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

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Dean’s Message

Well, we did it.

After a long campaign and a tremendous effort by so many Utah alums—especially the School of Medicine Alumni Association Board, who lobbied hard for the future of the medical school and the community at large—we will matriculate 20 more students this fall and next, and then 40 more for each year after.

While our in-state tuition (approximately $30,000 per year) has remained comparable to other state institutions, we recognize that we all need to help our students minimize their debt burdens.

None of the new state funding goes to student scholarships, which means we will soon have 40 more students needing assistance. A good majority of these future doctors need our support and investment as they lean toward both primary care and Utah practice.

I would like to personally extend my deepest gratitude, and ask you to do the same, to everyone involved in this effort. Thank you to Senator Valentine and Representative Kennedy for sponsoring the bill and to the Governor and the Legislature—their proactive vision for the future health and economy of Utah is a monumental benefit to Utah’s citizens. And thank you to President Pershing, Jason Perry and University of Utah School of Medicine alumni for your instrumental support in the passage of this bill. We experienced an unprecedented groundswell of support from our University communities, alumni, our students, our faculty, the dean’s office and the greater public at large. Thanks to everyone who pitched in for a better tomorrow.

One more side note: I’m excited to announce that as of June 24, 2013, Samuel R. G. Finlayson, MD, MPH, a Harvard-trained gastrointestinal surgeon, will become our new chair of the Department of Surgery at the University of Utah School of Medicine. We are grateful for the outstanding service of our interim chair, Dr. Pat Cartwright, who graciously agreed to serve when former chair, Dr. Sean Mulvihill, took on his new role of CEO of the University of Utah Medical Group. Dr. Finlayson has distinguished himself as an expert scholar on issues of surgical access, quality, and outcomes at Dartmouth and more recently, the Brigham and Women’s Hospital. Dr. Finlayson is an outstanding surgeon and academician, and we are delighted that he will be joining our leadership team at the U.

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

Best wishes,

Vivian Lee MD, PhD, MBA
Dean, School of Medicine
Senior Vice President for Health Sciences
CEO, University of Utah Health Care
I have served as the Director of the Alumni Relations office of the School of Medicine for almost seven years. It has been an extremely enjoyable time and exciting as the Alumni Association has expanded programs to meet the interests of our alumni and the needs of our current students.

In 2008 the Alumni Association underwent a five-year strategic planning process. The direction of that plan resulted in a growth of our student programs, including adding the HOST program (Help our Students Travel) for our fourth year students during their residency interviewing process, the Dinner with a Doc program, the Transitioning into Practice program for our residents, and setting up of the Student Emergency Fund. We began focusing more on interactions between students and alumni at events and with our medical student thank-you calls to donors.

We also worked on engaging with the departments in the SOM by collaborating with them on departmental CME programs during the Fall SOM Alumni Weekends. The Half Century Society Planning Committee formed in 2011 and began to focus on issues of interest to them and the school. Recently they met with Dean Lee and others to discuss ways the medical school can encourage students to consider primary care specialties and how the medical school can assist students who are interested in practicing medicine in rural areas of the state.

After completing our first-ever survey of our alumni, last month we began our second five-year strategic planning process and are still in the midst of that activity. Some of the issues raised have included meeting the needs of physicians across the spectrum of their practice, from recent graduates to mid-career and late career. The committee was also committed to find new ways to connect alumni back to the school, building a sense of pride among them for the school and the education they received.

From time to time I hear from some of our medical alums sharing their memories of medical school and beyond. Recently I received a very nice letter and photos from Retired Colonel Fred V. Jackman, MD, Class of 1951. He believed his class and the Class of 1950 were the first graduating classes which consisted of about 50% veterans returning from World War II. So the class was an interesting mix of older Naval and Army veterans and young students graduating with their MD degrees at age 24! Dr. Jackman graduated from East High School at 16 and started school at the U. However, as he put it, “my grades were so poor that I ran away and joined the Navy as soon as I turned seventeen!” He attended Notre Dame Midshipman School and served in Patrol Torpedo Boat Squadrons for eight months in the South Pacific before the PT boats were decommissioned and destroyed. When he returned to Utah he resumed his pre-med studies with more intent. When he was interviewing for medical school the professor interviewing him commented that he had “never seen a report card which ran so poor and then so well” but that maybe “the medical school could use some students who have something more than a 4.0 report card.” Soon after that he was accepted and graduated in three years (during the war and for a period after, the U graduated students in three years, so doctors, who were sorely needed at that time, could get into practice earlier.)

The picture below shows Dr. Jackman and some of his classmates on a cruise they took to Alaska together in 2005.

I hope to hear from many more of you in the years to come and will report in a future Illuminations on the completion of the latest strategic planning process.

Look for more good things to come in the future,

Kristin Wann Gorang
Director, SOM Alumni Relations Office

Cruise reunion for class of 1951
Sean Runnels, MD is a Cardiac Anesthesiologist from the University of Utah on a two year leave to work in Africa. The first year was spent in Guinea on the hospital ship Africa Mercy. The second year will be spent on faculty at the medical school in Kigali, Rwanda. Sean’s role is to help Mercy Ships design and implement a training program for local anesthesia providers as well as provide anesthesiology services for the extreme poor of West Africa. He is a graduate of Pacific Lutheran University and Oregon Health Sciences University. He trained in Anesthesiology at the University of Utah and sub-specialized in Cardiothoracic Anesthesiology at Papworth Hospital, in Cambridge, UK. His wife Diane Ellis, MD is an OB/GYN who has left her job at the Community Health Center where she provided care for the immigrant community and underserved in Salt Lake City. She is a graduate of Indiana University and The University of Medicine and Dentistry of New Jersey. She trained in Obstetrics and Gynecology at Oregon Health Sciences University. While on board, as well as on trips to Sierra Leone and Uganda, she performs vesiculo-vaginal fistula repair, obstetrics, gynecologic surgery, and tends to the medical needs of the women of the Africa Mercy crew. Their children Abigail (13), Elise (10), and Rhys (7) have enjoyed living on a ship for a year and look forward to living in Rwanda next year.
What is Mercy Ships?
The Africa Mercy is the world’s largest non-military hospital ship. It is owned and operated by the international non-governmental organization (NGO) Mercy Ships. The former rail ferry is 450 feet in length with a crew of approximately 400. It has been retrofitted with six operating rooms, ninety ward beds, and three ICU beds. The mission of Africa Mercy is delivering medical care to the poorest of the poor, who have no access to medical care in West Africa. The ship operates on a yearly schedule with ten months of active service anchored in a needed location followed by a two month resupply, staff transition and rest period in the Canary Islands, its home port.

What sort of medical care is provided?
We are in the surgery business. In a ten month field service approximately 2500 major operations (including cleft lip and palate, club feet, lower extremity surgeries in children, hernias, vesiculo-vaginal fistula repairs, plastics, and benign tumors), 2000 cataracts, and 20,000 dental procedures are performed. We do not treat fresh trauma, acute surgical processes, or malignancies. We simply do not have the resources on the ship to deal with such open-ended pathologies.

Our mandate is to provide surgical care only. We are only here for a fixed period of time and patients with medical problems like untreated malignant hypertension, which is rampant here, need to be followed and medicated for the rest of their lives. It’s hard enough in developed regions to get our patients to comply with hypertension treatment. In West Africa, the population has virtually no medical understanding, the medications are unavailable or unaffordable, and there is no immediate signal to the patient that they are better off because of the medications. Getting them to commit resources and comply with medical regimes is very difficult.

On the other hand, with surgical treatment there is a tangible life-changing benefit for them and their families and a very strong signal to the community that we did something that helped the patient. Once they are repaired, the fix lasts for life. It’s hard to overstate the impact of fixing straight forward surgical problems: take out a cataract and someone can see; repair a vesiculo-vaginal fistula and a young woman who leaks stool and urine can be accepted back into her home by her husband and mother-in-law; fix a cleft palate in a child and they can show their face in public, pull a rotten tooth or drain an abscess and prevent a facial infection and death. These are single interventions that have huge impacts with lasting effects. Very tangible results. This is the rationale for providing surgical care only.

Your family lives on the ship. How has that been?
There are about 30 families living on board with around 55 kids. The families are from all over the world so it is a very international group. Only the long-term crew is allowed to have children on board. Some volunteers are here for as little as a year, but most for two. A few families have been here for many years. A surgeon who has been with the organization for over 25 years has two kids who have grown up on the ship. It’s a very unique environment to grow up in. There is an accredited K thru 12
school on board. Class sizes are small and the commute to school is about 30 seconds. After school the kids get homework done and then head down the hall to play with the kids next door. It is a challenge to keep them active as the ship is a pretty confined space. There is a swimming pool, as well as an open deck where they can run and ride scooters. In a lot of ways it’s an ideal environment in the eyes of a grade schooler and pre-schooler with lots of friends, interested nice adults, and plenty of steel deck for roller blading and running, and a swimming pool! What more could you want at that age? When we first arrived my son Rhys, who was six and loves playing soccer, was watching a group of the older boys (10 -17) play soccer. It was obvious he wanted to play. The big boys asked him to play and he jumped right in. I commented to one of the moms that that was very nice for them to tolerate a six year old on the field. She laughed and pointed out that they have no choice; if they don’t let the little kids play they don’t have enough players to make teams! The kids don’t segregate by ages here. It’s been eye opening to see how much the little ones look up to the big ones, and how much the big ones enjoy taking care of the little ones.

It gets a bit trickier for the junior high and high school kids living on the ship. They have a harder time. They have a lot less interest in the nightly light saber battles on deck eight and not many kids to choose from if they don’t get along. There’s not much opportunity to gain autonomy or responsibility if this is the only world you know. The ship’s kids are a novelty and are treated as very special. A recurring worry with the families of the very long-term people is the potential for a difficult transition when they leave and become just another kid. That said I think it’s a net gain up to junior high; I’m less sure after that. It’s a really nice group of families and kids; I will miss that when we finish our service.

**Photos left to right: Child’s severely deformed legs; difficult airway intubation; children of Guinea waiting for care.**

**It’s hard when the full harshness of life is laid bare and brightly lit in front of you. No way to sugar coat days like those.**

What is Guinea like?

It’s very hot, dirty and the most dysfunctional country I have had the pleasure to travel in. It’s hard to overstate the lack of recognizable civil society here. Off hand, I can’t name any institution here that is functioning in even the most basic way, except the military and the mining companies. For comparison to the rest of the world, Guinea ranked 178th of 187 countries on the WHO human development index. It’s a testament to the dedication and flexibility of Mercy Ships that the Africa Mercy has operated without interruption for the last seven years.

Of late there has been a lot of ethnic/political violence with raids and reprisals, rioting and riot police shooting in the streets. Twelve people were killed last week. This was alarming to me. When I talked to one of our translators, he couldn’t understand why I was concerned; this sort of things happens on a regular basis. In fact, he saw the “small fighting” as a good thing as it acts as a release valve to keep the “big violence” at bay! It’s hard, even after being here for...
a year, to wrap my head around what it would be like to be from Guinea. One of our nurses boasted to one of our Guinean day workers, Fatmata, that she had lived in Africa on the ship for the last ten years, and therefore considered herself African. Fatmata deftly pointed out that you can only consider yourself African if you can’t leave during the next military coup!! I had to laugh at that one. She hit it right on the head.

The people are warm and a lot of fun. It is all about relationships here. Everyone is greeted and time is always taken to ask about your family and life before any business is done. It does make for slow going by American standards.

**What is the hardest day you have had?**

We had a three month old child, Noumou, arrive with sepsis. We are not a medical hospital and would be quickly overwhelmed and depleted of resources if we tried to treat every baby with sepsis. (One in fifteen babies here dies before age one.) The baby was housed in our feeding center putting on the pounds to get her ready for a cleft lip repair at six months. Once a baby is in the system, it is very difficult to say no to other treatment. After a great deal of hand wringing and discussion, we decided that it was reasonable to hydrate and give the child a blast of antibiotics, but no further treatment beyond that. Then a loud murmur was discovered! So now we have a baby with sepsis and a heart problem we can’t fix, at high risk for death, not good! She was hydrated and antibiotics were given. The next morning she turned the corner and got better. The dilemma of what to do with a kid with a hole in their heart and a cleft lip remained!! We used the age old technique of procrastination. We would see how she was at six months. Darn it, she gained weight, clinically didn’t have any signs of problems from her heart, but still had a very loud murmur. After a very long and emotionally difficult conference we decided that it was a low risk surgery and anesthetic, we had the expertise on board (I’m a cardiac anesthesiologist as is the other long-term anesthesiologist) and we could not rule out that she might live a long time with the heart murmur, so we did the surgery. It went fine and the baby went home without incident. Chalk up one small victory here in West Africa!! Then I heard yesterday that baby Noumou passed away at home a couple of days ago. She got sick and because of travel restrictions due to some riots her mom couldn’t get her here to be seen. It’s hard when the full harshness of life is laid bare and brightly lit in front of you. No way to sugar coat days like those.

**Have you been able to explore much of Guinea?**

Not as much as we would have liked. It’s a very difficult place to get around. The roads are the worst I’ve ever been on. There are military roadblocks with ill disciplined, armed and greedy soldiers who don’t seem to answer to anyone. In one five hour 100-mile trip we were stopped four times and asked to see paperwork, ID’s, etc. You then have to go and talk to the commanding officer who wants “what do you have for me” money. As a rule we do not pay to go past road blocks. Once you start, it will cost more on the way back. So at that point you all sit in the office until he gets bored and frustrated and tells you to go on. Hanging out with armed West African soldiers in a hot room for an unknowable period of time is not the most pleasant experience and does not foster a lot of desire to get very far off the beaten track. As a result there are not many tourists in Guinea and therefore not
much tourist infrastructure. This means there are few places to lodge overnight if you travel in the up country. Things are very expensive as you are either very rich or dirt poor. Too bad, as it is a beautiful place not far from Europe with a climate on par with Hawaii.

**What has your work been like?**

Part of our work is training local providers, which has been particularly challenging. There is one trained anesthesiologist for a country of over ten million people. Dr. Barry trained in Russia about 25 years ago and has had no continuing medical education since then. He comes to the ship once a week and we work together. There is no working anesthesia machine or ventilator available in Donka Hospital where he is the Professor of Anesthesia. They do have halothane and the ability to intubate patients, but no opiates or muscle relaxants. Most of the cases are done with Ketamine, spontaneously ventilating, on room air.

I spent two weeks in the operating rooms at Donka, observing their practice so we could try and make an effective training plan. The first thing that struck me was the lack of working equipment and supplies, medicines, IV fluids, etc. What also became clear was the lack of safe behaviors practiced by the providers. For instance monitors are available but no habit of putting them on until after induction of anesthesia. There is no habit of setting up or checking airway equipment before an induction. Several times the provider had to leave the room to fetch a laryngoscope to replace the unchecked-non-functioning scope. There was no effort made to mask-ventilate patients after induction! There are no muscle relaxants so the patients are spontaneously breathing most of the time. However, most patients stop breathing when the induction medicine is given until they are stimulated with intubation. If there is a delay while the airway equipment is set up the patient is not ventilated. It was hard for me to watch. Of course, the monitors were not on so there was no diving pulse oximeter to demonstrate the desaturation of oxygen taking place. No one I saw arrested, but I was told that it’s common for people to arrest on induction. What I did see was that many of the risks for catastrophic outcomes might be avoided through simple behavior changes.

The training program we have set up on ship is focused on modeling and practicing behaviors that reduce morbidity and mortality during the conduct of an anesthetic. I have these folks for at best ten days. We wash our hands before each case, pre-oxygenate patients, ventilate them when they are not breathing, put our monitors on before induction, confirm every endotracheal tube placement and do a time out before every incision. We go thru the same list every day, every case. At the end of the two weeks, they know the list by heart and follow it every time. I don’t know what happens when they go back home. I’m going to spend a week at the end of field service helping to introduce a new anesthesia machine to Donka. I’ll be looking to see if our training had any impact on care.

**What have you missed most while in West Africa?**

We went to a nice outdoor cafe to eat dinner and they had some kittens running around. I picked one up and it fell asleep purring on my lap. People don’t keep animals as pets here, there are plenty on the streets, but they are not the petting type. I realized I hadn’t touched a dog or a cat since I have been here. I miss our cats.

**What are you doing next year?**

Next year we will be living and working in Kigali Rwanda for the University Medical Center. Diane and I will be training residents and mentoring faculty. All of the trained doctors left Rwanda during the genocide, resulting in a discontinuity in the ability to train new physicians. The program is designed to provide training support from the U.S. and Canadian faculty over the next eight years and develop the administrative side of the departments. After that point, the medical training and departments should be running without help from us. It will be a very different approach to helping in Africa. We are both looking forward to the challenge. The kids are looking forward to having a cat and a back yard!
Thanks for All You Do:
The incredible growth of the University of Utah Health Sciences
By Steve Warner, former Associate Vice President of Health Sciences Development and Alumni

Many people think that the University of Utah is supported significantly by the State of Utah. Contrary to that belief, the University receives less than 1.4% from the State with the Health Sciences receiving less than four percent (4%) of its budget from the State of Utah. It is important to remember that the University of Utah is a state-assisted, not state-supported university. Private support of the University is vital to its future.

For 25 years, it has been a pleasure to work with the incredible donors at the University of Utah. It has been a remarkable period of growth. When I joined the University as its first major gift officer in 1985, total annual giving to the university was $22,773,076. In 2011, thanks to amazingly generous donors, annual giving to the University exceeded $187,300,000.

With the help of private giving, the University of Utah has undergone a transformation in the last 25 years. New buildings have sprouted everywhere on campus. Campus construction has helped fuel Utah's economy. The 33,000 students on campus today. A favorite statement of President Chase Peterson is, “The U of U is the most boot-strapped university in the country! Our pioneer heritage taught us to take a little and stretch it as far as we can make it go.” The U is continuing to do just that.

Without donor assistance, the construction of modern buildings would not be possible. Donors have helped build the Moran Eye Center, the George S. and Dolores Doré Eccles Critical Care Pavilion, the Huntsman Cancer Institute and Hospital, the Emma Eccles Jones Health Sciences Research Building, the Skaggs Pharmacy Institute Building, the John and Marva Warnock Engineering Building, the James L. Sorenson Molecular Biotechnology Building, the Roland Christensen Center, the John and Marcia Price Museum of Fine Arts, the Spencer Fox Eccles Business Building, the Thatcher Chemistry Building, the Crocker Science Building, the Frederick Albert Sutton Mines and Earth Sciences Building, the Marriott Library, the Annette P. Cumming Nursing Building, and the Ray and Tye Noorda Oral Health Building.

During my early business years, I found myself wondering what product would be the best one to sell someone where they would experience no buyer’s remorse. I wanted to present something to them that would bring them joy… days, months and years after they had invested in the product.

In 1985, I was lucky enough to find that product—education at the University of Utah. Donating to education is a unique opportunity to invest in the growth of individuals, while also investing in the improvement of society as a whole. I found that as donors invested in improving the educational experience and opportunities for future generations, they found significant joy and satisfaction. Feeling charitable toward another is a virtue that many parents and grandparents try to instill in their posterity. One is usually not born philanthropic. It generally takes teaching by example as well as personally experiencing the joy of giving to become fully converted to philanthropy. Although fundraising for the University of Utah was not my first profession, it has become my passion and delight.

I have had the opportunity to visit with students in the Spencer F. and Cleone Eccles Health Sciences Education Building. They comment that the facility is fabulous. The audio-visual capabilities are top flight and every student can see and hear. With the 150-seat classrooms, there is room to accommodate students without having to sit on the steps as was the case in the old A, B, C, and D classrooms. The clinical training facilities are a huge improvement with television monitors in each exam room. Students can review themselves while proctors and teachers critique their physical examinations. Because of its design and location, there is more interdisciplinary discourse than ever could have occurred in the old School of Medicine classrooms. With this new building, health, nursing, pharmacy, dental and medical students have opportunities to interact. This builds camaraderie and understanding about each other’s roles as they work together on the healthcare team.
Our family has had multiple opportunities to use the Huntsman Cancer Hospital, University Hospital, the Orthopaedic Hospital and the various clinics. With each occasion, we have been impressed with the quality of care. It has brought comfort to us in knowing that family members are being cared for in one of the best academic medical centers in the world. The facilities now equal the quality of its care givers. The Eccles Critical Care Pavilion that houses the William H. and Patricia W. Child Emergency Room, the Ezekiel and Kay Dumke Surgical Waiting Room and the Surgical and Medical Intensive Care Units have been a huge improvement. Caregivers share that it is so much more rewarding to care for patients in private, state-of-the-art rooms with spectacular views and plenty of natural light.

In the Health Sciences at the University of Utah there are 120 endowed chairs that have been funded, each with a gift of $1,000,000 or more, by generous donors through outright or planned gifts. These chairs are vital to the U. They provide top-producing faculty with time to focus on research where they otherwise would need to be that is so vital to the work of discovering and disseminating knowledge.

Scholarships have become more important than ever as the cost of education has escalated. Each year, the U tries to recruit Utah’s best-prepared and hardest-working students to the health sciences. Our competition is often against universities able to offer full-ride scholarships to these students. We are doing better at recruiting these outstanding students than we did when I first started at the U, mainly because of generous scholarships that donors have established.

During the 2002 Olympics, the U offered named endowed scholarships for a $10,000 contribution. Dozens of donors stepped forward and established these Legacy Scholarships as an Olympic tribute. Today, the U offers Legacy Scholarships for $25,000 that can be paid over five or ten-year periods or can be established through a bequest from your estate. A simple statement in one’s will that you plan to leave $25,000 to establish the John and Jane Doe Endowed Scholarship in Nursing will create a lasting legacy in your names that will bless students forever. These scholarships not only help students pay for their educations but encourage them by their knowing that someone in the community has taken an interest in them personally. That benefit alone can be wonderful for any student.

It has been a privilege to work closely with the School of Medicine Alumni Association. It has grown tremendously since 1995 when Kate Woodworth served as its first director. With some growing pains, it is becoming a mature organization. Today, under Kristin Wann Gorang’s dynamic leadership, the class reunions, the Awards Banquet, the CME Symposium, the Transitioning into Practice program, Dinner With a Doc, the HOST program and the Half-Century Society have either been started or have grown significantly. The alumni are playing an ever more important role, as has been demonstrated by their successful lobbying efforts to restore and increase the medical school class size and their current efforts to get more students to choose primary care specialties and consider practicing in underserved areas around Utah.

My wife, Liz, and I are third generation Utes and all of our children have at least one degree from the U. Our family’s roots go deeply into the soil of the University of Utah. Our fathers both were faculty members at the U. I feel this institution improves the quality of life in Utah. It is the State’s flagship institution. I believe what is done on this campus changes lives and engenders hope in providing a bright future for the generations that follow. I count myself lucky to have been able to provide many people with an opportunity to partner with the U in providing an optimistic future.

A few years back, I interviewed a senior at West High School for a Rotary Scholarship. I believe he was from Cambodia. He was placed on a boat by his parents, whom he never saw again, and was raised by his uncle in Salt Lake City. He worked long hours at McDonalds to earn money for college and had a positive, can-do outlook on life, having set his sights on medical school. I remember thinking at the time what a huge success it would be if this young man was able to realize his dream. I watched for this young man’s name and found he was accepted to the U’s medical school and, with the help of scholarships, is now an accomplished physician. There are dozens of stories like his and more waiting in the wings. Perhaps you are one of the donors who made this young man’s dream of becoming a physician come true.

There are many more like him who show great promise. Please support the University of Utah to give these hard-working students a chance to make their positive impact on the world.

Steve Warner is currently serving as a mission president in Hawaii for his church.
A study published last year in the journal Global Public Health focused on the relationships between the availability of HFCS and prevalence of diabetes in 42 countries in North America, Europe, Asia and Northern Africa. Based on the international analysis, it was reported that the countries using HFCS in their food supply have a 20% higher prevalence of type 2 diabetes than the countries that consume little. Further, out of the 42 countries studied, the United States had the greatest consumption of HFCS at 25 kg per person a year. The results were independent of total sugar intake and prevalence of obesity. The authors concluded that HFCS consumption may lead to negative health consequences distinct from and more deleterious than natural sugar.

HFCS is made from cornstarch and is widely used as an ingredient in many processed foods and beverages. During the production of HFCS, cornstarch is converted to short glucose polymers and fructose. Fructose gives desired sweetness to HFCS. Both sucrose (table sugar) and HFCS contains similar calories (4 calories per gram) but have different proportions of glucose and fructose. Sucrose consists of 50% glucose and 50% fructose linked through a glucosidic bond. HFCS contains slightly different proportions of glucose and fructose (usually either 55% [HFCS-55] or 42% [HFCS-42] fructose), but the glucose and fructose molecules are not linked by a chemical bond. HFCS-55 is mostly used in soft drinks whereas HFCS-42 is widely used in processed foods, baked goods, cereals, dairy products and beverages. HFCS is preferred to sucrose as it extends the shelf life of foods, is relatively cheaper than sucrose, can be added to variety of food products, and is stable in acidic foods and beverages. Soft drinks are one of the largest sources of HFCS.

The metabolism of fructose is distinct from glucose. High flux of fructose disturbs glucose metabolism...
and favors lipogenesis (synthesis of fat), hepatic insulin resistance, and obesity which contribute greatly to metabolic syndrome. Fructose is metabolized primarily in the liver, which contains abundant Glut-5, a transport protein that facilitates the uptake of fructose.

Fructose is more efficient than glucose in inducing lipogenesis. Indeed, when glucose and fructose enters the liver simultaneously, glucose enters glycogenic pathways whereas fructose enters lipogenic pathways. Thus high and prolonged ingestion of fructose may contribute to adverse liver fat accumulation which can lead to hepatic insulin resistance and NAFLD. According to the American Liver Foundation, NAFLD affects up to 25% of people in the US. NAFLD may cause steatohepatitis which can lead to cirrhosis followed by liver failure or even liver cancer. In addition, NAFLD is associated with cardiovascular disease, insulin resistance and metabolic syndrome. Hepatic fat influences the atherogenic lipid profile that can lead to cardiovascular complications. A meta-analysis of 10 prospective cohort studies published recently in the journal Circulation reported a consistent positive association between sugar-sweetened soft-drink intake and weight gain, as well as the risk of diabetes, cardiovascular disease and metabolic syndrome.

Increased fructose load in the liver can also enhance the formation of uric acid which can lead to gout in susceptible individuals. A recent study published in British Medical Journal analyzed the relationship between consumption of soft drinks/fructose and the risk of gout in men. The researchers followed more than 46,000 men with no history of gout for 12 years and found that consumption of sugar-sweetened soft drinks and fructose is strongly associated with an increased risk of gout in men.

Studies also focused on the effect of fructose on food-seeking behavior and food intake. Glucose ingestion stimulates insulin that acts centrally to increase satiety and blunt the reward value of food. Further, glucose intake increases the circulating levels of satiety hormone such as glucagon-like polypeptide-1 (GLP1) and attenuates the levels of appetite stimulating hormone such as Ghrelin. Fructose weakly stimulates secretion of insulin, attenuates GLP-1 but does not suppress Ghrelin. All these can lead to enhanced food-seeking behavior and increased food intake followed by weight gain and obesity. Indeed, a study published this year in Journal of American Medical Association (JAMA) reported the reduced ratings of satiety and fullness with the ingestion of fructose as compared to glucose. This study showed that ingestion of glucose but not fructose reduced cerebral blood flow and thus activity in specific brain regions that regulate appetite and reward processing.

While many of these studies support the negative impacts of fructose and HFCS on metabolism, controversy still exists about the unhealthy effects of HFCS. Specifically, many argue that there is insufficient evidence to show that the metabolism of HFCS is different from sucrose or that HFCS is worse than sucrose. However, reducing the overall “added sugar” regardless of type may be an important strategy to prevent various metabolic disorders. The major sources of added sugars in the U.S. are HFCS, honey, invert sugar, table sugar, corn syrup, and fruit juice concentrate.

Consistent scientific evidences indicate that changes in the dietary habits may be one of the best strategies to prevent or delay these chronic diseases and reducing added sugar maybe one of them.

Commenting on the paper that linked the availability of HFCS with the prevalence of diabetes, Dr. Tim Lobstein, director of policy for the International Association of the Study of Obesity said, “If HFCS is a risk factor for diabetes - one of the world’s most serious chronic diseases - then we need to rewrite national dietary guidelines and review agriculture trade policies. HFCS will join trans fats and salt as ingredients to avoid, and foods should carry warning labels.”

Acknowledgments: I would like to thank Dr. Eldon Wayne Askew, Professor and Chair, Division of Nutrition, University of Utah for his constructive suggestions and thoughtful review on this article.
Cadaver dissection within the gross anatomy laboratory is one of the first learning experiences that students encounter in their journey towards becoming a doctor, and yet the instruction of gross anatomy has remained basically unchanged for centuries. Although dissection’s primary purpose is the instruction of normal anatomy, anatomists claim that there is more to the experience of dissection than simply gaining anatomical knowledge. Yet it is the physicians who experience the training that are the true holders of knowledge about dissection’s level of richness, complexity, and utility, and how it relates to their clinical work.

In the fall of 2011 alumni of the University of Utah School of Medicine were asked to participate in a study examining the meaning that physicians take from their experience with full body cadaver dissection. The study was qualitative in nature and based on two primary questions: (a) What impact do physicians believe that cadaver dissection has had on their development as medical professionals and (b) What aspects of the dissection process remain salient following the transition from medical student to medical professional?

In all, 38 alumni who graduated between 1954 and 2002 participated in the study. They represented 17 areas of medical specialization from aerospace medicine to urology. They participated in in-depth interviews, either individually or as part of a focus group, or responded in writing to interview questions. Additional data were gathered from the School of Medicine yearbooks, in which quotes and images were compared to the memories shared by the alumni in the study. Participants were asked to choose a pseudonym from a list of trees, metals, and colors, and those pseudonyms are used in the quotes that follow.

The study revealed four interconnected themes: (a) Working with Peers, (b) Future Learning, (c) Patient Care, and (d) Confidence. These four themes revolved around one overarching core concept: Foundational Learning for the Future. This concept connected the multitude of experiences within the dissection laboratory, and each of the four themes played a specific role within that concept.

Foundation for Working with Peers
The process of dissection provided participants with a foundation for working with their peers, not only in medical school but throughout their career as physicians. Participants talked of the trials of working together as well as the benefits. As Dr. Brown stated, “There was teamwork in dissection. Medicine is completely teamwork now.”

Dissection was seen as more than just learning to work as a team; it was seen as an initiation into the world of medicine. Dissecting a human cadaver is only socially normative for a select group of people, and the same is true for many of the procedures physicians perform. As a result, there was a sense of unity amongst those who performed the act of dissection. “You’re all in it together, and it’s like you’re a member of a secret club or organization. It’s just part of your initiation” (Dr. Tungsten).

Although group work was not exclusive to the gross anatomy lab, participants noted how the longevity of the relationships they formed was unique to that class. Dr. Hickory, whose dissection experience occurred in 1950, stated, “Well, we got quite a close attachment. I’m still pretty closely attached to one.” Other participants noted that they actively work to maintain those attachments made during the dissection experience and socialize with one another on a regular basis.

When talking about their connection to peers, the topic of humor came up frequently. Participants referred to the “black,” “irreverent,” or “gallows” humor in the lab as a way to process what could have been a very somber and overwhelming experience. Humor was identified as a skill because participants continued to use it as a diffusion technique throughout their work as physicians. Those who graduated in the 1950s through the 1970s noted that much humor was modeled by Dr. Edward Hashimoto. Participants spoke with great respect about Dr. Hashimoto’s ability to teach anatomy but also reflected fondly on his sense of humor.

Foundation for Future Learning
A second theme that arose was seeing dissection as a foundation for the future learning acquired through medical...
school, residency, and practice. “I think it made it more memorable to take the human body apart in a coherent educational manner that helped us put things together and provided the framework for piecing together all the various bits of knowledge that we would then subsequently gain.” (Dr. Oak).

Participants talked about using the dissection to form a complex image of the human body in their mind, using that image when learning new information, and then accessing that image as they begin applying their knowledge in clinical work.

“When you’re out as an intern and you have somebody who codes, and it’s your first time to be there, having had that gross anatomy experience, being familiar with the body and all its parts, it just, it’s all right there. You don’t have to think in terms of textbook and try to remember, it’s just part of you now because you’ve seen it inside, outside, taken apart.” (Dr. Oak)

Participants noted the incredible complexity of the human body and the vast amount of knowledge they had to acquire in medical school in order to become a competent physician. At times that complexity and volume seemed overwhelming. Participants used their experience in dissection to provide some sense of order to the disorder, both in terms of chaos and disease.

Additionally, participants talked about the importance of gaining knowledge through the first-hand experience of dissection. Dr. Gold stated that even though as a psychiatrist she rarely puts a hand on her patients, “There is something about my having touched that cadaver, had my elbows deep in that person.” She noted that firsthand experience helps her to visualize what a person looks like on the inside, and appreciate the biological systems and physiological experiences.

For many participants the act of dissection rooted them within a medical lineage. They experienced part of medical history because they were aware that dissection had played a role in medical training for centuries. With that knowledge they could move forward through the rigors of medical training. Dr. Zinc stated, “I kind of equated that rudimentary kind of understanding of the human body as the basis that medicine began with, so I kind of, I kind of jumped into it all the way.”

Foundation for Patient Care
The third theme that arose was an understanding that dissection provided a foundation for patient care. Participants spoke about how dissection impacted the clinical work they would do as well as the interpersonal aspects of patient care. “[Dissection] was the very basis of when I saw a patient later…. I would sort of flash back to not only what I saw on the surface, but knew in detail what was underneath.” (Dr. Iron).

When discussing their time in the gross anatomy laboratory the topic of variation came up frequently as an important piece of the dissection experience. Dr. Oak explained, “Not everyone is exactly the same, so [dissection] provides the framework of variance to keep it all together.” This knowledge was an important piece of development for future clinical work because of the variation that the participants see within their patients.

Participants also spoke to the importance of physical contact with patients when it came to providing medical care. Dr. Brown stated, “You know, in some part your confidence in terms of touching patients and doing things starts in a gross anatomy lab. That’s the first thing that you’re touching.” Participants talked about how the dissection experience allowed them to become comfortable with touching others in a way that was intimate yet respectful.

When discussing the topic of respect the conversation frequently turned to recognizing the cadaver as a human being. “You’re not dealing with just a piece of meat; you were dealing with a person, whose body has sanctity and respect, and value” (Dr. Mahogany). For other participants, there was less of a sense of seeing the cadaver as a person and more as an object. None of the participants espoused a view that it was important to be completely detached. Rather, it was a matter of balance in being able to connect to the person but not allow that connection to get in the way of the work they were doing.

Foundation for Confidence
The final theme that arose was seeing the dissection experiences as a foundation for the confidence participants needed in their work as physicians. Confidence came from knowing what they were capable of, learning their limitations, and facing fears. Much of this confidence came from a sense of autonomy and personal responsibility. That experience was not limited to the gross anatomy laboratory, but for many it seemed to be their first memory in medical school of feeling like, “I can do this!”

Participants noted that having confidence is important because they are the ones that others call when they need
someone to be strong. A patient expects their doctor to be calm and collected. Dr. Oak noted that as the physician he has to remain focused regardless of his own internal reactions. He noted that the experience in the gross anatomy laboratory helped moderate those reactions. As he stated, “Having seen gross stuff we’re not grossed out as easily. [And that’s important] so you don’t seem shocked. When somebody comes to you with a bad injury, you don’t say ‘Oh my heck! Somebody call a doctor!’”

For some participants, confidence arose in gross anatomy from the sense of accomplishment of working through a challenging puzzle. As has been noted previously, dissection is not an easy process and the variation in and complexity of the bodies contributed to the difficulty. As students, the participants had to take information from lectures, books, the cadaver, and living anatomy and piece it all together as a coherent picture in their own mind. Participants also spoke about the importance of having humility as a physician. Participants spoke of gaining a sense of humility from the awe they experienced in getting to understand the true complexity of the human body. Dissection gave them insight into the intricacies of the human body, and the recognition that for the most part all of those intricate pieces work together without issue.

Additionally, participants talked about humility that came from making mistakes as they dissected. When asked why it was important to mess up in the gross anatomy laboratory, Dr. Olive explained, “It’s part of being human. It’s part of acknowledging that you’re human. It’s part of being smart and you’re not omnipotent. It’s humbling.” This points to a parallel process: making mistakes increased confidence by reducing hubris, and mistakes were accepted in the gross anatomy lab because they must be avoided in the clinical realm.

Dissection was also seen to build confidence by being an experience where the shocking becomes normal. Participants talked about many shocking experiences in the lab, the smell being most frequently referenced. Participants reflected that this ability to become comfortable with the shocking aspects of dissection was important in their development as physicians.

For many the most shocking aspect of the lab was becoming intimately acquainted with death. Participants noted that for many of them, their confidence was shaken when they were first faced with the dead bodies in the gross anatomy laboratory. However, moving past that initial aversion helped them to gain even greater confidence and was seen by some as a necessary step in their development as physicians. As Dr. Nickel explained, “It’s the beginning of what you have to do all of your life. Telling people they’re dying is a lot worse than being in there with a body, but I think being in there with a body is the first step towards that.”

In conclusion, the themes that arose in this research were not in and of themselves experiences exclusive to the gross anatomy laboratory. However the combination of the four primary themes was unique to the dissection experience. It is this combination that creates the foundational learning experience within the gross anatomy laboratory. These multidimensional learning experiences occurring simultaneously within the first year of medical school create the bedrock from which students begin the process of forming their identity as physicians.

Class of 1964 in cadaver lab.

For some participants, confidence arose in gross anatomy from the sense of accomplishment of working through a challenging puzzle. As has been noted previously, dissection is not an easy process and the variation in and complexity of the bodies contributed to the difficulty.

REFERENCES
1. Bender J. From Theater to Laboratory. JAMA. March 6, 2002 2002;287(9):1179.
Long Time Director of the Burn-Trauma ICU Retires

By Lezli Matthews, Nurse Manager, Burn Center

Jeff Saffle, MD, the director of the Burn-Trauma ICU from 1985 until August of 2012, will be remembered long after he retires and moves to his cabin in the woods. His legacy and commitment, his sacrifice of heart, mind, body and soul to the patients of the SICU and Burn Trauma ICU from 1982-2012 impacted so many. He will never be forgotten.

Dedication is the first word that comes to mind when I think of Jeff Saffle. He is extremely dedicated to his patients, day in and day out, because, as he says, “the patients need me.” Every day patients and families thank him for saving their lives, for doing such a great job taking care of their life-changing injuries, and for the care he gave their child. Dr. Saffle never stopped thinking, “What more can I do for this patient?” He came into the Burn ICU every morning, having studied overnight, with ideas for better ways to help the patients in his care. Thirty years of almost continually answering to a pager and a phone, being constantly alert for any patient need, is a long time, but he never complained and always seemed driven by his care for his patients.

Dr. Saffle was born and raised in Salt Lake City and flipped burgers and made shakes at the Iceberg drive-in on 39th South. He was an excellent student and was always 100% with Trivial Pursuit questions and the New York Times crossword puzzles. He attended college and medical school at the University of Chicago, graduating in 1976. He then returned to Utah, and completed residency training in surgery, as well as a fellowship in burn care, at the University of Utah. He joined the University of Utah faculty in 1982. Influenced by Dr. Glenn Warden, then director of the Intermountain Burn Center at University Hospital, he felt “called” to dedicate his profession to the care of the burn and trauma injured patient. He is board-certified in general surgery and surgical critical care. Dr. Saffle is past-President of the American Burn Association and the Southwestern Surgical Congress. He currently serves as chair of the American Burn Association’s Multicenter Trials Group, on the Medical Advisory Board and Research Advisory Board of the Shriner’s Hospitals of North America and as Director of the Department of Telemedicine for the University of Utah Health Care. Dr. Saffle has published over 140 articles in peer-reviewed journals, as well as a number of book chapters and abstracts.

While the director of the Burn Unit, Dr. Saffle was consistently sought after to teach his surgical precision and judgment. Others modeled his interdisciplinary team approach. His instinctual and perceptive ability to determine a patient’s diagnosis, infection or surgical need was exemplary. Students, physicians, and team members came in droves whenever and wherever he taught, and he made every patient experience a teaching moment. He encouraged everyone to think things through and use their minds to their fullest potential. He was brilliant in his ability to teach to the level of those trying to learn. He loved questions and discussions and no question was too simple for him to answer.

In 2001, Dr. Saffle was nominated by residents, nurses, interns and other physicians for his excellence in teaching and received the Distinguished Teaching Award for the University of Utah campus. I personally will be forever grateful for my thirty years of working and learning alongside this caring, giving and brilliant educator and caregiver.

Dr. Saffle teaching
We welcome all alumni, faculty and former housestaff back for a weekend of education, fun and reminiscing. Registration material will arrive by mail in July or go online to register for events at http://medicine.edu.utah/alumni.

Thursday Evening, October 10

Medical Alumni Awards Banquet

Grand America Hotel 6:30 p.m. Social, 7:00 p.m. Dinner

50 Year Celebration and Induction into the Half-Century Society
Presentation of Medallions to the Class of 1963

Presentation of Distinguished Awards

Alan S. Crandall, MD 1973
Distinguished Alumni Award

Dr. Alan Crandall received his medical degree from the University of Utah School of Medicine in 1973. He completed his advanced training in surgery and ophthalmology at the University of Pennsylvania Medical Center and Scheie Eye Institute. He joined the University of Utah Ophthalmology Department in 1981. Dr. Crandall is the John A. Moran Presidential Professor and Senior Vice-Chair of Ophthalmology and Visual Sciences, Director of Glaucoma and Cataract at the Moran Eye Center, University of Utah. He is also Co-Director of the Moran Eye Center International Division.

Distinguished Service Award

Zeke and Kay Dumke gave their first gift to the School of Medicine in 1966 and by the early 1990’s their financial and time commitment to the school and the health sciences had increased significantly. Zeke has served on the University Hospital Foundation Board of Trustees and the University Hospital Board, Kay on the University Nursing Development Board. Both of them serve on the Health Sciences Council, Zeke as a past-president. Through their foundation, The Katherine W. Dumke and Ezekiel R. Dumke Jr. Foundation they have endowed a chair to support the Division of General Internal Medicine. They were instrumental in the establishment of the Dr. Ezekiel R. and Edna Wattis Dumke Health Professions Building.

Zeke was one of the founders and president of Western States Management, the University of Utah Hospital Foundation, the Salt Lake Rotary Foundation, Dumke Insurance Agency, the Multiple Sclerosis Society of Utah and several mining companies. He served as past president of the Museum of Natural History, Red Butte Gardens, the Alta Club, Salt Lake Rotary Club and the Salt Lake Art Center. They have been supporters through their foundation of women’s athletics, especially women’s soccer and gymnastics. The Katherine W. Dumke Fine Arts & Architecture Library in the Marriott Library bears her name for her commitment to the arts. Kay was past chair and a board member for many years of the Neighborhood House, a program that provides affordable day care and support services to children and adults. They have both received numerous honors from the University of Utah and in the greater community for their service.

Zeke and Kay have four children, Betsy (Scott) Thornton, Claire (Steve) Ryberg, Zeke (Angela) Dumke III, and Andrea (Mike) Manship, who are their greatest source of pride.

Dr. Alan Crandall is a Diplomate of the National Board of Medical Examiners as well as a member of the American Board of Ophthalmology. He is a member and past president of the American Society of Cataract and Refractive Surgery, a member of the American Glaucoma Society, the European Society of Cataract and Refractive Surgeons and the International Intra-Ocular Implant Club.

Dr. Crandall has chaired more than 150 major national and international symposia, co-authored two text books and authored more than 200 peer reviewed articles. He has trained 29 glaucoma fellows and more than 100 residents.

Dr. Crandall started his humanitarian work in Ghana 17 years ago and has since traveled to more than 25 countries teaching cataract and glaucoma surgery.
Karen F. Buchi, MD, 1984  
**Distinguished Humanitarian Award**

Karen Buchi joined the University of Utah Department of Pediatrics in 1990. A firm believer in the University’s responsibility to the community, she helped establish South Main Clinic, a prenatal and pediatric clinic that cares for underserved families throughout the Salt Lake Valley. To launch the clinic, Dr. Buchi worked with a coalition including the Salt Lake County Health Department, the University Departments of Obstetrics and Gynecology and Pediatrics, and the College of Nursing. In addition to providing high-quality care, the clinic is a rigorous teaching facility for residents and students, who receive both medical training and a commitment to service from Dr. Buchi and other faculty.

As the pediatric medical director of the clinic, Dr. Buchi continued her strategy of engaging community resources to provide a wide range of care. She established a lay health promoter program by partnering with Holy Cross Ministries, developed a pharmacy program to help families afford medication, led the creation of a specialized prenatal clinic for substance-abusing women, and brought the Teen Mother/Teen Health Clinic to South Main. Through her commitment to serve and her talent for collaborative leadership, Dr. Buchi brought the University into the community.

Matthew T. Rondina, MD, MSCI, 2003  
**Golden Anniversary Prize for Clinical Investigation**

Dr. Rondina’s research is focused on understanding how platelets mediate host responses and cellular interactions in patients with infectious and inflammatory syndromes. He is currently the principal investigator on a K23 NIH Grant studying how altered platelet functions during sepsis contribute to immune responses and thrombotic complications. In addition, Dr. Rondina holds an R03 award from the National Institutes of Aging to examine how aging-related changes in platelet-leukocyte interactions increase the risk of inflammatory and thrombotic syndromes. He has also collaborated with other investigators to study these, and related cellular pathways, during settings of surgery, influenza, diabetes, and obesity. Dr. Rondina recently received the William D. Odell Young Investigator Award and a New Investigator Award from the American Geriatric Society. He serves on grant review committees for the National Institutes of Health and American Heart Association, mentors younger investigators, and referees for journals such as the American Journal of Respiratory and Critical Care Medicine and The Journal of Thrombosis and Haemostasis.

**Friday Morning, October 11 School of Medicine Department Events**

7:30 a.m. - 10:45 a.m.
We welcome current or former faculty, house staff, and reunion class members to attend a department of psychiatry or department of internal medicine program for a morning of information, instructional lectures and gathering of colleagues. A continental breakfast is served and CME credit is given. Site and speakers detailed in your registration packet coming in July.

**Dean Vivian Lee M.D., Ph.D., M.B.A.- State of the School Presentation**

11:00 a.m.

**Tour of L.S. Skaggs Hall, College of Pharmacy and Luncheon**

1:00 p.m.
The University of Utah College of Pharmacy is listed as one of the top-ranked Colleges of Pharmacy in the nation by U.S. News & World Report in its 2013 Best Pharmacy Programs rankings. Come with us and tour the new expansion of L.S. Skaggs Hall including the Poison Control Center, pharmaceutical research labs and learn the history of this exceptional school and building.

**Reunion Evening**

6:00 p.m. Reception, 7:00 p.m. Dinner Little America Hotel, downtown Salt Lake City

General reception first then individual groups will dine together in private rooms.


**Class of 1983** Dinner at Jan Bernhisel - Broadbent’s home
Saturday, October 12
Updates in Science, Practice and Policy
Spencer F. and Cleone P. Eccles Health Sciences Education Building Alumni Hall
7:30 a.m. – 12:15 p.m.  AMA PRA Category 4 Credit(s)™

Drink the Water … Don’t Breathe the Air: air pollution’s impact on health
Robert Paine, MD, Chief, Division of Respiratory, Critical Care and Occupational Pulmonary Medicine, The Kenneth P. Burbidge Presidential Endowed Chair for Pulmonary Medicine Lung Transplantation

Advances in Pain Treatment
Jill Sindt, MD, Assistant Professor, Department of Anesthesiology, University of Utah School of Medicine

Dietary Supplements – Fact or Fiction?
Laura Shane-McWhorter, PharmD, BCPS, FASCP, CDE, BC-ADM, Professor, College of Pharmacy, University of Utah

Reading the Genetic Tea Leaves: understanding which kids get cancer and why.
Joshua Shiffman, MD, Medical Director, High Risk Pediatric Cancer Clinic, Interim Director, Translational Oncology Center at Huntsman Cancer Institute, Assoc. Professor, Pediatrics, University of Utah

Health Reform in Utah – Philosophy, Politics, and Current Policies, Panel Discussion
• David Sundwall, MD, ’69, moderator, President, School of Medicine Alumni Association, Professor, Division of Public Health, Department of Family and Preventive Medicine, University of Utah School of Medicine
• Robert Spendlove, Deputy for State and Federal Relations, Utah Governor’s Office
• David Clark, Senior V.P. International Banking, Zions Bank, former Speaker of the House, Utah House of Representatives and Chair of Health Reform Task Force
• Linn Baker, Director, Arches Insurance Co., former Director, Public Employees Health Plans (PEHP), Utah

Football! Football! Football!
Tailgating Party and Utah vs. Stanford Football Game
Join your classmates and other SOM alumni for a rousing party and old fashioned tailgate at the Rosenblatt House with Dean Vivian Lee and her family. Then shuttle over to the Utah versus Stanford football game to cheer the Utes on to victory.

Accreditation: The University of Utah School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AMA Credit: The University of Utah School of Medicine designates this live activity for a maximum of 4.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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We would like to thank the following commercial company for their generous support:

MEGADYNE
The Electrosurgical Authority

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Intermountain Healthcare

Mountain Medical
Dean’s Roundtable featuring:
Thomas Rees, MD, ’48 and Greg Critchfield, MD, ’80

By Alicia Greeleigh

They say no one can do a nose like Thomas Rees, MD, ’48. But rest assured, the rest of his work wasn’t too shabby, either. Born and raised in Utah, Rees is widely considered the father of aesthetic plastic surgery. Throughout his 42-year career in New York, Rees built an impressive list of accomplishments that includes Clinical Professor of Plastic Surgery at New York University School of Medicine and president of the American Society for Aesthetic Plastic Surgery, among numerous other distinctions.

But what is less known about Rees is his unwavering dedication to public service. While he maintained an illustrious practice and reputation in New York City, Rees also went to Africa for months at a time to do pro-bono reconstructive surgery on cleft lips, burns, scars and a host of other deformities. From there, he helped co-found the renowned Flying Doctors of East Africa, known for its programs in reconstructive surgery, preventive medicine, community health care and health education. Now it is part of parent organization African Medical Research and Education Foundation (AMREF), the largest non-government health organization based in Africa. “We were young and idealistic back then, and decided we were going to save Africa,” Rees said. “But I think Africa really ended up saving me.”

During a conversation with medical school students and Vivian Lee, Dean of the School of Medicine, Rees talked about his career in aesthetic surgery and the 55 trips he made to Africa. He also imparted some profound life lessons about why people chose to be doctors, as well as cultivating a life outside of medicine.

On the history of plastic surgery and how he came to be an aesthetic surgeon:

Back then we never earned any money doing reconstructive surgery. You mostly did it for the fun of it and for teaching. But I had to earn money, so I did some aesthetic surgery on the side, and the more I did it the more I became interested in it. At that time, people thought there was something faintly wrong with it, with your egos or something. But it’s really as old as mankind — people got tattoos, pierced ears. And everyone is vain; anyone who says they’re not vain is lying. I like aesthetic surgery because I felt like I was really helping people.

On how he ended up in Africa and the creation of Flying Doctors of East Africa:

I was doing a fellowship in London with a very famous plastic surgeon, Sir Archibald McIndoe, and he invited me to come with him to Africa. When I got there it awakened in me a completely different understanding of what medicine was all about. I saw so many new things — cleft lips, burns, trauma and leprosy — and then I saw the social implications of these deformities. Patients with cleft lips, for example, were shunned by everyone including their families and had to become beggars. So one night, literally over half a bottle of Johnny Walker, we decided to start a mobile plastic surgery rotation and visit rural hospitals by flying back and forth from Nairobi. At first it seemed like an impossible task, but we decided to adhere to the dictum, “It’s better to light a single candle than curse the darkness.”

On the evolution of Flying Doctors of East Africa:

One of my partners’ brothers, who trained in the London School of Tropical Medicine, helped us see that we were missing an opportunity by just doing reconstructive surgery. When we operated on someone, they would frequently be infected with worms or malaria, but we couldn’t treat them. So we learned that we had to look at these patients as a whole, and not just run around operating on people. We added some public health workers who looked at the scope of a village and helped them install things like a well or vegetable garden, which brought new possibilities for the village. Through practical public health, we eventually established a school for training community-based health workers. We’ve trained 20,000 people to-date, and we do about 800,000 operations a year. Now we have a budget of $60 million a year and we keep records of everyone we treat so we can follow them and know how they’re doing. It’s a totally different approach to rural health care.
On the importance and complications of communicating with patients in global healthcare:

The problem of communicating your message to the people is a major issue. The best example I can give is that awhile back, we convinced Disney to make an animated film on malaria. We held a screening in a village, and about four minutes in, everyone was rolling on the floor laughing. No one took it seriously because they said no one had ever seen a mosquito that big before.

On how Africa affected him as a doctor:

It helped keep my feet on the ground, especially in aesthetic surgery, and renewed my enthusiasm for what being a doctor is all about. I don’t want to sound like an old curmudgeon, but things have changed a lot since my time. There’s no discussion of patients as human beings anymore. The work becomes very cut and dry, unfortunately, and if you do that too long, you lose the very germ of why you wanted to be a doctor in the first place. You stop looking at the patient as a whole person, and you become technicians, mechanics. It’s a very real problem. But going back to Africa renewed that fire in me of what it means to be in medicine.

On retirement and life outside of medicine:

I’ve taken up sculpting and use the pictures I took in Africa as inspiration. It’s really been a savior for me, because it keeps my hands busy. And that’s another point I want to make: Don’t just think about medicine all your life. Keep your eyes open. It gets very hard when you’re working as hard as you’re going to work, so keep your eyes open for something that interests you whether it’s art or literature or whatever, because eventually you will retire. I know so many doctors who retire and have nothing. They didn’t develop another side of themselves, and they get depressed and a lot of them die prematurely. So just keep your eyes and ears open. A lot of the good things that happened to me in my life were accidents, and I took advantage of them. Don’t be afraid to take advantage of opportunities that come up, even though they may sound difficult.

Dr. Greg Critchfield, MD, ’80, is best known for his time as President of Myriad Genetic Laboratories, but his career has moved from medical professorships to clinical pathology to chief science officer at Quest Diagnostics to president and CEO of multiple medical science companies. When he joined Myriad in 1998, Critchfield immediately recognized the vast impact their work could have on medicine, and subsequently grew the company’s annual revenues from $2.2 million to $326.5 million. Before his retirement in 2010, Critchfield was also responsible for turning Myriad into one of the world’s leading molecular diagnostics companies by launching several ground-breaking products. Under his leadership, Myriad gained the reputation of being the highest quality, highest throughput clinical sequencing facility in the world.

During a conversation with Vivian Lee, Dean of the School of Medicine, medical students received an inside look at his transition from clinical doctor to CEO, as well as invaluable insights into biotechnology and its role in clinical medicine.

On moving from the academic world to the business world:

It was an evolution for me. It wasn’t just one event. But it started after medical school when I went into pathology and realized that the areas that interested me the most were those where we could make significant advancements in our ability to measure and understand genetics. So after I went into academia, it became clear that a lot of the good science was at companies that were spun out of academia. So I left for Quest Diagnostics, and developed a deep passion for improving health of patients, while also materially improving the economics of healthcare delivery.

On how pathology has changed over the years:

Clinical pathology is understanding the distribution of data in health and disease to draw proper inferences to make better decisions. There are two major divisions of pathology, ana-
Anatomic pathology is looking through the microscope and rendering a diagnosis; autopsies would fall into that category. Clinical pathology is laboratory medicine — analyzing to what degree information overlaps, and how you can construct predictors that are sound from a statistical point of view that will separate patients into different categories. The categories you want are treatments that will make a difference in health and a difference in economics. I decided to specialize in clinical pathology because it can drive decision making in medicine.

**On the negative aspects of developing new technology:**

I think there is a great risk that studies won’t have enough data behind them. They’ll be half-baked, and researchers will go beyond what the data states and make claims that go far beyond what you can prove. I’ve seen this a lot, unfortunately. But, my fear is that this can happen much faster.

**On Myriad and the controversial issue of commercial vs. academic cancer research:**

Most studies begin in academic labs, and then you have to build a product that is going to make a difference clinically, which is not easy, but it has the potential to have an enormous impact. Myriad was controversial because the science of identifying cancer gene mutations was being pushed forward by a commercial entity, not an academic one. Questions arose as to whether Myriad would look out for people’s interests as much as an academic entity would. When I joined Myriad in 1998, there was no health care coverage for cancer testing or treatments. The reason was because there was no data, no proof that showed that the patient would benefit from identifying those gene mutations early on. I helped create a program where we could show that value, and as a result, many insurance companies began covering it. They knew a woman would be monitored more frequently if she were at risk, that doctors would be able to catch cancers earlier, which would save insurance companies money. The whole theme of health economics came into play, which was really important.

**On the impact of the Supreme Court if they decide to overturn the use of genetic patents:**

Well, first of all it’s not really patenting genes. What you’re patenting is a process that isolates and causes a new chemical entity to be analyzed. This is a way to protect a genetic area so you are able to invest in it. Myriad invested $200 million to build the market and the technology so they would be able to have the best sequencing without any mistakes. The Supreme Court decision could potentially have very chilling effects on biotechnology if the patents are not upheld, because universities do not have the wherewithal to create the commercial technologies that need to be practiced, because that’s not their mission. Their mission is to do basic science research, and there is a long road between doing the initial study to having something that is reliable and can be used commercially.

**On the difficulties of transitioning to being a CEO from clinical medicine:**

One of the things I did was that I was very careful to seek out excellent mentors. And this is a good note for everyone: throughout your careers you’re going to need mentors. For me, the people I worked with ended up being my mentors. I think you need to find a mentor who will understand what your dreams and hopes are, and who can help you clarify your thinking and give you good advice. It was invaluable for me to receive criticism from someone who knew what they were doing, and it helped me self-evaluate in a way that I had never done before.

**On how to stay on top of the fast-paced evolution of new diagnostic technology:**

My advice is that you don’t have to know the technology inside and out. The most important thing is being able to understand the implications and applications of that technology, and knowing concepts like sensitivity, predictive value and specificity. The key is to understand the basics and translate that into clinical medicine, and think critically about how you would use it with your patients. That is a critical core of skills.

To view the full videos of these and other roundtable sessions go to http://medicine.utah.edu/alumni/deans_roundtable/index.php
Anesthesiology
Leavitt, Wendy Lynne
University of Florida College of Medicine-Shands Hospital, Anesthesiology, Florida
Stoker, Robert Eldon
University of Florida College of Medicine-Shands Hospital, Anesthesiology, Florida
Romankowski, Mathew Leonard
Tucson Hospitals Medical Education, Transitional Arizona
Jackson Memorial Hospital, Anesthesiology, Florida

Dermatology
Bingham, Colby Scott
Intermountain Medical Center, Transitional Utah
University of Missouri Hospital and Clinics, Dermatology, Missouri
Millsop, Jillian Wahmei Wong
California Pacific Medical Center, Internal Medicine-Preliminary California
University of California, Davis, Medical Center, Dermatology, California

Emergency Medicine
Bunch, Steven John
New York Methodist Hospital, Emergency Medicine, New York
Crum, Ashley Anne
University of New Mexico School of Medicine, Emergency Medicine, New Mexico
Ellefson, Christina L.
University at Buffalo School of Medicine, Emergency Medicine, New York

Ernst, Ryan Paul
University of Washington Affiliate Hospitals, Emergency Medicine, Washington
Morgan, Michael Holmes
University of Utah Affiliate Hospitals, Emergency Medicine, Utah
Pressman, Andrew B.
William Beaumont Health System, Emergency Medicine, Michigan
Sawas, Anas
University Hospital-SUNY at Stony Brook, Emergency Medicine, New York
Schmitt, Robert Eli
Texas A&M College of Medicine-Scott & White, Emergency Medicine, Texas
Snow, Bryce Stuart
University of Wisconsin Hospital and Clinics, Emergency Medicine, Wisconsin

Emergency Medicine Program Candidate
Cox, Antony Robert
Emergency Medicine Program Candidate
Nielson, Phillip A.
Emergency Medicine Program Candidate

Family Medicine
Fink, Laura Elizabeth
Memorial Hospital of South Bend, Family Medicine, Indiana
Hyzer, Cornelius Whitney
Mercy Health System, Family Medicine, Wisconsin

General Surgery
Fowler, Aaron B.
Arrowhead Regional Medical Center, General Surgery, California
Lorimer, Patrick Daniel
Carolinas Medical Center, General Surgery, North Carolina
Nelson, Adam Campman
Icahn School of Medicine at Mount Sinai, General Surgery, New York
Smith, Matthew C.
New York Presbyterian Hospital-Weill Cornell Medical Center, General Surgery, New York
South, Samuel D.
McGaw Medical Center of Northwestern University, General Surgery, Illinois

Internal Medicine
Bautista, John Carbonell
Loma Linda University, Internal Medicine, California
Herman, Karl Elliott
Rhode Island Hospital/Brown University, Internal Medicine, Rhode Island
Long, Paul Michael
Boston Medical Center, Internal Medicine, Massachusetts
Vu, Nancy M.
Cleveland Clinic Foundation Program, Internal Medicine, Ohio

Internal Medicine – Pediatrics
Carey, Adrienne Leigh
University of Michigan Hospitals and Health Centers, Internal Medicine/Pediatrics, Michigan
Wilde, Megan Marie
University of Michigan Hospitals and Health Centers, Internal Medicine/Pediatrics, Michigan

Internal Medicine - Preliminary
Walker, Melissa Christine
University of Utah Affiliate Hospitals, Internal Medicine-Preliminary, Utah

Internal Medicine - Psychiatry
Chan, Aubrey Chi Ho
University of Iowa Hospitals and Clinics, Internal Medicine/Psychiatry, Iowa

Neurology
Jones, Rebecca
Mayo School of Graduate Medical Education, Neurology, Arizona

Brittney Williams draws name for the next student announcement
Leaver, Katherine E.  
Stanford University Program, Internal Medicine-Preliminary/Neurology  
California Stanford University Program, Neurology, California

Obstetrics – Gynecology  
Hill, Austin Michael  
Akron General Medical Center/NEOMED, Obstetrics and Gynecology, Ohio

Orthopaedic Surgery  
Barker, Jordan P.  
University of Missouri at Kansas City, Orthopaedic Surgery, Missouri  
Rice, Christopher David  
University of Wisconsin Hospital and Clinics, Orthopaedic Surgery, Wisconsin

Pediatrics-Psychiatry-Child and Adolescent Psychiatry  
Sin, Joseph Hon-Fu  
Cincinnati Children’s Hospital Medical Center, Pediatrics/Psychiatry/Child and Adolescent Psychiatry, Ohio

Physical Medicine and Rehabilitation  
Covington, Andrew Philip  
Banner Good Samaritan Medical Center, Internal Medicine-Preliminary Arizona  
University of Texas Southwestern Medical School, Physical Medicine and Rehabilitation, Texas

Preventive Medicine  
Narayan, Natasha P.  
Loma Linda University, Internal Medicine-Preliminary/Preventive Medicine, California

Psychiatry  
Bowman, David Richard  
Tripler Army Medical Center, Psychiatry, Hawaii  
Iyer, Varsha  
University of California, Irvine, Medical Center, Psychiatry, California  
Montenegro, Roberto Emilio  
Yale-New Haven Hospital, Psychiatry, Connecticut  
Pacheco, Luz Elizabeth  
Medical University of South Carolina, Psychiatry, South Carolina

Pathology  
Caron, Justin E.  
University of Utah Affiliate Hospitals, Pathology-Anatomic and Clinical, Utah

Pediatrics  
Ameel, Kristen Noel  
Indiana University School of Medicine, Pediatrics, Indiana  
Garvin, Daniel B.  
Central Iowa Health System, Pediatrics, Iowa  
Jones, Jake C.  
University of Utah Affiliate Hospitals, Pediatrics, Utah

Pediatrics – Global Health  
Rees, Christopher Adam  
Baylor College of Medicine, Pediatrics/Global Health, Texas

Otolaryngology  
Collett, Tolbin  
Loma Linda University, Otolaryngology, California  
Gale, Derrick Cripps  
Barnes-Jewish Hospital, Otolaryngology, Missouri  
London Jr., Nyall Robert  
Johns Hopkins Hospital, Otolaryngology, Maryland

Psychiatry Program Candidate  
Dakoulas-Dobias, Lynn L.  
Psychiatry Program Candidate

Ophthalmology  
Behunin, Nicholas Lynn  
Tucson Hospitals Medical Education, Transitional Arizona  
Penn State University/Milton S. Hershey Medical Center, Ophthalmology, Pennsylvania

Radiology-Diagnostic  
Jensen, Jeff D.  
Spartanburg Regional Healthcare System, Transitional, South Carolina  
Johns Hopkins Hospital, Radiology-Diagnostic, Maryland  
Johnson, Mark Barnett  
St. Vincent’s Medical Center, Internal Medicine-Preliminary, Connecticut  
University of Vermont/Allen Health Care, Radiology-Diagnostic, Vermont

Research Fellowship Candidate  
Brown, Summer Malia  
Research Fellowship Candidate  
Cole, Stacey L.  
Research Fellowship Candidate

Urology  
Lim, Amy Hyun Jung  
University of Wisconsin Hospital and Clinics, Urology, Wisconsin

Research Fellowship Candidate  
Brown, Summer Malia  
Research Fellowship Candidate  
Cole, Stacey L.  
Research Fellowship Candidate

Urology  
Lim, Amy Hyun Jung  
University of Wisconsin Hospital and Clinics, Urology, Wisconsin

Research Fellowship Candidate  
Brown, Summer Malia  
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Cole, Stacey L.  
Research Fellowship Candidate

Urology  
Lim, Amy Hyun Jung  
University of Wisconsin Hospital and Clinics, Urology, Wisconsin
Commencement 2013

Almost MD's - Jillian Wong, Tony Trinh, Sally Tran, Amy Lim, Natasha Narayan, Nancy Vu, Austin Trinh and Missy Walker

David Sundwall MD welcomes class of 2013

Our fearless leaders:
Wayne Samuelson MD, ’80
Vice Dean for Education
Vivian Lee MD, PhD, MBA, Dean
Karen Anastasopoulos,
Director, Administration

Varsha Lyer

Class of 2013 with Deans

Robert Stoker MD. Is this how he’ll make house calls?
Every year the School of Medicine Alumni Association Student Programs and Awards Committee sends out a nomination letter to all fourth year students asking them to nominate their classmates for the Alumni Association Fourth Year Award. Since 1990 the School of Medicine Alumni Board has presented this award to a graduating student who, in the opinion of their classmates and faculty, has demonstrated concern for their peers and exemplifies the ethical, moral, and academic skills deemed necessary to make an exemplary physician.

This year’s recipient was Jillian Wong Millsap. Classmates wrote in glowing terms of her unique academic ability, leadership and relentless dedication to serving in the community. She founded the Utah Chapter of the Asian Pacific American Medical Association, served as Student Body Secretary, and was the president of the very active Dermatology Interest Group. In addition she was the co-editor in chief of the University of Utah Medical School Newsletter; president of the American Women’s Medical Association and served as manager of the student-run Fourth Street Clinic. A fellow classmate commented that “medical school has been a time for her to guide other students to success while serving as an unofficial tutor to many of us.”

In addition to receiving her MD Jillian pursued a year of original research and a Master of Science in Gerontology. She was a research fellow at the UCSF Psoriasis Treatment Center and Psychodermatology Clinic. There, her overseeing professor, John Koo, professor and vice chairman, UCSF Department of Dermatology, stated that he had never met anybody with greater academic ability, leadership and community concern. “Jillian is the nicest, kindest, and most delightful person I have ever worked with. She was so productive that within the year she completed 35 manuscripts, 24 of which were published, including one complete book on the distinctive topic of Dermatogeriatrics which is a new field of medicine that Jillian singlehandedly started. Appreciating the gap between the unique dermatological and logistical needs of the geriatric population she came up with a vision of this subspecialty specifically catering to the needs of the elderly population.”

Despite her extremely busy and productive schedule during the year she also became involved with the National Psoriasis Foundation. She was the team captain for the UCSF Fundraising team for “Psoriasis Walk for the Cure” and claimed the top fundraising prize in competition with other major institutions including Stanford, U.C. Davis and major private health provider organizations.

The Alumni Association is proud to give this well-deserved award and gift of $1000 to Jillian and look forward to watching her continue to grow and develop into a phenomenal physician.
Moran Leaders Head National Academic Ophthalmology Organizations, Receive Top Ophthalmology Awards

Dr. Randall J Olson, MD, Professor and Chair of Ophthalmology, CEO, and visionary of the Moran Eye Center, just completed his term as the President of the Association of University Professors of Ophthalmology (AUPO) in March, 2013. Dr. Olson now continues to serve in the capacity of Past President until March 2014. The Mission of the AUPO is to strengthen academic departments of ophthalmology; to support chairs, program directors, and other faculty members; to promote excellence in ophthalmic education; to foster research and to promote ethical practice and excellence in eye care in order to ensure the best possible vision for the public.

Wayne Imbrescia, MPH, MHSA, Executive Director, Moran Eye Center and Executive Director, Ambulatory Care for the University of Utah, is setting a new precedent serving as the counterpart to Dr. Olson on the administrative side: Imbrescia is serving as President for the University Administrators of Ophthalmology (UAO). A national organization, the UAO is the premiere resource dedicated to meeting the specialized needs of administrators of academic ophthalmic practices. It is the first time that both presidents are from the same institution and serving at the same time.

Nick Mamalis, MD, Professor of Ophthalmology at the University of Utah, was presented with the American Society of Cataract and Refractive Surgery’s (ASCRS) greatest tribute: the Binkhorst Medal of Honor, an award of global prominence in April of this year. This award marks an unprecedented honor for Moran Eye Center as Dr. Randall J Olson was the 2012 recipient. Binkhorst Medal winners are selected for their “significant contributions to the science and practice of ophthalmology.” Dr. Mamalis’ work, specializing in the study and understanding of toxic anterior segment syndrome (TASS), has established him as a leader in the field of ophthalmology. He received the award at the American Society of Cataract and Refractive Surgery (ASCRS) and American Society of Ophthalmic Administrators Symposium and Congress in San Francisco, where he delivered the prestigious Binkhorst Lecture.

Yingbin Fu, PhD, Assistant Professor of Neurobiology & Anatomy, Neurosciences, Molecular Biology, and Director of Model Development, Moran Center for Translational Medicine, was one of 10 esteemed winners of the National Eye Institute (NEI) “Challenge to Identify Audacious Goals in Vision Research and Blindness Rehabilitation.” His winning submission: Precise Gene Editing In Vivo aims to permanently correct (by being delivered safely and efficiently into the eye) any disease-associated mutations in a patient through the use of molecules specially designed to target mutated DNA sequences. This strategy could also be applied to the genetic component of virtually any human disease, whether inherited or resulting from cellular responses to environmental stresses.

MORAN HUMANITARIAN EFFORTS

South Sudan Medical Mission: Alan S. Crandall, MD and Charles Weber, MD, completed a second major ophthalmic medical mission to South Sudan. Traveling with a small medical team and carrying in every single supply, from Q-tips to microscopes, Drs. Crandall and Weber helped restore sight to 325 patients with cataracts and trachoma. “The clinic in South Sudan is quite bare, but we are able to bring all the supplies we need in order to successfully operate on patients. Last year, we operated as bats flew around our heads and relied on a generator that didn’t always work. Fortunately, there is a new operating room that better suits the needs of the patients,” said Crandall.

Partnersing with the John Dau Foundation, the Moran Eye Center also took part in a profoundly moving peace
initiative between three warring tribes. Although South Sudan has a violent history and unstable conditions, the Moran Eye Center has committed to improve the quality of life of those affected with curable blindness.

Special Surgery Saturday: Under the direction of Moran Drs. Brad Katz, Jeff Petey, Bill Barlow, and Geoff Tabin and in partnership with the Fourth Street Clinic and the People’s Health Clinic in Park City, Moran surgeons, medical technicians, and staff donated their services to provide free cataract surgery to people in need, for the second annual special Saturday Surgery Day. Some of the patients had lost their jobs due to their poor eyesight, which resulted in the loss of insurance and necessary funds for the surgery.

Book Publication: The Co-Director of the John A. Moran Eye Center’s International Division and cornea surgeon Dr. Geoff Tabin and his partner Nepalese ophthalmic surgeon Dr. Sanduk Ruit are the subjects of Second Suns, an inspiring story of their quest to cure preventable blindness worldwide by author David Oliver Relin. Second Suns takes you on many harrowing missions with Dr. Tabin, Moran’s Dr. Alan Crandall, and many other wonderful doctors from Moran’s International Division. With their revolutionary, inexpensive style of surgery, Tabin and Ruit have been able to cure tens of thousands—all for less than twenty-five dollars per operation. Second Suns will be available June 2013.

Photos left to right: Wayne Imbrescia, MPH, MHSA; peace talks in South Sudan; consulting at Special Surgery Saturday; Yingbin Fu, PhD

In April at the American Physiological Society’s Experimental Biology meeting Markus Amann, PhD, assistant professor in the Department of Internal Medicine, received the 2013 Arthur C. Guyton Award for Excellence in Integrative Physiology. The award is given to an independent investigator who holds an academic rank no higher than assistant professor and is pursuing research that utilizes quantitative and integrative approaches and feedback control system theory for the study of physiological functions. Each award of $15,000 is designated for use in the awardee’s research program. Dr. Amann is also an Adjunct Assistant Professor in the Department of Anesthesiology and the Department of Exercise and Sport Science. He is interested in the effect of aging on muscle reflex during exercise. He investigated to what extent a potential effect might account for the aging-related reduction in limb blood flow frequently observed in the exercising elderly.
Charles Henry Hardin Branch, MD was the first Chair of the University of Utah, School of Medicine Department of Psychiatry, and from 1948 to 1970 he brought modern psychiatry to Utah and the Intermountain West. He is credited with seeding five states with trained professionals and changing the misunderstandings and biases of the general population toward mental illness.

Even at a young age Dr. Branch showed affinities which prepared him for the challenges of leadership as a psychiatrist and mental health advocate. He exhibited indomitable courage whenever the interests of members of the community were involved and an approach that cut across social, economic and racial boundaries. As a young college graduate, Dr. Branch chose to take a year off before attending medical school to travel around Europe. This experience left a deep impression on him, leading to his interest in furthering international relationships in the process of training people in the field of mental health and psychiatry.

He served in the military from 1942-1946, where he became adept at dealing with his patient’s problems tied to their personalities as well as their physical disease states. This interest in the ‘whole’ patient strongly influenced his interest in neuropsychiatric training in Philadelphia after the war.

In 1948, only one year after completing his residency, Dr. Branch was recruited to assume the chairmanship of the newly formed Department of Psychiatry at the University of Utah. Under his leadership the department rapidly attained nationwide prominence and he became a major national figure in the field of psychiatry. In 1963 he was elected President of the American Psychiatric Association. His excellence as a teacher and clinician, along with his exceptional capabilities as an administrator, allowed him to introduce psychiatry into the entire field of medicine, rather than as an isolated specialty. He stressed that fundamental principles were just as important in psychiatry and the behavioral sciences as they were in the practice of surgery, medicine and the biological sciences in general.

In a speech Dr. Branch gave to the student body at Brigham Young University in 1961 he emphasized that “There are just as many different kinds of mental illnesses as there are physical illnesses. They are just as diversified and the treatment and research activities addressing them are just as varied and important.” This is as true today as it was then.

His personality, innovative work in the field of psychiatry and training of many Utah medical students and residents ensured the department of psychiatry’s excellence at the University of Utah School of Medicine. Many mental health services in Utah reflect his influence.

He passed away suddenly in 1990 but is still well known in Utah and throughout the country as an outstanding contributor and pioneer in psychiatric education and care. He worked to enlighten the public and break down the barriers of the stigma of mental illness.

Currently, the Department of Psychiatry is planning to honor Dr. Branch by naming the newly remodeled auditorium/lecture hall at the University Neuropsychiatric Institute the “C.H. Hardin Branch Auditorium”. Dr. Branch’s son Skip noted that, “This tribute will provide a lasting legacy to my father’s commitment to expand psychiatry beyond an isolated specialty to a broader appreciation of mental health services as a vital community need.”

If you would like more information about this project, or to make a donation, please contact Anne Asman at 801-587-9821 or anne.asman@hsc.utah.edu.
New Academic Minor in Pediatric Clinical Research

By Brandy Harma

The Department of Pediatrics has instituted a new academic minor in Pediatric Clinical Research in the University of Utah School of Medicine. The establishment of this minor makes the University of Utah one of the few universities in the nation to offer an undergraduate program in Pediatric Clinical Research and enhances our national reputation for research.

The Pediatric Clinical Research minor, effective Spring 2013, is offered to undergraduate students across all disciplines and provides students 16 credit hours of direct, physician-supervised, clinical research experience. The minor is administered through the Department of Pediatrics Research Education Office under the leadership of Dr. Maija Holsti, Medical Director.

The Department of Pediatrics has offered undergraduate courses in clinical research since Fall 2010. Enrollment numbers steadily increased and student demand prompted the Department to propose that the University approve an official minor in this area. To date, 8% of graduating students who completed a course in pediatric clinical research have advanced to medical school, a percentage that is expected to increase now that the program is a recognized academic minor.

A minor in Pediatric Clinical Research prepares future physicians to succeed in the academic medical center setting. Students learn how to ethically and accurately conduct pediatric research using Good Clinical Practice guidelines. In addition to examining how clinical research affects the delivery of medical care, students become familiar with the different types of clinical research design and basic biostatistics. They gain a practical understanding of the Institutional Review Board Process and develop competency in reading, interpreting, and presenting a published clinical research paper. Undergraduate experience with the various components of clinical research practice and publication helps position medical students early for a successful career as a physician scientist.

Departmental Collaboration Furthers Goal to Establish University of Utah as a Leading Center for Myocardial Recovery

The University of Utah hosted the inaugural Utah Cardiac Recovery Symposium (U-CARS) on January 18&19, 2013. This unique conference was dedicated to better understanding the mechanisms and solutions for repairing the injured heart. Nearly 250 physicians and scientists convened within the University of Utah Health Sciences Education Building; including faculty and attendee representatives from across the nation as well as several international guests. Of note, Sir Magdi Yacoub, Distinguished Professor of Cardiothoracic Surgery from Imperial College of London and one of the pioneers of cardiac surgery and heart recovery strategies, gave one of two plenary lectures.

The conference was a truly collaborative effort from the Departments of Surgery and Medicine, University of Utah Hospital, Intermountain Health Care, and Primary Children's Hospital. Organized by Drs. Craig Selzman, Stavros Drakos, and Josef Stehlik as well as the Advanced Heart Failure, Mechanical Circulatory Support, and Heart Transplant team at the University of Utah, the symposium brought together thought leaders to exchange ideas, debate paradigms, and share information directly focused on issues related to myocardial recovery and regeneration. Enthusiastic discussions expanded across the basic, translational, and clinical sciences. Topics included debates on the definition of recovery and cardiac remodeling, translating genomic and molecular information to clinically-relevant strategies, use of ventricular assist devices as a bridge to recovery, lessons learned from established heart failure therapies, and novel therapeutic approaches including cell and gene therapy.

Feedback from the participants was uniformly positive and the team is looking forward to building off this success into next year’s program and further establishing the University of Utah as the leading center for the study of myocardial recovery.

Stavros Drakos, Douglas Mann and Josef Stehlik
A. Marsh Poulson Jr., MD. Lectureship 2013

The A. Marsh Poulson Jr., MD, Annual Lectureship memorializes the first subspecialty-trained reproductive surgeon in the Intermountain West. Dr. Poulson completed his undergraduate, medical school and residency training in obstetrics and gynecology at the University of Utah and a reproductive surgery fellowship at the University of Pennsylvania. He returned to the faculty of the Department of Obstetrics and Gynecology in 1969. In the 30 years Dr. Poulson spent at the University of Utah as a resident and faculty member, he taught over 3,000 medical school graduates and 436 residents in obstetrics and gynecology. He assisted thousands of couples in their desires to bring a child into their home. He and his colleagues began the first IVF program in the Intermountain West in 1982. The lectureship invites internationally recognized leaders in the field of reproductive endocrinology and infertility to enlighten colleagues, students and friends, as he did.

The 16th annual A. Marsh Poulson Jr., MD memorial lectureship and dinner was held on Wednesday, April 17th with the Healthcare Transformation Conference the following day, April 18th.

At the conference Andrew Croshaw, MBA, a partner at Leavitt Partners gave the A. Marsh Poulson, MD lecture: The Compounding of Compassion: The Real Struggle Underlying Health Reform in the United States. He spoke again later at the conference and moderated the panel discussion, UTAH Transition: Options, Obstacles and Opportunities.

The other three conference speakers and topics included Michael Magill, MD, Executive Medical Director, University of Utah Health Plans, University of Utah Health Care: Where are we on the journey toward health care transformation? Peter S. Edelstein, MD, Chief Medical Officer MEDai, Inc., Clinical Integration: Bringing Clinically Meaningful Predictive Analytics to the Provider and David Burton, MD, Executive Chairman, Board of Directors, Health Catalyst, LLC., Health Catalyst Provides Data Warehousing and Analytics.

Geriatric Medicine Training at School of Medicine to benefit from $1 Million Grant from Donald W. Reynolds Foundation

The University of Utah is one of ten institutions selected nationwide to receive funding as part of the Donald W. Reynolds Foundation’s 2012 call for proposals for its “Next Steps in Physicians’ Training in Geriatric” grants. The School of Medicine plans to use the funding for an ambitious program that will provide competency-based training in patient quality, safety and care transactions.

Mark Supiano, MD professor and chief of the school’s Division of Geriatric Medicine as well as director of the VA’s Salt Lake City Geriatric, Research, Education and Clinical Center, previously received a Reynolds Foundation grant while working at the University of Michigan. He continued his relationship with the foundation during his tenure at the U. The University has made major strides in providing geriatric education for its medical students and community-based primary care providers after receiving its first round of Reynolds Foundation funding in 2006.

The School plans to develop a two-level training program for residents in all of the school’s residency programs. The first level will introduce all 27 residency programs and 41 fellowship programs to required quality and safety training modules, with a particular focus on care transitions. Residents and fellows will learn to complete specific discharge summaries for older patients being sent to skilled nursing facilities. The second level of the program involves bringing advanced geriatrics training to six residency programs that have previously been involved in the “Chief Resident Immersion Training” program and the 10 fellowship programs in internal medicine sub-specialties. Supiano estimates about 250 physicians each year will benefit from participating in the training program.
Imagine waking up in the middle of the night and finding it difficult to move one side of your body. Your next thought is to wake your spouse and have them call 911 because you believe you are having a stroke.

An unlikely scenario? No, it is more common than you might think. According to the American Stroke Association, someone in the United States experiences a stroke every 40 seconds. That translates to nearly 800,000 people suffering strokes each year. If it has not happened already, chances are that someone close to you—a parent, child, friend, neighbor, sibling, or even yourself—will experience a stroke.

For stroke victims time is of the essence, and recognizing the signs of a stroke is crucial for effective treatment and recovery. Thanks to doctors at the Clinical Neurosciences Center (CNC) at the University of Utah, future patients will soon have a groundbreaking tool in the diagnosis and treatment of strokes—one that will be the first of its kind in the world and one that is expected to save 30 to 60 minutes: enough time to make a major difference in the degree of neurological recovery.

In early 2013, the CNC will complete construction on an ultra-modern angiography suite outfitted with an intraoperative MRI. This pioneering setup is the brainchild of Steve Stevens, M.D., Chair of the Department of Radiology, and will allow doctors to pinpoint the precise location and progress of a stroke in real time, while the patient is still experiencing stroke symptoms.

“Right now we base all of our current treatments on time. Time zero, or the onset of the stroke, starts when the patient was last well,” says Stevens. “Doctors then have up to 3 1/2 hours to give intravenous clot-busting drugs, and then after that time period, use catheter-based intra-arterial therapy to remove the clot.”

Stevens is hopeful that with real-time information from new MRI sequences, physicians will be able to better determine stroke onset. He says, “If you went to bed at midnight, and woke up at 6 a.m., by today’s standards you would be outside the treatment window for intravenous therapy. With the new MRI, we’ll be able to look at brain tissue and determine the precise time a stroke started and how progressed it is, enabling us to treat patients based on brain tissue and the survivability of that brain tissue. We are essentially shifting stroke diagnosis away from a time clock and over to a tissue clock for each individual.”

Many more practical applications and research opportunities using MRI are in the works, and Stevens and his colleagues are looking forward to the future of this technology and the advances it will bring to their patients. “We think this is big!” says Stevens. “Everybody’s excited to use this tool to improve our outcomes and expand treatment options for our patients.”
A. Mason Redd, MD

Dr. Redd never considered being a teacher but after a residency in psychiatry
Dr. Branch invited him to stay on as a member of the faculty. He has very much enjoyed his experience working with patients, medical students and psychiatry colleagues. He formally retired in 1999 but continued to work in consultation psychiatry at the University Hospital until 2001 when he and his wife, Karen, served a mission for the LDS Church in Japan, South Korea, Taiwan and Hong Kong. He continues to work as a volunteer for the LDS Missionary Department as Chairman of the Psychiatry Committee. In addition, he covers for colleagues on the University of Utah inpatient psychiatric units a week a month. He believes he has the best of both worlds, enjoying his experience working with patients, medical students and psychiatry residents as his wife of 20 years, Renee’, three delightful daughters and twelve grandchildren.

Class of 1978

Robert M. Beatty, MD

After completing his internship and residency at the Peter Bent Brigham Hospital, Massachusetts General Hospital and the Children’s Hospital/Harvard in Boston Dr. Beatty has practiced neurosurgery in the Greater Kansas City area for 29 years. This past year he was selected by US News and World Report as one of the top neurosurgeons in America. He has also received the Patients’ Choice Award and the Compassionate Doctor Recognition Award.

Rita Coleen Stice, MD

Dr. Stice practices plastic surgery at Metropolitan Plastic and Reconstructive Surgery in Omaha, NE. She has been married to Robert Wells for 28 years and has three daughters, Sarah (36), Emily (27) and Caitlin (23). She is a Fellow of the American College of Surgery, Diplomate of the American Society of Plastic Surgery, and a Certified Physician Executive, American College of Physician Executives, and has been on numerous national lists for top surgeons and top plastic surgeons for 20+ years. She has been involved with numerous medical exchange programs, serving as the medical director from 1990-2002 at the Tobold, Siberia medical exchange and at the District Hospital in Naivasha, Kenya since 2010. She has also gone on numerous medical mission trips to Guatemala since 1985 and enjoys biking, diving, mountain climbing, golfing and gardening in her spare time.

Class of 1979

Jay Swoboda, MD

Dr. Swoboda sends greeting from Taos, NM where he works full time at an outpatient VA clinic. He completed his family medicine residency in 1982 at the University of New Mexico and blended that with additional training in addiction medicine. Since completing residency he has split his time almost evenly between Oregon, Montana and New Mexico, both urban and rural practices and managed and unmanaged primary care clinics. He currently is on the volunteer faculty for UNM School of Medicine and is active in a community effort to reduce the mortality of prescription drug abuse. His picture shows him by a petroglyph which made him think he was staring at a 1,200 year old caduceus symbol and inspired him to reconnect to his medical school in Utah. He also enjoys writing poetry and sent the following poem. (see sidebar)

Class of 1980

Jeffrey R. Smith, MD

Dr. Smith practices orthopedic surgery, specializing in total joint replacement at Utah Valley Regional Medical Center and TR Hospital in Orem, UT. In 1991 he completed his fellowship in Adult Reconstruction/Total Joint replacement at the University of Utah and in 1994 he was honorably discharged from active duty in the U.S. Army. He served at Tripler Army Medical Center in Hawaii as the head of the Total Joint Section and assistant chief of the orthopaedic residency program. Since 1998 he has served at UVRMC in a variety of capacities including chairman of the orthopaedic surgery department, as medical staff resident and on the credentials committee.

Class of 1998

Glenn S. Buchanan, MD

Dr. Buchanan practices medical oncology at the Williamette Valley Cancer Institute and Research Center in Eugene, OR. He listed his significant achievements as his wife of 20 years, Renee’, three delightful daughters and twelve marathons completed!

Marc Johnson, MD

Dr. Johnson practices family medicine at the Intermountain Health Care clinic in Layton, UT and at McKay Dee Hospital. He is the chairman of the Ogden Surgical Medical Society and the Vice President of the Harei Health Initiative.

Class of 2003

Christian Feinauer, MD

Chris works as an emergency physician in Salt Lake City for EPIC.

Lindsay Malechek Klimes, MD

Lindsay works as a hospitalist at the Salt Lake Regional Medical Center in Salt Lake City, where she also serves as the chair of the Department of Family Medicine. She is adjunct faculty in the Department of Family Medicine at the University of Utah. She is the immediate past president of the Salt Lake County Medical Society and a current delegate from the Utah Medical Association to the AMVA Young Physicians section. She lists one of her significant achievements as a trip to Amsterdam, Rome and Hawaii last year!

Garden of Memories

They just threw her death certificate on my desk and said, “Would you fill this out?”
Or maybe they just said, “Fill this out.” She must have been more than a long list of primary and secondary diagnosis.
Nearly every time I saw her she cried. Cried for mercy, for help, for needs unspeakably unmeetable.
And I don’t know who suffered more, her or me for my pathetic inability to meet them.
Her last days spent fatally coiled in her bed.
Probably still angry for the day I had to tell her to stop walking because she kept falling, raising the liability rates for the poor manor.
Crying insconsolably and puzzling, pushing away my well-meaning hands.
I thought I knew her as a miserable and suffering soul who could not have possibly ever known a moment of joy.
Until I took a moment to look at the photo journal some well-meaning social worker must have put on the outside of her door to memorialize her better days.
A phenomenally beautiful smile and pictures of gardens, lush, now untended by her.
And all I could think of as I signed off on this certification of her passing is how much room for life will be left on our records shelves when her tome is removed.
And how many seeds she must have left behind by her transient being.

Written by Jay Swoboda, MD

He wrote this after working in a nursing home in Ennis, MT.
In Memoriam

S. William Allred, M.D.  MD 1946  5 March 2013
Jack W. Batchler, M.D.  MD 1968  22 March 2013
Stephen A. Beck, M.D.  MD 1974  7 May 2013
Taira Fukushima, M.D.  MD 1950  18 May 2013
Ralph G. Goates, M.D.  MD 1957  30 March 2013
Robert L. Jensen, M.D.  MD 1950  19 April 2013
Taira Fukushima, M.D.  MD 1964  18 May 2013
House Staff 1956  30 March 2013
Robert F. Lang, M.D.  MD 1957  14 February 2013
S. William Allred, M.D.  MD 1974  22 February 2013
Sherwin M. Maeser, M.D.  MD 1959  4 April 2013
M. L. Masterson, M.D.  MD 1959  10 May 2013
Lewis D. Michaelson, M.D.  MD 1950  6 March 2013
Norman L. Parker, M.D.  MD 1962  23 February 2013
George C. Pingree, M.D.  MD 1968  10 February 2013
McLaren Ruesch, M.D.  MD 1959  9 April 2013
Sylvester J. Sanfilippo, M.D.  MD 1955  2 May 2013
Tada Sato, M.D.  MD 1955  8 April 2013
Jon Q. Ward, M.D.  MD 1955  10 March 2013
Byron T. Weeks, M.D.  MD 1951  20 February 2013
Galen S. Woolley, M.D.  MD 1955  27 March 2013
Please visit our Web site at http://medicine.utah.edu/alumni

Class of 1959 at Half Century Society Luncheon

Watch the mail in July for your registration packet!
A registration form is also available on-line at http://medicine.utah.edu/alumni
where locations, fees and more details are available. Questions? (801) 581-8591