This year's reunion brought back the charter class — the class of 1976 — for their 30-year reunion. *ASPECTS* sat down with four members to reflect on their experiences at SIU and discuss how the practice of medicine has changed over the past three decades.

Reflections

Reflections on 30 years

Interviews by Karen Carlson • Photography by James Hawker

WHAT WAS IT LIKE ATTENDING A BRAND NEW MEDICAL SCHOOL?

Greg Renner: It was very stimulating. All that knowledge was out there, and we were soaking it in as fast as we could. SIU School of Medicine offered a very challenging and yet personal and supportive environment. For me, it was an environment I really thrived in. I enjoyed my time at SIU very much. The sense of camaraderie was a special feature for me.

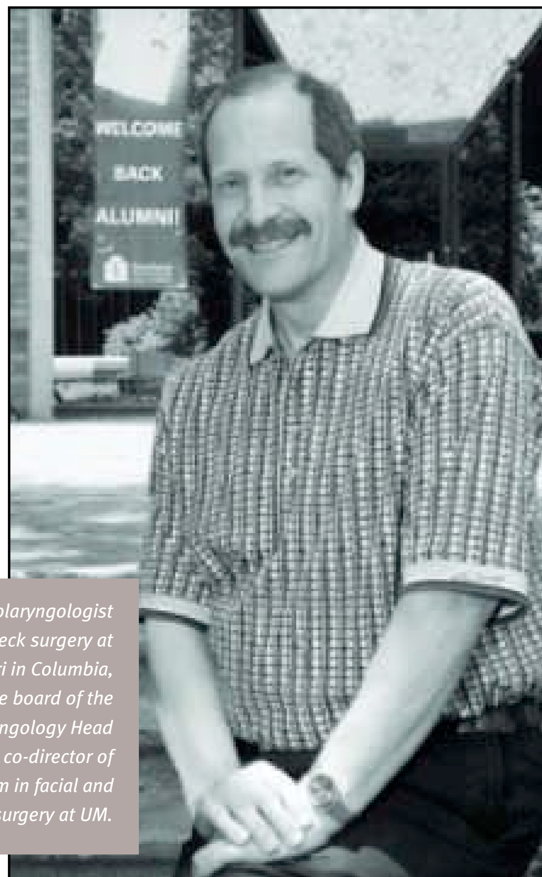
Tom Herrmann: What I recall is that the faculty and administration were personally invested in our success. They were the risk takers — we were the experiment. We benefited from a lot of extra attention. When we said something, people listened.

Philip Zumwalt: I was accepted at four other medical schools, but I decided I wanted to come to an area that was very focused on primary care and get me out there to be a rural physician. I didn't want to go to Chicago.

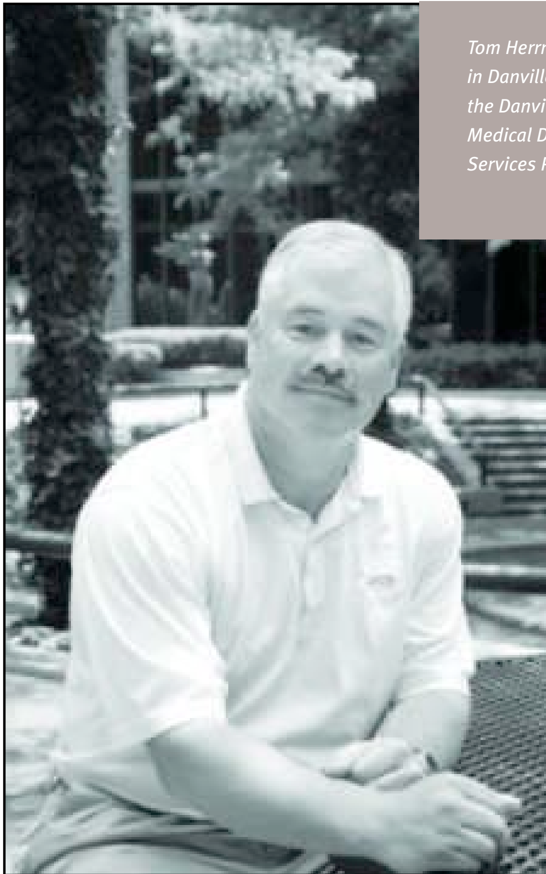
Stephen Goetter: I liked being able to sit down and talk with the professors — they had a vested interest in our success. And we were given the chance to mold the curriculum. Almost every one of us, when we got through with the three-year curriculum told the professors, 'you need four years'.

TH: I remember the first time we came to Springfield, there was a party at the dean's house. It felt special — we were their project.

SG: I remember groups of four or five students would study together. The idea was that we all got the grade. What we often did is that one guy would take one topic and teach it to everybody else. I learned how to be a team player in health care and learned how to teach myself and absorb things — that's key.



Greg Renner, M.D., is an otolaryngologist specializing in head and neck surgery at the University of Missouri in Columbia, Mo. He is on the executive board of the Missouri Society of Otolaryngology Head and Neck Surgery and is co-director of the fellowship program in facial and reconstructive surgery at UM.



Tom Herrmann, M.D., is a psychiatrist in Danville, Ill. He is vice president of the Danville Library Foundation and Medical Director of the Psychiatric Services Provena USMC.

■ HOW DID YOU CHOOSE YOUR SPECIALTY?

TH: I liked the stories of psychiatry. I considered internal medicine, but the average age of patients was 82. I wanted to listen to people stories.

GR: I liked the creativeness of plastic surgery and the creativity of anatomically trying to beat cancer while trying to preserve or restore normal form and function for the patient. Plus, in the head and neck I see the work that I do. I find that fulfilling. The personal connection to patients is rewarding, too. You play a major part of patients' lives.

SG: I always thought I'd want to do primary care. The premise of a new medical school seemed to fit what I was thinking I wanted to do.

But I didn't know what realm I wanted to do. In Carbondale, we were assigned a mentor to do physical parts of examination. My mentor described an internist as a "physician's physician." I liked that.

PZ: I grew up on a farm thinking I wanted to be a farmer until high school. I rode on tractors and thought it was too boring. Then I knew I wanted to go into family practice because of my local family physician. He said, 'You oughta come back here, and we'll stamp out disease in Iroquis county.' So that's what I did. I like family practice. I've got several families where I'm taking care of five generations at the same time, from a 98-year-old great grandfather to a newborn baby. I'm working with a lot of people I've known my whole life. That makes it enjoyable.

■ WHAT WERE YOUR FIRST DAYS LIKE AS A PHYSICIAN?

GR: We had to assimilate the knowledge base in three years. Evaluating the patient was OK, but the University of Missouri where I was a resident was a very different environment back then with major responsibilities given to residents from the very start. Being involved in Code Blue situations was frightening at first.

SG: I remember my first day on call. The bunk beds close together, my pager went off. I jumped up and slammed my head into the top of the bunk bed!

But I was well accepted. The nurses were very accepting. If there was a question in the middle of the night they helped me out. You have to develop a comfort level the first day in practice, seeing your first patient when you realize you're making all the decisions.

TH: At some point all the information clicks — you get an idea how the body and disease works — that's really the goal of medical school: to put enough knowledge in, add experience and it clicks. Halfway through my internship it clicked. It just made sense. But it took me six to eight months to feel comfortable.

PZ: I was goal oriented. I promised I'd practice in my hometown area. My families' great-great-grandfather's homestead is our farm. I knew I'd enjoy being around my dad, my cousin and my brother who all farm together. I never felt like I wanted to go anyplace else.

■ HOW HAS YOUR PRACTICE CHANGED OVER THE YEARS?

TH: I see a wide range of people. More people are getting and accepting psychiatric treatment as outpatients. That's more fun, treating and managing healthier individuals. And I'm maintaining their level of health much better. There is less stigma about getting psychiatric treatment, although it's still there. There are more tools now and more effective treatments. The change has made it fun. Now I

spend less time getting the story and more time teaching the patient. If they don't do what you tell them, the treatment is not going to work. People are also more knowledgeable about diseases such as bipolar, although some people come with preconceived ideas about what they need. You get more questions, and that's more challenging.

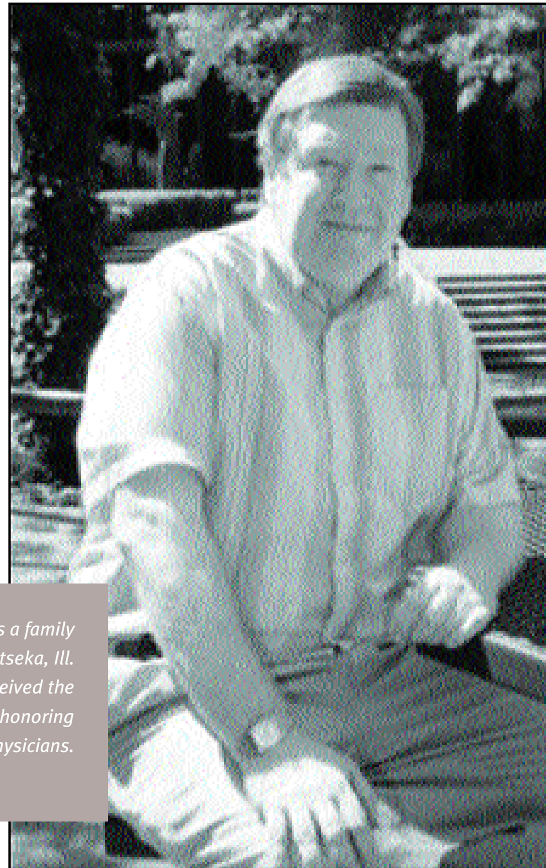
GR: It helps to get educated patients — they take some responsibility for what they do, and they have some understanding. They have to be part of their treatment.

SG: The technology has changed. CT scans provide a quick turnaround. Someone can walk into my office at 11 a.m. with abdominal pain, I can get a CT scan an hour and a half later, find acute appendicitis and have them in surgery by 2 p.m. That used to be a day-long procedure.

Technology has improved so many things, but it's put pressure on us and made patients a little more demanding. Some expect immediate gratification. And the slower pace in the early days of my practice in the '70s is gone.

GR: Technology has changed quite a bit, and it's expensive. Cancer therapy is going through a significant change. For a long time, chemotherapy wasn't very good for head and neck cancers, but now is playing a larger role with radiation therapy. Head and neck cancers as a group are still not good cancers to have. Understanding genetic changes is likely to have a major impact in the future. Medicine is advancing so rapidly even within my specialty it's harder for one person to know everything.

TH: Psychiatry practice has become a primary care. I don't do therapy — very few psychiatrists do, any more than a surgeon does physical therapy. The biggest changes are the understanding of chemistry, biochemistry, neurophysiology. When we were in school, drugs were found to be effective through trial and error. Drugs like Thorazine® were found by happenstance to make people in state hospitals not as sick. Those were the drugs I trained with. In the late '80s, designer drugs were developed to treat specific problems. The new drugs are better with fewer side effects. Technology has made the practice more efficient.



Philip Zumwalt, M.D., is a family practice physician in Watseka, Ill. In 2005, he received the "Doc Hollywood" Award honoring dedicated rural physicians.

SG: We're seeing basically the same thing for a little different reason. With the improvements in technology — stents are being used instead of bypass for heart patients. People with stents go home next day. When we were in residency here, heart attack patients would be in the hospital two weeks. Now it's an average of four days after surgery — that makes a big difference.

I think the big things that I see are improvements in anesthesia. The result is that my inpatient census is down considerably. I'm almost an outpatient physician.

When I started my practice, I wouldn't start seeing patients until 11 o'clock — I would spend most of the morning making patient rounds. Now, I get to the hospital at 7 a.m., and I'm done by 8 because I only have three or four patients to see. I spend much more time in my office than I do the hospital, although I have to work weekends and take call.

PZ: Laparoscopic surgeries get patients out of the hospital a lot more quickly. I used to have patients in the hospital for five or six days — now it's two or three. They'll come in for laparoscopic gall bladder surgery and go home later that evening or the next morning.

It used to be all family physicians did everything. Now I've got one specialist visiting the hospital every day: a general neurosurgeon, a neurologist, an anesthesiologist or a radiologist. That's developed over the last 20 years.

SG: There won't be family practitioners like Phil after he retires. His generation will be the last generation

to have a family practitioner who has the time and ability and willingness to pay the malpractice to do what he does.

HOW HAS THE COORDINATION OF CARE EVOLVED?

SG: Decatur's population of physicians and expertise has expanded tremendously over the years. When I went there were no rheumatologists, one pulmonologist, one gastroenterologist and one cardiologist.

GR: Coordination is major. My nurse practitioner spends a third of her time coordinating care. Back when I first started my career we didn't have that kind of person around. Now, I couldn't function without her.

TH: The biggest change in my area is the explosion of physician assistants. That's a whole new thing we never had much experience with. It doesn't affect me as much, but I work at a branch of Carle Clinic where half the people who are providers are physician extenders. That's a huge difference.

PZ: In Watseka, the last three physicians who retired have been replaced by nurse practitioners. It's hard to recruit a physician to come to a small town now, so you get a nurse practitioner to fill those shoes. There aren't too many of us left who specialize in family practice and obstetrics. Watseka doesn't have enough OB business to support two full-time obstetricians and gynecologists.

TH: Carle Clinic in Champaign has gone to a hospitalist model. It makes economic sense for a lot of reasons, but also may interfere with the continuity of care.

SG: Hospitalists are the future. Even so, I've inherited half dozen patients from people who started using hospitalists in Decatur because they didn't like it. The older patients don't like to be shuffled around — they want to be with one person, one familiar face who they feel is coordinating their care. For our kids, though, it's not going to make much difference. They will have five or six jobs in their lives, live in different places, see different doctors. They won't have long-term relationships with physicians.

Stephen Goetter, M.D., is an internist in Decatur, Ill. He is a past governor for the Illinois Downstate Chapter of the American College of Physicians and former medical staff president at Decatur Memorial Hospital.

TH: Patients shift doctors more quickly now. Every year or two, people switch insurance and have to switch physicians. The continuity is not there as much as it used to be.

SG: The next generation of physicians will make lifestyle choices. Most of them don't want to work like Phil works.

TH: Yes, physicians who open individual, small group practices — that's a thing of the past.

WHAT ADVICE WOULD YOU GIVE TO TODAY'S STUDENTS?

PZ: A big part of a medical student's experience should be learning everything but knowing that you don't have to remember it all in one day. Just know how to find it when you need it. And as a physician, you need to see the whole picture of your patient.

GR: Find a sense of balance in your life. Medicine is going to be demanding. It can be totally consuming as you set a high standard. But find a balance.

TH: Keep an open mind about what you want to do, and enjoy the experience. Medical school should be intense, a lot of work, and it should be fun. It was fun for me. ■