Challenge and Promise:
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At the University of Maryland Medical Center, significant breakthroughs are happening every day. Like our discovery and implementation of the genetic test that determines which particular drug will prevent future blood clots and heart attacks in catheterization patients. And as one of only nine vaccine development centers across the country, our research has helped lead to the development of the H1N1 vaccine, among many others. We’re among the few offering hip osteotomies, as well as cartilage transplants – innovative operations that help eliminate the need for joint replacements. So, let’s face it. With advances like these, only hope is on the horizon.

Learn more about our discoveries and innovations.
umm.edu/discovery
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The Congressional Budget Office estimates that by 2022, one-third of a family’s income will be absorbed by health insurance premiums. As the only state in the union where uniform hospital rates prevail by health insurance premiums. As the only state in the union where uniform hospital rates prevail for all public and private payers, Maryland is now experimenting with a model system placing the patient at the center of care, encouraging a clinically integrated network that includes both hospital and primary care physicians.

Alumnus Profile: Louis Domenici, ’78 20
Spotlight on Patient Care

One of Maryland’s best internists has held a series of administrative posts in the department of medicine and was recently named associate chair of quality improvement and patient safety. Louis Domenici, ’78, has a hard time saying no to anyone. However he’ll turn you down if the task requires giving up what he loves most—his practice.

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The Courage of Conviction

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t the start of each New Year we contemplate our goals, which often include recommitting ourselves to leading happy, healthy lifestyles. Never before has “good health” been on our minds as it has been with the passage of the Affordable Care Act (ACA), and our nation’s emphasis on preventive care. The ACA has dramatically impacted health professionals who now face the challenge of providing for an expanded patient population, in the midst of budgetary constraints and spending cutbacks.

Our patients need and deserve the highest-quality care, using the best resources available. In an era when the pervasive adage is “do more with less,” we must think strategically about how we will deliver this care.

The State of Maryland is unique because we operate under a Medicare waiver from the U.S. Centers for Medicare and Medicaid Services. Under this system, our hospitals, including those in the University of Maryland Medical System (UMMS), are exempted from the usual deductibles that arise with private versus federal reimbursement. Instead, hospital reimbursement rates are set by the state-run Health Services Cost Review Commission (HSCRC), and not by negotiations with insurance companies. As long as the rate of growth in healthcare costs remains lower than the rest of the nation, Maryland continues to keep the Medicare waiver, and the HSCRC continues to set hospital payment rates.

However, with the new waiver requirements, the HSCRC has imposed a new set of guidelines focusing on population health, reducing hospital readmissions and improving the quality of care, especially preventive care, in the most cost-effective manner. As we reflect on the New Year’s resolution for “good health,” this seems like a step in the right direction. For example, if we could provide rigorous preventive care for every adolescent patient with asthma living in the inner city, where the prevalence and severity of disease is very high, this could reduce the number of severe asthma attacks she or he had each month, thereby decreasing the extremely costly need to treat these patients in the emergency room. Hospitals that can accomplish the task of improving population health will receive a financial incentive, while hospitals that cannot will be penalized.

Making a significant impact on Maryland’s overall health is a challenging task. Therefore, this issue of the Bulletin features how UMMS is reexamining its strategic plan to meet the demands of health professionals who now face the challenge of providing for an expanded patient population, in the midst of budgetary constraints and spending cutbacks.

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Remembered: Irving J. Taylor, ’43M

Irving J. Taylor, a March 1943 graduate and pioneer in the field of biologic psychiatry, died November 14, 2014, at the age of 95.

Born and raised in Ellicott City, Taylor grew up working at the family’s furniture, appliance and jewelry store located on Main Street. He received an AB from Johns Hopkins University before matriculating at Maryland. During his first year of medical school his father purchased a 12-bed psychiatric hospital, naming the younger Taylor his partner.

Upon graduation, Taylor performed a rotating internship at Baltimore City Hospitals and received residency training in internal medicine at West Baltimore General Hospital. In 1945, he served on active duty as a neuro-psychiatrist in the U.S. Army Medical Corps and was discharged in 1947 with the rank of captain. He completed training as senior psychiatric resident at Spring Grove State Hospital from 1947 to 1949, then as a resident at the VA Hospital in Perry Point assigned to the outpatient mental hygiene clinic. Taylor also studied for two years at the Washington-Baltimore Psychosomatic Institute.

Certified as a psychiatrist in 1951 by the American Board of Psychiatry and Neurology, Taylor began the transformation of his small hospital into what would become a 204-bed facility with 500 employees. And along with it, he forever changed the practice of psychiatry. In 1953, he became the first psychiatrist in the country to treat inpatients with Thorazine, marking the beginning of modern psycho-pharmacology with disease-specific psychiatric treatments. His work continued with anti-depressants and anti-anxiety medications developed over the next two decades. Taylor is credited with opening the first adolescent psychiatric inpatient treatment program in Maryland, expanding treatment options for young adults and those suffering from substance abuse. He was also an advocate of continuing medical education for physicians before it was made compulsory, hosting and publishing the proceedings from the Taylor Manor Hospital Psychiatric Symposia. All of this was accomplished with the partnership of his father Isaac, his wife Edith, and later also his son, Bruce, MD.

“Irv was a man ahead of his time,” said Anthony F. Lehman, MD, MSPH, senior associate dean for clinical affairs and professor and former chairman of the department of psychiatry. “His early advocacy on behalf of persons with mental illness was instrumental in the state’s decision to establish the department of psychiatry at the University of Maryland.”

A distinguished lifetime fellow of the American Psychiatric Association, Taylor served on the board of review for the Maryland State Department of Mental Hygiene and was active in state medical and psychiatric associations as well as the National Association of Psychiatric Hospitals. Over the years the Medical Alumni Association of the University of Maryland, Inc., honored him with its two annual awards: the Honor Award & Gold Key, presented for outstanding contributions to medicine and distinguished service to mankind; and the Distinguished Service Award, citing his countless contributions to the association and school. He was a member of the 1807 Circle of the John Beale Davidge Alliance, a society recognizing the school’s most generous donors.

Throughout his life, Taylor remained active in the betterment of Ellicott City, assisting in the preservation of buildings located in the historic section—efforts that continue to give the area its special small-town charm. He was active in the Jewish National Fund, Israel Bonds, Jerusalem Foundation, Hebrew University, Tel Aviv University, the Technion in Israel, and the Delta Society, now called Pet Partners, as well as other charitable organizations.

Preceded in death by wife Edith, Taylor is survived by daughter Stephanie in addition to son Bruce, Bruce’s wife Ellen, ’78, their daughter Julie, ’14, three additional grandchildren, one great-granddaughter, and nephews Ronald J. Taylor, ’73, and Richard L. Taylor, ’75.
Thanks to the leadership of the late Irving J. Taylor, ’43, members of the Taylor family have been at the forefront of service and philanthropy to Maryland for more than seven decades, leading the way in supporting and transforming the care of patients with neuro-psychiatric illness.

Their most recent endeavor—the family’s gift to establish the Dr. Irving J. Taylor Professorship and Chair in the Department of Psychiatry—demonstrates this exemplary leadership and generosity in several ways. The endowed gift is one of the highest tributes an institution can bestow upon its most distinguished faculty, and this is the first of its kind for the department of psychiatry. It also celebrates the many contributions—personal, professional, and financial—made by Taylor and his family over the years.

“The Taylors know about giving back,” commented Steven Sharfstein, MD, president and CEO of Sheppard Pratt Health System, during the investiture ceremony in August, 2014, to recognize Bankole A. Johnson, DBS, MD, MBChB, MPhil, FRCPsych, DFAPA, FACFEI, as the inaugural Dr. Irving J. Taylor Professor and Chair in the Department of Psychiatry. “This is an extremely generous family. What could be a better capstone to a career than making this gift to the university that Irv loves and establishing an endowed professorship for the chairman of psychiatry here in Maryland?”

Practicing medicine and supporting the Maryland medical community are indeed Taylor family traditions. Irv realized the importance of supporting capital projects to advance the educational mission of the school, contributing funds to underwrite a computer lab in the early 1990s. Irving also endowed a pitze for psychiatric research at the University. In 2006, five Taylors—Irv, Bruce, MD, his wife Ellen, ’78; and nephews Ronald J. Taylor, ’73 and Richard L. Taylor, ’75—combined forces and resources to renovate the first-year lecture hall in the Bressler Research Building. Located on the first floor, the renamed Taylor Lecture Hall received an upgraded lighting and sound system, wireless internet service, and new seats, among other technical and aesthetic improvements.

A few years later Ronald and Richard funded an endowment for the Taylor Lectureship in Neurology and Psychiatry. And the two recently pledged a collective $500,000 to endow the presidency of the Medical Alumni Association, a leadership role that both have held at different times. Funds for endowing the alumni presidency generate operating income for the Association.

But that wasn’t all. In the fall of 2013, Ronald pledged a $500,000 bequest to establish the Ronald J. Taylor, MD, Fellowship in Psychiatry Endowment. The two-year fellowship will be awarded to a prominent junior faculty member demonstrating “an exceptional ability and commitment to medical education or research.”

“Part of my desire for giving to the school over the years is that it’s just the way I was raised,” Ronald says. “My family taught us the value of having a charitable nature, from my grandparents on down.”

Long since serving as president of MAA, both Ronald and Richard continue to play leading roles within the organization. In spring Richard will join Irving and Ronald as recipient of the MAA Distinguished Service Award, presented for outstanding contributions to the school and association. All three (in addition to Bruce and Ellen) are members of the John Beale Davidge Alliance 1807 Circle, a permanent society for alumni, faculty and friends in recognition of their financial contributions.

“We have been taught, and we sincerely believe, that philanthropy of any kind can be a powerful tool for creating change in the world,” said Richard. “We realize how grateful we are for everything we learned at Maryland, and for the opportunities we have had as a result. We want to ensure that others have the same experiences we did.”

Ronald hopes that his family’s commitment to giving will inspire fellow classmatess and other potential donors to consider giving back to Maryland.

“When we attended medical school, we were given a gift that had little financial risk for each of us. Now is our time to share,” he said.

And he emphasized that, as his own history of support has shown, it’s not necessarily what you give that matters most. “Everybody can do something, can give back at some level,” he said. “We all need to do what we can to improve medicine and change the way medicine practices in the future.”

“Maryland is incredibly fortunate to benefit from the generosity of many alumni and friends,” said Dean E. Albert Reece, MD, PhD, MBA, “We are especially grateful to the members of the Taylor family who stand out as leaders in their support of the school and its priorities and projects.”

The Taylor Family: A Model of Giving Back
**Burns Collection Moves with Mummies Exhibit to Cincinnati**

Mummies of the World: The Exhibition 2, featuring 11 pieces of Maryland’s Burns Collection of Anatomical Specimens, moved to the Cincinnati Museum Center in November. Cincinnati is the second stop in what is expected to be a three-year, multi-city tour of America. In April, 2014, the exhibit opened at the Buffalo Museum of Science for a five-month engagement, however popular demand kept it there an additional month as more than 80,000 viewed the collection. Mummies of the World is one of the largest displays of mummies and related artifacts ever assembled and is designed to bridge the gap between past and present, showing how science can shed light on history, the study of medicine, and cultures throughout the world. The Allan Burns Collection was brought to the medical school from Scotland in 1820 and was used for anatomy instruction to the first several generations of Maryland students. It is recognized as among the world’s oldest surviving set of specimens used for medical education.

**Trials Underway for Ebola Vaccine**

THE FIRST STUDY of a promising Ebola vaccine began October 8 in West Africa. Maryland’s center for vaccine development, in conjunction with its sister institution—The Center for Vaccine Development of Mali and the Ministry of Health of Mali—are testing the vaccine on front-line healthcare workers there. It was developed by investigators at the National Institute of Allergy and Infectious Disease Vaccine Research Center and consists of an adenovirus modified to produce a single attachment protein of Ebola virus. Immune responses directed against this single Ebola protein have been shown to be highly protective in animal model challenge studies, and researchers hope this response will be robust enough to protect humans.

"This research will give us crucial information about whether the vaccine is safe, well tolerated and capable of stimulating adequate immune responses in the highest priority target populations, the healthcare workers in West Africa," says Myron M. Levine, MD, director of Maryland’s center for vaccine development.

**Spinal Cord Injuries Cause Brain Inflammation and Degeneration**

Maryland researchers have found for the first time that spinal cord injuries (SCI) can cause widespread and sustained brain inflammation that leads to progressive loss of nerve cells, with associated cognitive problems and depression. The research, published recently in two articles, one in the *Journal of Neuroscience*, the other in *Cell Cycle*, highlights the close links between spinal cord injury and loss of brain function, and suggests potential treatment to prevent such changes.

"Animal studies have shown that traumatic brain injury, even mild repeated injuries, can result in progressive brain tissue damage and cognitive decline, as well as widespread brain inflammation. But little research has examined whether these problems occur after spinal cord injuries," said anesthesiology professor and noted neurobiologist Alan Faden, MD, who led the study. "Our studies are the first to show that isolated SCI can cause progressive loss of brain cells in key brain regions," said Faden. "The brain degeneration was demonstrated in different experimental models and animals. We also have identified certain molecular mechanisms responsible for these pathological changes and shown that certain drugs can prevent these injuries, including inflammation, brain cell loss, cognitive decline and depressive-like behaviors after injury."

**Transitions**

Joseph S. Friedberg, MD, is head of the division of thoracic surgery, thoracic-surgeon-in-chief for the medical system, and the Charles Reid Edwards Professor of Surgery at the school. Friedberg comes to Maryland from the University of Pennsylvania where he served as professor of surgery. He is a world leader in thoracic surgery, as well as a respected research scientist focusing on innovative treatments for mesothelioma.

Shyamasundaran Kottilil, MBBS, PhD, is co-director of the institute of human virology clinical research unit and associate director for clinical research in the institute’s division of clinical care and research. Kottilil is a world-renowned expert in infectious disease who joins the faculty from the National Institute of Allergy & Infectious Disease of the National Institutes of Health. His research focuses on Hepatitis B Virus, Hepatitis C, and Human Immunodeficiency Virus. He becomes a professor in the department of medicine division of infectious disease.

Robert V. O’Toole, MD, professor of orthopaedics, is now head of the school’s division of orthopaedic traumatology and chief of orthopaedics for the P. Adams Cowley Shock Trauma Center. A tenured professor, O’Toole is responsible for clinical oversight of the medical center, Midtown campus, as well as the facilities in Prince George’s County.
As the cost of health care spirals to consume excessive amounts of the average family budget, the University of Maryland Medical System (UMMS) characteristically finds itself in the forefront of those seeking solutions.

**The Maryland Experiment**

The new system is designed to place the patient at the center of care.

UMMS president and chief executive officer, Robert A. Chrencik, reports that the hospital system, built on a growth strategy that has worked well for the organization since its creation 30 years ago, currently is being given incentives to curtail growth and decrease patient utilization.

Maryland’s Health Services Cost Review Commission (HSCRC)—which is the only state agency in the country that sets the rates hospitals can charge—struck a deal with the federal government to significantly revise the state’s CMS “waiver” which dates back to 1977.

“Our job today is to help all our stakeholders—board members, physicians, staff and patients—understand and thrive in this new reality,” Chrencik reports.

Chrencik, whose expertise in every phase of hospital operation is extensive, has been with UMMS since its 1984 inception and has served as chief financial officer prior to his appointment as president and CEO in 2008. The 12-hospital system, the flagship of which is the University of Maryland Medical Center, has thrived under this continuity of leadership.

In 1977, HSCRC set uniform hospital rates for all public and private payers, including Medicare and Medicaid, making Maryland the only state in the country where all payers pay the same rate for hospital services.

“It was an effective ruling, both for hospitals and patients,” says Henry J. Froney, UMMS executive vice president and CFO. He explains that it eliminated cost-shifting from one-payer to another, and resulted in the federal government’s agreement to pay HSCRC set rates and “waive” the national payment system.

While other states experimented with this model many years ago, Maryland is the only state to retain this important provision. It also provides $800 million annually in uncompensated care, critical in reimbursement to all Maryland hospitals since there are no charity hospitals in the state.

Change, however, became inevitable as the cost of health care, specifically Medicare, has risen beyond any earlier projections. Medicare enrollment has risen from 20.4 million in 1970 to an estimated 86.5 million for 2035. In 2013, Medicare spending was $566 billion. In 2015,
it will be $397 billion, and in 2023, it is expected to soar in excess of $1 trillion. Putting this in the perspective of the average family budget, the Congressional Budget Office estimates that by 2022, one-third of a family’s income will be absorbed by health insurance premiums.

“As people are living longer, Medicare enrollment continues to increase, and as the cost of technology spirals, so too does the cost of care,” Franey says. He adds that it is expressly the increase in the cost of Medicare that led to enactment of a revised waiver which became effective in January 2014.

The new Maryland waiver, which is a model program for possible enactment throughout the country, retains most of its predecessor’s goals. It seeks to improve access to care, cost containment, equity of payment across payers and funding of uncompensated care. However, it has moved to a fixed, annually approved revenue amount that rewards hospitals for reducing avoidable hospital-based care, and penalizes increase of such admissions. It also increases incentives and penalties for quality, funds a portion of inflation, and provides seed funding for innovative approaches and strategies to minimize unnecessary utilization and reduce readmissions, a concern of the new waiver.

“We also are beginning to deliver care at the most affordable and appropriate locations among our 12 hospitals,” he says. “In addition, we are organizing our employed physicians across our system to better meet the needs of the entire population we serve.”

Some physicians question how the patient will fare in terms of the availability of new technology and evolving trends in patient care that traditionally are provided in an academic setting.

Walter H. Ettinger, MD, senior vice president and chief medical officer, says “We as doctors must be honest with ourselves. Not all emerging treatments and technology have resulted in better public health. Some have higher costs not reflected by evidence they are any better clinically. I believe, as doctors associated with academic medicine, we should be defining exactly when and for whom such technology makes a real difference. I think it’s also important to determine a cost benefit analysis.”

Ettinger reasons that, while as Americans, we want and demand the best, he believes we have to become realistic by looking at costs as a societal issue. “How much are we willing to spend on innovations that add only marginally to benefit?” he asks.

Ettinger agrees the new waiver affects tertiary hospitals such as the University of Maryland and Hopkins differently than it does community hospitals that are not charged with training the next generation of health care providers, developing new treatments, and researching new ways to treat disease. The academic medical centers also are those that treat the sickest patients, the unusual cases, and the patients who often need significant resources to stay alive.

“About 150 such academic medical centers across the country have become extremely expensive in part because of the money generated by clinical care which is allocated to research and education,” he says.

“We have had a powerful surge in research in Maryland over the past 10 years. It’s probably time for tertiary hospitals to retcon themselves, with the result that they won’t do everything within their own walls but will increase both patient care and teaching in the community.”

Ettinger’s insights into the recent changes in the current rate-setting protocols in Maryland appear to
be relevant to other states as well.

Joshua Sharfstein, former secretary of Maryland’s Department of Health and Mental Hygiene, and one of the architects of the proposal to modernize the all-payer rate-setting system, indicated he believes changes in the original waiver have been designed for success.

“Our overall hypothesis has been to create an all-payer system consistent with the current pattern of health care from inpatient to outpatient services,” he says. “Our aim has been a system that achieves enhanced patient care, better population health and lower cost. So far, it has been effective, and I believe projections for a full national model are positive.”

The new system is not foolproof, however. Certain events could trigger termination of the waiver. Franey says these include failure to meet the Medicare savings target for two consecutive years and/or failure to meet the Medicare savings target by $100 million or more. In addition, the all-provider Maryland Medicare spending growth, not just the hospital’s, must not exceed the national rate of growth by more than one percent.

“Finally, a major decline in the quality of care would cause termination,” Franey says. Will physicians have the same incentives hospitals have in reducing inpatient admissions and endorsing the clinically integrated care network? Both Franey and Ettinger agree “absolutely.”

“They must or the system fails,” Ettinger says. “We have the same incentives hospitals have in reducing inpatient admissions and endorsing the clinically integrated care network?”

The UMMS position is that most doctors don’t want to send patients to a hospital if they don’t have to. But without additional resources, they often have no choice. In the new system, the cost of case workers, pharmacists, therapists and others will be funded by the

There are challenges that must be recognized however. “We’re changing a system that has been in place for 50 years,” Ettinger says. “This is a massive transformation that demands people behave differently. It will take a great deal of effort.”

Are doctors likely to accept the change? “Probably not at first,” he says. “But once the system is in place, I think they will see the advantages, one of which is giving them more time with patients.”

The future under the new health care initiative remains uncertain. Challenge, promise, or a measure of both? Whatever the final assessment, it is being faced today by UMMS with thoughtful planning and intellect on behalf of patients, member hospitals, physicians and other healthcare providers.

Joshua

Winter 2014-2015

HEALTH MATTERS

Yes, our health does matter! It’s a topic worth discussing.

Join renowned physicians from the University of Maryland Medical Center and School of Medicine for a panel discussion and lunch, where we will address health matters, including presentations on ophthalmology, diabetes and infectious disease.

Thursday, February 19, 2015
12 – 2 pm Lunch and Panel Discussion
Boca Raton Resort & Club
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HEALTH MATTERS is free to the public, but registration is required. Reserve your seat at ummsfoundation.org/HMF. Please call 450-328-6068 with any questions.

The event will be moderated by E. Albert Reece, MD, PhD, MBA, Vice President for Medical Affairs, University of Maryland, John Z. and Akiko K. Bowers Distinguished Professor and Dean, University of Maryland School of Medicine.

Alumni Drs. Deborah and Joel Shlian made an estate plan gift to establish an endowment for the Institute for Genome Sciences (IGS) at the University of Maryland School of Medicine. Their gift will support the IGS team that has revolutionized genomic discoveries in medicine, agriculture, environmental science, and biodefense.

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A Dissection Room of Our Own: Places and Spaces of American Medical Education

By Mary Ellen Leuver

In an era when burying the body was the only option, and embalming was not practiced, anatomical dissection was a covert, illegal, and pungent affair. The spaces in which dissection was performed were thus hidden, often equipped through black market connections or with a shovel at the local graveyard.

Baltimore mob descended upon the small, windowless cadaver room of John Davidge, MD, in 1807, destroying his private space for medical education after neighborhood children had spied Davidge’s students performing the dissection of a subject thought to be recently buried in one of the local cemeteries. Over the next two centuries the spaces in which Maryland medical students learned the art and science of medicine have been dramatically transformed from that clandestine dissection room to glass-enclosed skyscrapers like the new R. Adams Cowley Shock Trauma Center. While it is tempting to attribute these changes to function, construction advancements, and modern aesthetics, these were not the only factors that transformed the spaces of American medical education. Instead, a series of profound social and cultural upheavals transformed the spaces in which students performed the dissection of the ill, until the turn of the 20th century these places were avoided by even the poor due to the intense social stigma associated with their use. Medical students, who earned degrees in Europe and completed apprenticeships at home, were not expected to learn from physicians and patients inside of these prison-like buildings for the poor. American medical education in the 19th century was instead a largely philosophical pursuit that combined practical bedside observations with lectures. It was in the homes and innermost private chambers of the ill that medical students observed the practices of established physicians. In these domestic spaces, the physicians’ actions, advice, and orders were held to the scrutiny and approval of the patient’s family. Physicians walked a fine line between craftsman, guest, and counselor. This environment was not conducive to exposing students to a broad array of patients and few lessons could be drawn about the effectiveness of the recommended care as physicians.

In the 1840s, physicians began searching for a way to regain patient confidence and to gain advantage and distinction by the 1830s physicians began searching for a way to regain patient confidence and to gain advantage and distinction. Advancements in surgery and hospital hygiene began to transform the hospital into an ideal place for patient care while the discoveries of medical science provided physicians with a new public authority. By the turn of the 20th century, American medical students began to learn in profoundly different spaces. In the new medical schools engagement in the clinic, the laboratory, and the pathology room had become central elements of medical education.

Today, the University of Maryland Medical campus is an expansive center of hospitals, clinics, and laboratories that reflect this complex history of American medicine. Across the United States, the sites of medical education are no longer hidden, but are instead advertised on promotional tourist materials and identified on city signs as showpieces of the urban landscape. Architectural designs have a profound power to dictate the lives of people who reside within them, but the priorities, values, and history of a society are also reflected in the places and spaces we build. The modern campus of the University of Maryland School of Medicine reflects the entirety of the transformation of American medical education. As medical science continues to evolve, the campus will follow as new practices and new knowledge shape the spaces of education and care.
I n 2013 the job-related network known as LinkedIn announced that a student in the United States as young as 14 could add his or her own profile to the company’s website. An earlier generation would have called such a profile a “resume” or perhaps even a simplified “curriculum vitae” to use the Latin for “course of life.” Whether or not students barely ready for high school should participate in professional job markets, a comprehensive CV has become a basic element in the position-seeking armament for any contemporary student. Institutions at nearly every level, including Maryland, provide assistance and instruction on how to put together an attractive CV.

The type-written résumé was in common use by the middle years of the 20th century, although students still relied heavily on letters of reference to document their suitability for professional positions. The drawbacks and inherent prejudices of that method came under attack—it was easily judged to be class-based and otherwise reactionary—yet reliance on letters written by others meant that people seeking jobs had less paperwork to handle and only a modest bureaucratic burden. A great irony of the 21st century is that our own era’s profusion of digitized systems, accompanied by the detailed accountability that accompanies it, felt a modest bureaucratic burden. A great irony of the 21st century is that our own era’s profusion of digitized systems, along with the detailed accountability that accompanies them, has led to more paperwork for everybody.

The latter may now be true even for eager young workers not yet old enough to drive cars legally.

Letters of reference rarely survive in the archives of colleges, universities or corporations. What do survive are pieces of evidence that could be used to put together a modern Curriculum Vitae. Among the many personalities from 19th-century medicine that would have been able to assemble impressive CVs was John Shaw Billings, a native of southern Indiana who earned his MD in 1860 from the Medical College of Ohio (later a constituent part of the University of Cincinnati). Billings became a staff surgeon in the Army of the Potomac during the early years of the Civil War and saw the consequences of battles including Chancellorsville and Gettysburg. By late 1864, however, he was stationed at the Office of the Surgeon General of the U.S. Army and would remain there for the next three decades with responsibilities in finance, record-keeping and cataloguing. His achievements during those decades and for the years that followed his retirement from the Army in 1895 read like any CV consultant’s dream.

To modern physicians, Billings is perhaps best remembered for assembling the Surgeon General’s library, a collection that later formed the nucleus for the National Library of Medicine. While working on the library, Billings began the earliest comprehensive bibliography of professional publications in his field, the Index Medicus, direct ancestor of today’s MEDLINE and PubMed. Billings then tried to establish an early form of public health record-keeping for the entire nation, although Congress failed to fund or otherwise support him to the extent he thought necessary. In an 1888 address to a Maryland State Sanitary Conference, he argued that “without such registration [of vital statistics], a state board of health is like a blind man trying to put out a fire.” His position as a commissioned officer did not prevent him from speaking out frankly albeit carefully.

Billings had originally been transferred to Washington by Surgeon General Joseph K. Barnes. Barnes had earlier that year (1864) succeeded the brilliant and hot-tempered William A. Hammond, MD, a native of Maryland, sometime Maryland faculty member and founding figure of neurology in America. Billings seemed to interact with anybody and everybody important in his own field and in nearly any other field that seemed to promise significance. He was recruited by Daniel Gilman to do the design work for what became the original hospital at Johns Hopkins, and he was a founding member and early president of Washington, D.C.’s celebrated Cosmos Club. Billings also sat at the head table during what was perhaps the most high-powered medical meal in 19th-century America: with over 200 other guests at Delmonico’s Restaurant in April of 1883, as a tribute to Dr. Oliver Wendell Holmes, Sr., the subject of an earlier column in Medicina Memoriae.

After his retirement from the Army at the hard-earned rank of Lieutenant Colonel, Billings was recruited to combine various tasks across New York and form what became the New York Public Library, second only to the Library of Congress as the greatest research library in the Western Hemisphere.

Despite his impressive record, which today would likely result in dozens of pages of a detailed CV, perhaps the greatest feat attributable to Billings had little to do with medicine. During the late 1870s, his work on vital statistics led him to become involved with planning the 1880 census. Among the young assistants who were supervised by him was an engineer named Herman Hollerith.

...It was Billings who first suggested to Hollerith that tabulation and analysis of the mass of Federal census data could be done better and faster if they used “cards with notches in the ends” along the lines of a Jacquard loom.

According to an account published by Hollerith’s daughter Virginia in the peer-reviewed historical journal Isis (61.1, 1971), it was Billings who first suggested to Hollerith that tabulation and analysis of the mass of Federal census data could be done better and faster if they used “cards with notches in the ends” along the lines of a Jacquard loom. These notches, or holes, would correspond to a given array of data points for each census entry. Billings himself would write, in 1885, that “to have the punching of these cards done by machine, by simply playing upon keys like those of a piano…and counted by machinery or by electricity” would result in a better and more rapid understanding of the raw information. He emphasized that such cards would be “an addition, not a subtraction” to the standard forms filled in by census takers.

According to his daughter, Hollerith offered to bring Billings into a commercial application of their idea as independent contractors; but for Billings the “only wish was to see the problem solved.” Hollerith then ran with the ball that Billings had given him. Their game first came into full play when Hollerith analyzed mortality rates for the City of Baltimore in 1887. A few years later, the census of 1890 was tabulated and analyzed using Hollerith’s machines. The process took less than one-fifth the time it had done for earlier censuses even though the data supplied were now far more extensive and detailed.

Herman Hollerith would eventually file over 30 patents for his machines. He incorporated in 1896 as the Tabulating Machine Company. After a series of mergers, the TMC became IBM—the International Business Machines Company.

Billings was a scientifically knowledgeable administrator who defined the best of his age in America during the Progressive Era. Perhaps in the 21st century, an era of ubiquitous computerized technology—all of it descended from Hollerith and Billings’s tabulating card machines—it might seem fitting to compose and then distribute through social media a complete and continuously updated CV for Billings. Call it a Curriculum Vitae Optimum—the best course of life.”

Medicina Memoriae

Curriculum Vitae Optimum

By Wayne Millan
Awards & Honors

❖ Gad A lion, PT, PhD, associate professor, department of physical therapy & rehabilitation science, received the John H. F. Maloney Lecture Award for 2015 from the American Physical Therapy Association (APTA). The honor is awarded to physical therapists who have made distinguished contributions to the profession of physical therapy in any area of clinical practice. A lion will deliver the John H. F. Maloney Lecture at the general session in National Harbor, Md., held June 3-6, 2015.

❖ Matthew Frieman, PhD, assistant professor, department of microbiology and immunology, received the innovator of the year award from the Dai- ly Record. Frieman was recognized for his work on developing therapeutics for the Middle East Respiratory Syndrome Coronavirus. The award is a way to recognize Marylanders and Maryland-based companies for innovative spirit in creating new products, new programs, new services or new processes that have helped their companies, industries or communities.

❖ W Jonathan Lederer, MD, PhD, professor, department of physiology and director of the center for biomedical engineering and technology, has been selected as the co-recipient with Dr. Roberto Boll from the University of Louisville of the 2015 Peter Harris Distinguished Scientist Award of the 2015 Peter Harris Distinguished Scientist Award of the University of Louisville. The award recognizes Dr. Lederer’s contributions to the field of genomics, and his work on the development of new technologies for the analysis of large biological datasets.

Books

❖ Michael Miller, MD, professor of medicine with a secondary appointment in epidemiology & public health, published Heal Your Heart: The Positive Emotions Prescription to Prevent and Reverse Heart Disease.

❖ Jacques Ravel, PhD, professor, department of microbiology & immunology, and associate director of genomics, institute for genome sciences, and Patr ic Ravel, MD, PhD, professor & chair of the department of microbiology & immunology, have been awarded the 2015 Peter Harris Distinguished Scientist Award of the University of Louisville. The award recognizes Dr. Ravel’s contributions to the field of genomics, and his work on the development of new technologies for the analysis of large biological datasets.

Grants & Contracts

❖ Ronna Hertzano, MD, PhD, assistant professor, department of otolaryngology head and neck surgery, was awarded a $5.1 million grant from the U.S. Department of Defense for the project “Towards a Molecular Understanding of Noise-Induced Hearing Loss.” The grant applies genetical modifyed mice to perform cell type-specific translation analysis using RNA-sequencing and is a collaboration between Maryland Vaccine Research Center, Park College (Ridder Deprez, PhD), and the Netherlands Cancer Institute (Ran Ellon, PhD).

❖ Karen Kellof, MD, professor and Matthew Laurens, MD, MPH, assistant professor, both in the department of pediatrics, were awarded a five-year, $1,391,278 over two years under the center for vaccine development vaccine trust. These grants are funded by the National Institutes of Health (NIH) to further develop and implement a Phase 1 Challenge Study to Evaluate Safety Immunogenicity and Efficacy of a Malaria Vaccine (mSPH adenovirus, GLA-SE) in Healthy Adults.

❖ Toni Pollin, MS, PhD, associate professor, department of epidemiology & public health, received a five-year, $3.7 Million grant from the National Human Genome Research Institute (NHGRI) for the project “Eco-Pathogenomics of Chlamydial Transmitted Infections.” This is a renewal of “Regulatory Mechanisms of Insulin Secretion.”

❖ Toni Pollin, MS, PhD, associate professor, department of medicine, received a four-year, $2.1 Million grant from the National Institutes of Health (NIH) for the project “Eco-Pathogenomics of Chlamydial Transmitted Infections.” This is a renewal of “Regulatory Mechanisms of Insulin Secretion.”

Code Breaker

Near 25 years ago, Claire Fraser was part of the first team of scientists to map the complete genetic code of a free-living organism, an achievement that launched the field of microbial genomics. Now director of the Institute for Genomic Sciences at the University of Maryland School of Medicine and one of the world’s most highly cited microbiologists, Dr. Fraser studies the microbiome in host of human diseases, and uses cutting-edge genomic tools that she helped develop to develop better methods of treating them.

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University of Maryland School of Medicine

The NeuroBioBank is a combined effort by the National Institute of Neurological Disorders and Stroke, the National Institute of Mental Health, the U.S. Department of Veterans Affairs for “NEU1 Sialidase Disrupts CD41-Driven Angiogenesis in Human Lung Endothelia” under the mentorship of department colleagues Jeffrey Hasday, MD, professor; Sergei Mammas, MD, associate professor; and Simeon Goldblum, MD. Professor Goldblum also received a four-year, $549,954 ment review grant from the Department of Veterans Affairs for the project “Eco-Pathogenomics of Chlamydial Reproductive Tract Infections.” The focus of this application is on the discovery of biomarkers with applications in the diagnosis, prevention and treatment of Chlamydial trachomatis and Neisseria gonorrhoensis co-infections. It comprises three projects that will evaluate the human genetic component of the infections, the host response (immune and miRNA), as well as the genital microbiome.

The Genomics Resource Center at the Institute for Genome Sciences (GRC), has received a two-year, $1.6 M grant from the National Heart, Lung, and Blood Institute (NHLBI) for the project “Eco-Pathogenomics of Chlamydial Reproductive Tract Infections.” The focus of this application is on the discovery of biomarkers with applications in the diagnosis, prevention and treatment of Chlamydial trachomatis and Neisseria gonorrhoensis co-infections. It comprises three projects that will evaluate the human genetic component of the infections, the host response (immune and miRNA), as well as the genital microbiome.

J. Kathleen Tracy, PhD, associate professor, department of epidemiology & public health, received a three-year, $9,792,000 contract with the Maryland Department of Health and Mental Hygiene for the project “Eco-Pathogenomics of Chlamydial Reproductive Tract Infections.” The focus of this application is on the discovery of biomarkers with applications in the diagnosis, prevention and treatment of Chlamydial trachomatis and Neisseria gonorrhoensis co-infections. It comprises three projects that will evaluate the human genetic component of the infections, the host response (immune and miRNA), as well as the genital microbiome.
Spotlight on Patient Care

Louis Domenici, ’78

What is it that distinguishes exceptional medical care? Intellect? Experience? Compassion? According to the department of medicine’s associate chair of quality improvement and patient safety, Louis Domenici, MD ’78, it is patience.

The internal medicine specialist who heads what is probably the largest practice at the medical school, considers the question momentarily before explaining his opinion. “We live in a society that wants immediate answers,” he says. “Unfortunately, we often don’t have such immediacy in medicine. I was taught by my mentors at Maryland, Domenici followed mentor Kushner to Baltimore’s Lutheran Hospital, returning to Maryland as assistant professor of medicine in 1985. Since then he has served as associate professor, division chief of general internal medicine, and director of clinical operations. In 2014, the department of medicine chair, Stephen Davis, MD, appointed Domenici to the quality improvement, patient safety post. He assumed the position following a lengthy record that includes numerous administrative leadership roles.

Domenici says, “I guess I have a problem saying no.” Discussing the issue of hospital reimbursement, Domenici says he believes the rates set for all Maryland hospitals in the early 70s was a successful system that kept costs down and reduced rates for Medicare.

Unfortunately, the downward pressure on Medicare has led to renegotiation with Medicare and a new system of reimbursement. Hospitals no longer are rewarded for admissions only but have moved to a population health process in which they serve a defined population with a goal to improve care, not only in the inpatient setting but in ambulatory services as well.

He adds that hospitals now will be capped for a specific number of admissions, and can be penalized if they exceed that number, while rewarded if they reduce it. Will the new system negatively affect patient care? “No, as long as the quality of care can be justified, there isn’t a problem,” he says. “It becomes a matter of working faster and more efficiently. For instance, many surgeries that were once inpatient procedures now are performed in an outpatient setting.” He adds that academic hospitals will face more change than community hospitals because their focus historically has been tertiary and trauma care.

“That’s not a good way to approach life—or medicine.” Domenici says, “We live in a society that wants immediate answers, but we will continue to work on the process until it becomes clear. That advice has served me—and my patients—well.”

Domenici, who points to the importance of carefully sorting through patient symptoms before making conclusions, had an introduction to medicine as an undergraduate when he took a summer job as a hospital orderly. Doctors at the hospital let him scrub in to observe surgeries. He recalls it cemented his interest in a medical career, as well as his decision not to pursue surgery.

His mentors at Maryland were Drs. Herbert Kushner, Frank Gallis and Theodore Woodward. “I was surrounded by outstanding interns,” he says. “So I suppose it was understandable that I would want to follow their leadership. Also, I graduated at a time when there was a shortage of family doctors, not unlike today.”

Upon completing his residency at Maryland, Domenici followed mentor Kushner to Baltimore’s Lutheran Hospital, returning to Maryland as assistant professor of medicine in 1985. Since then he has served as associate professor, division chief of general internal medicine, and director of clinical operations. In 2014, the department of medicine chair, Stephen Davis, MD, appointed Domenici to the quality improvement, patient safety post. He assumed the position following a lengthy record that includes numerous administrative leadership roles.

Domenici’s long experience with quality assurance reflects changes in the way issues are resolved. "I’ve learned as much from our residents, if not more, than they have learned from me. I have always been humbled by the accomplishments of the current crop of interns and residents. He believes, as well, that Maryland is exceptional in its preparation of students to the next step as interns and residents. "Our students appear able to integrate easily," he says. "I see bright and well-motivated students from other programs who come here and struggle because they are less prepared for the transition. While we have superb research programs that rival other schools, the mission of our school has always been to train doctors who will care for the people of Maryland. We’re proud of that distinction."

The man who, throughout his career, has never been able to say no, admits there have been times when he has said that word. "When my chairman asked me to take on this new assignment, I considered whether I should put administrative responsibilities aside," he says. "But then I told him I probably had one more challenge in me. However, I have turned down positions that would require my giving up my practice. I won’t do that. I never want to say goodbye to my patients."
Glass, a reconstructive surgeon who completed a surgical residency at Maryland, followed by a residency in plastic surgery at the University of Michigan, spent most of his career in private practice while a professor of surgery at the University of California, San Diego. About three years ago, he approached the medical school there with a plan for an innovative online program aimed at providing retired and inactive physicians with the tools to practice primary care in outpatient clinics throughout the country. “It took a year to convince them,” he says. “In the meantime, I approached other medical schools and received the same reaction—it isn’t possible to train doctors online.” Glass’ response was that this wasn’t a program to train interns and residents but highly skilled physicians with as many as 30 years of knowledge in a specific specialty, experience they would bring to the educational process. A basic rationale behind Physician Retraining and Reentry, which Glass ultimately founded with the collaborative participation of the University of California San Diego School of Medicine faculty, is the mounting decrease in the number of family practice physicians. The shortage is now estimated at 33,000 and anticipated to double within the next 10 years. His vision was to provide retired physicians and those who, for one reason or another were currently inactive within their specialties, an opportunity to become family practice specialists, working full or part-time in a critically under-populated field of medicine.

Glass’s vision was to provide retired physicians and those who, for one reason or another were currently inactive within their specialties, an opportunity to become family practice specialists, working full or part-time in a critically under-populated field of medicine.

HE WAS TOLD it would never succeed. It was contrary to conventional medical education. If failed, any medical school that endorsed it would risk negative impact on its reputation. Nevertheless, Leonard Glass, ’61, believed firmly in his concept for the retraining and reentry of physicians. As it turns out, he was right.

Glass admits one group of enrollees surprised him. They include minimally disabled physicians and include a woman in her late 50s who for 25 years practiced microvascular facial reconstruction. Due to trauma, she lost vision in one eye and, with no depth perception, can no longer perform surgery. Another physician suffered a minor stroke and lost full dexterity in one hand which keeps him out of the operating room. “These are skilled doctors who are far from voluntary retirement, and who want to continue to participate and treat patients,” he says.

Glass’s vision was to provide retired physicians and those who, for one reason or another were currently inactive within their specialties, an opportunity to become family practice specialists, working full or part-time in a critically under-populated field of medicine.

“Every day, 10,000 baby boomers in this country turn 65 and become eligible for Medicare,” Glass says. “For some, this will be the first time they have had health insurance. The Affordable Care Act is estimated to place an additional 30 million people who will be looking for a doctor for the first time.” According to Glass, this presents an urgency that health care in general must address, and physicians themselves are ideally equipped to do so.

Launched a little more than a year ago, Physician Retraining and Reentry has about 70 participants, of whom approximately 10 percent have completed the program. Generally, that takes a physician between four and six months but completion can be expanded to 12 months. Most participants are from California, which Glass attributes to word-of-mouth. However, there is a growing contingent from Florida, Maryland and the Midwest, and Glass estimates enrollment is expected to increase five to tenfold within the next year. He says he measures the success of this initiative by a graduate’s ability to enjoy working full or part-time following completion.

The program itself was written by UC San Diego School of Medicine family medicine faculty. Curriculum consists of 15 courses covering essentials of family medicine including cardiology, dermatology, neurology, endocrinology and medical records. There is competency testing throughout with exam questions and simulated patient evaluations. Participants receive 180 hours of AMA PRA Category 1 CME credits, and assistance in being placed in clinics.

Prior to the inception of Physician Retraining and Reentry, the only programs for retraining were those directed to doctors who sought refresher courses to familiarize themselves with the most recent advances within their specialty. A physician who wished to change to another specialty required an additional residency, which is impractical for most and difficult to obtain through medical schools seeking younger residents.

Who are the people most likely to seek retraining after successful careers in another specialty? Initially, retirees and those soon to be retired were the primary focus. “Many physicians want to slow down at 65, but they don’t want to retire,” he says. He mentions a psychiatrist now treating patients in an emergency room. The physician’s former psychiatric profession has often been valuable in the ER. However, today, he is no longer a psychiatrist but a family doctor. There are many still working, ORGYNs among them, who report being “burned out” by long and late hours. Women who have taken time out to raise a family and now favor a situation more compatible to their lifestyle, are among enrollees. Glass tells of one of the first participants, a board-certified internal medicine specialist who had worked for an insurance company for 18 years and missed patient contact.

Glass admits one group of enrollees surprised him. They include minimally disabled physicians and include a woman in her late 50s who for 25 years practiced microvascular facial reconstruction. Due to trauma, she lost vision in one eye and, with no depth perception, can no longer perform surgery. Another physician suffered a minor stroke and lost full dexterity in one hand which keeps him out of the operating room. “These are skilled doctors who are far from voluntary retirement, and who want to continue to participate and treat patients,” he says.

If anything, Glass is a man who is today more committed to his dream of retraining physicians than he was when he appeared to be a lone advocate of its importance. He claims, though, that none of his success, including the founding of the program, would have been possible without the influence of his Maryland mentor, Everard Cox, ’55, who describes as a fabulous surgeon, teacher, mentor, and war hero. He calls Cox, now in his 90s, a role model who was bigger than life and taught as much about life as he did about surgery.

Looking to the future of physician retraining, Glass says, “I believe it is essential that programs like ours continue to flourish. Otherwise, in five or 10 years, there will be gridlock in the delivery of health care. Unfortunately, it’s a situation currently ignored by too many. I just decided to get the ball rolling in the right direction.”

BY RITA M. ROONEY
Advancement

The Department of Economics Donald E. Wilson Endowed Scholarship Fund: Building Diversity in Medicine

Having a diverse physician workforce is critical to providing high-quality healthcare to our nation as a whole and in making health care available to those who need it most. The health care disparities that more diverse physician workforce is mounting in the U.S., as racial and ethnic diversity increases and a national physician shortage exists while one in every eight U.S. citizens is African American, one in 20 is Asian American, and one in every six Americans identifies as Hispanic/Latino, yet only one in 20 doctors does, according to the 2010 U.S. Census and the American Medical Association’s (AMA) Diversity in the Physician Workforce: Facts and Figures 2010.

By creating more opportunities available to those who need them, as well as providing high quality health care to our nation as a whole and in making health care available to those who need it most, the best questions will not be asked in devising effective solutions for tomorrow’s problems behind our world colleagues. Without diversity of thought, priorities, and backgrounds, the best questions will not be asked in devising effective solutions for tomorrow’s problems. Healthcare is one of the most important. We face a many issues. Healthcare is one of the most important. We face a critical crossroads for our physicians and biomedical scientific workforce, our nation will fall behind our world colleagues. Without diversity of thought, priorities, and backgrounds, the best questions will not be asked in devising effective solutions for tomorrow’s problems.

I have no doubt that as a nation we face critical crossroads for many issues. Healthcare is one of the most important. We face a critical crossroads for our physicians and biomedical scientific workforce, our nation will fall behind our world colleagues. Without diversity of thought, priorities, and backgrounds, the best questions will not be asked in devising effective solutions for tomorrow’s problems.

Items that are subject to probate are known as probate assets. Probate assets generally consist of property that is owned by the deceased at the time of death including life insurance and retirement account benefits.

Estate Planning Basics—Probate

PROBATE IS THE COURT-SUPERVISED PROCESS that manages, settles and distributes a decedent’s property according to the terms of one’s Will. Probate processes are governed by the probate court of the state in which one is domiciled at the time of death, and if property is located in other states, ancillary probate proceedings may have to be initiated in those other states. State law generally requires an estate to go through the probate process if the estate’s assets exceed a threshold amount; estates whose values are below the threshold may be able to avoid probate altogether or may have the option of using an informal or expedited probate procedure. If an estate goes through the probate process, the probate court supervises the:

• validation of the decedent’s Will
• appointment of an executor
• notice to interested parties
• administration of the estate
• identification, collection and valuation of estate assets
• payment of debts, expenses and taxes
• filing of a final accounting to all interested parties
• distribution of assets to beneficiaries

Items that are subject to probate are known as probate assets. Probate assets generally consist of property that is individually owned at the time of death and are transferred to beneficiaries according to the terms of one’s Will. Non-probate assets are property that is transferred outside of a Will, such as property that is owned jointly, and other property that is transferred to designated beneficiaries, including life insurance and retirement account benefits.

For some estates, avoiding the probate process may be advantageous. Although the probate process can take as little as three months, it can be extended for as long as two years or more depending upon the state and complexity of the estate. During this time, the probate assets may lose value (if not properly managed) or the family may be inconvenienced as the funds needed for support cannot be accessed until the process has been completed. There are costs associated with the probate process, such as court costs, attorney fees, executor fees and appraisal fees, which will reduce the value of the estate, and the process itself is a matter of public record which may compromise private family matters. Methods of avoiding the probate process include the use of a revocable living trust, owning property as joint tenants with rights of survivorship, establishing payable-on-death or transfer-on-death provisions, using designated beneficiaries on assets, and making lifetime gifts to transfer assets prior to death.

There are reasons, however, to consider using the probate system to aid in the transfer of an estate. The process may be of value when the Will is confusing, when there are multiple Wills and it can’t be determined which Will should be probated, when an estate is insolvent or it is anticipated that there will be significant disagreement among beneficiaries. In addition, probate provides a statutory limit on the length of time for filing claims against an estate. Many states have adopted the Uniform Probate Code, or some version of it, which has made their probate laws more consumer friendly, especially for smaller estates.

If you have questions about the estate planning or estate settlement process, or if you need to establish a formal wealth preservation and transfer plan, you would be well served by seeking guidance from a qualified attorney and from a qualified wealth planning professional.
Family, friends and significant others joined 157 members of the class of 2018 for medical family day on November 6, 2014, at the Hippodrome Theater. This special event, sponsored by the Whiting-Turner Contracting Company, gives family members of first-year students a glimpse into what medical school is really like for the students. The highlight is a ceremony welcoming the class into the field of medicine by presenting them with their first white coat.

“The White Coat Ceremony is a rite of passage. It symbolizes the beginning of your transition into the noble and privileged profession of medicine,” said E. Albert Reece, MD, PhD, MBA, vice president for medical affairs and the John Z. and Akiko K. Bowers Distinguished Professor and Dean. “It is, however, so much more than a mere ritual for the privileged. For, to whom this great honor and privilege is given, your service, compassion and high ethical standards are expected in return.”

Kathryn (Conniff) Hart, ’08, an assistant professor in the department of family & community medicine, was chosen to be the faculty speaker at the event. Her presentation included a photo from the day 10 years ago when she received her first white coat. She admitted she had not felt worthy of the coat yet, but her older brother, already a physician, told her not to worry.

The ceremony, which started at Maryland in 1997, formally presents students with white coats—the symbol of physicians and scientists—after they have completed their first course of anatomy. Faculty assist in the ceremony, welcoming their junior colleagues to the profession of medicine.

Once they received their coats, students recited an oath acknowledging their acceptance of the obligations of the medical profession. They also added their signatures to the school’s honor registry, a leather-bound book provided by the Medical Alumni Association that is signed by all our medical students in their first year, in which they pledge to maintain integrity throughout their years in medicine.

Phonothon Volunteers Treated to Appreciation Reception

The Medical Alumni Association staged a two-hour reception for the 125 student volunteers who worked a night during the fall phonothon in Davidge Hall. The event was held at the Pratt Street Alehouse, just two blocks from campus. In eight nights of calling beginning in late September, students reached about 1,000 alumni and raised more than $88,000 in pledges toward this year’s annual fund.

Clockwise: The Class of 2018; Ian Davis receives his white coat from father Stephen Davis, the Theodore E. Woodward Professor and Chair in the department of medicine; Enjoying the reception for phonothon volunteers were third-year students Tara Barry, Taylor Tulley, Nicole Brandlund, Elaina Bystrup, Michelle Hare and Michelle McCranie.

In 2000, Carol O. Tacket, MD, professor of medicine at Maryland, successfully tested a potato-based vaccine to combat the Norwalk Virus, spread by contaminated food and water. The new approach to deliver a vaccine through a plant was pioneered at the center for vaccine development and Cornell University.

In 1815, a library opened on the first floor of the medical building. The 500-volume collection was purchased from the family of the late Dr. John Crawford, a former Maryland faculty member.

J. Whitridge Williams, class of 1888, conducted investigations into the problems of the various phases of placentation. The work established Williams as the world’s leading authority on the subject. His book Obstetrics: A Textbook for the Use of Students and Practitioners was universally accepted to be the best in America. Chairman of the department of obstetrics at Johns Hopkins, Whitridge also served as dean from 1911 to 1923 and president of the American Gynecological Society in 1914.

A look back at America’s fifth oldest medical school and its illustrious alumni.
1940s
1947: Sidney J. Venable Jr., of Merion Station, Pa., sadly reports that wife Grace died on September 4, 2014, after their 70th wedding anniversary on June 10.

1950s
1950: Harry H. Bleecker of San Pedro, Calif., is looking forward to the spring Reunion and hopes to see in attendance all those still breathing. — Frank T. Kasik Jr., of Baltimore reports that his family now includes 13 grandchildren and 19 great-grandchildren, thanks to his three daughters and two sons who range in age from 47 to 67.

1960s
1960: Jerome Ross of Woodland Hills, Calif. is having some fun working half time of Los Angeles reports that he recently gave birth to a baby boy. She practices orthopaedic surgery specializing in shoulder and elbow in Bangor, Maine.

1970s
1970: Jerome Aronowitz and wife Nicole of Boca Raton, Fla., report that daughter Jessica recently gave birth to a baby boy. She practices orthopaedic surgery specializing in shoulder and elbow in Bangor, Maine.

1980s
1980: Richard M. Susel of Yardley, Pa., reports that daughter Danielle is training in internal medicine at Maryland after graduating there in May. William M. Williams of Sheridan, Wyo., retired on October 1, 2014 — Stuart Winakur of Baltimore enjoys being a grandfather of five including one who is a freshman in college. He has been retired from Towson Orthopaedic Associates since last February and lost wife Sandee in May 2013.

1990s
1995: Daniel S. Sax of Merion Station, Pa., reports that after wife Ruth of Pikesville, Md., have seven grandchildren —two in Baltimore, three in Albuquerque, and two in Woodland Hills, Calif. Ross continues practicing ophthalmology two days per week but is no longer performing surgeries.

1996: Charles E. Smith Jewish Day School and Old City Torah in Philadelphia reports that it’s been a wonderful ride. Now he adds, it’s time for family.

2000s
2000: Daniel S. Sax of Merion Station, Pa., reports that after wife Ruth of Pikesville, Md., have seven grandchildren —two in Baltimore, three in Albuquerque, and two in Woodland Hills, Calif. Ross continues practicing ophthalmology two days per week but is no longer performing surgeries.

2010s
2014: The The Curtis National Branch in Galveston in 2003. Michael E. Pelczar of Sheridan, Wyo., reports that he is totally retired from the practice of pediatrics in April 2014 and is recovering from a heart attack on June 7. He announces the birth of a second granddaughter born in July, and is thoroughly enjoying doing little more than his hobbies.

SAV E T H E D A T E
S A T U R D A Y , F E B R U A R Y 2 1 , 2 0 1 5
6:30 pm
Marriott Inner Harbor at Camden Yards
8th Annual C E L E B R A T I N G D i v e r s i t y
Reception and Dinner
HONORARY CHAIR
Donald E. Wilson, MD, MACP
Dean Emeritus, University of Maryland School of Medicine
PRESENTING SPONSOR
Medical Alumni Association of the University of Maryland, Inc.
Proceeds will benefit the Dean Emeritus Donald E. Wilson Endowed Scholarship Fund

classnotes
E. Sharrock of Bryan, Ohio, retired in December 2014 after 37 years in family practice. ▪ Panayiotis L. Sitaras of Fullerton, Calif., retired last March after 37 years of practicing neurosurgery in Hartford County. He was declared a “Hartford Living Treasure” by the county council for being the first neurosurgeon in Hartford County and for his dedication to his patients, the hospitals, and county. 1973: Jeffrey S. Lolek of Kalamazoo, Mich., retired after a 36-year career in pediatric hematology/oncology but continues to be involved as a volunteer in resident training and as director of the local pediatric oncology summer camp. 1975: Jill Karatinos of Tampa, Fla., published The Kol of the Autonomic Nervous System in Paj拮ilging. She is a diplomat of the ABPN in psychiatry and of the UCNS in neuropsychiatry, and she was recently reelected in general psychiatry. ▪ D. Ruppert of Baltimore reports that he has been retired since 2009, following a massive left hemispheric stroke. He is now much improved after treatment at Mercy Medical Center and rehabilitation at the University of Maryland Rehabilitation & Orthopaedic Institute (Baltimore). 1977: David Bright is living in La Bella Vita in Boulder, Colo., enjoying outdoor activities including mountain biking. He reports that son Steven is now Dr. Steven, as he is in his second year of an emergency medicine residency in Seattle. Bright invites classmates planning to be in the area to contact him through the alumni office. ▪ Martin Herman of Gulf Breeze, Fla., retired last August and is busy visiting five grandchildren. He also enjoys riding his 2012 Harley Electra Glide Limited, bowling, fishing, and wind surfing. Herman wishes classmates a happy and healthy New Year. ▪ David Strobel of Ellicott City, Md., reported the birth of his second grandson Sawyer on April 27, 2014. 1979: Owen Lee of Newark, Ohio, was presented with a 50-year milestone award from Licking Memorial Hospital for his work in interventional radiology. ▪ Peter E. Rork of Jackson, Wyo., and his foundation entitled “Dog is My Co-Pilot” were written up in the September/October 2014 Saturday Evening Post.

1980s ▪ 1980: Paul E. Driscoll of Indianapolis is executive medical director for the Franciscan Physician Network’s central Indiana region, overseeing all operations for this multi-specialty group of 225 physicians. 1981: Samuel Smith of Baltimore is a board member and active participant on the National Council on Patient Safety in Women’s Healthcare. 1982: Guilio A. Arnaud of Tableque, Okla., reports that his older daughter is gainfully employed after graduating from dental hygiene school last May while his younger daughter is expected to complete undergraduate studies next summer. ▪ Joseph W. Gattuso of Hollidaytown, Pa., reports that son Joseph married last August, and now Gattuso has just four daughters to go. 1983: Charles E. Hendricks of Seal Harbor, Maine, was named caregiver of the year by the Maine Hospital Association at its annual meeting last June. ▪ David P. Johnson of Sherwood, Ore., reports that he has one grandson and another on the way. Youngest daughter Sara is in her first year of medicine at Western University of Health Sciences College of Osteopathic Medicine of the Pacific-Northwest. 1984: Frederick E. Kuhn Jr., of Kingsville, Md., reports that daughter Courtney is a first-year law student at Maryland. ▪ David R. Meyer of Voorheesville, N.Y., says it was great seeing everyone at reunion last spring. He and wife Joy report that son Eric graduated last May from the University of Maryland College Park with a degree in psychology and neuroscience. 1985: Wendy J. Bergman and husband Monte of Winston-Salem, Mass., have three children. Max, age 19, Mecal, age 16, and Hanna, age 14 Bergman has been practicing with Reihart Medical Group for 25 years. Her husband is an attorney. ▪ 1986: Lisa A. Scheinin of Redondo Beach, Calif., was awarded a fourth-degree black belt in Taekwondo, and she is now eligible to receive the master which she hopes will happen in the next year or so. She won a national bronze medal in her division of Eskrima, and got the bronze medal in the Global Stick and Blade Alliance World Championships in Rome last July. Later, in November, Scheinin retired from the L.A. County Department of Medical Examiner-Coroner, where she had been deputy medical examiner for the past 23 years. She looks to having more martial arts competitions, travel, and riding roller coasters. 1987: Robert H. Baker of West Harrison, N.Y., received a medical care award from the New Rochelle, New York, branch of the NAACP at the freedom fund dinner on November 2, 2014. He is currently vice president of the Westchester County Board of Health. ▪ Charles “Patrick” Fitch and wife Ruth of Charlottesville, Va., reported that daughters Amanda and Jessica are both in nursing, while son Dylan is a full-time guitarist for a rising rock band, the Delta Saints. Fitch continues in his busy ophthalmology practice. ▪ Elizabeth R. Hatcher of Topoka, Kans., reports that she is still in private practice. 1988: Nancy L. Bunker of Water Mill, N.Y., practices solo pediatrics and travel medicine in Latham. ▪ Paola DeCandido and Gregg Heacock of Annapolis report that they are empty nesters, as son Matthew has joined his sister at Johns Hopkins University where he is studying mechanical engineering.

1990s ▪ 1995: Susan J. Boyd of New Market, Md., reports that five-year-old son Ross started kindergarten last fall. She works as Frederick Memorial Hospital’s Meredith S. Josephs of Baltimore is a diplomate of the American Board of Internal Medicine. ▪ 1996: F. Thomas Kaplan of Zionsville, Ind., is fellowship director at Indiana Hand to Shoulder Center, one of the largest fellowships in hand and upper extremity surgery in the country, educating seven fellows per year. 1998: Megan Malchak O’Brien of San Antonio works in the pediatric emergency room at Children’s Hospital of San Antonio, affiliated with Baylor College of Medicine. She is excited to be part of a growing pediatric training program at the first free-standing children’s hospital in the city.

2000s ▪ 2000: Marjorie Fridkin of Oakland, Md., is chief medical officer/service president of medical affairs at Garrett County Memorial Hospital. ▪ Jakub Kahl and wife Aspen live in Tampa, Fla., with their two children, Jack, age three, and Scarlett, who is one. ▪ 2002: Kendall K. Garing of Ashburn, N.C., is a hospitalist in internal medicine at Randolph Hospital. She reports that the change from private practice was due to the joint frustrations of massive paperwork and time-wasting prior authorizations that have become the hallmarks of primary care. ▪ Lisa Hile of Weston, Conn., is director of medical student education in the department of medicine at Yale University, charged with instruction for 30 sub-interims and more than 100 third-year medical students rotating through the department each year. She has some 20 publications and delivers lectures in all areas of emergency medicine focused on teaching the skills and tools of austere and...
Johns Hopkins as a pediatric hospitalist. Grybauskas looks forward to coming home, seeing old friends, and maybe finally making it to a reunion. 

J. Daniel Hess of Wilmington, Del., is chief resident in internal medicine at Christiana Care Health System after completing a combined emergency medicine/ internal medicine residency there in June.

Louis E. Kovacs of Baltimore is doing primary care sports medicine at the Union Memorial Hospital Arnold Palmer Sports Health Center. He is also team physician for Towson University football.

2010s: 2010: Mary R. Desi of Lutherville, Md., is in private practice in Shrewsbury, Pa. She and husband Jonathan have two children: Catie, age three; and Tommy, age two. 2011: YuangPu Zheng of New York City is doing a nephrology fellowship at Weill Cornell-New York Presbyterian Hospital after completing an internal medicine residency at Montefiore Medical Center. Elizabeth L. Kenez of Washington, D.C., married Noah Katzen on October 26, 2014.

Rachel E. Garvin and husband, Dan, of Ponte Vedra Beach, Fla., welcomed their first child, Marley Amelia, on November 4, 2014. 2006: Rachel E. Garvin and husband Dan live in San Antonio with daughters Zee, age 11 and Emma, age six. Garvin practices neurorehabilitation and emergency medicine at the University of Texas Health Science Center.

2008: Clarence Lam of Columbia, Md., is a state delegate representing District 12 (Howard and Baltimore Counties) in the Maryland House of Delegates. He is one of three incoming physician legislators to the Assembly, bringing the total to four. Lam is on the faculty at Johns Hopkins Bloomberg School of Public Health, serving as interim program director of the preventive medicine residency program.

2009: Dave have three children ages eight, seven and four. Shelley of Midlothian, Va., announce the birth of twin girls, Autumn and Kenley. They join London, Sierra and Brady. 2003: Amy Penziner-Bolde of Brooklyn is a field physician in the NYC Office of School Health.

Our Medical Alumni Association

Mission: The Medical Alumni Association of the University of Maryland, Inc., in continuous operation since 1875, is an independent charitable organization dedicated to supporting the University of Maryland School of Medicine and Davidge Hall.

Board Structure: The MAA is governed by a board consisting of five officers and nine board members. Each year more than 100 alumni participate on its seven standing committees and special anniversary class reunion committees.

Membership: Annual dues are $49. Dues are complimentary the first four years after graduation and can be extended until the graduate has completed training. Dues are waived for members reaching their 50th graduation anniversary or have turned 70 years of age. Revenues support salaries for two full-time and five part-time employees, as well as general office expenses to maintain the alumni database, produce the quarterly Bulletin magazine, stage social events for alumni and students, administer a revolving student loan fund, and oversee conservation of Davidge Hall and maintain its museum.

Annual Fund: The association administers the annual fund on behalf of the medical school. Gift revenues support student loans and scholarships, lectureships, professorships, capital projects—including Davidge Hall conservation—plus direct support to departments for special projects and support to the dean.

The Morton M. Krieger, MD, Medical Alumni Center is located on the second floor of Davidge Hall, 522 W. Lombard Street, Baltimore, MD 21201-1636, telephone 410.706.7454, fax 410.706.3658, website www.medalumni.org, and email mail@medalumni.umaryland.edu.
Joseph M. George Jr, ’38
General & Industrial Medicine
Las Vegas
November 30, 2014
Upon graduation, Dr. George received training at Maryland before opening a private general practice in Sudlersville, Md. During World War II, he served in the U.S. Army Air Corps as a flight surgeon and for a year was stationed in England. George moved his practice to Las Vegas after military service in 1946. Appointments included president of the Nevada State Medical Association, chief of staff for University Medical Center of Southern Nevada, senior aviation medical examiner for the FAA and national surgeon for the VFW. He was also a member of the faculty of the University of Nevada School of Medicine where he served on the admissions selection committee. Honors included the outstanding community service award in 1969 and living treasure award in 1983, presented by the governor of Nevada. George was a member of the Silver Circle of the John Beale Davidge Alliance, Maryland’s society for major donors. He was preceded in death by wife Dorothy and is survived by six children plus numerous grandchildren, great-grandchildren, and great-great-grandchildren.

David B. Gray, ’43
March Surgery & Surgical Oncology
Charleston, W.Va.
April 9, 2014
Dr. Gray interned at Mercy Hospital and became chief of surgery at the U.S. Army Hospital in Aurora, Colorado. During the Korean War, he served in Heidelberg, Germany to his practice in Las Vegas after military service in 1946. Appointments included chief of the medical staff, chief of surgery and member of the board of trustees at Charleston Memorial Hospital and its successor hospital, and clinical professor of surgery at West Virginia University School of Medicine. Gray was a talented tennis player, earning a top-20 U.S. ranking in his age bracket. He was preceded in death by first wife Virginia and is survived by second wife Mary; three children, three step-children, four grandchildren, 10 step-grandchildren, one great-grandson and 11 step-great-grandchildren.

Philip H. Lerman, ’44
Urology
Great Neck, N.Y.
October 5, 2014
Sinai Hospital in Baltimore was the site of Dr. Lerman’s internship, followed by residency training at Bronx Veterans Hospital. Appointments included chief of urology at Central General Hospital in Plannave, Md.; Island Hospital in Bethpage and Syosset Hospital. Lerman and wifeillian had four children including Sheldon, ’77, and Carole, ’82.

George A. Maxwell, ’44
Obstetrics & Gynecology
Covington, Ky.
November 25, 2014
The U.S. Naval Hospital in Bethesda, Md., was the location of Dr. Maxwell’s internship. After receiving certification as an epidemiologist, he was deployed to the Pacific Theater, joining the 2nd Marine Division in Saipan, Japan, where he was commanding officer of a malaria and epidemiology control unit. He was discharged as a lieutenant and remained with the Naval Reserve while completing residency training in surgery at Maryland General and at St. Agnes Hospital for OB/GYN. Maxwell returned to active duty during the Korean War. Upon separation from the military, he opened a private practice in Montgomery County and served on the part-time faculty at Maryland for nine years. Postgraduate work followed at Johns Hopkins, Massachusetts General, Northwestern Memorial and NYU Medical Center. After completion of coprology training at Johns Hopkins, Maxwell was invited to join its faculty of WPBG as a visiting professor and later instructed in nine countries in Africa, Asia, and Europe. Later appointments included chief of OB/GYN at Suburban Hospital in Bethesda and founder of the OB/GYN department at Shady Grove Adventist Hospital in Rockville. He moved to Rombai, Indonesia in 1982 to serve as a gynecologist for the Cal Pacific Center where he lived with his family until 1986. He returned to Maryland for what would be his final career appointment as a gynecologist for the Choptank Community Health System. He retired in 2001 to enjoy golf and play competitive tennis until the age of 92. Maxwell was preceded in death by wife Jeanne and is survived by four children and five grandchildren.

Pascal D. Spino, ’47
Pediatrics
Greenwich, Pa.
July 27, 2013
Upon graduation, Dr. Spino trained at Children’s Hospital in Pittsburgh and then opened a private practice in Greensburg. Appointments included president of the Westmoreland Hospital Medical staff, medical director for the Westmoreland Crippled Children’s Society and board member of the Cystic Fibrosis Foundation and Eplepsy Society. In 1949, Spino was recognized as pediatrician of the year by the Pennsylvania chapter of the Academy of Pediatrics, and in 2007 was honored as one of Greensburg’s citizens of distinction. He retired in 2000. Survivors include wife Aida, three children and 13 grandchildren.

John A. Googins, ’50
Public Health
Los Angeles, Calif.
April 23, 2012
Dr. Googins received training at Kansas University Medical School and later received an MPH from the Johns Hopkins School of Public Health. He was a state epidemiologist for the Oregon Department of Health, serving as chief of the office of disease monitoring and control. He retired in 1985. Honors included wood working.

Daniel D. King, ’55
Family Medicine & Geriatrics
San City, Ariz.
July 5, 2014
Dr. King trained at the University of Michigan before serving in the U.S. Army stationed primarily in Germany. Upon discharge he practiced in Redsville, N.C. for 15 years and then relocated to Sun City where he practiced for the remaining 35 years of his career. Survivors include wife Charlotte, one son, and two grandchildren.

Alexander Spock, ’55
Pediatrics, Allergy & Pulmonology
Durham, N.C.
October 3, 2014
Geisinger Memorial Hospital was the site of Dr. Spock’s internship and residency training in pediatrics. He spent two years as captain and chief pediatrician at the U.S. Army Dispensary in Fort Richardson, Alaska, before two years of fellowship training in allergy at Duke University where he remained his entire career. Spock was promoted to professor of pediatrics in 1977 and was founder and first president of the Duke Cystic Fibrosis Center. He authored or co-authored more than 190 scientific publications during his career and became professor emeritus in 2000. For more than four decades he organized an annual pediatric symposium which now carries his name and his interest in health covered the globe, as from 1968 to 1985, he was involved with Project Hope’s efforts to teach and improve medical care in Columbia, Poland and Tunisia. He was an avid Duke Blue Devil basketball fan and enjoyed travel, good food and wine, and jazz music. Survivors include wife Diana, four children and seven grandchildren.

Robert G. Stuck, ’56
Orthopaedics
Tuscaloosa, Ala.
January 11, 2013
Upon graduation and training, Dr. Stuck and his father founded a small community hospital in their hometown of Wolcott, N.Y. A few years later he trained in orthopaedic surgery and he later practiced in three cities in Georgia: Dalton, Daltonene, and Cusonng. He was preceded in death by a son and is survived by wife Kaye, one son, four daughters, plus several grandchildren and great-grandchildren.

William E. Rhea III, ’59
Pediatrics
Berkley, Calif.
October 6, 2014
Dr. Rhea interned at Providence Hospital in Washington, D.C., before serving two years as a general medical officer at Scott Air Force Base in Illinois. He completed training at Children’s Hospital and Research Center in Oakland, Calif., before becoming a founding partner of East Bay Pediatric Medical Group. Rhea later served as professor of human values in pediatrics at Children’s Hospital and Research Center. Rhea was a fan of the opera and enjoyed family activities. Survivors include wife Shirley, seven children, thirteen grandchildren including Erin, an employee of the Medical Alumni Office, and two great-grandchildren.

Linda S. Bartram, ’75
Nephrology & Internal Medicine
Bremerton, Wash.
September 6, 2014
Upon graduation, Dr. Bartram trained at Henry Ford Hospital in Detroit which included a nephrology fellowship in 1981. She then served as a major in the U.S. Army Medical Corp with appointment as assistant chief of nephrology at Fitzsimons Army Hospital in Aurora, Colorado. Bartram moved to Bremerton where she practiced nephrology and internal medicine until retirement in 2006. She enjoyed quilting. Survivors include husband Jay, one son and two grandchildren.
Faculty

Thomas J. Kenny, PhD
Behavioral Pediatrics
Baltimore
October 19, 2014

Dr. Kenny taught in the department of pediatrics from 1969 to 1995. Born and raised in Baltimore, he played lacrosse while attending Washington & Lee University. After college, Kenny served two years in the U.S. Army and afterwards received a master’s degree at Vanderbilt University in 1959 and a doctorate from Catholic University in 1969, both in psychology. He joined the Maryland faculty in the department of pediatrics and was a co-founder of the behavioral internship program in the department where he trained psychologists. Kenny was a charter member of the Society of Pediatric Psychology and served as its president from 1975 to 1976. He retired in 1995 and enjoyed swimming, playing squash and tennis, and waterfowl hunting. Survivors include wife Katherine, two daughters and six grandchildren.

When Life Is on the Line

Thomas Scalea is physician-in-chief at the University of Maryland R Adams Cowley Shock Trauma Center, the world’s most advanced trauma hospital. He and his team of nearly 500 physicians, nurses, technicians, and staff treat more than 8,000 critically injured patients each year. Many aren’t expected to survive; 97 percent of them do. Leading such an elite crew requires 100-hour work weeks—sometimes more—but Scalea doesn’t mind. “What could be better than doing this?” he asks.
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