elevated the stakes for the intern forcing him to cogently present each case. The scene might go like this:

“Dr. Keller do you have a case for me today?”

“Yes sir. Uh, this is a forty-nine year old male with jaundice, vomiting of blood and rectal bleeding…” I would begin with notes in hand, standing at attention, wearing a clean white shirt and my best tie—white pants were part of the uniform but not always too clean. The case history, physical findings and our diagnosis—in this case cirrhosis—preceded explanation of hospital treatments as I tried to include references to new research focusing on hematological nuances to engage Dr. Wintrobe’s main interests.

At the end, Dr. Wintrobe would pleasantly say, “Thank you, Dr. Keller. Next case.” If he was critical of the presentation, he might say “Harumph” or something more descriptive. If all went well, the feeling was like landing a trophy fish after a long struggling brawl in a rocking boat; if it went poorly, it was like being dunked in an ice-cold lake, wetted with all your gear. Preparation was the key; upscale performance was our goal, but most senior residents and professors actually were gracious and understanding.

Medical care today tends to either do too much or too little. From 1958 to the present, new treatments such as artificial joints, artificial heart valves, cancer treatments, and much more enhance medicine’s armamentarium. The down side has been the influence of increasing cost and the infestation of greed into what is now a complex, profit seeking “medical-industrial complex” as described by Dr. Arnold Relman. Cost and excessive profits from the medical enterprise compromise and sometimes limit the good we do; profit seeking and even dishonesty mar medicine’s reputation. Implementation of all the advances occurring since my internship must go hand-in-hand with empathetic bedside care.

The new storm, not the storm I experienced during my internship as described by James Baldwin, but a storm of profligacy now challenges the integrity of our profession.
Huntsman Cancer Institute (HCI) at the University of Utah is an academic research center with a robust clinical research program. Our goal is to help cancer patients live longer and better lives, and patient participation in clinical trials is an essential factor in this process. Clinical trials are closely monitored studies of new interventions for cancer patients aimed at improving the prevention, diagnosis, or treatment of cancer. Nearly all the cancer treatments used today began with a clinical trial. HCI has made a major effort to transform our clinical research enterprise by elevating both patient and physician participation in clinical research and by enhancing the quality and impact of our clinical research portfolio. An early phase clinical research program was defined as one of HCI’s highest priorities for areas of future growth. Sunil Sharma, MD, Senior Director of Clinical Research at HCI and founding director of the HCI Center for Investigational Therapeutics (CIT) and the Experimental Therapeutics Phase I Program, leads the program. The overall emphasis of the program has been to deliver efficient, high-quality, early phase clinical trials with the goal of bringing personalized medicine to our cancer patients. HCI now has expertise in the areas of drug discovery and drug development and the ability to offer novel therapies to our cancer patients.

Phase I clinical trials are first-time tests of drugs or treatments on human patients that researchers and physicians believe will be beneficial. At this early stage, researchers usually do not know the drug’s effectiveness, the best dose to administer, or what side effects may occur—each of which is studied closely in an early phase clinical trial. All patients involved in Phase I clinical trials receive a form of treatment for their cancer; none are administered placebos (medically inactive agents sometimes used in medical research for comparison purposes). The preclinical drug discovery program works closely with the Experimental Therapeutics Phase I Program, along with Dr. Sharma and Theresa Werner, MD, Associate Director of the Phase I Program. These leaders have active research enterprises and are experienced clinical trialists. The Phase I team is a large multidisciplinary group that allows close collaboration of all clinicians and researchers interested in early phase clinical trials under one infrastructure. This infrastructure also allows disease-oriented clinical researchers to accrue patients on disease- or genomics-defined early phase trials and serves as a great forum for the training of young physician-scientists.

HCI’s establishment of the CIT and Experimental Therapeutics Phase I Program has led to a remarkable increase in early clinical trial activity and expanded the clinical research portfolio. HCI’s therapeutic trial enrollment has increased three fold over the last several years, with more than 600 patients enrolled in a clinical trial in 2012, which represents almost 20 percent of all new cancer patients. In 2012, HCI had 45 Phase I trials, including 10 first-in-human studies, with a total of 178 patient accruals. These studies were distributed among novel therapeutic targets, genomic, and tumor backgrounds. The HCI CIT is now a leading Phase I program in the Intermountain West and the West Coast. Our referral pattern for early phase clinical trials extends over multiple states and includes more than 38 oncologists in the region. We work closely with these colleagues to offer participation in these novel clinical trials to all cancer patients in the Intermountain West. A major focus of the clinical research program is to “personalize” treatment decisions for
each cancer patient. Personalized or precision medicine is a medical model that proposes the customization of healthcare with medical decisions and treatments being tailored to the individual patient. The use of genetic information, and information about a patient's tumor, has played a major role in personalized medicine. For example, the CIT has integrated tumor genomic screening and molecular imaging into our early phase clinical trials as a way to individualize choice of therapy and to assess response to treatment. HCI currently uses a novel decision analysis protocol that integrates genomic screening for patients with metastatic solid tumors in a new trial where a 360 gene mutation panel is analyzed. This data has allowed directed referrals of patients with the appropriate genomic background to appropriate early phase clinical trials of targeted cancer therapies. In collaboration with our Molecular Imaging Program at HCI, we have established a "triple tracer" protocol that utilizes imaging tracers to create a full molecular image of the response to a particular therapy. This protocol is a companion trial to our Phase I clinical trials and allows us to assess response to therapy sooner than with regular imaging modalities. This will enable physicians to make changes to therapy based on an individual patient’s response to that therapy.

Cancer is a life-changing journey and those affected have the opportunity to help us understand cancer and improve cancer treatments by participating in a clinical trial. We are forever grateful to the thousands of patients and their families who have helped advance cancer research and cancer treatment through participation in early phase clinical trials at HCI.

The Phases of Clinical Trials

**Phase I trial:** The first step in testing a new treatment in humans. These studies test the best way to give a new treatment (for example, by mouth, intravenous infusion, or injection) and the best dose. Because little is known about the possible risks and benefits of the treatments being tested, Phase I trials usually include only a small number of patients.

**Phase II trial:** A trial to study the safety, dosage levels, and response to a new treatment.

**Phase III trial:** A study to test whether a new treatment has an anticancer effect (for example, whether it shrinks a tumor or improves blood test results) and whether it works against a certain type of cancer.

**Phase IV trial:** A study to compare the results of a new treatment with the results of the standard treatment (for example, which regimen yields better survival rates or fewer side effects). In most cases, studies move into phase III only after a treatment seems to work in phases I and II. Phase III trials may include hundreds of people.

**Phase IV trial:** After a treatment has been approved and is being marketed, it is studied in a phase IV trial to evaluate side effects that were not apparent in the phase III trial. Thousands of people are involved in a phase IV trial.
Teaching the Ward Boys in Gujarat, India

In October, 2013, the first class of 29 ward boys graduated from a training program developed by the University of Utah Division of Emergency Medicine Ward Boy Training team. The team consisted of Peter Taillac, MD, Chris Stratford, RN, Emily Sagalyn, MD and Chris Rees, MD, in association with professionals at Medical College Baroda (MCB), Sir Sayjio General Hospital (SSGH), and Shree Chhotubhai A. Patel Hospital and Community Health Center (CHC).

Who are ward boys? Ward boys are generally young men, but sometimes women, who are hired as untrained staff in Indian hospitals with responsibilities that include assisting physicians, nurses, and administrators with day to day hospital operations. Their job description includes cleaning the ward, stocking supplies, preparing patients for procedures, transporting patients, patient samples and orders from one area of the hospital to another. With time they become involved with patient care and education. Until now there had been no formal training for ward boys in any hospital in the State of Gujarat, India. Ward boys frequently sustain injuries and acquire illnesses due to lack of knowledge of proper sanitation and patient lifting and transfer procedures.

In response to this problem the University of Utah team traveled to Baroda, India to work with local health professionals to complete a needs assessment to determine what type of training would be most beneficial. The five day, 30 hour course developed from this effort focused on five areas: professionalism, communication, infection control practices, basics of patient care, and stress management.

Since Utah participants did not speak Gujarati, the curriculum was translated and taught to the physicians, nurses, and hospital administrators who then became the course instructors. The ward boys’ excitement built with each day of their training. They were attentive, engaged and participated enthusiastically. A simple written exam was given at the end of their training. They knew other students at MCB were given exams at the end of training and to require the same of the ward boys provided them validation and the confidence and motivation to do their job better. After completion of training, ward boys attended a formal graduation ceremony which recognized them with a certificate of training.

Some effects of the training became visible almost immediately. The first day pictures were taken of each ward boy to be included on the graduation certificate. On day two, three individuals returned freshly shaven asking for a photo retake. On graduation day, teary eyes during the ceremony confirmed the impact of the training experience on the participants. Though the original focus of the training was to reduce risk of infectious exposure to the ward boys, they quickly made the connection that their improved infection control practices would help save the lives of their patients.

Though the training program was designed for the ward boys, there was a spillover effect to the medical staff, administrators, nursing staff and others to perform to the same level of excellence as the ward boys. For example, as the ward boys instituted proper lifting and moving of patients, the nursing staff recognized ways to improve how they handled patients. The ward boys learned communication techniques and standards of professionalism that motivated other health care providers and supervisors to examine how they communicated. Even though the intent was to train one category of worker in the hospital, it caught the attention of all workers. The nursing department has subsequently asked for assistance in developing similar training for staff nurses in the hospital.

This pilot course was so successful that both Indian hospitals have committed to continue the training monthly until all 200 ward boys have been trained, and may extend the program to ward boys at other hospitals. This program is evidence of the benefits reaped when University of Utah faculty and staff partner with those in other countries to further the cause of education and improved health through collaboration and mutual support.
Classes of 1963, 1968, 1973

Class of 1963:
Front row, left to right: Ray Thomas, Fred Christensen, David Fairbanks, Kirk Neuberger, Robert Gibbons, Ken Ashby, Thomas Caine, Clifford Harman
Back row left to right: Roger Blomquist, Walker Ashcraft, Jack Bishop, Duncan Wallace, Gary Fogg, Harper "Tip" Pearse, Mason Redd, Kendrick Morrison, Bruce Fishburn, Michael Clement, Joseph Knight

Class of 1968
Left to right: Jon Ord, Andrew Grose, Ed Heyes, Nat Matolo and Sharadan Lisk

Class of 1973:
Back row, left to right: Greg Tanner, Davis Cracroft, Randy Olsen, Tom Rosenberg, David Hansen, Wally Bryner, Ben Marchello, James Emory and David Welling
Front row, left to right: Richard Boyer, Alan Crandall, Curtis Canning, Roger Larsen and Robert Matheson
2014 Alumni Weekend


Class of 1978
Left to right: Brent James, Bob Stephenson, Rick Farnsworth and Ken Buchi

Class of 1983:
Back row, left to right: Richard Graham, Richard Neville, Dan Ely, Tracy Frandsen,
Next row down: Dan Ostermiller, Mike Anderson,
Jan Bernhisel-Broadbent, John Richard, Curtis Defriez, and Scott Leckman
Front row, left to right: Steve Sloan,
Kerry Stratford, Jan Torgerson, and Jeffrey Smith
Front Row: Margo Heath-Chiozzi, Jane Torgerson,
Wendell Gibby, Phyllis Clark, Kathy Neal, and Camille Collett

Class of 1993:
Back row, left to right: Matthew Clark,
Catherine Harris, R. Neil Van Leeuwen, Stan Feil,
Martha Morgan, Trent Jones
Front row, left to right: (Laurie Rice '88),
Mona McCordie, Caitlin Ahern, Shole L. Wong

**Class of 1998**
Left to right: Janet Grissom, Marc Johnson, Raphael Allred, Catherine Smith, Kathy Ostler and Jen Geary

**Class of 2003:**
Back row, left to right:
Toby Ennis, Ryan Torrie, Andrew Spencer, Jim Dahle
Jason Blackham, Jake Clendenon
Christian Feinauer, Jason Sharp
Front row, left to right:
Lindsay Malechek, Catherine Strasser,
Rachel Woods Jessie Walsh, Christine Johns, Rachel Baar,
Rebecca Herold Moore, Mary Janowiak, Anne Perry

**Class of 2008**
Back row, left to right: Danielle Smith, Jody Quick Wixom, Eric Glissmeyer, Joshua Brinkerhoff, Wyatt Rivas, Farrant Sakaguchi
Front row, left to right: Ann Huntington, Michelle Korth Palmer, Christiana Sadler Rivas, Carrisa Sorenson Monroy
2013 Alumni and Medical Community Weekend

Over three hundred people attended the School of Medicine Alumni Association’s annual Awards Banquet, making for a great kick-off to the 2013 Alumni Weekend. Honorees included Alan Crandall, MD, ’73, Distinguished Alumni Award, Zeke and Kay Dumke, Distinguished Service Award recipients, Karen Buchi, MD, ’84, Distinguished Humanitarian recipient and Matthew Rondina, MD, ’03 the awardee of the Golden Anniversary Prize in Clinical Investigation. The show was stolen by the 50-year graduation class, the Class of 1963. The years since graduation melted away as they greeted one another, and chuckles were heard as the power point displayed pictures from their medical school years including quotes from classmates. As they stepped up to receive their medallions the larger assembly was impressed by their achievements and honors. From the banquet to the class reunions, department events, Dean’s talk, tours and the CME Symposium, the weekend was a resounding success.
2013 Alumni and Medical Community Weekend

Sean Mulvihill, MD, James Parkin, MD, ‘66, Bonnie Parkin and Kimberley Mulvihill, MD

Class of 1963 Half Century Society Medallions

Mary and Dee Rasmussen, MD, ‘60

Classmates Virgil Parker, MD, ‘57 and Orpha and Morris Gardner, MD, ‘57 catching up.

Past School of Medicine Alumni Board President Saundra Buys, MD, HS, ‘84 and School of Medicine Director of Administration Karen Anastasopoulos

Cecil Samuleson, MD, ’70, Scott Samuelson, MD, ’02, Sherman Smith, MD, ’76

Tom Caine, MD, ’63 and Mary Ellen Caine, Tip Pearse, MD, ’63 and Geri Pearse, Dick and Carol Faye and Pauline and Joseph Knight, MD, ’63
Distinguished Awards

Karen Buchi, MD, ‘84 receiving the Distinguished Humanitarian Award from Dean Vivian Lee and Dr. David Sundwall, President of the School of Medicine Alumni Association

Matthew Rondina, MD, MSCI, ’03 thanking his mentors while accepting the Golden Anniversary Prize for Clinical Investigation

Distinguished Alumni Award winner Alan Crandall, MD, ’73 and wife Julie Crandall

Karen Buchi, MD, ’84 accepting the Distinguished Humanitarian Award

Zeke and Kay Dumke celebrating with their family after receiving the Distinguished Service Award
On choosing a career in the military:
In 1940, Congress passed a law that allowed for the federal government to conscript all male physicians who graduated from medical school to two years of federal service. So there was a physician draft that was mandatory. That went on through the Second World War, the Korean War and through the Vietnam War as well.

On staying in the military beyond the required commitment:
Every time my wife, Alice, and I got to a point where we were trying to decide whether to get out of the service, they offered me an educational opportunity or a leadership opportunity that seemed exciting and challenging. As a consequence, we ended up staying a little longer, and a little longer until finally in 1990 I had the 30 years retirement credit from the federal government.

On choosing pediatrics:
I was torn between doing internal medicine and pediatrics. But after spending three months on call every other night at the Veteran’s Administration hospital here in Salt Lake City I decided not to be an internist. I was tired and medicine scared me away. I applied for and was accepted for a pediatric residency in Texas. I liked the patients and I liked their families. I loved pathology and I nearly became a pathologist. I loved the lab and the mystery and the challenges that came with pathology ... but I also liked to care for patients.

On his interest in respiratory syncytial virus, or RSV:
I got very interested in the pathology of lung injuries in children that had pneumonia. I began by looking at autopsy specimens to understand the pathophysiology of lung injury, then got interested in modeling these diseases in animals. RSV is ubiquitous in all human populations. I cared for a number of babies who had neonatal sepsis that died with Lancefield group B streptococci pneumonia. I began trying to model this disease in animals ... trying to understand how it is that mothers can be colonized with it and how babies become infected.

On RSV research with collaborator Dr. Greg Prince: We worked on a vaccine, but making a vaccine was very complicated and would take a long time... we thought that what we should do was figure out a way to protect at-risk children. With neonatal intensive care units, the first was at the U in 1965, came the ability to care for smaller and smaller and sicker and sicker babies. What we discovered was if recent nursery graduates got infected with RSV the winter after they graduated, they ended up back in the intensive care unit, back on a ventilator and a lot of those babies died. What a tragedy to have a family go through this intensive care experience, take the baby home and...
a month later come back and have the baby die of pneumonia caused by a virus. Ultimately we tried to figure out how to passively immunize babies. So we began developing antibody products. One of the drugs we developed, Synagis, is still given to high risk infants. It prevents them from getting pneumonia.

On commercializing the research:
We were both federal government employees and of course working in a federal lab, any intellectual property we developed belonged to the federal government. In 1987 the patent lawyers came and we wrote all the research down for them. A few weeks went by and they came back and said, “We don’t think this is ever going to work and we assign the rights to the inventors.” Greg and I started a little biotech company. We went to a lot of pharmaceutical companies that said, “our scientific people are excited but our marketers argue there is no market.” Finally we ran across some old friends, one had been head of Walter Reed. They had started a little company, Molecular Vaccines. They took our idea and together we found the money to do it.

On his role as Dean of the Uniformed Services College:
Our students were different, they were all indentured. They have a seven year active duty commitment. They get paid the whole time (about $45,000 annually), they pay no tuition, they have all their books provided. We’ve got the happiest medical students in the country. About 40 percent belong to the Army, 30 percent to the Navy, 30 to the Air Force and another seven or eight students belong to the public health services. The largest graduate education program in the United States, believe it or not, is operated by the Department of Defense.

On training medical students for the specific challenges of military service:
Students have to go through the basic course for officers—including the physical stuff. They learn who to salute, they learn how to put on your uniform, they learn how to get paid. Our students are probably the best trained of any in the country in tropical medicine and parasitology. They are taught how to take care of people who are going into harm’s way. They get trauma training. We have two major military exercises in military medical school...where students find themselves “at war”. They have to work in a situation where casualties are generated, they have to stabilize those casualties, they have to get them on to helicopter, etc.

On how military students cope:
They do well. They come in with that bent. They made a commitment to come to military medical school and they are wearing a uniform. We teach a culture of medicine, but we also teach a culture of military officership and that becomes a part of their lives. They go to school year round. Their summer breaks are taken up with military medicine simulation training. These students have not only gained a profession, they’re invested in a community. They come out understanding the nature of the lives of the men and women who serve in the armed forces. A military family is a unique family.

Alvin G. Cobabe, MD ’63

A farm boy from the Ogden Valley, medicine was a second career for Alvin Cobabe. First he ran his father’s sheep ranch, worked as an electrical engineer, a heavy equipment operator and ran a radio station. He also rebuilt a small airplane and earned his pilot’s license. Born in 1917 in Slaterville, Utah, he earned an associate’s degree after high school, but it wasn’t until his late 30s that Cobabe decided to fulfill his dream of becoming a doctor and returned to college at Weber State University. In 1963, at the age of 46, he graduated from the University of Utah School of Medicine—at the time, he was the...
Alvin G. Cobabe, MD ’63

oldest student graduated from the school.

Cobabe went on to have a successful general practice in Ogden and says he could never understand why someone paid him to do a job he loved so much. While working as a physician he developed family ranching property in Ogden Valley into Powder Mountain ski resort, which he owned and ran until 2006. Now in his 90s, Dr. Cobabe still enjoys flying, traveling and family. During the most recent Medical Alumni Weekend, Dr. Cobabe was inducted with the rest of his class into the Half Century Society of the School of Medicine Alumni Association.

On giving up ranching –building and running a ski resort–and going to medical school in his 40’s: I’ve had the opinion all the time, ever since I can remember, that if it’s worth doing, it’s alright to go ahead and do it. I was born premature and the doctor didn’t think I was worth saving. I didn’t like that. I didn’t think that he was a very good doctor and that I could do better. I was working out fixing fence and that didn’t give me a lot of satisfaction and besides I had some hay fever. I thought, so if I’m going to be a doctor, I’d better do it now before I get any older. I went down to Weber State and took some exams, enrolled and here I am. I was accepted to three medical schools, University of Southern California, University of Utah and University of Washington.

On developing the Powder Mountain ski resort, but not being much of a skier: I had taken a couple of my OB/GYN friends up the mountain on horseback to see the beautiful fall leaves. We stopped to take a rest and they said, “Boy that would make a beautiful ski hill. Hey Cobabe, why don’t you build a ski resort?” I didn’t say one word, but a little voice whispered to me: Build it. I started it in 1972. I had it for a long time. The reason that I sold it (in 2006) was it was getting too expensive to build the new equipment and I was getting older. The last lift that I built cost $10.5 million dollars. You can’t get that money back from ski passes.

On running the resort’s emergency clinic and trends in skiing-related injury: I worked up there about three days a week and about three days down in Ogden. It was amazing how the kind of injuries changed. We used to have great big long skis and man, they didn’t have good bindings, so they would give you a pretty good twist on the leg. Now the equipment is much better and more protective.

On what he thought he could do after medical school and just one year of internship (all that was required at the time): Well, I could cut a person open and take his appendix out and have his insides setting out there on the table on either side of his body. I couldn’t stand to kill a chicken and see it bleed, but it didn’t bother me a bit to operate on a person. I learned many things while in practice, not in medical school. Other people showed me how to do things. I did over a third of the appendectomies that were done in Ogden at the time. I set bones, put them in traction and put pins in, etc.

On his advice to students: I tried not to do anything that I didn’t know how to do. That’s one piece of advice I’d give. Don’t be afraid to branch out and learn things, but don’t stick your neck out far enough that you’re doing something that you don’t know how to do. Get someone else to help you. I slept a lot better at night when I knew the patient was getting good care.

On healthcare today: Well, we can provide the best health care I think of any place, but it’s getting very complicated. The thing that’s happening, each one of the different specialties is expanding so fast that I think even a person that really works at it can’t keep up with everything.

On medical training today: You have to stay narrow. We have to adjust to the times. I don’t know how to tell you how to pick what you like to do, that’s a decision that you have to make on your own, but once you get there you don’t want to be doing something you don’t like. One fellow I took in when my practice got too big … he didn’t like to take care of patients. He liked to see them to make a diagnosis, but you’ve got to like people to take good care of them.

On studying in medical school: The first quarter I got a D and I got put on the probation board, but I overcame that. I graduated in the top third of the class. It came easy for me. I think one can work too hard to try and learn and put in too much time. You need to govern your studies so that you are giving yourself time to absorb everything and make use of it as well as learn it. After about an hour of studying you’re not going to be learning anything very much new. You need to rest and do something different. I would suggest that you take a break, get a little rest and then go back and start where you left off. It will make your job easier and you’ll remember more.

On the question medical students should ask themselves: Why did you go into medicine? To make money? Or did you go into medicine to take care of people? And if you’re going to take care of people, what kind of care do you want to give them? Be honest with yourself. I don’t know why people ever paid me for doing something that was so much fun and that’s a fact. I just enjoyed the practice of medicine all the time that I was doing it.
The Fall semester started out with a bang for School of Medicine students, and it wasn’t all studying, dissection and tests! Every year the School of Medicine Alumni Association hosts a barbeque for the incoming freshman class. This year new dental students and some of the Global Health exchange students also joined in the mix. The party was hosted in Dean Vivian Lee’s backyard where food, games and swimming was enjoyed by all. October brought Dean Lee’s annual Halloween Party for students and faculty. The costumes and food were amazing and it was a great opportunity for students across the medical school years to get to know one another better. If medical students were judged on creativity the U of U students would win first prize!
What did you do last Summer?

- John Morgan conducted research in the Tumor Biology Center at Queen Mary, University of London (pictured with MS II classmate, Ben Hunter).
- Heidi Saxton presented at the International Conference on Mercury as a Global Pollutant in Edinburgh, Scotland.
- Sierra Debenham helped establish nine medical clinics in the Himalayas.
- Karen Manotas worked at Weill Cornell Medical College in alloimmune and pediatric hematology.
- Stephanie Woodward conducted research in pediatric endocrinology at Columbia University.
- Sarah Schoenhals traveled with the Moran Eye Center to Kumasi, Ghana.
- Michael Chen visited his brother who was living in Rome, Italy.
- Dave Warner traveled to Yellowstone with his wife.
- Farah Vega worked on a nutrition project with Chinese university students and MS II classmates Nick Larson and Erik Christensen.
- TJ Oswald conducted research at Vanderbilt University Medical Center's Digestive Disease Research Center in Nashville, TN.
- Lucy Brunker visited Washington, D.C.
Have you ever thought to yourself, “If only someone could invent this or that, my time at work would be easier and more enjoyable?” As a student physician interested in innovation and design, I imagined as a practicing physician I might have an idea for a medical device that would help physicians and patients. However, merely having an idea in contrast to actually being able to develop that idea into a technology is analogous to thinking about competing in a marathon compared to actually training for and running a marathon. I knew I would need more knowledge and skills if I wanted to become an innovator and inventor.

The Bench-2-Bedside (B2B) competition was the perfect opportunity to develop such skills. In B2B, forward-thinking, innovative leaders at the University of Utah allow students from across the university to form teams, develop medical devices and technologies, and compete for thousands of dollars to help take their ideas to the next level. Each step of the way, students are offered free workshops on topics ranging from idea generation to patent law, as well as advice from mentors.

I started looking around for teammates and ended up not getting further than my medical school class. Between the five of us, we found a diversity of backgrounds including mechanical and electrical engineering, education, public health, biostatistics, carpentry, and business. What I didn’t count on during B2B was how much fun I would have working with my teammates, who quickly became great friends. Additionally, I was able to witness how a team with a common vision can become something greater than the sum of its parts. This was evident as we were forced to rely on one another’s strengths in order to develop our device while keeping up with our coursework and other responsibilities.

We had recently learned how to perform gynecological exams as part of our curriculum in medical school and had heard our nurse instructors’ comment that the lighting systems for gynecological specula needed improvement. We set out to develop a better hassle-free lighting system that could be used with any speculum, metal or plastic. After weeks of brainstorming, designing, and prototyping, the GLO Light was born.

The GLO Light is a peel-and-stick, single-use LED light about one inch long, half an inch wide, and a third an inch tall that costs less than $2.00 per light to purchase. We designed it to fit on the inside bill of a speculum, where it is within the vaginal cavity and out of the way of the small opening of the speculum. Its positioning allows it to shed optimal light on the vaginal walls and cervix while creating minimal shadows. We believe its minimalist design will enable physicians to better visualize the vaginal cavity. We also hope it will aid global health efforts in areas where electrical power sources are scarce or unreliable.

At the competition, we were fortunate to win $10,000. As we finalize our design we are working with a patent lawyer to file a patent. By the New Year, we plan to get our light into the hands of practicing clinicians for research and development. By Spring 2014 we intend to license the device to an established company.

B2B has been a wonderful outlet for our creative and entrepreneurial sides. Although it is not an easy process it is teaching me the skills I need to be an innovator and inventor throughout my career as a physician.
Members of the American Association of Cancer Researchers (AACR) elected Mary Beckerle, chief executive officer and director of the University of Utah’s Huntsman Cancer Institute, to the AACR Board of Directors for the 2013-2016 term.

Beckerle is Associate Vice President for Cancer Affairs, a distinguished professor of biology, and holds the Ralph E. and Willia T. Main Presidential Endowed Chair in Cancer Research at the University of Utah. Beckerle is an Established Investigator of the American Heart Association and she has received a Senior Research award from the American Cancer Society. She was presented with the Rosenblatt Prize for Excellence, the most prestigious award given to University of Utah faculty members. In 2008, she was elected to the American Academy of Arts and Sciences.

Founded in 1907, the American Association for Cancer Research (AACR) is the world’s first and largest professional organization dedicated to advancing cancer research and to its mission to prevent and cure cancer. AACR membership includes more than 34,000 laboratory, translational and clinical researchers; population scientists; other health care professionals; and cancer advocates residing in more than 90 countries.

Nobel Laureate in Medicine Presents at Benning Lecture Series

The director of the National Cancer Institute (NCI) and Nobel Laureate in Medicine, Harold Varmus, MD, visited the University of Utah this fall to deliver the 2013 Benning Public Lecture in Medicine. This year, the Benning Society and Huntsman Cancer Institute (HCI) co-sponsored the lecture, which was held in the Rice Eccles Stadium Tower. Four hundred and fifty individuals attended, including students from West High School and Utah Valley University. Jon M. Huntsman, Jr., Chair of the Huntsman Cancer Foundation Board of Directors and Vivian S. Lee, MD, PhD, MBA, Senior Vice President for Health Sciences, CEO of University of Utah Health Care, and Dean of University of Utah School of Medicine co-hosted the event.

In addition to his scientific credentials and public service, Varmus is the author of a 2009 memoir, The Art and Politics of Science, which details his career path from graduate studies in English at Harvard University to medical school at Columbia University, his scientific work on the origin of cancer-causing genes with Michael Bishop, PhD, that would earn the pair a Nobel Prize, and his leadership roles at the National Institutes of Health and Memorial Sloan-Kettering Cancer Center.

In his lecture, Varmus talked about cancer research discoveries and how these discoveries have informed cancer treatment. Varmus described the importance of disseminating research discoveries to allow all cancer patients the best possible care no matter where they seek treatment. As part of this effort, Dr. Varmus spent the morning of the lecture meeting with researchers and students at the University of Utah.

Cancer genetics is the signature research strategy of HCI, and its researchers have identified genetic mutations responsible for a number of cancers including colon cancer, breast cancer, and melanoma, among others. The Human Genome Project, the largest collaborative biological project ever, required an international multidisciplinary team of scientists to complete, cost $3 billion and took nearly 13 years. Today, HCI’s cutting-edge genome sequencing equipment can survey a human genome in a week for only a few thousand dollars. The speed and accuracy of this technology gives genomics many uses in cancer research—both in the lab and in the clinic. The Utah Genome Project, a recent Health Sciences initiative, is designed to use genomics to advance the development of better disease prevention, diagnosis, and treatment methods through the discoveries of new genetic signatures for human disease and responses to drug therapies.

The H. A. and Edna Benning Presidential Endowment at the University of Utah sponsors the annual Benning Society Public Lecture in Medicine, a major public lecture held at the University of Utah each year focusing on leading-edge medicine.

Dr. Varmus was invited to provide the 2013 Benning Society Public Lecture in Medicine due to his record of scientific accomplishment in cancer genetics, and his leadership of the National Cancer Institute, which is part of the National Institutes of Health, and awards HCI its Cancer Center designation.
Recognition and Awards:

Randall J Olson, MD, ’73
received the 44th Annual Jules Stein Pettit Lectureship Award, from the Jules Stein Eye Institute, David Geffen School of Medicine at UCLA. He also received The Dr. Clark Lowe Rich Distinguished Surgeon Award at the University of Utah. This award recognizes one outstanding surgeon each year at the University of Utah who has demonstrated exceptional skill and dedication in the field of surgery, including teaching, advising, and mentoring medical students, interns, residents, or fellows.

Alan Crandall, MD, ’73
was awarded the inaugural Val A. and Edith D. Green Presidential Endowed Chair in Ophthalmology.

Bryan W. Jones, PhD, ’03 and Robert E. Marc, PhD
were declared winners in the 2013 Federation of American Societies for Experimental Biology (FASEB) second annual BioArt competition. Winning entries were unveiled on FASEB’s web site and were featured in an exhibit on the National Institutes of Health main campus. The winning image depicted a retina from a goldfish analyzed using tools called computational molecular phenotyping that reveal the metabolic state of all cell types in tissues. The NIH National Eye Institute provides support for this research project that seeks to map retinal networks from both normal and diseased tissues like retinitis pigmentosa and age-related macular degeneration.

Alessandra Angeleccui, MD, PhD, was awarded a $372,500 NIH/NEI grant for her research on parallel pathways in the visual cortex. Retinal degeneration, glaucoma, and eye trauma often produce such devastating eye damage that only a cortical prosthesis can restore vision. Lack of knowledge of the complex organization of the visual cortex and the inability to reproduce patterns of signaling required by the cortex have prevented such “synthetic vision” from becoming a reality. The Angeleccui Laboratory is the Moran Eye Center’s lead in developing this knowledge, making it unique among eye centers worldwide.

Outreach:

A Moran Eye Center team recently returned from the Navajo Nation where they screened a staggering 479 patients in two days as part of their “Data Collection Mission.” Partnering with Hope Alliance, who supplied glasses, the team gave each of the 479 individuals a visual acuity test. They plan to return with a pediatric team to follow-up with the many children in need of vision care.

The Utah strip of the Navajo Nation is one of the most underserved, isolated, and neglected regions in the lower United States. The high incidence of type 2 diabetes, UV exposure, and the overall impact of poverty have created an urgent and critical need for eye care delivery. Unnecessary blindness resulting from cataracts, lack of vitamin A during pregnancy, and diabetic retinopathy is commonly found throughout the 12,000 Navajo living on the Utah strip.

Access to specialized health care for citizens living in this remote Four Corners region is extremely limited. Most of these eye conditions are curable and preventable. In the upcoming months, the Moran’s Outreach Division, in partnership with the United Navajo Health Systems, Inc. will begin delivering eye care on the Utah Strip of the Navajo Nation.
Virtual Practice a First at Utah

The University of Utah Department of Orthopaedics was faced with the question of what could enhance the surgical skills of their residents. They realized the way surgical skills were being acquired was inefficient. Residents were not getting enough hands-on time to be proficient for the varied and different surgical procedures. The restricted 80 hour work week and a limited number of patients make it difficult for all residents to have the optimal opportunity for training.

Currently orthopedic board examinations only require a written test on surgical procedures, though that may change in the future to include some demonstration of surgical proficiency. An attending physician with knowledge of the resident must submit a report regarding the physical and technical capabilities of the applicant, which can be a very subjective evaluation. How can the orthopaedic training experience be made more hands on, efficient and quantifiable?

In a serious effort to answer this question the University of Utah became the first major orthopaedic surgery training center in the U.S. to purchase a VirtaMed system. This is a high fidelity surgical simulator residents can use to practice arthroscopic knee and shoulder surgeries. The simulator can create very realistic scenarios ranging from a meniscus tear to an anterior cruciate ligament injury, to arthritic changes within the knee. Dr. Robert Burks, the lead instructor on the machine, feels it gives residents a lifelike model that can be used over and over again. Changes can be made to each surgery via computer modeling. He feels it is a good way to teach a systematic, consistent surgical approach as the simulator can “force” the trainee to do things in a proper order. He acknowledges that not all surgery can be replicated with a simulator, but for the many that can, it provides a good environment where residents can learn the necessary skills and practice those skills over and over again before performing the procedure on a patient.

Currently simulation models are only available for arthroscopic knee and shoulder surgery, but soon there will be simulators available for hip and back surgery. Dr. Burks is currently working on the validation stage of testing to make sure the machine accurately scores how procedures are performed. If the current simulator testing is successful the orthopaedic department may consider more simulation-aided instruction to assist in resident training.

At a retirement reception for Randall Burt, MD, colleagues were asked to write a message to him in a book. A common theme emerged among the many heartfelt notes: “This place won’t be the same without you.”

Dr. Burt has left an indelible mark on the University of Utah through his decades as a physician, cancer researcher and leader. Burt received his medical degree from the University of Utah in 1974, then completed his internship and residency in internal medicine at Barnes Hospital in St. Louis, Missouri. He returned to the University of Utah School of Medicine for his fellowship training and went on to practice gastroenterology at University of Utah Health Care.

Burt’s primary interest as a cancer researcher was familial risk and inherited syndromes of colorectal cancer, and his genetic discoveries regarding inherited colon cancers are internationally recognized. His achievements include working with Dr. Eldon Gardner to characterize what came to be known as Gardner’s syndrome, being the lead clinical investigator of the group that discovered the APC gene in Familial Adenomatous Polyposis (FAP), and providing the first report of attenuated FAP. This discovery led to identifying this type of cancer in families and preventive and early treatment options to preserve life and health.
In addition to nearly four decades of colorectal cancer research, Burt has led multiple programs within University of Utah Health Sciences. He has served as chief of medicine at the Salt Lake City Veterans Affairs Medical Center, chief of the Division of Gastroenterology at the University of Utah, interim executive director at Huntsman Cancer Institute (HCI), senior director of prevention and outreach at HCI, senior director of HCI Clinical Services, director of the High Risk Cancer Registry and Clinics, director of the HCI Familial Colon Cancer Clinic, co-director of the HCI Family Cancer Assessment Clinic, and co-leader of the HCI Colon Cancer Program. Burt also held the Barnes Presidential Endowed Chair in Medicine.

Throughout the many positions he held, Burt remained a practicing gastroenterologist. His patients know him as a wonderful, caring doctor. At his retirement reception, a patient spoke through tears about how much she appreciated him. “I could call him any time,” she said. “No matter how busy he was, he would always take my call.”

The Randall W. Burt Endowed Chair in Gastroenterology was recently established in Dr. Burt’s honor.

Elizabeth H. Hammond, MD, ‘67 Recognized for Improving Patient Care by the College of American Pathologists

The School of Medicine Alumni 2007 Distinguished Alumna award recipient and current School of Medicine Alumni Association Board member, Elizabeth H. Hammond, MD, FACP, was recognized by the College of American Pathologists (CAP) at their fall annual meeting for her work to advance patient care and the specialty of pathology.

Dr. Hammond was honored as the first recipient of the CAP Pathology Advancement Award for her instrumental role to establish the CAP Pathology & Laboratory Quality Center. The Center is a forum for developing evidence-based, clinical practice guidelines aimed at improving patient care. She also was recognized with the CAP Excellence in Education Award for her leadership in creating education programs to help pathologists acquire new skills and knowledge leading to more accurate diagnoses, and ultimately, better patient care. Dr. Hammond was specifically honored for her role in educating pathologists on the molecular testing of breast cancer.

“I am deeply grateful to be recognized by the College of American Pathologists with these two prestigious awards,” said Dr. Hammond, a consulting pathologist with Intermountain Healthcare in Salt Lake City, Utah, and a professor of pathology and adjunct professor of internal medicine (cardiology) at the University of Utah School of Medicine. “Our hope is that patients everywhere will benefit from new testing guidelines and knowledge acquired by pathologists.”

Additionally, Dr. Hammond serves as director of Cardiac Transplant Pathology with the Utah Cardiac Transplant Program in Salt Lake City. She is a member of the National Quality Forum Scientific Advisory Panel for Cancer Specific Performance Measures. Previously, Dr. Hammond was the president of the Utah Society of Pathologists; president of the medical staff at LDS Hospital; chair of the Department of Pathology at Urban Central Region Hospitals in Sandy, Utah; and vice chair for translation research in the Radiation Therapy Oncology Group. She also served as vice chair of the National Cancer Institute (NCI) Group Banking Committee and as a member of the Cancer Diagnosis Program (NCI) Cancer Biomarkers Advisory Panel.

As an active member of the CAP, Dr. Hammond has served as a member of the CAP Board of Governors, as well as numerous CAP councils and committees. Dr. Hammond is an active member of numerous other professional societies, including the American Society for Clinical Pathology, the American Society of Transplantation, the International Society of Heart and Lung Transplantation, the American Society of Clinical Oncology, and the United States & Canadian Academy of Pathology.

Dr. Hammond received her MD from the University of Utah School of Medicine and went on to complete an internship at the University of Utah Health Science Center. She completed her residency at Massachusetts General Hospital in Boston and received fellowships from both the National Institutes of Health/Karolinska Institute in Stockholm, Sweden, and from the Massachusetts General Hospital in immunopathology/research. Dr. Hammond is board-certified in anatomic pathology. She is the author of 190 published manuscripts and three books.
Terry D. Box, MD, House Staff, ’83
Dr. Terry Box arrived at the University of Utah School of Medicine from his native state of Texas in 1977 to train in Internal Medicine after graduating from Southwestern Medical School in Dallas. He completed his residency in Internal Medicine in 1981 and Fellowship in Gastroenterology, Hepatology and Clinical Nutrition at the University of Utah in 1983. Currently, Dr. Box is Clinical Associate Professor of Medicine at the University of Utah. He joined the faculty in 2009 after a lengthy tenure in hepatology and liver transplantation at LDS Hospital in Salt Lake City from 1983 to 2009, where he personally underwent liver transplantation in 2002. At the University of Utah, as a member of the Liver Transplant Program, he continues his duties in the clinical care of patients with liver disease both before and after liver transplantation.

Since 1995, he has been actively involved in clinical research in the areas of chronic viral Hepatitis B and C as well as transplant hepatology.

After being introduced to the innovative use of interactive videoconferencing to advance healthcare in remote and underserved areas, he has been committed to replicating the same at the University of Utah. Project ECHO (Extension for Community Healthcare Outcome) was launched in October 2011 and has rapidly proliferated throughout Utah and the Intermountain West.

Craig A. Ensign, PAC, ’95, MPA, ’03
Mr. Ensign graduated from the University of Utah Physician Assistant Program in 1995. He earned his Master’s in Physician Assistant Studies in 2003. He works as a clinician in the University of Utah School of Medicine, Urology Division where he has practiced for the past five years. In addition to teaching in the University of Utah Physician Assistant Program, he also lectures on various urology topics at conferences around the country. Prior to going to PA school, Mr. Ensign earned his bachelor’s degree in journalism and public relations, also from the University of Utah, in 1986. He is married to Belinda Potter of Price, Utah and together they have four children ranging in age from 17 to 25. In his spare time he enjoys hiking in Utah’s fabulous mountains and canyons, sports and reading.

Bruce C. Irvine, MD, ’68
Dr. Irvine was born in Salt Lake and attended East High. His undergraduate degree is from Dartmouth College and his medical degree from the University of Utah. His internship and residency in general surgery were in Chicago and Boston.

He spent two years in the Air Force from 1974-1976 and then joined the Granger Medical Clinic where he practiced until retiring in September of 2013.

He met and married his wife, Rhonda, in Chicago when she was the head nurse of the Cook County Hospital Trauma Unit. They have three children and four grandchildren. They enjoy their children and grandchildren, fly fishing, skiing, pickle ball and golf.
Teresa L. Ota, MD, ’88
Dr. Ota was raised in Wyoming. She attended Colorado College in Colorado Springs, CO and obtained her MD at the University of Utah School of Medicine. Concurrently, she obtained her “Mrs” as she met and married her classmate, Peter Novak. They moved to Chicago where Dr. Ota completed her anesthesia residency at Northwestern University.

Wayne M. Samuelson, MD, ’80
Dr. Samuelson graduated from the University of Utah College of Medicine in 1980. He completed a residency in internal medicine and a fellowship in pulmonary diseases at Duke University Medical Center. He was a member of the faculty in the Division of Allergy, Respiratory and Critical Care Medicine at Duke for 10 years prior to returning to the University of Utah in 1995. He is currently a professor (clinical) in the Division of Respiratory, Critical Care and Occupational Pulmonary Medicine. He has served as Associate Dean for Admissions, Senior Associate Dean and is currently the Vice Dean for Education of the School of Medicine. He and his wife Marianne have five children and three grandchildren.

Dr. Ota practiced at Swedish Covenant Hospital in Chicago for 3 years while her husband completed his orthopedic surgery residency and fellowship. They returned to Utah where she practiced at Paracelsus Hospital for a year. She now practices anesthesia at St. Mark’s Hospital, St. Mark’s Outpatient Surgery Center and Lone Peak Hospital in Salt Lake City. She has held the position of Anesthesia Department Chairman at St. Mark’s Hospital.

She and Peter have two daughters who are away at college.

School of Medicine Gathering in Southern California, October 2013

Left to Right: Richard Graham, MD, ’83 and William Seare, MD, ’73, Albert Chen, MD, ’84 and Bill Velick, MD, ’69
Gathering to hear Dr. Vivian Lee present.
Call for Nominations

School of Medicine Distinguished Alumni, Service and Humanitarian Awards 2014 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:

- **Distinguished Alumni Award**
  - Excelling in Clinical Practice
  - Extensive Academic Activities
  - Research Accomplishments

- **Distinguished Service Award**
  - Service to the School of Medicine
  - Contribution to the Field of Medicine
  - Demonstrated Commitment to Enhancing Medical Education

- **Distinguished Humanitarian Award**
  - Outstanding Commitment to the Health of the Community
  - Service to Underserved Populations or in Challenging Situations
  - Community Service

**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 nominations.

**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 3, 2014

Send completed nominations to: Kristin Wann Gorang, Executive Director
540 Arapeen Drive, Ste. 120, Salt Lake City, Utah 84108, fax (801) 585-2613 or email to kristin.gorang@hsc.utah.edu

To download a nomination form and to see past recipients visit: [http://medicine.utah.edu/alumni/awards/nominations.php](http://medicine.utah.edu/alumni/awards/nominations.php)

**Questions?** Call Kristin at (801) 585-3818

**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 9, 2014 Alumni Association School of Medicine Awards Banquet.
Kenny Ashby, MD  
Dr. Ashby served as a Captain in the USAF. He served seven years as an anesthesiologist and chief of the operating room. In 1965 he developed a blood patch for post spinal headache. He lived in Alaska for 12 years and loves all things Alaskan. He is an FAA certified mechanic and commercial pilot with over 7000 hours of flying time. His hobbies include building airplanes and everything Alaska.

Walker J. Ashcraft, MD  
Dr. Ashcraft serves as the Medical Director of Marcus Daly Hospital Hospice where he has served on the board for 28 years. He went into general practice to care for people from birth to death. He finds that is no longer possible with modern day hospitalists, ER specialists, etc. He misses those days. Dr. Ashcraft enjoys reading, working on his tree farm, collecting stuff, and playing golf.

John (Jack) Bishop, M.D.  
Dr. Bishop retired in 1982 as an Air Force Colonel, Medical Corp. He served as chairman of the Department of Orthopaedic Surgery at Wilford Hall USAF Medical Center and Chief of Orthopedic Residency Program, USAF in San Antonio, Texas. He lives in Meridian, Idaho and has been in private practice since 1982. In his spare time he enjoys playing golf.

Roger D. Bloomquist, MD  
Dr. Bloomquist currently works as the Head of Radiology and Nuclear Medicine at the Sevier Valley Medical Center in Richfield, Utah. He is certified by both the American Board of Radiology, and the American Board of Nuclear Medicine. Dr. Bloomquist is the author of Integrated Theory of Intelligence, published in 1991, A Theory of Everything: MYSTIC, (2005) and most recently Integrated Theory of Consciousness. Dr. Bloomquist is a jazz musician and has recorded seven CDs.

Thomas Caine, MD  
Dr. Caine’s specialty is internal medicine and he is most interested in adult cardiology. He is a professor of internal medicine at the U School of Medicine. He is a past president of the School of Medicine Alumni Association and former Executive Board member of the University Hospital Foundation. He has also served as a bishop in his church. He and his wife, Mary Ellen, have six children.

Fred Christensen, MD  
Dr. Christensen resides in Paradise Valley, AZ. His specialty was neurosurgery. Since he retired he has enjoyed volunteer work, particularly being a reading tutor at a Title One grade school. He can’t think of any other way he would have liked to spend his life other than the practice of medicine.

Michael Scott Clement, M.D.  
Dr. Clement retired in 2011 from his work in pediatrics and public health. He was Cochise County Health Director, Assistant Director for Arizona State Department of Health, and a consultant in maternal and child health. He is the author of Children at Health Risk and editor of 12 other books. He is a medical photographer; many of his photos are in medical and nursing textbooks. In his spare time he enjoys horses and travel.

Alvin F. Cobabe, MD  
Dr. Cobabe graduated from medical school at age 46, the oldest graduate at the time, and established a successful general practice in Ogden UT. He always wanted to be a physician, but before he went to medical school he worked on his dad’s sheep ranch, was an electrical engineer, started a radio station, was a heavy equipment operator and got his pilot’s license. While working as a doctor he helped develop and open Powder Mountain ski resort and ran it from 1972 until 2006.

Robert B. Gibbons, M.D., M.A.C.P.  
Dr. Gibbons is a Master of the American College of Physicians and has been Regent and Treasurer of the American College of Physicians and Governor of the Colorado Chapter of the American College of Physicians. His specialty is internal medicine and rheumatology. Dr. Gibbons is a Clinical Professor of Medicine at the University of Colorado School of Medicine and the former Chairman of Medicine and Program Director of the Internal Medicine Residency at Madigan Army Medical Center in Tacoma WA. In his spare time he enjoys traveling, teaching and continuing medical education.

Clifford G. Harman, MD  
Dr. Harmon specialized in internal medicine and gastroenterology. He initiated an internal medicine training rotation for students and residents at Holy Cross Hospital while on faculty at the U and then went into full time consulting practice there. He and two of his colleagues formed The Salt Lake Endoscopy Center. He was the administrator there until his retirement in 1999. He has served in a variety of humanitarian roles internationally and in Utah and currently volunteers in an organization mentoring individuals with drug addiction coming out of jail or prison and seeking to re-enter society.

Joseph A. Knight, M.D.  
Dr. Knight is an Emeritus professor of pathology at the University of Utah. He was the first director of the ARUP laboratories. He has published 113 scientific papers; four books as a sole author and a co-authored another book. He enjoys daily exercises, getting together with his family, and traveling to Europe, around the United States and Australia. He is interested in the theories of the aging process, how lifestyle choices affect aging, and free radicals’ role in aging and diseases.

Kendrick Oliver Morrison, MD  
Dr. Morrison served as chairman of the Department of Surgery at Cottonwood Hospital for two years and chairman of various medical committees at Cottonwood and St. Mark’s Hospital until retiring from his Otorhinolaryngology practice in 2011. Dr. Morrison served a mission for the LDS Church as the Area Medical Advisor for the Europe West Area. Dr. Morrison loves photography, boating, water skiing, mountain motorcycling, four wheeling, traveling, and has his private pilot license.
Kirk Neuberger, MD  Dr. Neuberger spent most of his career as a general surgeon practicing in the St. George, UT area. He was chief of staff and chief of surgery at various times in two hospitals. He enjoyed the camaraderie that developed between classmates as they survived the combat-like experiences of medical school, having a 13% drop rate in their class. He was pleasantly surprised how well he felt he matched up with graduates of so-called “big name schools” while doing his residency. He is proud he has raised four self-sustaining kids.

Harper (Tip) D. Pearse, MD  Dr. Pearse was a professor of urology and radiation oncology at the Oregon Health Sciences University in Portland, Oregon. He also served as Chief of Urology at the Martin Army Hospital in Fort Benning, Georgia. He was director of J. Gibson Pleasant’s Urology Research Center and the principal investigator of the National Bladder Cancer Project. Dr. Pearse has contributed over 80 scientific articles to literature, including textbooks in urology and radiation oncology. His personal hobbies and interests include golf and painting.

Bruce Tall, MD  Dr. Tall was a urologist and practiced in Paradise, CA for most of his career, until he retired in 1995. He keeps fit by jogging and engaging in a variety of fitness activities and fly fishing, especially when visiting the family cabin in Island Park, ID. He and his wife raised six wonderful children. He feels the U medical school prepared him well for his residency at Washington University in St Louis, and for a successful career and life in Northern CA. and is very grateful for his education at the Univ. of Utah.

D. Ray Thomas, MD  Dr. Thomas worked as a pediatrician in South Salt Lake—Holladay area for 35 years, retiring in 2001. He appreciates the strong friendships he had with his patients and medical associates including several Utah Jazz players’ kids and children of several Utah politicians. He is still great friends with his three cadaver partners. Dr. Thomas enjoys music, playing the piano, composing music, playing tennis and various other sports activities.

R. Duncan Wallace, MD  Dr. Wallace is currently maintaining a small office practice in psychiatry while also serving as the medical director of Salt Lake Behavioral Health Hospital. During his years of practice he has been the medical director of eight psychiatric hospitals and thirteen psychiatric programs. This past year he published The Book of Psychological Truth, a Psychiatrist’s Guide to Really Good Thinking for Really Great Living. He enjoys traveling with his wife, spending time with his children and grandchildren, golfing, fly fishing and sharing time with friends.

Class of 1973

Curtis R. Canning, MD  Dr. Canning resides in Logan, UT where he has been in private practice for 32 years, teaching adjunct status at Utah State University. Dr. Canning served as the Utah Psychiatric Association president coinciding with the 2002 Winter Olympics. He was awarded the Distinguished Life Fellow Status through the American Psychiatric Association. His two cats, Chris and Penelope, went into the practice of medicine. He has two grandchildren who are the light of his life and he knows how grandparents at a distance survived in the “olden days” before digital technology.

Class of 1978

Richard Y. Farnsworth (Rick)  Dr. Farnsworth is a partner/owner (since 1984) at Utah Valley Pediatrics in Provo, Utah. Dr. Farnsworth enjoys all aspects of pediatric practice except for the paperwork and bureaucratic hassles. He enjoys working with residents, medical students, premédical students and has great work colleagues. He has taught neonatal resuscitation for many years, including in China. Dr. Farnsworth has 4 sons and 14 grandchildren whom he loves very much and hopes to spend more time with in the future.

Class of 1983

Camille Collett, MD  Dr. Collette is currently faculty at St. Mark’s Family Medical Residency which she helped start 20 years ago. Dr. Collette continues to see her own patients at the St. Mark’s Family Medicine Center. She and her husband celebrated 31 years of marriage in July 2013. Dr. Collett has one son who graduated from college and is currently living in beautiful Bozeman, Montana.

Donald Eckard, MD  Dr. Eckard lives with his wife, who is also a radiologist, in San Diego, California. He provides teleradiology services to hospitals across the United States. He was lucky to provide teleradiology services from Sydney, Australia for one of the years at his current job. He is also working on a series of books/products on health and fitness, but has found that the hard part is actually getting the books marketed. He has a son in Kansas City, Missouri who works IT for a local bank and a son in Houston, Texas working at Exxon. Life is good and he has no complaints!

Class of 1998

Janet W. Grissom, MD  Dr. Grissom practices at the Salt Lake Veterans Affairs Medical Center as the in-patient medical director of the psychiatry unit. From 2002 to 2010 she worked at Valley Mental Health and IFIC both in-patient and outpatient. She has attended and traded Olympic pins in the following Olympic games: Salt Lake City 2002, Athens 2004, Torino (Italy) 2006, Beijing 2008, Vancouver 2010, and London 2012. She currently has her e-ticket for Sochi (Russia) 2014! She has a daughter Cynthia who is 14 years old and the light of her life.

Class of 2003

Nicole Draper, MD  Dr. Draper lives in Denver, Colorado where she is the pathology course director at the Child Health Associate and Physician Assistant Program, University of Colorado.

Niloufar Tabatabaei, MD  Dr. Tabatabaei works in cardiology, with a subspecialty in electrophysiology at the Olmsted Medical Center in Rochester, MN. She is the director of echocardiography and of cardiac rehab at Olmsted. She was sorry to miss the ten year reunion and celebrating everyone’s accomplishments, but baby #2 was due the same weekend!

Class of 2008

Peter Crane, MD  Dr. Crane is a family physician in Montpelier, Idaho. Dr. Crane is finally doing what he dreamed of doing nine years ago when he started at the University of Idaho School of Medicine. He is a family physician in his hometown of Idaho. He enjoys a broad spectrum of medicine in primary care, emergency services, endoscopy, and obstetrics. In fact, the physician who delivered Dr. Crane retired and he took his place. In addition to working in rural Idaho, Dr. Crane enjoys participating in and organizing international medical service trips.
## In Memoriam 2013

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Degree</th>
<th>Date of Death</th>
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<tbody>
<tr>
<td>Ted B. Bernhisel, MD</td>
<td>MD 1946</td>
<td>2 September 2013</td>
<td>19 December 2013</td>
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<td>William R. Christensen, MD</td>
<td>MD 1952</td>
<td>14 December 2013</td>
<td>26 August 2013</td>
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<td>Ronald W. Dorchuck, MD</td>
<td>MD 1993</td>
<td>27 June 2013</td>
<td>14 November 2013</td>
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<td>Sheldon L. Gee, MD</td>
<td>MD 1963</td>
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<td>12 August 2013</td>
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<td>Arnold B. Gilbert, MD</td>
<td>MD 1958</td>
<td>20 December 2013</td>
<td>9 September 2013</td>
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<td>Paddy R. Graver, MD</td>
<td>MD 1962</td>
<td>18 December 2013</td>
<td>2 October 2013</td>
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<td>Hallard B. Harmon, MD</td>
<td>MD 1945</td>
<td>2 January 2014</td>
<td>4 December 2013</td>
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<td>Donald Houston, MD</td>
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<td>Leon M. Heferton, MD</td>
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<td>Rex D. Nash, MD</td>
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<td>15 September 2013</td>
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## 2014 Health Policy & Leadership Course

**Division of Public Health Classroom 203, 375 Chipeta Way, Suite A, Research Park,**

**Open to public 6:15-8:50 p.m.**

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<thead>
<tr>
<th>Date</th>
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<th>Speakers</th>
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<tbody>
<tr>
<td>2/5</td>
<td>Health Reform in the US and Utah</td>
<td>Greg Poulsen - Senior Vice President Intermountain Healthcare,</td>
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<td>David Clark - Senior Vice President International Banking, Zions Bank,</td>
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<td>Former Speaker of the House, Utah State Legislature,</td>
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<td>Jason Stevenson - Education and Communications Director, Utah Health</td>
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<td>Policy Project</td>
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<td>2/12</td>
<td>The Science of Health Policy</td>
<td>Bob Huefner, PhD - former chair, Utah Health Data Committee, Wu Xu -</td>
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<td>Director, UDOH Office of Public Health Informatics,</td>
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<td>Kathie Marti RN, MPH - Director, UDOH Office of Public Health Assessment</td>
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<td>2/19</td>
<td>“Organized Medicine”</td>
<td>Michelle McOmber, MBA - Utah Medical Association, Greg Bell – Utah</td>
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<td>Hospital Association,</td>
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<td>David B. Hansen, JD - Counsel, Public Employees Health Plan</td>
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<td>2/26</td>
<td>The Education of Future Health Professionals</td>
<td>Vivian Lee - Dean, U. of U. SOM, Sara Hart - PhD, RN, Assistant Professor,</td>
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<td>University of Utah, College of Nursing,</td>
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<td>Jennifer Coombs, PhD, PA-C - Division of Physician Assistant Studies</td>
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<td>3/5</td>
<td>Access to Care in the U.S.</td>
<td>Mark Supiano, MD - Chair, U. of U. Dept. of Geriatrics, Maureen Henry,</td>
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<td>JD - Former Director, Utah Commission on Aging</td>
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<td>3/19</td>
<td>Caring for our Growing Elderly Population</td>
<td>Mike Magill, MD - Chair, Dept. of Family and Preventive Medicine</td>
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<td>3/26</td>
<td>The Science of Improving the Provision of Health Care Services</td>
<td>Brent James, MD - Intermountain Healthcare, Quinn McKenna - CFO U. of</td>
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<td>4/2</td>
<td>Comparative Healthcare Systems</td>
<td>Richard Sperry, MD, PhD - Center for Healthcare Transformation and Health</td>
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<td>Literacy, John Nelson, MD Former President, American Medical Association</td>
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Medical School Halloween Party at Dean Vivian Lee’s Home

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