

U n i v e r s i t y M a g a z i n e

# CREIGHTON



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## INSIDE THE COST OF PRESCRIPTION DRUGS

BY: MICHAEL MAKOID, Ph.D.  
and ROBERT GARIS, Ph.D.

NO REFILLS  
10/12/01 BKP O

Creighton's Stroke Team

Jacob and Joseph

Nancy

**Entering  
Class of  
2002  
and You**



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Thank you for your support of Creighton University.

FALL 2001

U n i v e r s i t y M a g a z i n e  
**CREIGHTON**

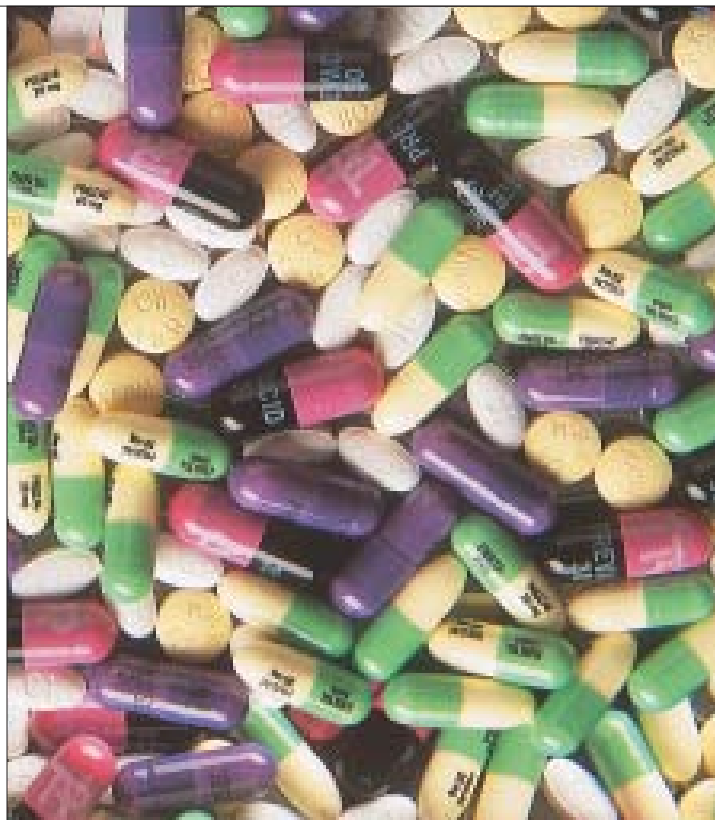


Photo by Michael Klieveter

## the **Inside** **Cost** of **Prescription** **Drugs**

By Michael Makoid, Ph.D.  
and Robert Garis, Ph.D.

**16** Prescription drugs are the fastest-growing component of America's \$1.1 trillion health care bill. The amount Americans spend on prescription drugs has more than doubled in the last five years — from \$61.1 billion in 1995 to nearly \$132 billion in 2000. What's driving this increase? Creighton's Michael Makoid, Ph.D., and Robert Garis, Ph.D., expose the costs behind our prescription drug bill.

## Features

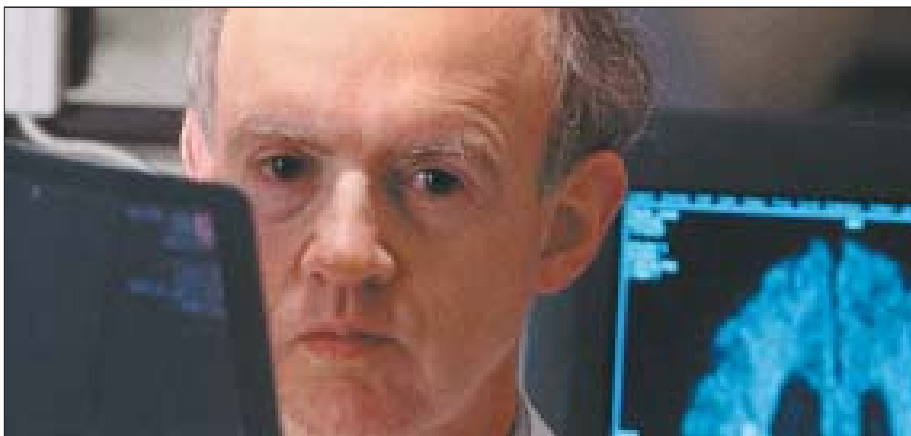
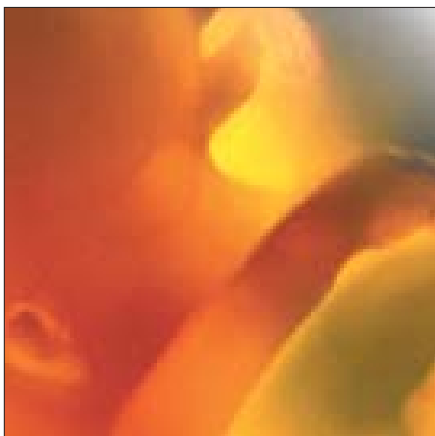


Photo by Montie Kruse, BA '83

### 26 Creighton's Stroke Team

"It used to be that you couldn't do anything for a stroke," says John M. Bertoni, M.D., Ph.D., professor and chair of neurology (pictured above). But new clot-busting drugs and a new type of brain scan, which allows for earlier detection, are making a difference. The key to successful treatment is rapid response. That's why Creighton University and Saint Joseph Hospital created a special Stroke Team. Free-lance writer Mary Kay Shanley, BA'65, examines this lifesaving initiative.



### 32 Nancy

*I had my picture taken today and it tickled. It was probably the ultrasound bouncing off my insides and my skin. ...* Creighton biologist Allen Schlesinger, Ph.D., investigates the beginnings of life from the perspective of an embryo named Nancy.

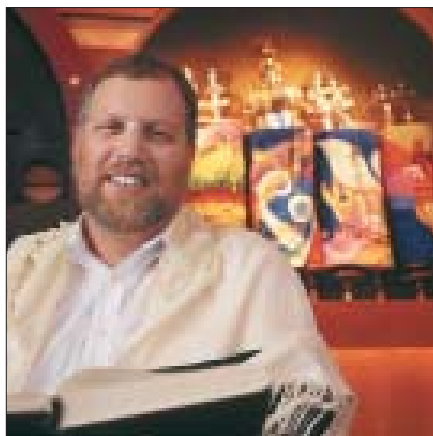


Photo by Bob Ervin

### 34 Jacob & Joseph

*"Now I can die, having seen for myself that you are still alive."* In the Torah, these were Jacob's first words to his long-lost son Joseph upon their reunion. But why would Jacob mention dying at a time of great rejoicing? Interpretations abound. Creighton law professor Lawrence Rafal finds meaning to this verse in a childhood trip to Budapest and the words of an old rabbi.

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#### Extending care

Creighton's School of Pharmacy and Allied Health Professions, in partnership with the Omaha and Winnebago tribes, provides physical therapy, occupational therapy and pharmaceutical care to Native Americans in northeast Nebraska.

#### Bright smiles

Creighton's School of Dentistry serves children in need through the Bright Smiles, Bright Futures program.

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#### Preserving the past

Marjorie Wannarka preserves the University's past as Creighton's archivist and through a generous gift designated for the preservation of endangered archival material.

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#### Luke Society

Creighton alumnus Wrede Vogel, BS'79, MD'83, reaches out to the poor around the world as executive director of the Luke Society.

### 55 The Last Word

Creighton alumna Mary Kay Shanley, BA'65, relives a flood of memories as she leaves her daughter off at college.

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#### Creighton University Magazine's Purpose

Creighton University Magazine, like the University itself, is committed to excellence and dedicated to the pursuit of truth in all its forms. The magazine will be comprehensive in nature. It will support the University's mission of education through thoughtful and compelling feature articles on a variety of topics. It will feature the brightest, the most stimulating, the most inspirational thinking that Creighton offers. The magazine also will promote Creighton, and its Jesuit Catholic identity, to a broad public and serve as a vital link between the University and its constituents. The magazine will be guided by the core values of Creighton: the inalienable worth of each individual, respect for all of God's creation, a special concern for the poor, and the promotion of justice.

Publisher: Creighton University; Rev. John P. Schlegel, S.J., President; Michael E. Leighton, Vice President for University Relations. *Creighton University Magazine* staff: Stephen T. Kline, Executive Editor; Rick Davis, Editor; Sheila Swanson, Associate Editor; Pamela A. Vaughn, Features Editor. Editorial Advisers: Charles J. Dougherty, Ph.D.; Kathryn Kersenbrock Bertolini; M. Roy Wilson, M.D.; Mark Huber; Diane Dougherty; Rev. Donald A. Doll, S.J.; Ruth Purtilo, Ph.D.; Valda Ford; Tamara Buffalohead-McGill; and Therese Vaughn.

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For more information on Creighton, contact the Undergraduate Admissions Office at 1-800-282-5835, [admissions@creighton.edu](mailto:admissions@creighton.edu).

To make a gift to the University, contact the Development Office at 1-800-334-8794.

For the latest on alumni gatherings, contact the Alumni Relations Office at 1-800-CU-ALUMS (800-282-5867) or check online at [www.creighton.edu/Alumni](http://www.creighton.edu/Alumni).

Send letters to the editor to Rick Davis at [rcd@creighton.edu](mailto:rcd@creighton.edu); fax, (402) 280-2549; Creighton University, Office of Public Relations, 2500 California Plaza, Omaha, NE 68178.

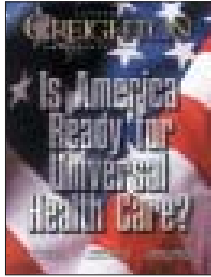
E-mail address changes and alumni news (births, weddings, promotions, etc.) to [alumdata@creighton.edu](mailto:alumdata@creighton.edu) or mail to Creighton University, Office of Development, 2500 California Plaza, Omaha, NE 68178.

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## Letters to the Editor

### Disgusted by article

I was frequently reminded during my years at Creighton that the Jesuit order was a socialistic society, not a democracy. Never has it been so clearly enunciated as in the article by your new chief anti-capitalist Dr. Donald Frey. His article could have been expected were he in residence at a liberal school such as Harvard but comes as a great disappointment to this conservative Midwesterner. No longer will I be a supporter of my old university nor recommend the enrollment of my grandchildren. His six pages are filled with conjecture and inaccuracies while the real truth lies in the medical professions' dissatisfaction with a decline in their formerly astronomical income by being forced to accept limits on reimbursement. Unlike Dr. Frey, many doctors are not enthusiastic about becoming federal employees or having their fees dictated at the even lower ridiculous level of Medicare. Perhaps you could have shown less bias had you given opponents of universal health care the opportunity to present six pages with color graphs also rather than a skimpy two pages. You might very well save some future postage by removing me from your solicitation lists as I am disgusted by this article.

William J. Egan, BA'52  
Omaha

### Wonderful article

My husband, William M. Wanamaker, and I are both Creighton graduates, he, from the School of Medicine, and, I, from the College of Arts and Sciences. My husband called my attention to the wonderful article by Dr. Frey about medical politics and economics in the 21st century. For some years, Dr. Wanamaker worked in academic medicine. In 1978, he began the private practice of neurology in Green Bay, Wis., from which he retired in November 2000.

Increasingly, during the last years of his practice, he has become involved in local medical politics, serving on and chairing the credentials committees of three local hospitals, and just about every other committee in the local medical scene. In his retirement, he continues to be involved in the delivery of medicine

by serving as a consultant for a large local practice group of independent physicians. Through all of this, he has held the opinion that a single-payor system is inevitable and probably necessary. Dr. Frey's article says it so eloquently. We would like to dispense copies of this article among select physician friends in the area.

Jane Wanamaker, BSMT'61  
De Pere, Wis.

### Public financing doesn't guarantee efficiency

Proposal of a solution to improve the U.S. health care system is truly a complex undertaking. I note that Dr. Frey's emphasis is on improving system outcomes instead of individual outcomes. He also seems to make the assumption that, in health care, publicly financed systems are preferable to competitive-based systems.

Having spent a career in a system of universal health coverage (the U.S. military), I have seen hospitals become clinics, staffs reduced, and more reliance on technicians, referrals and outside contracts. Facilities often were influenced by the political climate, not by area patient needs. Why is the headquarters clinic always better staffed? Stationed in Europe, I observed the deplorable state of government-reimbursed dental care in Germany and the Netherlands. Dutch friends complained about the inordinate number of early medical retirements allowed due to "stress" by the government-based program there.

Public financing is no guarantee of efficiency. How many government programs do you know that are paragons of efficiency? Ultimately, medical decisions will be made by politicians.

Do we really have a competitive system? How well can consumers judge their care? Perhaps we need measures to promote true competition through increased access to honest information. If our universal military health care system did not have to compete by comparison to a familiar private system, I have wondered whether facilities, training opportunities, and instrumentation would be as modern. What would my pay be? Is the Canadian system influenced by its proximity to a much larger, fairly familiar southern neighbor? When we hear about prominent foreigners coming to the U.S. for medical care, I doubt if they are concerned about the statistical output of the system, but, instead, their individual outcome. Competition helps promote that excellence in the practitioners and institutions that they seek.

It appears that we are progressing toward a right to health care supported by the government. Is our government the guardian of our freedoms and responsibilities, or is its purpose to fulfill all our material needs? With Congress already involved in universal access to cable TV, the Internet, and low energy prices, what next will become a right?

Why is it that people who neglect the most basic personal measures in preventive health care, saying that they "can't afford it," think that no treatment is too expensive when funding is from another source? In my experience, 10 percent of patients need 80 percent of treatment, almost all preventable.

Where is the discussion of individual responsibility and establishment of proper incentives? Why does the employer have to be involved in employee health care? Perhaps because the government has allowed the use of pre-tax dollars instead of after-tax? Why not equality for all? Doesn't direct payment (such as we use for almost all our other needs, including such essentials as food and shelter) have a place? What about mention of Medical Savings Accounts? Is low cost catastrophic health insurance still available? What are the implications of free prescription drugs for the elderly? Will it cure their ailments? With a drug for almost every condition, how will we limit costs?

Improvements can certainly be made to our system, and I do not pretend to have all the answers. Due to unquestioned assumptions and omissions, this article also falls short of providing answers. However, it is important to keep an open discussion of all ideas if we are to make progress.

Col. Wayne Grabow, DDS'78  
Great Bend, N.Y.

### Dr. Frey on target

Congratulations to Dr. Donald R. Frey and to you for publishing "Is America Ready for Universal Health Care?" in your Summer 2001 issue. I found it to the point and on target. This is the type of dialogue in which we were taught, as Creightonians, to engage.

What Richard Coorsh, vice president of communications for the Health Insurance



Association of America, (in the sidebar article titled "System Works, but Change is Needed") doesn't understand is that many states have opted not to provide existing health coverage programs to the poor (e.g., Texas, under George W. Bush). Coorsh's proposals for change do not seem to have the federal mandate that all states participate.

When I compare the cost of the high deductible (\$2,500-\$5,000) policies my farmer neighbors must purchase through supposed co-ops, I am appalled to discover that they often pay two to three times what I do and don't get half the benefits.

Good job and thanks for the thought-provoking article.

Sharyn James Baldacci, BSMT'62  
Stanton, Neb.

### A shameless rant

I just got my most recent installment of the *Creighton University Magazine*. How disappointed was I to find that the lead story was a shameless rant on the need for a

socialized system of medicine in the U.S.

I get this kind of propaganda all the time from the national media. I don't expect it from my *alma mater*. Considering the generally conservative cast of the Creighton student body (when I was there) and the alumni base, I am surprised and shocked that you'd actually put up not a fair and impartial evaluation of such a system, but a left-slanted diatribe worthy of the *New York Times* editorial page.

Did your magazine note that last year, over 5,000 seniors in the British Health Service died of infections due to unsanitary hospital conditions (*UK Telegraph*)? Or that waiting times for serious illnesses can be over six months? Did you think to report that recently 20,000 of the 36,000 doctors employed by the British NHS threatened to quit outright because of low pay, horrible working conditions and overwork (*UK Guardian*)? How about the 1,800 new doctors that the Canadian medical schools produced in 2000? Did you report that over 600, or fully one-third immediately left Canada to work in the "inferior" U.S. health care system?

The "response" you give is someone else who still wants to expand government intervention in the health care system, but only a little less. This is an opposing viewpoint? How about an opinion from someone who believes that the 43 percent take of government in the U.S. health care system is the root of the problem of spiraling health care costs? How about someone who believes that Medicare is a massive, costly mistake that is driving health care costs up, not down?

The same people who push for socialized medicine say, oddly, in the same breath that the U.S. has the greatest health care system in the world, yet bemoan the "scandal" of not having universal, socialized health insurance coverage. Maybe, just maybe, there is a correlation to having the best health care in the world and not having a system of socialized medicine. The correlation, for even minimally astute viewers, is manifest.

It is sad to see a fairly conservative university in one of the most conservative states in the union produce such a ridiculously biased piece of leftist propaganda. This country needs less government meddling in the health care system, not more.

Matthew Tucker, BSBA'92  
Lake Bluff, Ill.

## Clear on the issues

I always enjoy reading the *Creighton University Magazine*. In the most recent issue, I was very interested in the article "Is America Ready for Universal Health Care?" by Dr. Frey. He has made the issues related to this subject about as clear as could be.

Emery Szmrecsanyi, BS'59  
Grosse Pointe Farms, Mich.

## Disappointed by article

I was very disappointed to read the lead article on health care by Dr. Donald Frey. The statements he makes have no basis in fact and are just a carbon copy of the arguments used by U.S. Sen. Ted Kennedy in the health care debate in the 1992-93 era.

That is ancient history in our rapidly moving health care scene. I don't have the time to rebut each of his points, but when I received my MBA in health care from the University of California, Irvine, in 1998, my colleagues and I went to Montreal and McGill University Medical School for a detailed look at the Canadian health care system. McGill has been put in charge of all health care in Montreal and its environs, so we were able to inspect Montreal General Hospital as well as community clinics and the teaching hospital at McGill. I had classmates in charge of preparing hospitals for accreditation. They told me Montreal General would be closed down in a day if it were in the U.S. Plus, do you know there are more MRI machines in the city of Seattle than in the entire country of Canada? Plus, do you know there are paralyzing doctor strikes every few years while the government negotiates contracts? Plus, do you know the emergency room protocol for angina patients is to give them an aspirin for pain and send them home? That I saw in writing.

The problem is politics in health care. Decisions are made by non-doctors. Get government out of medicine and dentistry and we can again have a top quality system. Unfortunately, Dr. Frey doesn't seem to have a clue as to what is really going on. He sounds like an economist.

James J. Monahan, DDS'56  
San Marcos, Calif.

## Minor leaguers don't benefit from reserve clause

In my friend Jerry Clark's excellent, enjoyable and perceptive article on baseball (Summer 2001), he noted that St. Louis

Cardinal outfielder Curt Flood was able to "overturn" the "reserve clause." This isn't true. It only freed major league players, not minor league players.

On the contrary, for minor league players, the "reserve clause" is more restrictive than before Flood. Under the old "reserve system" a minor-league player was free from the end of the season until he received a new contract on March 1. Today, most minor-league players, as well as high school and college players who sign with a professional team, sign the 1995 Minor League Uniform Player's Contract. This is different from the big-dollar major league contracts. Every professional minor-league team, including teams in the independent Northern League, use this contract form.

Under the contract, a player is signed for seven years, during which time he can be dismissed or sold at any time. Professional baseball is not high school or college baseball; it is a rugged and, often, cruel business.

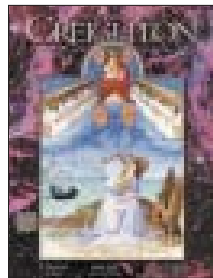
Ross Horning, Ph.D.

Creighton professor of history  
and former minor-league baseball player

## Taking exception to Revelation article

In his article "Revelation: It's All About Stars ... And the Evils of Cities" (Spring 2001), Dr. Bruce J. Malina often refers to the term "Jesus-group." I take it he has some antipathy toward the term "Church." So he may forgive my antipathy toward his term "Jesus-group," which belittles the Church.

Most of all I take exception to the statement, "... culturally informed, historical approaches to the New Testament are the only appropriate and suitable methods to discover what they (our ancestors in the Christian faith) said and meant by their witness." So,



only scholars like Dr. Malina can discover and, by implication, should teach what the New Testament means? I will concede that historical-critical methods can help us understand all the books of the Bible. But to say that they are the "only appropriate and suitable methods" to understand the Bible is nonsense. That would allow scholars to usurp the teaching role of the bishop in the Roman Catholic Church.

The idea is silly for another reason. The Old and New Testaments were not first given to mankind and the Church in this 21st century. The Church and the Catholic people have had the New Testament from the first century. Certainly first century Catholics understood them, so far as prophetic writings can be understood. The understanding of what those sacred writings mean has been handed down to us as part of the tradition of the Roman Catholic Church. Rather than looking first to modern scholars and their cogitations about what the Book of Revelation means, we should look first to the pope and our bishops, and then to the writings of the fathers of the Church that form part of the Church's tradition.

This leads to the question: Is Creighton anything more than just a "nominally Catholic" university?

Albert C. Walsh, JD'52  
David City, Neb.

**Author's response:** To interpret the Bible in the Church, one must read the official, magisterial documents on the subject. I am referring to the position of the magisterium articulated in: 1, "The Interpretation of the Bible in the Church" (April 23, 1993) — print copy available in *Origins* 23.29 (Jan. 6, 1994) 497-524. 2, J. Fitzmyer, "The Biblical Commission's Instruction on the Historical Truth of the Gospels," *Theological Studies* 25 (1964) 386-408. 3, Vatican II: *Dei Verbum* ("Dogmatic Constitution on Divine Revelation" — Nov. 18, 1965). Creighton's Department of Theology is far from "nominally" Catholic. The faculty know what the official, magisterial teachings are and present them as such.

Bruce J. Malina, Ph.D.  
Professor of Biblical Studies

## Note from the Executive Editor

We have made some changes in the design of *Creighton University Magazine*.

Our goals are to make the magazine more vibrant and exciting, and easier to read. In addition, it should be easier for you to find your favorite features.

We always strive to improve, and we hope that if you have comments or suggestions, you will share them with us by sending an e-mail to *Creighton University Magazine* Editor Rick Davis, BA'88, at [rcd@creighton.edu](mailto:rcd@creighton.edu).

Thanks for your loyalty to Creighton!

Stephen T. Kline  
Executive Editor



Photo by Jay Langhurst, BSBA'01

## Law School Hosts Judges' Reception

The first biennial "Creighton on the Bench" reception for Creighton University alumni who are judges was held April 24 at the Ahmanson Law Center. Pictured are: **front row** — Larry F. Fugit, JD'71, County Court; C. Thomas White, JD'52, former Chief Justice of Nebraska Supreme Court; Lyn V. White, JD'78, County Court; Patrick Borchers, dean of the School of Law; Richard J. Spethman, JD'61, District Court; **second row** — Samuel V. Cooper, JD'48, County Court; J. Patrick Mullen, JD'69, District Court; Ronald E. Reagan, JD'67, District Court; F.A. Gossett III, JD'72, District Court; Christopher Kelly, BA'74, JD'79, Separate Juvenile Court; **third row** — Michael McCormack, JD'63, Nebraska Supreme Court; George A. Thompson, BA'60, JD'61, District Court; William B. Zastera, JD'71, District Court; Gary B. Randall, JD'74, District Court; Douglas F. Johnson, JD'87, Separate Juvenile Court; **fourth row** — W. Mark Ashford, JD'78, County Court; Robert V. Burkhard, JD'52, District Court; Michael McGill, JD'64, retired, District Court; Stephen M. Swartz, BA'68, JD'71, County Court; Elizabeth Crnkovich (light blue), JD'83, Separate Juvenile Court; Mary C. Gilbride, JD'82, District Court; Thomas D. Thalken, BSBA'64, JD'66, U.S. Magistrate; **fifth row** — John C. Burke, JD'51, retired, District Court; Sandra L. Dougherty, JD'82, District Court; James A. Buckley Jr., JD'59, retired, District Court; the Rev. John P. Schlegel, S.J., Creighton president; Patricia A. Lamberty, JD'79, District Court; J. Michael Coffey, JD'74, District Court; **sixth row** — John E. Huber, BA'85, JD'88, County Court; Joseph F. Bataillon, BA'71, JD'74, U.S. District Court; John F. Irwin, JD'77, Court of Appeals; William M. Connolly, JD'63, Nebraska Supreme Court; Michael W. Amdor, BA'71, JD'76, District Court; Gerald E. Moran, BA'70, JD'73, District Court; **seventh row** (upper left) — Lawrence E. Barrett, JD'79, County Court; Charles L. Smith III, JD'70, Iowa District Court.



Photo by Dave Weaver

Fr. John P. Schlegel, S.J., works the controls of a backhoe at the groundbreaking for the new science complex on June 4.

## Construction of New Science Complex Begins

A \$48 million venture to renovate and expand Creighton's undergraduate and graduate health sciences facilities began to take shape at a groundbreaking ceremony on June 4. A new five-story structure and planned renovations to the Rigge Science, Criss II and III buildings will further Creighton's reputation for excellence in science education and research.

The new structure will be located just east of the existing Criss II and III buildings and north of the Rigge Science building. It will enclose more than 80,000 square feet. Additional classrooms, computer labs and offices will fill the new space, as well as an array of student amenities, such as a cafe surrounding an interior rotunda at the building's main entrance. The new structure should be fully operational in 2003.

Plans for the new space and renovated spaces in the Rigge, Criss II and III buildings include multi-purpose classrooms, lecture halls, high-tech teaching and research laboratories, shared core facilities for research equipment, offices and student common spaces.

## Governor Signs Tobacco Settlement Bill; Creighton to Receive Funds

At a ceremonial bill signing in July, Nebraska's Gov. Mike Johanns, JD'74, gave a boost to medical research and other health initiatives with funds from Nebraska's share of the settlement with tobacco companies. Creighton University, the University of Nebraska Medical Center (UNMC), the University of Nebraska-Lincoln (UNL) and Boys Town National Research Hospital will share a \$10 million pot for each of the next two years. In 2006, the amount will increase to \$14 million.

Nebraska legislators dedicated all of the state's settlement monies for health care services and research. Seven major areas — public health, minority health, behavioral health, biomedical research, developmental disabilities, juvenile services and respite care — will benefit from funds expected to total about \$1.2 billion over 25 years.

Creighton will focus its research in areas that are likely to garner National Institutes of Health (NIH) funding. Following the

federal government's Healthy People 2010 initiative, Creighton's research projects will target osteoporosis and chronic back conditions; heart disease and stroke; immunization and infectious diseases; maternal, infant and child health; respiratory disease; arthritis; vision and hearing, as well as other areas.

The primary goals of Creighton's new research efforts are to increase NIH funding;



Photo by Dave Weaver

Gov. Johanns greets Creighton President Fr. John P. Schlegel, S.J., after signing a bill that will provide monies for CU researchers.

to stimulate research that will have a positive economic impact in the state in areas such as biotechnology and pharmaceuticals; to improve health and life expectancy for all Nebraskans; and to enhance collaborative research among Creighton, Boy's Town National Research Hospital, UNMC and UNL.

## Around Creighton Austin Named Dean of College of Arts and Sciences

Timothy Austin, Ph.D., became the dean of Creighton University's College of Arts and



Austin

English at Loyola University of Chicago.

Born in the United Kingdom, Austin has been teaching at Loyola University Chicago

Sciences on Aug. 1. Austin replaces Fr. Al Agresti, S.J., who stepped down in December 2000 for health reasons. Prior to his position at Creighton, Austin was professor and chair of the Department of

since 1977 when he started as an assistant professor of English. He was named an associate professor in 1983 and assistant chair of the department in 1992 to 1994, when he was named full professor. In 1996 he was appointed as chair of the department. Austin also served as the associate dean of the Graduate School from 1985 to 1990.

His teaching experience includes doctoral, master's and undergraduate courses on three Loyola campuses, including its Rome Center for Liberal Arts.

He received his undergraduate degree in English language and literature from Lincoln College, Oxford University in England. Austin attended the University of Massachusetts in Amherst for his doctorate work in linguistics, which he completed in 1977.

## Creighton Receives Grant to Train Medical Interpreters

In the Omaha area, many people speak one language. Often it isn't English. Spanish, Nuer and Arabic are languages that must be spoken in health care settings to ensure appropriate care.

The state of Nebraska has 23 newly certified medical interpreters working in 18 organizations as a result of a new program created by the Creighton University Department of Obstetrics and Gynecology and the Douglas County Health Department. The goal is to improve medical care by reducing the number of miscommunications because of language differences. The training program was established with a two-year \$130,000 grant from the state of Nebraska.

The need for such a program is clear. Nearly half of the patients seen by Creighton University obstetrics and gynecology specialists need medical interpreters. Census data show that Omaha's Hispanic community grew by 185 percent between 1990 and 2000. Omaha is home to one of the largest U.S. populations of Sudanese refugees, numbering between 3,000 and 4,000, according to the Southern Sudan Community Association.

Creighton's Robert Bonebrake, M.D.,

assistant professor of obstetrics and gynecology and director of the division of maternal-fetal medicine, is the project director.

"Language barriers limit accessibility to health care and affect our ability to provide adequate health care once patients do enter the system," Bonebrake said.

**With the help of a two-year \$130,000 grant from the state of Nebraska, Creighton University and other program partners are teaming to train medical interpreters in order to improve access and care for Omaha's growing immigrant population.**

"We need appropriately trained health care interpreters to improve access and care. It's difficult for many health care professionals outside the largest organizations to find and afford translators. We hope that by developing a qualified pool of interpreters, more health care settings will have interpreter services so

that access and care improves for patients," Bonebrake said.

Program partners with Creighton's obstetric and gynecology department are Metropolitan Community College, Seattle Cross-Cultural Health Care Program, Nebraska Association of Translators and Interpreters, and Douglas County Maternal and Child Health Collaborative.

The University will offer health care sites for interpreter training opportunities. The county health department provides administrative support to help coordinate the program.

Metropolitan Community College will offer a non-credit medical interpreter certification course as well as a course geared toward training instructors of medical interpretation. These efforts have been developed based on the Seattle Cross-Cultural Health Care Program model. The college staff also will develop a new medical glossary in Nuer, the predominant language of Omaha's Sudanese community.

The first training of medical interpreters included participants from Nebraska and western Iowa and was held in late April of this year.

### Fr. Hauser New Rector of Creighton's Jesuit Community

The Rev. D. Edward Mathie, S.J., Provincial of the Wisconsin Province of the Society of Jesus, announced that the Rev. Richard J. Hauser, S.J., is the new Rector of the Jesuit Community at Creighton University. The appointment was made by the Rev. Peter-Hans Kolvenbach, S.J., Superior General of the Society of Jesus in Rome.

Fr. Hauser, who maintains his current positions as director of the master's programs in theology, ministry and Christian

spirituality, began the six-year term on July 1. He replaced the Rev. Thomas J. Shanahan, S.J.

Fr. Hauser joined Creighton's Department of Theology in 1972 and served as chair of the department from 1978 to 1990 and again from 1996 to 1999. He was awarded the University's distinguished faculty-administrator award in 1991. He served as the associate director of the Christian Spirituality Program since its inception 23 years ago and became the director in 1994.

He was ordained as a priest in 1968 and received his doctorate in religion and religious education from the Catholic University of America in 1973. Since 1975, Fr. Hauser has presided at a special candlelight Mass every Sunday at 10 p.m. in St. John's Church.

### Dougherty Leaves Creighton for Presidency at Duquesne

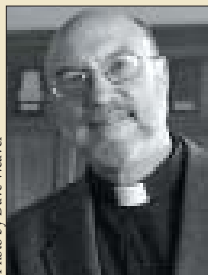
Charles J. Dougherty, Ph.D., former vice president for Academic Affairs at Creighton University, became president of Duquesne University in Pittsburgh on Aug. 15.



Dougherty

Dougherty had been at Creighton since 1975. He chaired the Department of Philosophy from 1981 to 1989 and was the director of the Center for Health Policy and Ethics from 1988 to 1995, when he was named vice president for Academic Affairs.

A search is under way for Dougherty's replacement.



Fr. Hauser

# Pharmacy, Allied Health Program Assists Native Americans

Chris Ross slowly swung his legs over the edge of the examination table.

"Can you lift your leg up?" asked Creighton alumna Sophia Chao, DPT'00.

Ross, 22, gingerly began to extend his stiff left leg. A grimace soon crossed his face.

"I can feel your kneecap grinding," Chao said. Her prescription: three exercises to increase the knee's strength and flexibility.

Ross and his mother, Marie Morgan, of Vermillion, S.D., were visiting the United States Public Health Service (USPHS) Indian Hospital in Winnebago, Neb.

The federally funded hospital, located on the Winnebago Indian Reservation in northeast Nebraska, has just 30 beds — 12 of which are designated for drug dependency. Funding is tight; the hospital is required to serve any Native American seeking care.

"Basically, we ration health care because of our funding situation," said Don Lee, the hospital's administrator.

Patients with critical needs take priority. In the past, rehabilitative services — such as physical therapy and occupational therapy — often were not provided.

"By the time we got down to that category, we never had the money," Lee said.

Thanks to a cooperative program between Creighton University's School of Pharmacy and Allied Health Professions and the Omaha and Winnebago tribes, Native American patients can receive the physical therapy, occupational therapy and pharmaceutical care they need at the hospital.

It began in 1997, when Creighton received a three-year, \$418,000 grant from the Department of Health and Human Services to provide physical and occupational therapy care at the Winnebago hospital and the Carl T. Curtis Health

Center in Macy, Neb.

"Our goal was to develop and implement, in cooperation with the Winnebago and Omaha tribes, culturally sensitive rehabilitation services in occupational and physical therapy," said Creighton Occupational Therapy Professor and Associate Dean for Research Charlotte Royeen, Ph.D.

Royeen is part of an interdisciplinary team of Creighton faculty working on the project. Other Creighton investigators include Gail Jensen, Ph.D., a physical therapy professor and faculty associate in Creighton's Center for Health Policy and

stipend support for students doing short- and long-term clinical rotations," Jensen said. "These students live in the communities (Macy and Winnebago) while they are on their rotations. It is through this experiential community-based time that they learn a great deal about themselves and the Native American communities."

The Macy health center and the Winnebago hospital serve as clinical sites for students in Creighton's School of Pharmacy and Allied Health Professions, as well as for students from Clarkson College in Omaha. In fiscal year 1999-2000, Creighton and Clarkson students put in nearly 10,500 volunteer hours at the hospital.

"The projects have taken on a life of their own as more students and disciplines are involved in the clinical services and community activities," Jensen said. "There is strong evidence of mission-in-action as students engage in learning experiences designed from the core values of respect for human dignity, promotion of social justice and commitment to community service."

The Creighton project has gained national attention, especially among universities looking to emulate it. Creighton has presented numerous papers and abstracts on the project at national conferences and meetings.

"It's a wonderful model of collaborative problem identification and problem solving," Royeen said.

Creighton alumna Patti Gengler, BS'93, OTD'00, an occupational therapist who splits time between the hospital and the Curtis Health Center, said she enjoys working in the rural setting.

"I like the fact that I get to spend time with the patients, talk with them and find out what's important to them," she said. "You don't see that much in the traditional setting, where things can be rushed."

And the need for these services? "In a nutshell, it's immense," said Lee, the hospital administrator. The physical and occupational therapy clinic averages 110 patient visits per month.

Gengler and Chao, for their part, are just glad they can help.

"We're giving to a community in need," Gengler said. "That's why we're here."



Photo by Monte Kruse, BA'83

Chao examines Ross' knee at the Indian Hospital in Winnebago, Neb. The Creighton School of Pharmacy and Allied Health Professions provides care at the hospital through a cooperative program with the Omaha and Winnebago tribes.

Ethics, and Mike Monaghan, PharmD, an associate professor and vice chair in the Department of Pharmacy.

The physical and occupational therapy program is now self-sustaining. The two tribes and Creighton University work as partners in clinical practice, evaluation research and education.

In 1999, Creighton received a second, \$454,000 grant from Health and Human Services to expand student training at the reservation beyond occupational therapy and physical therapy to include pharmacy.

"This second project also provides trainee

## Nath named McGraw Chair Holder

Ravi Nath, Ph.D., chairman of the Department of Information Systems and Technology and founding director of the Joe Ricketts Center for Electronic Commerce and Database Marketing, has been named holder of the Jack and Joan McGraw Endowed Chair in Information Systems in the College of Business Administration at Creighton University.

The McGraw Chair was established with a gift from John V. "Jack" McGraw Jr., who graduated from Creighton in 1953 with a bachelor of science in commerce, and his wife, Joan P. Davey McGraw, founders of the McGraw Group of insurance services.



Nath

In 1993, Creighton presented Jack with its Alumni Achievement Award.

Nath has a master's degree from Wichita State University and a Ph.D. from Texas Tech University. He spent the 1991-1992 academic year lecturing and conducting research in Africa as a Fulbright Scholar. He has published more than 80 research papers in the area of electronic commerce and information systems in various national and international journals.

Nath teaches information systems, electronic commerce and data mining at Creighton. He joined Creighton's faculty in the College of Business Administration in 1998, after rising to the rank of associate dean-academic programs in the Fogelman College of Business and Economics at the University of Memphis in Memphis, Tenn.

In April, at the Applied Information Management (AIM) Institute's 8th Annual Nebraska Technology Banquet, Nath was named "Educator of the Year: Post-secondary" by AIM.

## Educational Opportunities Grant Aids Students with Special Needs

Creighton University's Department of Educational Opportunity Programs has been awarded a four-year \$800,000 grant from the U.S. Department of Education to help fund

the Student Support Services (SSS) Program at Creighton.



Southerland

students that increase retention and graduation rates for traditionally low-income, first-generation students," said Wallace Southerland III, director of the Department of Educational Opportunity

"This funding is an indication that Creighton University is doing a good job in providing services to undergraduate

Programs at Creighton.

To qualify for the SSS program, a participant must be enrolled at Creighton, a first-generation college student, a low-income individual, a student in need of academic services offered by the program, or a student with a disability.

The award from the Education Department will provide services ranging from tutoring with specialists in science, math and writing, to academic counseling, to accessing cultural events in the city. The primary goals of the program are to increase the college retention and graduation rates of its participants and facilitate the transition from one level of higher education to the next.

During the 1999-2000 academic year, the SSS program provided support to 146 students, with 89 percent of those students in good academic standing. The Student Support Services Program is one of seven TRIO programs (Talent Search, Upward Bound, Upward Bound/Math and Science, Veterans Upward Bound, Student Support Services, EOC and McNair) funded under the 1965 Higher Education Act and the 1998 Higher Education Act Amendments.

## Creighton Participates in Prostate Cancer Study

The Creighton Cancer Center is among several Midlands health centers participating in a national study, sponsored by the National Cancer Institute, to examine whether supplementing selenium and vitamin E in the diet can protect against prostate cancer.

The study is the largest prostate cancer prevention study to date. It is also the first study designed to look directly at the effects of vitamin E and selenium, both separately and together, in preventing prostate cancer, the most common form of cancer, excluding skin cancer, for men. More than 400 sites in the United States, Puerto Rico and Canada are recruiting about 32,000 participants.

"Previous research involving vitamin E and selenium suggest that these nutrients might prevent prostate cancer, but we don't know for

sure," said James Mailliard, M.D., professor of medicine at Creighton and head of the Missouri Valley Cancer Consortium. "When this study is finished in about 12 years, we will know whether these supplements prevent prostate cancer."

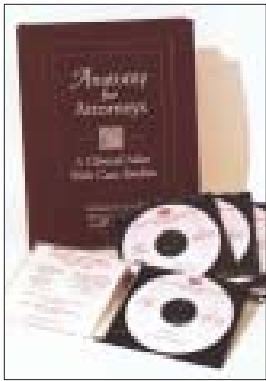
The American Cancer Society estimates that nearly 200,000 new cases of prostate cancer will be diagnosed this year in the United States. The chance of developing prostate cancer increases rapidly after age 50. Risk factors for the disease include being black — the disease occurs almost 70 percent more often in blacks than in whites — and having a father or brother with prostate cancer.

Selenium and vitamin E, both naturally occurring nutrients, are antioxidants. They are capable of neutralizing toxins known as "free radicals" that might otherwise damage the genetic material of cells and possibly lead to cancer. These nutrients were chosen for the study because of the results of two other large cancer prevention trials. To find out more about the study, call the Missouri Valley Cancer Consortium at (402) 898-8044.

## CU Professor Publishes *Anatomy for Attorneys*

Creighton University anatomy professor Thomas H. Quinn, Ph.D., BA'71, MS'73, has published *Anatomy for Attorneys: A Clinical Atlas with Case Studies*. Quinn co-authored the book with his father, the late surgeon Robert H. Quinn, BSM'41, MD'43, and his brother, attorney Terence R. Quinn. Robert Quinn passed away in July.

The book and accompanying CD-ROM are designed to convey general knowledge



of human anatomy and to improve the accuracy with which normal anatomy and injuries are discussed in the legal arena.

"With this book and CD, we want to help bridge the gap

between attorneys and physicians and other professional witnesses," Tom Quinn said. "The goal is to help the attorney become a better translator between professional witnesses and the jury. This isn't a malpractice book. We're trying to assist in communication. I think more justice can be done when everyone is speaking the same language."

The book is organized by anatomical systems, such as skeletal, circulatory, musculature and nervous systems. It contains glossaries, pronunciation guides and detailed illustrations to enhance the text.

"I think most people learn better visually," said illustrator Spencer Phippen. "In an illustration I can do things that I can't do in a photograph — I can take out unnecessary information and zero in on the point of emphasis."

The case studies in the book are based on actual cases. Tom Quinn testified in some of the cases highlighted, and Terry

Quinn represented clients involved in several others.

The CD-ROM contains all the illustrations found in the book. In addition to looking up words in a glossary, users can click on particular terms and hear the correct pronunciation.

The book and CD are distributed by Quality Medical Publishing Inc. of St. Louis.

Tom Quinn is president of the Anatomical Board of the state of Nebraska and is an officer of the American Association of Clinical Anatomists. He has lectured on anatomy and personal injury topics for attorneys throughout the country.

Terry Quinn is a partner of the law firm Johnson, Eisland, Quinn, Huffman and Clayborne in Rapid City, S.D. He lectures nationally on medical law topics and has written numerous articles on the subject. He also is past president of the State Bar of South Dakota and the South Dakota Trial Lawyers Association, is serving on the board of governors of the Association of Trial Lawyers of America and was the recipient of the South Dakota Trial Lawyer of the Year Award.

Robert Quinn was a professor of surgery *emeritus*, past chair of the surgery department and retired vice president of health affairs and dean at the University of South Dakota.

Illustrator R. Spencer Phippen is a certified medical and scientific illustrator who has won a number of awards and honors. He has been an active member of the Association of Medical Illustrators and currently serves on its board of governors.

## CU-Hosted Radio Program Airs in Several States

*Talking History*, the radio program hosted by Creighton University historian and John C. Kenefick Faculty Chair in the Humanities Bryan Le Beau, Ph.D., has been on the air in several states for three years. In July, the Organization of American Historians (OAH), the largest professional association of historians in the U.S., joined Creighton University as a co-sponsor. Members of the OAH executive board described *Talking History* as "a time-tested, excellent program, that will advance its mission of better educating the public in American history."

Oxford University Press also weighed in with its support for *Talking History* by underwriting the four-part series on "American Places" that aired in July.

*Talking History* currently airs in Omaha on KIOS FM; KFIU in Bloomington, Ill.; KUSF in San Francisco; KKSU in Manhattan, Kan.; and WRPI in Troy, N.Y. It also is heard periodically on stations in Chico, Calif., and Florida.

*Talking History* is available to public radio stations across the nation by satellite. Contact your local public radio station and let them know you want to hear *Talking History* on their station. You also can visit the *Talking History* website at <http://cuwebradio.creighton.edu/history/index.html> to listen to past programs.

## Visit Creighton's Online Ministries Website

What started as resources for Creighton University faculty and staff has become a worldwide ministry, drawing thousands of people to Creighton's Online Ministries website every day. Fr. Andy Alexander, S.J., and Maureen McCann Waldron, BA'75, MA'98, work together in Creighton's Collaborative Ministry Office, offering orientations and programs to support the Jesuit Catholic mission and identity of Creighton University. They also have made a rich tradition available to anyone around the world.

**Daily Reflections for Busy People** — Fifty faculty and staff share personal, practical daily reflections, which also can be downloaded to any handheld device.

**An Online Retreat in Everyday Life** — This retreat takes only a few minutes a day, yet can offer life-transforming graces.

Visit these and the other Online Ministries sites, and see what others are saying about Creighton's site. Click the Online Ministries link on the Creighton home page ([www.creighton.edu](http://www.creighton.edu)) or go directly to: [www.creighton.edu/CollaborativeMinistry/online.html](http://www.creighton.edu/CollaborativeMinistry/online.html).



Photos by Bob Ervin

Yuniva Leyva visits the Creighton dental clinic as part of the Bright Smiles, Bright Futures program. In the background are her mother, Isabel, and her brother, Josias.



Michelle Klabunde, left, a student in Creighton's cooperative dental hygiene program with Iowa Western Community College, works with her young patient, Marlene Garcia. Looking on at right are, front to back, Joanne Newmeyer, a dental assistant student at Metropolitan Community College; Sherri Chaidez, a dental assistant at the Indian-Chicano Health Center; and Marlene's mother, Poala Barrera.



Dr. Charles W. Wilcox, a dental professor at Creighton, examines Erin Bartolo. Watching from left are Creighton dental student Paul C. Anderson; Jane Lott, a dental hygiene instructor from UNMC; interpreter Maria Iniguez; and Erin's mother, Noemi Bartolo.

## Bright Smiles, Bright Futures

Children suffering from dental problems have difficulty eating, are distracted in learning and playing, and experience reduced self-esteem from their appearance.

With the help of The Colgate-Palmolive Bright Smiles, Bright Futures Volunteer Partnership, many children in need were given the opportunity to receive dental services at a Children's Dental Day. Creighton dental faculty and students joined with area organizations and volunteer dentists and hygienists to serve approximately 150 children on two dates in June at the Creighton University School of Dentistry.

Children were selected for the program by the Hope Medical Outreach Coalition. This

non-profit community organization coordinates the volunteer delivery of health care to homeless, indigent, uninsured and underinsured adults and children in the Omaha area.

In the recent Surgeon General's Report, *Oral Health Care in America*, it was noted that tooth decay is the single most common chronic childhood disease.

At-risk children from the Indian Chicano Health Center, the Charles Drew Health Center, Family Health Care (SONA) Clinic, the Stephen Center, MOBA Clinic, Omaha Public Schools, Douglas County Dental Clinic and area homeless shelters received services from this program.

## Saint Joseph Hospital Names New CEO

Saint Joseph Hospital named Philip P. Gustafson as president and chief



Gustafson

executive officer on June 1. Prior to his appointment at Saint Joseph Hospital, Gustafson was the chief executive officer of San Ramon Regional Medical Center in San

Ramon, Calif., a post he held since 1996.

Gustafson replaces J. Richard Stanko, who was with Saint Joseph Hospital for seven years, the last three as its president and CEO.

Saint Joseph Hospital is part of the Creighton Saint Joseph Regional Healthcare System. Owned and operated in a partnership between Creighton University and Tenet Healthcare Corporation, Saint Joseph Hospital is the primary teaching facility for the Creighton University School of Medicine.

## Fall Sports Information

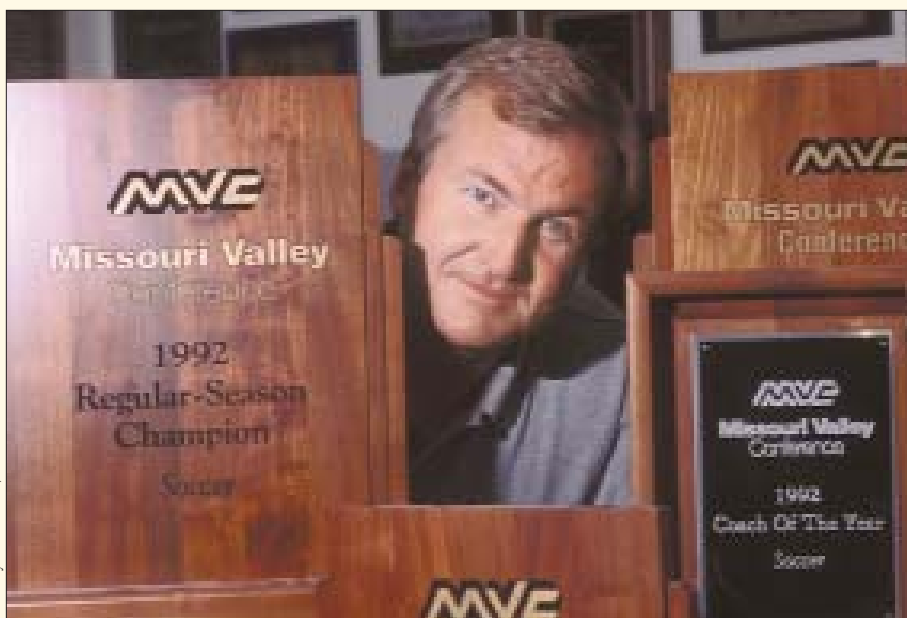
Looking for Bluejay fall sports schedules?

Check out the Athletic website at

[www.goCreighton.com](http://www.goCreighton.com)

for the latest on Bluejay athletics.

Photo by Monte Kruse, BA'83



Bob Warming returns to Creighton after leading the soccer program to national prominence in the early '90s.

## Warming Returns to Coach at CU

The Creighton men's soccer team will open defense of its 2000 Missouri Valley Conference championship and bid for its second straight NCAA Final Four appearance with a new coach, but a familiar face, on the sideline this fall.

Bob Warming, who coached at Creighton in the early '90s and led the soccer program to national prominence, has returned to the hilltop campus. When Creighton reinstated men's soccer in 1990, after a four-year hiatus, Warming was picked to rebuild the program.

Over the next five years, Creighton won its first three regular-season and conference tournament championships and qualified for the NCAA Tournament three times. Warming's 1993 squad was a perfect 19-0 and ranked No. 1 in the nation before a heartbreaking 2-1, four-overtime loss to Air Force in the first round of the NCAA Tournament. Warming said he is glad to come home to a program that he helped put on the map.

"When you create something from inception, no matter what it is, you have a special feeling for it," Warming said during an interview at his Creighton office, a row of conference championship trophies lining the shelf behind him. "When I left, the only

person I could have passed that off to was my best friend, Bret Simon."

Simon, an assistant under Warming at Creighton and before that at Berry College in Mt. Berry, Ga., took over for Warming in 1995 and continued Creighton's success. In Simon's six years at Creighton, the Jays went 96-26-9, qualified for the NCAA Tournament each year and reached the Final Four in 1996 and 2000. Simon left Creighton in February to take the head coaching

**Bob Warming, who coached at Creighton in the early '90s and led the soccer program to national prominence, has returned to the hilltop campus. He replaces Bret Simon who left Creighton to coach at Stanford University.**

position at Stanford. Warming said he tried to talk his friend into staying at Creighton.

"When Bret called me and told me he was thinking about leaving, I spent about 10 days trying to get him to stay," Warming said.

Warming had left Creighton after the 1994 season to become athletic director at Furman University in Greenville, S.C. In 1997, he was named head coach at St. Louis University and, in four years there, guided

the Billikins to four NCAA Tournament appearances and a Final Four appearance. He said he wasn't looking to leave St. Louis, where, in 1999, they had completed renovations on a 6,000-seat, on-campus soccer stadium. He also had every starter back from a team that, last season, won both the Conference USA regular-season and tournament titles.

"Things were looking pretty where I was," Warming said with a laugh. "It made it hard for me to leave, but it also made me realize that I could go because everything was in place for continued success, much like it was when I left Creighton."

Warming said the biggest challenge facing this year's Creighton team is replacing last season's senior leaders, including All-American forward Brian Mullan, who is now playing professionally with the Los Angeles Galaxy. But, thus far, he has found a team focused on getting back to the Final Four.

"They have a tremendous work ethic," Warming said. "They're a wonderful bunch of guys, and they're very close."

Warming said his Bluejays will have a "big target" on their back this year after finishing as NCAA Tournament runners-up last season. But the coach said he doesn't feel any extra pressure.

"Pressure is when you don't have a team, like in 1989," Warming said, referring to his first stint as Creighton's coach. "We have a program now, and programs stay solid."

### New Field on the Horizon

Warming is excited about University plans to build a new soccer complex east of the main campus. Preliminary plans call for the new facility to be built by 2003, he said.

"At St. Louis, we built what most people consider the top college soccer facility in the country," Warming said. "I know what we will do here can be better."

Warming also envisions a training facility, where Creighton soccer players could practice and host clinics and outreach efforts for students from across the city.

## Faculty Participate in Omaha's J. Doe Art Project

The J. Doe sculpture in front of the Lied Education Center for the Arts was done by Bob Bosco, associate professor of fine arts. It is one of over 100 such projects that have been placed throughout the Omaha area during the summer. Each is unique and has been completed by a different artist. John Thein, associate professor of fine arts, also created a piece called "Classic Doe," which is located at Regal Printing Company at 101st and L streets.

The J. Doe Project began by banding together a collection of artists and expanded to a citywide celebration of art for the people. Each featureless and genderless fiberglass sculpture is 6 feet tall. The idea for the J. Doe Project traces back to Zurich, Switzerland, where, in 1998, the original Cow Parade, a public art exposure project displaying a collection of fiberglass cows all around the city, took place. Since 1998, Chicago, New York, Houston, Kansas City, London, New Orleans and Cincinnati have undertaken similar projects.

The sculptures will be on display through September.



Photo by Mome Krause, BA'83

Bosco's work, entitled "The Dance of Life: Why Are We Here," presents a dual approach to understanding our humanity. The front (pictured above) is emotional; the back is contemplative.

## Morrison Seminar Room Dedicated



Photo by Dave Weaver

The Rev. Michael G. Morrison, S.J., former president of Creighton University, returned to campus for the dedication of the Morrison Seminar Room at Saint Joseph Hospital on May 23. Fr. Morrison served as Creighton's president from 1982 to 2000.

## CU Again Named One of Top Wired Campuses

For the second straight year, Creighton University has been named as one of the top universities in the country by *Yahoo! Internet Life* in its 2000 America's Most Wired Colleges-University Rankings. Creighton is ranked No. 81 in the university category, moving up 17 spots from the 1999 ranking.

More than 1,300 universities and colleges, from all 50 states, compete for the rankings, which are based on network systems; online application and registration, transcripts and classes; Internet research projects; extent of student Web services in the classroom and residence halls; electronic library resources; e-mail accounts; technology support and plans to incorporate technology in all aspects of campus life.

Creighton maintains an extensive website at this address: [www.creighton.edu](http://www.creighton.edu).

## 2001 BLUEJAY JAMBOREE

Dinner/Auction Fundraiser for Athletics  
Celebrate the 15th Annual Bluejay  
Jamboree on

Saturday, Nov. 3  
Creighton University Gymnasium

Chairman: Jim Niemeier, BSBA'84, JD'88

To donate an auction item or make dinner reservations,  
please call Carol Ketcham at (402) 280-1794.





# Inside the Cost of Prescription

By Michael Makoid, Ph.D., and Robert Garis, Ph.D.





Editor's Note: This is the third in a series on health care in the United States.



# Drugs

## About the authors

**Michael Makoid, Ph.D.** (right), is professor and chair of the Department of Pharmacy Sciences in the School of Pharmacy and Allied Health Professions. He is a founder of Pharmaceutical Technologies Inc., a pharmaceutical benefits manager that serves thousands of employers nationwide. He can be reached at [makoid@creighton.edu](mailto:makoid@creighton.edu).

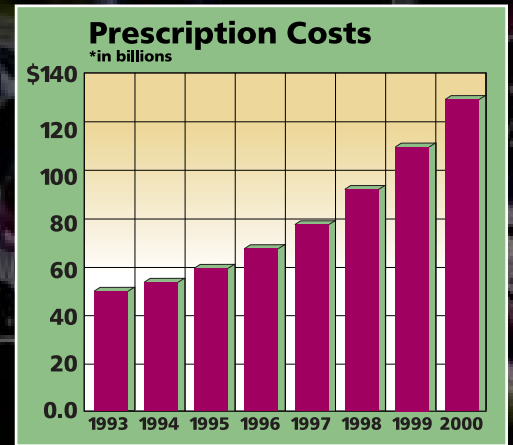
**Robert Garis, Ph.D.** (left), is an assistant professor in the Department of Pharmacy Sciences. His interests are in the costs of chronic illness and the pharmacy benefit management industry. He can be reached at [rgaris@creighton.edu](mailto:rgaris@creighton.edu).

Photo by Monte Kruse, BA'83



Americans spent nearly \$132 billion on prescribed drugs in 2000, as retail pharmacies filled a record 2.9 billion prescriptions. That equates to about 10.5 prescriptions for every man, woman and child in the United States, at a cost of about \$480 per person.

Prescription drugs remain the fastest-growing component of America's \$1.1 trillion health care bill. It's a bill, as you will see, with hidden costs. And it's a bill you pay, either out-of-pocket in direct payments or in co-pays and premiums, or out of the pool of wages and benefits set aside by your employer.



Let's take a closer look at four groups involved in your prescription drug benefit: The pharmacist, the drug manufacturer, the middleman and, you, the consumer.

## The Pharmacist

Independent pharmacies in the United States have been closing at an average rate of more than 1,000 a year over the past 10 years. Lack of profit is one of the leading reasons. Traditional chain drugstores have been making a marginal comeback, and pharmacies in supermarkets and mass merchandisers have enjoyed fantastic growth. Pharmacies surviving are the ones with additional revenue streams from other products. When stand-alone pharmacies, which generate all of their profits from pharmaceuticals, try to compete in that arena, they simply go bankrupt. In 1999, the average net profit for an independent pharmacy was 3.6 percent, according to the *NCPA Pharmacia Digest*. By comparison, from an investment perspective, banks offer certificates of deposit with a guaranteed 5 percent return on investment.

This is not to diminish the importance of pharmacists. Pharmacists have been viewed as the most trusted professionals for the last two decades, according to the Gallup Poll. Pharmacists play a critical role in your health care. Pharmacists are seen as reliable sources for drug

information and the last line of defense between you and a medication error.

But pharmacists are in short supply and the problem is getting worse. The government projects a 4 percent net increase in pharmacists by 2005 and a 40 percent increase in prescription volume. Meanwhile, professional studies indicate a correlation between medication errors and pharmacist workload.

## The Drug Manufacturers

Drug manufacturers are, for the most part, publicly traded companies, and one of their responsibilities is to generate a return on investment for stockholders, which they do. The return on equity in the drug industry has been 25 percent, according to Standard & Poor's. By comparison, the return on equity for retailing giant WalMart is 24 percent and for PepsiCo, it's 31 percent.

The amount Americans spend on prescription drugs has more than doubled in the last five years — from \$61.1 billion in 1995 to nearly \$132 billion in 2000. There are three major contributing factors: the proliferation of new expensive drugs, increased use of prescription drugs and price increases by drug manufacturers. Let's take a closer look at each.

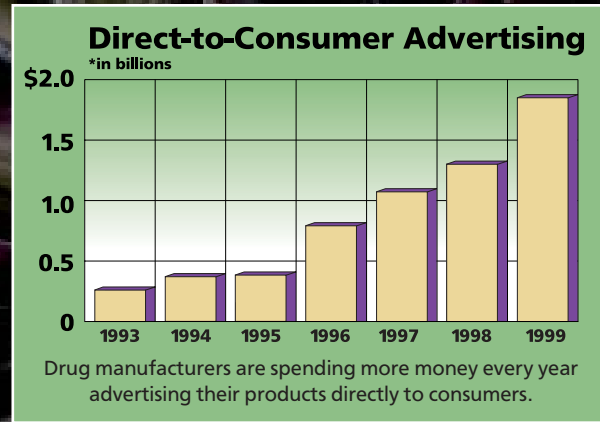
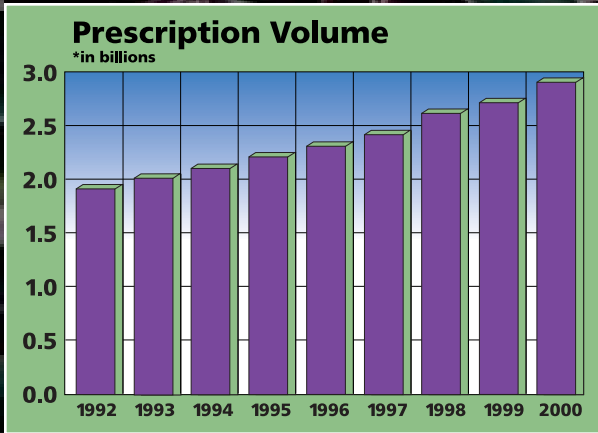
## More brand-name drugs

New drugs have shown success in treating devastating illnesses — such as rheumatoid arthritis, HIV/AIDS, congestive heart failure, heart attack, osteoporosis and schizophrenia — and, in the case of non-sedating anti-histamines and drugs like Viagra, are helping us live better lives.

Brand-name drugs, however, are costly to develop, manufacture and market. On average, about 11 years of research and some \$500 million goes into bringing a new drug to market. For every drug that makes it, hundreds never see the light of day because they fail to meet federal standards. The required documentation for a new drug application can exceed several carloads of text.

The patent life of a drug molecule is 20 years, but, because the patent is issued for the date of discovery or creation, the drug manufacturer has about eight and a half years by the time the drug hits the market to recoup its investment before the patent runs out.

Generic drugs require considerably less initial investment. Every molecule is a known entity, already thoroughly researched. These products can be marketed at a fraction of the cost of the brand-name products, and many brand-name drug manufacturers have generic subsidiaries. Remember, this year's generic drugs were last year's hot brand names.



**Prescription drug use rises**

The 2.9 billion prescriptions filled in 2000 were a 7.5 percent increase over the previous year and about 1 billion more than were filled just eight years earlier. These trends will almost certainly continue as Baby Boomers age.

Not only are consumers purchasing more prescription drugs, they are buying the more costly brand-name remedies. Of the 50 top-selling prescription drugs in 2000, only four were generic. The average price of the top-50 sellers was \$67.15, compared to \$19.65 for the average generic prescription.

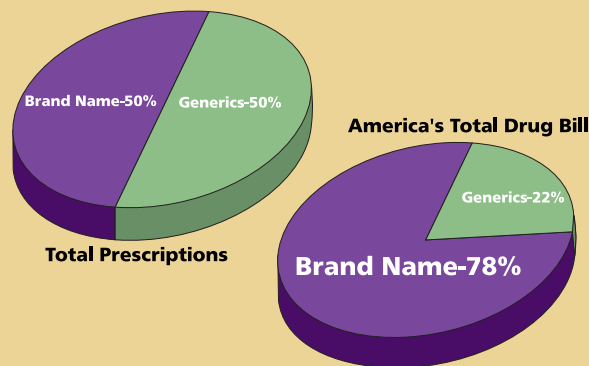
To influence drug use, drug manufacturers rely heavily on advertising and marketing, which can account for as much as 30 percent of drug manufacturers' costs. In addition to promotions targeting physicians, last year pharmaceutical manufacturers spent \$1.85 billion on advertising aimed directly at consumers. Did it work? Surveys in *Prevention Magazine* and by the FDA indicate that about a third of consumers ask for prescriptions by name because of advertisements they have seen. In 1999, drug manufacturers spent \$1.6 billion on direct-to-consumer advertising, and prescriptions for brand-name drugs increased 7.8 percent. One drug alone, Vioxx, a heavily advertised anti-arthritis medication, was responsible for more than 1 percent of the nation's total drug bill, bringing in \$1.5 billion and almost quintupling sales from the previous year. The 20 biggest prescription drug advertisers spent a combined \$900 million in 1999 on direct-to-consumer advertising, and

prescriptions for their products increased 25 percent. They had similar results in 2000. Combined with an average 8 percent increase in price, these companies realized a 34 percent increase in sales — for about \$6.8 billion in additional profit. But remember, we, the consumer, are choosing to purchase the more expensive products because of advertising. Isn't that what advertising is supposed to do — create demand?

generic prescriptions has risen only 1.7 percent annually. However, during that same time period, the price of brand-name prescriptions has increased at a rate of 10.5 percent annually.

Despite the fact that generic drugs represent nearly 50 percent of all prescriptions, they make up only about 22 percent of the total cost. The top 40 brand-name drugs, on the other hand, account for less than a quarter of all prescriptions

**Generic vs. Brand-Name Drugs**



**Rising cost of prescription drugs**

The cost of prescription drugs at retail has risen 6.7 percent annually from 1991 to 1998, according to a report from the Kaiser Family Foundation, far exceeding the 2.6 percent general inflation rate and the 4.6 inflation rate for medical care.

Again, the new brand-name drugs are fueling the increase. When generic drugs are taken into account, the rate of inflation in prescription drug prices is actually at its lowest level in 30 years. Over the last seven years, the price of

but represent almost 40 percent of America's prescription drug bill.

While there has been this proliferation of new, more powerful drugs, there have been relatively few new diseases. For some people, the newest brand-name therapy is the only one that will work, and they should be on those products. But for the majority, the generic therapies are more than adequate and should be the first line of defense, at about 20 to 30 percent of the cost of the newest brand-name therapies.



## Evaluating the drug manufacturers

Millions of people are alive and millions more lead relatively healthy lives because of the efforts of America's pharmaceutical manufacturers. These companies play a critical role as the sole source of new drugs and new therapies; however, consumers should be aware of practices by drug companies that don't necessarily add value, but may add cost. For instance, Bristol-Myers Squibb tried to extend its exclusive right to sell its anti-anxiety drug BuSpar (1999 sales, \$600 million), just as its original patent was expiring, by patenting a molecule that appears in the body as BuSpar is metabolized. The new patent, which was later disallowed by a federal judge, delayed the introduction of a cheaper generic version of the drug. The Federal Trade Commission (FTC) also recently challenged three agreements between brand-name and generic drug

companies that allegedly delayed or were intended to delay generic drug competition in order to maintain higher prices. The most recent came this past March, when the FTC filed a complaint against Schering-Plough Corporation and two generic drug companies — Upsher-Smith Laboratories and ESI Lederle Inc. The FTC charged that Schering paid \$90 million to the two companies to delay introducing generic versions of Schering's K-Dur, a heart medication with 1998 sales topping \$220 million. The drug makers deny any wrongdoing. The FTC is currently conducting a study to determine the frequency of these agreements and whether brand-name manufacturers are listing additional patents, shortly before previous patents are to expire, in an effort to delay introduction of generics.

## The Middlemen

Up until now we have been dealing with the highly visible costs of prescription drugs and their connected benefits. However, there is another group you normally don't see, whose services, it's been estimated, add another \$44 billion to America's already burgeoning pharmaceutical budget.

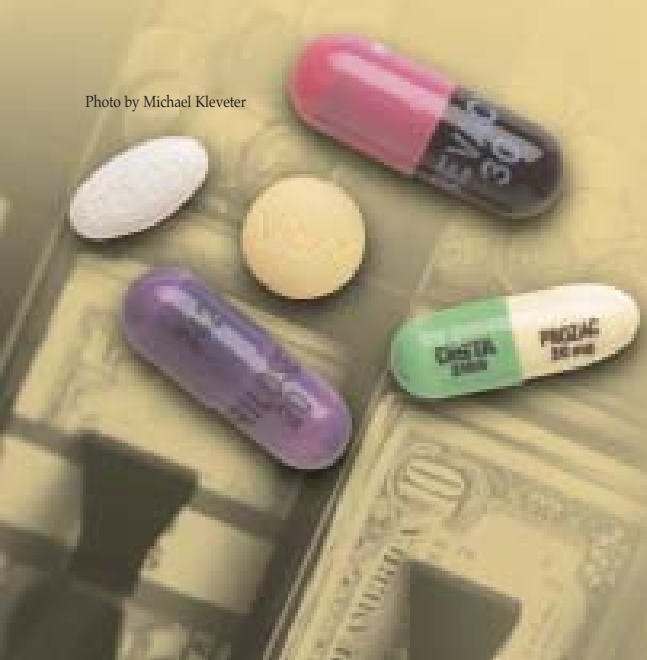
When we (the authors) filled prescriptions early in our pharmacy careers, if your health insurance included prescription drug coverage, you brought your prescription to our pharmacies and paid cash. Subsequently, you filled out a form and submitted the bill to your employer, and you waited for a reimbursement for some percent of the bill. Today, you bring in your prescription and a drug card. You pay a small co-pay and get your medication.

You don't fill out any forms, you don't submit a bill and you don't wait for a reimbursement.

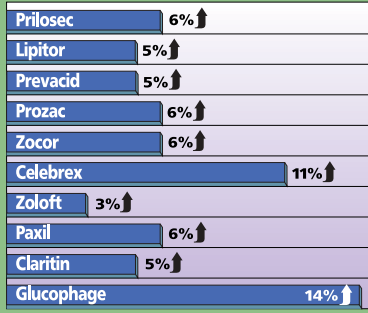
There is a price for this convenience. First, we lose our cost sensitivity. We rarely know what our prescriptions cost because we only see the co-pay. (In reality, we pay the full cost, either through our insurance premiums or through a reduction in the pool of wages and benefits set aside by our employer.) Secondly, this system requires an electronic connection between pharmacies and insurance companies. Your personal information is now available to anybody who sees this transaction, and this information about you can be sold. This electronic connection has fostered a plethora of industries funded entirely by you. Let's take a closer look at these middlemen.

Here's how it works. A patient brings a prescription to the pharmacy; the pharmacist fills it and sends out an electronic claim, which is a request for payment for your prescription. Within a few seconds, the pharmacist knows what he or she is getting paid and how much to charge the patient. In those few seconds, the claim is "handled" by several entities, each of which adds cost to the prescription. Many of these entities, as mentioned above, earn additional revenue by selling your data to the drug companies and pharmacy chains, which use that data to better market their products. You pay for this data collection, both in direct fees and in higher costs of pharmaceuticals. The sale of this information gives its purchasers unprecedented control over the industry. Targeted marketing takes on a whole

Photo by Michael Kleveter

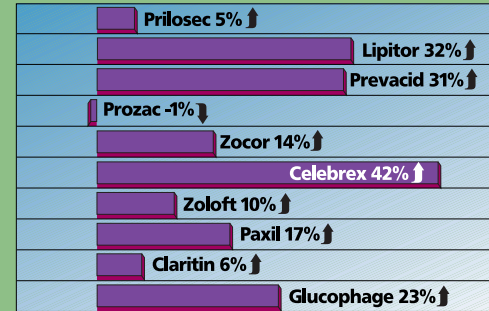


**Increase in Price**  
of the 10 top-selling drugs from 1999 to 2000



**Increase in Prescriptions**

of the 10 top-selling drugs from 1999 to 2000



new meaning when the target is a specific physician rather than a subspecialty group of doctors. This, along with direct-to-consumer advertising, is one of the critical marketing changes that has fueled the rising cost of pharmaceuticals.

**Software and Pre/post editor**

First, there is the computer software needed to run a modern pharmacy. The software manufacturer may require the pharmacist to send his or her claim through the software manufacturer's network and on to "the gate," charging a fee along the way.

The claim also may go through a pre/post editor, which verifies that the claim is filled out correctly. The pre/post editor maximizes the claim to the most that your individual insurance contract will pay. So, if a pharmacist normally charges \$20 for a drug and the customer's insurance plan will pay \$30, the customer is charged \$30. Sometimes, the pre/post editor does not return the whole difference to the pharmacist (in this case, \$10), so the actual cost (\$30) does not show up in the price of the prescription paid to the pharmacist.

**The gate and claims processor**

The gate provides telephone access between the pharmacist and the claims processor. If necessary, the gate can manipulate the data provided by the pharmacist to make it compliant with industry standards. The gate generally sells your data. They also charge the pharmacist for each transaction (the national average is about 12 cents for each claim handled) and assess a flat fee

to the processor. While 12 cents may not seem like a lot, this adds up for a health plan with thousands of people. And if the pharmacist makes a mistake in the data (such as getting your middle initial, birth date or Social Security number wrong), the claim will be rejected by the computer, and the pharmacist must resubmit the claim and is charged another 12 cents by the gate. The gate sends the claim on to the processor.

The claims processor validates the claim. The claims processor checks the customer's insurance plan and tells the pharmacist the price of the prescription and the co-pay the customer is to be charged. For this, they charge your insurance plan a set fee, which can range up to \$1 per transaction. Again, any mistake in the data and the claim must be resubmitted, resulting in the claims processor assessing another transaction fee. They also sell your data.

**The consultant, the insurance company and the PBM**

Because most companies don't have the expertise in-house to manage their medical benefits, they outsource the payment of their employees' medical and pharmaceutical bills, a process that often includes a consultant, an insurance company and a pharmacy benefit manager (PBM). The PBM is the firm behind your prescription drug card. For clarity, we will refer to the pharmacy benefit manager as the prescription card company. The consultant, working for your employer, recommends an insurance carrier, which, in turn, outsources the pharmaceutical claims to the prescription card company. The

prescription card company contracts with drug manufacturers, mail order pharmacies and repackers.

A good, educated consultant is worth the fee. But determining the "real" cost of prescription drugs can be tricky, since the average wholesale price (AWP) — the common industry measure of a drug's price — is somewhat akin to an automobile's sticker price. Just as the automobile industry has multiple car dealers selling the same vehicles at differing prices, the prescription drug industry has multiple vendors selling drugs at prices determined by each vendor.

Insurance companies negotiate contracts with medical groups and hospitals and offer those contracts to their clients. Most insurance companies outsource pharmaceutical contract negotiation and network maintenance to the prescription card companies.

The prescription card companies provide access to a network of pharmacy providers who are contracted to provide service and products at a negotiated price. The size of the network varies with the prescription card company. Many are local; some are nationwide. Most offer multiple co-pay options, along with a variety of other services. For instance, in one case, the prescription card company recommended an ergonomic consultant, who, through a suggested change in lighting, saved an employer roughly \$200,000 a year in migraine headache medication. While prescription card companies provide a valuable service, employers are best served by negotiating an up-front, flat fee to avoid hidden costs.

**The case of the repacker:** A repacker buys in bulk direct from the manufacturer, at a significant discount, and repackages the drugs into smaller containers for resale. That discount, however, is not always passed on to the consumer. Here is an example:

## Community Pharmacist



A prescription is received for 100 Daypro.

## Repacker



A prescription is received for 100 Daypro.



GD Searle Company – Producer of Daypro  
Because this drug has no generic equivalent, all prescriptions for the popular anti-inflammatory must be filled with Searle product.  
**Average wholesale price: \$1.42 per capsule**

Buying in bulk, the repacker purchases the product at a 34% discount, or about \$94 for 100 capsules.

Buying well, the community pharmacist can expect to purchase the product at a 14% discount, or about \$122 for 100 capsules.

The repacker repackages the capsules into smaller containers.



Because the drug has been repackaged, the repacker gets a new drug identification number. This allows the repacker to set its own average wholesale price.

Repacker sets its average wholesale price for the drug at \$2.30 per capsule.



Both the community pharmacist and the repacker have contracts to provide prescriptions at 10% off average wholesale price, plus a \$3 fee.



The community pharmacist, under the contract, fills the consumer's prescription for 100 Daypro, charging \$1.28 per capsule (10% off \$1.42 average wholesale price), plus a \$3 fee.

**Consumer's prescription cost: \$131**

**Pharmacist's profit: \$9**



The repacker, under the contract, fills the consumer's prescription for 100 Daypro, charging \$2.07 per capsule (10% off \$2.30 average wholesale price), plus a \$3 fee.

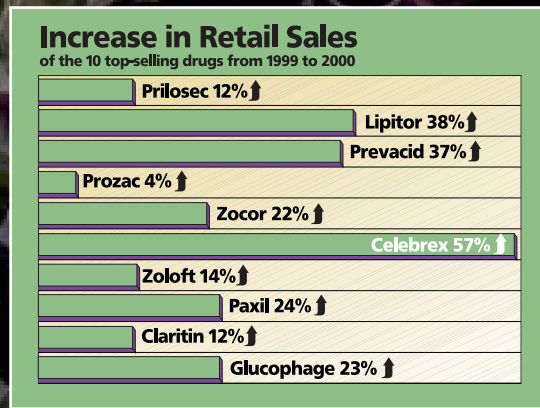
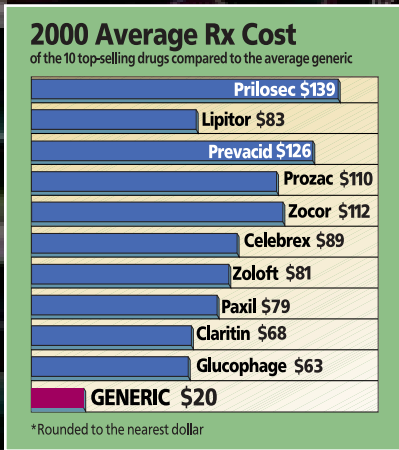
**Consumer's prescription cost: \$210**

**Repacker's profit: \$116**

## Hidden costs

Again, prescription card companies generally sell your data, and there can be a number of hidden costs from spread to a percent of savings clause to rebates to double billing. (All of these, except double billing, are legal practices and, in general, are embedded in a lengthy contract and seem to be reasonable to the employer. The problem is that most employers are not aware of the real price tag of their plan because of these hidden costs.) Many of these same opportunities exist for the insurance companies, as well.

The spread is the difference between what the prescription card company pays the pharmacist and what they bill the insurance company. For brand-name drugs, the prescription card company may pay the pharmacist 13 percent off the drug's average wholesale price and bill your insurance plan 10 percent off average wholesale price. If, for instance, the average wholesale price for your medication is \$2 per capsule, the prescription card company would pay the pharmacist \$1.74 per capsule while billing your insurance plan \$1.80 per capsule. In this case, the prescription card company is pocketing 3 percent (or 6 cents per capsule) off every prescription. For generic drugs, the drug's average wholesale price and actual acquisition cost can differ by 60 percent or more. The prescription card company sets the price that it is willing to pay. That price for the generic product is the MAC (Maximum Allowable Cost), which is generally well below the average wholesale price. Let's suppose



the average wholesale price for your generic capsule is \$2, and the prescription card company has set a MAC price with the pharmacist of 90 cents. Your insurance plan pays the prescription card company 10 percent off average wholesale price for generic prescriptions, which, in this instance, would be \$1.80 per capsule. The pharmacist is paid 90 cents per capsule and the prescription card company pockets 90 cents, or 50 percent of the total cost.

The percent of savings clause is a seemingly reasonable clause in a company's contract that stipulates that savings will be split if the prescription card company makes a switch that saves the company money. However, by having the pharmacist switch from a brand-name drug (average wholesale cost, \$60) to the generic (average wholesale cost, \$10), prescription card companies can collect a sizable fee, often above and beyond what they are already getting paid.

It's strange to see rebates as a hidden cost. But, let's suppose a drug manufacturer offers a prescription card company a rebate for buying a more expensive brand-name product. But instead of passing this "rebate" on to the consumer, the prescription card company pockets the rebate. In reviewing one company's records, we found that the prescription card company had actually blocked the filling of prescriptions with generic drugs, requiring the higher-cost brand-name products, because the prescription card company took the rebate as revenue!

All of the above scenarios are legal and are generally written in a company's contract with a prescription card company. However, there are also illegal practices. If, for some reason, the pharmacist changes your initial prescription (maybe you wanted a two-month supply because you're going on vacation), the first prescription must be removed from the system — a process called reversal — before an amended prescription can be submitted. We have found that some prescription card companies bill your insurance plan for the original prescription (plus all transaction fees) PLUS bill you for amended prescriptions, an illegal practice known as double billing. The prescription card company reports that the pharmacy filled the prescription twice, BUT the pharmacy reversed the original prescription and was only paid for the amended prescription. Your insurance plan, however, paid for the original prescription plus transaction fees, the reversal transaction, AND the amended prescription plus its associated transaction fees. Pinpointing responsibility is difficult, especially when the prescription card company claims computer error.

### Repackers

A repacker can buy large volumes of medication directly from the drug manufacturer at a substantial discount and repack it into smaller containers. The repacker then gets a separate drug identification number (or NDC) for that product and can set its own average wholesale price. *(The box on page 22 gives*

*an example of what's going on in the repacking scene.)* Not all repackers are rip-offs. A large chain can use its bulk buying power to increase its competitive edge and still maintain its margin.

## The Consumer of Health Care (You)

What can we do as consumers about these staggering costs? Well, we can start by asking for generic products, and, if none is available, asking for a therapeutically equivalent product that is on your prescription card company's formulary (list of covered drugs). Company's could provide financial incentives for employees to use generic drugs, or make employees who choose to use brand-name drugs when a generic is available pay the difference between the brand-name and the generic product. It's amazing how attractive a generic product becomes in this situation. Pharmacists could be given incentives to counsel the use of generic and formulary prescriptions. Tim Covington, PharmD, director of the Managed Care Institute at the McWhorter School of Pharmacy, estimates that we could save tens of billions of dollars if we increase the use of generic drugs. Will we? That's the \$132 billion — and rising — question. Remember, it's your money. ©

## The Value of Pharmaceuticals – A Revolution in Life

Editor's Note: The author is a Creighton alumnus and former president and CEO of Hoffmann-La Roche Inc. Hoffmann-La Roche, based in Nutley, N.J., is the U.S. prescription drug unit of the Roche Group, a research-based health care enterprise that ranks among the world's leaders in pharmaceuticals, diagnostics and vitamins.

By Patrick Zenner, BSBA '69

Bold endeavors lead to great accomplishments. Think of these examples. The accurate measure of time was merely a dream before 1268. Then, the invention of the weight-driven clock meant people no longer had to rely on the daily course of the sun to gauge time. Mechanical clocks allowed for more than telling time; they enabled a vast improvement in navigation and became an essential element in the growth of modern science.

Likewise, the invention of the printing press in the Western world nearly 200 years later (in 1450), revolutionized mass communications. Johann Gutenberg solved the problem of molding movable type and forever changed the world in a way that continues to this day.

Another 300 years would pass before the first factories, for textile production, appeared. The Industrial Revolution of the mid-18th century changed the economies of the modern world and reigned supreme until the dawn of the Information Age in the latter part of the 20th century.

In my lifetime alone, bold endeavors have led to incredible accomplishments that have revolutionized life for us all. The development of the integrated circuit has led to all of the electronics that we have become so used to — even dependent upon — in our daily lives; and the development of the jet engine revolutionized transportation, such that travel time anywhere in the world is measured in only hours.

But I think the most exciting accomplishments have come in health

care — specifically in pharmaceuticals — where I have spent my career. First, there was the standardization and mass production of medicines. Then, intensive research led to the development of treatments and cures for many diseases. Now, the focus is on the human genome as the key that will lead to much longer and healthier lives for future generations.

For much of the last century, pharmaceuticals have allowed for a Revolution in Life. This revolution is relieving pain and suffering, and increasing the quality of life for people the world over. As with all revolutions, the seeds of this one were sown years ago and are rooted in the pharmaceutical industry. Yet, in many ways, the revolution is still in its infancy — with its greatest accomplishments many years ahead of us.

Throughout the past 100 years, steady progress has been made in pharmaceuticals toward the goal of making life better for all people. Although pharmaceuticals — prescription drugs to most people — touch almost everyone's life today, many people may not know their overall value in the health care mix.

Prescription drugs add to our lives in significant ways — by extending life, by enhancing the quality of life, and by providing important economies in the health care system. The story of how innovative pharmaceutical products have come to provide these remarkable benefits is one of the great triumphs of the last century.

Americans born at the dawn of the 20th century faced an average life

expectancy of fewer than 50 years. But in these early years of the 21st century, a newborn can expect to live nearly 80 years. This increase in life span is due in part to advancements in medicines and our improving ability to prevent, cure and treat diseases.

Think back to such pharmaceuticals as the antibiotic penicillin and other “wonder drugs” that have cured or prevented diseases that had previously killed millions. The discovery of penicillin was a medical milestone. It meant that people were no longer defenseless against infectious diseases such as pneumonia, scarlet fever and



Patrick Zenner, BSBA '69, former president and CEO of Hoffmann-La Roche Inc.

tuberculosis. Similarly, the development of childhood vaccines introduced a new era in which the fear of losing a child to measles, mumps, Rubella, polio or other pediatric afflictions all but disappeared.

Today, innovative medicines are doing more than preventing deaths. In many cases, they are preserving lives — full, active lives that might otherwise be curtailed by sickness and disease. The

crippling effects of diabetes, heart disease and other chronic illnesses, including cancer and HIV/AIDS, have been substantially curbed by new medicines. People with these diseases now enjoy more freedom and dignity than ever before. In short, because of innovative pharmaceutical products, we have entered the 21st century fortified by the promise of living not just longer, but healthier lives — more so than at any time in our history.

The Centers for Disease Control and Prevention (CDC) recently released its 24th report on the health status of the nation and national trends in health statistics. The report found that the U.S. death rate related to human immunodeficiency virus (HIV) infection has declined more than 70 percent in three years. The number of deaths related to cerebrovascular disease, or stroke, have been cut by 65 percent over the last 30 years, and the number of deaths related to heart disease have been cut by more than 50 percent since 1950. These decreases in mortality rates can be attributed significantly to important advancements in pharmaceuticals.

The good news is that pharmaceutical development has been accelerating. In fact, more than 1,000 new medicines are in development to treat hundreds of serious diseases, including more than 100 for heart disease and stroke, more than 350 for cancer, more than 100 for AIDS and more than 200 to meet the special needs of children. And, the industry continues to deliver results. Companies brought more than 30 new treatment options to the medicine chest in 2000, including the first in a new class of antibiotics; four new medicines for cancer — two for leukemia, one for bladder cancer and one for prostate cancer; a new medicine for Alzheimer's disease, the fourth leading cause of death in the U.S.; and a new treatment for macular degeneration, the leading cause of blindness in people over the age of 50.

The more we can use prescription medicines to treat illness and disease, the more likely we are to reduce overall health care costs, too. Why? Because today's prescription medications make it

possible for many patients to either avoid being hospitalized or to reduce their length of stay. Several years ago, a Columbia University report, using data supplied by the National Center for Health Statistics, concluded that every \$1 increase in pharmaceutical expenditures is associated with a \$3.65 reduction in hospital care expenditures. So, prescription medications, while achieving the primary goal of restoring good health, have the secondary effect of lowering overall clinical expenditures.

Success in this Revolution in Life requires substantial investment, and risk in development is often great. During the development process for a drug, unforeseen clinical outcomes, introduction of a competing product, regulatory problems and other changes in the market can dramatically affect a new drug's economic prospects and the ability of a manufacturer to recoup its

In 2000, research-based pharmaceutical companies invested over \$26 billion in R&D on innovative new medicines.

research and development (R&D) costs. Due to the large and increasing costs associated with bringing a new drug to market — currently about \$500 million — full commercial success is possible only for a few products. These “blockbuster” products are often the most novel compounds and have significant market size, but they face the greatest risks from a scientific, regulatory and commercial perspective.

In 2000, research-based pharmaceutical companies invested over \$26 billion in R&D on innovative new medicines. Over the past two decades such investment has risen dramatically; the percentage of pharmaceutical sales allocated to R&D has increased from nearly 12 percent in 1980 to more than

20 percent in 2000. According to Standard & Poor's, pharmaceutical manufacturers invest a higher percentage of sales in R&D than virtually any other industry, including high-tech industries, such as electronics, aerospace, office equipment (including computers) and automobiles.

Why does the industry spend so much on R&D? The sobering fact is that, on average, only three of every 10 new drugs earn more than their average R&D costs. In other words, companies must rely on a few successful products to finance continuing R&D. On average, of every 5,000 to 10,000 compounds initially screened as potential new drugs, only five are tested in clinical trials and only one is actually approved by the Food and Drug Administration. So, the work continues everyday by thousands of scientists, clinicians and others. They are persistent even in the face of daunting odds.

The pharmaceutical industry, as a whole, is persistent because of the tremendous human need and the opportunities for success. The industry is sharply focused on improving its ability to enhance and prolong life by finding improved treatments for diseases and conditions such as Alzheimer's, arthritis, cancer, diabetes, heart disease, hepatitis, HIV/AIDS and many more. But the big news, I believe, is that the future will witness a dramatic transformation in health care that will permit us to attack the root causes of diseases with approaches tailored to much more specific segments of our population. This will be the result of work in genomics that I mentioned above.

Just as the development of the clock and printing press of a bygone era led to incredible enhancements in everyday life, so too, have pharmaceuticals enriched our lives in a few short decades. And yet, the Revolution in Life, brought about in large measure by advances in pharmaceuticals, has only begun. Thankfully, our children and grandchildren will be the beneficiaries of the bold endeavors that today's generations are pursuing right now. ●

# Creighton's Stroke Team

By Mary Kay Shanley,  
BA'65



Photo by Jim Fraher

George Bozikis and his wife, Beatrice, at home in Vernon Hills, Ill. Bozikis suffered a stroke in 1998 while flying with his family to California. After an emergency landing, he was rushed to the Saint Joseph Hospital/Creighton University Medical Center.

It was the kind of drama they turn into movies.

George Bozikis had put in a full day's work on Jan. 30, 1998, as a reservationist with United Airlines in Chicago. Then, he drove back to Mt. Prospect, picked up his wife, Beatrice, and son, Jim, grabbed a bite to eat and headed to O'Hare International Airport to catch a flight to California. The Bozikises were to attend a golden wedding anniversary party in Thousand Oaks that weekend, but the farthest west they got was Nebraska.

Their plane had been in the air about 75 minutes when Beatrice noticed her husband was sleeping. "That was strange," she said, "because he never slept on planes. But his eyes were closed and his head was hanging down."

"You OK?" she leaned over and asked George, who was 63.

"No," he mumbled.

"You OK?" she asked again.

"No," he responded. "Something's going on. I don't know what."

Panicked, Beatrice and Jim called for a flight attendant. By now, George was shaking and perspiring. With no doctor or nurse on the plane, the family decided he was having a heart attack.

"We were too far from Chicago to turn back," Beatrice recalled, "so the pilot made an emergency landing in Omaha. People were waiting to take us to Saint Joseph Hospital (Creighton University's primary teaching hospital). Nobody there asked for identification or insurance. But they did ask what time the incident occurred."

By a quirk of nature, Beatrice Bozikis had glanced at her watch when she first realized her husband was in trouble. It was 9:15 p.m. By the time they were in the emergency room, it was about 11 o'clock and for George Bozikis, that made all the difference in the world.

That's because this man, who had a little high blood pressure but had never been ill, did not have a heart attack. He had a stroke. And with a stroke, timing is everything. Nobody knows that better than members of the Creighton Stroke Team who guided George Bozikis' care beginning that January night.

But the Stroke Team was only one of three initiatives at the Saint Joseph Hospital/Creighton University Medical Center that benefited Bozikis. The others were a new technology and a new clot-busting drug. Together, they changed dramatically the way the hospital handles stroke patients.

It all began in 1997, with a new MRI scan called diffusion-weighted imaging. Diffusion-weighted imaging detects a stroke within minutes of its occurrence. Prior to this, imaging technologies weren't able to indicate brain damage until six to 24 hours later.

So why was early detection an improvement? "Well, it used to be that you couldn't do anything for a stroke," said John M. Bertoni, M.D., Ph.D., professor and chair of neurology in the Creighton School of Medicine. "We thought once the stroke occurred, the damage was done. But new research indicated that medications could make a difference in patient recovery, if the meds were administered within a certain amount of time."

Here's why time is vital: Strokes are caused when oxygen-rich blood is cut off from brain tissue. This interruption can happen when a blood vessel in the brain or one leading to the brain is blocked, clogged or bursts. When deprived of blood and oxygen, brain tissue begins to deteriorate. The longer the deprivation, the more damage is done. If the blood and oxygen supplies are not re-introduced, the damaged tissue dies. Depending upon the extent of damage, a stroke can cause permanent disability or death. But researchers were finding that certain medication — given early on — could replenish blood and oxygen, thus minimizing or even avoiding tissue damage.

Shortly after Saint Joseph instituted diffusion-weighted imaging, the hospital was selected by the University of Texas Health Sciences Center in San Antonio as one of a dozen sites to participate in a national protocol study for t-PA, a clot-busting drug. The U.S. Food and Drug Administration approved the use of t-PA in 1996 for treating acute strokes with no bleeding.

However, the drug had to be given within three hours of the stroke; if it were administered after that time period, damage already done to the blood vessels could result in t-PA causing severe bleeding in the brain.

"We knew patients would have to meet a lot of qualifications to receive t-PA," said Bertoni. "One, of course, was meeting the time requirement. We'd have people coming in, saying they had a stroke when they woke up at 8 o'clock that morning. But in reality, they could have suffered the stroke 10 minutes after they went to sleep the night before and not realized it. So we were aware up front that a lot of the stroke patients who

Said Wesley Grigsby, M.D., medical director of Emergency Services at the hospital and associate clinical professor of medicine at Creighton, "At first, we didn't really know where we were going with this thing. We just knew that stroke had been such a hopeless disease in the past. That was changing, and we discussed how we could react."

Added Bertoni, "We also knew that a stroke patient works with a lot of people in addition to the doctors — nurses, the pharmacist, physical therapist, social worker. We understood that we needed a comprehensive team if everybody was to be included in the Pathway."

Eventually, Bertoni, Grigsby, David



Photo by Dave Weaver

Stroke patient Lyle Ward at home in Neola, Iowa, with his wife, Maxine, and their dog, Sidney.

came to the hospital would not qualify for t-PA."

Still, Bertoni and others understood that a rapid, efficient, effective response to stroke patients who fit into the time frame would be essential. They began to talk about how those patients would be handled from entry to the hospital through admittance and discharge. What resulted from those conversations was the creation of the Stroke Team and development of the Pathway — the process the team would follow from admittance through (and sometimes beyond) discharge.

Formation of the Pathway wasn't quite that simple, however. For a year, people studied and reviewed literature about the changing treatment for stroke.

Lefkowitz, M.D., then associate professor of radiology, and others developed Stroke Protocol, 30 pages worth of directives outlining what each member of the Stroke Team on the Pathway should do, beginning with when an apparent stroke victim came to the hospital. "A patient may have the symptoms suggesting a stroke, but we don't always know if it is a stroke or not," Grigsby explained. "There are some things that can mimic a stroke, and we don't want to provide aggressive treatment for a stroke if this is not the cause of the patient's symptoms. This is because clot-dissolving medication that we use for stroke can cause major and even life-threatening side effects, the most

significant of which is major bleeding.”

Additionally, only 5 percent of stroke victims arrive in a time frame that enables them to receive clot-busting drugs. “In fact,” Grigsby said, “to be eligible for such medication, the person has to get here within 90 minutes of the stroke because he or she still has to go through diagnostic testing.”

The protocols detail patient management from hospital entry to the emergency room, to admittance and through to discharge. In layperson terms, the protocol is a set of do-this/do-that directives. The protocol ranges from the simple — beepers alerting the Stroke Team members that a possible stroke patient has arrived — to the complex — medical personnel going through a 20-point assessment to figure out where the patient is on the stroke scale. The points are so detailed and broad-based as to address everything from neurology checks and nutrition assessment to interaction with a social worker and physical therapy directives that say, “Do this on Day One. Do that on Day Two.”

Lyle Ward, 83, of Neola, Iowa, was another patient on the receiving end of the Stroke Team’s care in August 1999, and, two years later, he’s still grateful. “I got up about 6 o’clock that August morning to take my blood pressure medicine and all at once it hit me,” said the retired farmer who was walking two miles a day at the time. “I went numb



A new MRI scan, called diffusion-weighted imaging, allows physicians to detect a stroke within minutes of its occurrence. Stroke damage can be seen in the scan above as the white area at left.



Dr. Grigsby performs endotracheal intubation, a procedure that aids a patient in breathing. This procedure is sometimes necessary as a lifesaving measure in patients with stroke.

Photo by Monte Kruse, BA'83

on my left side. I called to my wife and she said right away I’d had a stroke.”

So did the doctor at the Alegent Health Community Memorial Hospital in Missouri Valley who told Ward, “I’m

sending you to the Stroke Team at Saint Joe’s in Omaha. That’s the best place I know.”

Obviously, doctors like Bertoni agree, pointing out that, “George Bozikis made a great recovery from his (first)

*“One of the benefits of the Stroke Team Pathway is that it saves time and money. For example, on Day One, you get everybody involved. On Day Two, if the patient goes to therapy, the therapist is already involved. But without that involvement, what if we say on Day Six that the patient will be discharged and then the physical therapist says, ‘Well, wait. I haven’t seen the patient yet.’ So the patient has to spend another day in the hospital.”*

**— Dr. John Bertoni, professor and chair of neurology**

*"In the past, treatment of stroke had advanced very slowly, and little could be done. Once in awhile, there might be little things we could add to advance our treatment, but there were not dramatic improvements. Development of the Stroke Pathway is an additional advancement in the treatment of stroke, and we are hopeful that with major research being conducted with new drug therapies, we will continue to see further success in our treatment of this debilitating disease."*

**— Dr. Wesley Grigsby, director of Emergency Services  
Saint Joseph Hospital/Creighton University Medical Center**

stroke, and I believe this is due to the promptness of his arrival at Saint Joe's and the promptness of the treating physicians." (*Editor's note: Mr. Bozikis has since suffered two seizures and is now in rehab.*)

Ward, like Bozikis, arrived within a time frame that made him eligible to receive medication connected with one of the studies in which the hospital was involved. Four days later, he went home. "I've had no more strokes," he said. "Everything's been pretty good although I don't have the full use of my arm and my hand won't grip anything."

Still, he and wife, Maxine, are well satisfied with their experience with the Creighton Stroke Team. "I probably wouldn't have gotten the same attention if I hadn't been one of the Stroke Team's patients," he said.

Actually, Bertoni said, "Patients who come in to a center with Stroke Pathways get more efficient and expert

care, even if they end up not qualifying for new medications like t-PA. They are seen rapidly, and 'plugged in' to testing and treatment as soon as possible. All the caregivers — including general medicine and family practice personnel — function as part of the Stroke Team here. The team approach is emphasized at our conferences and in the clinics and the emergency rooms."

Carolyn Peterson, nurse coordinator, said approximately 120 patients are seen by the Stroke Team each year.

The t-PA drug is now in clinical use. Additionally, the Pathway is still operational although, like most processes, it is continually being modified.

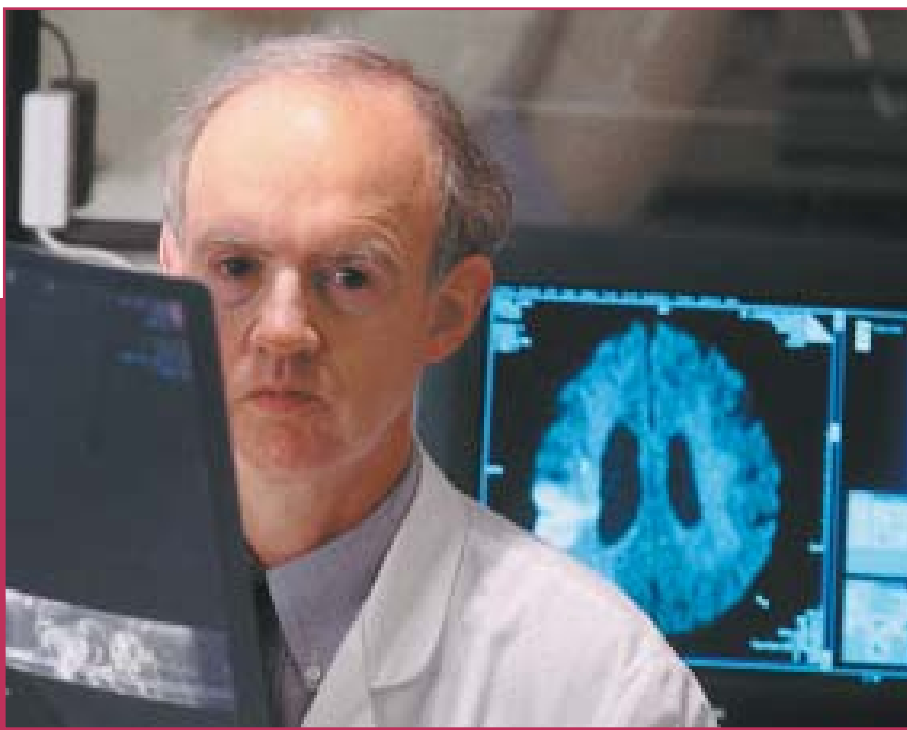
"The Pathway we built was based on consensus of Saint Joseph's staff," Peterson said. "Other hospitals, no doubt, have developed a system that works best for them."

The Stroke Protocol checklist also

remains an integral part of the operation. "That checklist is what everybody throughout the hospital should be thinking about," said Bertoni. "We have it posted at every station where a patient can enter the hospital — from ER to Family Practice — and at the nursing stations. This makes it easy for new doctors and medical staff to come up to speed." Additionally, Bertoni periodically presents updates about Stroke Protocol. "And if I don't see the instructions posted at a nursing station, I say, 'Well, call Station X because they have theirs right out front where everyone can see it,'" he said.

Still, Bertoni sees a need to improve vigilance and "be sure we treat everyone who may benefit. This requires education of the public as well as caregivers. So much more can be done to prevent stroke before it happens.

"The future for stroke treatment," he continued, "will most likely include combination therapy with t-PA and other agents, and new approaches to keep vessels open through surgery or devices that mechanically open blood vessels. It will be an exciting time for all of us!" ©



# Are at You Risk?

Each year, 750,000 Americans have a stroke. It is our nation's third leading cause of death and a leading cause of adult disability. Identify the risk factors that apply to you:

## UNCONTROLLABLE RISK FACTORS

### Are you over age 55?

Yes  No

Chances of someone having a stroke go up with age. Two-thirds of all strokes happen to people who are over age 65. Stroke risk doubles with each decade past age 55.

### Are you male?

Yes  No

Males have a slightly higher stroke risk than females. However, because women in the United States live longer than men, most stroke survivors over age 65 are women.

### Does your family have a history of stroke?

Yes  No

Although actual risk varies, people with a family history of stroke are at risk for stroke themselves.

### Do you have diabetes?

Yes  No

People with diabetes have a high stroke risk. This may be due to circulation problems that diabetes can cause. You can manage this risk factor for stroke by following your doctor's recommendations to control your diabetes.

### Are you of African-American or Hispanic descent?

Yes  No

African-Americans and some Hispanics have two to three times the stroke risk of most other racial groups. This may be due to diet, a greater incidence and severity of high blood pressure and diabetes.

Having one or more uncontrollable risk factors does not necessarily mean you will have a stroke. But pay special attention to your lifestyle factors and treatable medical disorders that you are able to control to lessen your overall risk.

## CONTROLLABLE RISK FACTORS

### Do you smoke?

Yes  No

Smoking doubles your risk for stroke. It speeds up hardening of the arteries, increases the chance for blood clots to form and raises your blood pressure. The good news is that if you quit smoking today, your stroke risk from this factor may decrease significantly.

### Do you consume more than two alcoholic beverages a day?

Yes  No

Studies show that drinking alcohol in moderation — up to two drinks per day — may reduce your risk for stroke by almost half. However, drinking more than two drinks per day may increase your risk for stroke by as much as three times. Since alcohol is a drug that can interact with medication you are taking, discuss alcohol consumption with your doctor.

### Are you overweight?

Yes  No

Excess weight puts a strain on the entire circulatory system. It also makes people more likely to have other stroke risk factors such as high cholesterol, high blood pressure and diabetes. Your doctor can recommend a weight reduction program that includes changes in diet and exercise.

**Is your blood pressure consistently more than 135/85?** Yes  No

Having high blood pressure or hypertension makes you four to six times more likely to have a stroke. It is the single most controllable stroke risk factor. Hypertension affects approximately 50 million American adults or about one-third of the population. Your doctor may recommend treating your condition with a combination of the following: starting a low-salt diet, adding moderate amounts of potassium to your diet, losing weight, stopping smoking, enjoying exercise and taking medication.

**Do you have an irregular heartbeat?** Yes  No

Atrial fibrillation, also known as AF, is a particular type of irregular heartbeat that affects more than 1 million Americans. AF can increase your stroke risk 4 to 6 times. It can be treated by cardioversion, a procedure in which an electrical stimulus is used to restore your heart's normal rhythm. When this does not work, treatment concentrates on preventing the formation of blood clots through medication.

**Do you have heart disease?** Yes  No

Heart disease is an important risk factor for stroke. Plaque that builds up in the arteries can break away and migrate to the brain. This plaque can get caught in the narrow blood vessels of the brain causing a blockage that results in stroke.

**Is your cholesterol level more than 200?** Yes  No

High cholesterol is an indirect risk factor for stroke because it can put you at greater risk for heart disease. A cholesterol level of more than 200 is considered high. If you don't know what your cholesterol level is, find out. If you do have high cholesterol, work with your doctor to develop a plan to lower it. Simple lifestyle changes in diet and exercise may lower your cholesterol. Though most people can control their cholesterol levels through diet and exercise, some cannot and need prescribed medication.

**Have you had a Transient Ischemic Attack (TIA) or stroke?** Yes  No

TIA's are brief episodes of stroke symptoms that usually last for only a few minutes. Unlike stroke, TIA's do not result in permanent brain damage. TIA's should never be ignored! More than one-third of all people who experience TIA's will go on to have a stroke. If you have already had a stroke, you may be up to 10 times more likely to have another.

Detection and management of stroke risk factors are the best ways to lower your risk for stroke. If you answered yes to any of these questions, you may be at increased risk for stroke. If any of the controllable risk factors listed apply to you, the National Stroke Association recommends a visit to your doctor to discuss your individual risk and to develop a treatment plan.

Information is from the National Stroke Association. For more information, call 1-800-STROKES (800-787-6537) or visit [www.stroke.org](http://www.stroke.org).

**Call 911 if you see or experience any of the following symptoms:**

**Sudden numbness or weakness of face, arm or leg, especially on one side of the body; sudden confusion, trouble speaking or understanding; sudden trouble seeing in one or both eyes; sudden trouble walking, dizziness, loss of balance or coordination; sudden severe headache with no known cause. Stroke is a medical emergency.**

I had my picture taken today and it tickled. It was probably the ultrasound bouncing off my insides and my skin and all the membranes that surround me. My mother wanted me to have my picture taken.

The doctor says I'm 14 weeks old. He's wrong on a lot of counts, but I'll get around to that a little later.

This was my first picture, and I could tell from my mother and doctor's reaction that they think they've discovered me. It's sort of like Columbus "discovering" America. I've

been here all along and the fact that they finally found me today isn't a big deal. As I said, I've been here all along.

They're not even positive as to whether I am a boy or a girl yet. I'm a girl. Now this is interesting. My mother and father have my name picked out. They say that if I'm a girl my name is to be Nancy (after my maternal grandmother). So I know my name right now. I'm Nancy. I've been Nancy since the moment my father's sperm brought an X-chromosome into my mother's egg. I can tell you exactly the moment I became Nancy: It was 10:47 p.m., June 11, 1990.

Let me tell you a few things about human eggs that you may not know.

Guess when they

are formed? I'll bet you think they are formed starting at puberty, mature and then are released one at a time as a woman ovulates. Not so. All the future eggs a woman will ever possess are formed when that woman is still an embryo inside her mother's uterus! Isn't that amazing? A human female embryo begins forming these future eggs (called primordial germ cells) when she has been developing for just a few weeks. These cells are detectable using special immunological stains. They migrate to a membrane outside of her body. She hasn't even formed arms or legs or eyes or her heart yet, but there are these future eggs! More and more form while her tiny ovaries are developing inside her body. Then these future eggs begin migrating until they reach the ovaries, where they become primary oocytes, the first step on the way to becoming a mature egg cell. There are a lot of them at the beginning, probably about 2 million, but many primary oocytes die until there are about 350,000 survivors at the time a baby girl is born. Then the surviving primary oocytes just sit there, partially

# Nancy

By Allen B. Schlesinger, Ph.D.  
Professor Emeritus of  
Developmental Biology

completed, during the years of childhood. When the girl reaches puberty, these primary oocytes are activated, one each month on average, to continue the developmental process that was interrupted way back before the girl was even born! Unlike sperm cells, which are produced by the millions day after day for years and years, all the eggs a woman will ever have available for ovulation are the very same ones she had on the day she was born. There is something very special about these cells. No other kind of cell in a woman's body can become an egg. I can trace myself back to a particular one of those primary oocytes, in my mother's body while my mother was an embryo inside her mother! This gets kind of scary. I don't want to think about it any more.

This business of having your picture taken leads to some interesting thoughts. When I'm actually born (I don't know the exact day for that event) my dad will take pictures of me to send to everyone. On the back he'll write, "Nancy, age 1 hour." In the baby book, this will be on Page 3. The picture they took today will be on Page 1, and the ultrasound they'll take when I'm about 5 months along will be on Page 2. The doctor has a Polaroid camera attached to the ultrasound machine, and he gives out

these pictures. My mother will save them and put them in the book. It will be odd because the first picture will say I'm 14 weeks old, the second will say I'm 5 months and the third will say I'm 1 hour old. See what I mean about interesting thoughts?

I know a lot about myself that my mom and the doctor don't. I can explain it most easily by considering this picture-taking business. For example, if it is possible to find me with the ultrasound at 14 weeks, I assume I could be found at 13 weeks or at 10 weeks for that matter. I know I was there. Perhaps the machine isn't good enough to find me, but that's the same old Columbus kind of discovery problem again. Let's imagine a day some years from now when they'll have an ultrasound that's a great deal better than the one they have now. It will be possible to take my picture at 4 weeks. It will be possible to have Page 1 of the baby book with a picture of "Nancy at 1 Hour" that is really at one hour. I really existed at 1 hour just as surely as I did at 2 hours or 2 weeks or 2 months. And I was Nancy.

Yes, I have been a particular human being all along. At the moment my father's sperm and my mother's egg united my parent's genes, I've been Nancy. I am a unique combination of my parents' genetic potentialities. None of my brothers or sisters has this particular genetic makeup. I have always had a genetic identity, not only as a human being, but as Nancy.

Think about the pictures. Suppose we had an ultrasound videotape running every moment since my conception until my birth. Nine months of videotape of Nancy. Are you going to tell me I ever went out of existence as an individual? Are you going to tell me that at one moment I wasn't Nancy and a moment later I was?

Please don't patronize me because I am an embryo. Logic doesn't cease for embryos. And don't you dare tell me I don't exist as a particular, unique genetic entity. I am not my mother. I am Nancy!

And let me tell you something else. Let's run the ultrasound video on my

mother's abdomen during the last week in May 1990. You may remember I was conceived on June 11. On May 29, I left my mother's ovary as an egg. I was a particular, real, identifiable egg. With the videotape run in reverse from the moment of my birth to the moment of my ovulation I have been me. None of the other eggs in my mother's ovaries became me. And only one of the billions of sperm my father produced actually entered the egg that was me. The fact that before I was an embryo I was very small and was in two parts doesn't mean that I didn't exist. Logic holds for eggs and sperm as well as embryos and children.

Remember I said that the doctor was wrong about my age. I've been in actual real-world existence in my mother's ovary and my father's testis. My DNA, I repeat, my DNA, has been in existence before I was "discovered" by the ultrasound. The tape, played in reverse, shows no gaps, no missing moments of my existence. It may make you uncomfortable to think of me as being really in existence before you "found" me, but I have been here all along. Furthermore, I was an egg in my embryonic mother when she was inside my grandmother!

You are quite right to say that I have been here only as a potentiality. I wasn't yet expressed. But let me tell you something very important about potentiality. From the time of my eggness and spermness I have had only two potentialities. Remaining Nancy was one. Not remaining her was the other.

When did my life begin? From my point of view I have been a continuum. I've never been dead. I am a continuation of the living state. I come from humans and insist that you accept that fact. I don't know about legal definitions of the start of my existence. Pick a moment from the videotape that fits into your sensibilities. Whatever you can live with.

I think I look better from the right side. I'll try to turn that way for my next picture. ●

## Reading the Torah

Nearing the end of his life, Moses commanded the priests to read to the people "the Law" every seven years (Deuteronomy 31:10). Researchers believe that some time later, certain prophets began to regularly read the Torah in the presence of the people — see, for example, the Book of Nehemiah (8:18). And during the time that Jews were banished to Babylon, it became the custom to publicly read a portion of the Torah each week and to complete the entire reading on an annual cycle.

The modern custom is to read a portion of the Torah, the first five books of the Bible, each Saturday morning at Sabbath services, on a set annual cycle, with the same portion read each year on the corresponding date of the Jewish (lunar) calendar. The text for each Sabbath is further divided into seven portions.

As a trained Torah reader prepares to chant the text at the reading table (usually elevated), certain members of the congregation are honored by being called up (referred to as *aliyah*, meaning to "go up" or



Photo by Robert Ervin

Raful

"ascend") to stand next to the Torah as it is read. Those who are so honored recite a short blessing praising God just before and just after the reader finishes a portion of that day's reading. Congregations award the *aliyah* honor for all sorts of reasons: for those who are celebrating a happy occasion, for those who are mourning the recent death of a relative, for those who are about to embark on or have just returned from a long journey, or for those who are about to marry. Many congregations follow the ancient custom of awarding an *aliyah* to a stranger, a person new to that synagogue, because we are commanded to love the stranger, for "I was a stranger in a strange land" (Exodus 22:20, 23:9). This story is about my *aliyah* in a new, strange synagogue.

# Jacob

You, dear reader, must surely remember the story of Jacob and his 12 sons, from Bible stories, from the musical *Joseph and the Amazing Technicolor Dreamcoat*, or from recent animated movies. You may remember that Jacob believed that a wild beast had devoured Joseph, his favorite among 12 sons, when in reality Joseph's brothers had thrown him into a pit, stolen his coat of many colors and then sold Joseph into slavery in Egypt. Twenty-two years later, after Jacob learned that Joseph was alive, he set out with his family to move from Canaan to Egypt. God spoke to Jacob in a dream, telling him not to fear this trip and that the Children of Israel would return to this homeland as a great nation.

In our annual reading of this portion of the Torah (see "*Reading the Torah*" at left), I have always been confused about Jacob's words on seeing his son Joseph after this long period of exile. The climactic moment of the story of Jacob and Joseph, in which Jacob is reunited with his son Joseph and meets his two grandsons, Manasseh and Ephraim, is reported in Genesis, Chapter 46, verses 28-30:

"And Jacob sent Judah ahead of him to Joseph, to point the way

before him to Goshen. So when they came to the region of Goshen, Joseph ordered his chariot and went to Goshen to meet his father; he presented himself to him and, embracing him around the neck, he wept on his neck a good while. Then Jacob said to Joseph, '**Now I can die, having seen for myself that you are still alive.**'" (Emphasis added.)

Rabbi J.H. Hertz, the editor of the volume of the Torah, the five books of Moses, that we use in our synagogue, writes this interpretation of Jacob's words in this verse: "Having once more seen Joseph, there was nothing more for him to live for. He had attained the highest joy in life."

This interpretation has always confused me. First, I am shocked, I guess, that this is really the first thing Jacob says to Joseph. Joseph was thrown into the pit by his brothers when he was 17. His brothers took his coat of many colors, tore it and placed animal blood on the coat, and then they told Jacob that Joseph was dead, when, in fact, he had been sold to a passing band of Ishmaelites.

Twenty-two years had elapsed between Joseph's disappearance and Jacob meeting Joseph again. Jacob thinks his son is dead, and then miraculously sees him alive. I wonder why he would then say "Now I can die." As a matter of fact, Jacob did NOT die after he saw Joseph again — the Torah tells us that Jacob actually lived 17 more years in Egypt. But Jacob, thinking for 22 years that his son was dead, now sees a grown man, presumably wearing the beautiful clothes of a nobleman, and he is obviously overcome with shock and emotion. But now really — he now has NOTHING else to live for? Surely Rabbi Hertz has misinterpreted the text. Now Jacob has EVERYTHING to live for. He has all of his children together, and, even more, he has all of his grandchildren together. Now is not the time to die — now is the time to celebrate, to rejoice, to live!

Because Rabbi Hertz's interpretation has never made sense to me, I looked for

# & Joseph

By Lawrence Raful  
Professor of Law



Photo courtesy of the Bowdoin College Museum of Art

This 17th century painting depicts Jacob, on his knees and overcome with joy, reuniting with his lost son Joseph.

other interpretations from the great scholars and sages of the past. Onkelos, an early Aramaic translator of the Torah, wrote that the verse means, “If I were to die now, I would be comforted, having seen your face and knowing you are still alive.” That’s a little better, I guess — “If I were to die now ...”

The great French rabbi, Rashi (1040-1105), author of probably the most famous Torah commentary, interpreted Jacob’s phrase in this manner: “Until now, I thought I would die twice: once in this world, and once in the world to come, because I thought God would punish me for causing your death. Now that I see you are alive, I know that I will die only once, in this world.” Perhaps Rashi thinks that this is the response of a man who has been racked with guilt and sorrow for 22 years.

Another famous Torah scholar, Toldos Yitzchak, had a different view of Jacob’s words: “If I had not seen you today, I could have been considered dead long ago, from the time they showed me your bloody, torn coat. But today, seeing that you are alive, I will only die once, when my time comes.” This comment is curious, too — the assumption is that Jacob was dead inside when he lost his favorite son, but now that he has his son back, he will only die at the end of his physical life.

None of these interpretations is very satisfying to me. We know Jacob to be a complex person, a man who has been through many experiences (for instance, stealing Esau’s birthright, being fooled into marrying Leah before Rachel and wrestling with an angel). Now he sees his favorite son, whom he gave up for dead. Surely Jacob meant more in this phrase than meets the eye. I searched for another interpretation, and I remembered that I had heard one in a sermon many years ago.

In December 1968, my brother and I took our first trip to Budapest, to visit our grandparents (may they rest in peace), our aunts and uncles, and our cousins. My mother, about whom I have written before in these pages, is Hungarian and a Holocaust survivor. On the Sabbath that December in which the portion about Jacob and Joseph was read, my grandfather Andor took his

daughter and his two American grandsons to synagogue.

I don’t know why I remember the details so clearly, but it seems like just yesterday. It was so cold that day and we had on suits and ties and warm coats, and we walked into a tiny, dimly lighted room — not the main sanctuary, which was closed because of the shrinking size of the congregation, but a small side room that was used for services. The room smelled of the coal-burning stove, but we kept our coats on because the stove couldn’t chase the cold. Everyone looked at us — we were so out of place, it was as if we had landed from Mars. The average age of the handful of congregants was well over 80, and they all had expressions of sorrow and sadness. Because the communist rulers discouraged religious practices, they hadn’t seen teen-agers in their synagogue for many, many years.

On the *bimah* (the raised platform in the front of the room), two or three men were leading traditional Sabbath services, and behind them sat an elderly, overweight yet regal looking man. Mom whispered to us that this was the famous Rabbi Domany, who had taught Mom and her two sisters in Hebrew School many years before, in a world where no one knew of Nazis and yellow stars and Jewish laws. She had not seen him since before the war. He held a cane in his hand and appeared to be of limited sight. When we came in, one of the men on the *bimah* went over to him and whispered, and he nodded his head that he understood.

The service to read the Torah began, and they continued to run the service in low, monotone voices. Then, to our surprise, my brother and I were each called up for an *aliyah*. My older brother, Bruce, went up first, and the congregation fixed their eyes on him, wondering, perhaps, whether this teenager, this American kid, would know what to do. Then he broke the silence with a strong, confident voice as he recited the traditional blessing before the reading of the Torah. You could see the surprise, relief and awe on the faces of those elderly people, amazed that there were still young people somewhere in the world who knew the

proper Hebrew blessings. I followed my brother, and I received the same reaction.

At the conclusion of the Torah service, there was a murmuring in the room. Apparently, the rabbi had decided that he would speak, and, from what we learned later, the rabbi was old now and rarely gave sermons or spoke at all. It was like that scene in *Fiddler on the Roof* when everyone is told to quiet down: “Shh, shh — the rabbi is going to say something.” Except this wasn’t musical theater — this was the real thing.

The rabbi struggled to pull himself up, and, using his cane, he walked slowly and with difficulty to the reading table. He spoke without notes, and his thoughts came from his heart and his mind. The rabbi said that year after year he had heard the story of when Jacob once again saw his dear son Joseph. Rabbi Domany said he never really understood what Jacob meant — and he quoted from memory the Hebrew words of the Torah — “Now I can die, having seen for myself that you are still alive.”

The rabbi said that now he understood the meaning of the words and the explanation from the rabbis of old. “What can it mean, that Jacob was



Photo courtesy of Lawrence Raful

Raful, second from left, with his brother, Bruce, right, visiting grandparents Netka and Andor Taubner in Budapest in 1968.

“Now I can die,  
having seen for  
myself that you  
are still alive.”



Photo courtesy of Lawrence Raful

Rabbi Domany, seeing Raful's mother and her two young sons, finally understood the meaning of Jacob's words.

ready for death, having seen his son's face?" the rabbi asked. The rabbi answered his own question, saying, "It is not enough to merely find your lost son, because how can one rejoice at finding a lost son if that son no longer believes in God?" Rabbi Domany reminded us about Jacob's history, about when he wrestled with an angel (Genesis 32:25-31). Remember that after Jacob wrestled with the angel, the Torah tells us that Jacob saw God face-to-face? After that time, the rabbi said, Jacob had a gift of great insight into the character of people.

Jacob was able to look into Joseph's face and realize that even though his son had become a high-ranking Egyptian official, his son was still righteous and spiritual, still a God-fearing man. And therefore what Jacob really said, Rabbi Domany explained, was: "I will now be able to die in peace, since I have seen your face and I know that you remain righteous." And it's Joseph's righteousness that most concerned his father, Jacob; it was his righteousness that showed that he didn't merely exist, but that he was truly "alive." The rabbi told us that this interpretation comes from the famous verse in the Talmud: "Only the righteous are truly alive."

Rabbi Domany then said he finally understood this interpretation because like Jacob and Joseph, he was here this

day when Taubner Zsuzsi (that's Mom's maiden name) returned from the concentration camp, from the pit into which she, like Joseph, was thrown, and now she returned to her home like Joseph, with her two sons, who were today called to the Torah and who have continued to remain Jewish. And Rabbi Domany said that today he felt like Jacob, and he concluded in a soft voice: "Now I can die in peace, because I have seen your face and the faces of your children, and I know that you are yet alive." And he sat down.

I found that interpretation in my research — it comes from another great Jewish scholar, Rabbi Chaim ben Attar, who wrote, "Jacob possessed the ability of the righteous to recognize the spiritual state of an individual." When Jacob says, "... since I have seen your face and I know that you are yet alive," Rabbi Chaim interpreted this to mean "... you still remain righteous, for only the righteous are truly alive."

This makes sense to me. Jacob didn't care as much about Joseph's chariot and fancy clothes — he met his son and said, "I can see in your face what you have become in your adult life, and I can live the rest of my life in peace, knowing that WHEN I die, my beloved son will carry on my faith." Rabbi Hertz is wrong —

this is not the time for Jacob to die — this is the time to rejoice.

Rabbi Domany obviously understood this thought. On that day, Jacob saw in Joseph what Rabbi Domany felt when he realized that a Holocaust survivor had returned to his congregation, when he heard me and my brother recite the prayers in the synagogue. It was as if Jacob had looked into my mother's face, and no longer did he see her thrown into the pit of the concentration camps, or the torn, bloody coat with a yellow star. Rather, Jacob looked into my mother's face and saw the righteousness of her faith, and the faith of her sons. He could see in her face her dedication to working with her synagogue and with charitable groups, and to carrying on her faith and tradition, and yes, even the righteousness of making chicken soup.

That's the lesson that the Torah teaches us with this phrase. We read about an incredibly emotional moment in Jacob's life, and we gain from this story the understanding of what life is really about. We all may think we are alive, but it's not enough to merely breathe in and out, to carry on a daily routine. Life means more; as Jacob understood, only the righteous are truly alive. ©



Bruce, left, and Larry Raful with their mother, Susy, last year.

Photo courtesy of Lawrence Raful

# Librarian and Archivist Marjorie Wannarka Creates a Lasting Legacy

Since joining the Creighton University staff in 1952, Marjorie Wannarka has been a beloved member of the Creighton family.

A native of Fairmont, Minn., Wannarka relocated to Omaha after accepting the position of director of the Health Sciences Library. Fr. Carl Reinert, S.J., president of Creighton at the time, had hired Wannarka without having personally met her, making a wise decision that would greatly benefit the University for decades, and ultimately generations, to come.

*"I feel it is of great importance to preserve a record of Creighton's history, including what happened in the early years, how the University developed and how it has evolved throughout the decades." — Marge Wannarka*

Wannarka remained the director of the library for 39 years, and currently is the director of the University's archives located in the Reinert Alumni Memorial Library.

As the resident archivist, she has the daunting task of overseeing thousands of photographs, documents and other memorabilia that chronicle Creighton University's rich history over the past 123 years.

As the gatekeeper to Creighton's past, Wannarka provides an invaluable service to members of the University community who wish to learn about Creighton's history.

"My role is to spread the word about the archives, sharing the University's fascinating history with others," Wannarka said.

"I feel it is of great importance to preserve a record of Creighton's history, including what happened in the early years, how the University developed and how it has evolved throughout the decades."

Wannarka takes great pride in being able to provide a firsthand account of much of the University's development.

"Having lived through as much of the University's history as I have, I'm able to quickly identify who people are and realize what that person has meant to Creighton," Wannarka said.

With her distinctive wit and kind manner, Wannarka has touched the lives of

to facilitate the students in their research with her capable insights into the 'information maze.' She is a uniquely talented, one-of-a-kind person anyone should be so lucky to meet once in a lifetime. She remains a dear friend."

Wannarka recently decided to commemorate her time at Creighton by naming the University the beneficiary of her individual retirement account.

"I have always had a great respect for the students, especially their optimism, as well as for the Jesuits. As the unifying factor for all of us, the Jesuits provide a sense of direction and purpose to our



Photo by Dave Weaver

Wannarka, pictured above in the University's archives in the Reinert Alumni Memorial Library, has worked at Creighton University for nearly 50 years.

countless students. From the nursing student learning the ropes of the Health Sciences Library, to the medical student studying for Step I of the Board Exam, to the undergraduate student searching for the perfect archived photograph, she has made an impact on Creighton students.

Eugene Merecki, MD'60, has kept in contact with Wannarka some 40 years after graduating from the University.

"One of the things that most impressed me about Marge is that she represented the spirit of the medical school as it existed then," Merecki said. "She was able

work," Wannarka said. "The most rewarding part of my job has always been the people."

Through her generous gift designated for the preservation of endangered archival materials, Wannarka continues her Creighton legacy and ensures that future generations of students will have access to the University's rich history.

"Since the University provided me with an opportunity to learn, contribute in meaningful ways and grow both professionally and spiritually, I would like to provide the same opportunities to others," Wannarka said.



Photo by Jay Langhurst, BSBA'01

Under the direction of Assistant Professor of Fine and Performing Arts Frederick Hanna, D.M.A., the Creighton University Symphony Orchestra performs at a concert last spring in the Lied Education Center for the Arts.

## Alumnus's Gift Hits High Note with Creighton's Music Programs

Helping Creighton's music division strike new chords of excellence, Dr. Melvin Sommer, BA'36, recently established an endowment fund in support of music education.

The generous gift will support the purchase and repair of instruments for student use and faculty instruction. Moreover, the fund will offer a springboard to inspire future gifts to Creighton's music and other fine arts programs. As an endowed gift, Sommer's contribution will benefit current and future students.

Former interim dean of the College of Arts and Sciences Patricia Fleming, Ph.D., is pleased with the gift and the impact it will have on current and future music students.

"Dr. Sommer's gift will make a tremendous difference in the education of Creighton students," Fleming said. "In this high-tech information age, it is imperative that we continue to appreciate the value of the fine arts."

Sommer has been a patron of the arts, particularly music, for decades. He is honored to help ensure that future

Creighton students can explore their interests and talents in music.

"Creighton has always afforded wonderful opportunities for generations of individuals, and I would like to help them continue that trend," Sommer said. "I hope my gift to the music program in the College of Arts and Sciences will assist aspiring musicians to achieve their dreams of a career in music."

While preparing music majors to become tomorrow's cultural leaders, Creighton University's music division offers a wide spectrum of musical opportunities for the entire campus and greater community, including the Gospel Choir, Jazz Ensemble, Symphony Orchestra, Chamber Choir, Wind Ensemble, University Chorus, Javanese Gamelan, Mixed Chamber Ensembles and private lessons. Nearly 200 Creighton students participate in these various campus ensemble groups.

Thanks to Sommer's gift, the University can further advance its commitment to providing a wide spectrum of educational opportunities in music.

### Make the Gift of Music

In an age that exalts the disciplines of science and math, music education and other fine arts often get upstaged. You can help bring Bluejay musicians front and center with a gift to the Creighton Music Division Fund. Your contribution, however great or small, will support important touring and performance initiatives, instruments, musical composition equipment, scholarships, scores for the library and much, much more.

By making a gift to the Creighton Music Division Fund, you will be sending a resounding vote of confidence in Creighton's arts programs. Please send your check to Creighton University, Office of Development, 2500 California Plaza, Omaha, NE 68178-0115.

For additional information on the Creighton Music Division Fund, please call the Development Office at (402) 280-2740 or toll-free at 1-800-334-8794.

# Annual Fund Helps Law School Students Make the Bar

In the fiercely competitive climate that grips today's law schools, students need all the help they can get to make the bar. Oftentimes, it is the help alumni extend through their contributions to the Creighton University Annual Fund that makes the difference.

As one of the pillars of Creighton's financial stability, the Annual Fund supports scholarship assistance, student research and employment opportunities, cutting-edge computer software, library periodicals and other learning resources.

In the last fiscal year, alumni, friends and parents contributed \$233,160 to the School of Law's current operations, \$6,387 more than was projected.

Patrick Borchers, dean of the School, has witnessed the effects of the Annual Fund firsthand.

"Last year our School had an extraordinary year," Borchers said. "We exceeded our goal, and we hope to continue that trend this year."

As dean, Borchers determines how current operating dollars are used throughout the School, depending on the most pressing needs.

In addition to student aid, the Annual Fund provides critical revenue to help purchase various resources for the law library as well as everyday necessities such as furniture, supplies and computers for administrative use.

"Though seemingly mundane," Borchers said, "these funds are crucial to the enterprise of providing students with a legal education."

The Annual Fund also augments the value of a Creighton degree. The more alumni who participate in annual giving, the higher the University is ranked in national surveys.

Creighton's traditionally excellent Annual Fund participation rate of 29 percent has helped the University secure its number one status among Midwestern universities in *U.S. News and World Report's* "America's Best Colleges" edition for the past five years. Nearly half of Creighton law school alumni made

gifts to the University last year.

"For me, the participation rate is more important than the overall monetary amount," Borchers said. "It's a great boost, emotionally and psychologically to see so many graduates paying tribute to the School."

Borchers also believes that the Annual Fund is an excellent conduit between current students and alumni. Through the

fall and spring phonathons, student callers visit with alumni, update them on current campus events, learn about the history of their School and make valuable professional contacts. Alumni, even recent graduates encumbered with debt, are able to give back to their School in a way that makes a difference.

"Even the smaller gifts from students who are just starting out mean the world to the Annual Fund and the School of Law. The gifts show that they think enough of the School and the education they received to make sacrifices to give," Borchers said.



Photo by Monte Kruse, BA '83

Dan Kotrapu, JD'99, studies in the Klutznik Law Library located in the School of Law. Gifts to the Annual Fund support scholarship assistance, student research and employment opportunities, cutting-edge computer software, library periodicals and other learning resources. During the last fiscal year, alumni, friends and parents contributed \$233,160 to the School of Law's current operations through gifts to the Annual Fund.

## About the Annual Fund

Gifts to the Annual Fund, large and small, ensure the continuing caliber of a Creighton University education. These gifts provide a dependable stream of income that bridges the gap between tuition and the actual cost of a Creighton education. Your financial support represents a powerful vote of confidence in the University and the education you received. Supporters of the University who contribute \$100 or more in unrestricted gifts are eligible for the following donor recognition clubs:

Creighton Society Jesuit Circle .....	\$5,000 & above
Creighton Society Founders' Circle .....	\$2,500 - \$4,999
Creighton Society Sustaining Member .....	\$1,000 - \$2,499
Loyalty Club.....	\$500 - \$999
Sponsors.....	\$250 - \$499
Associates .....	\$100 - \$249

# Non-Western Thought Focus of New Endowed Lecture Series

As Creighton University advances its horizons of teaching, research and service into a new millennium, another generation of students is examining the same age-old questions that have faced humankind since time began. Yet, today, these young pioneers are stretching their worldviews beyond traditional Western thought to explore contemporary issues of economics, medicine, law, environment, politics and education through a wider intellectual and spiritual telescope.

In recent years, Creighton has become increasingly committed to educating its students to transcend the boundaries of their own backgrounds; to achieve a deeper understanding of themselves and



Fr. John P. Schlegel, S.J., with Susan and Daniel Semrad.

their place within their own cultures and beyond; and to live and work in an interdependent world.

Helping Creighton to think globally, Daniel, BSBA'71, and Susan Semrad of Lincoln, Neb., recently established an endowed lecture series in non-Western thought. This exciting initiative will help expand the worldview of Creighton's

students and faculty so they can examine various topics through a more cross-cultural lens.

"I have a longtime interest in Eastern studies," Daniel said. "Having traveled extensively throughout the world, I am attracted to esoteric disciplines and traditions such as Buddhism and Hinduism. I knew Creighton had an interest in moving more toward diversity, enriching curriculum and providing greater learning opportunities for students. The lecture series seemed like a perfect fit for the University, introducing those traditions to Creighton faculty and students."

The endowed lecture series will enable Creighton to secure renowned speakers who will engage the campus in dialogue with the philosophical and spiritual traditions of Asia, Africa, Native America and Oceania. The series will be coordinated through Creighton's Department of Philosophy.

A lasting testament to the Semrads' far-reaching vision, the endowed lecture series will be a permanent asset that will benefit students and faculty.

As with all endowed funds, the University will invest the principal of the gift and apply the earned interest to annual expenses.

## New Tax Rules Allow for Easier Charitable Giving

by Steve Scholer, JD'79  
Director of Estate & Trust Services

There are few occasions when I would say this: The IRS has some good news to announce. Though your IRAs and qualified retirement plans are still subject to an income tax and an estate tax, the IRS has introduced simpler rules governing the required minimum distributions you must take after you reach age 70. These new rules make it much easier to leave IRA and other qualified plan assets to charity, a move that will save your estate not only death taxes but also income taxes. For some estates, the combined burden of these two taxes can be 70



Photo by Monte Kruse, BA'83

Scholer

distribution of 6.7 percent of the account value. Under the new rules, the mandatory minimum distribution will drop to 3.95 percent, more than a 40 percent decrease. As your age increases, so does the mandatory minimum distribution you must take.

percent or more.

The new IRS rules allow individuals to stretch out the required minimum distribution. Under the old rules, a single person age 70 was required to take a

Under the old rules, naming Creighton as a percentage, or residual beneficiary, of the account provided you with a future estate and income tax advantage, but sharply increased the minimum amount you were annually required to withdraw from the account. Now, naming Creighton as a beneficiary of your IRA, or qualified retirement plan asset, will not cause increased distributions and will still generate substantial income and estate tax savings. If you have an IRA or qualified retirement plan, you should review your beneficiary designations and determine how the new rules impact your retirement accounts. If you would like more information and a table illustrating the new distribution rates, please call the Office of Estate and Trust Services at (402) 280-2885 or 1-800-334-8794, or e-mail [sscholer@creighton.edu](mailto:sscholer@creighton.edu).

# The Long Goodbye

By Mary Kay Shanley  
BA'65

For two days, we'd been moving boxes filled with my daughter's life from the Explorer to her dorm room. She wouldn't let me help unpack, but she wouldn't unpack, either. So the Explorer emptied out and her half of the rectangular room filled up.

Finally, all that was left in the van were my books on tape — Amy Tan's *The Kitchen God* and John Grisham's *A Time to Kill* — plus a motivational tape that would get me halfway back to Iowa from Amy's new home in Massachusetts.

Now it was our last morning together. I ordered eggs, toast and coffee; she ordered orange juice and a bagel. After breakfast, I would be leaving. She would not.

I'd spent the drive out from West Des Moines listening to Amy talk constantly, plucking topics that stretched from her final days of summer back to her childhood. But by the time we got to Boston, her chatter had given way to ramblings that were intermittent, disjointed. Sentences started, but didn't end. Until finally, she turned toward me and said, "It's farther to this school than I thought ..." Her voice trailed off, and, until I got stuck in heavy Boston traffic and began cursing the entire East Coast, Amy was somewhere alone in her mind.

Now, sitting behind a bagel and juice, she looked so small. "I can't stay here, Mom," she said finally.

I knew that had been on its way since we arrived. I also knew that she could stay. That she would stay. Indeed, that she must. That not staying would affect the rest of her life. I knew

because 28 years earlier, I'd been the girl who looked so small, standing in the drive that went from Gallagher Hall to California Street.

I'd not chosen a school 1,300 miles from home. Still, when your insides are wracked by hollowness, there is no difference between 1,300 miles and the 200 miles that separated Webster City, Iowa, and Omaha. My parents, too, had helped move boxes filled with my life into my half of a rectangular room. And as that weekend wore on, the realization that I did not

want to go away to college gnawed into and through every fiber in my body.

"I cannot stay here," I told my parents in that driveway. They responded that I could — and that I would. Because I was strong. Then, they kissed me and drove off in their Buick LeSabre while I watched and waved and wondered if maybe they didn't love me after all.

Wasn't that just yesterday?

"Amy, 28 years ago," I began.

"I know, Mom," she interrupted. "You stayed. But I can't. I can't." And then, only her eyes were pleading because she could no longer find her voice.

We walked out of the deli in silence, greeted by the comforting warmth of a Massachusetts morning. And in front of a sign reminding you that Jay's Deli serves breakfast and lunch, I knew we must say goodbye. "You're going that way, Amy, to your meeting. And I'm going this way, to the car."

She did not respond.

"You can stay, Amy. You are strong." Then I kissed her. "Now go, and don't look back."

I turned away and stepped beyond the curb into the street. As I climbed into the Explorer, I was aware that I had done what I must do. Twenty-eight years ago, my parents had given me a strength that, this particular morning, I must pass on.

As I pulled out into traffic, I slid *A Time to Kill* into the tape deck. I couldn't listen yet to *The Kitchen God*. The author's name was Amy. ©



## Profiles of Achievement

# Spirits of Creighton

Creighton University, through its Spirit of Creighton Award, annually honors two students at May commencement who represent the best qualities of the University's founders.

The Spirit of Creighton Award is the University's highest student honor. It recognizes initiative, enterprise, academic achievement and outstanding character traits — all qualities found in the most recent honorees, Chad N. Scholl of Plattsmouth, Neb., and Amber Van Kirk of Lincoln, Neb.

Scholl, who received a doctor of pharmacy, has battled personal adversity to succeed inside and outside the classroom. When he was 9 years old, Scholl was diagnosed with Ewing's sarcoma, a form of cancer. He underwent 14 operations and three years of chemotherapy. The summer before he entered pharmacy school, Scholl had aortic valve replacement.

Scholl's illness, however, did not stop him from serving others or from achieving academic success. An inspiration to many, Scholl served as class vice president, was a student representative of Nebraska Health Systems



Photo by Monte Kruse, BA '83

Chad N. Scholl

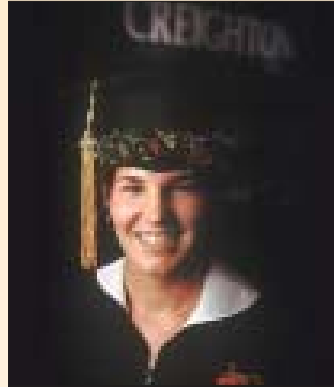


Photo by Monte Kruse, BA '83

Amber Van Kirk

Pharmacists and was president of Phi Lambda Sigma, a leadership honor society. Scholl also was a consistent volunteer for Habitat for Humanity, Adopt-A-Highway and ALS benefits.

Van Kirk, who received a bachelor of science degree in nursing, was a true student-athlete. A four-year member of the dean's honor roll and Creighton's crew team, Van Kirk was named a Central Region Scholar-Athlete and an Academic All-American.

Van Kirk also was a model of service to others. She was a volunteer for Girls Inc., campus Red Cross, Dorothy Day soup kitchen and spent the summer of 2000 as a participant in Creighton's Institute for Latin American Concern (ILAC) program in the Dominican Republic, delivering health care to the needy.

Congratulations to Amber Van Kirk and Chad Scholl — and to all the Creighton students they represent — for their commitment to living as people for others in the spirit of Creighton University. ©

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