Fall-Winter 1983

UNIVERSITY OF MINNESOTA

Medical Bulletin

A Publication of The Minnesota Medical Foundation

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Commentary

By Pearl P. Rosenberg, Ph.D.

There is a saying among women physicians that warm speculums were never used until there were female obstetricians. This saying epitomizes the impact which growing numbers of women in medicine have had on the medical profession itself. The medical field is finally developing an awareness of the special requirements of a woman's body that until recently had often been viewed as a pale imitation or perhaps marred replica of a man's body.

Not since the nineteen hundreds have women been entering the medical field in such significant numbers. Most people are unaware that the turn of the century represented the "heyday" of women physicians with women comprising 37% of the graduating class at Boston University School of Medicine. This occurred at the height of the suffragette movement, and women were swept into medicine as well as into other professions. Eventually, women won the vote, but unfortunately the nation lapsed back into Victorianism, and women went back into the parlor, kitchen, and bedroom. Medical school openings for women fell dramatically and stayed at 4 or 5% until the forties when America was at war, and women were again welcomed into the work force. By 1945, women numbered 14.4% of the freshman class in the United States, and today women are 30% of the freshman class nationwide.

Minnesota's record in regard to women in medicine has always been strong relative to the rest of the country. In 1900, Minneapolis was rated first in the country in terms of

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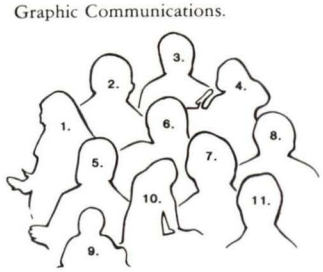


Cover: The cover illustration of these women of medicine, drawn by Jim Larson, an artist in Biomedical Graphic Communications, includes many of the women featured in this issue of the **Bulletin.** They include: 1) Clara Bloomfield, 2) Hulda Thelander, 3) Linda Hedemark, 4) Regina Morantz, 5) Silvia Azar, 6) Jan Adams, 7) Barbara McClintock, 8) Nancy Meryhew, 9) June LaValleur Randall, 10) Claire Pomeroy and 11) Pearl Rosenberg.

Medical Foundation reports one of best years ever

The Minnesota Medical Foundation recorded one of its best years ever at year end in June 1983. In the annual report mailed to all donors in October, the Foundation reported $5,054,083 in total revenues for 1983, an increase of 9.0 percent over the previous year.

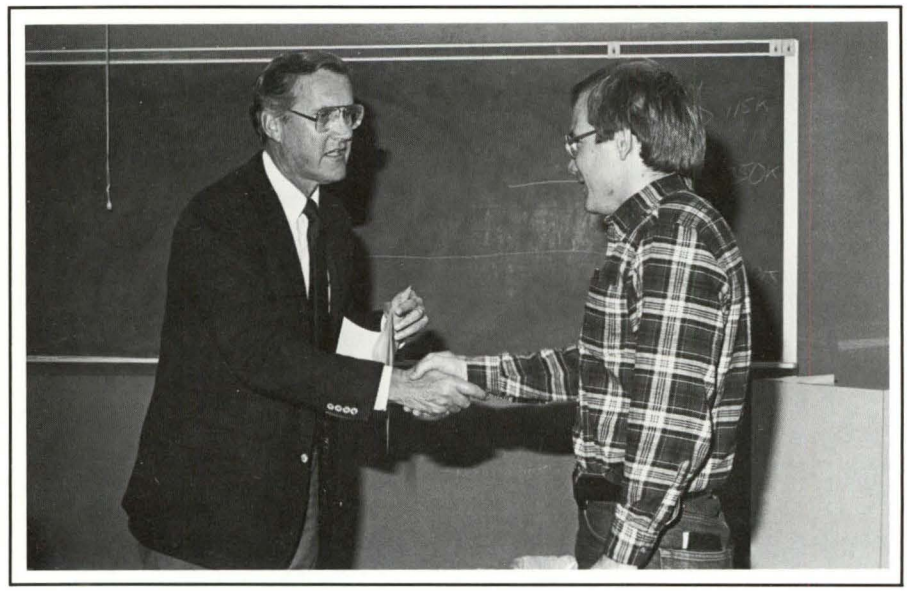
Total assets of the Foundation on June 30, 1983 were at a record level of $17,351,078, according to the report.

Total gifts and grants received by the Foundation increased by an encouraging 10.5 percent over the year before, from $3,478,539 in 1982 to $3,842,723 in 1983. While the Foundation's investment earnings totaled $1,151,127, up only slightly compared to the previous year, the capital gains for the year showed tremendous improvement in 1983 ($2,722,135) compared to a loss of $619,653 the previous year.

Foundation Executive Director Eivind O. Hoff said in the report, "Particularly significant this year was the growth we experienced in the number of contributions received (3,943) compared to about 3,000 in 1982. This represents a healthy 31.4 percent increase."

During the year just ended $3,928,365 was expended in programs and supporting services for the University's medical schools. This is an increase of 31.9 percent over the same period a year earlier.

"We are indebted to our many friends who, through their generous contributions, have allowed the Foundation to once again fulfill the purposes for which it was founded 45 years ago," said Hoff. "The year 1983 was indeed a good one for the Minnesota Medical Foundation."



Research grant awarded

David Thomas, associate professor of Biochemistry, was one of ten faculty members whose research grants were approved by the Minnesota Medical Foundation at its fall Board meeting. He received an award of $15,000 from Eivind Hoff, executive director, for research equipment. The Board approved $55,000 in research grants at the meeting.

MMF receives $200,000 estate

The Minnesota Medical Foundation has received $200,000 from the estate of the late Lillian M. Vines of Robbinsdale, MN.

Named for her late husband, Harold Thomas Vines, the gift has been designated for use in funding scholarships for medical students at the University of Minnesota Medical School.

Dr. Hostetter receives Hartford Fellowship

Dr. Margaret Hostetter, assistant professor, Pediatrics, has been named one of the twelve 1983 John A. and George L. Hartford Fellows by the John A. Hartford Foundation in New York.

Dr. Hostetter will receive $105,000 over a three-year period as support for the early stages of her medical research career as well as a stipend paid to the Medical School for research expenses.

Oegema receives Volvo Award

Theodore R. Oegema, Jr., associate professor, Departments of Orthopaedic Surgery and Biochemistry, has received the Volvo Award for Biochemistry.

The award was given in recognition of studies on the effect of chymopapain on the intervertebral disc. Two others were named along with Dr. Oegema as recipients of the award.

Part of the data from the study was gathered using instrumentation purchased with Minnesota Medical Foundation funds.

Foundation approves $110,600 for grants

The Board of Trustees of the Minnesota Medical Foundation approved 20 grants for medical research totalling $110,600 at its quarterly meeting October 27.

The grants were made to faculty and students from the University of Minnesota Medical School.

The following faculty members received research grants from the Foundation: John R. Babson, assistant professor, Pharmacology, $7,000; Larry D. Bowers, associate professor, Lab Medicine/Pathology, $5,500; James Carey, instructor, Physical Medicine and Rehabilitation, $5,000; Dr. Deborah K. Freese, assistant professor, Pediatrics, $7,500; Donald B. Jump, assistant professor, Medicine, $5,000.

Also, Harry T. Orr, assistant professor, Lab Medicine/Pathology, $3,000; Dr. Brian H. Rank, fellow, Medicine, $5,000; Robert J. Roon, associate professor, Biochemistry, $7,500; Dr. Peter T. Silberstein, medical fellow, Medicine, $4,500 and Dr. Sally Weisdorf, instructor, Pediatrics, $5,000.

Six students were awarded grants by the Foundation. They were John Axelson, Year 3, $1,200; Jerome F. Breen, Year 4, $500; Ira Davis, Year 4, $800; Michael Madison, Year 3, $1,200; Charlene E. McEvoy, Year 2, $1,200 and Joseph C. McRaith, Year 4, $1,200.

Special grants awarded were as follows: Dr. Samuel Schwartz, emeritus research professor, Medicine, $12,000; Dr. Seymour Levitt, professor and head, Therapeutic Radiology, $12,500; Dr. David D. Thomas, associate professor, Biochemistry, $15,000 and Dr. Michael Mauer, professor, Pediatrics, $10,000.

Dr. Westermeyer appointed member of NBME committee

Dr. Joseph Westermeyer, professor of Psychiatry and Adjunct Professor of Psychology and Anthropology, has been appointed a member of the National Board of Medical Examiners' CBX Case Development Committee.

The Computer-Based Examination (CBX) is an important developmental project of the National Board directed at improving the measurement of clinical competence of candidates for medical licensure. CBX is an interactive patient simulation designed to test clinical decision making and problem solving.

The National Board is committed to implementing CBX within the next few years as a major segment of the National Board's Part III examination which is the final step toward NBME certification.

CCRF benefit brings $95,000 for cancer

The Children's Cancer Research Fund raised $95,000 at this year's benefit starring Neil Sedaka in October. This is more than double the funds raised last year. The money will be used to support children's cancer research at the University of Minnesota.

Medtronic Fellowship awarded

Roger R. Laroche, right, a first year medical student at the University of Minnesota Medical School has been selected as the 1983–84 Medtronic Fellow. This scholarship award will provide $10,000 toward medical education and living expenses during the first two years of medical school. This is the first year for the award. Presentation of the check and a certificate was made at the Foundation's annual meeting by Lawrence W. Shearon, left, divisional vice president of Medtronic's Pacing Systems Clinical Research. The Medtronic Fellows selection committee consisted of Paul Citron, vice president, Applied Concepts Research for Medtronic; Celeste Madrid, a minority medical student and two members of the Medical Foundation staff.

1983 Annual Fund exceeds goal by 40%

Contributions to the 1983 Annual Fund Program at the Minnesota Medical Foundation grew by 58 percent over the previous year, according to Tom Patterson, director of Annual Giving Programs.

A total of 4,202 contributors (an increase of 14 percent over the previous year) donated $702,786 (140 percent of goal) through the annual giving program. Approximately 34 percent of the Foundation's annual giving donors were alumni. Their contributions represented 39 percent of the total money donated to the Annual Fund in 1983.

Patterson recognized Dr. Reuben Berman, '32, for his leadership as chairman of the Annual Fund for the past two years. Dr. Harvey O. Beek, '33, is national chairman of the 1983–84 Annual Fund.

Alumni contributions by class to the 1983 Annual Fund are as follows:

Class Year	Number Giving	Dollar Total for Class
1920	2	$ 300
21	4	345
22	2	100
23	11	25,450
24	1	500
25	3	125
26	7	425
27	8	625
28	7	725
29	19	31,250
30	9	550
31	12	3,790
32	25	15,000
33	25	9,965
34	25	3,490
35	19	11,950
36	10	840
37	18	12,900
38	16	1,620
39	26	4,460
40	14	1,345
41	19	1,925
42	14	2,240
43	28	3,450
44	34	4,200
45	37	6,310
46	26	2,130
47	17	1,925
48	13	1,125
49	7	875
50	19	7,990
51	22	6,000
52	29	5,120
53	20	1,700
54	31	2,540
55	24	12,385
56	24	3,380
57	26	3,575
58	27	3,175
59	29	5,750
60	34	5,275
61	24	3,525
62	37	6,825
63	33	2,300
64	35	4,975
65	37	5,200
66	39	5,325
67	59	5,775
68	32	3,930
69	33	3,610
70	36	2,600
71	35	3,725
72	35	4,075
73	34	2,250
74	42	3,625
75	30	4,950
76	40	3,350
77	37	1,950
78	26	1,250
79	19	950
80	23	855
81	16	680
82	6	135
83	1	25

Metabolism study sponsored by 3M

Jeffrey Berg, a fourth-year graduate student, is currently working on the metabolism of drugs by the kidney and liver in a quantitative way. His research is sponsored by a grant of $20,600 from 3M to support biomedical education and research at the University's Medical School.

With the help of a radio isotope enrichment technique that was developed here at the University, Berg is trying to find a way to study metabolism in the whole animal. Using this advanced technique, Berg can study the transportation of organic compounds by the liver in a way no one else can.

Originally from Chicago, Berg received the BS degree in biochemistry from the University of Illinois (Urbana).

Dean announces two special appointments

Dean Neal Gault, Jr. announced two special appointments to the faculty in the Medical School. Dr. Kurt Amplatz has been appointed professor of Radiology and Dr. Jonathan Pederson has been appointed associate professor in Ophthalmology.

Dr. Simon receives Heart Association grant

Dr. Geza Simon, assistant professor of Medicine at the University of Minnesota has received a second year grant-in-aid research award from the American Heart Association, Minnesota Affiliate.

Dr. Simon's project "Unidentified Humoral Agents in Experimental Hypertension" will be conducted at the Veterans Administration Hospital during 1983–84. Dr. Simon is also a staff physician at the Veterans Administration Hospital.

The American Heart Association, Minnesota Affiliate has awarded over $411,000 in fellowships and grants-in-aid to Minnesota researchers during 1983–84. Other awards were presented to individuals doing heart research at the University of Minnesota, Mayo Clinic, University of Minnesota-Duluth and the Hennepin County Medical Center.

UMD's Wallace receives $380,000 from EPA

Dr. Kendall B. Wallace, assistant professor of pharmacology at the UMD School of Medicine, has received $380,000 from the Environmental Protection Agency (EPA) to study "Fish Surrogates for Higher Vertebrates in Risk Assessment."

The three-year study will assess acute toxicity of environmentally significant chemicals in freshwater fish as compared to common laboratory mammals to provide a data base upon which the EPA can determine human health risk assessments on a greatly expanded repository of experimental chemical toxicity data.

Wallace has been a member of the UMD medical school faculty since 1981.

Timely loan repayment crucial for survival of student loan program

Thirty-three medical schools of 114 reporting have failed to meet the five percent delinquency standard for collection of Health Professions Student Loans (HPSL) as of June 30, according to the Association of American Medical Colleges.

Any of those 33 schools failing to meet either the five percent standard or to improve their delinquency rate by 50 percent as of December 31, 1983, will be suspended and ineligible to make loans from new or revolving HPSL funds. Any schools suspended as of December 31 that fail to meet the five percent standard or make a 50 percent improvement by June 30, 1984 will be terminated from the program and must return all HPSL revolving funds to the U.S. Treasury.

Of the 33 schools over five percent, 18 were in the six to ten percent range, nine were in the 11–15 percent range, three were in the 16–20 percent range and three were over 30 percent.

According to Mary Kaye Butler, bursar at the University, the Medical School there reflects a 4.59 percent delinquency rate as of September 30 as regards the number of borrowers. However, in terms of the amount of money borrowed, the delinquency rate increases to 7.82 percent.

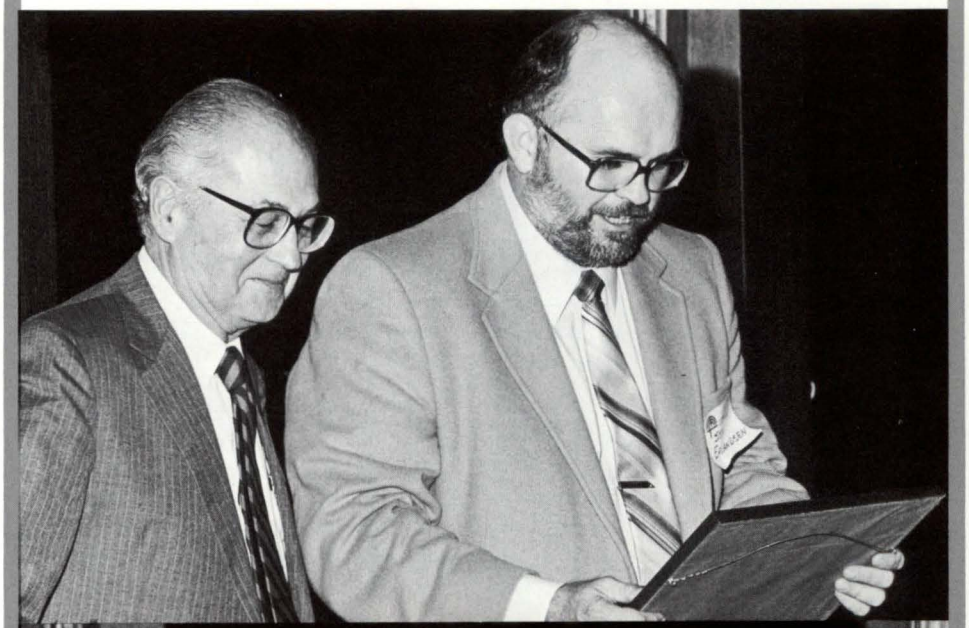
Traditionally, Health and Human Services has accepted the lower of the amount of delinquent principal or the number of delinquent borrowers for its calculation. However, a new rule proposed by HHS, mandates that schools determine delinquency rates based only on the amount of delinquent principal.

"The implementation of that rule would not be good news for medical students," said Butler. Our ability to make loans to new students would be considerably deminished."

Butler said the number of delinquent borrowers represented by the 4.59 percentage figure is 48, and the

(See "Loan" page 6)

Foundation award winners honored at annual meeting



Above — Foundation President Dr. John Coleman, left, presents the 1983 Phase A Distinguished Teaching Award to Stanley L. Erlandsen, Ph.D., professor of Anatomy. Phase A students selected Dr. Erlandsen.

L — The Dr. J. Jacob Kaplan Research Award was presented to Dr. Theodore J. Loftness.

R — Phase B medical students voted Dr. Morris Davidman, right, the recipient of the 1983 Phase B Distinguished Teaching Award which was presented by Dr. Coleman.

Helene Rudnick

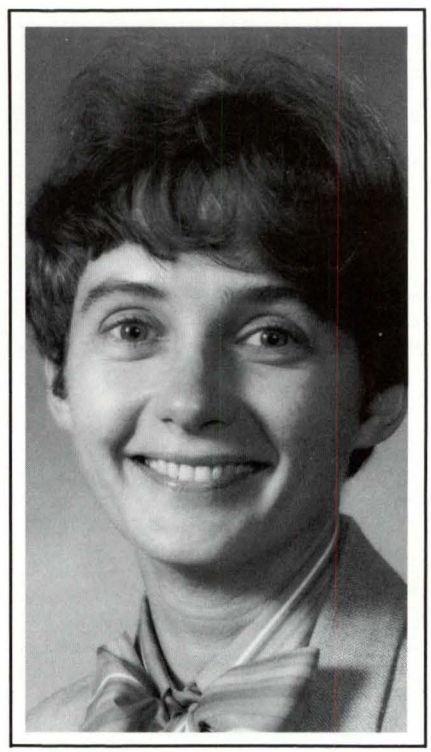
Two join Foundation staff

The Minnesota Medical Foundation has added two new members to its staff according to Eivind Hoff, executive director.

Helene M. Rudnick has been appointed student aid director and Mary Alice Sell has been named prospect research coordinator.

Rudnick comes to the Foundation from the Southern Illinois University School of Medicine where she worked in student aid for four years. She is graduate of Finch College (BA) and the University of Pennsylvania (MA) and received her Ph.D. degree from Southern Illinois.

Sell joined the Foundation in August from the University of Minnesota Comprehensive Epilepsy Program where she was a community program specialist. She is a graduate of Douglas College (BA) and Rutgers University where she received the Master of Library Service degree.



Mary Alice Sell

Loan from page 5

dollars represented by the 7.82 percentage figure is $241,020.

Names of the delinquent borrowers have been turned over to the Board of Regents with a request from Butler's office that they be permanently reassigned to the Department of Health and Human Services for collection action.

At the Minnesota Medical Foundation, where loans to medical students have been provided since 1971, delinquency also presents a problem. The current delinquency rate there, according to Helene Rudnick, director of student aid, is 9.4 percent. The Foundation reports that 70 physicians are not current with their loan accounts, and as of September 30 there was $375,000 of loan principal past due.

Steps are currently underway in the Foudnation to correct the delinquency situation.

"We would like very much to continue to provide financial aid to our medical students," said Eivind Hoff, executive director of the Foundation, "but we must rely on timely payments from past borrowers to maintain this level of service. I am confident that our alumni will do everything they can to help in this regard," said Hoff.

Wannamaker Lectureship report shows $20,922

The Lewis Wannamaker Memorial Lectureship, which was established in the Minnesota Medical Foundation in April, has almost reached its $25,000 goal. According to Tom Patterson, director of Annual Giving, 227 contributors have so far made contributions totaling $20,922.

Dr. Wannamaker had been professor of pediatrics and microbiology for 31 years prior to his death in March.

Dr. Quie named award recipient

Dr. Paul G. Quie, professor of pediatrics, recently received the Maxwell Finland Award from the Infectious Diseases Society of America for outstanding contributions to the understanding and control of infectious diseases.

Dr. Quie is chief of staff of the Hospitals and Clinics and also serves as chairman of the Research Grants Committee of the Minnesota Medical Foundation.

Foundation names new trustees

Four new members were elected to the board of trustees of the Minnesota Medical Foundation at its annual meeting in October.

Elected to four-year terms were Dr. Arnold W. Lindall, president of Immuno Nuclear Corporation, Stillwater; Donald W. McCarthy, chairman, president and chief executive officer of Northern States Power Company; Carl R. Pohlad, president and chief executive officer of Bank Shares Inc. and F & M Marquette National Bank and James R. Spicola, executive vice president and director of Cargill, Inc.

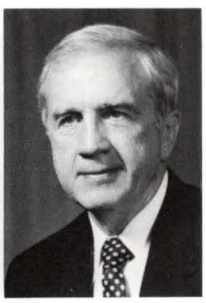
Judge Stephen Maxwell, St. Paul; and Drs. Edward Segal and Donn Mosser were re-elected.

Also serving as new ex-officio trustees are Dr. Jan Adams, president of the Medical Alumni Society and Lauris Krenik, chairman of the Board of Regents.

Thank you from MMF

Mary Dempsey, professor, Department of Biochemistry, received a certificate of appreciation recently from MMF Executive Director Eivind Hoff for her service on the Foundation's Research Grants Committee since 1978.

Lindall



Pohlad

McCarthy

Spicola

Dr. Manning named Emergency director

Dr. Carol Ann Manning, former director of the emergency room Walk-In Clinic at Hennepin County Medical Center, has been named director of emergency services at University of Minnesota Hospitals.

Manning, a native of Davenport, Iowa, has also worked in emergency rooms of several other Twin Cities' facilities, including Fairview Southdale, United, Methodist and Abbott-Northwestern hospitals and North Memorial Medical Center. In addition, she served for several months as a staff doctor in the emergency room of a pediatrics ward in the largest Kampuchean refugee camp in Thailand.

Manning received her medical degree from Iowa in 1977. She completed her undergraduate studies at Brandeis University in Massachusetts in 1973, receiving a bachelor's degree in biology.

As director of University of Minnesota Hospitals' emergency room, Manning supervises 12 senior residents from the department of internal medicine. She replaces Dr. Christina Shih who resigned to accept a position at the University of California, San Francisco.

Manning also holds an academic position as assistant professor in the department of medicine in the Medical School.

Salk lectures

Dr. Jonas Salk, developer of the first polio vaccine, delivered the Max Winter-Minnesota Vikings lecture at the University November 7. He told a group of 300 health professionals that future vaccines will be based on killed viruses instead of live viruses, and that people will be immunized against dozens of diseases with a single shot. Salk is the founder of the Salk Institute for Biological Studies in San Diego. The Salk anti-polio vaccine was licensed in 1955 and was later replaced by the Sabin live-virus vaccine in 1963.

A Bulletin Feature

HISTORIAN OFFERS TALE OF LONG, HARD STRUGGLE FOR FEMALE PHYSICIANS

WOMEN IN MEDICINE:

By Angelo Gentile
Senior Information Representative-UMD

Editor's Note: The main source for this article is Regina Morantz, an historian, author and faculty member at the University of Kansas. Most of her comments and viewpoints expressed in the article were taken from two speeches she gave during Women's History Week last spring at the University of Minnesota's Duluth campus as well as statements she made at a news conference there and a brief interview.

Medicine in the 1800s was in a state of flux. The discovery of anesthesia and other technological developments; the lack of licensing requirements for doctors; and a general health reform movement combined for institutional chaos in the medical profession. At the same time, significant changes were taking place in the social definition of men's and women's roles in the U.S.

This combination of chaos and social change actually served to make it easier for women to enter the medical profession in the 19th century, so says Regina Morantz.

She should know. Morantz has done extensive research on the history of women in medicine as an historian, author and faculty member at the University of Kansas. She has published numerous articles on the subject and has written a book: "In Her Own Words: Oral Histories of Women Physicians."

"Before anesthesia, the necessity of inflicting pain on patients constituted an integral part of the self image and ideology of physicians," Morantz explains. "Empathy was to be balanced with . . . manly detachment . . . which women, it was argued, could not achieve. This was often used as an objection to women in medicine."

But the use of ether and chloroform weakened this argument, Morantz claims, and "feminized medicine by undermining more generally the heroic image of the physician."

Other influences, such as not requiring doctors to have licenses and a health reform movement created what Morantz calls "a temporary fluidity" which "allowed women who wished to achieve professional status to do so before definitions of professionalism crystallized once

more . . . These were conditions which made the medical profession vulnerable to the entrance of women."

Changes taking place

In addition to institutional chaos, changes were taking place in men's and women's social roles. Industrialization brought changes in the organization of work and family life. Men became separated from home and domestic responsibilities. An elaborate ideology emerged based on separate spheres for men and women — men being considered "public" and women "private."

Women, by making a home a model for social interaction, played an unprecedented part in what became the reformist critique of industrializing America, Morantz says. "Many middle class women who took their moral and social role seriously, understood that to purify society, some women might indeed have to enter it," explains Morantz.

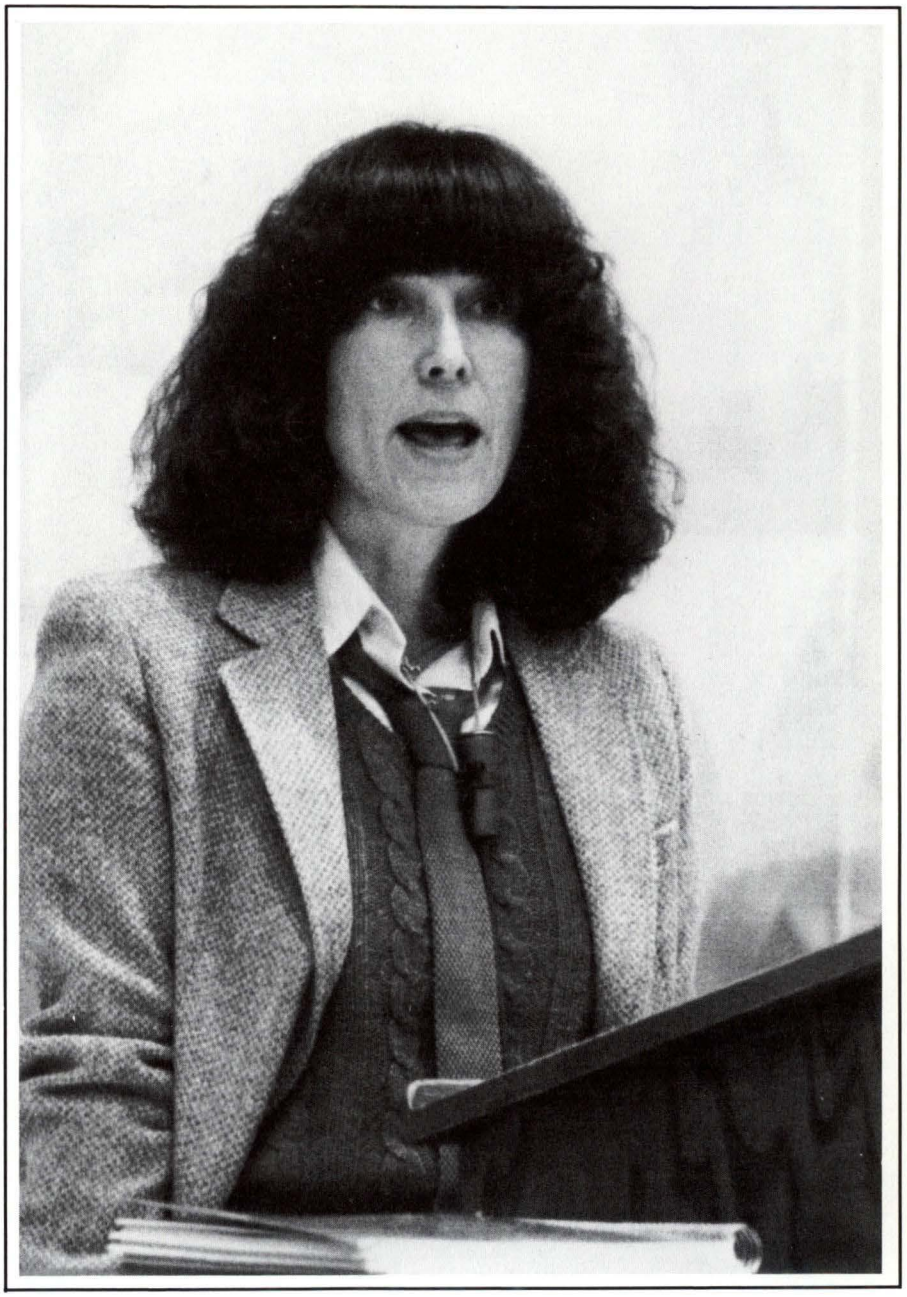
One of them finally did. In 1848, amid a disgruntled faculty and an agitated dean of students, Elizabeth Blackwell became this country's first female medical student, enrolling at Geneva Medical College, a small school in upstate New York.

In the decades following Blackwell's graduation from Geneva, hundreds of women sought medical training "armed with the conviction that medical science needed the leaven of tender humanity women represent," Morantz says.

The rationale at the time was that "Men had taken a curative approach and had sorely neglected (the concept of) prevention" and so women medical students adopted prevention "as their special province," according to Morantz.

By 1880, a handful of medical schools accepted women on a regular basis, but still dissatisfied with the progress of medical coeducation, female pioneers founded five regular and several sectarian women's medical colleges, complete with hospitals providing clinical training for female graduates.

By the end of the 19th century, according to Morantz, female physicians numbered between four and five percent of the profession, a figure that remained fairly stable until the 1960s. Currently, about 25 percent of the medical students in the U.S. are female.



Morantz

No more female fanfare

During the last third of the 19th century, most state and local medical societies quietly admitted women without fanfare. More than 75 percent of women doctors were regular physicians, a reflection of the decline of sectarian medicine and an illustration of the movement in the medical profession toward standardization.

In the 1890s, women's medical societies were founded in many states, and in 1915, the American Medical Women's Association was established.

But something happened. In the early part of the 20th century, the number of women in medical schools declined from 1,280 to 992 (between 1902 and 1926), accord-

ing to Morantz. After peaking at 6 percent of the national total in 1910, the percentages steadily shrank, and only in 1950 did women physicians again reach 6 percent. It wasn't until the 1970's that dramatic alterations in the numbers of women in medical schools again occurred.

What happened? Morantz points to two reasons: changes in the organization of the medical profession and the delivery of medical care along with shifts in cultural beliefs regarding women's roles.

"The modern medical profession grew to maturity in the first three decades of the 20th century," Morantz says. "Issues of professionalization took the center stage, as the roles of professional associations, state licensing agencies, and colleges and universities gradually emerged into their modern form."

The first priority was raising standards of medical education. In 1910, a study on medical education by Abraham Flexner stated that medical schools needed to be placed under control of universities. Flexner's study stated that preliminary education requirements needed to be enforced, curricula needed to be lengthened, laboratory facilities needed to be improved and these schools should affiliate with hospitals providing clinical training.

As a result of this professional reform, 92 schools merged or closed their doors between 1904 and 1915. Meanwhile, the better schools improved their facilities through the generous help of new philanthropic foundations which spent millions of dollars between 1910 and 1930 on medical education and research, Morantz explains.

Demise of "prevention ideology"

With the advent of coeducation, most of the women's medical schools closed. Along with the closings came the eventual demise of women's "prevention ideology," a concept, Morantz says, "which was no longer suited to the problems of the new century."

With coeducation, the process of assimilation divided women physicians, those believing that women should act differently than their male counterparts (separatists) and those who thought they should assimilate themselves.

Regina Morantz currently is a faculty member at the University of Kansas and is widely regarded as an outstanding historian and dynamic lecturer who has spoken at universities around the U.S. and Canada. She earned her Ph.D. from Columbia University in 1971 and has been the recipient of numerous honors and awards including a Charles Warren Fellowship at Harvard University for this year. She has published many articles on women and medicine, health reform and sexuality, in addition to her book.

"This is a conflict that exists today," Morantz points out. "Women in medical schools don't know if they should behave in a way that has already been defined by doctors, that is, behaving like men, or whether they should be different."

Morantz cites a view expressed by a pediatric resident at Johns Hopkins Hospital back in 1940 as an example of an assimilationist:

"I am strongly opposed to any organization's or individual's attitude which sets women apart from men . . . in the early days of women in medicine they no doubt had to band together, but now in most sections of the country the quicker the woman physician can forget any feeling that she is in a class apart from her male colleagues, the happier she will be . . ."

Medical care was clearly changing too. As Morantz points out, "Treatment had become fragmented . . . the general practitioner became an endangered species, care shifted from the home to the hospital and nurses and social workers took on the 19th century physicians' supportive and teaching role."

She adds: "There is no question that the expansion of nursing undercut one of the most powerful 19th century arguments for the existence of women physicians," the concept of prevention or holistic health care.

Social factors at work

So much for changes in the medical profession. Morantz also thinks social factors were at work as well in the 20th century. "The image of woman-as-mother gradually gave way to the image of woman-as-mate . . . more positive attitudes (emerged) toward pleasure, individual self-fulfillment, sexuality . . . It is likely that medicine, as it took on its modern face, appeared too strenuous, too inflexible."

Morantz also blames a loss of public feminism. "Until the 1960s when a revitalized feminist movement focused attention on the interaction between women's public and private lives, medical women generally engaged in intimate and solitary struggles." In addition, institutional discrimination should not be overlooked as a reason for the decline in the number of women doctors during this period, Morantz notes. However, this institutional discrimination, Morantz believes, was "the most visible element of a more distressing kind of exclusion. Women fell victim to the social dictates of a culture still characterized by extreme sex stereotyping. The vigorous, detached, almost god-like figure of the 20th century physician kept all but the most determined women from challenging cultural barriers."

Women did finally regain positions as medical students and physicians in full force in the 1960s with the rebirth of feminism which "convinced large numbers of women that professional careers need not conflict with marriage, motherhood, and fulfillment," Morantz says.

Increase growth

While women remained only 9 percent of medical school applicants in the 1960s, that number had burgeoned to nearly 30 percent by the end of the 1970s. Morantz predicts that within the next decade women will make up between 20 and 35 percent of the medical profession.

With this increase have come significant gains. For the first time,

women physicians are demanding power in setting health care policy, in making decisions pertaining to medical practice and in determining how medicine is taught.

Morantz adds that they are bringing new attitudes and styles to clinical practices. "Women are socialized to be more emotional. But for example, doctors aren't allowed to cry over a patient, for instance, who has cancer. They are supposed to keep their distance. But women are questioning these models of what doctors are supposed to be like."

In addition, women doctors are becoming more accepted as patient prejudices decline, Morantz notes. Does this mean a happy ending? Morantz says it's not that cut and dried, that the medical profession is constantly changing, but that for women, "things are getting better. Attitudes are changing and are a lot different than they were 30 to 40 years ago."

"Commentary" from page 1

the percentage of women physicians in the community — 19.3% — followed by Boston, Los Angeles, and San Francisco. And in 1982, when the national rate was 30.8% freshman women in medical school, 38% of the freshman class at the University of Minnesota Medical School-Minneapolis were female. Just last year, Duluth had 50% women in their freshman class of 48 students.

Much more important than the numbers game is the effect of the increasing number of women in the medical field. In 1968, the rate of women candidates and accepted women medical students began to grow, and in 1973 the first Women in Medicine (WIM) organization at the University of Minnesota was begun. WIM not only functioned as a support group for women students, but also worked actively to create awareness and to change the subtle and not so subtle sexual harassment taken for granted in the classroom and on the ward. Lecturers who were insensitive and used slides or jokes derogatory to women were sent letters and spoken to by representatives of the women's group. Departmental chairmen were alerted to the concerns of women regarding questionable practices, and the first formal notice of the policy of the medical school regarding the need to maintain equal access to all patients and training situations for both male and female students was sent to all faculty. Today there are few classroom incidents to report although they still occur on the wards. When the Dean's Office receives a complaint, it is followed up, often by the chief of the particular service involved.

Hopefully, we are changing the face of medicine from the point of view both of women as receivers of health care and of women as givers of health care. Within a few years, one physician out of four will be a woman, and we will have reached the critical mass stage where women can become an active force in change. In obstetrics and gynecology, as women approach caring for women from a woman's point of view, menstruation, pregnancy, and menopause are not viewed as disease entities but rather as part of the normal developmental life sequence. The rates of radical mastectomies and hysterectomies are slowly decreasing. Premenstrual syndrome is being seriously investigated. Hot flashes have been carefully monitored, and proved to have a physiological and not psychological basis. In pediatrics, the needs of the mother and father are viewed as critical in the care of the child, and new data is being obtained on the assistance one must provide for more effective parenting of the newborn. In family practice, there is a new focus on the unique requirements of the single parent family. And women physicians are demanding a more humane and reasonable work schedule which is efficient and of benefit to both sexes.

WOMEN IN MEDICINE

However, there is more to be done. The life of a woman resident is still difficult on many services; a resident's pregnancy is seen as a rank betrayal; and, the male cliques still withhold power and information from female colleagues. Women's medical needs are still underserved. Financing for women's medical education is still harder to come by. Women are still shamefully under-represented on faculties.

But change is in the wind. Willy-nilly, the profession is responding, and it is both an exciting and challenging time to be entering the field. Women physicians can honestly step forth proudly, shoulders back, and feel in their bones that "tomorrow belongs to us."

Caucus member Pearl Rosenberg holds a Ph.D. in clinical psychology and psychotherapy from Harvard University, was awarded the 1983 "Feminist of the Year" award from Chrysalis, and is currently Assistant Dean of the University of Minnesota Medical School in Minneapolis.

Support group here for female students

At the turn of this century the city of Minneapolis was listed as having one of the highest percentages (18) of women in medicine in this country. Obviously, a lot has changed since then, from percentages of almost zero to the Medical School's current female enrollment of 39 percent.

"That didn't happen without hard work and courage," said Assistant Medical School Dean Pearl P. Rosenberg. Seven women decided in 1973 that a place was needed where they could talk about medicine and that a sort-of support group would be helpful. Connie Ganapes and Annette Hansen, both first-year students then, and now medical alumni (Class of '77) were two of the organizers.

Dr. Rosenberg recalled that "Connie had been working with a male faculty member as a researcher. When he was invited to present a paper about his research, he asked Connie to talk about their work. She did so enthusiastically. Following the presentation," said Dr. Rosenberg, "he got all the strokes and she received no credit. Connie was angry."

The group began, interestingly, with a grant of $1,000 given by the faculty member for whom Connie had worked as a researcher.

Since that time ten years ago, Minnesota has had one of the most active and most professional women's groups for students in the country, according to Rosenberg. Each year since 1977, when four women students first attended a leadership workshop in development sponsored by the Professional Resources Research Center of the American Womens Association, women medical students from the U of M have hosted a national symposium at the University. The one scheduled for July 1984 will focus on new research in women's health.

Increasing the awareness of women medical students has been the primary area of interest for the local group. Like most other medical schools, the major complaint from women students has been that male faculty members were not sensitive to the concerns of women. "Women were told that they had no sense of humor or that they were too sensitive or that they shouldn't be in medical school at all," said Rosenberg. "And, prior to 1972, women just wouldn't speak up."

Following the formation of the women's support group, female students would get together to decide how to handle what they considered inappropriate references to sexual organs, sexist slides used in lectures and male locker room talk.

"Most often, the group would take a positive and constructive posture in a formal letter. Some faculty members assumed a defensive posture, but they didn't do it again, and that's all we wanted," said Rosenberg.

"All along Dean Gault and Sully (Associate Dean Albert Sullivan) were very supportive — very concerned that faculty should be more aware of the needs of women medical students," said Dr. Rosenberg.

As for today's woman medical student, "It's important to know there is a group here to be supportive in case of need," said Rosenberg. "Minnesotans should be proud that they've been in the forefront of the women's movement in medicine, and I believe we will continue to work together to keep the University of Minnesota Medical School among the top in the country in this regard." — **DN**

Original Foundation scholarship helped her "almost squeak through"

She doesn't know who recommended her, but she was and still is very grateful. It wasn't much by today's standards, but in 1949 this farm girl from Clayton, Wisconsin was, with some resourcefulness, able to ". . . almost squeak through a whole year of medical school with it."

The student was Mildred Schaffer Hanson, Class of '51, and she was the first woman to receive a scholarship from the Minnesota Medical Foundation. In fact, she was one of five medical students to receive the original $500 scholarships awarded by the Foundation.

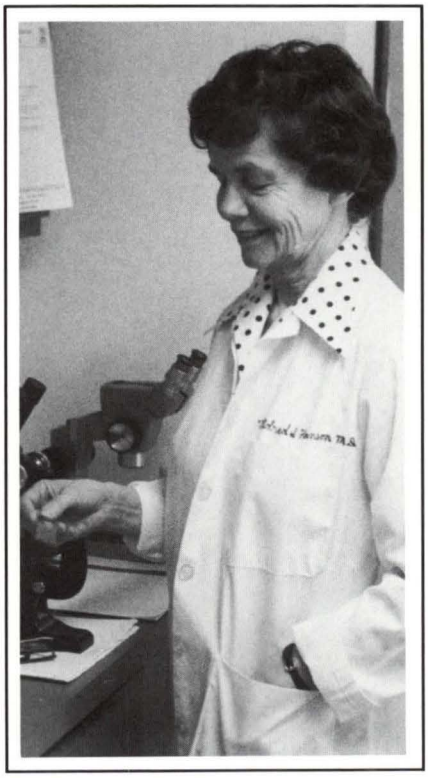
"At that time I was living in a group of co-op houses owned by the University," said Dr. Hanson. I worked as a student counselor to earn my room and board. My tuition was $187 per quarter."

Dr. Hanson's memory of those days is quite clear. She recalls how difficult it was to make ends meet, and has taken steps to do her part to minimize similiar financial problems for today's medical students. In addition to being a faithful and generous annual contributor to the Medical Foundation's student aid program, Dr. Hanson has established a scholarship fund at her hometown high school for promising students who wish to go into the medical field.

Dr. Hanson currently practices obstetrics and gynecology in Minneapolis. Following graduation from Medical School she interned at Minneapolis General Hospital and was in general practice in the Twin Cities and later in Two Harbors, MN. In 1956 she returned to the Twin Cities for her OB-GYN residency at Hennepin County Medical Center (Minneapolis General, then).

Dr. Hanson is a staunch believer in family planning, and is medical director of Minnesota Family Planning. She has written the organization's policy manual and formal standards of medical practice, and conducts clinical research for Planned Parenthood on different contraceptive methods.

"Our biggest societal problem today, and one that continues to become even bigger, is world population and food production and supply," said Dr. Hanson. "Unfortunately our family planning needs as a world people are not being met politically, and as a result, there have been tremendous medical and health implications."



Dr. Mildren Hanson remembers how that $500 scholarship helped when she was a student in 1949. As an annual contributor to MMF, she is returning the favor for today's medical students.

The future of medicine will depend on how physicians handle the ethical problems that confront them in their profession, Dr. Hanson believes. "People have got to be better educated about the future and its problems," said Hanson. "AMA could and should be doing more in the area of public education and addressing the subject of ethics of medical care more directly."

Dr. Hanson believes that the growth of women in medicine is long overdue. "Women physicians, despite their home and family commitments, do an excellent job and compare favorably to their male counterparts in the profession," she said. "Women in medicine have allowed women's concerns to be heard. That's one of the major reasons there have been changes in the practice of performing mastectomies. Women physicians pushed and got passed legislation that gave women the right for alternative forms of treatment of breast cancer," said Dr. Hanson.

The role of women in society will continue to change as it has during the last 40 years, Dr. Hanson believes. "And, these very sizeable societal changes will take place because women can control their own reproduction which allows them to be in control of their own lives," said Hanson. — **DN.**

She wants to be a doc even though she wore brown socks

WOMEN IN MEDICINE

The theme is a recurring one: women, trying to make their way in and into medicine without emotional or financial support, without role models, and without the fair shakes that seem often to have been reserved only for the male of the species.

Times are changing, in most cases for the better, according to women physicians and women medical students. But, even with general improvement in the national condition, life for one of the University of Minnesota Medical School's first-year students has been a personal struggle. And it's not over yet.

June LaValleur Randall is one of 384 women medical students enrolled at the University of Minnesota. A 42-year-old mother of three children, June grew up in a farm town two miles north of Ashby, MN. "You could always tell the city kids in Ashby (population 415) because they wore white socks, while us kids from the country wore brown ones," said June.

She recalls, "It was a Protestant, White, Scandinavian community. I didn't even know a Catholic till I was 16. We were so secluded."

Like other young women, June's female role models were teachers, store clerks and homemakers. "I was raised to be an individual, which meant the goal was to get married, and I could choose to whom," June said.

Needed something more

Following the death of her father, June moved to the city (Ashby) with her mother, where she completed high school. She knew she needed "something else" besides marriage in case her husband died, so she enrolled in and completed a laboratory technology program at vocational school. Two weeks following her graduation she achieved her goal: she was married.

For 12 years, June worked as a lab technician in various clinics in the Ashby area. During that time three children were added to the Randall family.

"It wasn't until after we had our third child that I realized I needed and wanted to do more than be a lab technician," said June. "I wasn't content being a wife and mother only."

Encouraged by the local doctor to look into becoming a physician's assistant, June entered a program at St. Cloud State University in 1973. Then a resident of Osakis, MN, where the Randall's moved in 1962 when Mr. Randall purchased a service station, June had to travel 120 miles round trip daily for three years to attend classes.

As a physician's assistant, June worked for Dr. Arlys Solien, a general surgeon. "He was the first to convince me that I could become a physician. And, I needed lots of convincing," said June.

It was in the spring of 1981 when the clinic hired another doctor and June was terminated. "I think that was the real turning point," said June. So, at the age of 40, June LaValleur Randall returned to St. Cloud State University to complete her undergraduate program — to pick up her remaining science courses. "It was worth the risk," June said.

"I knew I wanted to be a doctor,"

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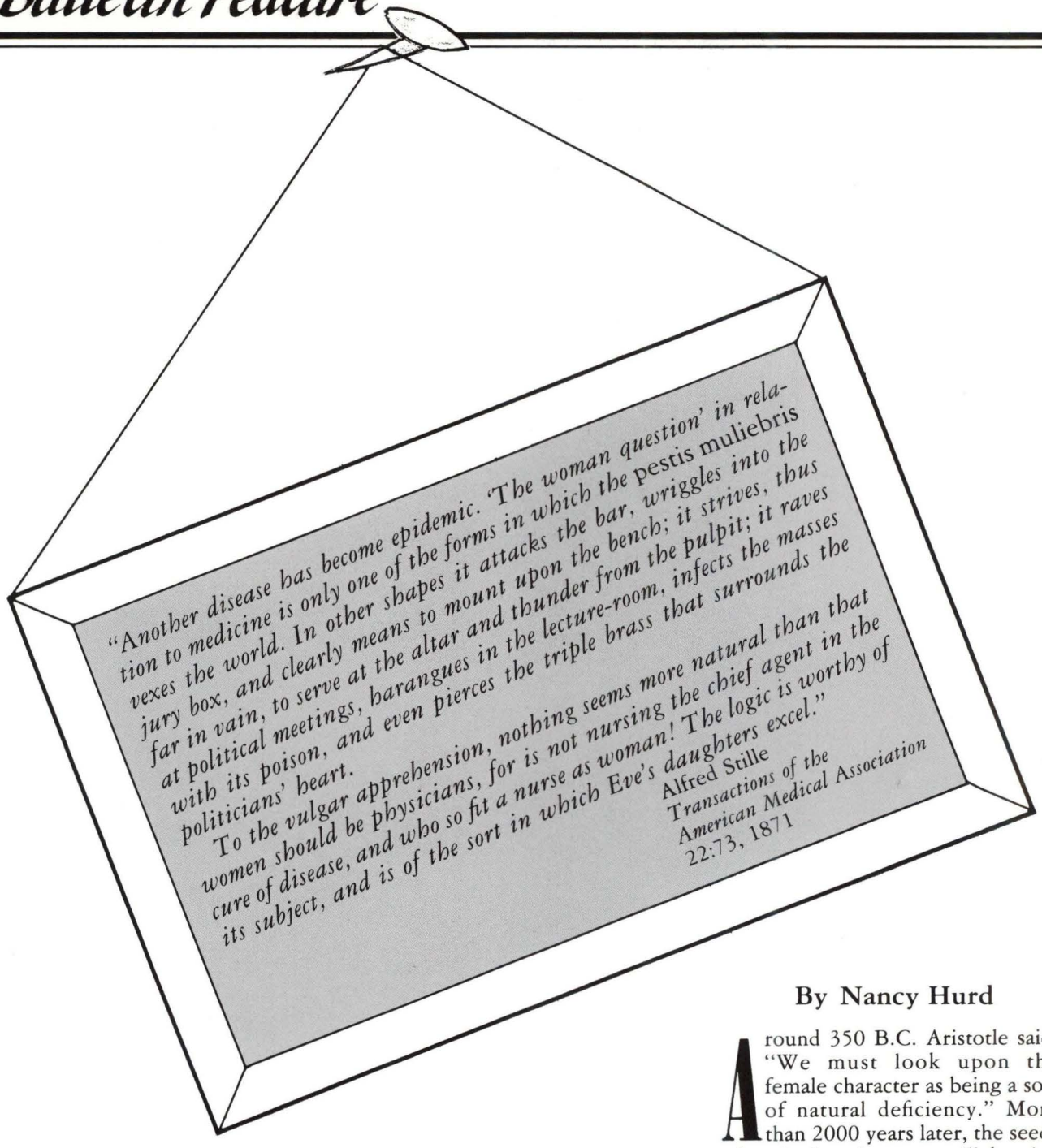
June LaValleur Randall

A Bulletin Feature



By Nancy Hurd

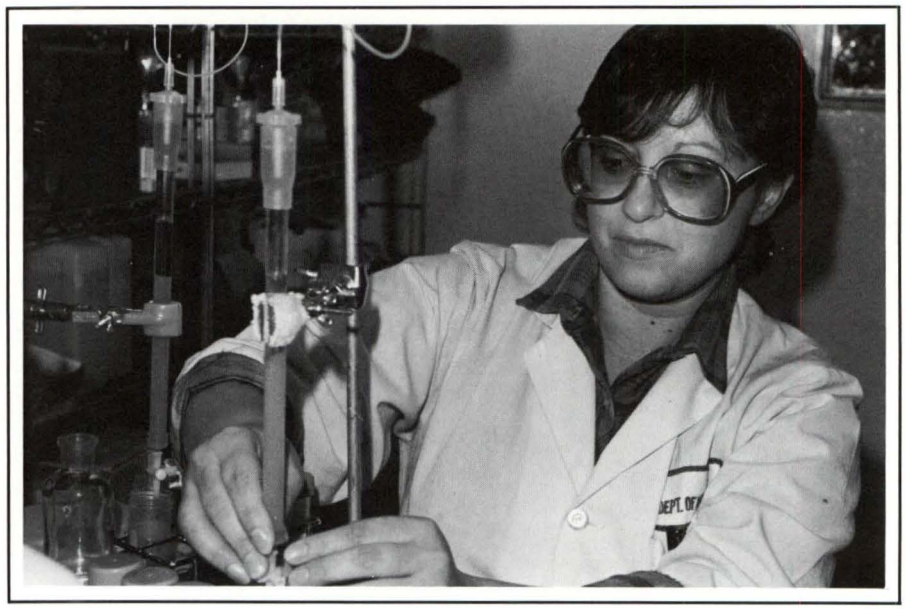
Around 350 B.C. Aristotle said, "We must look upon the female character as being a sort of natural deficiency." More than 2000 years later, the seeds of such thought were still bearing fruit. Even today, in the 1980s, expressions of negative sentiment toward the professional abilities of women may be found, although it is not as popular to admit them publicly. How have such attitudes influenced the lives of six female physicians in one of the more traditional bastions of male dominance, academic medicine? However slowly and imperfectly, change is carving new faces in the granite-like institution.

Ranging in age from 48 years to 28 years, they come from Argentina; New York; Ortonville, Minnesota; St. Paul, Minnesota; West Virginia, and Massachusetts, modern members of that elite group, the *pestis muliebris,* the "feminine plague." Although each has specialized in internal medicine, their subspecialty areas of expertise, their experiences, and many of their opinions are as diverse as their origins.

Representing less than 7 percent of the approximately 90-member faculty of the Department of Internal Medicine, these women have, nonetheless, not found themselves taking comfort in the presence of each other. In fact, most of them do not know each other at all. "I had to learn to function in a male dominated environment, so I guess that a long time ago I stopped looking for the other women," said Dr. Nancy Meryhew, assistant professor of medicine and member of the rheumatology, immunology, allergy subspecialty section. Dr. Claire Pomeroy, assistant professor and general internal medicine specialist, explained, "I know them as colleagues, not friends. I don't feel any special tie to the other women just because they're women. I find that I have a lot more in common with other male physicians who are doing the types of things in which I'm interested."

Although they may not need other women now, several would have liked to have been exposed to more women during their medical educations. Mentors play an important role in the lives of medical students who must choose a residency, and residents who are deciding upon careers in subspecialties in private practice or academic medicine. Many of the women found mentors among the generally male faculties, but still felt the lack of female role models.

"Dr. Tom Stillman, a rheumatologist at the Hennepin County Medical Center, served as a mentor for Dr. Meryhew during her clinical residency where, she recalled, he had played a vital role in her decision to pursue rheumatology. "He loved rheumatology and still does. He was a superb teacher and clinician. He definitely made a difference," said Meryhew. "It wasn't until the last year of my fellowship that I thought about academic medicine," she added, "and, again, I had a very strong mentor in Denver who encouraged me to consider it. I think one of the most difficult things for young women going into medicine as a whole, or into internal medicine, or into academic medicine is that there were never any female role models. It wasn't that you absolutely had to have a role model, it was just that when you start thinking about different career options, you have a tendency to think about people you know in those careers. It's natural that if there's someone that you like and respect as a physician, you might think more about what he or she is doing. And there were no female role models as I went through medical school, none as I went through my internship, my residency, or my fellowships," said Meryhew, a 1974 graduate of the University of Minnesota Medical School. "The younger women going through medical school now have some female models, and not only do they have some female role models in academic medicine, they have models with very diverse personalities. That gives them a chance to see that it can be done, and how different people adapted to different situations. The lack of role models was a real problem for us, but I think that is changing. That's going to be very positive for the women going through now," Meryhew said.



Dr. Meryhew purifying monoclonal antibodies by using column chromatography.

Lack of role models

Dr. Pomeroy, who plans to pursue a fellowship next year, suggested that the lack of role models has influenced women's decisions to enter academic medicine, as well as their advancement within academia. "You really need the support of mentors and role models to advance. I don't really call that discrimination, but it is the lack of a support system, and it has the same ultimate effect. I think that the situation will improve as more women get into medicine and become role models," she said.

Improvement and change are familiar themes in medicine, as well as recurrent themes in the experiences of these six women. One who has seen a number of changes is Dr. Silvia Azar, associate professor and renal disease subspecialist. Dr. Azar graduated from medical school at the National University of Cordova in Argentina in 1959. From a typical

class of 40-60 percent women and a national attitude that favored women in medicine, she and her husband, also a physician, came to the United States, first to Tennessee, then to Minnesota. "Probably my peers, those of my age group, see women from a different angle than younger doctors," said Azar, who filed a sex discrimination suit against the University in 1978. "I have noticed that the younger male doctors treat the females as equals. I have seen it there, but that is not what you see between physicians of my age. Of course, the younger physicians are at the same level. When competition starts I don't know how they are going to be," she said. Dr. Azar's suit was settled out of court in 1981.

"The important thing to remember is that there are more differences between individuals than between men and women," said Dr. Pomeroy. "There are some differences in the ways people react to you and what society expects of you, but those things are external influences rather than inherent in the people themselves," she said.

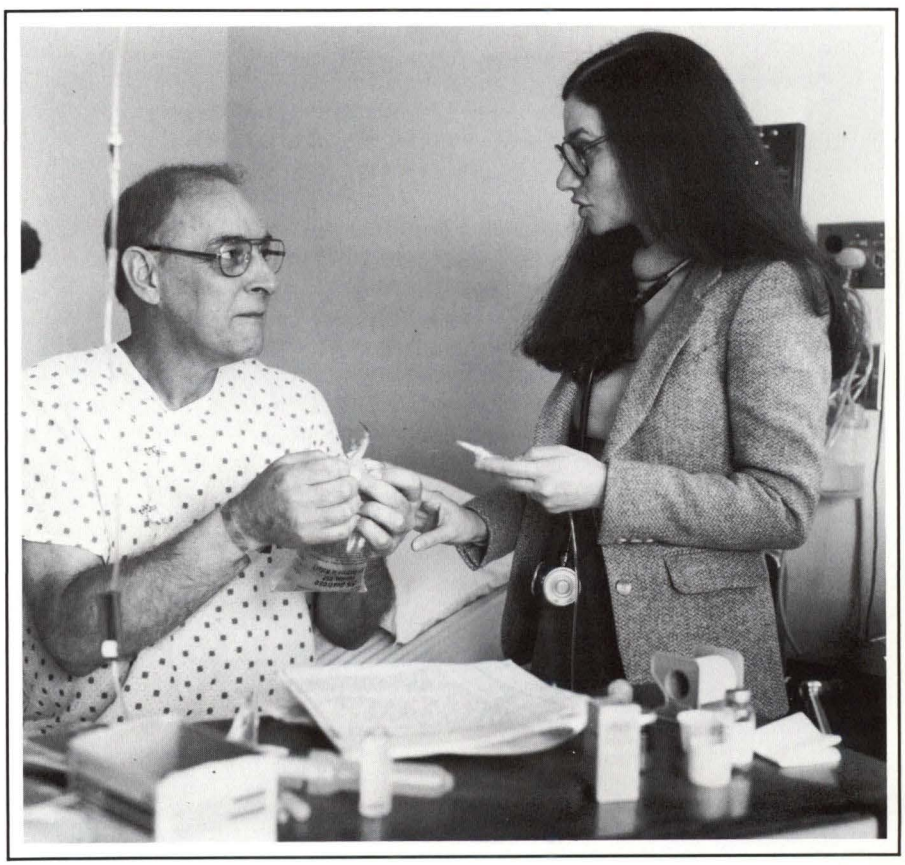
"Frequently I get positive feedback from my patients," said Dr. Linda Hedemark, assistant professor of medicine and pulmonary medicine subspecialist. "Occasionally, it's from a woman who is glad to have a woman doctor. Many times it's from someone who is just glad that someone is finally sitting down and explaining things to them, or spending time with them. And I've had people referred to me specifically because I am a woman — much more positive feedback than negative. However," she recalled, "during my training, I experienced people not wanting to see a woman doctor more often than I do now. It seems to be changing," said Hedemark.

Most recent addition

The most recent female addition to the department of medicine faculty, Dr. Sharon Luikart, assistant professor and member of the oncology section, concurred, "I still remember going to examine patients and having them say, 'Oh, but I've never been examined by a "lady doctor".' I would ask them if they really thought that that was going to bother them a lot, and usually at that point they wouldn't admit it, so I would go ahead." "When I was in medical school," explained Luikart, a 1975 graduate of Duke University Medical Center, "women constituted less than 10 percent of the house staff group or the student group. As that percentage has increased, people have become more accustomed to having female physicians."

Dr. Clara Bloomfield, professor of medicine and oncology subspecialist, was in medical school in the sixties. "Now that people are referred to me as one of the world's experts, I never see that shock," said Bloomfield. "People are coming to see me because they seek a physician with my expertise. So, they couldn't care if I were neuter or anything else. That really makes all the difference. In general, if people are interested in me just because I am a woman, I won't see them," added Bloomfield, who feels very strongly about her role as a researcher and clinician. "I would not say that what I am providing patients with is primarily tender loving care. I give patients mostly intensive therapy that is aimed toward cure. In other words, it is not at all the woman serving as the mothering, tender, care-giving sort of thing. And I, as a physician, do not use the role of the doctor in a traditional mothering role. In our section, for example, there are male physicians who are much more mother figures. Of all the people in leukemia, I am by far the least thought of as being the supportive, warm type. A lot of women do practice medicine that way, but I do not — that's a function of personality."

That personality is not, Bloomfield believes, a product of her survival in the medical arena,



Dr. Bloomfield, right, explains to patient Bernard Healey his new medication procedure for which he will be responsible at home.

but rather, her natural tendency. "I remember interviewing an intern candidate here," she said. "At the end of it, he got up and said, 'Dr. Bloomfield, can I tell you something?' And I said, 'Sure, what?' And he said, 'You are not the most aggressive woman I have ever met. You are the most aggressive person that I have ever met.'"

For women who are not naturally aggressive, other qualities seem to be useful to a career in medicine. "I think [women in medicine] need to be very good," said Dr. Hedemark, "but I don't think that it needs to be expressed in aggression."

"You have to have some toughness," added Dr. Luikart. "In the earlier days, at all levels, from the patients being uncomfortable, to nursing staff being uncomfortable, to some of the other doctors being uncomfortable, you could easily be hurt. If the female doctors had problems with the nursing staff, generally, the other faculty members and doctors who were male and had never had any problems, would assume that it was the female physician's fault, or not a real problem. Usually, if there are still people who have problems accepting [female physicians]," said Luikart, "I can talk to them and come to some understanding. I think in the past I tended to ignore it, but now I don't think that is useful, because then things don't change."

"For a woman to get beyond society's expectations, to do well enough in school and in the sciences, to get into medical school, and to be determined enough to go through it all, she has to be an aggressive person," said Dr. Pomeroy. "I don't think that aggression is a necessary trait to being a good doctor, but I do think it's an asset. "That doesn't mean that an aggressive person cannot also be empathetic," she said.

"I certainly equated aggression with success, and with success in academics as I went through my training," said Dr. Meryhew. "I don't know that that is as true now as it used to be. I think it's changing. Twenty years ago women may have had to be more aggressive. They were judged by male standards, against male peers, and aggression is a male characteristic. I think, however, that the young women going through medical school now are much more self-assured than most of us were. They're much more comfortable in who they are and in being women in medicine — they see no difference between being a male or a female in medicine."

Dr. Hedemark in bronchoscopy room where she conducts fluoroscopy for lung biopsies.

At the edge

"When I went through medical school," recalled Dr. Meryhew, "I was right at the edge between the classes that had very few female students and the larger classes that were incorporating more women. There were about 10 percent women in my class, but within one to two years of my graduation 25 to 30 percent of the entering students were women. In a class of 10 percent women, though, you're always noticed. Sometimes the lack of anonymity was a positive thing, sometimes it was a negative thing."

A 1975 graduate of the University of Minnesota Medical School, Dr. Hedemark commented, "There were some overt differences in the way we were treated. I didn't notice them on a daily basis or all that frequently. But, there were always a few times when a professor would be in the middle of a lecture on anatomy, for example and classically, and it did happen, show a slide of a nude woman and make some remark. Otherwise, I didn't feel a lot of discrimination."

"At the time that I went to medical school," said Dr. Pomeroy, a 1979 graduate of the University of Michigan Medical School, "a lot of men thought that I was an exception, that I was not typical of what women in our society are. I think that's a more subtle kind of discrimination than women who went to medical school 20 years ago felt."

Some subtle types of discrimination occur long before medical school, pointed out Dr. Meryhew. "Women may be hindered in the sense that not every woman is encouraged as she goes through her early education to make the most of her abilities. All during high school,

for example, I was told that I should be a nurse by school counselors."

Dr. Bloomfield was given the opposite advice, not by a school counselor, but by her mother. "When I was nine years old," said Bloomfield, "I came home from school one day and I told my mother I had decided what I was going to be. She said, 'Isn't that nice, dear, what are you going to be?' And I said, 'I'm going to be a nurse.' She said, 'You're going to be a nurse? You might as well be a doctor.' I said, 'fine.' That was it. Now why I would have been interested in medicine at all, I don't know. No one in my family is medically related."

Dr. Hedemark, on the other hand, came from a family where medical role models included her father, great grandfather, two uncles, and "a bunch of others." However, Dr. Hedemark's father, a surgeon and general practitioner in a small Minnesota town, encouraged his children not to go into medicine. "I think he saw medicine as a very difficult lifestyle," said Hedemark, who also married a physician, "and in particular, for him, it was. But I'm sure I picked up the interest from him."

Attitudes are often more difficult to change than actions. "There is a woman that I know," said Dr. Luikart, "who asked someone who is a leading specialist in his field to write a letter for her when she was applying for full professorship. She told me that he wrote in his letter that she had accomplished the most of any woman in her field. Of course, she really resented that, having accomplished more than most of the men in her field as well. Dr. Luikart said that she was not aware of any major problems of discrimination, but that women still have a distance to travel in the political arena.

Dr. Pomeroy concurred: "People in political positions like in the AMA, leaders in the medical community, those running academic institutions — if you look at organized groups of physicians they are run by men, not by women. That's a fact. You can't ignore it, and you have to explain it somehow."

"Trickle up"

One explanation for that phenomenon is the "trickle up" theory which states that not enough time has elapsed since numbers of women have been accepted into medical school for them to become full professors, deans, or to hold political positions within the medical field.

"I think academic medicine in general has been slower to accept women," commented Dr. Hedemark. "There has been a time lag, but once they are there, for the most part, advancements are pretty much the same. You'll still find, I think, that there are proportionately fewer numbers of women with full professorships and fewer numbers in political positions. I think that will continue to change." The question of enough time for both career and family puts an added burden on women, said Hedemark, the mother of a one-year-old child. "I think some women will still have to make choices about how much involvement they can handle, in particular when they are part of a two-career family with children."

"It is currently easier in our society for men to combine medicine and family," said Dr. Pomeroy. "There are some advantages to being in a non-traditional (for females) occupation," she added. "It pays well, and money makes it easier to combine those things."

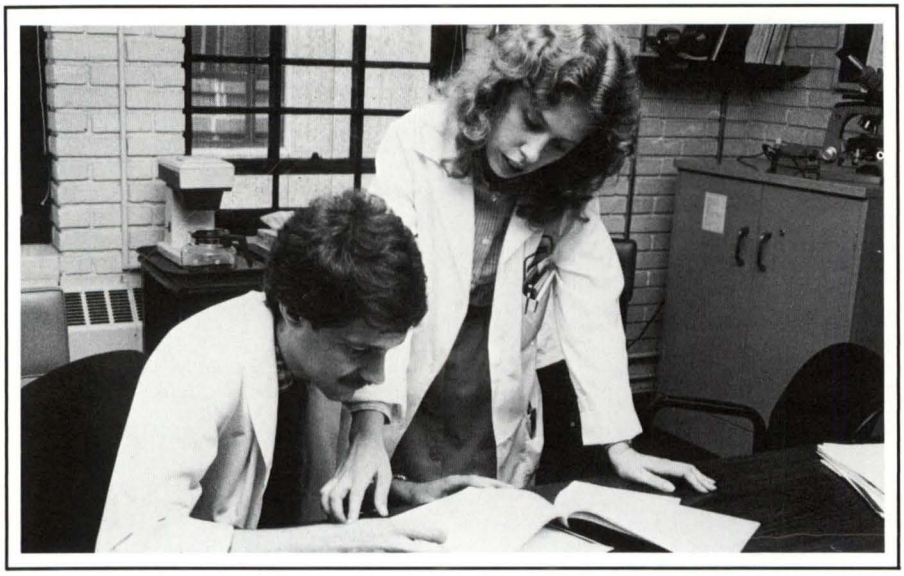
Dr. Meryhew also feels that one of the most difficult aspects of being a female physician is trying to balance one's personal and professional lives. "There is still a tremendous inequality between men in professional careers and women in professional careers," she said. "I think it is very clear that women can succeed in medicine, that there is a real need for women in medicine. But, it's clearly a 70-hour per week job." Meryhew suggested that this may be another reason why many women who are capable of pursuing academic medicine choose not to. "It's very difficult to put in those kinds of hours and come home and keep a relationship going and raise a family. It means that you either have to be very, very bright and very organized, and have a husband who helps a great deal, or be able to afford to have someone help at home," she said. Dr. Pomeroy noted, "There are a lot of women, especially younger women who don't view success in medicine as their only goal. They want success in other parts of their lives too."

The desire to have a family influenced Dr. Azar's career while she was doing an internship in pediatric surgery. "I was doing a rotation in neurosurgery during my eighth month of pregnancy," said Azar, now mother of six children. "For many years," said Dr. Azar, "my regular day was sixteen hours. If I'd leave early, I'd take work home and do it when the kids were sleeping. However," commented Azar, "for a woman to have a family and be successful in a career, she needs her spouse's help. Although it has not been easy," Dr. Azar said, "Our family is a very tight one. We have very good kids — they have given us no problems whatsoever."

Incredibly demanding

With or without children the demands on one's time are great. "When you're an intern, you think it's going to get better, but the further you go in medicine, whether in private practice or in academics, it's still incredibly time demanding," said Luikart. "It's hard for me to say it is stressful when I am doing what I really want to do, and have a fair amount of control over how I do it. In that sense, it is not stressful, I think demanding is a more accurate description."

"As an intern," Dr. Pomeroy recalled "I had a patient who presented as having a bad reaction to a sulfa drug. I sat down with my resident, and we went through all the symptoms. For each symptom, we listed each disease that symptom could implicate. By the time we were done, the only thing that was common to each symptom was arsenic poisoning, Indeed, that's what



Dr. Pomeroy, right, reviews patients' records with former Internal Medicine resident Dr. Jim Arrigoni.

he had, and we saved his life by figuring out what he had and by treating him emergently. That was so exciting — to sit down and intellectually go through a differential diagnosis and come up with the right answer by doing it the right way, and then saving someone's life as a result. That taught me," said Pomeroy, "that all those things about how to make decisions that people had been telling me and all those little bits of information that I had been acquiring to make a differential diagnosis were now directly and obviously translated into a diagnosis that someone else hadn't been able to make. It was a dawning of awareness that what we had been able to do really made a difference, and that was really fun!"

In Dr. Luikart's residency program, she was on call as an intern five nights out of seven and as a resident, every other night. "There are moments in the lives of all interns and residents that are not extremely happy, and there may have been, during those unhappy spells, some second thoughts about exactly what I was doing, but never any doubts that I wanted to be a doctor." "A lot of the time," said Luikart, "you were operating in a sleep-deprived state where even minor problems could be magnified. There were many men that actually did quit that program. I don't know of any women that did. All of us had our moments of being unhappy, male or female, and I'm sure that each of us had problems peculiar to our sex, but they were probably of an equal degree. There was a very high divorce rate in the population," she added.

Dr. Hedemark also felt that her internship year was one of the more difficult parts of her training. "It was extremely intense. I was in Boston for my first year, and it was grueling," said Hedemark. "I was on a very difficult call schedule, added to long weekends, with never any time to myself. After about eight months of it, I found I was getting very depressed. After that year, I think things evened out rather quickly; it didn't take long for that to be behind me." Dr. Hedemark returned to the University of Minnesota to finish her residency.

Self importance

Hedemark believes that among the rewards of medicine is a personal feeling of self importance and self worth. "I decided to be a doctor when I was nine years old, and so it has been a part of my image for a long time," said Hedemark. She feels, however, that one of the most important factors by which she judges her own success in medicine is her competence as a physician, as a caregiver. "Certainly I would also like to be a good teacher and productive in research, but the most important thing, for me is being a good caregiver," said Hedemark, who finds an element of frustration in the patient care at a large university teaching hospital. "Certainly, you can bring the most advanced technology to patient care, but in terms of the way the system works, it's not the most efficient for optimal patient care. Hedemark is currently researching ventilatory control by which breathing is controlled in patients with restrictive lung diseases such as interstitial lung disease, pulmonary fibrosis, and scoliosis. Drug treatments that may improve, or cure shortness of breath, and the pathogenisis of respiratory failure are additional elements that she is investigating.

After completing her medical degree at Duke, Dr. Luikart taught at Yale University before coming to the University of Minnesota. "The University has a very good reputation in oncology and in clinical oncology," said Dr. Luikart, "and it was made clear to me that there would be support for laboratory research, which there has been — some from the **Minnesota Medical Foundation**." Dr. Luikart is studying membrane changes in neoplastic cells as a way of looking for alternative therapies for cancer that are less cytotoxic to the patient's noncancerous cells. "The idea is that you can manipulate the cells either to differentiate, or to make the cell mature so that it can no longer divide, or you can make subtle changes in the membrane that make it less sticky or less able to migrate, things that make it less likely to metastasize." "To responsibly meet the needs of patients is obviously very important," said Luikart, "and I like the research very much — it's very fulfilling to me."

Dr. Meryhew, who is involved in the systemic lupus erythematosus clinic, has been conducting research on an animal model of hemolytic anemia. About 10 to 15 percent of

the patients with hemolytic anemia are patients with lupus, said Meryhew. "When I started, my skills were primarily clinical. I would suspect that remains the aspect of medicine that I do best," she said. "But I really enjoy teaching, research, and clinical activities. I think that it's one of the most exciting things about academic medicine — you're never doing just one thing, so there's a constant challenge. It's difficult to be good at just one, but to try to be good at all three is really tough."

As well as the rewards of the challenge of the constantly changing medical profession are the rewards that one receives from the gratifying experience of having patients improve, said Meryhew. "It's almost an expected reward. We don't always get it, but it's certainly a good feeling when we do. Many of the diseases that we see as rheumatologists," she added, "are diseases of women, so a lot of our patients like to see female doctors. That's been a real plus for me." As well as her interest in the area, Meryhew finds advantage in the fact that there aren't a lot of emergencies in the middle of the night. "It's a good subspecialty for someone who might want to have a family, too." Meryhew stressed that success in medicine to her means that she is happy at what she is doing, and doing it well. "I don't perceive success in terms of how far up the academic ladder I climb, but rather in terms of what I am doing — doing it well, doing it to the best of my capacity, and hopefully getting positive feedback from my colleagues."

"Traditionally," said Dr. Bloomfield, success in academic medicine is measured by how fast you're promoted, how many papers you publish in the right journals, and how many grants you receive. I think success is doing what you want to do, and having the freedom to do it, to pursue the areas of investigation that you wish. What may be success to someone else may be simply to be able to spend time on the ward with their patients, to get positive feedback from them, and so on. But, I think there's no question that academia has defined its criteria for success." Bloomfield finds her rewards primarily in clinical research. "The practice of medicine, as distinguished from clinical research, does not interest me. That's a very important distinction, and so, most of what I do has nothing to do with the alleviation of pain or discomfort." She added, "What I do is extremely interesting. What we're learning about the nature of the malignant cell is very exciting. It's an area of great intellectual ferment at the current time. What interests me most are the things that I discover. And I like the flexibility of the life style. The hours are long, but they're flexible. And the ability to move up, if you're good, is clearly there unlike some fields of business where it's really important to conform to models of how things are done. The main purpose as far as I'm concerned is the ability to interact with the brightest and best minds in the world. That's what I think is interesting. You are not restricted to a small circle of people in the same building or town. Most of my friends are people from all over the world who are bright and stimulating. That's exciting and there aren't many areas where you can do that," said Bloomfield.

Threat prompts action

Although Dr. Bloomfield was promoted rapidly, in 1977 while still an associate professor, she found it necessary to threaten to take a position elsewhere in order to negotiate the salary she deemed adequate. "My salary was low for a long time, but Dr. Ebert's objective was always to keep people's salaries as low as he could — it wasn't just women's that were kept low," said Bloomfield. "I think women tend not to be as aggressive about salary as they ought to be. I think that is a societal thing. We're taught to believe that money is not an important value and so, I think, traditionally women have not been as aggressive.

Salary raises tend to be a function of how much you push for them, more so than promotion. The basis for promotion tends to be publishing, but whether you get yourself an extra couple of thousand dollars or not is often related to how often you're in the chairman's office," added Bloomfield. "Women with spouses at a similar economic level may feel that it isn't worth arguing about," she said. "While women tend to not like confrontation, and perhaps tolerate it less well than men on an average, many men don't like going in and asking for salary raises either," said Bloomfield.

It was only after she had filed suit against the University for not making available to her the same opportunities available to others that Dr. Azar discovered that she had been also the lowest paid assistant professor for the longest period of time.

As part of the settlement, the University admitted no wrongdoing. "Not only that," continued Dr. Azar, "but they probably still believe that they acted right. And that's what I say will take some generations to erase."

Dr. Azar contends that women are not discriminated against during the earlier stages of their careers, but that discrimination occurs later when women try to advance. "I don't know how it will be for coming doctors," commented Dr. Azar.

'Playing the game'

"There are more women, so they are more visible. Things have changed so that they are given equal access to many things. Now, of course, that is at the lower level. We still have to see action at the higher levels. Women now are more aware of things and demand more. And the younger they are, the more aggressive they are, and the more they play the game. I guess that is a concept that is inherent. Maybe I shouldn't even be in a university if I don't believe in that," ('playing the game') she mused. "I can be political if there are steps that I have to take to achieve certain things, such as writing grant proposals. But for personal success, whatever I consider the most dear to me, I won't do that.

Dr. Azar describes her hypertension research.

I won't compromise my integrity for that. I guess it takes longer [to achieve one's goals] if you believe that."

Sexist treatment minor

Although most of the women had experienced minor sexist treatment at some point in their lives, only Dr. Azar, who had already gone through a lawsuit, felt she could speak openly. One woman related discriminatory practices against women during her residency at an unnamed medical school. She was not willing to publicly discuss what had happened because she felt that the incident was the fault of only one individual, and not a policy of the medical school, and because the person responsible is now in a politically powerful position. Another woman was not given lab space when she was hired as an assistant professor. She was told that it was because she did not yet have any grant support. Yet, a male assistant professor, hired in another section at the same time, was given a large, fully-equipped lab although he did not yet have grant support. The female physician involved also believed that this was an isolated incident. She was given a laboratory after her (male) section head fought to help her get it. Another female physician said that initially she had not been included in weekly research discussions.

Some male assistant professors expressed much more strongly than some of the female assistant professors the opinion that the department practices sexist policies. More often than not, these are men who have daughters who may someday wish to attend medical school or whose wives are in medicine. One father said that when his daughter tells adults that she wants to be a doctor, instead of responding encouragingly and taking her seriously as they do his son, they often say, 'Oh, how cute.' Another male physician compared the current situation in academia with the Russian system where 60–65 percent of those receiving medical training are women, yet 95 percent of the faculty are men.

Less than 7 percent of the 90-member Department of Medicine faculty are women. Four of these six women were hired in the last three years, along with 19 men. That means that the department hired women in 21 percent of the assistant professor positions available. That reflects the changes in academic medicine that most of the women observed. However, one male physician's comment to that was that it was meaningless because "assistant professors are academic cannon fodder — they work hard, it doesn't cost much to hire them and they can be dumped easily." It would be much more meaningful, he said, if women were hired at the associate or professor level.

Yet the counter argument is made that women have been admitted to medical school in greater percentages only recently, and that there are simply not enough women at higher levels in the potential hiring pool. Also noteworthy is the limited number of women medical school graduates going into academic medicine.

It may be too early to tell if the current women in academia are promoted as rapidly, or more or less rapidly, than the men in academic medicine, and whether the numbers of upper level women in academic medicine will grow so that they may be hired at levels above assistant professor, or if the attrition rate will change, and why.

Salary comparisons

Comparisons of the salaries of the 19 male assistant professors hired within the last three years to the salaries of the four female assistant professors results in the following: The average actual salary for the men for the 1983–84 year is $54,200. The average actual salary for the women for the same year is $47,457. However, one of the female assistant professors does not

yet have the sub-specialty training of the other faculty members. If her salary is not included in the average, the women average $51,276. The high salary for the men is $65,000, the low is $48,000. The high for the women is $55,000, the low is $48,828.

Salary comparisons are not the only measure of equal treatment within academic medicine. Other important items include whether one is on a tenure track, whether the tenure situation is fully explained to the new faculty member, whether the criteria for promotion are explicitly stated at the time of hiring, whether the faculty member is given adequate lab space and equipment, whether the new member is allowed teaching, research, and clinical responsibilities, whether one is placed in charge of a special program, and whether one's research is given exposure through grand rounds, research conferences and seminars.

A poll of two-thirds of the male assistant professors hired within the last three years and the four female assistant professors hired within the last three years indicated that there were no significant differences in the treatment of the men and women currently being hired in these areas. Both sexes expressed confusion about the tenure system, and the majority said that although they had a good idea about the criteria for promotion, they had never been told explicitly. Nearly everyone had received adequate lab space, and some of the men had been required to share space as had some of the women. Whether a junior faculty member gives grand rounds or conferences depends upon the faculty member within the section assigned to delegate those tasks.

One frustration with promotional priorities expressed by several of the male faculty members, as well as some of the female members is that patient care is not rewarded appropriately, that publications and grants are too high a priority. Two-thirds of the women joined the department of medicine without having procured grants; all have grants now. One-third of the men joined without grant support; half of those do not currently have grants, although they have applications in process.

Although no one interviewed believed that a viable alternative to the current granting situation exists, several ironies were mentioned.

"It puts a lot of pressure on us," said Dr. Meryhew. "We're asked to do so many different things. That's challenging and exciting, but hard to do, and I'm not sure it's reasonable to expect us to be able to do all this well. It would be nice if those people who were good at clinical skills and good in teaching could have the opportunity to excel in academic medicine doing just that, and those people who are more comfortable in the laboratory and have very well defined research skills could use those skills solely in research, rather than both groups having the pressure to write grant proposals and papers.

Lives become busier

As doctors' and researchers' lives become busier with seeing patients, attending conferences, giving lectures, participating on committees, most find themselves in their labs less and less. Often a lab technician is hired to do the lab work, while the M.D. or Ph.D. is relegated to finding funds to keep the lab and lab tech working. A tremendous time burden is placed on the rapidly vanishing species of researcher who feels that it is also important for the most highly trained individual to spend time in the lab doing "hands-on" work. "That's the only way I can find my answers," noted Dr. Azar. "A technician doesn't have the background to observe details that may be extremely important." She added that through her work in her lab, she knows exactly what is going on, and that those medical researchers who have not made it a priority to "do" research, but rather "direct" it from their offices, are missing a lot.

Dr. Azar has been studying the effects of environmental factors such as maternal salt excess on blood pressure development in genetically hypertensive rats. One of her more recent projects involves cross-suckling studies to determine if the salt-induced hypertensogenic factor from milk is a requisite for full expression of hypertension, or whether a genetic predisposition is also required. "I have strong convictions in what I do, and if I believe in what I am doing, I am going to keep doing it until I really get what I am after," emphasized Dr. Azar. "Even though this [research] is not popular, and will not bring me grant money right now, I keep working at it. It might be easier to switch, but I'm not happy working on something when I already know where it will lead."

Dr. Azar said that she believes the answers are to be found in the questions she is asking. "It just happens that they have not yet gotten onto that track — in a few years they will," she said. Dr. Azar finds that while she is on the wards seeing patients, her research must be set aside. "You have to dedicate yourself to what you are doing, and do it full time," she said. "So many times you are tempted to ask if it is worth it, and when you balance things, you say, 'yes, it is worth it, because I like doing it, and I find a reward from the fruits of my work.' So, to me it's worth it. That's what makes me happy. That's what keeps me going," said Azar.

Additional perspectives on motivation given by the youngest female faculty member, Dr. Pomeroy, who is conducting research into health care delivery systems, and resident education. "Medicine is always changing," said Pomeroy. "Understanding how the human body works is fascinating, and it's exciting to know about something that is that essential to life. When I was a junior medical student on my medical rotation, I stayed very late one night, sort of building up my karma. I was across the hall when one of my patients started breathing in a very funny manner. I walked

across and saw that her central line had become disconnected and a big bubble of air had gotten into her heart. That can be fatal. I was just a fledgling little medical student and somehow, out of the depths of my mind, I came up with what was the right thing to do. I guess that made me realize that you really can save people's lives, and that you really can have an impact. Sometimes the drudgery of learning gets hard, the drudgery of being up all night gets hard, but then there are those moments like that stand out, and they just make you feel so good that they can get you through all the other times," Pomeroy continued.

"I don't think of myself as a "woman in medicine," I think of myself as a physician. One has to maintain an historical perspective, because it's really important to remember that women have paved the way before me, and I appreciate very much what they've done. I think it's a real danger to forget what those women went through, and to say, 'oh see how easy it is, you guys were making a big deal out of it.' They broke a lot of barriers, and because they did that, I can now be in medicine without thinking of myself as a woman in medicine."

"June" from page 15

June told herself, but the logistics of making it happen proved to be the major problem. "My friends would ask, how can you do this to your kids?" said June. "And, I would always answer, 'How can I not do it FOR them.'

A lot of discussion

Needless to say, there was a lot of discussion about mom going to medical school. "I knew if I didn't try it I just wouldn't be happy." Ever since the children could remember, June worked inside and outside the home. Therefore, June reasoned, "They would be accustomed to their mother being away.

"At dinner one evening my children and I were discussing the prospect of my attending medical school. Stuart, our 13-year-old, said, 'Go for it mom.' That's what I needed to hear," said June.

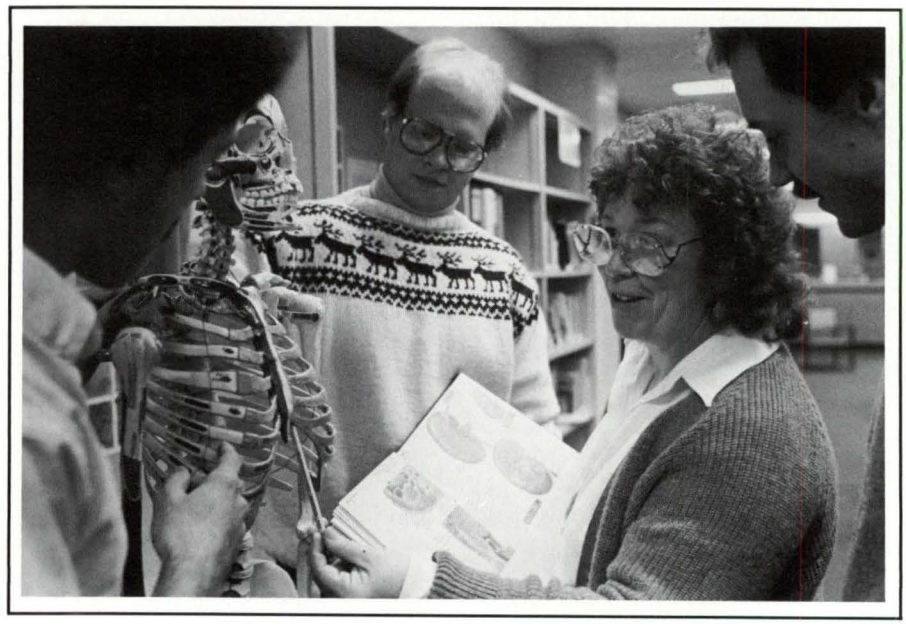
Now that June is a medical student, one of the most difficult problems for her is "the lack of emotional and financial support from my husband. He's never wanted me to do this," said June. "He has never had to bear full responsibility for the children and I believe he is concerned about that."

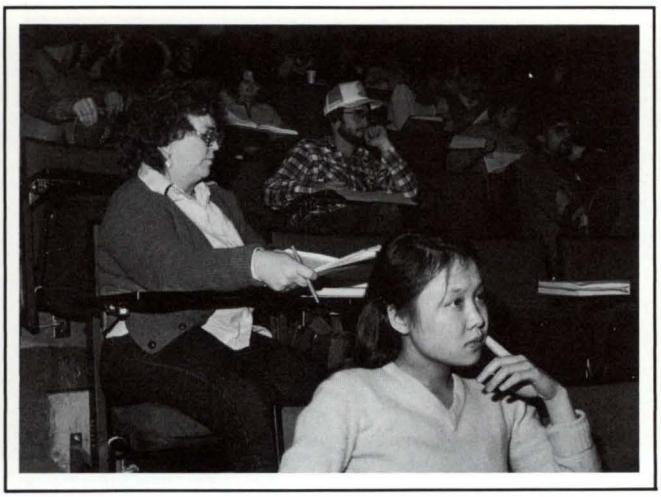
When June returns home on the weekends, she and her husband do not discuss medical school at all. "It creates tension," said June, "so we just don't talk about it. My primary support group is outside the family. My biggest supporters are my mother Elva and my sister," said June.

Financial burden

"Overwhelming" is the word June uses to describe the financial burden of going to medical school. "I don't like not knowing if I will be able to pay tuition next quarter," she said. June receives financial aid in the form of government loans and plans to reapply to the Minnesota Medical Foundation for help. She said she has already paid $5,000 in expenses and owes $8,000. "I just don't know where it's coming from, but I have faith," said June.

Academically, June said she was used to not studying very hard and getting good grades. However, here at the Medical School, "I'm studying my buns off and just making it. At 42, it's not as easy to memorize as it was when I was 20 years younger," said June. "It is not easy for compulsive people like me not to memorize





all the material we're given — and there is lots of it."

When June returns to Osakis on the weekends her time is not at all structured. She enjoys family games when her children and husband are not out hunting. She is an avid bridge player (something she really misses as a medical student). More often than not, she takes time to do some weekend studying in between washing dishes and cooking meals — the things for which her early role models trained her well. Church on Sunday also becomes a part of her weekend schedule.

"Definitely a rural person," said June, "I enjoy theatre, classical music and golf." She shoots a 9-hole score of 40.

June is careful not to offer advice to others. She said she realizes that there are expenses — not always monetary — in the earnest pursuit of goals. "If I were to do anything differently, it would be not to limit my goals because of my sex like lots of women did in the 1950s. I wouldn't wait so long to make decisions about my own life. It's harder to make those decisions when you get older."

June hopes to return to Osakis when she finishes medical school. She likes direct patient care and may well be Osakis's family doctor.

No doubt, she'll be a good one. — **DN.**

Dr. Hulda E. Thelander receives alumni award

Dr. Hulda E. Thelander, former head of the department of pediatrics at Children's Hospital in San Francisco and founder of one of the nation's first child development centers, has received the University of Minnesota's highest alumni honor.

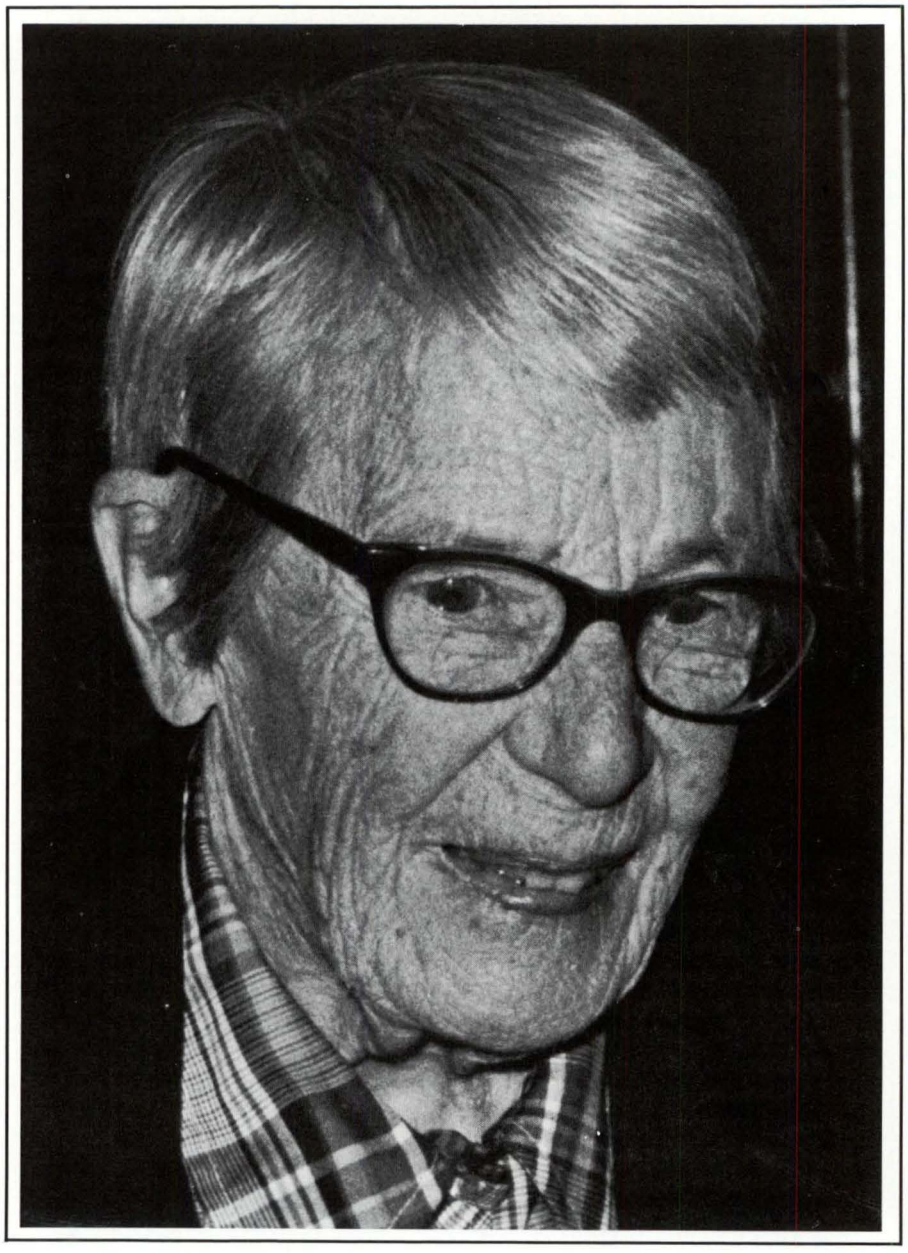
Dr. Thelander, who earned three degrees from the university, including an M.D. during the 1920s, was presented the Outstanding Achievement Award during an orientation session for the Medical School's freshman class in September on the Minneapolis campus.

Receiving a standing ovation from the new medical students, Dr. Thelander received her award from Dr. Neal Vanselow, vice president of Health Sciences, who said it was an honor for him to present this award to such an outstanding alumna. He pointed out that since Dr. Thelander attended the University of Minnesota, 500,000 students have also attended, 300,000 have graduated and only 750 have received recognition as outstanding alumni.

A native of Little Falls, Minn., Dr. Thelander began nursing studies at the Swedish Hospital in Minneapolis during World War I, but soon decided to become a doctor. The Missionary Society provided a medical school scholarship and she graduated from the university's Medical School in 1925.

After spending a year as a medical missionary in China, she was forced to leave because of the revolution. She returned to the United States and established her medical practice in San Francisco.

During the 1940s, Dr. Thelander was involved in the treatment of children during polio epidemics. She became affiliated with the Children's Hospital in San Francisco, where she served as chairperson from 1951 to 1962. She also held academic appointments at the University of California at San Francisco and at Stanford Medical School.



During World War II, Dr. Thelander served for two years as a lieutenant commander in the U.S. Navy. She is best known for inspiring the Child Development Center, which continues to serve San Francisco and northern California. The center, which provides diagnosis and treatment, includes a nursery school for handicapped children.

Dr. Thelander has published more than 130 professional articles and pioneered studies of brain damaged children that led to significant improvements and proper management of neurological defects during the early years of life.

Now in her 80s, Dr. Thelander lives in northern California.

Class Notes

'40 Dr. Michael A. Wainstock is clinical professor of ophthalmology at Michigan State University College of Medicine and also clinical associate professor of ophthalmology at the University of Michigan (Ann Arbor) and Wayne State University Schools of Medicine (Detroit).

In 1982, Dr. Wainstock won an award at Michigan for the concept and prototype of an 'Ultrasonic Guided Gamma Probe for Intraocular Melanoma Detection.'

Earlier this year, he received an award from the Institute of Technology for a 'Contact B Scanner Interfaced with a Solid State Photo-Multiplier for Melanoma Detection Using Chloroquin Iodide-123.'

Dr. Wainstock lives in Bloomfield Hills, MI.

Dr. Harriet Gregory-Bragg is president, Massachusetts Division, American Association of University Women. She is listed in the most recent edition of *Who's Who of American Women.*

'42 Here's an interesting birthday story. Dr. Harold Ravits, St. Paul, recently celebrated his 65th birthday. He requested that his friends and relatives forgo personal gifts and instead make contributions to the Fund for Minnesota Dermatology at the Minnesota Medical Foundation. The result: 31 gifts totalling $1,170. Thank you, Dr. Ravits.

'43 Dr. Robert G. Tinkham, consultant in the Department of Physical Medicine and Rehabilitation, retired in September after a 19-year career at Mayo Clinic.

Dr. Forrest H. Adams, director of research and education, Pediatric Cardiology Medical Group, Inc., San Diego, CA, and former head of the Division of Pediatric Cardiology at UCLA Medical Center, has returned from Hawaii to Southern California. The Adams' home on the Island of Kauai was 75 percent destroyed by Hurricane Iwa in November '82, and is now being rebuilt.

Since moving to San Diego, he has joined six other pediatric cardiologists in private practice, and he has completed editing the third edition of the textbook *Heart Disease in Infants, Children and Adolescents.*

'44 Dr. Chester Anderson, Hector, MN, has been named Family Doctor of the Year by the American Academy of Family Physicians. He is the only family practitioner in this town of 1,300, where he has lived since 1948.

'46 Dr. R. G. Norby, Venice, FL, is on staff at Venice Hospital. He is also a senior clinical instructor at Case Western Reserve in Cleveland.

'54 Dr. Oleg Jardetzky has been appointed chairman of the Directorate of the NMR Center at Stanford University School of Medicine. He was also elected to deliver the Linus Pauling Lecture for 1983–84 at Stanford University.

'55 '66 PhD Dr. John Woods, Department of Plastic Surgery at Mayo Clinic, was elected director of The American Board of Plastic Surgery at its recent annual meeting.

'56 Dr. Stacey Day is professor of biopsychosocial medicine and chairman, Community and Social Medicine in the College of Medical Sciences, University of Calabar Medical School in Nigeria. Dr. Day was also recently initiated into the Peoples' Mgbe Society and conferred with the chieftaincy title of Ntufam Ajan of Oban, for his work in rebuilding the health center in Oban, Nigeria.

'57 Dr. Matthew Divertie, division of Thoracic Diseases and Internal Medicine at Mayo Clinic, has been appointed to the National Heart Lung, and Blood Advisory Council of the National Heart, Lung, and Blood Institute.

'60 Dr. James D. Fètt has received a 1982 national leadership award in Indian Health Service for his work as medical director of the Bemidji Program Indian Health Service (MN, WI, MI).

Dr. Conrad Wilkowski has been named head of the Division of Infectious Diseases and Internal Medicine at Mayo Clinic.

'65 Dr. J. Michael McMillin is now professor of medicine and coordinator of research and faculty development at the University of South Dakota School of Medicine in Sioux Falls, SD.

'68 Dr. Joseph Messick, Jr. has been named head of St. Mary's Hospital Section of Anesthesiology at Mayo Clinic.

'69 Dr. Henry Keys, Rochester, NY, is associate professor and clinical director of radiation oncology at the University of Rochester Cancer Center.

Dr. Stacey Day

In Memoriam

'70 Dr. Noel K. Dysart is assistant for professional training in the Office of the Surgeon General of the U.S. Navy. He was also recently appointed alternate chapter chairman for Uniformed Services, Chapter East, American Academy of Pediatrics.

'78 Dr. Nancy L. Carroll has been appointed senior associate consultant in the Department of Pediatrics, Community Pediatrics at Mayo Clinic in Rochester, MN.

'79 Drs. Helen M. Story, Joel R. Haugen and Jerry P. Rogers were among twelve recipients of $1,400 awards from the American Academy of Family Physicians to help finance their interests in the part-time teaching of family practice.

Dr. Story, Linton, ND, is teaching at UND Family Practice Center. Dr. Haugen, Hawley, MN, is teaching at the University of Minnesota. Dr. Rogers, Moorhead, MN, is teaching at the UMD School of Medicine.

Dr. Gregory Joel Koski is currently practicing orthopaedic surgery in Santa Monica, CA.

Dr. Gardner Bemis has joined the neonatology division at Hennepin County (MN) Medical Center.

Dr. Lynn A. Christianson, Edina, MN, has been appointed a consultant in the Department of Anesthesiology at Mayo Clinic. He served an internship at Parkland Memorial Hospital in Dallas and served a residency in anesthesiology at the Mayo Graduate School of Medicine from 1980 to 1983.

Dr. William Goodchild, psychiatrist and associate professor in the Medical School, died September 4th in North Memorial Medical Center in Robbinsdale.

Malvin E. Herz, the Minnesota Medical Foundation's first non-physician president, died August 22nd at his home in Excelsior, MN. Mr. Herz was 81.

A St. Paul school dropout (8th grade) Mr. Herz founded *Modern Medicine* in 1932 after jobs as a plumber's helper, a bank employee, a salesman at the former Golden Rule stores and a Duluth theatre manager. He purchased the *Journal Lancet*, a Minneapolis medical magazine, with Louis M. Cohen in 1929.

Their publishing firm, Modern Medicine Publications, Inc. later launched a Canadian edition. After WWII foreign editions in 20 other nations and six languages were added, and three other medical journals were founded.

When Herz and Cohen sold their company to Cowles Publications in the early 1970's, combined circulation of their magazines was 400,000.

Mr. Herz was active in numerous civic organizations in the Twin Cities. He was past chair of the Minneapolis Medical Center board and a member of the Mount Sinai Hospital and National Publications boards.

The Minnesota Medical Foundation, this past summer, received a gift of $100,000 from Mr. and Mrs. Herz for teaching development at the Medical School.

Dr. Eva Shaperman Gordon, '31, died July 29th of a massive heart attack in San Diego, CA.

Dr. John Bitely, '83, died October 18th in an automobile accident in Toledo, Ohio. He was in his first year of surgical residency. A memorial fund has been established for medical student aid in his name at the Minnesota Medical Foundation, Box 193, Mayo, U of M, Minneapolis, MN 55455.

Dr. Leonard B. Moyer, '30, Golden Valley, MN, died October 11th at North Memorial Hospital, Robbinsdale, MN.

Dr. Charles C. Cooper, '32, died July 15th. He retired to Mesa, AR in 1976.

Dr. Paul Adams, Jr., '49, died August 31st in St. Paul, MN. He was 68. He was a retired pediatric cardiologist at Variety Club Heart Hospital.

Dr. Alice Harrison Fuller, '32, died October 7th in Minneapolis. She was 92. She practiced as a pediatrician in Lincoln, NE and Minneapolis. She had been recently honored for her 50 years with the American Medical Association.

Dr. William R. Goodchild, '53, died September 6th in Golden Valley, MN. He was 59.

He practiced psychiatry in the Twin Cities since 1963 and was on the staff of Golden Valley Health Center, North Memorial Medical Center and Mt. Sinai Hospital.

Dr. Goodchild was a member of the AMA, APA, Minnesota Medical Society, Hennepin County Medical Society, Minnesota Psychiatric Society and was an associate professor of psychiatry at the U of M Medical School.

Dr. Stanley C. Peterson, '34, died September 24th at the Presbyterian Homes of Minnesota in Arden Hills, MN. He was 75.

Dr. Peterson was in general practice in Luck, WI prior to serving as a flight surgeon in France and Italy during WWII.

He worked at Austin (MN) Clinic and St. Olaf's Hospital in Austin for 25 years before retirement.

Letters

Editor:

Every trade magazine or journal comes to our home as my husband is a newly elected state senator and your '83 summer bulletin was one of them. The cover of yours caught my attention however as we just returned from vacationing all along the Rocky Mtn range and find mountains so awesome.

I just wanted you to know that (from a layman's point of view) I found both Ralph Bovard and Eric Johnsons stories very interesting. Tho Bovards terminology was completely foreign to me, I found his explanation of the instruments used intriguing. Eric's daily journal was easier reading and equally as exciting. I wish to thank both gentleman for their contribution.

The column of "The Miracle Trap" by D. J. Tice I found to be a drama unfolding and wondering how far the good Lord will allow us to go?

Thank you for an enjoyable evening of reading.

Violet Anderson
Grocer and Sen. Don Anderson's helpmate.

Letters welcome

Letters from readers of the Medical Bulletin are invited. We welcome your suggestions and comments about this magazine so that it might be improved upon for the benefit of everyone.

The only requirement we have for your letter to be published is that it be signed. You may request that your name not be printed, but we do ask that you sign your letter.

Address correspondence to: Medical Bulletin, 535 Diehl Hall, University of Minnesota, Minneapolis, MN 55455.

Calendar

Jan. 25	Minnesota Medical Foundation Board of Trustees meeting, Minneapolis Hilton Inn, (Industrial Blvd.) 5 p.m. Call 612-373-8023 for information.
Feb. 8-10	Training workshop in pulmonary function testing. St. Paul-Ramsey Medical Center. 18-23 Credit Hours. Call 612-221-3992 for information.
Feb. 16-17	Current concepts in perinatal medicine. St. Paul-Ramsey Medical Center. 12 Credit Hours. Call 612-221-3992 for information.
Mar. 2-3	Primary care update. St. Paul-Ramsey Medical Center. 14 Credit Hours. Call 612-221-3992 for information.
Mar. 8-10	Current concepts in cardiopulmonary medicine. St. Paul-Ramsey Medicine Center. 19 Credit Hours. Call 612-221-3992 for information.
Mar. 10	Occupational and environmental pulmonary diseases. St. Paul-Ramsey Medical Center. 7 Credit Hours. Call 612-221-3992 for information.
Mar. 23-24	Obstetrics update. St. Paul-Ramsey Medical Center. 14 Credit Hours. Call 612-221-3992 for information.

What's New with You?

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City, State, Zip

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Minnesota Medical Foundation
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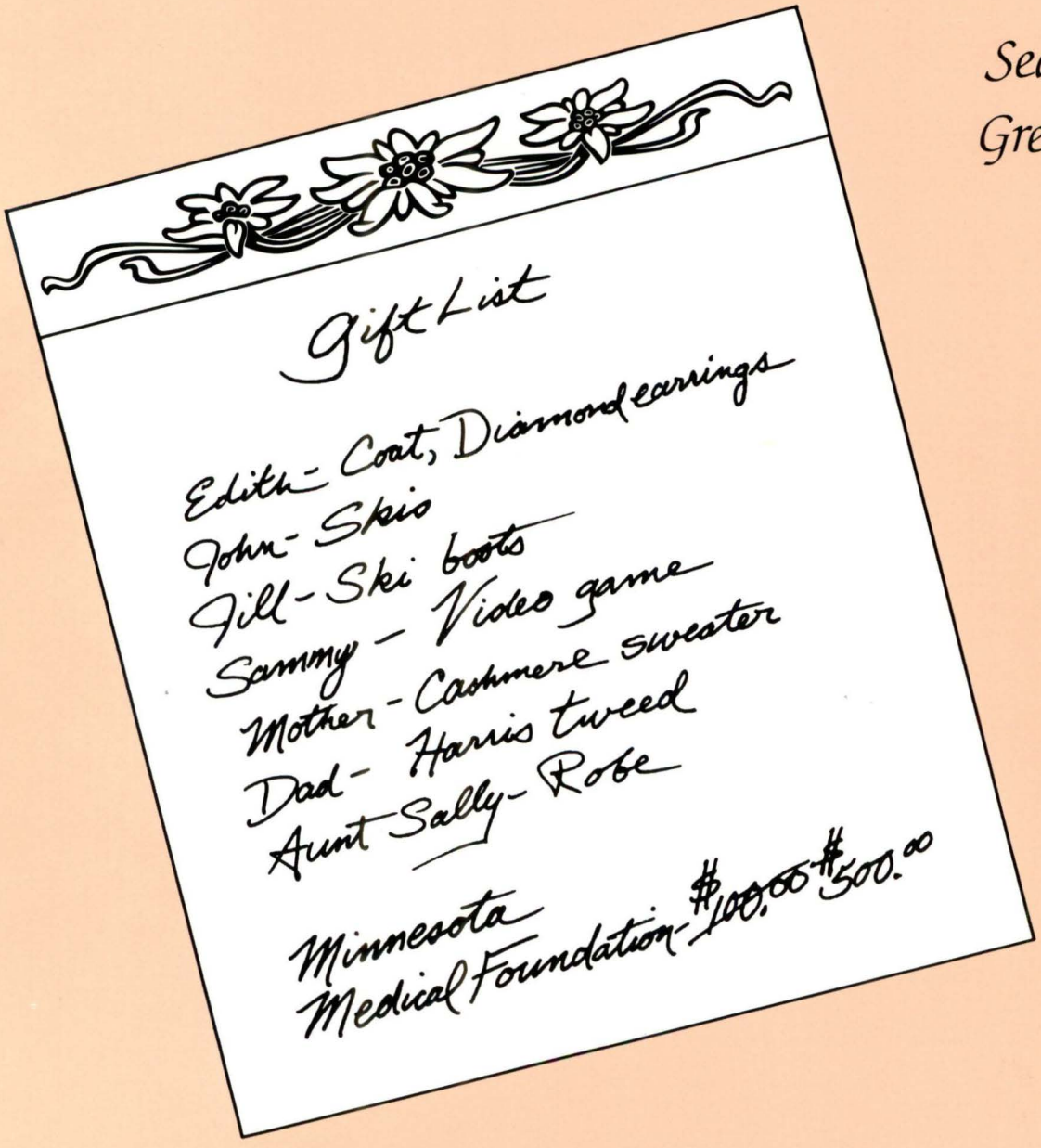

Season's Greetings

- **Your year-end gift to the Minnesota Medical Foundation is deductible for 1983 if dated by December 31, 1983, even though your check will not be cashed until 1984.**
- **In the current fiscal year, the foundation will spend about three quarters of a million dollars on loans to needy medical students and about $ 3 million on medical research and equipment for the University of Minnesota Medical Schools in Minneapolis and Duluth. The most important gift is yours.**