Remembering Chase
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What’s Inside

1 Dean’s Message
2 Alumni President’s Message
3 Remembering Chase
5 Physician/PA model: the time is now
9 Global Citizens
14 Alumni Weekend
• Reunions
• Distinguished Awards
20 Student Life
• Dean’s Roundtable with:
  - Elder Russell M. Nelson, M.D., ‘47
  - Brent James, M.D. ‘78
• White Coat Ceremony
26 News Notebook
32 Alumni Notebook
• Alumni News
• In Memoriam

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Dean’s Message

One thing in life is certain: change.

Change is the opportunity to grow and improve. At the University of Utah, we are embracing change, whether it is new ways of delivering health care, the genomics and technological revolutions, or new approaches to training future health care providers. Our physical landscape is also about to change dramatically, as we envision a new heart of our health sciences campus and a new Medical Education and Discovery (MED) building for our students, faculty, and staff.

“To improve is to change; to be perfect is to change often.”

– Winston Churchill

One thing I learned from Chase Peterson, (1929-2014), is that we can all motivate change by asking the right questions. Few of us could do this better than he. You could set your watch by his attendance at various grand rounds, town halls, and lectures. I knew when I was giving a presentation and saw him on the front row, he would eventually ask a tough question. And true to his very positive nature, he’d always close his comments with a reassuring word of encouragement. We were fortunate to know him and carry forward his unique ability to inspire change.

This ability comes in many forms. Elder Russell M. Nelson, M.D., ’47, who shared his experiences at one of this year’s Dean’s Roundtables, marked his life and career by service—to his patients and family, his church, his country and to science.

From this vast perspective, Elder Nelson’s words ring especially true in this time of great change in our health care systems; he said, “You work on building your own life as well as building the lives of people around you, while you’re learning how to save lives.” The alignment of Elder Nelson’s faith, family, and science as a means of influencing change is something we can all strive to achieve.

Another Dean’s Roundtable participant, Brent James’, M.D., M.Stat. ’78, words of wisdom reflect similar sentiments. As Chief Quality Officer at Intermountain Healthcare and Executive Director of Intermountain Institute for Health Care Delivery Research, Dr. James helped to define what it means to be a health care establishment that is a learning organization, and we feel privileged to claim him as one of our own. When it comes to tackling change, especially in health care, Dr. James can’t get enough of it.

“I see the rate of improvement accelerating,” he said at our recent roundtable. “To be on that ride—I wish I was 24 again.” His advice? “Get lost in it. Master it. Enjoy it. Don’t learn the tricks of the trade. Learn the trade. Learn every chance you have and when you do that, you’ll find that opportunity will knock.”

Sincerely,
Vivian S. Lee, MD, PhD, MBA
Private practice quickly revealed the critical importance of humanism and of listening to patients and I often wondered if this was the Osler secret. It turns out the answer is yes to all of the above. Osler, by many descriptions, had become a master of all these. Dedicated, keen, focused, knowledgeable but never confusing the fact that it is people who have diseases not the other way around.

The 2014 edition of the University of Utah School of Medicine Alumni Association Awards Program acknowledged an alumnus who I believe is our own Osler incarnate, Dr. Thomas Caine. He received the Distinguished Service Award in recognition of his many years as a clinician, teacher, administrator, for his community service, and his extraordinary patient care. No doubt there are many who will say they felt better when Dr. Caine walked into the room. I consider myself very fortunate to have associated with him as a medical student and resident at Utah; and even more privileged to be part of the alumni association leadership as he received this tribute.

I am just as impressed with the other awardees. Dr. Anthony Temple, the Distinguished Alumni Award recipient, had a prominent career as a pediatrician, researcher, and executive guiding others with critical clinical information such as the dosing of acetaminophen and ibuprofen; something we take for granted. His involvement with poison control centers on a local, regional and national basis resulted in multiple awards of achievement and recognition, not to mention the countless children and adults helped through these services. His professional contributions permeate our society every day.

The Distinguished Humanitarian Award went to two dedicated individuals associated with the Fourth Street Clinic. Founder Dr. Alan Ainsworth, and Medical Director Dr. Christina Gallop. The clinic, with a very modest beginning in 1988 by Dr. Ainsworth, has now become a marvelous collaboration of medical care, teaching, training, volunteering, education and hope; it is more than a medical and dental facility, it is a community asset. Dr. Gallop’s passionate advocacy for those she serves is both inspirational and humbling. Absolutely, amazing people.

All four of these award-winning alumni represent what Osler demonstrated. Medicine is about people. People who need and want to be helped by souls who truly care. Yes, there must be knowledge. Yes, there must be the wisdom of experience and the assistance of technology. But it is still about one human being helping another.

The Alumni Association is delighted to recognize the great work of our graduates, house staff, educators, researchers and clinicians. The longer I am involved, the more pride I feel in my connection to the individuals highlighted in this edition and the institution they represent. I think even Osler would feel better.

Dale Hull, MD, MPA ’85
School of Medicine Alumni Association President
This is the exceptional opportunity my predecessor, F. Marian Bishop, PhD, MSPH, faced when Chase N. Peterson, MD, joined the ranks of the Department of Family and Preventive Medicine in 1992, after a lifetime of state, national, and international achievements. I was a most fortunate beneficiary of Marian’s warm welcome of Chase Peterson as a new Professor of Family and Preventive Medicine when I became chairman in 1995.

I think of Chase as a diamond with endless facets that glistened with enlightenment and gave perspective and depth to each other. But despite his stature and level of accomplishments, Chase was one of the most humble, approachable, kind, and encouraging people I have ever known. To students and colleagues he was a fully present, curious, supportive, and inspiring faculty member; a team player who was a priceless gem to the department. Chase ended his days still fully serving others until his death on September 14, 2014.

What a privilege it was to have known and worked with Chase Peterson! When he stepped down from the presidency of the University of Utah, Chase joined the Department of Family and Preventive Medicine to teach medical students. Doing so was quite an endorsement of the importance of Family Medicine to the future of health and health care; an idea not obvious to all back then, but one that would be validated rather emphatically over time. Chase continued faithfully in this role for his remaining 23 years. Throughout, he was consistently gracious, inspiring, encouraging, and always striving to elevate the conversation about the most important aspects of the profession.

Chase’s cheerful eye twinkle, warmth, and enthusiasm earned him many friends among our faculty and staff. He initiated probing and enlightening conversations about primary care, death and dying, the role of the physician, and hope for transformation of health care. He continued to serve the School of Medicine in many other ways, including years on the demanding and important admissions committee. At the same time, he contributed to an amazing array of community boards, including shepherding the merger of the Salt Lake Symphony and Opera. In the midst of this very busy schedule he found time to write his memoirs.

I had a small experience of what an internationally-recognized leader Chase was on a visit to Oxford University in England. I picked up a local Oxford calendar and immediately opened to a page with Chase’s photo in full academic regalia, representing the U in one of the most venerable houses of learning in the world.

Someone called Chase a “public intellectual,” and that he was. But he was also a friend and source of encouragement to many. The U is enormously better because of his leadership, but more important we are all better for having our lives touched by Chase Peterson.

The following statements are but a few of our department faculty members’ memories and testimonies of the privilege of working with Chase:
Stephen C. Alder, PhD, Professor and Chief, Division of Public Health

“I first interacted with Dr. Chase Peterson when he was assigned the office next to mine. As a new assistant professor, I was extremely intimidated by his stature as a former University of Utah president along with his many career accomplishments. However, he reached out to me as his office neighbor to get to know me and what I was about. He always wanted to know how I was doing and remembered in detail our conversations over the years. He willingly provided a listening ear and gave thoughtful feedback. I always left conversations with him feeling more confident and optimistic. Even as age began to take its toll, he still stopped each time we ran into each other to ask how I was doing and request updates on activities that we had previously discussed. His presence is missed, but to the many of us who were the recipients of his wisdom, we now have the opportunity to pay it forward.”

Susan Cochella, MD, MPH, Associate Professor, Division of Family Medicine

“Chase taught each group of students coming through the Family Medicine clerkship about mindfulness, years before the term was invented. He did this by sharing two key stories at the end of each course debriefing. He asked students to reflect on their preceptor and posed the question if anyone on the staff or any patients had mentioned that this doctor was the “best doctor in the world.” The majority, if not all, of the students in each group would raise their hand. He would then add perspective by offering that we can all be the best doctor in the world no matter what specialty we are in, if we can keep the needs of the patient, from the patient’s perspective, as our priority while we care for them. “And what a privilege” he would add, “to serve others in this way, and go to sleep at night knowing you have done your best to be the best doctor in the world in a personal way for someone that day.”

Rick Henriksen, MD, Instructor, Division of Family Medicine

“You should always ask your patients to teach you something new.” This advice was given to medical students for many years. Chase loved thick-skinned potatoes lathered in butter. He never knew why some potatoes had the thick skins until he asked my potato-farming patient. Chase approached teaching and patient care with humility.”

David N. Sundwall, MD, Professor, Division of Public Health

“I was always in awe of Chase Peterson – his stature (professionally and physically) was daunting to me. His attending a prestigious prep school in New England, then Harvard University and Medical School, were very unusual for a young man from Utah, and very impressive to me. But he accomplished so much more than just obtaining an Ivy League education, including becoming Dean of Admissions at his alma mater, Harvard, and eventually President of the University of Utah. Throughout his remarkable career he remained remarkably approachable and humble.”

It is difficult to sum up my reflections of such an extraordinary man. I will always be grateful to Chase for his advice and support for me as Chairman of the department, whether through thoughtful handwritten notes or personal drop-in visits to my office. He was always excited about the future, and especially about what the department, Health Sciences Center and University could accomplish. I loved hearing his stories of pivotal moments for the U, such as when he facilitated the move of Primary Children’s Hospital to the campus.

Chase’s death is a huge loss to the department, the University and the State of Utah. But Chase left us all with such a great legacy. He gave everyone who knew him wisdom beyond what words can describe, but I will attempt: Unfailingly gracious, Always elevating, Gentlest of teachers.

How I will miss Chase Peterson, Mentor, inspiration, friend.
Celebrating Physician Assistants

What sets the Utah Physician Assistant Program (UPAP) Apart?

Forbes recently rated the physician assistant master’s degree as the best choice for long-term job opportunities. The UPAP master’s degree continues to be in strong demand, with 1,000+ applicants expected to contend for 44 slots next year.

UPAP has long been ranked by U.S. News and World Report as one of the top training programs in the country, garnering the #2 ranking in 2014. Utah’s master’s program is one of the oldest in the country and has developed curriculum other institutions use. UPAP faculty possess decades of clinical experience and have dedicated extensive effort to develop and hone classroom and small group teaching skills. Numerous PA programs share the strength of faculty expertise and meeting their differing missions; however, the clinical exposure Utah’s first year students receive is carefully planned, extensive, and remains one of UPAP’s more distinctive attributes.

Students have the opportunity to do international training including programs in Ghana, Thailand, Guatemala and Nepal. At the same time, the school has a strong mission to train PAs to work in rural and underserved areas domestically, including participating in a student run clinic at the Malheh Free Clinic and a required rural rotation at community health centers around the state.

Most incoming students are from Utah and have an average of five years previous experience in healthcare. The majority stay in state after receiving their degree.

For more info on what sets UPAP apart from other PA programs visit:  http://medicine.utah.edu/physician-assistant-program/why-upap.php

Physician/PA model: The Time is Now

Craig Ensign, MPAS, PA-C, Jennifer Coombs, PhD, PA-C

Physician assistants (PAs) have emerged as one solution to the nation’s physician shortage dilemma. Current literature asserts that the use of PAs facilitates access to health care, improves quality of care, shortens hospital stays, and exponentially increases revenue. From a solo practice to a large hospital institution, PAs are proving invaluable in the delivery of medical care in the 21st century.

Nationwide, nearly 100,000 licensed PAs are practicing within the physician/PA model; 1,000 are located in Utah. Additionally, in Utah there are about 1,400 Advanced Practice Registered Nurses, including Nurse Practitioners (NPs) and Nurse Midwives. PAs and NPs are frequently referred to as mid-level providers or advanced practice clinicians, although they prefer their specific titles. A significant difference is that PAs remain committed to the medical model of training and working under physician supervision whereas NPs have lobbied to practice independently. Their training is under the nursing model, although they collaborate with all health care providers.

The first three academically trained PAs emerged from Duke University in 1967, under the direction of Dr. Eugene A. Stead, Jr., chairman of Duke’s Department of Medicine. Dr. Stead’s vision addressed two salient needs: relieve the physician shortage of his era, and utilize the valuable experience of corpsmen returning from Vietnam. Six years earlier, Dr. Charles L. Hudson, president of the National Board of Medical Examiners and later president of the American Medical Association (AMA), formally presented the concept of mid-level providers at an AMA conference.

The profession has evolved significantly since its bold, yet tenuous, beginning 50 years ago. Competition to get into any of the nation’s 187 PA programs is intense and Utah is no exception. Each year The Utah Physician Assistant Program (UPAP) receives about 1,000 viable applications for its 44 spots. Located in the Division of Family and Preventive Medicine in the School of Medicine at the University of Utah, graduates of the 27-month program receive a Master’s of Physician Assistant Studies (MPAS) degree. Following graduation, PAs are required to pass the Physician Assistant National Certification Examination to become certified and earn the title PA-C.

Ranked number two in 2014 by U.S. News and World Report, UPAP is one of the oldest and most respected programs in
the country, with continuous accreditation since 1971 by the Accreditation Review Commission on Education for the Physician Assistant. Prerequisites for application to UPAP include a bachelor’s degree; a GPA of 3.0 or higher (this year’s average GPA is 3.52); and course work including chemistry, biology, anatomy, and physiology. Strong candidates also complete courses in writing, statistics, microbiology, and genetics. Since diversity and tolerance are essential qualities in medical providers, demonstration of cultural conscientiousness through class work and/or life experience is significant. In keeping with the roots of the profession, patient care experience is paramount; candidates are required to have completed 2,000 hours of significant direct patient care prior to application, but the average student has logged more than 4,000 hours.

The first year of training, the didactic phase, includes 64 credit hours of graduate level academic course work (the average graduate program requires 48 hours). In addition to the classroom, each week students spend one day in clinical rotations and at least half a day practicing history taking and physical exam skills in small group tutorials led by experienced and specifically trained PAs. During the second year, students work full time in clinical rotations under the direct one-on-one tutelage of physician preceptors. Finally, students produce and present a master’s project during their clinical year.

As predicted by Drs. Stead and Hudson, the original concerns regarding non-physician providers, specifically patient acceptance and quality of care, have not hampered the movement. In fact, the literature consistently substantiates the value and quality of PAs working in the physician/PA model.

Improved quality of care
In the 1950’s and 60’s significant change occurred in the make-up and delivery of medical services. As the medical knowledge base grew and technology exploded, the days of the general practitioner were coming to an end. It became impossible for a single person to stay abreast of the full spectrum of new information and technology, run an outpatient clinic, perform surgery, deliver and take care of babies and moms, attend to hospitalized patients, take call, manage a business, and have a satisfactory quality of life all at the same time. Out of necessity, specialty practices and training evolved and became the norm, while the general practitioner role became obsolete. Family practice emerged as a specialty unto itself and, along with other specialties, replaced the general practitioner. Today many specialties are shorthanded. Family practice, traditionally the gateway to medical services, is disproportionately shorthanded. Although the quality of medical care has unquestionably improved, the shortage of providers has made access difficult.

Increased patient access
In 2015, physician shortages are still a concern. There is a projected shortfall of 130,000 physicians by 2025. As ominous as that number is, it may be too low because the Affordable Care Act’s projected 31 million new enrollees are not included in the calculations. PAs and NPs are counted on to make up the difference. Around the country, there is an average of 44 students in each of the 187 PA programs for a total of 8,228 graduates.

Amanda Johns, MPAS, PA-C at Migrant Clinic Outreach - Brigham City, UT
in 2014. By 2017 the number of PA programs is projected to reach 238 for an estimated national PA graduating class of 10,472. The profession's rapid growth is projected to continue in the foreseeable future. The bottom line is this: there aren't enough physicians and surgeons to go around, but their advanced training and expertise is more accessible utilizing the physician/PA model.

**Patient acceptance**

How are patients responding to the option of seeing a PA or NP? Most patients, when given the option of seeing the physician, or a PA or NP, are agreeable to seeing the mid-level provider, especially if it means they can be seen more quickly. After they’ve seen a PA or NP once, they are much more willing, and likely, to schedule with them in the future. In addition to increased levels of confidence in PAs and NPs from patients who have seen them before, younger patients are significantly more willing to be seen by a PA or NP on their initial visit, even when timing isn’t a qualifier. The literature indicates the physician/PA model is working very well.

**Improved outcomes**

A significant concern of Drs. Stead and Hudson and all the visionaries, as well as the argument against the profession from its detractors, has been concern that quality of care by non-physicians will be lower than by physicians. Studies looking specifically at quality and outcomes have consistently shown there is no difference, with few exceptions, in care rendered by a physician, PA, or NP. This is a result of the exceptional training PAs receive, and the synchronization of practice style and communication between a PA and their supervising physician. The key to maintaining high levels of patient satisfaction and quality of care is utilizing the physician/PA model effectively. That model requires the PA to work exclusively within the physician’s scope of practice, and within the confines of his or her training and experience. It also means the supervising physician may appropriately prepare and train the PA to do virtually anything he or she does, except be the primary surgeon. And finally, when the model works well, both the PA and the patient are confident of the physician’s involvement and concern, even if from a distance.

**Maximizing practice revenue**

Overall, approximately 35% of PAs across the country work in family practice, the remaining 65% work in every other specialty. The contribution a PA makes financially depends entirely on the type of practice he or she works in and how they are utilized. In a family practice setting, the PA salary is generally about 45% of the physician’s; in other specialty practices the PA salary is about one third. These levels are averages across the nation, and they can be significantly different based on the type of practice and how they are utilized. The tremendous advantage of utilizing PAs is that at a lower cost for employment, they can generate similar revenues to their supervising physician. In a surgical practice, for example, the PA is able to keep the surgeon in the operating room in two significant ways: reduce the surgeon’s time burden by managing pre and post op care; and generate surgeries in the clinic while the surgeon is in the operating room. In the operating room itself, because of the familiarity that develops between the surgeon and PA, set up time and operating time are both shortened. Additionally, the patient’s actual hospital stay is shorter when a PA is working in the service.

The time is right to further advance the physician/PA model. If you are ready to consider hiring a PA in your practice, or if you are considering an additional PA, here are some helpful resources:

1. The American Academy of Physician Assistants (AAPA) has a site titled How to Hire a PA. The site provides information regarding interviewing, contracts, state licensing, and malpractice/liability (http://www.aapa.org/).
2. The Utah Academy of PAs has an employment tab where potential employers can post job listings and view resumes (http://www.utahapa.org/). The Utah Medical Education Council also hosts a bulletin board with both PA and NP jobs (http://www.utahmec.org/).

3. Second year PA students need practices in which to train. To accept a student and be a preceptor for one to four months is an excellent way to get to know a potential employee, and to get to know what contributions a PA can make in your practice. Additionally, it can be extremely gratifying to mentor a student. If you would like to consider preceptoring a student, contact Amanda Moloney-Johns, MPAS, PA-C at UPAP. (http://medicine.utah.edu/physician-assistant-program/program/preceptors/index.php).

References:


This year, the 12 University of Utah Physician Assistant students traveling to developing countries in the 2015 summer semester organized a successful fundraiser based on a cherished, decades-old Utah Physician Assistant Program tradition—The Salmon Barbecue, held each year at the home of the former director of UPAP, Don Pedersen, and his wife, Kathy. Not only did they reach their goal to raise money for their voyages abroad, they also inspired faculty, friends, and honored guests of the PA community with their vision of global citizenship.

PA Student Lee Rogers said to the attendees at the September 6th Salmon Barbecue: “Tonight is a night not to focus on congratulating us or patting us on the back for our good intentions, but to think of those whom we will directly serve: the Thai children in the AIDS orphanages, Burmese refugees on the Burma-Thai border, the Ghanaian families who journey many miles to receive their care from Medical Assistants.”

The global elective gives PA students the opportunity to work in hospitals, clinics, and refugee camps in countries scattered across the world and has historically drawn a diverse group of students: some have already served on religious missions abroad, some are the children of immigrants, and some have never before left the United States. No matter their background, global elective students are driven by their commitment to help others, especially the underserved.

Until Don’s retirement as Professor Emeritus early in 2014, the annual Salmon Barbecue kicked off each academic year for students and faculty with great food, live entertainment and the opportunity to mingle outside of the classroom.

When the PA students proposed keeping the tradition alive for at least one more year by reconfiguring the event as a fundraiser, the Pedersens happily obliged. Don and Kathy, Senior Advisor and Program Manager of the School of Medicine Department of Family and Preventive Medicine Global Partners Program, credit the students with making the night a success by inspiring the attendees with their goal of being contributing citizens to the global community.

The students were able to reach their fundraising goal with a silent auction of items generously donated by the students, their families, and local businesses.

As the band played and dinner was prepared, guests were invited to walk through the Pedersen’s gardens where the students decorated oak trees with photographs and biographies of each student lending insight into the reasons they are so passionate about their global electives.

“Oneir backgrounds were so diverse and yet they were united in their desire to help people in far-flung communities,” remarked Dr. Michael Kalm, former President of the Utah Psychiatric Association. The students’ motivation to serve a global community especially inspired him.

PA student Chelsey Schumaker, ‘15, told the audience how her class expects to graduate into a world of medicine that is radically different from that of 20 years ago. “This culturally immersive experience strengthens our appreciation of the role of culture in health and healing narratives.” The world is smaller, more interconnected, and interdependent. Forcibly displaced people worldwide exceeded 50 million in recent years and many will be future patients of physician assistants.
The global elective coincides with the University’s goal to engage more students and faculty in international study and research in an era of increasing globalization. Many students note that the elective was a deciding factor when choosing the Utah physician assistant program. UPAP is dedicated to producing not just highly trained physician assistants, but civically responsible medical professionals with a commitment to serving individuals from all backgrounds and cultures.

Students have the opportunity to get hands on experience without going abroad in the Utah physician assistant program’s service learning activities where they are exposed “to underserved, diverse, and/or cultural aspects of different communities” by providing school-aged children with annual physical examinations in Head Start programs or providing medical care to the uninsured at the student-run free clinic at Maliheh.

“When the night ends and we all go home, I’d encourage you to remember that although we think of global health as helping those who live in far off lands in dire circumstances, we are all part of the global community, and as such, it is our responsibility to help those who live close to home and who may be struggling for whatever reason.” Rogers said, concluding his speech. “While we are asking you to help us help those who do live far away, don’t forget to help those who are here.”

As the night concluded, it was clear that the students achieved far more than their initial goal of raising money for their global health electives—they raised awareness of the needs of people all over the world and helped define what it means to be a global citizen.

Utah Physician Assistant Nadia Miniclier Cobb honored as Humanitarian PA of the Year

Last May the American Academy of Physician Assistants honored assistant professor Nadia Miniclier Cobb, PA-C with the PAragon Humanitarian Award, at its annual conference in Boston. The award recognizes a PA who has demonstrated an outstanding commitment to human rights and also exemplifies the PA profession’s philosophy of providing accessible and quality healthcare on a domestic or international level. Cobb received the award for her work in Ghana to improve the skills of local medical providers.

While assisting a team of public health students in rural Ghana, she recognized an opportunity to enhance the clinical education available to the physician assistants (PAs) of the African nation. Cobb led the way in establishing a partnership between the University of Utah PA program and the College of Health, Kintampo (CoHK), home to Ghana’s largest training program for PAs. She helped create a continuing medical education (CME) program that offered a structured experience and engaging curriculum.

Since the CME program began eight years ago, more than 2,600 Ghanaian PAs have taken its courses. As part of the program, in 2012 a team from the University of Utah and students from Kintampo provided free treatment in two rural areas of Ghana previously underserved by medical professionals. Students provided care to an average of 4,500 patients, who received neurological and dermatological evaluations, dental care, immunizations, family planning, well child checks and deworming for children.

Cobb’s work also caught the attention of the World Health Organization (WHO); she was invited to join a WHO working group to assess the medical education needs of PAs around the globe.

Cobb, who was born in Kenya, lived throughout Africa while her father worked as an Associated Press reporter. Now, as an assistant professor and director of the University of Utah’s Office for the Promotion of Global Healthcare Equity, she is working to further expand the U’s PA studies curriculum to involve more service learning so students will get a broader education as they learn from and serve a variety of communities.

Cobb also received Utah Business magazine’s Healthcare Heros Non-Physician award in October 2014.
In October 2014 Kristin Wann Anderson, Executive Director of the School of Medicine Alumni Relations and radiologist Ron Ruff, MD, ’81 interviewed radiologists Richard Keller, MD, ’63 house staff alumnus, (retired) and Ken Nowers, MD ’98 to discuss how the practice of radiology has evolved over the years. Here are their observations:

Anderson: What is the most significant change you have seen in radiology during the course of your practice?

Keller: Definitely the improvement in image production and the computerization of radiology is the biggest change. Between my residency in 1959 and my retirement in 1995 I saw the remarkable introduction of CT scanning, nuclear medicine, ultrasound, and MRI technology, all computer-based. These innovations increased the radiologist’s ability to diagnose disease. During my residency the county hospital bought a 6” image intensifier which was one of the first in the area. Fluoroscopy previously had been performed with dark adaptation with red goggles. The fluoroscopic image was greatly improved as was efficiency with image intensification.

Nowers: Personal computers and tele-radiology have created the greatest changes during my career. As a radiologist, you can now potentially read images anywhere you have computer access. In the past it was the radiologist in a dark reading room looking at films and the clinicians would often come down and review images in person. You could have the luxury of reading them over a day or two, now it is almost real-time radiology. The majority of studies are read within 30-minutes in our practice. Now we can be miles away from the clinician, we don’t have to be on-site anymore. This has changed the interaction of radiologists with clinicians and has also changed the nature of radiology as radiology groups around the country can compete for radiology contracts no matter their location. It definitely has improved patient care due to improved image viewing capabilities and faster diagnosis.

Ruff: Today’s CT scan is much improved over the 1980’s CT imaging. Back then you’d have 12-14 images to look at, maybe up to 60-70, now you can get up to 2,000 images or more and receive the scans much faster and return the diagnosis.

Nowers: One of the current challenges for radiologists is reading so many images. In a trauma case you may get 2,000-3,000 images. Radiologists are expected to read the images, dictate and finalize multiple reports within a few minutes of the studies being completed.

Ruff: How have you seen the role of the radiologist in patient care evolve over your career?

Keller: In my career the interaction was always between the radiologist and the clinician, either in person or over the phone, and it was a very intense and dynamic interaction, but we rarely interacted with the patient.

Nowers: That is beginning to change more, when I first started practice we only had patient interactions when personally performing a study or procedure on a patient. It was very rare we directly talked to the patients about their diagnosis. As we begin to transition into the value-based model of medicine we are seeing more focus on direct reports to the patient either person to person or by phone. Patients now frequently have both the images and the reports from their imaging studies. This generates more questions from patients directly to us, the radiologists.

Ruff: At times, depending on who is referring, the radiologist may know more about the patient’s disease state than the primary doctor does, because they have to cover such a broad range of diseases and may not be as familiar with some...
of the nuances of specific diseases. As radiologists we have to be careful not to step on other physicians’ toes, especially when patients want to know more about their scans and diseases directly from the radiologist. Our interaction with patients has increased dramatically. At Mountain Medical, where I work, we now have full-time radiology assistants working 24/7 doing direct consulting with patients. They work both inside and outside the hospital and are conduits between patients and our radiologists. I would be on the phone all day if I were at McDonalds, trying to keep up with the orders as fast as you can, so I don’t know if the radiologist’s position on the physician totem pole has really changed!

Ruff-I’m not sure where we are on the totem pole, but it’s certainly true that hospitals and clinicians are more dependent on radiologists than they used to be. If you took away all the radiologists the hospital ERs would close. A decade ago only 3% of ER patients were scanned, now 13% of all patients get a CT scan ordered by the ER physician and they need a radiologist there to read them.

Keller-Radiologists used to be the low man on the totem pole. Maybe that’s not the case anymore?

Ruff-The incentives are somewhat perverse since the physician or the hospital benefits from tests ordered. It has gotten progressively worse over my career and I think a lot of it is because the technology has become so efficient and quick. Physicians will decide to take five to 10 minutes to order a test as opposed to spending time with a patient to find out what is going on. Also, when I first started out ER docs would call the patient’s primary care doctor and they would come into the ER to see them and admit them. Now intensivists and hospitalists take care of the patient in the hospital and the primary care doctor often doesn’t even know they are hospitalized. This causes a problem because the ER docs or hospitalists don’t know the patients like the primary care doctor does, so may work up everything, not knowing a certain condition was long-standing and is already being treated. This is because we are in a hospital-based medical system, but I believe a shift is starting to occur.

Ruff-Do you see a role for radiologists in the evolution of healthcare practice, improving health care outcomes and decreasing costs?

Keller-I think the speed of sending the images to clinicians and the immediate knowledge can decrease costs. Also, precision in diagnosis because of the new imaging modalities focuses more clearly the clinical problem and directs treatment, with, of course, all the newer diagnostic and therapeutic tools available in medicine outside radiology.

Nowers-Many current thought leaders in radiology are focusing on providing more value in imaging. The Imaging 3.0 Initiative advocated by the ACR suggests answering patient questions and it’s been shown that the more distracted a radiologist is while reading films, the more errors they make. The assistants can pull up the films and our notes and answer many patient questions for us, then consult with us when necessary.

Keller-Radiologists used to be the low man on the totem pole. Maybe that’s not the case anymore?

Nowers-The average person on the street often still doesn’t know what radiologists do, or that we are even physicians. We are still very much a service industry and sometimes it does feel a bit like working
Choose what you want to do based upon what you love doing. Don’t worry as much about potential threats to the field or forecasted changes. You are going to have to go to work every day for many years. If you don’t like it, it will be a long career not to be happy.

Ken Nowers, MD ’98

radiologists should be involved in all steps of the imaging process from reviewing exam orders to performing the exam and consulting with patients and physicians to communicate findings. One of the ways that we can decrease cost is by having better access to prior studies performed at other institutions. There is now a central, national repository called “See My Radiology” and the majority of hospitals now contract and pay for their services to access images for patients imaged at other sites. It’s still a slower process and there are security concerns since it is a cloud-based service, but it is a start and is better than waiting for days to get a prior image.

Keller—This is a long-term problem. When I was practicing it was difficult to get prior films if they had not been performed in our departments, in order to compare with current studies. Old studies are very important to evaluate new disease and evaluate changes in pre-existing disease.

Nowers—Another way radiologists can have a big impact to reduce costs is by following radiology guidelines, using evidence-based medicine, standardizing when to test again for incidental imaging findings.

Anderson—What are the biggest challenges of being a radiologist, both in the past and currently?

Keller—The breadth of the specialty. You must know the pathology of all diseases: the pathologic anatomy and the normal anatomy. It is a major learning process to understand a disease and its expression on images.

Nowers—The fast growth of knowledge and the rapid technology change has been challenging, which plays into the breadth of the specialty. That’s why we’re seeing more sub-specialization nowadays. That’s part of the reason radiology residencies have increased from the three years Dr. Keller did to four years, plus a clinical year, for a total of five years, and then many residents do one or two extra years of fellowship.

Anderson—What has been your greatest frustration or disappointment in your career?

Keller—I was never disappointed in my choice to be a radiologist. At times there were frustrations that came with handling the business side of the practice, especially as I got nearer to retirement and the systems became more complicated, but the excitement and motivation to keep learning has been one of the great joys of my life.

Ruff—I’d have to say the same thing. There are many distractions from radiology when you are your own business; things like personnel issues, business issues, insurance, interactions with various hospitals, etc. Probably 30% of my time is spent on these side issues which keep me away from focusing on radiology. I think that’s why across medicine we’re starting to see more physicians being employed by large groups or hospitals. It started with primary care docs and now up to 50% of all physicians are employees and that is predicted to increase in the next five years to 80%. We really saw it happen with cardiologists. Within a three year period cardiologists went from 40% working for a hospital group to 80% due primarily to reimbursement changes that occurred with cardiac imaging.

Nowers—This same evolution is occurring among radiologists too. It’s a way to control costs and get a more balanced lifestyle with set work hours; on the other hand you give up the autonomy and control you have if you are your own boss.

Ruff—There’s also been a change more recently in the number of hours worked outside of traditional work hours. I’d say 30% of my work time is now spent after hours; when I started it was much lower. If you go to a hospital over the weekend the only physicians you’ll find there are the ER docs, trauma surgeons, hospitalists/intensivists and radiologists.

Ruff—Do you have any advice for students considering a radiology residency in the future?

Nowers—Choose what you want to do based upon what you love doing. Don’t worry as much about potential threats to the field or forecasted changes. You are going to have to go to work every day for many years. If you don’t like it, it will be a long career!

Keller—The challenges to being a radiologist are great, but there are also great rewards, especially in diminishing the burden of illness in the patients we serve; the personal good we can do.

Nowers—Radiology is a wonderful career where you get to see almost every interesting case that comes into a hospital. It’s hard to beat that! 😊
Class of 1964:
L to R
Back Row
Larry J. Wright, Robert L. Arbon, Lewis J. Barton, Barry L. Stein, James C. Simmons, O’dell F. Rigby, Norman W. Pincock, Lynn L. Bateman
Front Row
Fred L. Anderson, J. Richard Taylor, David H. Steiner, Donald R. Eisert, Grant R. Fairbanks, Chong-Sang Kim, Paul Geniec

Class of 1969:
L to R
Back Row
J. Preston Hughes, Robert Miner, Stephen Taylor, John Thueson, Roger Lewis, Theron Brown, James Allen, Richard O’dell, David Sundwall, Kent Jones
Front Row
Michael Preece, Clark Jaymes, Sherman Johnson, David Scott, Lyman Stevens, Rodney Peterson

Class of 1974:
L to R
Back Row
Robert Jackson, Richard Black, Paul Sontag, Randal Gibb, Ralph Bradley, Jerome Freeman, Darrell Dixon, Brent Petty
Front Row
Dennis Hughes, Jeffrey Booth, Dixon Larkin, Kraig Jenson, Marsden Blanch
Class of 1979:
L to R
Paul Urie & Peg Simons

Class of 1984:
L to R
Kevin Tracy, Ron Day,
Connie Mitchell, Kevin Funk,
Marilyn Roubidoux, Steve
Santora, Mark Valentine

Class of 1989:
L to R
Tamara Lewis Sheffield,
Rodney Cuny, Martha Ives,
James Roth, Ralph Myers
Alumni Weekend

Class of 1994:
L to R
Greg Layton, Nate Momberger, Scott Hopkins

Class of 2004
L to R
Jason Shah, John Dame, Rachele McCarthey

Half Century Society Luncheon and Program
June 3, 2015  University Guest House - Speaker: Dale B. Hull, MD, MPA, ’85
My Remarkable Journey with Paralysis

Medical Alumni and Community Weekend
Celebrate the Past & Envision the Future-recognizing 50 years of the people and achievements of the School of Medicine
October 9-10, 2015

Friday, October 9
Department Events
Dean’s State of the School Address
Awards Banquet and 50-year Class Celebration (Class of 1965)

Saturday, October 10
Continuing Medical Education Symposium

Get in touch with classmates and see who is coming to your class reunion by posting on the School of Medicine Alumni Association Facebook page!
Beginning in 1991 the University of Utah School of Medicine has celebrated the school’s 50-year graduates and Distinguished Award winners at its annual Awards Banquet. The banquet has grown from 100 participants to 350 in 2014. In 2007 a new alumni group, The Half Century Society was created and meets together both during Alumni and Medical Community Weekend and in June for an annual luncheon and presentation. In 2012 a new Distinguished award, the Distinguished Humanitarian Award joined the Distinguished Alumni and Distinguished Service awards. The Awards Banquet kicks off the weekend, which also includes class reunions, CME opportunities, a presentation by the dean of the medical school and often tours of new additions to the medical school.

The 2014 honorees included Anothony R. Temple, MD, ’68, Distinguished Alumni Award and Thomas H. Caine, MD, ’63, Distinguished Service Award. Allan D. Ainsworth, PhD and Christina Gallop, MD, MPH, received the Distinguished Humanitarian Award in recognition of their work with 4th Street Clinic.

“I always love the School of Medicine Alumni weekend, seeing so many of our alumni and their families coming back to see the school and one another. It’s great to hear them talk of their years of medical training together, the years just seem to melt away as they share their memories with lots of laughter” says Kristin Wann Anderson, SOM Alumni Relations Executive Director.
Alumni and Medical Community Weekend

Steve and Shirley Taylor, ’69

Joan and Brent Petty, ’74 and Carol and Paul Sonntag, ’74

Jeffrey Booth, ’74 and Marsden Blanch, ’74

Thomas Higgins, MD presenting on Prescription Opiate Use and Abuse, The Data, The DOPL and Your Practice - Saturday morning CME symposium

Grant Fairbanks and Jayne Norris reviewing the Class of ’64 yearbook

Updates in Science and Practice CME Symposium
Distinguished Awards

Spencer Eccles congratulates long-time friend Tom Caine, MD, ’63 on his award

Anthony Temple, MD, ’68 receives the Distinguished Alumni Award from Dean Vivian Lee and David Sundwall, MD, ’69

Thomas Caine, MD, ’63 receives the Distinguished Service Award from Dean Vivian Lee and David Sundwall, MD ’69 President of the School of Medicine Alumni Association

Fourth Street Clinic Distinguished Humanitarian plaque

Christina Gallop, MD accepting the Distinguished Humanitarian Award

Allan Ainsworth, PhD and wife Colette Herrick celebrate his Distinguished Humanitarian Award with friends
On finding work-life balance as a father, surgeon, scientist and church leader:

“My first priority is to my wife and then to my children. My work is to support my wife and my children, not the other way around. You cannot support them by staying at home. You’ve got to go out into the world and do something worthwhile. And if you’re a doctor, you’ve got to be a good doctor. You can’t be a mediocre doctor because that isn’t fair to your patients. That means you’re going to be away from [your family], but when you’re home, you’re home. Leave the day’s traffic behind. Give them 100 percent of your attention when you’re there. I used to tell myself, ‘Russell, don’t you walk into that house, until you can bless the lives of your children and wife.’”

On choosing medicine:

“My father wanted me to go into his line of work, advertising. I started working for him and his firm when I was 10. The most motivating thing for me was Christmas time while working at a post office sorting mail. It was a dreadfully dull job and I kept looking at the clock wondering when my time was going to be up and I thought, ‘I better get an education.’ In high school I discovered I loved biology and math, and I loved people. I told Mom and Dad, ‘I don’t want to disappoint you, but I want to be a doctor.’ They said, ‘We’ll be glad to help you. We’ll support you any way we can.’”

On choosing surgery:

“I kind of drifted into surgery because of Emil G. Holmstrom, M.D., an obstetrics and gynecology professor who had been recruited to the U. from the University of Minnesota Medical School. He suggested I do an internship and residency in Minnesota; he said he could get me an interview. It was the unknown. I went into surgery because I thought it would be a challenge. I liked not only the discipline of medicine, but the opportunity to get in and do something about it, which a surgeon can do. And I went into cardiac work because no one knew anything about it.”

On becoming a researcher:

“In medical school the textbooks said, ‘You never touch the human heart, because if you do, it’ll stop beating.’ That’s how very little we knew about the heart in 1947. It was against that backdrop that I started doing research on the heart in Minnesota. One thing led to another. We started work on the heart-lung
machine. I was part of the team that did the very first open heart operation employing extracorporeal circulation in March 1951. It was a turning point in the history of surgery, because it went from a question of whether you can open the human heart and have the patient survive to what will you do now that you can get in there.”

On pushing the boundaries of medicine:
“T was operating at LDS, but was director of the thoracic surgery program for the U for 17 years. It proved to be a nice blend, because [at LDS] I had the patients who were coming to me for cardiac surgery, while the U had a smaller service, but some complicated cases. We went from those early experiments on whether or not the heart would allow you to touch it to sodium ratio perfusions so we could turn the heart on and off. Every basic step was hard. I only operated on about one patient a month because we would find so many surprises with each operation. We’d have to go back to the lab. It took us a year to figure out how to get blood out of the body and have it stay liquid and have it return to the body and be able to clot again. There were pains and heartache and tears along the way. But before we were through we could literally say heart surgery was a lot safer than abdominal surgery.”

On the nexus of science and faith:
“If something’s true, it ought to be part of you, whether it comes from the scientific lab or from the scriptures or from God himself. You can’t say, ‘I’m gonna check my religion at the door.’ Faith gives you strength in raising your family, it gives you strength in caring for your patients and it gives you strength in reading the literature. In my day I subscribed to 17 different journals. You don’t have time to read 17 journals a month, but you have time to read the abstract. And if the abstract is inconsistent with what you know to be eternally true you don’t read the article. It accelerated the rate at which I could read and study and to know what things I wanted to incorporate in my life and practice. It’s very easy for people to be self-centered and think they are really smart to the exclusion of truth that comes from heavenly messengers. It’s important for you to assimilate truth from wherever it comes and don’t exclude divine revelation.”

On the power of prayer:
“I remember a patient from Kanab, Utah. He had mitral stenosis, [or narrowing of the heart’s mitral valve], and tricuspid regurgitation, [a disorder in which the heart’s tricuspid valve does not close properly, causing blood to leak into the right upper heart chamber]. I told him, ‘We can help your mitral stenosis but can’t do anything about your tricuspid regurgitation. I can’t operate on you.’ He came back to me and said, ‘I’ve been referred to you for help. …Have you prayed about my problem? Operate on me and the Lord will tell you what to do.’ So I accepted him for surgery and I prayed and prayed but I never got an answer. My resident said as we made the incision, ‘What are you going to do about his tricuspid regurg?’ I told him I didn’t know. So, we were at the point of no return. We’d operated upon his mitral valve and fixed his very bad stenosis and then opened up the right atrium and looked at his tricuspid valve. His anulus was so big I could fit my whole hand in there; normally three fingers would be about the right diameter. Then the most amazing picture was drawn in my mind. I realized, ‘This circumference is too big. Reduce the circumference of the ring and the valve tissue will be adequate to close that hole.’ I put a tuck here and a pleat there, tightened it up and reduced the circumference of the ring. He lived for years after that.”

On the early days of the U’s medical school:
“We spent the first two years on lower campus, just opposite the Union building and Kingsbury Hall. We had 52 in our class and 26 of us graduated. A lot of students had to repeat one or two years, and some were just asked to leave and not come back. The medical school transitioned from a two-year to a four-year program in 1944, and I was in the graduating class of ’47. We had a young faculty and they were bright. Our classes were small. I remember Louis S. Goodman [pharmacologist and chemotherapy pioneer]. Edward Hashimoto was our anatomy professor. He would go to the blackboard with a piece of chalk in one hand and a piece of chalk in the other hand and draw his pictures with both hands concurrently. Max Wintrobe, a hematologist who pioneered new ways of measuring the hematocrit, was very demanding and helpful to me.”

On building a life while saving lives:
“In learning to save lives you will submit yourself to other peoples’ schedules and demands. You gotta pass medical school. Then you go into your chosen field and you have to pass other peoples’ exams to get certified and the hospital privileges, and so on. You spend the first preparatory period of your life meeting other peoples’ expectations. But then comes the time when you stop worrying about saving lives and you start building lives. You build lives with things that aren’t measurable, like faith, virtue, knowledge, temperance, patience and kindness, even charitable attributes. I go to a lot of funerals now and nobody ever asks how much money the person made, or how many operations she did, or how many cases he had as a lawyer. All the things that will be spoken about you at your funeral are attributes of spiritual dimension, not physical. So you work on building your own life as well as building the lives of people around you while you’re learning how to save lives. That’s my parting advice to you.”
Brent James, M.D. ’78
Chief Quality Officer for Intermountain Healthcare

“If health care is going to change, Dr. Brent James’ ideas will change it,” declared a front-page story in the Nov. 3, 2009 edition of The New York Times. Spending on health care in the U.S. was outpacing inflation and policy makers, pointing to the spending of other countries, were questioning whether consumers and taxpayers were getting their money’s worth. Fixing health care topped the national agenda—the Affordable Care Act was just beginning to take shape—and Dr. James, an early champion of evidenced-based medicine, was winning accolades for his work to improve the quality of health care by reducing variation in medical practice.

On choosing a career in quality and safety
“It was a complete accident, in truth. I was trained as a clinical researcher. I came from the Dana Farber Cancer Institute, the largest multi-center clinical trials group in the world. I was over GI tumors. I’d typically have about five or six big randomized trials running at any given point in time. I did that for years [and]…suddenly became a single parent with a three year old and moved back to Salt Lake to get closer to family. I took the job at Intermountain pretty much sight unseen. I was a fairly traditional academic researcher and I got here and discovered that I’d fallen in among administrators. There was a guy named Steve Busboom, who was President of Finance at Intermountain, and he had heard about variation literature, variation in clinical practice. …Steve wanted to drive it to a deeper level. Up to that point everybody had looked at hospitalization rates—how often were patients treated for a particular problem with a particular treatment—and it showed massive variation geographically. Steve wanted to see if we've got these patients in our facilities, in our hospitals, do we treat them the same for the same disease?”

On variation in medical practice, and why it matters
“One of the first things we studied was a surgical procedure called a transurethral prostatectomy [removal of part of the prostate gland through the urethra]. We looked at 16 urologists doing high volumes of this surgery and asked how long was each patient in the operating room? And we looked at the grams of prostate tissue removed. The fellow removing the most was removing 42 grams of prostate tissue and those at the median were removing 13 grams. So compare 13 to 42 on very carefully balanced patients, that’s a significant difference. Surgical times ranged from a low of about 38 minutes to a high of 90 minutes. What we did was take the tools of clinical research and swung them over and focused them on care delivery performance. Up until that point, everyone assumed if you were a trained physician, you were a master. The fact
that you did it meant it was quality. What we were doing was completely destroying that idea.

What came out of that were dramatic reductions in variability along with significant improvements in outcomes and reductions in cost of care. The funny thing was, as you’re looking at the detailed data, there was never an instance where one physician was consistently good or consistently bad. We were tracking about 90 individual factors. I’d have the guy who appeared to be the best guy in the group—he was best on grams per minute, for example—and on average, he had a lot to teach. The trouble was that there were also things where he was the worst guy in the group. And if you looked at the data for any length of time, you walked away convinced that it wasn’t a matter of picking the best physician. Best care was scattered across that group and every one of those physicians had something to teach and something to learn. The group knew more than any individual."

**On creating a learning environment**

“The first reaction from the urologists was challenging the data. My response was, ‘I’ve never seen a perfect set of data. Let’s go through your cases, doctor, and see if we’ve got it wrong or right.’ After a little bit of that we decided the data was pretty accurate. No one is really enthusiastic about getting examined. The way I approached it was, every physician commits to study the care they give to their patients and the outcomes that occur with an aim to improve their care. That’s why we call it the practice of medicine. It’s part of our core ethical commitment. I said, ‘That’s what this is all about. I’m not interested in whether you’re a good doctor or a bad doctor. I’m not sure that I could tell statistically. On the other hand, you guys are really different from each other. Why?’ What that does is stimulate thought and creativity. …Some of the administrators wanted to say: Good doctor, bad doctor. But mathematically, statistically, your ability to do that is extremely limited.”

**On the shortcomings of rankings and score cards**

“There are a whole series of problems. David Eddy, the guy who was the father of evidenced-based medicine, did a lot of work in this area. He took the example of prenatal care for identifying birth outcomes. He identified in the literature all the factors that contribute to good birth outcome; there are seven big ones. Prenatal care is one of them. It’s roughly equivalent to the other six. But that’s the one that physicians could control. The trouble was, if you then modeled it and said that of all the science we know for predicting a good birth outcome, what portion of the variability in outcomes does prenatal care explain? It’s about 25 percent. Seventy-five percent of the factors that determine good birth outcome are unknown to current medical science. And that means if I do comparisons, I’m making the implicit assumption that those 75 percent are equivalent across whomever I’m assessing. In addition there are mathematical problems; you get these very wide confidence intervals. And there’s a set of documentation problems such as, did they measure it correctly, did they record it accurately, etc.

The portion of outcome variability that you can predict in health care ranges from about 10 percent to 85 percent, depending on what you’re looking at. The strongest models are looking at things like open-heart surgery. But sometimes what you can measure is quite low. People who try to evaluate us from the outside, they don’t evaluate that, and it makes a huge difference. ‘They don’t ask themselves, ‘how good is the science?’”

**On process-focused, versus person-focused quality improvement**

“What we learned from this is that you don’t focus on the person. You focus on the process. A TURP [transurethral prostatectomy] is a process. And when we looked it that way, we started to say, how can we best execute this process? It’s the idea that people can change. Person-focused judgment systems provoke a predictable pushback by whoever’s judged. In contrast, learning systems focus on process. We studied this twice at the Institute of Medicine and our definition of transparency is a process-based definition. When the government does it, their definition of transparency is what they call accountability. But it turns out the accountability approach is very seriously, methodologically flawed.”

**On dealing with complexity**

“The aim is to identify processes that improve your practice of medicine, then systemize them and measure against them. People can cheat. But good physicians don’t cheat. What is your purpose, to look good if you can manipulate these systems like crazy, or to be good in terms of what really happens when people come to seek your help in their hour of need? And it’s a choice you’ll have to make. Most of us, when faced with it,
make the right choice.

My favorite way to do it is to take a care delivery group, a clinic or a hospital, and identify clinical processes having a large impact. You design a standard approach to this particular process. Labor and delivery is the biggest single process that Intermountain operates. It’s 11 percent of our total system volume with 34,000 deliveries a year. Well, we hammered out an evidenced-based practice protocol for it and blended it into the workflow with the aim of reducing the burden on clinicians. Here’s the problem.

I can demonstrate scientifically that, with rare exceptions, I can’t write a protocol that fits every patient. The people who come to us for help are different from one another. But it’s a way of dealing with complexity. Medicine has become complex. In a complex environment, if I standardize my work, it means I don’t forget things and it makes me faster.”

On choosing medicine

“I was on a Ph.D. track for physics and I was going to be a physics researcher. By real happenstance, the University of Utah was a hotbed of computer science, and the physics department had gotten heavily involved in it. We were writing computer programs to do symbolic calculus. Anyway, I was talking to a post doc at Columbia University, the finest physics program in the world at that time, and he was on his second post doc and he couldn’t get work. That was news to me, so I said, ‘What should I do?’ and he said, ‘Medicine. It has really interesting research problems and pretty easy money.’

I got into medical school and I encountered patient care, and the next thing I knew, I was in a surgery residency. It was great, there were interesting problems and you were problem solving. It was physically and mentally challenging. And I enjoyed it. However, early in medical school I’d arranged to do a fellowship at the National Cancer Institute, and it reminded me of my research side. I’ve always been able to get into whatever I’m doing and get lost in it and that happened at the National Cancer Institute. You just develop skills and that’s when opportunity knocks. I didn’t have a plan. My career was a series of accidents, serendipity.”

On the future of medicine

“I think it will be better. When people ask, ‘Do you think I should go into medicine,’ I say, ‘Definitely.’ If your interest is helping people when they need help, it’s the best profession in the world. The difference will be, complexity. David Eddy, again, said, ‘The complexity of modern medicine exceeds the capacity of the unaided, expert mind.’ It has forced it to team-based care. So your skills at leading an effective clinical team are going to become more and more important. One of the ways you simplify is you go to standard work…so you can focus your attention on the stuff on the edges. It’s a way of dealing with complexity. Some of you will get into the job of building the standard work to free up your colleagues so they can think. Every generation faces a challenge of making it better than we are today. I see the rate of improvement accelerating. To be on that ride—I wish I was 24 again. Get lost in it, though. Master it. Enjoy it. Don’t learn the tricks of the trade. Learn the trade. Learn every chance you have and when you do that, you’ll find that opportunity will knock.”

Every generation faces a challenge of making it better than we are today. I see the rate of improvement accelerating. To be on that ride—I wish I was 24 again. Get lost in it, though. Master it. Enjoy it. Don’t learn the tricks of the trade. Learn the trade. Learn every chance you have and when you do that, you’ll find that opportunity will knock.”
White Coat Ceremony

Dr. Dale Hull, President of the School of Medicine Alumni Association was honored to represent School of Medicine alumni by presenting incoming medical students with a Littman Cardio III stethoscope, each purchased by an alum, former house staff or a faculty member.

The Calvary Baptist Church Choir performed at the White Coat Ceremony and Board of Trustee member, and Calvary Baptist Church pastor, Reverend France Davis, spoke. As he welcomed the Class of 2018 into the start of their training for the medical profession he encouraged them to live with purpose and to care for others. Paraphrasing Luke 14:28 he said “to whom much is given, much is required” and stressed that the incoming class is being given a lot; medical education, training, and mentorship from outstanding professors. He urged them to move forward with confidence, always realizing that helping others reach their highest potential will lead them to value others and in congregate, value themselves.

He stressed that life’s journey is about working with others and that no one group, culture or community by itself can heal individuals, but that medicine should be practiced as a “healing team”, thus it is important to make room for others on the team.

Finally he emphasized that relationships are always built on mutual respect, not on titles or positions. It is important to check one’s ego at the door, to listen to others and to partner with diverse individuals, since working with people from other backgrounds or other points of view expands your view.

He closed his address by encouraging the students to find a place in their lives where their service makes a positive difference and then to move forward to continue to grow that service.

*The White Coat ceremony can be viewed at: [http://medicine.utah.edu/index.php](http://medicine.utah.edu/index.php)*
Every September the Health Sciences at the University of Utah hosts a Scholarship Dinner to recognize the donors that give and the students who receive endowed and named scholarships. It is an opportunity for donors sponsoring endowed scholarships or the Five for Five Scholarship ($5,000 for five years for a named scholarship) to meet their scholar(s). This year, philanthropist Father Rick Lawson spoke on behalf of the donors. One student from each college—Health, Medicine, Pharmacy, Nursing, and Dental—spoke on behalf of the student scholarship recipients. Ballard Scholar and fourth year student Samuel M. Passi expressed gratitude for the confidence someone he didn’t even know had in him on his quest to become a physician. He shared how being aware of that confidence made him work harder while in medical school, knowing someone was counting on him to succeed.

Digital Imaging in Pathology; New Insight for Translational and Personalized Medicine  By Mohamed Salama M.D., Associate Professor, Pathology

Only 30% of pathology laboratories in the country use whole slide digital imaging (WSI). What sets the Department of Pathology at the University of Utah apart from many medical schools and academic departments is the practical approach to apply imaging for medical students’ teaching, clinical and collaborative research applications, as well as leveraging existing and state-of-the-art laboratory testing.

Digital imaging promises to revolutionize the practice of pathology. In an era of increasing technological sophistication and sub-specialization, patients’ interests are best served by optimally connecting specimens with pathologists who are best equipped to interpret them. WSI enables this connection through computerized technology to scan and convert entire pathology glass slides into digital images. Whole slide images have the property of immediate transportability to primary or consulting pathologists in any connected site. They are virtual microscopes that produce high resolution diagnostic quality images that can be used anywhere across the web.

Digital pathology allows slide interpretation away from the central lab, where transporting specimens becomes a one-way electronic process instead of two-way physical trip, greatly reducing turnaround time for rendering an often actionable clinical diagnosis. Unlike glass slides, which can be lost or damaged during transport or possibly fade with time, images can be archived and retrieved easily. And, unlike traditional microscopy, WSI permits annotations and clinical metadata to be presented with the image, potentially with all the clinical and prognostic information needed to correlate morphology with genomic, proteomic or immunohistochemical data.

Another power of digitization is the ability to perform morphometry with computer-aided image analysis. Image analysis improves accuracy and reproducibility by eliminating variability between pathologists’ interpretations which is essential to foster translational research efforts in the study of new biomarker discovery as well as for patient care.

Innovation and Research
Pathologists at the University of Utah have a strong history of innovation and adopting unique strategies in health care. Driven by the vision that digital technology will redefine how pathology is practiced, and backed by the leadership of the Department of Pathology and ARUP Laboratories, we spearheaded efforts to establish a state of the art infrastructure for WSI to liaise between patient care and clinical research. Our collaboration brings together clinicians, scientists and academicians into one complex at ARUP Laboratories to serve our mission in areas of patient care excellence, research and education.
Several digital imaging applications have been successfully implemented in clinical care at the University of Utah. These include adopting digital microscopy and telepathology at the weekly Clinical Hematology Oncology Adult Treatment Planning Conference at Huntsman Cancer Institute, remote interpretation of a frozen section, value-added services to ARUP Laboratories reference clients nationwide, second opinion intradepartmental consultation, and the potential of insourcing international business.

The Department of Pathology and ARUP Laboratories partnered with the Scientific Computing and Imaging Institute (SCI), in order to meet the rapidly growing demand for software development in data visualization, image processing, and data management. The first collaborative patent for cell based classification application was filed and the product was successfully licensed through the Technology and Venture Commercialization office at the University of Utah. Additional collaborative efforts between SCI and ARUP are ongoing to develop WholeSlideExplorer, which provides a unique solution to multi-platform visualization of histopathology images stored either locally or in the cloud. WholeSlideExplorer provides a simple, intuitive interface and workflow, enabling users to review and make diagnoses from anywhere, including mobile devices. Furthermore, Whole Slide Explorer extends industry standards, such as quantitative analysis, image processing, and digital annotation, to its interactive streaming data model.

**Education**

In 2009, WSI was introduced as an innovative approach to enhance medical students' learning experience at the University of Utah in the classroom as well as at home. Additionally, digital pathology facilitated group learning by enabling discussion of interesting slides viewed on large computer monitors. Designing course-specific modules with slides available to everyone at the same time, as well as slides shared between multiple courses, is a significant cost savings for the institution. WSI benefits are not limited to medical students, but are extended to graduate medical education trainees in pathology and other clinical disciplines.

**Digital imaging is transforming pathology into a quantitative science**

The availability of image analysis tool sets is essential as we enter the age of personalized medicine. We now have the ability to use a number of image analysis tools across a wide range of technologies to help facilitate biomarker assessment in clinical practice and translational research. The power of automated image analysis lies in its ability to transform pathology into a more accurate and quantitative science. At ARUP Laboratories, digital pathology and image analysis tools are applied in translational research for tumor morphological and biomarker profiling, as well as to determine drug efficacy in several pharmaceutically funded clinical trials.

**From images to clinical decisions**

Interpreting tissue slides manually is labor intensive, costly and carries a significant risk of inconsistency, which can impede decision making. In contrast, digital images can be shared widely with the possibility of automation and increased throughput. Advanced image analysis and data mining has been successfully used to identify a set of quantitative multi-parametric features that can stratify patient cohort retrospectively according to clinical outcome. Once these feature sets are determined, the digital tool can survey biomarkers and prospectively predict outcome, as well as the response to various treatment options for a given patient. Digital imaging enables customization of healthcare using biomarker based image analysis with medical decisions, practices, and/or products being tailored to the individual patient; the earmark of personalized medicine.

There is no doubt that digital pathology creates opportunities for clinical, educational, and research purposes. However, its full adoption into the clinical laboratory faces several challenges. These include FDA regulatory issues, development of standards of practice and validation guidelines, workflow modifications, as well as defining situations where WSI technology will really improve practice in a cost-effective way. Our pathologists and researchers continue to play a pivotal role in applying these tools to their practice to advance the care of our patients. We are about to make the leap to a pure digital work flow in pathology with new insights into the future of translational and personalized medicine.
Moran Residents Keep a Good Thing Going

Moran first-year resident, Dr. Eileen Hwang, was honored with the “Randall J Olson Scholar Award” during the 5th Annual Achievement Rewards for College Scientists (ARCS) Foundation Utah Scholar Awards Luncheon, October 14, 2014. With the honor, Hwang received a $15,000 unrestricted award to use towards her research interest. The ARCS foundation is committed to advancing science and technology in the United States by providing financial awards to academically outstanding US citizens completing degrees in science, engineering, and medical research. Hwang earned her MD, PhD, and studied the hereditary diseases of collagen through a National Institutes of Health F30 fellowship at Robert Wood Johnson Medical School in New Jersey.

In addition to Hwang, Moran residents Brian E. Zaugg, MD, and Brian C. Stagg, MD, received ARCS 2012 and 2013 awards respectively. “Within ophthalmology, we have three residents, each of whom has been honored with an ARCS award of $15,000 for research the first year of their residency training,” said Dr. Jeff Pettey, director of the John A. Moran Eye Center Training and Residency Program. “Moran is really supportive of ARCS by providing matching funds for our second and third years to encourage residents to continue their research. All three residents have already done some incredibly exciting work. These awards really are a testament to the power of philanthropy in research.” Drs. Zaugg and Stagg have made extraordinary advances in research quantifying cataract outcomes, and Dr. Hwang is investigating biophysical techniques used to measure blood molecules in relation to the genetic risk factors for advanced macular degeneration.

“Every year when we meet our new ARCS scholars, I am simply amazed,” said Margaret Niver McGann, ARCS Foundation Utah Chapter president. “These young men and women bring dedication, hard work, ambition, and sharp minds to their graduate studies and to solving practical problems.” The ARCS Foundation was founded in 1958 by four forward-thinking women who saw the importance of supporting science and technology education in the United States. A half-century later, this remarkable organization has grown to include more than 1,600 women who volunteer their time and resources. Only US universities whose departments are ranked in the top 100 in the country are eligible to receive ARCS Foundation scholar awards.

New Division of Transplantation and Advanced Hepatobiliary Surgery Established in the School of Medicine

The Division of Transplantation and Advanced Hepatobiliary Surgery was created on September 1, 2014. Surgeons included are Drs. Robin D. Kim, MD as Division Chief, Jeffrey Campsen, MD, and Thomas Chaly, MD.

The Division of Transplantation and Advanced Hepatobiliary Surgery was formed out of necessity to accommodate the evolving specialized surgical discipline. World class care in this field requires not only fellowship trained surgeons, but also a cohesive strategy involving surgical, medical, and scientific disciplines. The division status facilitates four main goals:

1. Continuing to offer high level comprehensive surgical care in a highly specialized field.
2. Partnering with the University Hospital as well as the Department of Surgery and other departments to understand and optimize value-driven care.
3. Promoting basic and translational investigation of end-stage organ disease and hepatobiliary oncology by utilizing strengths of the Huntsman Cancer Institute, industry, and the University of Utah resources.
4. Fostering experts in the field to train in hepatobiliary cancers, end-stage organ disease, and immunology.

The Division goal is to become a world class destination for end-organ diseases and hepatobiliary oncology care.
Dr. Jarrett is originally from Ogden, Utah where he graduated from Bonneville High School in 1973 and from Weber State University in 1977. He is a member of the University of Utah School of Medicine class of 1982. He completed an internal medicine internship at LDS Hospital in 1983, and a residency in obstetrics and gynecology at the University of Utah in 1987. He is board certified and is a Fellow of the American College of Obstetricians and Gynecologists. Dr. Jarrett is an Assistant Clinical Professor in the Department of Obstetrics and Gynecology at the University of Utah.

He retired in 2004 and enjoys meeting people in various places around Utah Valley when they say, “Aren’t you Dr. Robins? You took care of me, my children and my grandchildren” or “You saved my baby’s life.” In 2007 he became the medical director of the Volunteer Care Clinic, a free clinic in Provo, for two nights a week, and still enjoys that work. The other days he spends on his ranch feeding cattle and horses. He married LaVinia Argyle in 1957 and they have five children, 34 grandchildren and twenty great-grandchildren. He has served on the School of Medicine’s Half Century Planning Committee for the past three years, and is currently chair of the committee. He feels honored and a bit frightened to serve on the Alumni Board as the Half Century Society’s representative.

Dr. Pippitt is a native of Idaho, and attended the College of Idaho for her undergraduate studies in Biology. She went to medical school at the University of Utah, graduating in 2006, and stayed with the U for her family medicine residency. She is board certified in family medicine and currently practices at the University of Utah Sugarhouse Clinic part time in addition to seeing patients in the University of Utah Headache Clinic in the Department of Neurology where she holds an adjunct faculty position. She teaches medical students in the first two years of medical school where she is the course director of Foundations of Medicine (a first semester class) and course director of a two year longitudinal course called Layers of Medicine which discusses ethics, humanism, public health, gender studies and many other aspects key to becoming a successful physician.

She is married to Rich Patten and in her spare time she enjoys reading, spending time with her husband, family, and friends, and also enjoys numerous outdoor activities. She is very honored to be a member of the School of Medicine Alumni board at the school that has played such a key role in her education.
Outgoing School of Medicine Alumni Association President David Sundwall is Named 2014 Utah Doctor of the Year

The University of Utah School of Medicine Alumni Association was proud as their outgoing president, David Sundwall, received the 2014 Utah Doctor of the Year Award from the Utah Medical Association.

Dr. Sundwall spent 24 years working in government and private sector health positions in Washington, D.C. He served as the President of the American Clinical Laboratory Association from 1994 to 2003. From 1988 to 1994 he was Vice President and Medical Director of American Healthcare Systems, an alliance of not-for-profit multi-hospital systems. Before that he was Administrator in the Health Resources and Services Administration (HRSA). He has been recognized for his contributions to healthcare policy and advocacy. Dr. Sundwall has worked as an advisor, task force member and chairman of numerous committees involved with public health policy and quality. In addition, his federal experience includes serving as the Assistant Surgeon General in the Commissioned Corps of the U.S. Public Health Service. He is currently the Vice Chair of the Medicaid and CHIP Payment and Access Commission in Washington DC.

In 2005 he returned to Utah to lead the Utah Department of Health for six years. He is a professor at the University of Utah School of Medicine’s Division of Public Health. In 2011 he was recognized by the School of Medicine as their Distinguished Service recipient. Throughout his career he has maintained his clinical connection to patients, volunteering a half day each week at the HealthCare for Homeless Project, a public clinic in Washington, DC. and currently volunteering two half-days each week in the Public Health Clinics of Utah at Salt Lake Clinic and one half-day at the Community Health Clinic in Midvale.

Harry L. Gibbons, M.D., M.P.H., ’58 Receives the Walter and Sylvia Goldenrath Award

Class of 1958 alumnus Harry L. Gibbons, M.D., M.P.H., received the 2014 Aerospace Medical Association’s (AsMA) Walter & Sylvia Goldenrath Award at the Association’s Honors Night ceremony in San Diego, CA last May. The award is presented annually to a member who has made a significant contribution in the field of aerospace physiology.

Dr. Gibbons was recognized for his contributions to pilot education and safety. He initiated a program with the U.S. Air Force and Flying magazine which has resulted in thousands of civilian pilots receiving physiological training in U.S. Air Force altitude chambers. He made contributions to aircraft accident investigation which ultimately led to the FAA improving evaluation of the cardiovascular status of airmen. He has investigated over 300 fatal aircraft accidents. His paper on the hazards and problems associated with civil air ambulance services led to the establishment of air ambulance safety regulations in his home state of Utah and helped to form national regulations increasing the safety of air ambulance operations in five other states. He organized and taught numerous classes on aviation safety and led the organization of the FAA Accident Prevention Program.

After receiving his MD from the University of Utah in 1958 and an M.P.H. from Harvard University in 1963 Dr. Gibbons served in the U.S. Army as a Flight Surgeon at Fort Bragg, NC, from 1959-1961. He attended the Advanced Course in Aerospace Medicine at Brooks Air Force Base, TX, and obtained board certification in aerospace medicine from the American Board of Preventive Medicine in 1966 and was named Chief of the Aeromedical Research Branch at the FAA’s Civil Aeromedical Institute that year. From 1971-1993 he was Executive Director of Health for Salt Lake City-Salt Lake County in Utah.

He is a lifetime member of the Society of U.S. Army Flight Surgeons, a Fellow of AsMA and of the International Academy of Aviation and Space Medicine. He was the first chair of AsMA’s Aviation Safety Committee and of AsMA’s Air Ambulance Subcommittee, and has published extensively in Aviation, Space, and Environmental Medicine.
Many thanks to the following Half Century Society members for their financial support of the School of Medicine at the School of Medicine Alumni Awards Banquet each fall. They have also been strong financial supporters of the school. The Half Century Society was formed in 2007 to continue a relationship with class members who graduated 50 years or more from the School of Medicine in recognition of the value of their degree from the University of Utah, and to continue to support the school for future generations. Below are 2014 gifts received from each reunion class. Many thanks to the following class members who chose to put the School of Medicine on their list of philanthropic causes.

2014 Reunion Class Giving Back to School of Medicine
Total Reunion Class Gifts, $80,589.32

Class of 1964-$27,275.00
14% participation
Lewis J. Barton, MD
Lynn L. Bateman, Jr., MD
Chong-Sang Kim, MD
Norman W. Pincock, MD
J. Ronald Rich, MD

Class of 1969-$518,028.40
30% participation
Anonymous
James F. Allen, MD
William Theron Brown, MD
DeVon C. Hale, MD
Clark Edman Jaynes, MD
Sherman B. Johnson, MD
Dennis L. Lombardi, MD
Michael R. McFadden, MD
Richard H. OdeI, MD
Gary V. Petersen, MD
Rodney C. Petersen, MD
Alan R. Pratt, MD
Jack B. Rampton, MD
Lynn B. Stevens, MD
David N. Sundwall, MD
Stephen D. Taylor, MD
John M. Thueson, MD

Class of 1974-$11,325
15% participation
Robert S. Bennion, MD
G. Munsden Blanch, MD
Jeffrey E. Booth, MD
R. Ralph Bradley, MD
Randal B. Gibbs, MD
Larry H. Isaksen, MD
Richard A. Jackson, MD
Don B. Madsen, MD
Brent G. Retty, MD
Rodney A. Pollary, MD
Paul L. Sonntag, MD

Class of 1979-$9,563
17% participation
Shelley Agricola, MD
D. Craig Allred, MD
Alan G. Avondet, MD
Ronald M. Carn, MD
Don A. Coleman, MD
Damil B. Cook, MD
E. Dean Flanders, MD
Lillian Grant, MD
Clair S. Hixson, MD
Randolph L. Johnston, MD
Alan R. Patterson, MD
Marta J. Petersen, MD
Raymond Reid, MD
James D. Sanchez, MD
Jaye Swoboda, MD
H. Garrett Tobler, MD
Gary W. Whiting, MD

Class of 1984-$5,100
10% participation
Stephen H. Andersen, MD
Karen F. Buchi, MD
Leon S. Jackson, MD
Charles C. Obasiolu, MD
Susan W. Paullin, MD
Franklin D. Robinson, MD
Thomas Calwell Thomas, II, MD

Kevin A. Tracy, MD
Tamara Zagorec-Marks, MD

Class of 1989-$2,851.89
8% participation
Robin M. Berger, MD
Jonathan Phillip Hale, MD
J. Bennion Heaton, MD
Mark E. Hill, MD
Robert James Munson, MD
Gina Sanders Nelson, MD
James T. Roth, MD
Tamara Lewis Sheffield, MD

Class of 1994-$1,794.94
10% participation
Wesley A. Elliott, MD
Randall S. Fortuna, MD
Regan B. Hansen, MD
Scott Alan Hopkins, MD
John Joseph Klein, MD
Robert Dean Pearson, MD
Peter V. Sundwall, Jr., MD
Michael Oliver Tremoza, MD
Christopher R. Wood, MD

J. Ronald Rich, MD
Chong-Sang Kim, MD
Class of 1949
John W. Callister, MD

Class of 1952
Robert P. Igo, MD
John B. Richards, MD
James R. Mann, MD
Lawrence E. Stevens, MD
Mary Lou P. Peak, MD

Class of 1954
Alvin C. McCuistion, MD
J. Alton Ross, MD

Class of 1955
Archie M. Bruggger, MD
Gerald V. Snarr, MD
H. Kent Staheli, MD

Class of 1956
Wald C. Perkins, MD
Aaron Bertrand Brill, MD, PhD

Class of 1957
Charles R. Borup, MD
Wallace D. Crosby, MD
D. John Gosch-Barker, MD
Marvin L. Rallison, MD
Joyce D. Johnson, MD

Class of 1958
Arthur F. Budge, MD
E. Ute Knowlton, MD
James O. Mason, MD
John Gary Maxwell, MD
Joseph H. Nelson, MD
James G. Smith, MD

Class of 1959
Glen K. Lund, MD
M. Moreno Robins, MD

Class of 1960
Kitchener E. Head, MD
F. Neal Mortensen, MD
Noel Nellis, MD
Dee M. Rasmussen, MD
Gene E. Speakman, MD

Class of 1961
Enoch G. Dangerfield, MD
Dorian R. Faber, MD
LaMar M. Fox, MD
David R. Haymond, MD
George A. Jutila, MD
Frank W. Kleist, MD
NEL M. Kelsington, MD
John G. Moore, MD
William R. Schmidt, MD
A. Owen Smoot, V, MD
James W. Freston, MD

Class of 1962
Michael S. Pecora, MD
Joseph V. Cook, MD

Class of 1963
John E. Bishop, MD
Kenny Ashby, MD
Walker J. Ashcraft, MD
Thomas H. Caine, MD
Bruce R. Fishburn, MD
Donald T. Rees, MD
A. Mason Redd, MD
Bruce A. Tall, MD

Class of 1964
Lewis J. Barton, MD
Lynn L. Bateman, Jr., MD
Chong-Sang Kim, MD
Norman W. Pincock, MD
J. Ronald Rich, MD

2014 Half Century Society Giving
Classes 1945-1964
Total 2014 Gifts, $73,022.77
Donor participation rate of Half Century members-21%

Class of 1945
Henry A. Theuerer, Jr., MD

Class of 1947
W. Dean Belnap, MD
Joseph E. Jack, MD

Class of 1948
Allan L. McCall, MD
Howard E. Sclater, MD

Class of 1949
John W. Callister, MD

Class of 1951
Burton F. Brasher, MD
Reid R. Kimball, MD

Class of 1952
Robert P. Igo, MD
John B. Richards, MD
James R. Mann, MD
Lawrence E. Stevens, MD
Mary Lou P. Peak, MD

Class of 1954
Alvin C. McCuistion, MD
J. Alton Ross, MD

Class of 1955
Archie M. Bruggger, MD
Gerald V. Snarr, MD
H. Kent Staheli, MD

Class of 1956
Wald C. Perkins, MD
Aaron Bertrand Brill, MD, PhD

Douglas B. Hart, MD
Joseph W. Hess, MD
William E. Miller, Jr., MD

Class of 1957
Charles R. Borup, MD
Wallace D. Crosby, MD
D. John Gosch-Barker, MD
Marvin L. Rallison, MD
Joyce D. Johnson, MD

Class of 1958
Arthur F. Budge, MD
E. Ute Knowlton, MD
James O. Mason, MD
John Gary Maxwell, MD
Joseph H. Nelson, MD
James G. Smith, MD

Class of 1959
Glen K. Lund, MD
M. Moreno Robins, MD

Class of 1960
Kitchener E. Head, MD
F. Neal Mortensen, MD
Noel Nellis, MD
Dee M. Rasmussen, MD
Gene E. Speakman, MD

Class of 1961
Enoch G. Dangerfield, MD
Dorian R. Faber, MD
LaMar M. Fox, MD
David R. Haymond, MD
George A. Jutila, MD
Frank W. Kleist, MD
Nel L. Mangelson, MD
John G. Moore, MD
William R. Schmidt, MD
A. Owen Smoot, V, MD
James W. Freston, MD

Class of 1962
Michael S. Pecora, MD
Joseph V. Cook, MD

Class of 1999-$1,830.00
7% participation
Anne Gin Wi Lin, MD
Chad M. Gonzales, MD
Jorid D. Gray, MD
Eric R. Jensen, MD
Ayako Kamaya, MD
Daniel D. Ririe, MD
Maria A. Schwartz, MD

Class of 2004-$2,376
5% participation
Brett A. Christian, MD
Joshua James Larson, MD
Rachelle M. McCortney, MD
Tracy James Robinson, MD
Preston Daniel Ward, MD

Class of 2009-$445.00
6% participation
David E. Allen, MD
Julia Kate Deloach, MD
David R. Lamber, MD
Kelli Corinne Lund, MD
Debra S. Regier, MD
Lindsay H. Wilson, MD

The Half Century Society was formed in 2007 to continue a relationship with class members who graduated 50 years or more from the School of Medicine. Members of the Half Century Society meet for an educational luncheon each June and at the School of Medicine Alumni Awards Banquet each fall. They have also been strong financial supporters of the school. Many thanks to the following Half Century Society members for their financial support of the School of Medicine.
Class of 1964

Fred L. Anderson, MD
Dr. Anderson spent his entire professional career in cardiology as a faculty member at the University of Utah School of Medicine. He retired in 2004 as a Professor Emeritus. He served as associate chief of cardiology and acting chief of cardiology at the University Hospital, chief of cardiology at the Salt Lake VA Hospital, and director of preventive cardiology, cardiac catheterization, and non-invasive laboratories. In his free time he enjoys playing the trumpet, raising fish and water plants in his back yard water gardens, and golfing. Dr. Anderson also initiated a three year humanitarian rheumatic fever prevention program testing 1200 children of Kosrae for pharyngeal streptococcal throat infections, treating those who tested positive.

Lynn L. Bateman, MD
Dr. Bateman managed an internal medicine practice in Provo for 42 years. While there he started the ICU, pulmonary department and neurology department. He served five years as an LDS Bishop and spent 4 months in Samoa working on the rheumatic fever epidemic. He is married to Joan Pace and enjoyed raising their seven children.

Lewis Barton, MD
Dr. Barton practiced internal medicine, specializing in nephrology in Salt Lake City for 37 years, retiring in 2007. He did a fellowship in nephrology at Parkland Memorial Hospital in Dallas, Texas. He served on the School of Medicine’s Alumni Association Board of Directors from 2007 to 2013 and has enjoyed participating in School of Medicine activities. Dr. Barton enjoys back packing, camping and family travel with his wife Suzanne.

Donald R. Esert, MD
Dr. Esert’s career as a radiation oncologist was spent in academic medicine working at the Medical College of Wisconsin, Harbor/UCLA General Hospital, the Medical College of Virginia and Vanderbilt University, which he retired from as a full professor and chairman of the Center for Radiation Oncology. He is a Fellow in the American College of Radiology and has served as a fellow in radiation oncology at the Rotterdam Radiotherapy Institute and the National Cancer Institute at the University of London. During his career he was especially interested in the development of three-dimensional treatment planning and quality assurance in treatment delivery. He very much enjoyed his academic career, retiring in 1996. Since retiring he has enjoyed photography and travelling with Judy, his wife of 48 years.

Chong Sang Kim, MD
Dr. Kim retired in 2003 as a neurologist at the Kaiser-Permanente Medical Center in Orange County but continued working as a part-time clinical faculty in the hospitalist program and the Department of Neurology at the University of California at Irvine until 2008 when he retired from medicine. Since then he has traveled widely and has studied foreign languages, including French, Japanese, and Spanish. He spent three months in Okazaki, Japan studying Japanese in 2001.

Norman W. Pincock, MD
Dr. Pincock practiced primary care internal medicine in Escondido, California from 1970 to 2013. He served as chief of staff at Palomar Medical Center as well as chairman of the Department of Medicine. He was an associate professor of medicine, UCSD School of Medicine and a member of the San Diego Medical Society from 1988 to 1993. Dr. Pincock currently plays on a men’s senior baseball league. He is also a member of the Barber Shop Harmony Society, singing in a quartet named “A Song and a Smile.” Dr. Pincock is married and has eight children and 21 grandchildren.

OdeLL F. Rigby, MD
Dr. Rigby practiced urology at the Salt Lake Clinic with outstanding colleagues until he retired in 2004. He has been married to Joy, a wonderful woman, and very much enjoyed raising six great daughters with her.

Grant R. Fairbanks, MD
Dr. Fairbanks specialized in plastic surgery and is still working full time at his clinic by St. Mark’s Hospital. He believes his artistic background in sculpting has helped him in his career. He did general surgery training at the Univ. of Maryland, plastic surgery at the Univ. of Michigan. He has received numerous awards and recognition for his teaching and has lectured around the United States and the world.

In Memoriam 2014

Allan H. Barker, MD  MD 1952  1 Jan 2015
William W. Barney, MD  MD 1960  10 Sep 2014
Roger W. Davis, MD  MD 1968  22 Jul 2014
Gerald N. Goodman, MD  MD 1959  3 Dec 2014
Jerome S. Griffith, MD  MD 1948  3 Nov 2014
Alumni News

at various plastic surgery conferences. He served as a plastic surgeon on the hospital ship Hope in Tunis, Tunisia and enjoys teaching the cadaver course on facial/nasal anatomy every other year to medical students at the U.

James C. Simmons, MD
Dr. Simmons worked as an anesthesiologist in Bozeman, MT until he retired in 2000. Because money was tight in medical school and he and his wife Janet already had three of their six children, he joined the US Air Force his senior year, did a military internship and then served back four years with the Air Force. His first placement was in Great Falls, MT, which he loved, so after getting out of the military he returned to Montana as a family medicine physician. Four years later he decided to return to the University of Utah and completed a residency in anesthesiology in 1972. He still loves to do anything out-of-doors, has horses and enjoys hunting and fishing in beautiful Montana. He and Janet have also travelled quite a bit since he retired, to Europe several times and New Zealand and Australia.

J. Ronald Rich, MD
Dr. Rich retired in 2013, from his neurosurgery practice located at Santa Monica UCLA Medical Center. He completed his post-doctoral fellowship with the National Institutes of Health and in 1971 was named chief of neurosurgery science at the Harbor, UCLA Medical Center. In 1986 he served as chief of medical staff at Santa Monica UCLA Medical Center and in 2003 was president of the Calif. Assoc. of Neurological Surgeons. He was named as one of the Best Doctors in America—America’s Top Surgeons in 1996. He and his wife Linda enjoy traveling and cheering for the UCLA football team, except when they play Utah! He’s gotten into wine tasting since one of his three sons opened Talisman Vineyards in Sonoma and is also the winemaker at Moraga Vineyards in Bel Air CA.

James R. Swenson, MD
Dr. Swenson served as a plastic surgeon on the hospital ship Hope in Tunis, Tunisia and enjoys teaching the cadaver course on facial/nasal anatomy every other year to medical students at the U.

Lizan J. Wright, MD
Dr. Wright served as the medical director of both Microbiology and Urology for Salt Lake City IHC Hospitals. He was president of medical staff for LDS Hospital. He is the father of three great children and five even better grandchildren. Dr. Wright has enjoyed international endeavors teaching in medical school in Kenya, doing research in Ethiopia and giving polio vaccines in India. After 36 years in Internal Medicine practice he is enjoying his retirement.

J. Richard Taylor, MD
Dr. Taylor did his dermatology residency at the University of Oregon and then served on the faculty at the University of Miami School of Medicine for 31 years. He specialized in the treatment of psoriasis and was involved with numerous pharmaceutical studies for psoriasis drugs. In 2002 he retired as a full professor and the chief of dermatology at the Miami VA Hospital and moved to Tallahassee where he went into practice with his daughter-in-law, whom he had trained while on faculty at the Univ. of Miami, until fully retiring in 2012. He has four sons, all of whom he reports made it through college and beyond and are gainfully employed, and seven grandchildren. He enjoys reading in his spare time.

Larry J. Wright, MD
Dr. Wright served as the medical director of both Microbiology and Urology for Salt Lake City IHC Hospitals. He was president of medical staff for LDS Hospital. He is the father of three great children and five even better grandchildren. Dr. Wright has enjoyed international endeavors teaching in medical school in Kenya, doing research in Ethiopia and giving polio vaccines in India. After 36 years in Internal Medicine practice he is enjoying his retirement.

To register for weekend events or update information go to http://medicine.utah.edu/alumni

Class of 1984
Franklin D. Robinson II, MD
After residency Dr. Robinson accepted a staff position at UCDMC in Sacramento, California. He helped develop the EM residency program and was acting residency director for 2 years. He has been in the military since 1972, beginning as a Navy Corpman, and served in both the UT and CA National Guard. Dr. Robinson has been deployed eight times with deployments to Iraq, Afghanistan, Kosovo, Bosnia and Germany. He is currently deployed in support of OEF at Camp Arifjan Kuwait with the 3rd Medical Command. With the end of this deployment November 2014, he will have completed over 42 years of military service. Dr. Robinson is currently a staff physician at South Sacramento Kaiser Hospital, a level 2 Trauma facility. He is married to Dinah Hernandez and has five children and five grandchildren.

Class of 1993
Darren Kay, MD
Dr. Kay did his internship and residency in emergency medicine at Texas Tech University School of Medicine. He is currently is working for Northwest Tucson Emergency Physicians in Tucson, AZ.

Class of 1992
Simmons, MD
Dr. Simmons worked as an anesthesiologist in Bozeman, MT until he retired in 2000. Because money was tight in medical school and he and his wife Janet already had three of their six children, he joined the US Air Force his senior year, did a military internship and then served back four years with the Air Force. His first placement was in Great Falls, MT, which he loved, so after getting out of the military he returned to Montana as a family medicine physician. Four years later he decided to return to the University of Utah and completed a residency in anesthesiology in 1972. He still loves to do anything out-of-doors, has horses and enjoys hunting and fishing in beautiful Montana. He and Janet have also travelled quite a bit since he retired, to Europe several times and New Zealand and Australia.

Kaye H. Kilburn, MD

Conrad J. Knowles, MD

Stanley N. Mogerman, MD

Chase N. Peterson, MD

John Robert Stewart, MD

James R. Swenson, MD

Charles Robert Tweedy, MD

MD 1994
7 Aug 2014
22 Aug 2014
13 Sep 2014
14 Sep 2014
24 Jul 2014
11 Oct 2014
20 Jul 2014

MD 1995

MD 1996

MD 1958

Faculty

MD 1959

MD 1983

33
School of Medicine Distinguished Alumni, Service and Humanitarian Awards 2015

Submission Criteria

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

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

Curriculum Vitae: A CV should be included with the submissions for the Distinguished Alumni Award. A CV is recommended, but not required for the Service and the Humanitarian nomination.

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

Deadline: March 2, 2015

Send completed nominations attention Kristin Wann Anderson
540 Arapeen Drive, Ste. 120, Salt Lake City, Utah 84108. Fax to (801) 585-2613, or email to kristin.anderson@hsc.utah.edu.

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

Announcement of Awards: Awards will be announced in May of each year and printed in the June edition of Illuminations magazine. Recipients will receive their awards at the October 9, 2015 Alumni Association School of Medicine Awards Banquet.