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ON THE COVER: Feranmi Okanlami (M.D. 2011), assistant professor of family medicine, and of physical medicine and rehabilitation, in his standing wheelchair. Read more about physicians and medical students who have disabilities, beginning on p. 14. Leisa Thompson Photography
Changing Times

The world of a physician is much different today than in times past. We need to evolve and innovate to reduce physician burnout.

In 1980, I bought the top-selling typewriter for $100 to prepare manuscripts. In less than 10 years, personal computers had hit the scene and my typewriter became an obsolete paperweight. Sometimes, what was great yesterday is not so great today.

This is something I think about in the early morning or late at night, my two favorite times of the day. These are the only times that are truly mine, when I am free to stop and think, rather than meet the rigorous demands of my career as a physician: patients, staff and colleagues, administrative duties, and now, primarily, leadership responsibilities. It’s why so many of my emails go out at 4 a.m. or 10 p.m.

As I failed to recognize until recently, if we are to build and maintain a physician workforce, we need to change.

Like many physicians of my era, my career prospered by following my role models. I quickly acclimated to the unyielding culture of medicine: always be on-call, never say no to any request, prioritize your job, and adapt to every demand. The idea of prioritizing responsibilities outside of medicine, including important family commitments, was rarely discussed until the last 10 years.

This old and still powerful system that served me well is on the precipice of becoming the typewriter of our times. “It’s just the lifestyle,” I’m told by colleagues. Not really, is my answer. Accepting that belief trivializes the complexity of the world our new physicians encounter. By all measures, those entering health care are bombarded with exponentially more information than prior generations.

In the 1980s, it really was possible to memorize and know nearly everything needed in a medical specialty. Today, information is instantly available and continually improving, and society lives and breathes 24/7. It should be no surprise that physicians are overwhelmed and looking for solutions.

Study after study demonstrates that physician burnout — generally defined as a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment — is a major problem across the country. Physician burnout is more than just feeling wrung out. Burnout can lead to medical errors and lapses in care; it diminishes our workforce. Burnout is a major reason that physicians switch jobs or leave medicine altogether — an ominous trend as the U.S. experiences a growing doctor shortage.

We also know that burnout takes a special toll on women, who experience greater societal pressure to maintain work-home balance, making it twice as likely that they leave the profession.

Is there a solution? No, there is no single solution. But here are a few ideas.

First, those of us who grew up in another era need to understand this is not a lack of professionalism or commitment.

Second, we need to innovate how we perform our clinical and other duties. For example, is it really necessary to start procedures at 7 a.m. or clinic schedules at 8 a.m.? If we adhere to yesteryear, we effectively eliminate the portion of our workforce that cares for young children or aging parents, or has other morning commitments. At the end of the day, we control how flexible our schedules are, and how other clinical obligations are implemented.

Third, and maybe most importantly, we must constantly reduce administrative overhead. We are quick to add new mandatory credentialing and slow to shed those that are less relevant.

You and your colleagues surely have more great ideas. Please join me in becoming an engaged and transformative leader in your setting — from small groups to large group practices to major academic and health care programs. We can and will transform tomorrow, today.

Marschall S. Runge, M.D., Ph.D.
Dean, Medical School
Executive Vice President for Medical Affairs, U-M
CEO, Michigan Medicine
LETTERS TO THE EDITOR

Just a correction for the article “The Hunt for a Bioterrorist” by Lara Zielin [fall 2018]. She writes that: “Terry Abshire spotted abnormalities while studying anthrax spores under a microscope.” Terry actually discovered the abnormal colonies of *B. anthracis*, or “morphotypes,” when she grew them on sheep blood agar plates, not when examined under a microscope. We look forward to reading Dr. Decker’s book.

Jennifer Chua (Ph.D. 2005)
Microbiologist at U.S. Army Medical Research Institute of Infectious Diseases and Tunnell Government Services

R. Scott Decker responds: Dr. Chua is correct. The morphology variants are seen on sheep blood agar plates after an extended growth time and in the proper incubation conditions.

It was a great pleasure to see the 3D printing work highlighted in the latest *Medicine at Michigan* issue [fall 2018, “The Promise and Progress of 3D Printing” by Katie Vloet]. I think this work has already made and will continue to make a significant impact in medicine. I have enjoyed working with the many wonderful colleagues mentioned in the article and continue to work with them on many projects in 3D medical printing after moving to Georgia Tech.

Scott J. Hollister (Ph.D. 1991)
Professor of Biomedical Engineering, Georgia Institute of Technology and Emory University
Patsy Alan Dorris Chair in Pediatric Technology
Director, Center for 3D Medical Fabrication
Director, Tissue Engineering and Mechanics Laboratory
“There is a group of parents who look like they have a gap in expert guidance around whether kids should get flu vaccines, specifically whether their kid should get [the] flu vaccine.”

“If mom is depressed, she might not present to prenatal care, she might not eat well, she might not sleep well. All of this will have an impact on the pregnancy outcomes and the baby. ... If we could get in earlier, and provide some treatments such as psychotherapies ... then we could prevent new onset of illness.”

“Social deprivation is bad for brain structure and function. Sensory deprivation is bad for brain structure and function. Circadian dysregulation is bad. Loneliness in itself is extremely damaging.”

“I don’t think it’s acceptable for firearms to be a preventable cause of death and remain the second cause of death of children and teens. We’re not doing enough to keep kids safe.”

1 Sarah Clark, MPH, associate research scientist in the Department of Pediatrics and co-director of the C.S. Mott Children’s Hospital National Poll on Children’s Health, spoke to CNN.com regarding parents’ decisions about whether to vaccinate their children against the flu.

2 Maria Muzik, M.D. (Residency 2006), associate professor of psychiatry, and of obstetrics and gynecology, and co-director of the Women and Infants Mental Health Program, spoke on an NPR panel that discussed the importance of screening pregnant women and new moms for early signs of depression.

3 Huda Akil, M.D., the Gardner C. Quarton Distinguished University Professor of Neurosciences, professor of psychiatry, and co-director of the Molecular and Behavioral Neuroscience Institute, was quoted in a Scientific American article regarding the psychological harm caused by solitary confinement.

4 In an NPR article, Rebecca Cunningham, M.D. (Residency 1999), professor of emergency medicine, associate vice president for research-health sciences in the Office of Research, and director of the U-M Injury Center, discussed a study she and her colleagues conducted that evaluated causes of death for U.S. children. The study, published in the New England Journal of Medicine, found that twice as many kids were killed by guns than by cancer, and that firearm fatalities are second only to those from car crashes.
Mott’s “Lego Guy”

Race cars. Submarines. Airplanes. Dolphins. A frog whose motion sensor-activated tongue flicks out to catch a fly. These are some of the custom Lego kits that John McInerney, a 2016 graduate of U-M’s Penny W. Stamps School of Art & Design, takes to Mott patients in their rooms. “For me, the best part is watching something I made come to life through the kids and see it bring smiles to their faces,” McInerney says. Read more at medatmich.org/lego.
Methamphetamine and opioid use in pregnancy has increased substantially in the United States, leading to a public health crisis that affects delivery and birth outcomes, according to a study led by Michigan Medicine. For each condition, a disproportionate rise occurred in rural compared with urban counties in three out of four census regions, says lead author Lindsay Admon (M.D. 2012, Residency 2016), assistant professor of obstetrics and gynecology, and a graduate of the National Clinician Scholars Program at U-M's Institute for Healthcare Policy and Innovation.

Among pregnant women in all parts of the country, methamphetamine-affected births doubled — from 1.2 per 1,000 hospitalizations in 2008–2009 to 2.4 in 2014–2015. The rate of opioid use quadrupled from 1.5 per 1,000 delivery hospitalizations in 2004–2005 to 6.5 in 2014–2015, according to the findings published in the American Journal of Public Health. The study sample included about 47 million deliveries in U.S. hospitals between 2004 and 2015.

The prevalence of each condition varied geographically. By 2014–2015, methamphetamine use was identified among approximately 1 percent of all deliveries in the rural Western U.S., which was higher than the incidence of opioid use in most regions. Opioid use affected 3 percent of all births in the rural Northeastern U.S. For pregnant women with methamphetamine use, the risk of severe maternal morbidity and mortality was 1.6 times the rate identified among moms with opioid use. The incidence of nearly all other health outcomes examined was also higher among deliveries to moms with methamphetamine use compared to opioid use.

Rise in Meth and Opioid Use During Pregnancy

BY BEATA MOSTAFAVI
Disparities in Life-Threatening Birth Experiences

Each year, tens of thousands of American women need emergency treatment to save their lives while they deliver their babies or immediately afterward. A Michigan Medicine-led study in the journal Obstetrics & Gynecology shows that about 1.6 percent of births involve such care. The research also reveals how much a mother’s racial and ethnic background — and her health before pregnancy — affects her risk of a life-threatening birth experience.

“Women of color who have chronic conditions before they have their baby appear to experience a double-whammy effect,” says Lindsay Admon (M.D. 2012, Residency 2016), the study’s lead author, assistant professor of obstetrics and gynecology, and member of the U-M Institute for Healthcare Policy and Innovation. “This should force us to think about how to structure care to best serve these vulnerable women — not only during pregnancy, but before and after giving birth, too.”

Disparities in Life-Threatening Birth Experiences

2.5 million birth hospitalizations analyzed

40,873 women underwent an emergency procedure or received a diagnosis of a life-threatening condition

218,000 women would have suffered a life-threatening problem if the rates were extended to the entire population of women who delivered in U.S. hospitals from 2012 to 2015

10 types of maternal morbidity examined, including blood transfusions — which accounted for nearly three-fourths of all cases of severe morbidity

231 of every 10,000 births among non-Hispanic black women led to one of the severe problems

139 of every 10,000 births among non-Hispanic white women led to one of the severe problems

50.5 of every 10,000 black mothers needed a life-saving treatment other than a transfusion

40.9 of every 10,000 white mothers needed a life-saving treatment other than a transfusion

28% reduction in cases of severe maternal morbidity that would be achieved among racial and ethnic minority women if they experienced severe maternal morbidity at the same rate as non-Hispanic white women
Shaping the Future of Research at U-M

It is my pleasure to introduce myself and share our current strategies from the Michigan Medicine Office of Research. In October 2018, I was appointed by the Board of Regents to the role of interim chief scientific officer for Michigan Medicine and executive vice dean for research at the Medical School, after having served in a number of research-related positions at the Medical School and university.

For the last nine years, I have served as the senior associate dean of research for the Medical School. My personal research interests impact the field of immunology and inflammation in acute and chronic lung diseases, and the understanding of how cytokine and chemokine biology progress these diseases.

Michigan Medicine has remained dedicated to discovery research, and we continue to cultivate a vibrant and robust community of private investigators and scientists. Many people may not realize that the Medical School contributes 40 percent of all research expenditures across the entire university, followed by the College of Engineering (16 percent) and the College of Literature, Science, and the Arts (13 percent). Our $580 million in research funding, from a variety of sources, is critical to the advancement of basic science and translational research.

We have identified some crucial areas of research, such as cancer, opioid addiction, mental health, and cardiovascular diseases, and focused our investigative efforts on turning lethal diseases into chronic diseases and chronic diseases into curable diseases. We also are better equipping our researchers, learners, and staff with the tools they need to succeed. And, as we approach the 10-year anniversary of purchasing the former Pfizer research site — now our North Campus Research Complex (NCRC) — we are in the final phase of fully populating this important acquisition. This activity is part of a well-calculated plan based on renovating and maximizing our productive research space, both on our main medical campus and at NCRC, so that our scientists are not hampered by space constraints in their use of the most modern and progressive research protocols.

Another area of focus is increasing the diversity in our faculty and leadership. History has shown that collaborations between investigators with different experiences, backgrounds, and viewpoints are more likely to produce meaningful discoveries, and at a more rapid pace. When we say that we seek the “best and brightest,” our reference is framed within a global context and our broader university-wide diversity initiative.

Looking to the future, I believe my charge is to continue and strengthen Michigan Medicine’s commitment to attracting and retaining the best scientists in the world. I’m incredibly excited about the future of research here, and I look forward to sharing more about our strategic vision and the pivotal milestones that will help shape the next era of health care.

Steven L. Kunkel, Ph.D.
Interim Chief Scientific Officer, Michigan Medicine
Interim Executive Vice Dean for Research, Medical School
Peter A. Ward Distinguished University Professor of Pathology
Endowed Professor of Pathology Research, Department of Pathology
According to a recent study, there are striking inconsistencies in parental leave policies at the nation’s top medical residency programs. These inconsistencies illustrate the challenge of balancing the training of the next generation of doctors and supporting trainees’ personal and family needs.

Of the 15 teaching hospitals in the study, which appeared in JAMA in December, eight had an institutional policy providing paid child-bearing or family leave for residents. The average maternity leave was 6.6 weeks. For same-sex couples, adoptive parents, or fathers, paid leave policies averaged 3.9 weeks. The study’s authors encourage developing transparent and consistent policies that take into account both the importance of medical training and the need to honor childbearing years.

“Becoming a doctor includes a long period of training and service,” says Reshma Jagsi, M.D., D.Phil., director of the Center for Bioethics and Social Sciences in Medicine at U-M, and the study’s co-senior author. “It’s challenging for individuals to make family planning decisions when accommodations are ad hoc, expectations are opaque, and policies vary so widely. No one should have to choose a medical career at the cost of being able to have a family.”

Residency or a Family?

BY NICOLE FAWCETT

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Keep Persisting

BY LAUREN CRAWFORD

There are times when history gets made quietly, marked not by bold headlines but by small, significant changes. Wendy Uhlmann (M.S. 1987), clinical professor of internal medicine and human genetics, made that kind of history last year: She became the first genetic counselor and the first faculty member at the U-M Medical School to achieve the rank of clinical professor with a master’s degree.

“I kept knocking at the door,” she says. “I kept persisting.”

Uhlmann earned a bachelor’s degree in biology from Oberlin College, and, during a one-month winter term project with Thomas Gelehrter, M.D., professor emeritus of human genetics and of internal medicine; and genetic counselor Diane Baker, M.S., the founder of the U-M Genetic Counseling Program, became enamored of the field and its possibilities. A year later, in 1984, she began work as a cytogenetics technologist in the U-M Division of Pediatric Genetics.

After that, she never looked back.

In 1987, Uhlmann earned her master’s in human genetics from U-M. She worked as a prenatal genetic counselor at Wayne State University and, in 1993, accepted a position as a genetic counselor/clinic coordinator at the U-M Medical Genetics Clinic. She has served as an executive faculty member of the Genetic Counseling Graduate Training Program since 1997.

Uhlmann established herself as a leader and mentor, and has served as president of the National Society of Genetic Counselors (NSGC) from 1999–2000 and on national committees; co-edited A Guide to Genetic Counseling, used internationally in genetic counseling graduate programs; received several leadership awards, including NSGC’s lifetime achievement award; and actively participates in research, writing, and teaching.

“It has been gratifying to see the field evolve and grow, at U-M and internationally, with the expansion of genetic services and genetic testing into different medical specialties,” she says.

Above all, Uhlmann stresses that her story is a Michigan story — and her time here and at Oberlin gave her the tools to succeed. She is also honored to have paved the way for others: Her genetic counselor colleague, Monica Marvin (M.S. 1994), was recently appointed clinical associate professor.

“THERE is now a pathway for genetic counselors and other allied health professionals actively engaged in clinical care, teaching, and research to seek faculty appointments, and to receive academic recognition for the work they’re doing.”

— Wendy Uhlmann, M.S.
Professorships

In October 2018, the Darrell A. Campbell Jr., M.D., Collegiate Professorship in Transplant Surgery was inaugurated. Created through gifts from family, faculty, alumni, friends, and the Department of Surgery, it honors Campbell, a U-M surgeon whose contributions to clinical care, research, and medical education have had a profound influence on Michigan Medicine. Campbell’s commitment to patient care and safety, excellence in practice, and organizational responsibility makes U-M one of the most esteemed academic medical centers in the nation. Chris J. Sonnenday, M.D. (Fellowship 2008), associate professor of surgery and associate professor of health management and policy at the School of Public Health, is the first Campbell Collegiate Professor of Transplant Surgery.

Susan Brooks (Ph.D. 1992), professor of molecular and integrative physiology and of biomedical engineering, became the first Christin Carter-Su Collegiate Professor of Physiology in September 2018. The endowment recognizes Carter-Su, a renowned researcher and mentor who holds both the Henry Sewall Collegiate Professorship in Physiology and the Anita H. Payne Distinquished University Professorship in Physiology. Also professor of molecular and integrative physiology, and of internal medicine working in the Division of Metabolism, Endocrinology, and Diabetes, Carter-Su has received many honors and awards for her work, including the Roy O. Greep Lecture Award for outstanding contributions to research in endocrinology from the Endocrine Society, the Bodil M. Schmidt-Nielsen Distinguished Mentor and Scientist Award from the American Physiological Society, and the 2018 Women in Endocrinology Mentor Award.

The Askwith Research Professorship in Food Allergy was inaugurated in October 2018 and celebrates Bertram J. Askwith, longtime friend and supporter of U-M. A 1931 graduate of the U-M College of Literature, Science, and the Arts, Askwith served as vice chair of the university’s Michigan Difference campaign. Inspired by his grandson, who has a severe food allergy, he created the Askwith Fund for Innovation in Asthma and Allergy Management in the Center for Managing Chronic Disease at the U-M School of Public Health. In 2014 and 2015, Askwith made significant contributions to establish the Askwith Food Allergy Fund in the Mary H. Weiser Food Allergy Center. The first Askwith Research Professor in Food Allergy is Simon Hogan, Ph.D., also a professor of pathology.

James Douglas Engel, Ph.D., professor of cell and developmental biology and former director of the U-M Center for Organogenesis, will serve as the first Elizabeth C. Crosby Collegiate Professor. The professorship, which was inaugurated in October 2018, honors Elizabeth Caroline Crosby, Ph.D., who in 1936 became the first female professor at the U-M Medical School. Crosby, a dedicated researcher and teacher widely published in comparative anatomy, was the first woman to be awarded the Henry Russel Lectureship at U-M in 1946. Crosby was also presented the National Medal of Science by President Jimmy Carter in 1979. In her 64-year association with the U-M Medical School, she taught more than 8,000 medical students and laid the foundational principles for neuroscience as it is studied today.

Richard G. Ohye, M.D. (Fellowship 1998), became the first Edward L. Bove, M.D., Professor of Cardiac Surgery in October 2018. Bove, the Helen F. and Marvin M. Kirsh Professor of Cardiac Surgery, professor of surgery, and professor of pediatrics, served as head of the Section of Pediatric Cardiovascular Surgery in the Department of Surgery, was appointed inaugural chair of the newly formed Department of Cardiac Surgery in 2011, and is credited with building the U-M Division of Pediatric Cardiovascular Surgery. Ohye, also associate chair of the Department of Cardiac Surgery, head of the Section of Pediatric Cardiovascular Surgery, and co-director of the C.S. Mott Children’s Hospital Congenital Heart Center, was recruited to U-M by Bove in 2000.

In October, Rishindra M. Reddy, M.D., became the first José José Alvarez Research Professor of Thoracic Surgery. Named in memory of Alvarez, an esophageal cancer patient who received care at U-M, and created by his family after his death, the endowment was established with the hope that “no one else has to go through” such a devastating diagnosis. Alvarez was treated by Mark Orringer, M.D., now the Cameron Haight Distinguished University Professor Emeritus of Thoracic Surgery, and Orringer helped bring Reddy to U-M. Reddy is also the clerkship director for surgery, chair of the U-M Comprehensive Robotic Surgery Program, and chair of the Medical Affairs Advisory Committee.

The David W. Learned Collegiate Professorship in Anesthesiology was inaugurated in November 2018 and celebrates Learned’s legacy at U-M. Learned (M.D. 1959, Residency 1962), clinical assistant professor emeritus of anesthesiology, has spent his career teaching quality improvement and lecturing on environmental and electrical safety, in addition to perioperative blood and fluid therapy. In 1991 he became the director of anesthesia at the W.K. Kellogg Eye Center, where he remained until he retired in 2013. Highly regarded by colleagues, former trainees, and students, Learned is known for his commitment to furthering the art and science of medicine and his belief in the importance of mentoring the next generation of anesthesiologists. Paul Picton, M.D., chief of the adult anesthesiology service; senior associate chair for clinical affairs and quality within the Department of Anesthesiology; and associate professor of anesthesiology, will serve as the inaugural Learned Collegiate Professor.
In less than a decade, millennials will make up an estimated 75 percent of the workforce. Broadly defined as the generation born between 1980 and 2000, millennials came of age in a society that was stretching its digital limbs. By 2000, the internet was a household staple, and with it came email, instant messaging, and a global ecosystem of interaction. As a result, millennials developed novel communication styles — and today, the professional world is trying to keep up. Communication is the cornerstone of mentorship, and it is critical to navigate these differences effectively to ensure the success of these relationships, says Jennifer Waljee, M.D. (Residencies 2009 and 2011, Fellowship 2012), MPH, associate professor in the Section of Plastic and Reconstructive Surgery and lead writer of “Mentoring Millennials,” published in April 2018 in JAMA.

Waljee, along with Vineet Chopra, M.D., associate professor of internal medicine; and Sanjay Saint, M.D., MPH, the George Dock Collegiate Professor of Internal Medicine, proffered ways to facilitate and enrich communication between different age groups, and pointed out some common misconceptions about the newest generation of physicians.

You begin the article with an example of a medical student who, while speaking with an older colleague, is busy typing on his phone instead of maintaining eye contact — but for perhaps unexpected reasons. What does this situation illustrate, and why was it important to include? In recent decades, the ways in which we obtain information and communicate with one another have changed dramatically with the expansion of technology and online resources. The devices we use for these purposes — whether it is a phone, a watch, a tablet, or a laptop — are powerful tools that allow us to quickly communicate with individuals across the globe as well as readily access information to complete a task at hand. However, they may also influence how social cues are perceived, such as eye contact or attention, and our ability to relate to others. When an individual is using these devices, it can appear isolating and distracting in groups. In addition, the etiquette for using these devices varies by situation and is often undefined, leading to frustration in instances where expectations, intentions, and actions are misperceived. The example in the piece was provided to underscore how a device, such as a smartphone, can be a powerful tool to provide new information on a clinical problem, yet may be misconstrued as a distraction.

In the article, the “concern” of older generations is mentioned when discussing millennials’ “values, expectations, and ethos.” Could you expand upon this? It is incredibly common to hear the phrases “when I was your age” or “in my day,” followed by an example of how an activity or experience was challenging in the past due to differences in available technology or resources. This is usually viewed through the lens that these experiences build character and resilience, and by default the next generation must
somehow be less equipped, motivated, or committed given their access to an easier experience. However, it can also easily be argued that many aspects of our lives today are much more challenging compared to prior generations, such as the pace of communication, expansion of social media, and professional expectations. In our piece, we hoped to uncover these misperceptions and spark conversations between mentors and mentees to bridge these common divides.

What did you and your co-authors seek to accomplish with this piece? In this thought piece, we wanted to spark conversations among mentors and mentees to allow their relationships to grow. So often, we give up on a potential mentor/mentee relationship when it does not fit our preconceived ideas of how interactions should play out. Although these “failures” can certainly occur for a variety of reasons, it is critical for both mentors and mentees to recognize the perspectives of others and flex or accommodate in order to find synergy. These perspectives are often influenced by past experiences, such as how a mentor was expected to act as a mentee many years prior. As our culture changes and shifts, it is critical that we are able to respond and engage the next generation of academic physicians to ensure a vibrant, diverse, and innovative workforce.

What surprised you about this work? This piece clearly struck a chord for many readers, and we received numerous critiques and accolades. It was surprising how loaded the term “millennial” is for so many. The stigma associated with this term often clouds the deeper message that communication and a curiosity to understand why individuals act and react in certain ways is the essence of a successful mentor/mentee relationship. ❭

Read an extended version of this interview at medatmich.org/mentoring.

Honors

Gary Hammer, M.D., Ph.D., the Millie Schembechler Professor of Adrenal Cancer, has been elected president of the Endocrine Society, beginning in 2020. He is the director of the Endocrine Oncology Program at Michigan Medicine.

William Herman, M.D. (Residency 1982, Fellowship 1987), the Stefan S. Fajans/GlaxoSmithKline Professor of Diabetes and director of the Michigan Center for Diabetes Translational Research, has been appointed to the National Clinical Care Commission. The commission evaluates and provides recommendations on federal programs related to complex metabolic or autoimmune diseases that result from insulin-related issues, such as diabetes.

J. Michelle Kahlenberg, M.D., Ph.D. (Fellowship 2011), the Giles G. Bole, M.D., and Dorothy Mulkey, M.D., Research Professor of Rheumatology, was awarded the annual Mary Betty Stevens Young Investigator Prize by the Lupus Foundation of America.

James Leonard Jr. (M.D. 1972, Residency 1975), professor emeritus of physical medicine and rehabilitation, received a lifetime achievement award from the American Association of Neuromuscular and Electrodiagnostic Medicine.

Costas Lyssiotis, Ph.D., assistant professor of molecular and integrative physiology, and of internal medicine, was awarded the prestigious Research Scholar Grant from the American Cancer Society. The winning project will look at intratumoral metabolic crosstalk mechanisms in pancreatic cancer, studying how tumors survive and grow with the hope of developing targeted therapies. Howard Crawford, Ph.D., professor of molecular and integrative physiology, and of internal medicine, and Marina Pasca di Magliano, Ph.D., associate professor of surgery, are co-investigators.

Okeoma Mmeje (M.D. and MPH 2006), assistant professor of obstetrics and gynecology, received the Passion for Public Health Award from the Michigan Department of Health and Human Services.

Lori Pierce, M.D., professor of radiation oncology and vice provost for academic and faculty affairs, was elected president of the American Society of Clinical Oncology. Her appointment begins in 2019 with a year as president-elect, followed by a one-year term as president. She also was named the 2019 Woman of the Year by the United Way of Washtenaw County Women United group.

Joshua Stein, M.D., the Edward T. and Ellen K. Dryer Career Development Professor in Ophthalmology and Visual Sciences at the W.K. Kellogg Eye Center, is the recipient of the Lighthouse Guild 2018 Pisart Award. A pioneer of big data analyses in the field of ophthalmology, he focuses on trends in eye care services. ❭

Read an extended version of this interview at medatmich.org/mentoring.
One physician rose above early doubts about his future to become a department chair. Another physician returned to medicine after he was paralyzed during his residency. And prospective medical students with disabilities now have “a seat at the table.” Throughout Michigan Medicine, people with disabilities are breaking down barriers and showing the world just how capable they are.

BY KATIE VLOET
The patient tells his story with his hands, postures, and facial expressions: a rapid-fire set of movements that he uses to explain to his physician that he has continued post-surgical pain in his right foot, believes he is no longer able to work in a factory because of the pain, and fears living in isolation because he has so few people with whom he can communicate.

In the past, that feeling of isolation followed him to his doctors’ offices. He would try to understand what the physician was saying to him, always through an interpreter. Sometimes the conversations went smoothly, but, more often, misunderstandings arose. Misunderstandings that led to confusion about one of his previous foot surgeries and made him wary of the entire medical community.

But on this day, the patient could not be happier with the care he is receiving from Michael McKee, M.D., assistant professor of family medicine and medical director of the Michigan Medicine Deaf Health Clinic at U-M’s Dexter Health Center. “Dr. McKee really understands. I can talk right to him,” he says through a medical scribe at the Deaf Clinic who also communicates in American Sign Language (ASL). “Dr. McKee’s sign is so good. The best.”

McKee’s fluid and fluent signing has developed through a lifetime of communicating with ASL and being part of the Deaf* community. He has bilateral profound sensorineural hearing loss and uses a combination of a behind-the-ear hearing aid and a cochlear implant.

The Deaf Health Clinic is led by McKee and also includes Philip Zazove, M.D., the George A. Dean, M.D., Chair of Family Medicine, who is Deaf — and whom physicians once said would be lucky to grow up to be a janitor. The clinic is providing a vital service to patients from all over Michigan. More than 100 Deaf patients, and many others who are hard-of-hearing, go to the Deaf Health Clinic to receive accessible care, most for the first time in their lives. They are just a fraction of the millions of people in the United States who have significant hearing loss. The National Center for Health Statistics reports that approximately 20 percent of American adults (48 million) have some degree of hearing loss, a number that is increasing rapidly as people are living longer and experiencing age-related hearing loss.

“I think Mike and I are the only two physicians in Michigan who sign,” says Zazove. “People come to us from all over the state. The communication barriers, especially when you’re talking about mental health, are very difficult to overcome with patients who have hearing loss.” He and McKee want to ensure that Deaf and hard-of-hearing patients can access and receive health care that is equal to their hearing counterparts’ care.

The clinic is just one element of Michigan Medicine’s inroads in the treatment of patients with disabilities, from deafness to mental health issues to paralysis. U.S. Census Bureau data show that one in five Americans has a disability, and barriers to quality health care arise at every turn: accessibility of physicians’ offices, narrow parking spots, hard-to-read signage, conversations with health care providers, and more. Progress in clinical and research settings is occurring throughout Michigan Medicine, particularly in the Department of Physical Medicine and Rehabilitation and the Department of Family Medicine — thanks in no small part to physicians who themselves have disabilities. The U-M Medical School is also being recognized for its efforts in improving experiences for students with disabilities, with the goal of including those students and also of enhancing the experience of their classmates by providing them a more inclusive perspective.

Lisa Meeks, Ph.D. (Fellowship 2018), assistant professor of family medicine, was the co-investigator and lead author of a first-of-its-kind report released in 2018 by the Association of American Medical Colleges (AAMC) that explored the current state of medical education for medical students and physicians with disabilities. The report revealed common barriers to inclusion, as well as opportunities that will help enhance the academic medicine community’s approach to students, trainees, and physicians with disabilities. These mechanisms will be more deeply explored in October 2020, when the U-M Department of Family Medicine hosts the inaugural World Congress on Disability in Medicine, bringing together researchers, educators, and health care providers from around the globe to address equal access to education, training, and improved access to health care for people with disabilities.

*This story uses the terms Deaf and deaf to mean, respectively, someone who self-identifies as Deaf or hard-of-hearing; and someone with hearing loss who identifies with the hearing world. The distinction is widely used among people who have hearing loss.
The World Health Organization’s International Classification of Functioning, Disability, and Health (known as the ICF) is a widely used system for determining whether someone has a disability. The classification system measures people’s difficulty with cognition, mobility, self-care, interacting with other people, life activities, and participation.

“We have a societal norm, and if you have a level of functioning that challenges your ability to function in society, you have a disability,” says Edward A. Hurvitz, M.D. (Fellowship 1989), the James W. Rae Collegiate Professor and chair of the Department of Physical Medicine and Rehabilitation. Self-perception also plays a role. Hurvitz sees patients with spinal cord injuries who say they don’t have a disability “because they are able to function perfectly well in society.” Other patients have less-severe injuries or conditions but have a disability because they are not able to function well in society, he says. “There is not a single standard that applies to everybody.”

The department is working with the Coalition for Disability Access in Health Science and Medical Education to host the event, and partnering with the Medical School, the Department of Physical Medicine and Rehabilitation, the Office for Health Equity and Inclusion, and other schools and departments.

At the Department of Family Medicine Deaf Health Clinic, social worker Leslie Pertz, LMSW, an ASL-Certified Interpreter and licensed social worker, provides care to patients who have mental health issues. A medical assistant is committed to becoming fluent in ASL, a scribe already is fluent, and a front desk clerk can communicate with patients using sign. The team is finding ways to reach Deaf and hard-of-hearing people, especially in rural parts of the state, through telemedicine, including for mental health services. For Zazove, this isn’t just about improving care for a single population. “We’re a public university, and we need to take care of all of the people of Michigan,” Zazove says. “It’s the right thing to do.”

The clinic’s patients often say how they are receiving better care than ever before. The patient with the post-surgical foot pain, for one, feels fortunate to have the clinic in Michigan. “Four years ago, I started to see Dr. McKee, and my health has been better since then,” he says. “I feel very supported to have someone who understands me.”

**DISABUSING DISABILITY**

Feranmi Okanlami (M.D. 2011) — now an assistant professor of family medicine, and of physical medicine and rehabilitation — never thought, “I can’t be a doctor now.” He did not let himself spiral into despair or think about quitting. Nobody would have blamed him if he had, but anyone who has met Okanlami knows that giving up is not on his jam-packed to-do list.

The former Stanford track All-American was in the third year of his orthopaedic surgery residency at Yale when he attended a Fourth of July pool party in 2013. He jumped into the pool — just a jump, not a fancy dive or backflip — and the impact of hitting the bottom or side of the pool, or possibly someone’s leg, left him immediately unable to move anything from his chest down.

Yet he knew, even in those early moments of his spinal cord injury and paralysis, that this was not the end to his lifelong dream. “I did not necessarily know how I was going to be able to get back to medicine and be a physician, but I believe in the verse Philippians 4:13: ‘I can do all things through Christ who strengthens me.’”

Okanlami began to see that he would have an opportunity to demonstrate that having a disability doesn’t mean people can’t achieve their goals. He grew exhausted from inpatient and later outpatient rehabilitation near his home in South Bend, Indiana, but he never slowed down. Each day, with every assisted step on the treadmill, every range-of-motion stretch, every turn on the stationary bike, every surgery, he slowly learned to walk again.

Meanwhile, Okanlami earned a master’s degree in engineering, science, and technology entrepreneurship from the University of Notre Dame; was appointed by South Bend Mayor Pete Buttigieg to sit on the county board of health; and coached the River City Rollers wheelchair basketball team.
What happens when a person with a physical disability ages? How do his or her needs change? What is it like to manage conditions like diabetes when you’re already living with a spinal cord injury or cerebral palsy?

“It adds another level of complexity,” says Michelle Meade, Ph.D. (Fellowship 2000), associate professor of physical medicine and rehabilitation. With that in mind, Meade sought funding from the National Institute on Disability, Independent Living, and Rehabilitation Research to establish a Rehabilitation Research and Training Center (RRTC) program at U-M. She and her team received the five-year, $4.3 million funding in 2018.

“My ultimate goal is to make it easier for folks who are aging with a physical disability to do so. We hope the RRTC serves as the infrastructure and backbone for continued focus on collaborative research and community interaction,” she says.

Known as the Investigating Disability Factors and Promoting Environmental Access for Healthy Living RRTC — or IDEAL, for short — the U-M center will use the research it generates to develop evidence-based interventions to help this patient population live better. “I wish more health care providers were aware that people with disabilities are working hard to make their best life possible,” Meade says. “They encounter many challenges in trying to make that happen.”

The IDEAL RRTC has four main objectives:

• Identify environmental factors — including practices, programs, and policies — that are associated with healthy aging for individuals with long-term physical disabilities from diverse backgrounds, particularly those from low-income and racial/ethnic minority communities.
• Develop interventions to modify environmental factors to enhance the health, functioning, and participation of individuals aging with long-term physical disabilities.
• Serve as a national resource center to improve outcomes for people aging with long-term physical disabilities, their families, and other stakeholders by providing information, training, and technical assistance to a variety of groups — including individuals with disabilities, disability and rehabilitation researchers, clinicians and service providers, and policymakers.
• Engage key stakeholder groups, particularly disability- and aging-related organizations, to bridge programs and practices for older adults and people with disabilities, and maximize the relevance and usability of the knowledge generated by the RRTC.

“We don’t want people with disabilities to always have to ask more questions and do more research,” Meade says. “How do we make it so it’s not entirely up to them to make things better?”

The IDEAL RRTC is led by Meade and her co-principal investigators, Philippa Clarke, Ph.D., professor of epidemiology at the U-M School of Public Health, and Robyn Rontal, J.D., MHS, policy analytics director for the Center for Healthcare Research and Transformation in Ann Arbor. “The center is truly leveraging what’s best about U-M: partnering with our colleagues and communities to make a difference,” Meade says.

Kylie Urban contributed to this report.
He transitioned to the family medicine residency program at Memorial Hospital in South Bend, where he reveled in the scope of the work. “I was able to take care of patients from cradle to grave — delivering babies, taking care of patients in nursing homes, and everything in between.”

In 2018, he joined Michigan Medicine. While some patients are unaccustomed to being treated by a physician with a physical disability, most of them adjust quickly. “As long as I’m able to demonstrate my complete competence in whatever it is that we are talking about that day, patients actually connect with me more,” Okanlami says. “I think they often don’t see the chair in the same way because they see me as human.”

Surgeries and intense physical therapy have returned some function to his legs, to the extent that he is able to walk short distances with the use of forearm crutches. His hydraulic standing-frame wheelchair allows him to essentially stand while performing medical procedures. It also has given him insight into the ways he is viewed when he is in the chair. “When I’m seated, people don’t expect as much of me — that I have a degree or the experience that I’ve had. I get more ‘buddy’ and ‘pal’ when I’m seated,” Okanlami says. “I get a lot more ‘sir’ when I’m standing.”

Okanlami’s connection with patients who have physical disabilities is often instantaneous, he says. He and other physicians with disabilities “may be able to advocate for patients in a way that others may not have the ability to do, and we can have an amazing impact on the entire population of people we care for.”

One of those physicians has been a mentor to Okanlami: Karin Muraszko, M.D., chair and Julian T. Hoff, M.D., Professor of Neurosurgery, who has spina bifida and uses a wheelchair. Muraszko, a legend at U-M and the wider medical community, also is the first female chair of neurosurgery in the country. She specializes in pediatric neurosurgery. “I think parents of my patients see hope, see possibility, because they have met someone with a disability who is their physician,” she says.

Okanlami also has taken on the role of director of medical student programs in the Medical School’s Office for Health Equity and Inclusion (OHEI). He has adopted a catchphrase — “disabusing disability™” — on social media and beyond, with the intent of demonstrating that being disabled doesn’t mean one is unable.

“Even as practitioners, taking care of individuals with disabilities is not something that most people are comfortable with,” Okanlami says. “As we go into medicine, we are going to encounter people with different levels of function, and it’s something we are not doing a good job preparing our medical students for: a world where you go into a room and your patient might come in a wheelchair, and then how do you address that? How do you get them onto the examination table? How do you perform your physical exam when the person can’t lift their leg for you? A lot of people don’t know how to treat you just because of a lack of knowledge — not because they don’t want to, but because they just don’t know how.
“And we don’t talk about that to medical students. As a faculty member, I want medical students to know that it’s OK to be human.”

A SEAT AT THE TABLE
When Molly Fausone and Chris Connolly applied to medical schools, they knew from the start that not all application processes were equal, and that not all schools would welcome them.

They both discovered that many programs had technical standards requiring students to perform physical tasks such as lifting a patient. Fausone and Connolly both use wheelchairs due to paralysis in their legs, so this simply wouldn’t be possible.

Technical standards vary by institution. Their purpose is to ensure a uniform set of attributes among enrollees. At many schools, these standards have not changed since 1979, when the AAMC issued recommendations for a universal skill set among applicants to ensure success in any specialty. “Many of them might not be consistent with the current interpretation of the law, frankly,” says Rajesh S. Mangrulkar, M.D. (Residencies 1997 and 1998), the Margaret S. Roll Professor of Medical Education, associate professor of internal medicine and of learning health sciences, and associate dean for medical student education at the U-M Medical School. “Legal experts say some of these wouldn’t pass muster under the Americans with Disabilities Act.”

Fausone found U-M to be welcoming and encouraging. Connolly applied after the school revised its technical standards in 2016 to include students with a physical disability or functional limitation, as long as alternative or supplemental means can help them learn the required hands-on coursework. In addition to physical and chronic health disabilities, the school can accommodate students with learning disabilities (such as dyslexia), mental health conditions (such as anxiety or depression), and ADHD by offering extra time on exams or a testing environment with limited distractions.

The move reflects the true aim of medicine and medical education, says Steven Gay, M.D. (Fellowship 1997), assistant dean for admissions and associate professor of internal medicine. “As physicians, we don’t turn anyone away; our responsibility is to address every individual. By the same token, there is no substitute for learning with people who are different from you. “Everyone needs to have a seat at the table.”

Fausone has experienced that seat-at-the-table mentality. She was accepted at many medical schools, “but Michigan is the only school that reached out to me and said, ‘You’re a good fit; let’s see how we can make this work.’”

The change in perspective is a useful one, not just for medical students who have disabilities, but for their peers, patients, and others, says Meeks, one of the country’s top researchers in this field. “We teach that to be disabled is a bad thing. The point of medicine is to fix the problem.”
Meeks says, “We need to change that perspective, within the medical community and in our treatment of patients.”

Fausone has thrived at Michigan, as has Connolly, an M2. Fausone, an M3, points out that she has needed few accommodations — mostly extra time for tests and a few equipment modifications. Muraszko taught her skills such as how to scrub in before surgery. She also thinks her presence as a medical student helps to normalize disabilities among her peers, and to strike down the divide between physician and patient. “Being a patient is a role,” she says, “not an identity.”

Clarissa Love, a project associate manager with OHEI, points out that “every one of us has multiple identities: race, gender, sexual orientation, age ... disability is just one part of that identity, and it’s one that isn’t always visible to your colleagues.” Love has helped spearhead the Michigan Medicine Disability Council, a group that focuses on disability awareness and advocacy for patients, faculty, staff, and learners. The council’s goal is to “increase awareness and promote a system in which every program and department works together to adequately support the needs of our community members with disabilities,” says David J. Brown, M.D. (Residency 2003), associate vice president and associate dean for health equity and inclusion, and associate professor of otolaryngology—head and neck surgery.

Not all disabilities are physical. Rahael Gupta, now an M4 at Michigan, had always thought of herself as optimistic and fun-loving — until her depression grew so debilitating that she thought of stepping in front of a bus one night. The incident prompted her to take a seven-month break from medical school in 2016 to receive therapy and medication. She did not know, however, how much of her personal story she should communicate in explaining her résumé gap. Many well-meaning faculty members suggested she vaguely cite health problems. “As an aspiring physician, I may be committing self-sabotage by telling my story,” Gupta wrote in a 2018 JAMA editorial. “I admit openly that I am just as vulnerable to the elements of life as are my future patients, hoping that others will do the same.”

Gupta’s experiences inspired her to create a project and accompanying video called Physicians Connected, which encourages an open discussion in the medical community about mental health conditions among students and practitioners. “If I have learned anything after spending most of my short life in pursuit of academic distinction, it is that the appeal of the dividends — good grades, high praise, awards — is as ephemeral as the warm glow felt on their receipt,” she wrote. “Not so with the call to protect human life; that’s something truly worth living for.”

Kevin Joy contributed to this story.

Read the stories of physicians from around the world who have disabilities by searching Twitter and Instagram for #DocsWithDisabilities, a social media campaign from the Michigan Medicine Department of Family Medicine that was co-created by Lisa Meeks, Ph.D., assistant professor in the department.
Feranmi Okanlami (M.D. 2011) played basketball with his 7-year-old son recently. Just a small, sweet moment between a father and son — or that’s what it would have been, if it weren’t something so much bigger.

Okanlami, paralyzed from the chest down during a 2013 pool accident, has regained some mobility and function since then, but still uses a wheelchair most of the time. So sharing some moments on the court with his son was particularly meaningful to him. “My son said, ‘Dad, now we can play together,’” Okanlami recalls.

That moment reminded Okanlami of why it is so important to him to try to get an adaptive sports program started at the university.

While he is pushing for the creation of an adaptive sports program for U-M students, Michigan Medicine already has a competitive wheelchair basketball team for kids. The Michigan Rollverines, run by the U-M Adaptive and Inclusive Sports Experience (UMAISE), a joint effort of the Department of Physical Medicine and Rehabilitation and the Department of Family Medicine, competed in its first tournament earlier this year. The team received new sports wheelchairs in 2018, thanks to support from Dance Marathon, a nonprofit led by U-M undergraduates.
1. “It’s bigger than sports. It’s bigger than disability,” Okanlami says. “It’s about diversity, equity, and inclusion. It’s about being able to participate in sports with your friends, or your classmates, or your son.”

2. Okanlami (below, in chair) has led several wheelchair basketball outings, during which able-bodied and disabled students, faculty, staff, and members of the community have played together.

3. Jimmy Moceri, a wheelchair basketball star, fixes a wheel before hitting the court.

4. “When you give kids the opportunity to use their chair to play a sport and have fun, it’s eye-opening for them and also for their parents, who get to interact with their kids in a different way and see their kids in a different light,” says Daniel Ellman, a Michigan Medicine communication specialist who is the head coach of the Rollverines. The team has grown quickly since it formed in September 2018.
5. “We started with about five or six regular participants. Since then, we’ve grown to around 15 kids, aged from 4 to 16, and we come together every week to improve skills and to help our kids learn how to work together and have fun as a team,” says Meghan Veiga, program coordinator and an assistant coach for the team, as well as a recreational therapist in the Department of Physical Medicine and Rehabilitation.

6. Volunteer coach Mark Bacon, a senior manager in Management Information Systems at U-M, helps a young player.
Aron Thatcher was 5 years old in the summer of 1990 when his mother brought him to an otolaryngologist at U-M. The boy had a history of recurrent respiratory papillomatosis (RRP), and, on this day, his breathing was loud and his voice was extremely hoarse.

Charles Krause, M.D., then the chair of otolaryngology–head and neck surgery, called on one of the newest members of the faculty to help. So new was Brian Wiatrak (M.D. 1984) that he was still setting up the computer in his office — he hadn’t even begun to see patients. But he had extensive experience as a resident and fellow, and he was skilled in the field of pediatric otolaryngology.

Wiatrak examined Thatcher and was surprised to find an extensive glottic web with some tiny papillomas growing on and around it. He told the family that surgery needed to be performed promptly to divide the web and remove the papillomas. Wiatrak performed a laser division, and, over the next couple of years, performed more laser procedures. The web did not recur, Thatcher’s voice quality improved dramatically, and the papillomas went into remission.

If the story ended here, it would tell of the successful treatment of a physician's first patient. Not bad. But the universe had more in store for Wiatrak and Thatcher.

Fast forward to 2011, 21 years later. Now the director of pediatric otolaryngology at Children’s Hospital of Alabama, Wiatrak was invited to speak at a meeting tied to the dedication of the new C.S. Mott Children’s Hospital and Von Voigtlander Women’s Hospital. A few weeks before the meeting, he received a departmental newsletter from U-M that introduced four new otolaryngology residents. One name stood out: Aaron Thatcher.

It couldn’t be, Wiatrak thought. But, open to the possibility that the world had just become smaller and more miraculous, he searched the name on Facebook. He reached out, asking if this was the same Aaron Thatcher he had treated all those years ago.

Thatcher replied: “Yes!”

Aaron Thatcher, M.D. (Residency 2016, Fellowship 2017), had decided at a young age that he would be a doctor. He’d had 21 surgeries by the time he was 6 and, for show-and-tell in school, he had brought endoscopic photographs of his larynx. It became clear to him that the influence of his surgeons and other health care providers was in no small part responsible for his career goal.

Medical school helped him shape his interests; he thought about working with children, perhaps in oncology. But then he caught the surgery bug, the desire to “heal with steel,” and there was no looking back. His interest refined further to otolaryngology, which now seems predestined but actually happened through a careful process in which he learned about his personality, strengths, and goals.

When he was accepted as a resident at U-M, he thought of the physician who had treated him when he was 5 and was disappointed to learn that Wiatrak was no longer at Michigan. “I had been wondering about him. But I was just starting out my training. I was nervous to reach out to a busy surgeon like him,” Thatcher recalls. “When he found me on Facebook, I was eager to meet him.”

And so, more than two decades later, Wiatrak and Thatcher were reunited. They had an emotional, if brief, conversation at the Mott meeting. “I learned that, in some way, Aaron’s medical condition and experience with the health care system — and possibly with me — led him to a career in otolaryngology,” Wiatrak says. “ Fate? Coincidence? Who knows? I cannot name the phenomenon, but it certainly makes me think about the forces that affect people as their lives unfold.”

This also would be a fine place to end the story: a successful treatment of a first patient, a reunion, a touch of serendipity. But we aren’t quite finished.

The two physicians stayed in contact and sent each other occasional notes. Thatcher reached out to Wiatrak for an opinion on research he was conducting. Thatcher accepted a position at U-M as an assistant professor of otolaryngology–head and neck surgery, now specializing in pediatrics — exactly the job that Wiatrak began in 1990. In fall 2018, the two presented on the same panel at the Michigan Work Society academic meeting. The topic: respiratory papillomas.

Thatcher’s own experience, meanwhile, inspires patients who have RRP, as well as their families. “They appreciate seeing someone who has recovered from it,” Thatcher says. When he meets patients, he wonders what their futures hold, and if the long arm of coincidence will reach out once again. “I can’t help but hope,” he says, “that one of them will go on to become an otolaryngologist.”

The patient was just a child when he met the physician. Years later, inspired by his own medical journey and treatment, he would follow in that physician’s footsteps.

By Katie Vloet
Caren Stalburg was walking down the halls of a hospital in Addis Ababa, Ethiopia, during an educational outreach trip in 2018. About to present to a group of learners, she was preoccupied with her thoughts — until someone called her name.

“Dr. Caren?” It was an Ethiopian doctor — one she didn’t recognize — who seemed puzzled to see her wandering the hospital. Figuring this was someone from the learning cohort she had yet to meet, Stalburg nodded and politely responded with a “hi.”

“Dr. Caren,” the doctor exclaimed, “I’m taking your MOOC!”

A few years earlier, Stalburg (M.D. 1992, Residency 1996) had launched a massive open online course (MOOC) on health education and pedagogy titled Instructional Methods in Health Professions Education. Designed to bring educational theory to health professionals, the class has had over 47,000 enrollees since it was first introduced on the Coursera platform in 2013.
In Addis Ababa, thousands of miles from the U-M Medical School, she was meeting one of her online students face-to-face. It was an unimaginable coincidence — but it demonstrated exactly the kind of reach U-M and the Medical School want to achieve through MOOCs and online education.

CONNECTING LEARNERS

MOOCs have been around, in one iteration or another, since 2006. They were first conceptualized as a means of connecting long-distance learners, the number of whom grew concomitantly with the expanse and ubiquity of the internet. After a humble beginning through RSS feeds, MOOCs have evolved and adapted, often employing leading-edge methods of presenting and disseminating information. To date, there are 81 million MOOC students enrolled in almost 10,000 courses, with over 800 participating universities.

Multiple platforms, among them Coursera and edX, have been developed to accommodate this new breed of classroom, but, overall, the concept remains the same: to offer knowledge and information, presented by accredited lecturers and teachers, to those who might not otherwise be able to access it. Many of these courses are free, and those that do cost money are decidedly less expensive than a full semester of college-level classes. Some even offer financial aid to those who need it.

In spring 2012 — the “year of the MOOC,” according to the New York Times — U-M joined the growing digital learning landscape, and Michigan Medicine was eager to try its hand.

“At the Medical School, we were first out of the gate across campus to call for a range of proposals from our faculty,” says Rajesh Mangrulkar, M.D. (Residencies 1997 and 1998), the Marguerite S. Roll Professor of Medical Education, associate dean for medical student education, and associate professor of internal medicine and of learning health sciences.

Like all good scientists, the team that spearheaded the MOOC project approached it as an experiment, Mangrulkar explains. They weren’t sure what to expect, or how, exactly,
to translate the complexity of medical sciences to an easily digestible online experience. Mangrulkar recalls the questions that guided them: “Could we focus on some courses that dealt only with knowledge? Could we focus on some that had both knowledge and skills development? Could we look for proposals that had an international focus? With a range of medical content and teaching skills? Could we impact our medical students here at Michigan through a MOOC?”

**MAKING A MOOC**

After putting out the call for proposals, they received over 20 applications and eventually narrowed the total down to six pilot MOOCs. Following a kickoff meeting in January 2013, the Medical School was officially in the market of the MOOC, and various offices came together to help in this endeavor — including Michigan Medicine’s Health Information Technology and Services (known at that time as Medical School Information Services), U-M’s Center for Interprofessional Education, and the Office of Academic Innovation.

“We created the Office of Academic Innovation to foster a culture of innovation in learning across U-M’s 19 colleges and schools,” says James DeVaney, associate vice provost for academic innovation. “U-M occupies a unique institutional position at the intersection of really big, really good, and really public. Given our unique institutional strengths, we are driven to reimagine the great public research university — including broadening access to learners at all levels, creating a more personalized and inclusive model for residential learning, and providing a flexible and networked model for global and lifelong learning.”

Although what goes into the creation of a MOOC differs depending on the subject material, the instructors do have some shared experiences — like learning how to be comfortable in front of a production team.

“The actual recording took the least amount of time, but, for me, was the most intimidating part of the process,” says Kelli A. Sullivan, Ph.D., associate research scientist and lecturer of anatomical sciences. “The folks at Academic Innovation were great in helping me get over my camera shyness.”

Sullivan, along with Kathleen Alsup, Ph.D., and Glenn M. Fox, Ph.D., both lecturers and curators in the Division of Anatomical Sciences, teach Anatomy, a grouping of four self-paced courses available through edX’s XSeries program that launched in 2017 (as of January 2019, the series is also available as a specialization on Coursera). The lecturers team-teach Anatomy 403: Human Structure and Function at the Medical School, and the program “mirrors the topics covered in the course,” says Alsup.

Stalburg, too, learned quickly that lecturing in front of a camera is a skill that one develops over time, and that it is quite different from a classroom setting. “It’s much like being a newscaster or presenting on television: You have your slides and your script, and you’re looking at a camera. One of the challenges is when you are giving your lecture, there are no people in the room; there’s no feedback. So, for me, it was about looking at the camera and thinking about the people who were going to be listening on the other side. You try to make it conversational; you try to make it personal.”

Beyond the camera work, the actual diffusion of information has to gel with the platform itself. In Stalburg’s case, she had to consider things she never had previously — like whether or not an illustration was free to use under the Creative Commons license, since a large part of what makes MOOCs work is their ability to be open-access.

The Anatomy lecturers took a different approach to illustrations. After receiving an award from the Academic Innovation Fund, they were able to bring on an anatomical illustrator.

“We felt that was very important to the success of the MOOC for two reasons: anatomy is a very visual subject and is difficult to conceptualize without excellent images, and we wanted to have resources that were not constricted by copyright to allow us to make these illustrations free for anyone’s educational use,” says Alsup.

Creating a MOOC invariably demands “months and months of forethought, planning, and development,” says Stalburg. And, sometimes, you have to account for things you would never expect.

“Many people confuse MOOCs with online learning ... (but) they’re not synonyms. Online learning has many of the same principles, but the thing about Coursera or edX is that it’s about learning at scale, and the computer programs automate things in the background. At the beginning, if we didn’t have the right set of parameters for the computer to identify, people might get the questions wrong, even though they said the right thing. It’s just that
the grading algorithm hadn’t been programmed to pick up the language, so we had to do some adjustments there.”

Fox agrees: “Designing a MOOC seemed so much more intentional than designing a traditional course. Having time in the classroom, you can pivot and adapt on the spot, but with a MOOC there is a greater delay from ideation to delivery.” But, he adds, there are some unique advantages, like “being able to support U-M learners while magnifying your efforts for a worldwide audience.”

MICHIGAN ONLINE AND BEYOND
Both the health sciences education and anatomy MOOCs have become enormous successes. The Anatomy XSeries Program had 568 verified students and over 25,000 auditors after only one year on edX. Meanwhile,

Stalburg’s course is currently being used by Guyana’s Ministry of Education for health system faculty development. That success has manifested in other interesting ways for Stalburg, too: She is often recognized in educational and medical settings. One former student, who enrolled in the class with her husband, was almost starstruck when Stalburg walked into a meeting. “I said, ‘Let’s send your husband a selfie,’” Stalburg laughs. “It’s all very humbling, but that’s the thing: It’s so not about me. It’s from an open educational resource standpoint, which is how I came into this space.”

Mangrulkar, too, stresses the importance of accessibility, and feels certain that MOOCs are a preview of more dynamic learning curricula to come, both at the Medical School and around the world.

“I don’t know what MOOCs will look like, but I wonder whether we (in medical education) will continue to have ‘courses’ in 10 years,” he says. “The residential experience is going to be all about problem solving, teamwork, applied knowledge, mutual discovery — things that are far more active than lecturing, and require learners to come together. I think people are going to be getting knowledge and information in a variety of different ways, including MOOCs. The goal of the Medical School has to be about building on the knowledge in person, to develop the creative thinkers that we need to take that information and translate it into solutions.”

No matter what shape MOOCs take in the coming years, U-M will continue to innovate, create, and adapt its programs to provide the best opportunities for students. In 2018, the Office of Academic Innovation officially launched Michigan Online, a robust fleet of Michigan faculty-led MOOCs, many of which are free to alumni, students, faculty, and staff at all three U-M campuses. In addition to free certificates, learners can explore opportunities on Michigan Online to earn U-M credits and, beginning in fall 2019, even complete an online master’s degree.

“We created Michigan Online to broaden the impact of U-M’s mission to develop leaders and citizens who challenge the present and enrich the future,” DeVaney says. “By inviting students, faculty, staff, alumni, and learners around the world to take advantage of this unique opportunity to learn from U-M experts and each other, we are deepening our commitment to quality learning at scale. Through Michigan Online, we aim to better understand and meet the lifelong and life wide learning needs of our growing U-M community.”
HEALTH MOOCS BY U-M FACULTY.
FIND OUT MORE AT AI.UMICH.EDU/PORTFOLIO

ANATOMY XSERIES AND SPECIALIZATION: COMPREHENSIVE STUDY OF FUNCTIONS BETWEEN THE MAJOR ORGAN SYSTEMS

INJURY PREVENTION FOR CHILDREN AND TEENS: PROACTIVE APPROACH TO INJURY PREVENTION

INSTRUCTIONAL METHODS IN HEALTH PROFESSIONS EDUCATION: GROWING A COMMUNITY OF EDUCATORS

UNDERSTANDING AND IMPROVING U.S. HEALTHCARE: U-M STUDENTS CONNECTED ACROSS SCHOOLS AND CAMPUSES

INTRODUCTION TO CATARACT SURGERY: PREPPING STUDENTS FOR THE O.R.

SERVICE TRANSFORMED – LESSONS IN VETERAN-CENTERED CARE FOR HEALTH PROFESSIONALS: UNDERSTAND UNIQUE NEEDS

SLEEP: NEUROBIOLOGY, MEDICINE, AND SOCIETY: UP-TO-DATE INFORMATION ON THE MANY ASPECTS OF SLEEP

THORACIC ONCOLOGY: MODERN LUNG CANCER DIAGNOSIS AND CARE

ADVANCED SEARCHING IN THE HEALTH SCIENCES: FUNDAMENTAL COMPONENTS OF ADVANCED LITERATURE SEARCHES

BREAST DENSITY NOTIFICATION: MODULAR LEARNING AND RESOURCES FOR PCPs

TEACHING AND ASSESSING CLINICAL SKILLS: OBTAIN, EXPAND, AND IMPROVE SKILLS

* The original group of pilot MOOCs funded after the Medical School’s 2013 call for proposals.

KELLI A. SULLIVAN, Ph.D.
Associate research scientist and lecturer of anatomical sciences

GLENN M. FOX, Ph.D.
Lecturer and curator in the Division of Anatomical Sciences

KATHLEEN ALSUP, Ph.D.
Lecturer and curator in the Division of Anatomical Sciences
At the start of the Victors for Michigan fundraising campaign, we asked you to be victors for medicine. You gave nearly $1.5 billion to advance research, clinical care, and education at Michigan Medicine.
106,871 donors — a number that almost fills the Big House

NEARLY $1.5 billion raised by Michigan Medicine during the Victors for Michigan campaign — exactly $1,497,027,267

$784 million for research

$81 million for students

$34 million for facilities

119 new endowed professorships

50 states donors from all states
Dear Fellow Victors,

Our charge was clear: “Medicine needs victors.” We answered the call. Thank you for your extraordinary partnership.

In these pages, you’ll find just a glimpse of what we have achieved — and how our gifts are at work.

Together, we are increasing treatment options and transforming the way patients receive care. We are fueling discoveries and innovations that will lead to decades of progress. And we are supporting vibrant new talent in every area of medicine.

In contributing financial resources as well as passion and expertise, we are realizing shared goals and pushing the bar higher.

Our gifts celebrate family members, honor compassionate faculty and staff, and turn personal experiences of triumph and heartbreak into hope for people here and around the world.

It has been an honor to be with you on this journey. In supporting Michigan Medicine through the Victors for Michigan campaign, we are all victors in making lives better. It does not get better than that.

Go Blue!

Richard Rogel (BBA 1970, LLD Hon 2009)
Chair, Michigan Medicine Victors for Michigan Campaign

142 new endowed scholarship funds

$125 million for faculty

$473 million for programs

163 new endowed research funds
A $17.5 million campaign contribution from Sidney and Madeline Forbes established a groundbreaking research institute that is driving the rapid development of innovative technologies and new therapies for cancer patients.

The Forbes Institute for Cancer Discovery is a unique research enterprise within the Rogel Cancer Center. It is bringing together faculty from disparate areas — including medicine, business, pharmacy, dentistry, engineering, and public health — to pursue high-risk, high-reward projects with the potential to advance cancer research from the laboratory to the clinic.

The gift also established the Madeline and Sidney Forbes Professorship in Oncology, which is held by Max S. Wicha, M.D., the Forbes Institute’s director.

Today, cross-departmental teams led by Senior and Emerging Forbes Scholars are advancing personalized immunotherapy; identifying a potential new drug for pancreatic cancer; targeting a complex gene that drives the growth of many cancerous tumors; and identifying new biological targets for breast cancer treatment, among other projects. The Forbes Institute also is leveraging its Director’s Innovation Fund to support the development and implementation of cutting-edge technologies.

The ultimate goal: increase the number of cures and the quality of life for cancer patients, bringing hope to people around the world, including the 1.7 million Americans diagnosed with cancer each year.
The Rogel Cancer Center: A New Era in Care, Research, and Education

Richard and Susan Rogel’s transformational commitment to cancer care will boost innovative research and develop the next generation of pioneers in the field. Their $150 million gift — the largest ever to Michigan Medicine — already is enabling new programs that span patient care, research, and education, and that create an infrastructure that others can build on.

All gifts to cancer care during the campaign have fueled an energized, campus-wide focus on the disease group and a brighter future for patients and families. The Rogel Cancer Center’s vision includes:

- The transformation of the patient experience, including seamlessly incorporating cutting-edge clinical research and precision treatments into the patient setting
- A major new initiative in cancer immunology that will lead to new understanding of how the immune system sees and responds to cancers from the start
- Higher-risk and higher-payoff investments in research to advance knowledge across all cancers
- Breakthroughs in drug discovery, especially for cancers stubbornly resistant to current therapies
- A heightened focus on cancer prevention, risk management, and policy
- Unprecedented support for learners and early-career faculty seeking to devote their lives to cancer care and research
Keeping Top Talent at Michigan Medicine

Srijan Sen (M.D. and Ph.D. 2004), the Frances and Kenneth Eisenberg Professor of Depression and Neurosciences, is a leading expert in the biology of stress and depression. His work has furthered the understanding of the links between stress and depression and helped to identify genes and other biological factors involved. In the past few years, his research has garnered national and international attention.

Sen’s work is supported by U-M alumni Frances and Kenneth Eisenberg, whose transformational gift of $10.75 million to the U-M Depression Center is being used to accelerate the development of precision treatments for clinical depression, bipolar disorder, and related illnesses. The Eisenbergs’ gift created the named professorship that Sen holds and helps to fund his groundbreaking studies and those of others to advance the understanding and delivery of improved clinical services. Their gift supports the creation of essential collaborative partnerships between the Depression Center and other units at U-M, as well as companies and organizations outside of the university; the Frances and Kenneth Eisenberg Emerging Scholar Award for early-career research and the Frances and Kenneth Eisenberg Research Prize; and an endowment to sustain future research.

Emerging data already are fueling national and global interests.

Sen leads the national Intern Health Study, a project that tracks thousands of training physicians as they transition into the highly stressful intern year. He has found that, in the U.S., one in four doctors has depression, and 300 to 400 physicians die by suicide every year. Residents and early-career doctors are especially affected, potentially from their experiences as medical students and the high level of responsibility they gain.

“There is a strong link between depression in doctors and the quality of care that they provide for their patients,” says Sen. “Physician training is a rare situation where we can reliably predict that a large cohort of people will experience a dramatic increase in stress. This model allows us to understand how stress gets ‘under the skin’ and increases risk for depression and other disorders.”
Victors for Tomorrow’s Leaders

Third-year medical student Marwa Ayyash, a recipient of the Brehm Scholars Medical School Fund, is pictured here with her family after receiving her white coat. Ayyash wrote a letter of thanks to Bill and Dee Brehm, who have given generously to Michigan Medicine and other areas of U-M throughout the years. This scholarship fund, established during the Victors for Michigan campaign, was one of their most recent gifts. Their philanthropy has supported projects including the Brehm Center for Diabetes Research & Analysis; an eight-story addition to the W.K. Kellogg Eye Center; and scholarships for many students — including Marwa and her sister, Mariam Ayyash, an M4.

“Mr. and Mrs. Brehm, my family and I can never thank you enough. Whether you know it or not, you are frequently discussed in our household and referred to as the ultimate example of altruism, generosity, and kindness. You have touched our lives in many ways and I am always humbled by your gift. I only hope to make you proud and pay it forward one day.”
CHEAR Expands Children’s Health Research, Named in Honor of Susan B. Meister, Ph.D.

A gift from U-M alumni Susan and Paul Meister will expand the university’s impact on children’s health research. The Child Health Evaluation and Research (CHEAR) Center at Michigan Medicine will now be known as the Susan B. Meister Child Health Evaluation and Research Center in honor of Meister (Ph.D. 1982), a respected health care policy expert.

Widely recognized as a model for working across disciplines, the center is a leader in advancing health services research to improve the lives of children and families and is one of the largest of its kind focused on children. The work is multidisciplinary, encompassing numerous specialties and partnering with more than 10 schools across campus. The center focuses on advancing child health by improving national and international policies; creating and testing innovative research methods; and preparing the next generation of interdisciplinary leaders. A new partnership with primary care pediatrics is poised to develop novel approaches for identifying at-risk children and families.

In addition to providing operational funding for CHEAR, which was founded in 1998, the gift from the Meisters will provide support to recruit and retain highly regarded innovators to bolster what is already one of the largest and most interdisciplinary groups of academic researchers in the country studying how to improve child health. The gift also will help launch a training program for postdoctoral fellows holding an M.D. or Ph.D., as well as provide seed funding for young researchers.

“We are honored that Dr. Susan Meister and Paul Meister have chosen to convey their continued support and trust through this transformational gift that will fund research, recruitment, education, and an operational structure necessary to ensure our continuing success and impact,” says Lisa Prosser, Ph.D., the center’s director, and professor of pediatrics and of health management and policy.

Susan and Paul Meister are active volunteers and ardent supporters of programs across the university, including Michigan Medicine, the Life Sciences Institute, and more.
Victors for Pediatric Brain Tumor Research

The boy who inspired the #ChadTough movement died in November 2015 at age 5, but Chad Carr’s legacy has already made a lasting impact at Michigan Medicine.

Thousands of supporters from across the country came together to raise the $30 million needed to establish and name the Chad Carr Pediatric Brain Tumor Center in his honor. Leading the way were gifts of $5 million each from U-M alumnus and Regent Ron Weiser and Eileen Weiser; Wayne and Shelly Jones and the Jones Family Foundation; the Glick family and Alro Steel; as well as a generous gift from the ChadTough Foundation. In all, some 1,500 donors have given to the ChadTough Fund at U-M, including many faculty and staff who were touched by the family’s journey.

It hasn’t taken long for the research funding to result in new discoveries. After Chad’s death, the Carr family donated his tumor to research — “Chad’s last physical gift,” his mother, Tammi Carr, calls it. The tumor was sequenced and new research has established that a mutation in a gene known as PTEN — not previously seen as a major driver of diffuse intrinsic pontine glioma (DIPG), the type of tumor Chad had — plays an early and important role in DIPG’s genetic life story.

“We believe that the work happening in Chad’s name at the U-M Chad Carr Pediatric Brain Tumor Center will change the future for other children,” Tammi Carr says. “This is Chad’s legacy.”
Victors for Groundbreaking Research

When Albert Wheeler, Ph.D., began to lose his vision to glaucoma, he had to decline an offer to participate in a national commission on AIDS because he could not travel alone. One of his daughters, Judge Nancy Wheeler, was later diagnosed with glaucoma as well.

“When I started experiencing the same things that my father did, I began to realize that vision loss robs you of your motivation because you can’t do what you used to do,” Judge Wheeler says. “Now I understand. Everything is more difficult.”

She and her sisters — Alma Wheeler Smith, a former Michigan state senator and representative, and Mary W. McDade, an appellate judge in Illinois — established the Albert Wheeler Glaucoma Research Fund in his memory. The former Model Cities Health Clinic, founded by their late mother, Emma Wheeler, also contributed. “We want to support research so that people can be cured,” Judge Wheeler says.

The fund at the W.K. Kellogg Eye Center is being used to support the efforts of two senior glaucoma researchers working to develop and test new drugs for glaucoma as well as to identify genes related to the disease.

It is fitting that a tribute to Dr. Wheeler would involve the breaking of new ground. He was the first African American tenure-track professor at U-M, joining the faculty in 1952 in microbiology and immunology. He also was the first (and still only) African American mayor of Ann Arbor, as well as a leader in the effort to end racial segregation locally, statewide, and nationally.
All Giving Matters: Our Community of Victors

“Cancer is the worst,” wrote 6-year-old Jacoby “Jack” Hughes in a 2017 letter to C.S. Mott Children’s Hospital. After his father, Andy, was diagnosed with cancer, Jack decided to take action. He set up a small store in his bedroom, using a cedar chest and piano bench to display his wares; signs posted on his door and window listed the hours of operation. Gum, used toys and books, and trading cards were up for grabs, all priced at $1 or less. A Pokémon tin served as a till. His patrons — friends and family who paid a bit more than market price — helped Jack raise $112.65, which he promptly sent to Mott, along with the handwritten letter. “While it’s not a huge amount of money,” says his mother, Carmen, “it was raised with a love for both U-M and his dad.” Now, Andy is doing well, and the Hughes family is grateful for the care he received and the support their community provided.

Jack is one of many special people whose compassion has inspired creative philanthropy. In 2017, instead of receiving gifts for his 9th birthday, former Mott patient Mark Shapiro asked his friends to donate to the Mott Giving Library, which provides free books to Mott patients and their families. After spending time at the library, Mark, an avid reader, knew that this was the perfect cause to support. As his mother, Susan Malinowski, M.D., says, “It was a natural fit!” Over $1,300 and some beautiful, handmade bookmarks were given to the library in Mark’s honor.

Seven-year-old Mallory Braden, who received echocardiograms at Mott, was similarly moved to give back to the hospital that helped her. After earning $109 by selling homemade slime, Mallory donated to the Gift of a Bear program. Mallory’s own bear, Teddy, is always there to comfort her, and she felt “everyone should have a teddy when they are scared,” says her mother, Lacie.

Philanthropy comes in all shapes and sizes, from the annual student-run Dance Marathon to the Mott Block Out Cancer campaign to Giving Blueday. Michigan Medicine patients, both current and former, as well as friends, family, faculty, and staff, are dedicated to improving the lives of others any way they can.
The New Landscape of Innovation

Many transformational gifts to Michigan Medicine during the Victors for Michigan campaign were recognized with the naming of new spaces and programs.

1. Von Voigtlander Women’s Hospital, Ted and Jane Von Voigtlander
2. Chad Carr Pediatric Brain Tumor Center
   - Jones Family Foundation
   - Regent Ron and Eileen Weiser
   - The ChadTough Foundation
   - Glick Family and Alro Steel
3. Susan B. Meister Child Health Evaluation and Research Center, Susan and Paul Meister
4. Samuel and Jean Frankel Cardiovascular Center
5. Aikens Hybrid Operating Room, Robert and Ann Aikens
6. Rogel Cancer Center, Richard and Susan Rogel
7. Joyce and Don Massey Family Foundation Emergency Critical Care Center and traumatic brain injury programs
8. A. Alfred Taubman Medical Research Institute and Biomedical Science Research Building
9. Mary H. Weiser Food Allergy Center, Regent Ron and Eileen Weiser
10. Davidson Family Food Allergy Laboratories, William Davidson Foundation
11. Heinz C. Prechter Bipolar Research Program, World Heritage Foundation-Prechter Family Fund and Waltraud E. Prechter
12. Forbes Institute for Cancer Discovery, Madeline and Sidney Forbes
A Tribute

“The highest reward of success,” A. Alfred Taubman said, “is the opportunity to make a difference for other people.”

We thank Mr. Taubman for his enduring generosity to U-M and Michigan Medicine. His giving to Michigan included the $100 million endowment of the A. Alfred Taubman Medical Research Institute. As co-chair of the Michigan Medicine Victors for Michigan campaign, and as one of the largest donors in the history of Michigan Medicine, Mr. Taubman has ensured a vibrant future for the study and delivery of human health.

A. Alfred Taubman, 1924–2015
Thank You for Being a Victor for Medicine

Your support has brought what is possible to new heights.

The generous gifts that you have shared with Michigan Medicine — totaling nearly $1.5 billion, the largest amount ever during a campaign — have advanced how we study and treat disease, made new innovative therapies possible, and, most importantly, changed the course of many patients’ lives for the better. Your support has brought hope and belief in what we can accomplish together, now and in the future, to improve the health and quality of life in our communities and beyond.

On behalf of Michigan Medicine and the University of Michigan, I sincerely thank you for your partnership and leadership in our Victors for Michigan campaign. Because of your support and dedication, we have reached new, unprecedented milestones in philanthropy that will shape and transform our research, education, and patient care missions.

With gratitude,

Marschall S. Runge, M.D., Ph.D.
Dean, University of Michigan Medical School
Executive Vice President for Medical Affairs, U-M
CEO, Michigan Medicine

A special thanks to our campaign leadership:

Jonathon S. Aaron, Robert and Ann Aikens, Brian Campbell, Jim and Sandra Danto, Kenneth and Frances Eisenberg, David S. Evans, Sidney and Madeline Forbes, Jon B. Gandelot and Lisa Mower Gandelot, George and Joyce Helms, Paola M. Luptak, Susan B. Meister, Wally Prechter, Chair Richard and Susan Rogel, Brian Rooney, Burton Shifman, Co-Chair A. Alfred (1924–2015) and Judith Taubman, Mary H. Weiser, Regent Ron Weiser, Larry Wolfe (Kahn Foundation), and Charles Woodson
In the latter part of 1921, the doctor’s friends saw that his astonishing devotion to work was putting his health at risk. If he wouldn’t stop for a rest, they warned, he at least had to slow his pace, even if just a little.

He admitted he’d been pushing himself too hard for too long — certainly since he’d led Michigan’s roentgenology efforts beginning in 1913. Actually, he’d been doing this ever since medical school, when he’d impressed the Michigan faculty as perhaps the most brilliant student they’d seen.

“He knew the risk he was running,” said his colleague Reuben Peterson, M.D. “But something this important drove him on, regardless of the cost.”

For years, the doctor had been so busy with the department’s day-to-day affairs that he’d had too little time for his own research. Even so, at just 46, he’d already made a major mark, with pioneering work in tuberculosis; in the X-ray location of foreign bodies in the eye; in cardiac measurements.

Now he was glimpsing the outline of his most ambitious work: a full-length monograph on peritoneal pneumography. In a storm of labor, he blocked out the entire book, chapter by chapter.

Then, at the beginning of January 1922, he was suddenly very sick. The diagnosis was acute pneumonia. He checked himself into University Hospital.

U-M’s First Radiologist
James Gerrit Van Zwaluwenburg (M.D. 1908) was born in 1874 near Zeeland, Michigan, in the heart of the Dutch-American enclave founded by Calvinist emigrants. When his parents sold their farm, there was enough cash to help him pay for preparatory work at Hope College. In his final year there, Van Zwaluwenburg taught chemistry to help cover his tuition. He entered U-M as a sophomore, and his professors remarked on his extraordinary mind and ferocious work ethic.

Van Zwaluwenburg had always wanted to become a doctor, but there was no money for medical school. So for five years he earned his living as a metallurgical chemist, saving what he could for tuition. By 1903 he was back in Ann Arbor for medical training and was soon appointed as a “demonstrator” in anatomy, dissecting cadavers as junior students watched. He developed an uncannily detailed memory of the human body’s intricate structures — knowledge that would serve him well.

When he graduated, the great internist George Dock, M.D., asked “Van,” as everyone called him, to join the faculty as an instructor in internal medicine.

He made a fierce first impression — thick hair swept back; intense gaze; a manner of utter frankness. He was quite unlike the surgeon Hugh Cabot, M.D., the epitome of the Harvard-trained Boston Brahmin and later dean of the Medical School. But Cabot quickly saw Van’s quality. “Lean, lank, and uncouth in appearance,” Cabot said, “there was nothing either lean or uncouth about his personality.”

He married and had children, but if ever a doctor was married to his work, it was Van Zwaluwenburg, who bought a house on Cornwell Place, practically next door to the hospital buildings on Catherine Street.

Soon Albion Hewlett, M.D., Dock’s successor, asked Van to help him study the heart’s architecture using X-rays — the new technique known as roentgenology. Van leapt on the project. He quickly mastered the technology and amassed hundreds of X-ray plates, making a major contribution to estimating a heart’s volume.

He was seeing a new science blossom, and “once lighted,” a friend said, Van’s enthusiasm for X-rays “was inextinguishable.” He was appointed assistant professor of roentgenology — U-M’s first radiologist. Then, in 1917, the regents authorized him to organize a Department of Roentgenology and named him its chair.

The Voice of Authority
With X-rays revolutionizing diagnoses, other departments deluged him with requests for imaging examinations, and his workload soared. He responded by becoming a superb executive. He
used dictaphones and insisted on sending typewritten reports to referring departments. He devised a filing system that made any X-ray instantly retrievable. He kept charges low but made the service pay.

He was as familiar to his colleagues as a brilliant and caring brother, unfailingly making time to help when asked. “It was not by chance, or because his name was hard to spell or pronounce, that he was ‘Van’ to all of us,” one said. “We addressed him thus because we loved, admired, and respected him.”

Colleagues thought he had the ideal scientific mind: always restless in the search for more data, keenly critical in analyzing another's views, but always open to the possibility of error in his own analysis. “It was so customary to ask what Van's diagnosis was, no matter how special the field or intricate the problem,” Peterson said, “that the clinical staff took it as a matter of course, only occasionally thinking of the many hours of study, the scientific interest, and the keen and comprehensive mind necessary for such accurate diagnostic skill.”

He had no hobbies, only his fascination with his work. Once, at a train station, Van and Augustus Crane (M.D. 1894), a radiologist from Western Michigan, got into a fierce debate about the best method of measuring heart volume. The arrival of Van’s train cut the discussion short. Several days later, Crane received a letter from Van — “five long, closely spaced, typewritten pages in which he explained his position with such force, breadth of view, and unquestioning friendship that I was deeply impressed.” It was so persuasive that Crane later sent it to a medical journal for publication.

That habit of going the extra mile sometimes concerned his colleagues. As dean, Cabot learned to curb his urge to ask him for help. He knew Van would work himself to exhaustion before saying no.

A Life Cut Short
In the hospital in 1922, he lasted only a few days, and died on January 5 at age 48, his book unfinished. “How can we replace him?” colleagues asked. A year later, gathering to remember him, they were still stunned by the loss. Preston Hickey, M.D., who would succeed Van Zwaluwenburg as chair of radiology, said: “We cannot help feeling that some blind fate or inscrutable providence tore him away from his life work scarcely begun.”
A Safer Way to Travel
One alumna’s mission to improve automotive safety and protection for children.

BY MIKE WILK

Marilyn Bull (M.D. 1968), a neurodevelopmental pediatrician at the Riley Hospital for Children at Indiana University Health, realized early in her career that it was easier to prevent accidents than heal the issues they caused.

In Bull’s first three years at Riley, while directing follow-up programs for the neonatal intensive care unit (NICU), she saw premature infants face significant dangers after leaving the hospital — and not from complications related to their preterm births. Two former NICU patients suffered permanent brain damage and another died as the result of car crashes.

“It made no sense that caregivers and families gave so much love, attention, and care to these children, but we hadn’t protected them from a tragedy that could have been prevented,” Bull says.

At the time, the safety benefits of car seats hadn’t been fully recognized, and not every family had a seat for their child. Bull set out to change that. In 1980, she launched Indiana’s first car seat lending program at Riley, allowing parents to borrow car seats for their infants. She grew that effort into the hospital’s Automotive Safety Program, one of the country’s most comprehensive child passenger safety initiatives.

Bull’s research has also influenced car seat laws around the nation, and helped improve auto safety equipment and practices around the world. She developed the curriculum for passenger safety technicians on Safe Transportation for Children with Special Needs and served on boards and committees for the National Highway Traffic Safety Administration (NHTSA), American Academy of Pediatrics, and Association for the Advancement of Automotive Medicine.

Bull has been honored with the White House and U.S. Department of Transportation Champion of Change Award, the NHTSA Public Service Award, and the C. Everett Koop Medal of Distinction from Safe Kids Worldwide.

Her efforts have contributed to a marked decline in child traffic injuries and deaths over the past four decades, and Bull continues to innovate better methods to safeguard children. She is working to improve passenger protections for children with special needs and enhance ambulance safety for pediatric patients.

“My biggest joy has been making a difference for families,” Bull says. “We might not be able to completely fix a problem, but we can make lives better.”

A Safer Way to Travel
One alumna’s mission to improve automotive safety and protection for children.

Class Notes

Alumni: Share your news!
Submit recent achievements and honors at medatmich.org/mam-notes.

1960s
Michael J. Schermer
(M.D. 1969, Residency 1970), an ophthalmologist and eye surgeon, was the second recipient of the University of California, Davis’ Ernest Tschannen award, named for a major philanthropist in the Sacramento region. Schermer was also honored by UC Davis’ Cal Aggie Alumni Association with the 2017 Distinguished Achievement Award as part of its 44th Annual Alumni Award Gala.

1980s
Ronald L. Dalman II (M.D. 1984), the Walter C. and Elsa R. Chidester Professor of Surgery and chief of vascular surgery at Stanford Medicine, was elected vice president of the Society for Vascular Surgery. Dalman will rise to the position of president in 2020–2021.

Christopher Dechant Harner (M.D. 1981), professor of orthopaedic surgery, vice chair for academic affairs, and program director of the Sports Medicine Fellowship at the University of Texas McGovern Medical School, will serve as the 132nd president-elect of the American Orthopaedic Association in 2019–2020. Harner was also the 2018 godfather for the American Orthopaedic Society for Sports Medicine Traveling Fellowship to Europe; the 2018 Siegling Visiting Professor and graduation speaker for the Medical University of South Carolina’s department of orthopaedic surgery; and the 2018 Frank and JoAnne Noyes Endowed Eminent Visiting Scholar in Sports Medicine and Bioengineering at the University of Cincinnati College of Medicine’s department of orthopaedic surgery.

Hilary McClafferty (M.D. 1986), associate professor of medicine, clinical assistant professor of pediatrics, and co-director of the Arizona Center for Integrative Medicine Fellowship at the University of Arizona, published *Mind-Body Medicine in Clinical Practice* (Routledge/Taylor Francis Press) in 2018. McClafferty is also the medical director of pediatric emergency medicine at the Tucson Medical Center.

Mary Lynn Moran (M.D. 1987), a double board-certified facial plastic and reconstructive surgeon in

“My biggest joy has been making a difference for families. We might not be able to completely fix a problem, but we can make lives better.”

— Marilyn Bull
Woodside, Tennessee, was elected by the American Academy of Facial Plastic Surgery to the position of president-elect. Moran, the first woman president in the history of the organization, will take office in October 2019.

David R. Rosenberg (M.D. 1988), chair of the Department of Psychiatry and Behavioral Neuroscience and director of the Translational Neuroscience Initiative at Wayne State University, was recognized as a 2017 Crain’s Detroit Business Healthcare Hero. Additionally, Rosenberg, also the psychiatrist in chief at the Detroit Medical Center, was nominated to the National Academy of Medicine.

Peter S. Staats (M.D. 1989), chief medical officer of the National Spine and Pain Center and chair of the World Institute of Pain’s Board of Examination, received four lifetime achievement awards in 2018–2019, given by the American Society of Interventional Pain Physicians; the West Virginia Society of Interventional Pain Physicians; the New York and New Jersey Societies of Interventional Pain; and the North American Neuromodulation Society.

“I chose a career in medicine as a means to help those I saw suffering from preventable conditions. My goal has always been to create a positive impact at scale.”

— Ikenna Nwamba
Ikenna Nwamba (M.D. 2015) spent his childhood engrossed in scientific literature. Flipping through the pages, he was enamored of new technologies that conveyed promise for improved health and wellbeing. Nwamba also spent time in Nigeria, his parents’ birthplace, and began to see the consequences of a limited health care system that lacks indispensable resources. That realization, coupled with his fascination with science and technology, led him to pursue a career in health care service and innovation.

“I chose a career in medicine as a means to help those I saw suffering from preventable conditions. My goal has always been to create a positive impact at scale,” he says. “For me, that started with understanding how to care for patients first.”

Between his second and third years of medical school, he volunteered at Harris & Hughes Hospital in Port Harcourt, Nigeria. While there, he contracted typhoid and malaria.

“Falling ill in Nigeria crystallized the vision,” he recounts. “It was striking to me that, in a country where mobile phone use is widespread, I couldn’t access a physician on-call service where I could schedule an appointment or quickly obtain medical advice.”

These first-hand experiences compelled Nwamba to found PogoDoc, a telehealth solution built to improve access to care for patients in Africa. “In light of advancements in technology and medicine, the challenge of health care has evolved from investigating breakthroughs at the benchside to facilitating greater access at the bedside.”

Now, as an internal medicine resident at Jackson Memorial Hospital in Miami, Nwamba is focused on understanding how technological considerations are influenced by diverse regulatory frameworks and the sustainable service architecture designs that support them. His ultimate goal: “To redefine the health care experience.”

Looking to the future, Nwamba is excited to collaborate with U-M alumni to build out the remaining medical infrastructure for Africa and beyond. “With the right minds, strong cultural understanding, work ethic, and the alignment of the correct resources, anything is possible,” he says. 🗣️

For a longer version of this article, visit medatmich.org/nwamba.

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**1990s**

**Louito Edje** (M.D. 1995, MHPE 2017) was appointed to the Accreditation Council for Graduate Medical Education’s Family Medicine Residency Review Committee for a six-year term. Director of the residency program for the department of family medicine at St. Luke’s Hospital in Perrysburg, Ohio, Edje was also selected as the plenary speaker for the American Academy of Family Physicians’ 2019 Thomas Stern Lectureship series.

**Srini Tummala** (M.D. 1995), a vascular interventional radiologist, was appointed vascular interventional services director of the Limb Preservation Program in the Department of Interventional Radiology at the University of Miami Health System’s Miller School of Medicine.

**Andrea Wendling** (M.D. 1994), a family physician in Northern Michigan, was named Michigan’s 2018 Rural Health Professional of the Year by the Center for Rural Health. Wendling is a professor of family medicine and director of the rural medicine curriculum for Michigan State University’s College of Human Medicine.

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**2000s**

**Lamont Jones** (M.D. 2002, Residency 2007), vice chair of the department of otolaryngology–head and neck surgery at the Henry Ford Health System, was awarded a five-year, nearly $900,000 grant from the National Institutes of Health to study the role exosomes may play in the formation of keloids.
Minor Coon, Ph.D.

Minor Jesser “Jud” Coon, Ph.D., the Victor C. Vaughan Distinguished University Professor Emeritus of Biological Chemistry, died Sept. 5, 2018, at age 97. He began his career at U-M in 1955, serving as chair of the Department of Biological Chemistry for 20 years. Coon is best known for his pioneering work with the cytochrome P450 system. He initially isolated this compound, which has become known as the metabolism system for medications, hormones, toxins, and other substances.

Coon received many awards, including his election to the National Academy of Sciences in 1983 and the establishment of the Minor J. Coon Professorship in Biological Chemistry at U-M in 1991. That same year, he received an honorary doctor of medicine from the Karolinska Institutet in Stockholm. The International Conference on Cytochrome P450 was held in France in honor of his 80th birthday.

He was a generous mentor to many rising scientists over the years and was ahead of his time with his support for women in the sciences. The Minor J. and Mary Lou Coon Award is presented annually to the student at U-M in biochemistry who best exhibits excellence in research, teaching, and service. Coon retired in 2002.

This obituary was adapted from an article in the University Record.

In Memoriam

Mark B. Ardis (M.D. 1955): 9/30/2018
Henry A. Boldt (M.D. 1954, Residency 1962): 9/26/2018
Robert Bradham, M.D. (Residency 1956): 12/20/2018
Jack A. Brown (M.D. 1957): 12/2/2018
Robert E. Byler, M.D. (Residency 1969): 9/10/2018
Robert B. Cameron (M.D. 1962): 6/28/2018
Michael R. Chobanian (M.D. 1970): 8/23/2018
Sahir H. Cittan, M.D. (Residency 1971): 11/2/2018
Charles D. Cobau, M.D. (Fellowship 1965): 7/5/2018
H. Kermit Counts (M.D. 1968): 8/6/2018
Donald L. Davidson (M.D. 1942): 11/29/2018
George A. DeJong (M.D. 1942): 4/8/2018
Willoughby F. Donnellan (M.D. 1958): 8/6/2018
James R. Edwards, M.D. (Residency 1960): 6/16/2018
Reza Ehtessabian, M.D. (Fellowship 1975): 5/24/2017
Albert L. Exline, M.D. (Fellowship 1952): 7/16/2018
Stephen C. Farr, M.D. (Residency 1976): 11/30/2018
Marion S. Ferszt (M.D. 1952): 10/7/2018
William J. Gorham (M.D. 1960): 5/6/2018
James A. Gunn, M.D. (Residency 1952): 10/11/2018
James M. Harkema (M.D. 1968, Residency 1974): 10/9/2018
John H. Henzel (M.D. 1962, Residency 1964): 10/2/2018
Patrick F. Jewell (M.D. 1958): 12/12/2018
Robert D. Johnson (M.D. 1945, Residency 1952): 9/12/2018
John P. Kemph, M.D. (Fellowship 1957): 12/16/2017
A. Richard Kendall, M.D. (Residency 1962): 1/19/2017
Robert M. Komorn (M.D. 1964, Residency 1970): 10/24/2018
William J. Kube (M.D. 1961): 11/30/2018
William Hubbard, M.D.

William N. Hubbard Jr., M.D, dean of the U-M Medical School from 1959 to 1970, died Nov. 12, 2018, at age 99. Hubbard was one of the nation’s youngest medical school deans upon his appointment at age 39, and was the school’s first full-time dean without private practice and departmental administration responsibilities.

During his tenure, he reorganized policies and practices, emphasizing the importance of translating medical research advances into educational programs for students and practicing physicians. He was successful in involving the entire faculty in the affairs of the school, and aimed to provide leadership that would help students and faculty work more effectively. He also directed a $33.5 million program to remodel existing buildings and construct new ones at the Medical School.

In 1969, he became the first Medical School dean to also have responsibility for directing the medical center. He stepped down in 1970 to become vice president and later president of the Upjohn Company. Presidents Kennedy, Nixon, and Ford appointed him to national boards, including his 1974 appointment to the board of the National Science Foundation.

Hubbard maintained close ties with the U-M Medical School and returned to campus for commencement exercises well into his 90s.

Konrads V. Lubavs (M.D. 1958): 7/15/2018
William F. Malarney (M.D. 1962): 7/26/2018
Chester J. Materowski, M.D. (Fellowship 1960): 5/17/2018
Frank W. Matthews (M.D. 1954, Residencies 1958 and 1959): 7/7/2018
Robert M. Michels (M.D. 1948): 12/1/2018
Norman D. Moss (M.D. 1957): 10/20/2018
Joseph G. Nelson (M.D. 1956): 7/16/2018
Robert W. Poel (M.D. 1959): 12/7/2018
William A. Pruet, M.D. (Residency 1960): 10/7/2018
David A. Reinke (Ph.D. 1964): 10/27/2018
Steven L. Rodis (M.D. 1972): 9/29/2018
Johannes Schokker (M.D. 1966): 7/18/2018
Frank Shubeck (M.D. 1953, Residency 1958): 10/30/2017
John H. Smith (M.D. 1955): 11/19/2018
James B. Spaulding (M.D. 1954): 8/24/2018
Carol S. Steffenson (M.D. 1976): 8/2017
David J. Stinson (M.D. 1962): 8/28/2018
John H. Tedford, M.D. (Residency 1962): 10/15/2018
George F. Wagoner (M.D. 1959): 11/7/2018
Charles H. Watson (M.D. 1957): 10/28/2018
Warren S. Wille (M.D. 1946, Residency 1953): 7/15/2018
Mark A. Zamorski, M.D. (Residency 1992): 8/17/2018
Justin A. Zivin, M.D. (Residency 1973): 2/17/2018
Changing the Way We Talk About Cancer

BY MICHELLE RIBA, M.D.
Last summer, our nation mourned the death of beloved singer/songwriter Aretha Franklin. The news hit especially hard here in Michigan, where the star grew up. I followed along with the tributes that honored her legacy — but that also described, over and over, how she had “lost her battle with cancer.”

As director of the PsychOncology Program at the U-M Rogel Cancer Center, this type of language has always struck a chord. Often, when the media talk or write about cancer, they use militaristic language. Phrases such as “lost their fight” or “the war on cancer” are common.

The militaristic language used to describe cancer speaks to years of thinking about the disease with a fighting kind of spirit. The media uses it; the American Cancer Society has used it; and the Obama-Biden Plan to Combat Cancer was an example of a recent call to action. In our day-to-day work with patients, however, these terms aren’t in our lexicon. This raises the question: Is the gap in the language that is used a problem? What is the impact on patients and families?

In fact, this language can have a negative effect on the emotional state of patients with cancer. Many people who have cancer already struggle with day-to-day activities, so asking them to take on their disease in a militaristic way can make it even more difficult. The phrase “losing their battle” presents connotations of failure. It can make a person whose cancer-related death is imminent wonder: If I had done something differently, would I have “won” the battle?

This language may impact patients in terms of palliative care, too. Sometimes families feel that it’s a sign of giving up to not try more active treatments, to not “soldier on.”

It has always struck me that the language that is used for cancer is a different vocabulary than we use for dealing with other illnesses. Why and how did this come to be? One rarely hears that someone “lost their battle with heart disease.” Some of the combat-derived language could be rooted in the fundraising efforts behind cancer, to bolster support for donations to research — a worthy goal, to be sure. And in the context of philanthropy, maybe this type of language is indeed very helpful.

It is important, though, to examine how we use such language and terminology. Words matter. Partnerships between patients, clinicians, and the media could be helpful. Communicating in a language that is sensitive, caring, and supportive could alter what the headlines shout out.

With my patients, we talk about how to live with cancer and chronic conditions. These days, many people live long and productive lives with cancer. I often encourage my patients to set achievable goals and to draw on support from friends and family. For example, it is always important to focus on relationships, getting enough sleep, exercising, assessing and treating distress and emotional problems, and following a healthy diet. We should encourage our patients to live as well as possible.

The needs of individual patients can be varied, not just in how they live their lives with cancer but also in the language that resonates with them. For some, referring to cancer as a battle could be motivating; a warrior trying to slay a dragon. It is time, however, that we consider the people who might feel burdened by it and offer some alternative terminology, such as “living with cancer.” And at no time should we refer to someone losing his or her battle with this disease. That’s why we are putting together a team at the Rogel Cancer Center that will develop a strategy for addressing this issue, working in conjunction with the Patient and Family Advisory Committee. We need to remember that we are not talking about a skirmish in a war or a basketball game between rivals; we are talking about the entirety of patients’ lives.

To learn more, visit www.rogelcancercenter.org/psychoncology-clinic.

Michelle Riba, M.D., is the director of the PsychOncology Program at the U-M Rogel Cancer Center and associate director of the U-M Depression Center.

The phrase “losing their battle” presents connotations of failure. It can make a person whose cancer-related death is imminent wonder: If I had done something differently, would I have “won” the battle?
Jasmine Harris always knew her future would involve medicine, but, prior to attending the U-M Medical School, she took a few gap years to better acquaint herself with the people she would one day help and the systems that treat them. She worked as a clinical research assistant at the Children’s National Medical Center in Washington, D.C., and saw the world of pediatric emergency medicine up close; she also saw, through volunteering, how health disparities affect minority populations. And she knew she had to act. Harris, now an M2, is working to address those disparities and improve the lives of both patients and aspiring physicians from underserved communities. Through those formative, real-world experiences, Harris — pictured here at the Ann Arbor District Library’s Traverwood branch, one of her favorite places in Ann Arbor — came to understand her strengths, her courage, and her ultimate purpose as a medical professional.

“I used to feel insecure about my journey being different from others’, but now I see it as a critical part of becoming the person and future physician that I am today. Being a non-traditional student has allowed me time to learn more about myself and solidify my love for medicine. During my gap years, I was able to strengthen my scientific background and be involved in research and volunteer opportunities that made me feel wholeheartedly that this was the path for me. “Medicine provides the unique opportunity to work with people from all walks of life, and, in pursuing it, I hope to combat health disparities while promoting health equity and culturally competent care. I want to be both an advocate and ally for my patients.”

— Jasmine Harris
Thank you.

Because of you, we’re able to change the future of health care. Donors gave nearly $1.5 billion to Michigan Medicine during the Victors for Michigan fundraising campaign. Read about the impact of these gifts, beginning on p. 34.