EDITOR's NOTE

Response has been excellent to the alumni questionnaire printed in the Spring issue of the Medical Bulletin. We've received some photos, some new addresses, and lots of news items about alumni from some of the earliest classes to the most recent.

We also have received from Dr. Walter Bailey (Med. '64) results of a questionnaire he sent to his classmates for a special 10 year class reunion held in St. Paul in June.

These and other alumni news materials are being compiled for preparation of a major "Alumni Notes" section in the Fall issue of the Medical Bulletin.

There is another blank questionnaire printed in this issue — we've decided to make it a regular feature of every issue. You are urged to fill it out, include your picture if you have one (black and white, please) and return it to us so that we can bring your classmates, house officers and teachers up to date on your career.

A larger than ever "Alumni Notes" section is anticipated for the Medical Bulletin next time.

—tp
"We who are blessed with money by birthright and good fortune have an obligation to do what we can to help others. I think that money should be given where it can do good during your lifetime, when you can get the satisfaction of seeing it work. I get pleasures out of seeing the development of things I helped with over at the University. It's just plain wrong to hold onto money and sit on it and let the tax people take it away from your widow. Outside of a comfortable living, I think a man is just plain selfish if he doesn't give away money as best he can."

Paul Dwan, Emeritus Professor of Pediatrics, said that a few days after his 70th birthday this year but he has practiced it all his life — with the complete support of his wife, Faith.

Dr. Paul Dwan is a son of John Dwan, one of the founders of the 3M Company. Paul grew up in Two Harbors, Minn., where 3M started. His father was an attorney and secretary for the struggling young company. Paul remembers his father doing an Irish jig in the parlor while waving his first 3M dividend check. It was in 1918 and the check was for $1200. His father died a year later when Paul was only 16. The Minnesota Mining stock his father owned would eventually be worth a fortune.

Only seven years later, at 23, Paul Dwan was him-
self a father, and also a medical doctor. He started medical school at the University of Minnesota, completing two years, and then transferred to Harvard where he received his M.D. in 1928.

He had been a sophomore medical student at Minnesota when he went on an Alaskan trout and salmon fishing expedition with his brother. They traveled on the S.S. Prince Rupert. There was only one girl their age on board and they flipped a coin for her. Paul won. Sometimes when he tells the story today he says he lost, but both he and Faith know that is a joke.

The girl was Faith Sturtevant, one of five daughters of a pioneer family from Seattle. That was August of 1925 and they were married on December 26 the same year. They honeymooned in a log cabin at Bush Lake, Minn., only about five miles from where they live today.

"We’ve been married 48 years and we’re still in a log cabin five miles from where we started. That’s progress," Paul says.

And it is progress! They built their year-around cabin home in Bloomington in 1937 and have lived there ever since. But it took some doing to get Faith back to Minnesota.

She was one Seattle girl who couldn’t see much attraction to life in Minnesota. She urged the transfer to Harvard Medical School and Paul agreed. But he began working on the return to Minnesota almost immediately. In 1931, the Dwans moved to Minnesota and Paul became a clinical assistant professor of

(Continued next page)
pediatrics at the University of Minnesota Medical School.

For more than 40 years he taught medical students and attended clinic patients at the University of Minnesota without a salary. Instead, he gave millions of dollars of his own money to support medical education and research.

He also started a private practice of pediatrics in 1931, with Chester Stuart and Erling S. Platou. Dr. Platou was to become the first president of the Minnesota Medical Foundation and Dr. Dwan a charter member. In 1939, Paul Dwan acquired a ‘‘life membership’’ in the fledgling Minnesota Medical Foundation for $100. It is the Foundation’s good fortune that Dr. Dwan never felt that was a realistic price for a life membership.

His consuming interest in medicine has been pediatrics, especially pediatric cardiology. As a clinical professor of pediatrics at the University of Minnesota, he was instrumental in developing a pediatric cardiology program here. He was one of the first doctors to use sulfonamides to prevent recurring attacks of rheumatic fever and one of the first pediatricians to recognize that congenital heart defects could be helped by early surgery.

Dr. Dwan had rheumatic fever himself as a child, and several times since. The Navy wouldn’t take him for military service because of it during World (Continued next page)
War II. So he stayed home, too "frail" to serve in the military, and continued a full-time private practice of pediatrics. He also began and directed the War Memorial Blood Bank in Minneapolis and the blood bank in St. Paul, continued to operate a blood bank at the University, directed a rheumatic fever program in St. Paul and taught medical students as a clinical professor of pediatrics. As commanding officer of the blood procurement program of the Minnesota National Guard, he attained the rank of major.

It was his own history of rheumatic fever that interested him in the hearts of children. He became the first specialist in pediatric cardiology and opened a practice in pediatric cardiology in Minneapolis in 1946.

He received the Gold-Headed Cane Award from Minnesota's department of pediatrics in 1973 in recognition of his outstanding contributions to medicine — contributions of medical expertise, diagnosis, patient care and teaching.

In addition to those invaluable contributions, however, he has also contributed generously from his private wealth to support professorships, research, facilities and purchase of essential medical equipment. He pledged more than a quarter of the cost of construction of the new Cardiovascular Research and Training Center which is now nearly completed at the University of Minnesota. The pledge ensured the construction of the building. He and Faith have endowed a professorship in pediatric cardiology, which is now held by Dr. Russell V. Lucas, a former student of Dwan’s.

At one time, Dwan’s property in Bloomington totalled 94 acres. He recently gave 55 acres of it to the city for its first and only public golf course. He says
it was a "partly selfish" gift because he loves golf and he didn’t want to see the land opened for housing development.

Paul and Faith’s gifts of money and property are not all enumerated here because they would rather we didn’t talk about them. They are continuing to make new charitable contributions and to bolster favorite projects they have supported in the past.

Paul has had what he wanted out of life. His wife, Faith, Their son, Pete, and their grandchildren. His medical practice and the chance to teach eager young medical students. A cabin overlooking the Minnesota River, where he can see deer at the saltlick and watch for quail and partridge that he put there himself. The opportunity to do things for other people with his money while he is alive to see the results.

At two separate parties in honor of his 70th birthday this past June, he received a gold-plated putter from the City of Bloomington and a Captain’s Chair from the Minnesota Medical Foundation. Both have honored places in his home.

There really isn’t much you can give Faith and Paul Dwan that they need or want. But the University and the Medical Foundation can say thanks. And to the Dwans, that’s enough.

—tom patterson
In 1928, Wallace D. Armstrong had a master's degree in organic chemistry but found himself with the unlikely job of testing ton batches of lubricating grease for a company in Texas. Smoking was forbidden in the plant, so a lot of the workers chewed tobacco. They would come by and spit in the kettles of grease he was supposed to be testing. It made him mad enough, often enough, to look for the change that would take him to Minnesota — where he would stay for the next 45 years.

He and Mary Bradley were married in Texas and left for Minnesota only a couple of weeks later. "Wally" had a job as a teaching assistant for the Medical School while he worked on his Ph.D. in physiological chemistry, a subject he hadn't heard of three weeks before coming to Minnesota. He would later express regret over the Medical School giving up the name in favor of "biochemistry." He felt that "physiological chemistry" seemed to say much more about the application of the science of chemistry to the physiological process.

He was head of the department, under one name or the other, for 28 years. He retired this year because the rules say you have to at age 68. Also this year, the University gave him its highest faculty title, that of Regents' professor, and an office in Diehl Hall where he can work on his writing.

"I had to retire to get carpeting," he says of his new office. "But the furniture slid around better on my old bare floors in Millard Hall."

Actually, he spent as much of his life in Owre 15 lecture hall as he has in any office. He has told many people that when he dies he thinks it would be appropriate that his funeral be held in Owre 15.

His last lectures to medical students were given this year in the new lecture rooms of the health sciences building called "Unit A." He didn't like it very well. The blackboards are green and not plentiful enough and the podium seemed too far away to see the students in the back rows.

His "complaints" are always mild jabs. Given with humor and a bit of sarcasm. We talked about the audio-visual equipment in the new building. He is not against anything that will help students learn but he remarks that someday the Medical School and medical students will discover a great new learning tool — books.

He has always relied heavily on books for his own education. After getting his Ph.D., he went on to Medical School at Minnesota, mostly because he couldn't find a job. "If I could have found a job with my Ph.D., I probably wouldn't have gone to Medical School," he admits. At the end of his junior year of Medical School, Dean Harold Diehl called him in and chewed him out because Diehl had just discovered that Armstrong had completed his junior year while working full-time as an instructor. Then Dr. Diehl congratulated Armstrong on his work and helped draw up a less demanding schedule for his senior year. The junior year had been full-time lectures and clinics and Armstrong admits today, "I never heard a gynecology lecture in my life."

That confession about his own medical school curriculum led to a discussion about today's curriculum.

"The main change in the new curriculum has been a depreciating and downgrading of basic sciences in the Medical School program," he says, "From what (Continued next page)
Dr. Armstrong, about 1939, with a Geiger Counter he made.

Wallace Armstrong, in 1926, graduating from the University of Texas.

Teaching in 1974.
was formerly two years to about 10 months. I was terribly anxious about it at first. Now I am a little more relaxed. The basic sciences have now developed to such intricate and involved disciplines that I no longer think we have to teach all of it to all medical students. Nor do I think, as I did earlier, that we will lose all future basic scientists. It just isn’t proving true.

“‘My general observation, with some reservations, is that each medical class is better than the last. There was an exception, one class of S.O.B.s, I won’t say which.

“‘I was on the committee that approved the new curriculum. The old curriculum was inappropriate with the new emphasis on primary care. I’m pleased to see how well most students do under the new cur-riculum. It’s to their credit. As I have seen the new curriculum work, I am convinced even more than before that for a large number of students it doesn’t matter what you do with the curriculum, they will do well. For another significant group it also doesn’t make any difference, they won’t do well. Manipulations of the curriculum may help some of those in the middle.

“‘I have a somewhat facetious prediction. About 15 years from now some of our graduates of this curriculum will be assistant professors in the Medical School. They will be sitting around talking about the curriculum and one of them will say to the other, ‘I think the thing to do is have a four-year curriculum; first, two years of basic science and then two years of clinical.’ It will be as good an idea as we have now.’

What about grading?

“I prefer to call it evaluation. People are evaluated all the time. You are evaluating me right now. It is my philosophy that students who do well ought to be recognized for superior learning and capabilities. You can underline capabilities. I also think that students who don’t do well should have that brought to their attention. By reputation medical students are vicious competitors up to the start of medical school. Now we’ve said that’s enough competition. Procrastination is a trait of almost everyone. Unless constantly evaluated, we tend to let things slide.

What about the three-year curriculum option?

“I am convinced the school should abandon it. I suspect it doesn’t produce as good a product. I think students select the three-year option for financial considerations. The main reason I’d like to see it dropped is that it restricts the whole curriculum. We can’t squeeze in more teaching time for the disciplines that need it because the school cannot add the teaching time and still take care of the three-year student. It places the Medical School in a kind of trap. The school would have to say that the freshman class admitted in 1976 would not have the three-year option. Otherwise they would always have to offer it to some students already enrolled or accepted.’

This is Wallace Armstrong as teacher and administrator. What of the scientist? He is considered one of the world’s best authorities on fluoride biochemistry. In 1937 he found that non-carious teeth often contain more fluoride, which initiated research leading to major programs to prevent tooth decay by increasing the amount of fluoride in drinking water. Armstrong was the chief scientific witness in a famous trial in Ireland on the legality of adding fluoride to water. Most of the major countries of the world now add fluoride to their drinking water.
But not the city of Brainerd in central Minnesota. In 1967, Minnesota gave every community in the state until 1969 to fluoridate its drinking water. There were arguments, but Brainerd is the only community still fighting fluoridation in the courts in 1974. Should they be forced to comply with the law and add fluoride? A somewhat surprising answer from fluoridation's number one proponent, Dr. Wallace Armstrong: "I think maybe Brainerd should be forbidden to add fluoride for at least 10 years. They don't want it and it would give scientists a 10-year control study. I have no doubt that fluoride is of benefit to teeth and no doubt that it is harmless to general health. Instead of fighting Brainerd, we could join with them in a study."

Armstrong is one of the leading hard-tissue chemists in the world. He led pioneer studies on bone remodelling and the distribution of tracer calcium in the skeleton, and in the use of radioactive tracers to determine skeletal growth and change. His work fostered new methods of treating metabolic bone diseases, such as the use of fluoride to prevent osteoporosis. He has authored 165 articles in professional journals. He received the Biological Mineralization Award from the International Association of Dental Research in 1966. He was named an honorary member of the American College of Dentistry in 1958 and received an honorary D.D.S. degree from the University of Stockholm in 1955. He is a member of the International Association for Dental Research and was its president in 1945. Since 1970 he has been a special consultant to the Director for the National Institute of Dental Research.

On Sept. 15, he begins a full-time position with the National Institute of Dental Research, as scientific director on loan to the institute from the University of Minnesota.

There are still other sides of Wallace Armstrong we haven't even touched on. The voracious reader — and teller — of history. His lectures often tie in stories of Civil War medicine. The world traveler. "My wife would be packed for Antarctica in no time if I suggested the trip."

But one last story of the teacher. This year's freshman class in medicine asked for an extra review session before the final exam. But when Dr. Armstrong came to give the review the students had set up a farewell party instead.

He was flattered by the party but told friends later at lunch, "I worked hard on that review session and some of them could have used it."

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Dr. Richard L. Varco

ARMSTRONG, VARCO ARE REGENTS' PROFessORS

The University of Minnesota's highest faculty title of Regents' Professor was bestowed in June on Dr. Wallace Armstrong, retired head of the biochemistry department, and Dr. Richard Varco, professor of surgery.

Armstrong retired this year after 45 years on the faculty. He earned his Ph.D. and M.D. degrees from the University.

As a result of his pioneering work in fluoride he acquired the informal title of "Mr. Fluoridation" in scientific circles. He is considered one of the leading hard tissue chemists in the world. (See larger story on Dr. Armstrong elsewhere in this issue).

Varco has been a member of the University faculty since 1941 and participated in the nation's first successful open heart surgery at University Hospitals. He was a member of the surgical team that received the Albert Lasker Award in 1955 for developing the controlled cross-circulation technique of dry-field, direct-vision heart surgery.

He later led a number of surgical teams that performed the first kidney transplants in the state. He is currently co-director of a $5.8 million five-year study of jejunoileal bypass surgery and the effect on cholesterol levels in chronically obese patients. Varco received his M.D. and Ph.D. degrees from the University of Minnesota.
MEDICAL SCHOOL GRADUATES 262
The University of Minnesota Medical School graduated a record 262 young physicians in June, about 60 per cent of whom will begin their graduate medical training in the state.

CLASS HONORS
Several graduates received special honors on Medical School Recognition Day.


Janet M. Glasgow Memorial Award for Women: Vicki J. Carlson, Janell N. Shaw, Susan M. Tange. The award is given to the outstanding women in the graduating class by American Medical Women's Association, Inc.

Most Promising Clinical Practitioner Award of the Minnesota Medical Foundation: Scott F. Davies and David W. Hilfiker. Winners were selected by poll of the graduating class. Each winner received a certificate and they split the $500 cash award.

Undergraduate Research Award of the Minnesota Medical Foundation: Gregory Grabowski for his study of the role of a sterol-carrier protein in the liver synthesis of bile acids. He received a certificate and a $500 cash prize. His research was selected for this prize by the Honors and Awards Committee of the Medical School.

The Upjohn Award: John P. Navins, as a member of the senior class who shows exceptional promise for making an outstanding contribution to medicine.

THE CLASS OF 1974
The following list of 1974 medical graduates includes the student's hometown, undergraduate college, and place and type of internship or residency.

ABRAHAM, PAUL A.
Excelsior
Carleton
Intern: Hennepin County General Family Practice

ANDREWS, RICHARD J.
St. Paul
St. Olaf
Intern: U. of Minnesota Hospitals Family Practice

AGNESS, DAN E.
Edina
St. Olaf
Intern: Kaiser Foundation-Santa Clara Straight Medicine

ANDERSON, CRAIG E.
Minneapolis
Gustavus Adolphus
Intern: St. Mary's Hospital, Duluth Rotating

ANDERSON, JAMES L.
Minneapolis
South Dakota State
Intern: U. of Minnesota Hospitals Family Practice

ANDERSON, JOY ROGICH
Hibbing
Gustavus Adolphus
Intern: U. of Minnesota Hospitals Family Practice

ANDERSON, JOY ROGICH
Hibbing
Gustavus Adolphus
Intern: U. of Minnesota Hospitals Family Practice

ATKIN, HOWARD B.
Minneapolis
Northwestern
Intern: St. Paul-Ramsey Hospital Rotating Medicine

AUSTIN, PETER S.
Duluth
U. of Minnesota-Duluth
Intern: Good Samaritan, Portland Straight Medicine

AYERILL, REX T.
Mankato
Arizona State
Intern: U. of Maryland Hospital Surgical Residency

AMUNDSON, DENNIS A.
Bagley
U. of Minnesota-Duluth
Intern: U. of Minnesota Hospitals Family Practice

ATKIN, HOWARD B.
Minneapolis
Northwestern
Intern: St. Paul-Ramsey Hospital Rotating Medicine

AUSTIN, PETER S.
Duluth
U. of Minnesota-Duluth
Intern: Good Samaritan, Portland Straight Medicine

AYERILL, REX T.
Mankato
Arizona State
Intern: U. of Maryland Hospital Surgical Residency

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Dr. John Alden, Minnesota Medical Foundation President, presents MMF's 1974 “Most Promising Clinical Practitioner Award” to David Hilfiker, left, and Scott Davies.

A small cyclist looks for a route around the line of graduates.

(Left to right) Steve Welton, Charles Belt (in suit), Mark Sharon, Michael Belzer.
On stage for Recognition Day (left to right) Dr. H. Mead Cavert, associate dean; Dr. Robert J. McCollister, assistant dean; Dr. N. L. Gault, dean; Dr. John F. Alden, president of the Minnesota Medical Foundation; and Joseph I. Markoff, a member of the class who played processional music.
DAVIES, SCOTT F.
Faribault
College of Holy Cross
Intern: U. of Minnesota Hospitals
Straight Medicine

DAVIS, CHARLES R.
St. Paul
U. of Minnesota
Intern: Los Angeles Co.-USC
Straight Medicine

DAVIS, MERRILL L.
Minneapolis
Johns Hopkins
Intern: Mount Carmel Hospital
Columbus, Ohio
Rotating

DAY, THOMAS W.
Minneapolis
Dartmouth
Intern: St. Mary's, Duluth
Rotating

DICK, GARY F.
Fargo, N.D.
North Dakota State
Intern: Grady Memorial, Atlanta
Straight Medicine

DICKEN, ROBERT A.
Thief River Falls
Concordia
Intern: U. of Minnesota Hospitals
Family Practice

DIEM, THOMAS J.
St. Michael
U. of Pittsburgh
Intern: U. Hospitals, Madison, Wis.
Straight Surgery

DIGHTMAN, LOWELL R.
Helena, Montana
Montana State
Intern: Malcolm Grow
USAF, District of Columbia
Family Practice

DOBIS, JAMES H.
Hibbing
St. Thomas
Intern: St. Paul-Ramsey
Family Practice

DODSON, STEVEN R.
Fridley
U. of Minnesota
Intern: Hennepin County General
Family Practice

DOMINO, TERRY G.
St. James
U. of Minnesota
Intern: U. of Minnesota Hospitals
Family Practice

DONAHUE, MARY H.
Big Lake
U. of Minnesota
Intern: St. Mary's, Duluth
Rotating

DONEHOWER, ROSS C.
Detroit Lakes
Hamline
Intern: Johns Hopkins
Straight Medicine

DONSKER, DAVID B.
St. Paul
U. of Minnesota
Intern: U. of Washington, Seattle
Pathology Residency

DOOLEY, COLLEEN N.
Watertown
U. of Minnesota
Intern: Hennepin County General
Pediatics

DRESSEL, THOMAS D.
Robbinsdale
U. of Minnesota
Intern: Hennepin County General
Surgery

DRUSCHEL, CHARLOTTE M.
Minneapolis
U. of Minnesota
Intern: Cook County Hospital,
Chicago
Family Practice

Dvoracek, John E.
Minneapolis
U. of Minnesota
Intern: Riverside General, Calif.
Straight Medicine

EASTWOLD, CONRAD E.
Minneapolis
St. Olaf
Intern: Blodgett Memorial,
Grand Rapids
Family Practice

ENGMAN, FREDERIC J.
Silver Bay
Gustavus Adolphus
Intern: St. Paul-Ramsey
Medicine

ERICKSON, DONALD L.
Austin
Luther college
Intern: U. of Minnesota Hospitals
Family Practice

ERICKSON, ROLLAND P.
Faribault
Concordia
Intern: Hennepin County General
Medicine

ESTRIN, DAVID L.
St. Louis Park
U. of Minnesota
Intern: Hennepin County General
Ophthalmology Residency

FERRIS, FREDERICK O.
San Diego
San Diego State
Intern: Northwestern Hospital, Minneapolis
Medicine

FLANNERY, MICHAEL J.
St. Louis Park
U. of Minnesota
Intern: U. of Minnesota Hospitals
Straight Surgery

FLAX, JAMES W.
Excelsior
Antioch College
Intern: Mary Imogene Bassett Hosp.,
Cooperstown, New York
Psychiatry Residency

FLINK, JAMES R.
Morgantown, West Virginia
Miami University
Intern: Hennepin County General
Medicine

FOSSEY, BRUCE D.
Edina
U. of Minnesota
Intern: U. of Minnesota Hospitals
Surgery

FOSTER, CRAIG A.
Minneapolis
Gustavus Adolphus
Intern: U. of Minnesota Hospitals
Residency in Otolaryngology

FOX, DWIGHT R.
Roseville
U. of Minnesota
Intern: Hahnemann, Philadelphia
Psychiatry Residency

FRANK, HARVEY J.
Minneapolis
U. of Minnesota
Intern: St. Paul-Ramsey
Family Practice

FRASCONE, RALPH J.
St. Paul
St. John's
Intern: St. Paul-Ramsey
Family Practice
Kodak does a booming business at graduation.

<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
<th>School</th>
<th>Intern:</th>
<th>Specialization</th>
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<td>GALLEA, WILLIAM S.</td>
<td>Hopkins</td>
<td>U. of Minnesota</td>
<td>St. Mary's Hospital, Duluth</td>
<td>Rotating</td>
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<td>GARBISCH, BRUCE D.</td>
<td>Lake City</td>
<td>Luther College</td>
<td>St. Paul-Ramsey</td>
<td>Family Practice</td>
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<td>GEHANT, JAMES C.</td>
<td>Madison</td>
<td>St. Olaf</td>
<td>St. Paul-Ramsey</td>
<td>Straight Medicine</td>
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<td>GEHLENSE, JANE A.</td>
<td>White Bear Lake</td>
<td>U. of Minnesota</td>
<td>Milwaukee County General</td>
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<td>GOODWIN, COURTNEY J.</td>
<td>Perry, Iowa</td>
<td>Iowa State University</td>
<td>U. of Minnesota Hospitals</td>
<td>Family Practice</td>
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<td>GORKIN, ROBERT A.</td>
<td>St. Paul</td>
<td>U. of Minnesota</td>
<td>Mayo</td>
<td>Straight Medicine</td>
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<td>GRABOWSKI, GREGORY A.</td>
<td>Robbinsdale</td>
<td>U. of Minnesota</td>
<td>U. of Minnesota Hospitals</td>
<td>Pediatrics Residency</td>
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<td>GREEN, MELVIN G.</td>
<td>Norfolk, Virginia</td>
<td>Rockford College</td>
<td>Norfolk General</td>
<td>Rotating</td>
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<td>GROPPOLI, DAVID J.</td>
<td>St. Paul</td>
<td>College of St. Thomas</td>
<td>San Bernardino County Hospital</td>
<td>Medicine</td>
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<td>GROSKREUTZ, THEODORE A.</td>
<td>Sherburn</td>
<td>Augsburg</td>
<td>Miller, St. Paul</td>
<td>Rotating</td>
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<td>GRUDEM, CHARLES M.</td>
<td>St. Paul</td>
<td>U. of Minnesota</td>
<td>St. Francis Hospital, Peoria</td>
<td>Rotating</td>
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<td>GUNDERSON, DONALD V.</td>
<td>Milan</td>
<td>Concordia</td>
<td>Bronson Methodist</td>
<td>Kalamazoo, Michigan</td>
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<tr>
<td>HAMMES, WILLIAM J.</td>
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<td>U. of Minnesota</td>
<td>St. Paul-Ramsey</td>
<td>Surgery</td>
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<td>HANSON, ROLF C.</td>
<td>Spring Grove</td>
<td>Luther College</td>
<td>Cook County Hospital, Chicago</td>
<td>Rotating</td>
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<td>HARRISON, MYRON C.</td>
<td>Rock Springs, Wyoming</td>
<td>Northwestern</td>
<td>Presbyterian Medical, Denver</td>
<td>Rotating</td>
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HAUGE, NOEL A.
Minneapolis
Augsburg
Intern: U. of Minnesota Hospitals
Pediatrics Residency

HEIDEMAN, GERALD L.
Minneapolis
St. Thomas
Intern: U. of Minnesota Hospitals
Family Practice

HELLELOID, CHARLES R.
International Falls
U. of Minnesota
Intern: Hennepin County General Surgery

HERSETH, RALPH H.
Kennedy
U. of Minnesota-Duluth
Intern: St. Mary’s Hospital, Duluth Rotating

HILFIKER, DAVID W.
Tomawanda, New York
Yale University
Intern: St. Mary’s Hospital, Duluth Rotating

HILGER, PETER A.
St. Paul
U. of Minnesota
Intern: U. of New Mexico Otolaryngology Residency

HOHAG, DAVID E.
Bloomington
St. Olaf
Intern: Santa Clara Valley Center Rotating

HOKENESS, STEVEN A.
Rushmore
U. of Minnesota
Intern: Roger Williams General Providence, Rhode Island
Straight Medicine

HOLLENHORST, ROBERT W., JR.
Rochester
St. John’s
Intern: Hennepin County General Medicine

HOLMGREN, RONALD L.
Litchfield
St. John’s
Intern: St. Paul-Ramsey Rotating

HOM, DOUGLAS L.
Battle Lake
U. of Minnesota
Intern: Albany Medical, N.Y. Medicine

HUNTER, DAVID L.
Maddock, N.D.
North Dakota State
Intern: Santa Clara Valley Medical Straight Medicine

IDELKOPE, BRUCE I.
Minneapolis
U. of Minnesota
Intern: Southern Illinois University
Straight Medicine

IRONS, KENNETH L.
Hinckley
Bethel College
Intern: St. Mary’s Hospital, Duluth Rotating

JACKSON, PAUL A.
Moorhead
Concordia
Intern: Hennepin County General Rotating

JACOBS, DONALD M.
Edina
U. of Illinois
Intern: Hennepin County General Rotating

JAROSCH, PAUL F.
St. Louis Park
U. of Minnesota
Intern: Northwestern Hospital, Mpls. Straight Medicine

JETZER, THOMAS C.
Sheboygan
Augsburg
Intern: U. of Minnesota Hospitals Straight Surgery

JOHANNSEN, RONALD A.
Minneapolis
U. of Minnesota
Intern: St. Paul-Ramsey Rotating Medicine

JOHNSON, DAVID E.
Minneapolis
Wheaton College
Intern: Tripler Army Medical Center Honolulu, Hawaii
Surgery

JOHNSON, GAIL G.
Grand Rapids
Macalester
Intern: Tripler Army Medical Center Straight Pediatrics

JOHNSON, ROBERT J.
Plainview
St. John’s
Intern: Hennepin County General Family Practice

JOHNSON, SANDRA M.
Chippewa Falls, Wis.
Marquette
Intern: LaCrosse Lutheran Hospital LaCrosse, Wisconsin
Straight Medicine

JOHNSON, SPENCER A.
Grand Rapids
Bethel College
Intern: St. Paul-Ramsey Rotating

JOHNSON, STEPHEN H.
St. Paul
St. Olaf
Intern: Mayo
Straight Medicine

JONES, ROBERT E.
Tioga, N.D.
U. of North Dakota
Intern: Childrens Hospital, San Fran. Pediatrics Residency

KAUFMAN, RONALD W.
St. Louis Park
U. of Minnesota
Intern: U. of Minnesota Hospitals
Straight Medicine
Dr. Owen Wangensteen, Regents' professor of surgery, attends graduation in the special attire of his honorary doctorate from the Sorbonne and the University of Paris.

LARSON, RICHARD D.
Bagley
U. of N.D.
Intern: Winnipeg General Hospital
Rotating

KURETH, CAMILLE M.
Minneapolis
St. Olaf
Intern: Children's Hospital, Detroit
Pediatrics Residency

LABRESH, KENNETH A.
Bloomingtion
M.I.T.
Intern: Roger Williams Gen. Hosp., Providence, Rhode Island
Straight Medicine

LANG, CATHERINE H.
St. Paul
College of St. Catherine
Intern: St. Paul-Ramsey
Medicine

LARRIS, DONALD R.
St. Paul
Stanford
Intern: U. of Minnesota Hospitals
Straight Surgery

LARSEN, PETER A.
St. Paul
Conordia
Intern: St. Paul-Ramsey
Rotating

LAWRENCE, MARK A.
Minneapolis
U. of Chicago
Intern: Hennepin County General
Rotating

LEMBREBLE, PAUL J.
Mendon, Mass.
Dartmouth
Intern: Hitchcock Memorial Hospital, Hanover, N.H.
Straight Medicine

LEUNG, FRANCIS K.
Hong Kong
U. of Minnesota
Intern: Cleveland Clinic Hosp.
Straight Medicine
LIETZAU, CAROL J.
Springfield
Valparaiso University
Intern: Methodist Hospital,
St. Louis Park, Minn.
Family Practice

LILLESTOL, MICHAEL J.
Bismarck, N.D.
North Dakota State
Intern: Northwestern Hospital, Mpls.
Straight Medicine

LONDBORG, LINDA J.
Unalakleet, Alaska
North Park College
Intern: St. Paul-Ramsey
Straight Medicine

LUNDE, PAULA A.
Preston
U. of Illinois
Intern: Northwestern Memorial/VA
Chicago
Straight Medicine

LUNDBORG, LINDA J.
Unalakleet, Alaska
North Park College
Intern: St. Paul-Ramsey
Straight Medicine

LUNDQUIST, KIPTON J.
Edina
Brown University
Intern: Hennepin County General
Straight Surgery

MAC RAE, MARGARET A.
Mankato
Mankato State
Intern: Hennepin County General
Rotating

MAHOWALD, ROYD J.
Minneapolis
St. Olaf
Intern: Veterans/LA Center, L.A.
Straight Medicine

MARKOFF, JOSEPH I.
Minneapolis
Oberlin College
Intern: Long Island Jewish Hospital
Straight Medicine

MARQUARDT, MARK J.
Austin
Valparaiso University
Intern: Jackson Memorial, Miami
Family Practice

MARTIN, LAWRENCE M.
Rochester
St. Olaf
Intern: Mayo
Straight Medicine

MARTIN, WILLIAM J.
Rochester
Marquette
Intern: Mayo
Straight Medicine

MATLOCK, GORDON A.
Lewiston, Idaho
U. of Idaho
Intern: St. Paul-Ramsey
Medicine

MATSUURA, JOHN K.
Columbia Heights
U. of Minnesota
Intern: Mayo
Straight Surgery

MAY, TERRY A.
Bemidji
U. of Minnesota
Intern: St. Paul-Ramsey
Rotating

McCULLUM, DAVID G.
St. Louis Park
U. of Minnesota
Intern: San Bernardino County
Family Practice

MERHEW, NANCY L.
St. Paul
Hamline
Intern: Hennepin County General
Rotating

MILNE, GREGORY J.
Osseo
U. of Minnesota
Intern: Hennepin County General
Psychiatry

MINAIAI, LLOYD A.
Hilo, Hawaii
U. of Hawaii
Intern: Miller, St. Paul
Straight Medicine

MITCHELL, MARTHA
Wayzata
St. Olaf
Intern: Hennepin County General
Family Practice

MONAHAN, PAUL P.
Minneapolis
U. of Minnesota
Intern: Los Angeles County Hospital
Rotating

MOREN, MARYANNE M.
Gilbert
College of St. Catherine
Intern: Hennepin County General
Family Practice

MUELLER, FRANCIS L.
St. Paul
U. of Minnesota
Intern: Highland General
Oakland, California
Rotating

NAVINS, JOHN P.
St. Paul
St. Mary’s
Intern: Naval Oakland Hospital
Oakland, California
OB-GYN

NEILS, RICHARD E.
Sauk Rapids
St. Olaf
Intern: Roger Williams Hospital
Providence, Rhode Island
Straight Medicine

NEITZKE, THOMAS R.
Detroit Lakes
U. of Minnesota
Intern: St. Paul-Ramsey
Medicine

NICHOLAS, GEORGE A.
Waterloo, S.D.
U. of South Dakota
Intern: Sioux Valley Hospital
Rotating

O’BRIEN, WILLIAM J.
Minneapolis
U. of Minnesota
Intern: U. of Minnesota Hospitals
Family Practice


degists’ Professor of Neurology Dr. A. B. Baker congratulates medical graduate Colleen Dooley.
Cap and gown is not required. This procession of medical graduates shows a typical mix of dress for the day. Donna Wolseth, William Wilson, Edwin Wilson, Tom Wiberg, Olyn Wersing, Dennis Weisenburger, Nolan Weinberg. A mini-diploma was presented to each graduate by MMF.

<table>
<thead>
<tr>
<th>Name</th>
<th>College</th>
<th>Intern</th>
<th>Field of Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>OKADA, MICHAEL D.</td>
<td>Northfield</td>
<td></td>
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</tr>
<tr>
<td>OLSON, DAN M.</td>
<td>Montevideo</td>
<td></td>
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<tr>
<td>ONSTINE, QUENTIN D.</td>
<td>New Ulm</td>
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<tr>
<td>PATTISON, GEORGE H.</td>
<td>Stubb's Bay</td>
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<tr>
<td>PAULSON, J. CRAIG</td>
<td>Richfield</td>
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<tr>
<td>PEASE, JAMES S.</td>
<td>Huron, S.D.</td>
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<tr>
<td>PEASLEE, ERNEST M.</td>
<td>Stillwater</td>
<td>U. of Minnesota</td>
<td>Straight Medicine</td>
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<td>PEDERSON, BRUCE M.</td>
<td>Bensonville, Ill.</td>
<td>Blackburn College</td>
<td>Doctor's Hospital, Seattle</td>
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<td>PEDERSON, L. DANA</td>
<td>Northfield</td>
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<tr>
<td>PENCE, THOMAS V.</td>
<td>Exsclor</td>
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<tr>
<td>PETERSEN, R.</td>
<td>Avon, S.D.</td>
<td>U. of California</td>
<td>Surgical Residency</td>
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<td>PINKERT, TED C.</td>
<td>Pipestone</td>
<td>U. of Minnesota</td>
<td>St. Mary's Hospital, Duluth</td>
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<td>PLADSON, TERENCE R.</td>
<td>St. Cloud</td>
<td>St. Cloud State</td>
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<td>PLETT, JUDITH A.</td>
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<td>U. of Minnesota</td>
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<td>Massapequa, New York</td>
<td>Brandeis University</td>
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<td>Billings, Montana</td>
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<td>Internships/Residencies</td>
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<td>Rochester</td>
<td>Gustavus Adolphus</td>
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<td>SELLAND, BRADFORD A.</td>
<td>St. Paul</td>
<td>Concord</td>
<td>U. of Michigan Hospitals Straight Surgery</td>
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<td>Hawley</td>
<td>Concordia</td>
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<td>SEVERSON, MICHAEL V.</td>
<td>Shakopee</td>
<td>U. of Delaware</td>
<td>Mayo Pediatrics Residency</td>
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<td>ROSEN, DARREL J.</td>
<td>St. Louis Park</td>
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<td>Robbinsdale</td>
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<td>Roseville</td>
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<td>U. of North Dakota</td>
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<td>ROSENFELD, ROBERT K.</td>
<td>Livingston, New Jersey</td>
<td>Rutgers</td>
<td>Latter Day Saints Hospital Salt Lake City Straight Medicine</td>
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<td>SHARON, MARK W.</td>
<td>Lone Rock, Iowa</td>
<td>U. of Iowa</td>
<td>Northwestern Hospital, Mpls. Straight Medicine</td>
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<td>SPIKA, JOHN S.</td>
<td>Edina</td>
<td>Presbyterian Medical, Denver</td>
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<td>RUMSEY, TIMOTHY J.</td>
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<td>STEANE, JERRY W.</td>
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<td>Children's Hospital, L.A. Pediatrics Residency</td>
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<td>SCHAUB, GREGORY C.</td>
<td>Anoka</td>
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<td>STEAN, MARK S.</td>
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<td>SCOTT, DAVID J.</td>
<td>Indiana, Pennsylvania</td>
<td>U. of Michigan</td>
<td>St. Paul-Ramsey Family Practice</td>
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<td>St. Paul-Ramsey Pathology</td>
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<td>STENBERG, MARK G.</td>
<td>East Grand Forks</td>
<td>U. of Minnesota</td>
<td>Butterworth Hospital Grand Rapids, Michigan Rotating Medicine</td>
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<td>SCOTT, DAVID J.</td>
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<td>U. of Michigan</td>
<td>St. Paul-Ramsey Family Practice</td>
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<td>Milwaukee County General Rotating</td>
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<td>STEER, CLIFFORD J.</td>
<td>St. Paul</td>
<td>U. of Minnesota</td>
<td>St. Paul-Ramsey Rotating Medicine</td>
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<td>SCHOTZKO, CHARLES P.</td>
<td>Springfield</td>
<td>St. John's</td>
<td>Hennepin County General Rotating</td>
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<td>STEER, CLIFFORD J.</td>
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<td>St. Paul-Ramsey</td>
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<td>Indiana, Pennsylvania</td>
<td>U. of Michigan</td>
<td>St. Paul-Ramsey Family Practice</td>
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<td>SMITH, MICHAEL J.</td>
<td>Minneapolis</td>
<td>U. of Minnesota</td>
<td>St. Paul-Ramsey Family Practice</td>
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</tbody>
</table>
Richard Trinity, a member of the medical class of '74, pauses on the mall in front of Northrop Auditorium after graduation ceremonies to diaper his daughter.
WELTON, STEVEN J.
Fargo, N.D.
North Dakota University
Intern Menninger School of Psychiatry
Topeka, Kansas
Psychiatry Residency

WERNER, RICHARD S.
Minneapolis
U. of Minnesota
Intern St. Paul-Ramsey
Surgery

WERNING, OLYN R.
Chokio
North Dakota State
Intern U. of Minnesota Hospitals
Family Practice

WIBERG, THOMAS A.
St. Paul
St. Thomas
Intern Milwaukee County General
Straight Medicine

WILENBRING, MARK L.
Virginia
U. of Minnesota
Intern St. Paul-Ramsey
Rotating

WILSON, EDWIN E.
Hopkins
U. of Minnesota
Intern Mayo
Straight Medicine

WILSON, WILLIAM L.
St. Louis Park
Macalester
Intern St. Paul-Ramsey
Family Practice

WOLSETH, DONNA G.
Fargo, N.D.
U. of North Dakota
Intern Hennepin County General
Rotating

WORNER, THERESA M.
Breckenridge
College of St. Teresa
Intern State/Kings County, N.Y.
Rotating

YANAGIHARA, RONALD H.
Honolulu, Hawaii
U. of Hawaii
Intern Cedars-Sinai, Los Angeles

YOUNGREN, THOMAS R.
St. Paul
U. of Minnesota
Intern U. of Minnesota Hospitals
Family Practice

ZLONIS, MICHAEL S.
Duluth
Beloit College
Intern St. Paul-Ramsey
Rotating Pathology

ZIEMER, PAUL F.
Richfield
St. Olaf
Intern Hennepin County General
Family Practice

ZUREK, MICHAEL A.
Lakeville
St. John's
Intern U. of Minnesota Hospitals
Family Practice
By James R. Flink, M.D. '74

(Address presented to faculty and guests at Medical School Recognition Day, University of Minnesota, June 7, 1974, on behalf of the graduating class).

Tradition says that a student representative speaks at graduation in "response" to having been granted our M.D. degrees. It isn't difficult to realize that it would be well nigh impossible to find a truly representative figure in this graduating class. Not only are there three-year graduates, four-year graduates, and graduates who transferred from North Dakota, South Dakota, Dartmouth, and other two-year medical schools, but there are people with backgrounds from philosophy to mechanical engineering and biology. Then, too, there are those who have received degrees ranging from B.A. and B.S. to R.N., M.A., and Ph.D. before coming to medical school.

Therefore, my comments will unavoidably be unrepresentative and subjective. I would like to explore two topics. First, how the process of medical education has affected us, and second, what I see as the most difficult problem facing us in our future in the profession of medicine.

Education's severest critics have accosted institutions of higher learning as factories taking the raw materials of individuals with different backgrounds, myths, models, expectations, and goals, and turning out a technical product with the "Good Housekeeping Seal of Approval"—our diplomas. Medical education used to be almost that rigid, but we have come through a curriculum that has tried to be flexible to our individual needs and goals. We have all had our moments of frustration and anger in trying to mesh the gears of our own plans with those of the medical education machinery, e.g., the course scheduling computer, but we have had more things our way than graduates in the old curriculum. Then too, we have grown as a result of being forced to recognize our deficiencies and our desires and to formulate plans to meet those needs. Even so, our experiences and the results of those experiences have a few common threads.

Despite our differences most of us are compulsive, aggressive, and individualistic because without those qualities we wouldn't have made it this far. I feel that we have refined our compulsive traits. We are more conservative, not politically, but in the sense of being more cautious, than we were four years ago. The need to be exacting, even in our imprecise "clinical judgment", has been ingrained. Regardless of our specialty, we are now required and require of ourselves documentation and rationale before we act. We are more responsible people than four years ago. Having been exposed to real patients with real problems, we have cast off some of our more "rabble rousing" and carefree tendencies, particularly during that 8 to 12 to 36 hours a day we have spent in our roles as a physician to be.

The reasons seem manifold. Perhaps most important is that it is more than a little aweing to make decisions concerning life and death. Medical school has molded not only our intellect but our behavior. Some of the behavior modification has been and will be useful. For example, the art of interviewing, which is half learned and half intuitive, and which requires a modification of our learned ways of dealing with people, and provides 90%, so we are told, of the information necessary for diagnosis.

On the other hand, some of the behavior and attitudes expected of us are intangibles of what society and our professional colleagues expect of us as physicians. For example, some societal expectations and images are of the physician as wealthy and money grubbing, or as scholar and possessor of secrets. Professional expectations range from dress codes, of which our little white clerk coats are an example, to status measured in the number of articles published or the size of our salary. Both society and the profession encourage a heavy-handed use of the prestige and the class distinction often associated with our newly acquired titles.

None of these examples applies to anyone in particular—they are caricatures, a distortion of reality for the purpose of making a point, but I feel that we should continue to make the distinctions between necessary practical and useful behavior and attitudes, and those vestiges of myth, superstition, and social class that shroud medicine. That is, we should retain what there is of our individuality. Some of the refined (Continued next page)
civility and responsibility is essential in our roles as physicians, but it gets in our way when we expect the same of all of the members of the health care team and of our patients. We tend to forget that we were selected out for these qualities and that these qualities have been magnified. A failure to recognize and cope with these qualities leads only to frustration.

Although we have become more responsible in our professional lives, it seems that we have been somewhat irresponsible in our personal lives. There is the constant struggle to find the time and energy to grow with our spouses, children, or euphemistically speaking, our “significant others.” Although we have all managed somehow to keep sane under the pressures of the last four years, we have all put off “contemplating our navels” as Dr. Sullivan is wont to say. Medical school has taken us out of the main stream of everyday life and put us in the rather isolated world of medicine. The result of four years of isolation from our families and friends, and ourselves, has produced some divorces, some drop-outs, some burn-outs, and some automatons, but the vast majority without these overt effects of stress and pressure have not been unaffected and the outcome is still in the balance we will make between our professional and personal lives.

I would now like to turn from what has happened to what might happen. Politically and socially there has been turmoil and uncertainty which is unlikely to be resolved by a resignation or impeachment. Professionally, there have been great strides in medical information and technology. We are on the verge of major changes in the organization of the medical non-system and its financing. However, I feel that the most important issues that we have to face as physicians are personal ones, or rather interpersonal ones. What we do with our personal lives undoubtedly affects the efficiency of our professional activities, but the interpersonal relationship I am referring to is the physician-patient relationship.

We have been trained as scientists, the purveyors of medical technology to the objective realities of patients’ diseases. There has always been a conflict be-

THE PHYSICIAN: ARTISAN OR ARTIST?

By James B. Nelson, Ph.D.
Professor of Christian Ethics
United Theological Seminary of the Twin Cities

(Address presented to graduating medical students at Medical School Recognition Day, University of Minnesota, June 7, 1974)

While I am indeed grateful for the invitation to address you on this special day, the fact that I come from outside the medical profession has its perils as well as its possibilities, as I am well aware. A good Catholic friend told me of the mother of a large family who was speaking to her priest one Sunday following mass. “That was a beautiful sermon you preached today on the joys of holy matrimony, Father,” she said. Then she added, “If I knew as little about it as you do, I think I could be as eloquent myself!” That is the peril, I feel on this occasion, but I welcome the challenge.

Dr. Flink’s fine remarks have already raised some very important issues surrounding the art of medicine. I should like to pursue some of them and add one or two others. But, first, what is an “art”? The word in its basic meaning and linguistic ancestry signifies a skill or an ability. But skills and abilities
between the scientist and the humanist in each of us and between the objective and subjective reactions and interactions we have with patients. Objectivity is essential to insure maximum accuracy and decrease the number of mistakes we will all make. Our subjective reactions to patients evoke emotions, the obvious and universal result of people dealing with other people, but the red flag of caution when it occurs in the professional situation.

It seems to me that we try to maintain our objectivity by maintaining a distance between ourselves and our patients. We have been taught that a physician loses his or her ability to function when he or she becomes personally involved with the patient and we mock the T.V. doctors for their ability to limit their practices to one patient a week. However, once the diagnosis has been made and treatment begun there is time and room for empathy when dealing with patients, not as objects but as fellow human beings.

Dr. Pearl Rosenberg defines empathy as being a combination of sympathy and objectivity, an understanding that does not imply nor require agreement. In can be directed to different types of ends. The dictionaries suggest that one may be designated either an artisan or an artist, depending upon whether that person's skills are directed principally toward a utilitarian purpose or an aesthetic purpose. Thus, the artisan is the skilled craftsman, whose abilities are aimed at some tangible goal, some useful end. The artist, on the other hand, is primarily concerned with the imaginative communication of a perception of the quality of life — its beauty, its intended form, its reality.

If such be the case, the physician is called to be neither one nor the other, but clearly both — consciously and conscientiously both artisan and artist. But there may be considerable pressures to dilute or overlook the significance of one or the other side of this necessary professional tension.

Consider, first, the physician as artisan — one highly skilled and competent in a craft, the science of medicine. This excellent medical school places considerable emphasis upon caution, exactitude and sufficient rationale in making clinical judgments. And who among us would deny the importance of this? Yet, there is a temptation which the class of '74 may feel more keenly than some other classes have.

If my math is correct, many of you finished college about 1970. If so, your college days were shaped by the most radicalizing period in recent American history. Entering college you were accompanied by the escalation of our nation's most brutal war. Your sophomore year matured you to the sound of assassins' bullets. Your junior year began with a national political convention wherein youthful hopes for change were dashed by political pro's and overreacting police. Your senior year climaxed with the invasion of Cambodia and the killings of Kent State students. And if your elders have forgotten the profound impact of these events, surely you have not, for they colored the very fiber of your social consciousness.

In light of your biographies, it is not only understandable but commendable if you still carry within you some critical doubts about the established institutions of our society and some doubts about the power of technique and technology to usher in the good life. And in light of your biographies you may be particularly sensitive to past medical education and practice which often suppressed the affective and human side of medicine in an over-adulation of its rationality and science. But, if, in your zeal to correct the past, you should dilute the physician's calling to be a highly (Continued next page)
competent and skilled craftsman, will humankind really be served any the better? You are called to be an artisan, and a very good one at that.

In another but equally important sense I invite you to reaffirm yourselves as artisans. For by remembering that you are an artisan, you will be less inclined to be a high priest.

I say that recognizing the pressures which our history and our culture will place upon you. Recall that in Western civilization the medical person was almost always regarded as a priest, a religious functionary, for until the age of the Renaissance it was assumed that diseases were divinely or demonically caused. For the next 300 years the religiosity of medicine declined: it was too late in the development of human thought to blame God for diseases, but still too early in the development of science for medicine to work its own wonders. But in the 20th Century, America’s high faith in science coupled with medicine’s proven efficiency combined to assure doctors religious status once again . . . whether they wanted it or not (and I suspect some did and some didn’t).

While the high priestly image of physicians is beginning to change, there is still considerable public sympathy for it. Occupational prestige and rewards? Doctors are still at the top. The “generalization of expertise”? It is still there: though your professional training has been rather narrowly focused, though your professional schedule may permit little time for the study of public issues, nevertheless many people will still cast you into the role of expert on every non-medical matter from school bond issues to foreign policy — because you are a doctor.

And many patients still experience a visit to the doctor in a definitely even if unconsciously, religious way. To them your costume of white is not only the sign of clinical cleanliness, but also the symbol of purity which divides the holy from the diseased. They revere your technical language as a language of cultic power. And their ritual with you seems to involve their confession of sin, your assurance of absolution, and your prescription of penitential acts. If all this seems to be stretching things a bit, just pause and reflect: most folks perceive the words of their clergy as “counsel,” the words of their lawyer as “advice,” but they perceive the words of their doctor as “orders” to be “religiously followed.”

But you and I also know that things are changing, and we are beginning to see the “secularization” of the medical profession. It is a new assertion of the voice and power of some of the laity, calling for a de-sanctification of the professional and for a democratization of the health care institutions. The process began earlier in other institutions. The Reformatons of the 16th century brought the process to the church (even though some clergy have not yet noticed). It came to the political state in the West in the 18th and 19th Centuries (even though some public officials still seem to believe in the divine right of kings). And medicine is experiencing it now.

But this secularizing process is never easy or comfortable for those most intimately involved. It may call for rethinking the inherited professional self-image. But it can be liberating — for a high priestly role really belongs to no human being, whether clergy or politician or corporation executive or physician. It diminishes the humanity of those who assume it and endangers the humanity of those whom they affect.

Surely the physician’s alternative is not simply the role of applied scientist, an engineering model with patient as “case” and doctor as “plumber.” Nor is the alternative a simplistic affirmation of radical equality which denies the very real and important functional differences between physician and patient.

Yet, there is an alternative which, thankfully, many physicians now embrace: that of fellow-citizen with special competence — artisan. This professional image invites new possibilities of trust and confidence with patients, for they know they will be neither forced nor allowed to abdicate their own freedom in significant choices. The artisan welcomes the public into the partnership of setting priorities in medical emphasis and resource allocation. And as artisan I suspect you will find criticisms of your profession by others less personally threatening than those who feel any such criticism an af-front to their status. You are called to be an artisan.

But the art of medicine also requires the artist within you. Here is the other side of the coin, that delicate balance to which your profession invites you. Beyond utilitarian skills, the artist is concerned with the imaginative communication of life’s quality, its beauty, its human reality. The artisan deals in analysis, with objective facts, with general laws. The one who is also artist deals with wholeness, with feelings, with the uniqueness and particularity of subjects. The physician as artisan sees carcinomas and statistical prognosis; the physician as artist sees also and just as clearly a person with hopes and fears.

Indeed, does not the commitment to care about persons undergird and often go beyond the mandate to cure diseases? Sometimes you can cure. Often you can relieve pain. Always you can care. When I am ill, my need certainly is for therapy, but it goes beyond that. My human hunger is for one who gives himself personally to me, in terms of myself, not just technologically to me in terms of my defects. Genuine compassion (literally “co-suffering,” the ability of another to understand what my illness means to me) is neither pity nor paternalism, and it cannot be feigned. But when present it is unmistakably sensed by the patient. And that is part of your artistry.

Also integral to artistry is the ability to make moral decisions with a keen sense for the ethical issues which lie beneath the practical situations. To make wise moral decisions with others, not on their behalf is artistry.

Medical ethics is not the same as compassion, however essential that is. Neither is medical ethics limited to the rules governing relations among fellow professionals. Nor is it confined to considerations of law and medical jurisprudence. Nor is it simply a matter of deciding who shall decide. Medical ethics asks the difficult questions concerning how and why we make those particular decisions which will best care for the humanity of others in a medical situation. What rules of practice, what use of procedures, what principles of action, what covenants of loyalty are the most enhancing of the humanness of others.

If your medical training has made
The values of human life have not just another familiar cliche. Or it can facts of human biology. We know factually, ceasing of artificial resuscitation, Henry K. Beecher's distinguished definition. We know scientifically, that death is a process, not an instantaneous event. But just when in the course of this process is the person really dead? When is the ceasing of artificial resuscitation, when is the removal of organs for transplant morally viable? Even Dr. Henry K. Beecher's distinguished Harvard Medical School Committee finally concluded that they could not define death. Scientifically they could define the "irreversible coma," and they could recommend that such coma be taken as a sign of death. But saying that such coma was death would be making a judgment based upon non-medical assumptions — upon ethical, philosophical, religious assumptions — about what constitutes life.

What, then, does it mean to be human, to have authentically human life? That question weaves through the fabric of every major medical ethical issue. "Death with human dignity"? What does that mean? It can become just another familiar cliche. Or it can become an occasion for jesting. As it was for the spritely 80-year old man who remarked that a death with dignity is basic and fundamental. But it is an ethical starting point, not a final answer book. In practice, even in the face of uncertainty you will have to decide and act. Then as physician you owe a moral obligation to the individual patient. The code to which you will subscribe is basic and fundamental. But it is an ethical starting point, not a final answer book. In practice, even in the face of uncertainty you will have to decide and act. Then as physician you owe a moral obligation to the individual patient.

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The code to which you will subscribe is basic and fundamental. But it is an ethical starting point, not a final answer book. In practice, even in the face of uncertainty you will have to decide and act. Then as physician you owe a moral obligation to the individual patient.

You will be driven to that imagination and to that tough-minded grappling to the degree that you are sensitive to the mysterious gift of human life. For some of you that sensitivity may come from deep religious convictions. For others of you it may come from a sturdy humanistic commitment to people. However it comes, artistry in medicine is well nigh impossible without it.

And that, I take it, is what Thornton Wilder was getting at in Our Town, a well-worn play that still wears well. Do you recall the scene wherein Emily Gibbs, having died during childbirth, is allowed through the miracle of the playwright to turn the clock back a number of years, leave her grave on the hill above Grover's Corners, and return to her family for one day — her 12th birthday?

Emily appears in the kitchen that morning, where her mother is busy fixing breakfast: "Oh, Mama, just look at me one minute as though you really saw me. Mama, 14 years have gone by. I'm dead... But just for a moment now we're all together... Let's look at one another."

And so goes the day. People too busy to notice. People somehow not touching each other. Finally, it is too much, and Emily cries out: "I can't go on. Oh! Oh. It goes so fast. We don't have time to look at one another. I didn't realize. So all that was going on and we never noticed. Take me back up the hill — to my grave. But first: Wait! One more look. Good-by, good-by world. Good-by, Grover's Corners... Mama and Papa. Good-by to clocks ticking and Mama's sunflowers. And food and coffee. And new-ironed dresses and hot baths... And sleeping and waking up. Oh, earth, you're so wonderful for anybody to realize you. Do any human beings ever realize life while they live it? — every, every minute?" Then a moment later she finds her answer. "The saints and poets, maybe — they do some."

She might well have added, "the artists." And that is your calling. Artists and artists. Our best wishes and highest hopes go with you.
NEW DIRECTOR OF GRADUATE MEDICAL STUDIES SETS PROGRAM

Dr. Douglas Fenderson

Douglas Fenderson, Ph.D., has been named director of the University of Minnesota's office of continuing medical education and associate professor in the hospital and health care administration program.

A Minnesota native, Fenderson earned his bachelor’s degree at the University of Minnesota in 1952, his master’s in 1956 and his Ph.D. in educational psychology in 1966. He served for three years as the principal investigator and director of the Commission on Education, a joint venture of the American Board and the Academy of Physical Medicine and Rehabilitation.

In 1969 he was named chief of the health services manpower branch of the National Center for Health Services Research and Development. As director of the National Institute of Health’s office of special programs in the Bureau of Health Manpower Education during 1972, he took an active role in the development of medical school outreach services through area health education centers.

The graduate medical education programs for 1974–75 follow. For information about other programs and graduate services for M.D.s, write to Dr. Fenderson, Box 293 Mayo Building.

CONTINUING MEDICAL EDUCATION PROGRAM 1974–1975

PAIN SYNDROMES: Sponsored by the department of neurosurgery, September 6–7, 1974.


THE MANAGEMENT OF CEREBRAL PALSY: Sponsored by the department of physical medicine and rehabilitation, September 9–14, 1974.

OBSTETRICS AND GYNECOLOGY: Sponsored by the department of medicine, September 18–20, 1974.

INTERNAL MEDICINE REVIEW: Sponsored by the department of medicine, October 1–5, 1974.

COMPUTERS AND TECHNOLOGY IN CLINICAL MEDICINE: Sponsored by the division of health computer sciences, date to be announced.

LEARNING DISABILITIES: Sponsored by the division of pediatric neurology, October 18, 1974.

MINNESOTA MEDICAL ALUMNI SEMINAR ON SEXUALITY: Sponsored by the Minnesota Alumni Association, October 18–19, 1974.

PRINCIPLES IN COLON AND RECTAL SURGERY: Sponsored by the division of colon and rectal surgery, November 6–8, 1974.


TOPICS IN PHYSICIAN ACCOUNTABILITY, PART II: Sponsored by the department of medicine, November 13–16, 1974.

PEDIATRICS: Sponsored by the department of pediatrics, February 3–5, 1975.

PULMONARY DISEASE: Sponsored by the department of medicine, February 13–14, 1975.

PERINATOLOGY: Sponsored by the department of obstetrics and gynecology, February 22, 1975.


ALLERGY: Sponsored by the department of medicine, April 3–5, 1975.

CANCER: PRACTICAL AND THEORETICAL ASPECTS OF DIAGNOSIS: Sponsored by the department of laboratory medicine and pathology, April 23–25, 1975.

OPHTHALMOLOGY: Sponsored by the department of ophthalmology, May 5–6, 1975.

CLINICAL DERMATOLOGY FOR FAMILY PRACTITIONERS: Sponsored by the department of dermatology, May 15–17, 1975.

GENETICS, CLINICAL APPLICATIONS: Sponsored by the medical genetics program, May, 1975 (date to be announced).

SURGERY: Sponsored by the department of surgery, May 19–21, 1975.


Additional courses will be announced. These may include minor surgery, hypertension, infectious disease, emergency medicine and recent advances in applied laboratory medicine and pathology.
MMF SETS ANNUAL MEETING
FOR WEEK OF MEDICAL ALUMNI REUNIONS

MMF Annual Meeting: Oct. 17
Medical Alumni Reunions: Oct. 18–19
Homecoming Football (Minnesota vs. Iowa): Oct. 19

The Minnesota Medical Foundation will hold its Annual Membership Meeting on Thursday, October 17, 1974, to make it easier for medical alumni to attend both the Foundation’s meeting and medical alumni reunion activities the following two days.

Guest speaker for the Minnesota Medical Foundation meeting will be Dr. A. B. Baker, Regents’ professor of neurology, speaking on “Aging and the Human Brain.” Dr. Baker is considered one of the world’s foremost experts on stroke.

The MMF meeting will be held at the Minnesota Club in St. Paul. For further information, write or call the Foundation: 5412 Powell Hall, University of Minnesota, Minneapolis, Minn. 55455. Telephone: (612) 373-8023.

ALUMNI REUNION

Reunion classes of the Medical School (1924 MB’s, 1929 MB’s, 1934 MB’s, 1939 MB’s, 1944 MB’s, 1949 MB’s, 1954 MD’s, 1959 MD’s and 1964 MD’s) will meet Homecoming weekend in Minneapolis. Donald D. Dahlstrom, Med ’62, is reunion chairman for 1974.

Schedule:
Friday, Oct. 18
8:30 a.m. Registration and continental breakfast, Radisson South Hotel
9:30 Bus to U of M campus
10-11:30 Tour of Health Science Center, spouses welcome
11:30 Bus back to hotel
12-1:30 p.m. Luncheon, Garden Court Center, Guest speaker is Dr. Mary Calderone on “Education for Sexuality.”
2-4 p.m. Seminar sessions, Radisson South.
Dr. Don Hastings, “The Doctor as Sex Educator.”
Dr. Murray Rosenberg, “The Doctor as a Sex Educator of His Own Children.”
Dr. John Mathers, “The Doctor as a Sex Educator in the Community.”
6:30-8 Social Hour, Garden Court
8-12:30 Dinner Program, Entertainment, Great Hall East
Richard A. DeRemee, Med ’59, M.C.

Saturday, Oct. 19
10:30 a.m. Brunch, Great Hall West
12:15 Bus to Minnesota-Iowa Football Game

For registration information, write or call: University of Minnesota Medical Alumni Association, 2610 University Avenue, St. Paul, Minn. 55114 Telephone: (612) 373-2466.
DR. HARVEY SHARP
GETS 'DIMES' GRANT

Dr. Harvey L. Sharp, professor of pediatrics, has received a $55,866 two-year grant from the National Foundation — March of Dimes to fund his attempt to determine the exact cause of a relatively common congenital condition which makes individuals highly susceptible to fatal liver and lung disease.

Children born with low blood levels of the liver anti-enzyme alpha-1-antitrypsin (a1AT) run high risk for cirrhosis of the liver, and, in adult life, emphysema.

Dr. Sharp will try to isolate and purify a1AT from blood and liver and analyze its chemical structure and properties. He will also attempt to show whether the inheritable deficiency results from inability of the enzyme to pass through liver cell walls into the blood and whether this in turn results from abnormal molecular structure of a1AT itself or another enzyme which normally aids in manufacture or secretion of a1AT in the liver.

"Answers to these questions might enable physicians to devise specific treatment for the condition, possibly by enzyme replacement," Sharp said.

Sharp received a $7500 grant from the Minnesota Medical Foundation in 1973 and a $3900 grant in 1970 for liver enzyme studies. MMF emphasizes start-up support of promising researchers in its granting program.

CORRECTION

The Article, "One Student's Reaction to RPAP," in the Spring issue of the Medical Bulletin was inadvertently credited to the wrong author. The article was written by Dr. John Fremstad, medical class of '73.
ASSISTANT DEANS FOR STUDENTS

The University of Minnesota Medical School has named two faculty members to assistant deanships for student affairs.

The appointments of Pearl Rosenberg, Ph.D., associate professor in the department of physical medicine and rehabilitation and the division of health care psychology, and George Williams, M.D., associate professor in the department of psychiatry and School of Public Health, were announced recently by Dean N. L. Gault.

On the University faculty since 1966, Dr. Rosenberg has specialized in group dynamics and interpersonal relationships. She has worked with students and staff in medicine, psychology and therapy programs and teaches in the schools of nursing and public health, the agricultural extension division and the human sexuality program. She earned her master's degree in clinical psychology in 1948 and her doctor of philosophy degree in clinical psychology and psychotherapy from Harvard University in 1952.

A University faculty member since 1955, Dr. Williams has taught a course on psychosomatic medicine to medical students, lectured to advanced students in public health nursing and hospital administration, and served as acting director of the public health program in maternal and child health.

He graduated from the St. Louis University School of Medicine in 1945. Before joining the University faculty he was director of the Rochester-Olmsted County Health Department Counseling Clinic.

ALUMNI DEATHS

It is the policy of the Medical Bulletin not to report cause of death in obituaries. Readers may direct inquiries or comments to the editor.

Ross Danforth Benson — 1912
Died Dec. 25, 1973, at Deaconess Hospital, Billings, Mont. He was 91.

Anthony S. Berlin — 1937

John P. Burton — 1939
Died Feb. 8 in Monroe, La., at age 57. He had been psychiatric director of the Monroe Mental Health Center.

Lloyd B. Dickey — 1923
Formerly head of the department of pediatrics at Stanford and a consultant to the Kaiser-Permanente Group, San Rafael, Calif., until his death recently.

Donald E. Dille — 1945
Died March 21 at age 52. He had practiced in Litchfield, Minn. for 28 years. He was a past president of his county Historical Society, long time county corner, a member of the Litchfield School Board, the American Medical Association, the Mid-Minnesota Medical Society and the Minnesota State Medical Association.

Kenneth W. Douglas — 1939
Died March 13 in Medical Lake, Wash., where he had been superintendent and medical director of the Interlake School.

S. Paul Ehrlich — 1926
Died in May at age 72.

Douglas Garrow — 1930
Died May 14. He had practiced in St. Paul for 40 years.

Hubert W. Lee — 1929
Died Dec. 21, 1973, at age 77. He was a specialist in ENT and a staff member of St. Joseph's Hospital in Brainerd, Minn.

James Theodore Mills — 1924
Died Jan. 15 at age 72 at Baylor Hospital, Dallas, Tex. He was certified by the American Board of Otolaryngology and the American Board of Plastic Surgery, serving as a member and chairman of the latter board. He was a past president of the American Association of Plastic Surgeons and the American Society of Plastic and Reconstructive Surgeons. He served on the faculty of the University of Texas Southwestern Medical School and on the staff of the Baylor Hospital.

Bjarne Pearson — 1929
Died Feb. 26 at age 73 in Frederick, Md. He was certified by the American Board of Pathology and served on the faculty of the Wayne State University School of Medicine in Detroit. He was formerly with the Detroit Institute of Cancer Research.

John N. Perkins — 1919
Died Jan. 31 in Portland, Ore., at age 81. He was certified by the American Board of Psychiatry and Neurology and was for many years associated with the Veterans Administration.

James (Jacob) A. Polzak — 1924
Died March 16 at age 77. He was chief of urology for many years at Northern Pacific Hospital in St. Paul. He had also been affiliated with the Samaritan Hospital in St. Paul, Metropolitan Medical Center, North Memorial and Hennepin County General Hospitals.

Francis X. Roach — 1942
Died March 11 at age 54. He was certified by the American Board of Urology and was affiliated with the Cameron Hospital and St. Joseph's Hospital, Stockton, Calif.

Ralph Rossen — 1933
Died June 26 at age 64 in his home in St. Louis Park, Minn. A Minneapolis neurologist and psychiatrist, he was long-time superintendent of Hastings State Hospital and was (Continued next page)
DEATHS continued

Minnesota's first state mental health commissioner in 1950. He was also director of the L. E. Phillips Psychobiological Research Fund at Mount Sinai Hospital.

Emmett LeRoy Schield — 1924

Rolland H. Wilson — 1922
Died Jan. 11 at age 78 in Winona, Minn. He served as city health officer for Winona and was a past president of the Minnesota State Medical Association.

Toshio Yumibe — 1954
Died Feb. 3 at age 47 in Bakersfield, Calif. He had been affiliated with the Mercy, Greater Bakersfield and San Joaquin Community hospitals.

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The third annual Medical Student Achievement Awards of the Minnesota Medical Foundation were presented recently to George R. Biltz, a computer expert from Perham, Minn.; R. Kristina Gedgaudas, the first woman medical student to receive the award; Gregory Grabowski, a student researcher who also received the Foundation's annual Student Research Prize at his graduation; and John Hobbs, a black student who came to Minnesota via Montana from the streets of Tallahassee, Fla., through the "Upward Bound" program for under-employed and disadvantaged youth.

The award was established in 1972 to reward medical students who excel in academic performance, student leadership or community service. Winners each receive a $1,000 prize.

Biltz, a 1974 graduate, received the award primarily for his work in applying computer technology to medical research, patient care and medical education. He spent his last academic quarter of medical school on a research externship at the Institute of Clinical Biochemistry in Oslo, Norway, where he worked on a computer program to help diagnose metabolism diseases which cause neurologic complications in children.

Earlier, Biltz worked with Drs. Eugene Johnson and Jesse Edwards at the University of Minnesota on a study which used a computer to determine whether doctors could predict heart attacks from patient serum enzyme profiles. He also developed a computer-assisted instructional program to teach the principles of pediatric cardiology to medical students. It was one of four programs demonstrated with Dr. James Moller of the University in an award-winning educational exhibit at the 25th Annual Meeting of the American College of Cardiology. He is also a member of the editorial board of the Journal of the History of Medicine.

Kristina Gedgaudas conducted research in the University's radiology department entitled, "Macromolecular Synthesis in Fast and Slow Growing Ascites Tumors." She has received several outstanding grades in her medical school work and frequently returns to clinical rotations after completing the required time to continue following the care of patients she began working with and expand her knowledge. She has also done cardiovascular research at the University and recently served a pediatrics externship at Boston Children's Hospital. She will graduate in 1975.

Grabowski, a 1974 graduate, received grades of "outstanding" in each of his clinical rotations. He worked nights and weekends studying the role of a sterol-carrier protein in the liver synthesis of bile acids, presenting his paper on his work at the American Federation for Clinical Research meeting in Atlantic City. The paper deals with the process by which
liver cells manufacture the unique salts of bile by a series of chemical steps which take place in different locations in the cell. Grabowski presented new evidence to support the view that a special protein carries the product of one chemical step to the site of the next step. Grabowski also served as a volunteer at the Cedar-Riverside People’s Free Clinic for the past three years. He also served on the scholastic standing committee of the Medical School.

John Hobbs enters his third year of Medical School this fall. He found his way to the University of Minnesota Medical School via Montana from his hometown of Tallahassee, Fla. He readily admits that he had no plans for education beyond high school until

ASYMPTOMATIC GONORRHEA IN RURAL MINNESOTA

By David W. Hilfiker, M.D. ’74

The reported incidence of gonorrhea had been rising by more than 10% per year. Recent screening by culture of women in non-venereal disease clinics had revealed an average 4% positive for gonorrhea. Screening of women in private physicians’ offices had revealed 3.8% positive. As gonorrhea in women is asymptomatic in approximately 85% of cases, physicians had been urged to begin screening all women undergoing pelvic examination — especially women under 26 — as an effective way of bringing the epidemic under control.

Many rural physicians in Minnesota, however, had maintained that the incidence of gonorrhea in their communities did not approach the stated national levels, and they had not initiated screening programs.

In the fall of 1972, with the financial help of the Minnesota Medical Foundation, the encouragement of the University of Minnesota Medical School, and the active assistance of 21 rural physicians, we designed a study to assess the efficacy of culturing all women presented themselves to outstate physicians for pelvic examination. We used the recommended Transgrow medium to transport the cultures to the state laboratories for interpretation. The study was designed to measure the percentage of positive cultures obtained by busy primary physicians in their offices rather than the percentage under strict research conditions.

The initiative for this study came from several third-year medical students who were about to spend a year learning and practicing medicine in outstate Minnesota through the Rural Physicians Associate Program. On arriving in our small towns throughout the state, we solicited the cooperation of our preceptors, many of whom participated actively in the study themselves. The Minnesota State Department of Health counsellors in the federally-sponsored “Project Upward Bound” took an interest in him and arranged for him to attend Carroll College in Helena, Mont. He later transferred to the University of Montana in Missoula where he completed his pre-medical training.

Hobbs received the award for high academic achievement, for service to the Medical School’s Scholastic Standing Committee and Minority Student Admissions Program, and for contributing a great amount of his time and effort to tutoring and counsel­ling fellow minority medical students who found it more difficult than he to adjust to the state or the Medical School. He is also continuing to carry out a private study of sickle cell anemia.

The Minnesota State Department of Health, for the number of positive cul­tures was very low. (See Table I).

In the fall of 1972, with the financial help of the Minnesota Medical Foundation, the encouragement of the University of Minnesota Medical School, and the active assistance of 21 rural physicians, we designed a study to assess the efficacy of culturing all women for whom a pelvic examination was performed, regardless of age or presenting complaint. Cultures on Transgrow medium were taken in standard fashion, the medium was incubated for 16-18 hours at the participating clinic, and the Transgrow was mailed to the State Department of Health. For each woman cultured we recorded: age, marital status, whether patient suspected she had venereal disease, known exposure to venereal disease, gonorrhea symptomatology (dysuria, vaginal pain, lower abdominal symptoms), birth control methods used and results of culture.

From November 1972 until March 1973, 2128 endocervical cultures were obtained in 10 different clinics scattered throughout Minnesota. We attempted to culture all of the women for whom we performed a pelvic examination and, for the most part, had no difficulty in this. We were very surprised by our results as the reports began coming back from the State Department of Health, for the number of positive cultures was very low. (See Table I).
Our results surprised us. Our implicit intention had been to show that it made sense for rural physicians to screen all women for gonorrhea, yet only one clinically non-suspect patient of 2042 had a positive culture using the recommended medium and procedures. Clearly it did not make sense to screen all women. Even the age group at risk (under 26) had only one positive culture in 714 clinically non-suspect patients.

The question of how many of our patients actually had gonorrhea cannot be so clearly resolved. Our high percentage of “No Growth” reported (62%) would lead some authorities to suggest that either our media or our culturing techniques were inadequate. The media, however, were continually monitored by the State Department of Health and found to be adequate. Our techniques were taken directly from the recommended literature, and no student or physician reported deviating significantly from the recommendations. In addition, the 62% “No Growth” was fairly consistent in all 10 clinics, showing no individual variations indicative of poor technique. Many other authorities in the field believe that a “No Growth” can be considered a “negative” result (no gonorrhea present) and would conclude that our small positive culture return accurately reflected the incidence of gonorrhea in the population sampled.

Certainly no trustworthy conclusions can be drawn from our study concerning the actual incidence of gonorrhea among rural women in general. Women suspecting a venereal disease may travel to other towns or urban centers for diagnosis and treatment in order to remain anonymous. Perhaps the population visiting a physician’s office for pelvic examination would be less likely to contract gonorrhea than the general population. Nevertheless, the extraordinarily low incidences noted in our study suggest that there is something different about the rural Minnesota population from both the urban populations and from other rural areas in which similar screening programs have found a much higher incidence of gonorrhea.

There are, of course, certain instances which would seem to warrant routine screening in a rural Minnesota clinic. Women with any suggestive symptoms or those who suspect VD contact should, of course, be cultured. It would seem that routine screening of all pregnant women is indicated to prevent neonatal complications. In specific rural communities with high mobility, close contact with an urban area, and/or other differences which might suggest more likelihood of disease, a physician might feel that routine screening is warranted. If a physician has any reason to suspect the existence of gonorrhea in his community, screening is simple, inexpensive, and not very time consuming. Screening all patients might prevent a local epidemic. In general, however, it was our conclusion that routine screening in all clinics in rural Minnesota is not warranted.

The results of our study so interested one of my classmates, Michael Bess, that he reviewed the relevant literature and combined the report of our study with his review. This more technical report and review of the literature of asymptomatic gonorrhea is available in the June issue of Minnesota Medicine.

<table>
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<th>AGE</th>
<th>POSITIVE CULTURE</th>
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<th>OVERGROWN WITH OTHER ORGANISMS</th>
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<table>
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<th>AGE</th>
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<td>6</td>
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<td>859</td>
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Address ________________________________________________

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Honors, fellowships, medals, honorary degrees

Major field of practice

Special interests

Family

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Dr. Repine has had firsthand knowledge of nearly all of the Foundation's programs, first as a medical student and now as a newly-appointed instructor in internal medicine who is gaining national attention with his research into the function of the neutrophil.

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Since graduating, Repine has earned other MMF research grants totalling $13,000, to keep his studies going until he could attract federal support. His articles are now appearing in the scientific literature and recognition of his work is spreading. He has received Fellowship Grant support from the American Lung Association of Hennepin County. He recently was chosen for a Young Pulmonary Investigator Award from the National Institutes of Health, which includes a grant of $15,000 per year for two years.

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(Left to right) Martha Mitchell, Lloyd Minai, Nancy Meryhew, receiving medical diplomas from Regents' Professor Wallace Armstrong.