EYE PIECE: Dr. Paul Sullivan, an emeritus DMS faculty member, was honored at the Cogan Ophthalmic History Society's 2010 meeting for pioneering, in 1968, a way of treating a detached retina. The Cogan Society is named for an illustrious 1930 DMS alum, Dr. David Cogan.

Pomp, circumstance, and inspiring speeches

The student speakers who took to the podium at DMS's June 12 Class Day ceremony were an inspiring—and international—lot. Yolanda Nesbeth, the graduate student speaker, grew up and earned her undergraduate degree in Jamaica. Roberto Nicolalde Flores, the health policy student speaker, arrived in the U.S. from Ecuador a decade ago to pursue his education. And the medical student speaker, Rajesh Ramanathan, was born in India and has lived in Saudi Arabia, Singapore, and Indonesia. But despite their diverse backgrounds, they sounded common themes: the importance to them of the Dartmouth community and their desire to represent that community well in their careers.

"As Dartmouth graduates, now we have an enormous responsibility, and that is to pay back to society all the cumulative privileges that it has provided to us," said Flores.

Note: Nesbeth struck a similar note. "Dartmouth is the type of place where people work together rather than compete with one another to achieve positive results," she said. "Do something that makes a lasting impact."

Like Nesbeth, keynote speaker Dr. Albert Reece, dean of the University of Maryland School of Medicine, is from Jamaica. His distinguished career as a clinician, researcher, and educator—he is also chair of the Association of American Medical Colleges' Council of Deans—provided another source of inspiration for the 192 graduates.

Degrees: Among them were 86 new M.D.'s; 41 Ph.D.'s (5 in biochemistry, 8 in genetics, 12 in microbiology and immunology, 7 in pharmacology and toxicology, 6 in physiology and neurobiology, and 3 in health policy and clinical practice); 42 M.P.H.'s; and 23 M.S.'s.

A number of graduates were singled out for their accomplishments. See the adjacent box for the prizes presented at Class Day and an earlier awards ceremony.

The students handed out some honors, too: the Basic Science Teaching Award to Dr. Virginia Lyons, an associate professor of anatomy; the Clinical Science Teaching Award to Dr. Timothy Lahey, an assistant professor of medicine; and the Thomas P. Almy Housestaff Teaching Award to Dr. Arne Olsen, an instructor of surgery.

"Do something that makes a lasting impact," urged one student speaker.

At the Dartmouth-wide commencement the next day, two honorary degree recipients had medical ties: Dr. Regina Benjamin, U.S. surgeon general, and Dr. Agnes Binagwaho, permanent secretary of the Rwanda Ministry of Health.

Step: Since then, the graduates have scattered across the country and around the globe—surely heeding Ramanathan's encouragement to "step boldly into new situations and challenges, for it was that boldness that has led to today's achievements."

Amos Esty

Class of 2010 Awards and Prizes

Dean's Medal Linton Evans, Duncan Meiklejohn

Good Physician Award Matthew Cheney

John W. Strohbehn Medal for Excellence in Biomedical Research Christopher Baker

Frederic P. Lord Award in Anatomy Duncan Meiklejohn

Department of Anesthesiology Award Yi-Cai (Isaac) Tong

C. Everett Koop, M.D., Courage Award Crandall Peeler

John F. Radebaugh Community Service Award Katherine Ratzan Peeler

Leonard Tow Humanism in Medicine Award Katherine Ratzan Peeler

Julian and Melba Jarrett Memorial Prize Haitham Ahmed

Saul Blatman Award for Excellence in Maternal and Child Health Sarah Dotters-Katz

Payson-Hampers M.D.-M.B.A. Scholars Award Eugene Hsu, Jessica Morgan

Department of Medicine Paul Gerber Award Austin Kim

Merck Manual Awards Chiaka Abara, Jennifer Bentwood, Benjamin Snyder, Sherzana Sunderji

American Academy of Neurology Prize Nu Chai

Barry D. Smith, M.D., Award for Excellence in Obstetrics and Gynecology Elizabeth Mayhall

Dr. Freddie Fu Orthopaedic Surgery Award Christos Photopoulos

E. Elizabeth French Award in Pathology Darcy Kerr

New Hampshire Pediatric Society Award Noah Hoffman

Department of Psychiatry Award Rajendra Aldis

Harte C. Crow Award in Radiology Marius Pakalniskis

Hitchcock Foundation Student Research Prize Eric Arehart, Maren Speck

Douglas P. Zipes Research Prize in Medicine Haitham Ahmed

Arthur Naitove Surgical Scholar Award Nicholas Bayley

Dartmouth-Mosenthal Surgical Society Omri Ayalon, Peter Bartline, Linton Evans, Duncan Meiklejohn, Christos Photopoulos, Rajesh Ramanathan

American Medical Women's Association Glasgow-Rubin Achievement Citation Virginie Achim, Maren Speck

John and Sophia Zaslow Prize Haitham Ahmed

For a WEB EXTRA with links to historical publications and previous articles about the history of women at DMS, see dartmed.dartmouth.edu/f10/we06.

DOG DAYS: A dozen dog-and-owner teams, certified by Therapy Dogs International, are among DHMC's 600 volunteers. A visit from a friendly pooch has been shown to relax patients, slow their heart rate, and even lower their levels of stress hormones.

Cause for celebration: A 50th and a 50/50 ratio

Half a century ago, a dean at Dartmouth Medical School wrote the dean of Radcliffe College and asked her to look for qualified women who might be interested in attending DMS. That letter made Dartmouth history and changed the course of Valerie Leval's life.

Then a recent Radcliffe graduate and now Dr. Valerie Leval Graham, she became, in the fall of 1960, the first woman admitted to DMS. In fact, never before that fall had a woman been admitted as a regular student to *any* program at Dartmouth (rather than just allowed to take courses). A woman was also admitted to Dartmouth's graduate program in zoology that fall. But it would be 8 years before a woman was admitted to Dartmouth's Tuck School of Business, 10 years for the Thayer School of Engineering, and 12 years for the undergraduate program.

That 1960 letter was a signal to Graham—a fine arts graduate of Radcliffe who had just completed her premed requirements at Harvard—that DMS would be open to her application, even though the School had never before admitted a woman.

Blackwell: In fact, DMS passed up a chance to make history a century earlier. In 1852, the faculty rejected an application from Emily Blackwell, whose famous older sister, Dr. Elizabeth Blackwell, in 1849 was the first American woman to earn an M.D. "In the opinion of this Faculty we should not be justified by the medical profession of New England in complying with her request," wrote Dr. Edmund Peaslee, then secretary of the DMS faculty. (Emily Blackwell did go on to earn an M.D., graduating from Western Reserve Medical College in 1854.)

As for Graham, she'd been out of college for four years by 1960. She'd worked first as a teacher in England, then at the Metropolitan Museum of Art. Still unsure what to do in life, she took an aptitude test, which revealed that she was best suited for medicine or teaching. Having tried teaching, she opted for medicine.

In fact, DMS had passed up a chance to make history in 1852.

Idea: "I loved the idea of having a community of patients in a practice," she recalls, but being a trail-blazer for women "never crossed my mind." Her high school and college experiences had instilled in her the idea that she could do anything she set her mind to. However, she says, "my family was very conventional. It never occurred to them that their daughter would do such a thing. But," she adds, "they were supportive." She felt confident about the course she'd chosen when she earned an A in organic chemistry at Harvard.

Today, 50 years later, that letter from DMS's associate dean, Dr. Harry Savage, is a clue that the faculty had changed its mind since 1852, deciding not only to admit women but to seek them out. DMS had also just begun to accept more students from colleges other than Dartmouth. Back then, DMS offered only a two-year preclinical program (graduates transferred to other schools to complete their M.D.'s), and the tiny—just 24 students per class—all-male student body came almost entirely from Dartmouth.

Graham applied to 10 schools and was offered three interviews. (An in-person interview is required for admission, then and now, to most medical schools; being offered an interview is almost as exciting as being accepted.) It was late in the summer of 1960, and DMS needed to fill the place of a Dartmouth premed who had dropped out.

Savage had lined up six interviews for Graham the day she visited Hanover. Midway through the day, her father called to say she'd been admitted to Boston University, and if she intended to accept the offer she'd need to start classes the next day.

When the interviewers heard that news, Dr. Heinz Valtin told her, "Come back at three o'clock and we'll have an answer for you." Upon being offered a place in the Class of '62, Graham was speechless for a moment. Finally, one professor said, "Well, are you going to accept?"

Attitudes: When classes began, she was at first met with open resentment from her 23 male classmates. They had not expected to find a woman in their midst, and they thought one of their Dartmouth friends should have gotten the open place. Most DMS students back then lived in the medical fraternity house, Alpha Kappa Kappa (AKK), while Graham roomed in a private home. But gradually her classmates' attitudes began to change, and she became a regular at the Sunday faculty talks at the AKK house. By the year's end, the fraternity asked her to be a member—a move the national organization rejected.

After graduating from DMS she went on to Harvard Medical School, along with most of her classmates. Graham has done the

The DMS Class of 1962 was the first to include a woman—one among 23 men.

GREEN WAY: A new "green roof" adjacent to the Birthing Pavilion promises to mitigate temperature fluctuations, reduce runoff, cost less to maintain, and extend the life of the roof up to 200%—not to mention the fact that it provides an appealing patio for patients.

THEN & NOW

A reminder of the pace of change, and of timeless truths, from the Summer 1964 issue of the *Dartmouth Medical School Quarterly*:

"Medicine is unique among the learned professions that deal with . . . individuals . . . in the degree to which content, method and application are all dependent on science," wrote Dr. Gilbert Mudge, then the dean of DMS. "To be sure, science unadorned is not a sufficient basis but, excluding witchcraft or its various modern counterparts, medicine without science is certainly not much of a profession."

56
Faculty in the basic science departments in 1964

290
Faculty in the basic science departments in 2010

$115.6 million
Research income in FY09

Determining death, when minutes matter

Death, so the maxim goes, is one of life's certainties. But in this era of high-tech medical interventions, determining the precise moment of death isn't always cut-and-dried. That determination is vitally important, however, when the deceased could be an organ donor.

Organs: Medical experts all around the world are now taking a closer look at the length of time doctors should wait to determine death before organs are removed for transplantation. One of those experts is Dr. James Bernat, a Dartmouth neurologist and a national authority on medical ethics.

Most vital organ transplants come from donors after they've experienced brain death. "The brain-dead donor is the ideal organ donor because circulation continues," Bernat explains. "So the organs are perfused by the beating heart up to the very moment that they're procured."

Over the last two decades, however, "donation after circulatory death" (DCD) has become increasingly common. In such cases, organs are removed from deceased donors some period of time after their hearts stop beating and their blood stops circulating. DCD, Bernat says, "has become a very common phenomenon that now represents 20 to 25 percent of all deceased organ donation."

In the U.S. and Canada, DCD protocols allow for organ transplantation in "controlled" situations, in which circulatory death occurs after the donor has been removed from life support. In controlled situations, doctors know exactly what interventions and medications the donor received before death—but even so, uncertainties remain.

The most pressing question is how long doctors should wait after the heart has stopped before removing organs. In some situations, auto-resuscitation—the spontaneous return of a heartbeat—can occur after a person's heart has stopped beating. So a surgeon must wait long enough to ensure that the patient has died, but not so long that the organs begin to decay.

Heart: According to Bernat, some hospitals wait just 65 seconds after the heart stops beating before organs are removed. Others wait 5 minutes or more. "Individual hospitals that start programs in DCD develop their own protocols," he explains. "The whole thing is kind of ad hoc, and it cries out for some kind of national standards."

After circulation stops, a waiting period of 2 to 5 minutes is prudent.

In an attempt to establish standards, Bernat convened a group of experts from across the U.S. and Canada in late 2008 at the request of the Health Resources Services Administration, a division of the Department of Health and Human Services. Their recommendations were published in *Critical Care Medicine* a few months ago.

Bernat and his colleagues urge that the cessation of circulation, not just heartbeat, be used to determine death for DCD. After circulation stops, a waiting period of 2 to 5 minutes before removing organs is a prudent choice given current data, the group stated. That recommendation applies specifically to controlled situations.

JON GILBERT FOX

Bernat is leading the national effort.

Many European countries allow for DCD in uncontrolled situations. In those cases, the deceased donor has suffered cardiac arrest, often outside a hospital, and can't be revived. The U.S. may consider uncontrolled DCD protocols in the future, Bernat says. His group hopes to meet again to discuss death determination in those instances.

Standards: Bernat decries the fact "that doctors practicing in one state are using different standards of death determination than in another state. There's really a pressing need," Bernat concludes, "for some type of standardization."

Kirsten Weir

LOWDOWN: The New Hampshire Department of Health and Human Services says DHMC's rate of hospital-acquired infections is 36% lower than the U.S. average. Nationwide, such infections lead to an estimated 99,000 deaths and $30 billion in excess costs each year.

An alarming result (and that's a very good thing)

Amid the bustle of DHMC's orthopaedic unit sits a monitor displaying each patient's vital signs in neat, orderly rows. As a nurse zips by, she hovers for a moment, assesses the colored squares, then bustles off again. If a patient's oxygen level or heart rate should plummet, she knows her beeper will sound and that within seconds she can be at the proper patient's bedside.

"Many people, nationwide, have died because they weren't monitored" continuously, says DHMC's Kenneth Lee. "They could have been rescued." Lee, a clinical manager in biomedical engineering, helped install and test the new monitoring system, Patient SafetyNet, on DHMC's 36-bed orthopaedic unit.

Pagers: The system uses a network of pulse oximeters, which measure heart rate and blood oxygenation through a probe placed on a patient's finger. The devices are linked to the central monitor and to nurses' pagers.

In most hospitals, monitoring in surgical units involves "sampling of intermittent vital signs and clinical examinations," plus closer surveillance of high-risk patients, wrote Drs. Andreas Taenzer and George Blike of DHMC in *Anesthesiology*. The paper detailed the orthopaedic unit's experience with Patient SafetyNet, which is made by a company called Masimo.

They estimate that the system will save 150 ICU bed-days a year.

Unit: For 11 months before and 10 months after the system's installation, the unit tracked how many patients had to be transferred to the ICU or treated by special resuscitation teams. The authors also compared results on the orthopaedic unit to those of other units.

They found the system significantly reduced rescues and ICU transfers; they estimate it will save 150 ICU bed-days a year. "It's not a given that every safety investment is cost-effective," says Blike, "but in this case it was. The system paid for itself."

The results were so impressive that the project received this year's Health Devices Achievement Award from the ECRI Institute, a nonprofit dedicated to evidence-based patient care. Two additional DHMC surgical units and four medical units have since adopted the system. More are likely to follow, says Jean Avery, senior clinical quality specialist.

But the system's success was not a foregone conclusion. On a busy inpatient unit, where one nurse cares for several patients, it is important that alarms sound only when action needs to be taken. Otherwise, nurses can become desensitized to alarms, as the authors of the paper found when they tested the Masimo system on another unit. If it's calibrated for high sensitivity, it can generate too many false alarms—such as if a patient changes position and bumps the pulse oximeter. By the time the nurse gets to the patient's bedside, his or her vital signs would have recovered.

Delays: To combat this problem, the team built in two delays: a 15-second delay before the alarm goes off at the bedside, and an additional 15-seconds before the nurse is paged.

Such monitoring "could potentially become the standard of care," Avery believes, since it reduces costs and complications and keeps ICU beds open for patients who really need them.

She had a chance to experience its benefits from a patient's as well as a nurse's perspective. A relative and a friend had surgery at DHMC during the test period. "I felt better knowing that they had that system there watching them at night," says Avery. "It was comforting."

Eliza C. Mackintosh

JUNIPER TRAILS

Staff nurse Kimberly Belanger-Demers checks the monitor.

THEN & NOW

A reminder of the pace of change, and of timeless truths, from the 1980 DMS admissions brochure:

"Although Dartmouth did not admit its first woman medical student until 1960, the percentage of women in DMS classes since 1968 has consistently exceeded the national average. . . . Since 1976, graduating classes have averaged 26% women."

1852
Year DMS denied admission to Emily Blackwell, sister of Dr. Elizabeth Blackwell, the first American woman to earn an M.D.

58%
Percentage of women in DMS's 1987 entering class

49%
Percentage of women in all graduating classes nationwide in 2007

TUBE TOPS: A TV show featuring Drs. Ira Byock and Elliott Fisher of DMS has won a George Foster Peabody Award for excellence in journalism and been nominated for an Emmy. The show, on *60 Minutes*, was titled "The Cost of Dying."

THEN & NOW

A reminder of the pace of change, and of timeless truths, from a 1991 history of Mary Hitchcock Memorial Hospital, which opened in 1893:

"Until well into the 20th century, hospitals weren't considered a proper place to have a baby; respectable women had their children at home. No exception to the rule, Mary Hitchcock was open for two years before the first baby was born within its walls, and until 1920 the hospital's exquisitely detailed annual reports . . . did not even bother to detail the specific number of births. Not even the hospital's own medical staff . . . saw the institution as a fit place to give birth."

1,135

Births at Dartmouth-Hitchcock Medical Center in fiscal year 2009

DMS exports its measurement methodologies

DMS researchers have become well known throughout the United States for their measurement of usage patterns within the health-care system. Now they're helping to develop similar efforts in other countries, including the small, newly independent nation of Kosovo.

Ties: In 1999, DMS's Dr. James Strickler began working, under the auspices of the International Rescue Committee, with refugees from the Serbian conflict in Kosovo. Since then, he has led a number of initiatives that have forged strong ties between DMS and Kosovo, including student exchanges.

In 2009, Hoxha returned to DMS from Kosovo as a Fulbright Scholar.

In 2003, a medical student named Ilir Hoxha was one of the Kosovars who visited DMS. The contacts he made at Dartmouth sparked his interest in health-care economics and policy, so Strickler encouraged him to apply for a grant to study at the Dartmouth Institute for Health Policy and Clinical Practice (TDI). In 2009, Hoxha returned to DMS as a Fulbright Scholar and spent four months working with TDI faculty. His aim was to assess whether the methods developed there to study the U.S. health-care system could be applied to Kosovo.

Skeptical: Dr. David Goodman, the director of TDI's Center for Health Policy Research, worked closely with Hoxha. At first, Goodman says, he was a little skeptical of the idea of using TDI's methodologies in Kosovo because of the country's extremely limited resources.

But Hoxha was confident that studying variations in health care was essential in Kosovo, which is still early in the process of rebuilding its health-care system following its decimation during the war. "For a country with few resources, the study of efficient use of resources becomes even more important," he says.

Goodman soon agreed. "In under-resourced countries, small measurements may have very big effects, because the needs are great," he says. "If you start building it in now, you gain benefit as you start reconstructing the health-care system."

Andrew Goodman, a 2010 graduate of the M.P.H. program at TDI (and David Goodman's son), was likewise interested in studying health-care variations in Kosovo, but he had two questions: First, were Kosovar physicians interested in studying variations in the practice of medicine? And second, how much did they already know about the concept? With the help of Hoxha and TDI faculty members, he drafted a survey to answer those questions.

Nuances: After developing the draft, Andrew Goodman spent three weeks in Kosovo this past spring, meeting with physicians and policymakers to get their feedback on the survey. He used their comments and suggestions to hone it, ensuring that it was sensitive to cultural nuances and that the concept of variation was explained clearly.

He and Hoxha had anticipated that knowledge of health-care variations would be quite low,

Everything in Kosovo's health-care system, from the ambulances that ply the streets of Pristina to the infrastructure in the country's hospitals, needs to be rebuilt.

For a WEB EXTRA with links to both slow-motion and regular-time video of the 1995 implosion of the old MHMH, see dartmed.dartmouth.edu/f10/we01.

SPEAKEASY: Whether in Greek or Gujarati, the DHMC interpreting service can help patients and their families communicate with staff. Spanish is the language most often requested; sign language is second. Also common are Arabic, Russian, Chinese, and French.

BIG BANG FOR A SMALL TOWN

A number of buildings on the Dartmouth campus have been razed over the years so newer structures could take their place. But only one campus demolition in Dartmouth's 241-year history was accomplished by dynamite rather than a wrecking ball or bulldozer. Exactly 15 years ago, on September 9, 1995, a controlled implosion brought down the eight-story main building of the old Mary Hitchcock Memorial Hospital. Before Dartmouth-Hitchcock's 1991 move to its Lebanon campus, MHMH sat for almost a century at the corner of Maynard Street and Rope Ferry Road in Hanover.

Dartmouth officials had determined that an implosion would be the least expensive, least disruptive way of demolishing the structure. It took over 500 pounds of dynamite but only 15 seconds to topple the 304,000-square-foot building. Several thousand spectators showed up to watch the plunger being pushed. First came a few puffs of smoke and muffled bangs as the strategically placed blasts went off. Then the building crumpled in upon itself amid a cloud of dust (*pictured above*). By the time the dust cleared, eight stories had collapsed to the height of one.

A parking lot and two dorms now occupy the site. See the box above for links to video of the implosion. A.S.

SURGERY ON YOUR MIND?

DHMC's new Outpatient Surgery Center (*pictured below*) opened on schedule in June, with a promise of convenient in-and-out access for patients. The $32-million, 41,000-square-foot, stand-alone facility has eight operating rooms—four currently in operation and four that will come on line next year.

Before the OSC, DHMC's 27 operating rooms were maxed out. As a result, routine, same-day surgeries often had to be delayed to make way for emergency cases. Such schedule disruptions were inconvenient for patients and expensive for the Medical Center, which has to pay staff overtime when the operating room schedule runs longer than planned. Now, the OSC will handle some 4,500 routine procedures each year, freeing up the ORs in the main hospital for more complex, lengthy procedures.

Greater *on*-demand OR capacity, ample *on*-site parking, a guarantee that more procedures will happen *on* time: those are benefits that anyone can get *on* board with. J.D.

When needy people talk, Nick Ellis listens

There's nothing unusual any more about medical students who do international volunteer work. Few, however, take the time to found a global outreach organization and to nurture its growth—while keeping up with their medical studies. DMS fourth-year Nick Ellis is one of those few.

Ellis's interest in international health started early. In high school, he traveled to Costa Rica on an exchange program, where he first learned about the health disparities so prevalent in Latin America. Over the next few years, he returned to volunteer in Ecuador, Panama, and Peru.

Premed: At McGill University, Ellis majored in international economic development and as a senior decided to pursue a career in medicine. It was in 2005, during a post-baccalaureate year at the University of Maine to complete his premedical requirements, that Ellis founded MEDLIFE—Medicine, Education, and Development for Low Income Families Everywhere. The organization sends students to impoverished communities in Peru and Ecuador to provide medical services.

MEDLIFE now has chapters on over 20 college campuses nationwide.

But what MEDLIFE is really about, says Ellis, is listening to people. Before he founded the organization, he volunteered for a large international nonprofit dedicated to helping the poor. "A mother came to the organization . . . because her daughter needed heart surgery," he recalls. "The national director's response was essentially that what her daughter needed didn't fit into their mission statement."

Need: Ellis learned a lot from that response. At MEDLIFE, he says, the goal is to listen. "This work isn't about providing a service that we feel is necessary," he says. "It's about providing a service that people living in poverty say they need."

For example, earlier this year in a rural community in Ecuador, Ellis encountered a newborn with pulmonary hypoplasia, or incomplete development of the lungs. He learned that the child had been born three months early after her mother had fallen down a steep hill; the fall had induced labor. At the community's request, MEDLIFE built several staircases in the mountainous village. "It can't be something we own and dictate how it's run," Ellis says. "It has to be something they run."

On every mission, MEDLIFE hires a local doctor who works with students while they run mobile clinics for a week or two. MEDLIFE supports that doctor by providing medications, transportation, a small salary, and basic equipment. The volunteers organize the clinic, handle logistics, and teach preventive measures such as tooth-brushing and hand-washing.

Wake: MEDLIFE's approach was in the vanguard of a reassessment that's taking place among international nongovern-

CHINA CABINET: Dr. Murray Korc, DMS's chair of medicine, traveled to China in July to be honored by the Chinese Society of Clinical Oncology for Distinguished Achievement in Pancreatic Cancer Research and Clinical Management.

THEN & NOW

A reminder of the pace of change, and of timeless truths, from the 1970 MHMH-DHMC annual review:

"The cleanliness of every area of the Hospital is the responsibility of Housekeeping. . . . Until 1933 there was no such thing as a housekeeping department. This work was delegated to nurses. Volunteers helped out during wartime. Not until 1948 were nurses freed from cleaning patient beds, using disinfectant solutions on the metal and a whisk broom on the mattress. Even keeping 'hoppers' and other bathroom fixtures shining . . . was left to nurses and, particularly, student nurses."

200
Number of housekeeping employees in 2009

2 million
Square feet they keep clean

Medical students continue to reach out to Haiti

The contrast was stark. One evening this past May, Dartmouth students enjoyed delicious food and live music and dance in Hanover, N.H., while 2,000 miles away in Haiti, hundreds of thousands of people struggled to find food, shelter, and basic medical care.

But there was a direct tie between the two settings. It was four months since an earthquake had left Haiti in ruins, but Dartmouth students were continuing to seek ways to help the ravaged nation. That evening, the help came in the form of the fourth annual Dance for a Dream, a DMS-led fund-raiser.

Local: The evening featured an auction of Haitian artwork, the sale of handmade Haitian candles, a raffle with prizes donated by local businesses, and toe-tapping performances by seven student music and dance groups.

This year's Dance for a Dream proceeds went to an organization based in Port-au-Prince called GHESKIO. The acronym is derived from the French version of the group's name: Haitian Study Group on Kaposi's Sarcoma and Opportunistic Infections. "We chose to support GHESKIO," says Stephanie Rolin, the M.D. student who spearheaded the fund-raiser, "because they have a lot of rebuilding to do."

GHESKIO has managed to "embrace what is . . . necessary to provide education, care, housing, shelter, medical care for this population," explains Dr. Peter Wright, a pediatric infectious disease specialist at Dartmouth. He has worked with GHESKIO since 1990 and spoke at Dance for a Dream about conditions in Haiti. "There is little question," he says, "that Dartmouth is very committed to . . . doing something long-term in Haiti."

"Just to see how motivated people are to help out in Haiti . . . is a great thing," agrees Daphnée Charles, one of two Haitian undergraduates admitted to Dartmouth after the disaster. She also spoke at Dance for a Dream, as did the other Haitian undergrad, Ronel Lefranc.

"Dartmouth is very committed to . . . doing something long-term."

Among the performers at the event were DMS's *a cappella* group, the Dermatones; an Irish dance troupe; a bluegrass group; a contemporary dance ensemble; and a group that melds South Asian dance with hip-hop. Dartmouth officials estimate that students have collectively raised over $1.5 million for the Haiti relief effort—including $5,000 from Dance for a Dream.

The funds will be put to good use. "GHESKIO is responsible for providing HIV care . . . for about 40% of the people in the country that are getting such care," Wright says. In fact, GHESKIO, which was founded in 1982, was the first organization in the world dedicated to fighting HIV/AIDS. After the quake, the group set up refugee camps and field hospitals, in addition to continuing to care for AIDS patients.

Trial: Two months after Dance for a Dream, Rolin flew to Haiti, thanks to a Fogarty Grant from the National Institutes of Health, to work for six weeks at GHESKIO on a multinational trial aimed at preventing the transmission of HIV from mother to child. Accompanying her were Wright and another DMS student and Fogarty Grant recipient, Jody Epstein, a certified lactation consultant.

Such contributions of time and money may seem minuscule compared to the massive needs in Haiti. But their significance, says Wright, "is really the effort . . . and what that means."

Krupa Patel

These Haitians are waiting for care at a clinic run by GHESKIO.

A PODCAST A DAY . . .: DHMC has launched a podcast series called "Healthy Highlights." The episodes are on topics ranging from medication safety to nutrition and tobacco cessation to aging. To subscribe, go to dhmc.org/goto/health.

Learning to live well—but not for revenge

"Living well is the best revenge" is an aphorism that dates back half a millennium. But by turning the concept of "living well" on its ear, Dr. Robert McLellan and his team at Dartmouth-Hitchcock have devised a program for employees—called Live Well/Work Well (LW/WW)—with a less misanthropic premise. Instead of a lavish lifestyle, the program promotes a sensible diet, moderate exercise, diligent monitoring of health signs, and counseling. Not only does such a regimen benefit individual employees, but their better health results in improved efficiency and productivity in the workplace.

Employees' better health results in improved workplace productivity.

Word: Jody Barna, an early disciple of the program and a 15-year veteran of DHMC's Blood Bank, spread the word among her coworkers at the very start of LW/WW. Her typical lunch shows her dedication: it's a mix-and-match combination of items brought from home (iced coffee and bulgur salad) plus a chicken Caesar salad purchased in the DHMC cafeteria.

She thinks the best feature of the program is the free on-site exercise opportunities, including a fitness room with showers. Although she faces an hour-long commute home every evening, she puts in a 45-minute workout before hopping in her car.

Marion Cate, a fitness/lifestyle coach, is the manager of LW/WW's Health Improvement Program (HIP). She spends half of her time on physical fitness coaching and half managing HIP. HIP's offerings range from yoga classes to gatherings called Laughter Club. In addition, HIP personnel are available to discuss almost any aspect of an employee's health.

Fitness and nutrition are important components of LW/WW, but it has other aspects, too. Another of its initiatives is the Employee Assistance Program (EAP), which is managed by Sara Koury. It provides support for employees facing psychosocial difficulties, such as smoking addiction, stress, weight reduction, grieving, or family relationship or behavioral health issues. The EAP also offers counseling for financial and legal problems and is open to dependents and retirees as well as employees.

MARK WASHBURN

Marion Cate, second from the right, pictured with some of her LW/WW colleagues, is a fitness/lifestyle coach.

Benefits: New to LW/WW is the Workability Program, which helps employees while they're recovering from an illness or injury and upon their return to work.

Each component of LW/WW has care managers who can provide information about employee benefits and advise employees on the overall coordination of their care.

According to McLellan, the medical director of LW/WW, and Karen Gollegly, its administrative director, parts of the program precede their involvement. When McClellan joined DHMC in 2003, there was already a Section of Occupational Medicine focused on workplace illnesses and injuries and safety in the workplace; the EAP was already well established, too.

But in 2009, LW/WW became one of DH's five strategic initiatives. Many of the earlier efforts and some new ones were merged under a single umbrella. As McClellan puts it, "If we cannot improve the health of our own workforce, how will we be able to improve the health of the community?"

Data: McLellan's team is already hard at work collecting the data that they are certain will eventually show improved employee health—and increased productivity.

Roger P. Smith, Ph.D.

Worthy of note: Honors, awards, appointments, etc.

Three members of the DMS faculty were recently appointed to endowed professorships, one of academe's greatest honors:

James Weinstein, D.O., copresident of Dartmouth-Hitchcock Medical Center, director of the Dartmouth Institute for Health Policy and Clinical Practice, and a professor of orthopaedics, was appointed to the Peggy Y. Thomson Professorship in the Evaluative Clinical Sciences. Established in 1994 by Dr. Andrew Thomson, DC '46, in honor of his wife, it was the first endowed chair in the U.S. devoted to this health services field. For more about Weinstein, see the feature beginning on page 32 and dartmed.dartmouth.edu/sp10/v03.

Elliott Fisher, M.D., a professor of medicine and director of the Center for Population Health and Policy, was named to the James W. Squires, M.D., Professorship. It was established to honor Dr. Squires, director of the New Hampshire Endowment for Health and founder of the Matthew Thornton Health Plan. For more about Fisher's work, see dartmed.dartmouth.edu/su09/f02 and dartmed.dartmouth.edu/w07/v01.

And **Jason Moore**, Ph.D., a professor of genetics and director of bioinformatics, was appointed to the Third Century Professorship. This chair was established to recognize excellence in teaching and scholarship and to enable the incumbent to develop inno-

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