New doctoral program looks to promote the bench-to-bedside link

New doctoral program coming soon to a medical school near you!” At least that’s how the marketing flyer might read.

DMS is developing a Ph.D. program, called the Program in Experimental and Molecular Medicine (PEMM), to focus on translational research—bringing discoveries quickly from the lab bench to the bedside.

There has been a growing realization by the biomedical community of a disconnect between discoveries made in the laboratory and their translation into practical applications for patients. “One of the reasons we have not been able to move things forward more efficiently is that we don’t have the workforce that . . . understands how to do this,” explains PEMM’s director, Murray Korc, M.D.

Idea: Traditionally, Ph.D. scientists have been trained in basic research and M.D.’s in patient care. A few individuals have worked in between to turn lab findings into treatments or preventive strategies. “The idea for PEMM is to help contribute to the pool of individuals who are trained in the basic sciences and who also understand the concept of clinical investigations, clinical trials, how to advance discoveries more quickly, how to translate them into something that will benefit everybody,” says Korc, who also chairs the Department of Medicine.

PEMM will have five tracks:

- Cancer biology
- Molecular pharmacology and toxicology
- Systems biology
- Vascular biology
- Neuroscience

Train:

Michael Cole, Ph.D., associate director of PEMM and a professor of pharmacology-toxicology and of genetics, says the program will “train a new generation of health-care researchers that will be better prepared to do translational research.”

Once PEMM receives final approval from the Dartmouth College Board of Trustees, discoveries made by this “new generation” will be coming soon to a clinic near you.

Kristen Garner
Hummingbirds may be among the world’s smallest birds, but they pack a big punch at DHMC. Every spring and summer, inpatients get to watch the tiny iridescent creatures hover around feeders that have been set up by Joyce Langevin, R.N. Over a decade ago, DHMC’s “hummingbird lady”—inspired by a patient’s family who hung a hummingbird feeder outside of their loved one’s hospital room—began placing and maintaining the feeders all around One West.

It’s a task Langevin takes very seriously. Each year in late April, she starts to track hummingbirds’ migration patterns on www.hummingbirds.net. In early May, she sets up the feeders. And then every week until mid-September, she cleans and refills the feeders with a fresh, homemade sugar-water solution: four parts water to one part sugar—and hold the red food coloring, which, according to Langevin, can harm a hummingbird’s delicate liver.

Langevin (pictured at left) retired in 2003 to battle breast cancer, but she has continued to care for DHMC’s hummingbirds—and, indirectly, all the patients on One West. “It’s something I can still do for patients that I’m just not ready to give up,” she says. A.P.

Heart-to-heart discussions about devices

The phrase “3D Symposium” may conjure up an image of a 3-D movie extravaganza. But the three D’s stand for Dartmouth Device Development.

Key: It’s an event dreamed up by Dr. Aaron Kaplan, a DMS cardiologist. He invites about 50 key stakeholders in the medical device industry to an annual retreat in Vermont. Attendees include leading clinical investigators; senior managers from medical device manufacturing firms; entrepreneurs; regulators, including the director of devices at the Food and Drug Administration (FDA) and his British counterpart; payors, including the chief medical officer at the federal Centers for Medicare and Medicaid Services; venture capitalists; investment bankers; and lawyers. The group spends a couple of days candidly discussing the development and commercialization of medical devices.

“The idea is you bring these folks together who are often transacting business—I don’t like to say this—on opposite sides of the table,” says Kaplan. “This is very unusual, providing a forum for people [who are] working on the same problems but who don’t normally work together because of perceived barriers. It’s “a forum that removes a lot of those barriers and that can facilitate dialogue.”

The first 3D Symposium, in 2003, “was phenomenal,” says Kaplan. It was just after a new drug-eluting stent had been released, “and there was a concern about subacute thrombosis.” A stent is a metal mesh tube that’s inserted in an artery to keep it open, and “drug-eluting” means it slowly releases drugs to reduce the risk of reblockage. This stent was the first of its kind recommended for FDA approval, but there were worries it might cause small blood clots. “The FDA had filed a letter and then came to the conference,” says Kaplan. The discussion culminated in a published paper about developing better post-market surveillance strategies.

Process: That first year, participants also talked about differences between the European and U.S. regulatory environments. In Europe, the approval process for medical devices requires only that a device be proven safe. But in the U.S., both safety and efficacy have to be shown.

“There’s a movement afoot called harmonization,” to standardize the criteria in Europe and the U.S., says Kaplan. While the 3D discussions weren’t responsible for the movement, they did help to demystify the process.

In fact, demystifying the device development process has been an important result of the 3D sessions and the papers published afterward in leading journals like Circulation and Health Affairs. “Part of the dilemma is that often the clinical community sees device development as a black box,” says Kaplan. The 3D papers have helped educate clinicians and the public by describing the device development process, the regulatory hurdles, and other challenges. It “also...
helps enrich dialogue to regulators and the business community as to how to meet patients’ needs quicker,” says Kaplan.

Other topics covered have included conflicts of interest and what’s known as the Humanitarian Use Device/Humanitarian Device Exemption (HUD/HDE)—a process meant to facilitate the approval of devices intended for rare conditions. But a post-3D report, published in Circulation, raised awareness about misuse of the HUD/HDE process to circumvent the normal, long approval pathway. The report may have changed “the way start-up companies are looking at that pathway,” says Kaplan. “I don’t know how much of that is from the symposium, but it helped educate the community, . . . identified some of the pitfalls, and made sure [the process] is used more appropriately.”

A topic being considered for next year’s retreat is Institutional Review Boards—committees that review and monitor any biomedical research involving human subjects. The 2006 3D Extravaganza—er, Symposium—is already “sold out,” or oversubscribed, as Kaplan puts it.

Laura Stephenson Carter

Editorials examine the bulk of the evidence

B

B

ran and beans may help keep you regular, but don’t count on them to protect you against colon cancer. Despite more than three decades of studies on dietary fiber and its relationship to colon cancer, the connection between the two remains ambiguous. Dr. John Baron, a DMS epidemiologist, explained why in a December editorial in the Journal of the American Medical Association (JAMA).

“We have changed ‘the way start-up companies are looking at that pathway,’” says Kaplan. “I don’t know how much of that is from the symposium, but it helped educate the community, . . . identified some of the pitfalls, and made sure [the process] is used more appropriately.”

A topic being considered for next year’s retreat is Institutional Review Boards—committees that review and monitor any biomedical research involving human subjects. The 2006 3D Extravaganza—er, Symposium—is already “sold out,” or oversubscribed, as Kaplan puts it.

Laura Stephenson Carter

Editorials examine the bulk of the evidence

B

B

ran and beans may help keep you regular, but don’t count on them to protect you against colon cancer. Despite more than three decades of studies on dietary fiber and its relationship to colon cancer, the connection between the two remains ambiguous. Dr. John Baron, a DMS epidemiologist, explained why in a December editorial in the Journal of the American Medical Association (JAMA).

“We have changed ‘the way start-up companies are looking at that pathway,’” says Kaplan. “I don’t know how much of that is from the symposium, but it helped educate the community, . . . identified some of the pitfalls, and made sure [the process] is used more appropriately.”

A topic being considered for next year’s retreat is Institutional Review Boards—committees that review and monitor any biomedical research involving human subjects. The 2006 3D Extravaganza—er, Symposium—is already “sold out,” or oversubscribed, as Kaplan puts it.

Laura Stephenson Carter

Editorials examine the bulk of the evidence

B

B

ran and beans may help keep you regular, but don’t count on them to protect you against colon cancer. Despite more than three decades of studies on dietary fiber and its relationship to colon cancer, the connection between the two remains ambiguous. Dr. John Baron, a DMS epidemiologist, explained why in a December editorial in the Journal of the American Medical Association (JAMA).

“We have changed ‘the way start-up companies are looking at that pathway,’” says Kaplan. “I don’t know how much of that is from the symposium, but it helped educate the community, . . . identified some of the pitfalls, and made sure [the process] is used more appropriately.”

A topic being considered for next year’s retreat is Institutional Review Boards—committees that review and monitor any biomedical research involving human subjects. The 2006 3D Extravaganza—er, Symposium—is already “sold out,” or oversubscribed, as Kaplan puts it.

Laura Stephenson Carter

Editorials examine the bulk of the evidence

B

B

ran and beans may help keep you regular, but don’t count on them to protect you against colon cancer. Despite more than three decades of studies on dietary fiber and its relationship to colon cancer, the connection between the two remains ambiguous. Dr. John Baron, a DMS epidemiologist, explained why in a December editorial in the Journal of the American Medical Association (JAMA).

“We have changed ‘the way start-up companies are looking at that pathway,’” says Kaplan. “I don’t know how much of that is from the symposium, but it helped educate the community, . . . identified some of the pitfalls, and made sure [the process] is used more appropriately.”

A topic being considered for next year’s retreat is Institutional Review Boards—committees that review and monitor any biomedical research involving human subjects. The 2006 3D Extravaganza—er, Symposium—is already “sold out,” or oversubscribed, as Kaplan puts it.

Laura Stephenson Carter
Clinical trials: Hunting for a stroke of luck

Fran Hunt stumbled into her office at DHMC one day last October. She’d felt fine while driving to work but started to feel strange as she walked in from the parking lot. She began veering and bumped into the door as she entered the building.

“I go in my office and I sit down and I realize I can’t move my right hand, I can’t move my right leg,” she recalls. “If I didn’t know any better, I’d think I was having a stroke,” she remembers thinking. But she considered herself too healthy for that.

Then the phone rang. “My speech was slurred when I tried to speak,” says Hunt. The caller, a colleague in another office, thought at first Hunt was kidding around but soon realized she was in trouble and called for help. Within minutes, Hunt was being rushed to the emergency department, where Dr. Timothy Lukovits, a neurologist who specializes in stroke, treated her right away. His team administered tissue plasminogen activator (tPA), which dissolved a blood clot that had lodged in a cerebral artery. She recovered completely. In fact, after a two-night hospital stay, she drove herself home.

But not everyone is as lucky. Stroke is the third-leading cause of death in the U.S., killing about 160,000 people a year—out of the 700,000 who suffer a new or recurrent stroke. There are about 5.5 million stroke survivors in the U.S., many with permanent disabilities.

**Act:** Administering tPA within three hours is one proven way to treat stroke. Rapid evaluation and treatment of stroke patients is now routine at DHMC, thanks to a “stroke alert” system. When the emergency department gets word a stroke victim is en route, staff are prepared to act even before the patient arrives.

Lukovits and an interdisciplinary team of colleagues are also collaborating on three clinical trials to find other ways to treat and prevent the devastating consequences of stroke.

Lukovits is principal investigator at DHMC for a trial called CLOSURE-I, for patients with patent foramen ovale—a hole in the septum, or wall, separating the upper chambers of the heart. The defect allows blood to circulate back to the body without going through the lungs first. If debris is present, it may travel to the brain and cause a stroke. The standard treatment is blood thinners or to get a device implanted to repair the defect. The multicenter trial is sponsored by the device manufacturer.

Another trial, sponsored by the National Institutes of Health, is for patients with narrowed carotid arteries, which supply the brain with blood. The Carotid Revascularization Endarterectomy vs. Stenting Trial (CREST) is comparing carotid endarterectomy, surgical removal of arterial plaque, to stent-assisted carotid angioplasty, in which a tiny balloon is temporarily inflated in the artery and a mesh tube inserted to hold the vessel open. Dr. Richard Powell, a DHMC vascular surgeon, is the principal investigator and DHMC is one of 110 participating centers. It is “the largest trial comparing stenting and endarterectomy ever,” says Lukovits.

**Factor:** And Lukovits is the principal investigator of a trial DHMC just joined, to determine if Factor VII, a clotting factor typically administered to hemophiliacs, is safe and effective way to stop bleeding in patients with acute intracerebral hemorrhaging. About 15% of strokes are due to such hemorrhaging. Currently, “there’s no proven treatment,” says Lukovits.

While Hunt is not participating in any of the trials, she and Lukovits are working hard to ensure that she won’t have another stroke. She doesn’t smoke or have high blood pressure, two risk factors. But she discovered that she has high cholesterol and diabetes, also risk factors. She’s being treated for both.

Laura Stephenson Carter

Tanzanian agreement targets the global impact of AIDS

In Tanzania, when you hire someone for a new position, you often have to hire two people because one will [soon] be dead from AIDS”: Dr. Stephen Spielberg, the dean of Dartmouth Medical School, was sharing something he’d been told by Dr. Kisali Pallangyo, his counterpart at a Tanzanian medical school. Tanzania has some of the highest HIV infection rates in the world, Spielberg went on, and its social fabric is unraveling as many young, potentially productive members of society are lost to AIDS. And those who’ve died have left behind more than a million orphans.

“I’s international AIDS important?” Spielberg asked. Then he answered his own question: “Yes.”

**Mark:** DMS’s dean was speaking at a ceremony in November to mark the signing of an agreement between Dartmouth and Tanzania’s Muhimbili University College of Health Sciences (MUCHS).

On the Dartmouth side, the joint effort—called the Global Health Initiative—is being led by DMS and Dartmouth College’s John Sloan Dickey Center for International Understanding. It also involves Dartmouth’s Tuck School of Business and Thayer School of Engineering. Projects under way include the creation of a global health program in Tanzania; public programs at Dartmouth to raise awareness of the global health threat of avian flu.

**Laura Stephenson Carter**
awareness of global health issues; a new course in global health for undergraduates; and even a course in Kiswahili, one of the languages spoken in Tanzania. DMS and MUCHS students and faculty will also study and do research at each other’s institutions. And Tuck students have been invited to determine the feasibility of developing a pharmaceutical industry in Tanzania.

The initiative builds on the DARDAR project, a collaboration between Dartmouth and MUCHS that began in 2000. Led by Dr. C. Fordham von Reyn of DMS and Dr. Pallangyo, DARDAR includes a clinic for children with HIV/AIDS, a trial for a tuberculosis vaccine, and a five-year Fogarty Foundation grant for training researchers in Tanzania. The word DARDAR was drawn from the first three letters of “Dartmouth” and of “Dar es Salaam,” the city where MUCHS is located. In addition, the acronym is similar to the Kiswahili word “dada,” which means "sister," emphasizing the relationship between the two institutions.

Contacts: “When we go overseas, we look to . . . where there are already good contacts made with a strong academic institution we can partner with,” said Dickey Center Director Kenneth Yalowitz at the November event. Yalowitz, who is a former ambassador to Belarus and Georgia, retired from the U.S. Department of State in 2001 and so has considerable experience with global initiatives.

“We’re trying to approach these kinds of problems not just as isolated medical issues, and not just as isolated social issues,” Spielberg said, “but as a continuum of society. Is [AIDS] important to all of us in the world?”

Yes—that’s the clear answer from Dartmouth.

Laura Stephenson Carter
representative of the Children’s Alliance of New Hampshire.

Lampman says he is drawn to public policy for the same reason that he is drawn to medicine. “You just want to help people,” he explains. “You want to make other people’s lives better.” He and fellow PHPAC members have also been inspired to act by the health-care inequalities they have witnessed both during their clinical rotations and in their personal lives.

Wonder: “Coming into medical school,” says Salma Dabiri, a fourth-year medical student and a PHPAC member, “I always thought there were never enough resources.” But as her training has progressed, “you start to wonder,” she says. “Is it that those resources are there and they’re just not appropriately distributed? That’s a different question entirely. It’s difficult to ask all these questions when you’re so fully involved in your day and you’re taking care of your patients.”

Rob Lampman, who starts his clinical rotations this fall, worries that he, too, will feel the time constraints of the clinical setting and will not be able to play as active a role in PHPAC. “We are looking for another student to pick up leadership of this organization,” he says.

The U.S. health-care system is full of gaps, points out O’Donnell, so “the Robs of the world are trying to make a system without gaps.” And O’Donnell is staying on the lookout for more “Rob” to make PHPAC an ongoing force at DMS.

Jennifer Durgin

Laying the groundwork for gene therapy

A few years ago in France, 10 children with a severe immunodeficiency disorder—made famous by the “boy in the bubble”—underwent a new gene therapy treatment. Initial results were spectacular. Nine of the 10 children, who otherwise would have died, were pronounced free of the disorder. But shortly thereafter, three of the “cured” children developed leukemia.

When it was discovered that the leukemia had been caused by the treatment, the worst fears about gene therapy were realized. If genes can be inserted into someone’s DNA to “fix” a disorder, could those genes also cause new problems? The French trial (known as X-SCID) showed the answer was “yes.”

Lab: With that realization, the field of gene therapy was pushed back to the lab bench. It was clear that scientists needed to understand more about gene therapy in order to make it safe. One of the scientists doing that bench work today is Dr. Michael Greene, a hematology-oncology fellow at DHMC and this year’s Tiffany Blake Fellow. The Tiffany Blake Fellowship, underwritten by the Hitchcock Foundation, funds a year of research for a physician just beginning an investigative career.

The fellowship will fund Greene’s research on retroviruses—molecular vehicles, or vectors, by which therapeutic genes are inserted into a cell. Greene aims to reveal some of the factors that determine exactly where a retrovirus inserts itself.

Until X-SCID proved otherwise, many researchers assumed that retroviruses (and the therapeutic genes they carry) inserted themselves randomly. Greene recalls being taught this in the mid-1990s. “I specifically learned that retroviruses insert randomly into the genome,” he says. “Now that I’ve become interested in this problem, I’ve gone back to the research of the ’80s and ’90s, and it’s pretty clear that that thought wasn’t true.” There may be a random component, he explains, but there are other factors at play, too. Understanding these factors is a small but vital step toward making gene therapy safe and realizing its potential—possibly curing hundreds of diseases caused by genetic mutations.

Greene has been interested in gene therapy ever since learning about it as an undergraduate biology major at Clarkson. Since earning an M.S. in cellular and molecular biology at West Virginia University in 1996 and his M.D. at the University of Connecticut in 2000, he’s been at DHMC—first as a resident and now as a fellow. He used his elective time during residency to work in the lab of Dr. Christopher Lowrey, who studies gene therapy, and will conduct his fellowship research there.

One day, Greene hopes to direct his own lab, but he doesn’t want to do research full-time. “I want to always work with people,” he says. He recently did a two-month rotation at the Fred Hutchinson Cancer Research Center in Seattle, where he gained experience with bone marrow transplants from one individual to another. (In most bone marrow transplants at DHMC, patients are given their own treated cells.) “The way of getting gene therapy . . . into people,” says Greene, “is with a bone marrow transplant,” so the training will likely come in handy.

Wide eyes: “My ultimate goal,” Greene adds, “is to be the old doctor at some medical school somewhere, where young medical students with wide eyes are going to come up and ask me what it was like to treat people with cancer with poison [chemotherapy] . . . back in those dark times.” Given Greene’s accomplishments so far, he appears to be headed in that direction.

“He’s one of the best lecturers around,” says Lowrey, who enlisted Greene to help teach pharmacology and hematology-oncology. “He has an unbelievable knowledge of medicine,” adds Lowrey, “and the students just love him.”

Jennifer Durgin
Team turns to evidence to treat childhood trauma

Teenagers today live in a shooting-gallery world,” explains Stanley Rosenberg, Ph.D. “They get beaten up by sibs, by parents, by neighborhood gangs. If you look at who is being victimized in our culture, adolescents are just up there at the top.” Up there helping them, though, is Rosenberg, a professor of psychiatry at DMS and a longtime trauma researcher.

Childhood physical and sexual abuse are the most toxic forms of trauma and can lead to post-traumatic stress disorder (PTSD). Less intense forms of trauma, too, such as witnessing a sudden death or surviving a car accident, can sometimes lead to PTSD. And early exposure to trauma can result in “very non-optimal ways of adapting to the world,” says Rosenberg, including substance abuse, academic failure, and involvement with the criminal justice system—all of which can be risk factors for poor functioning in adulthood, including mental illness.

Early: The key is to intervene early, says Rosenberg, “to limit these toxic, self-exacerbating cycles that people get into following trauma exposure.”

Rosenberg is heading a project that aims to do just that, by providing evidence-based treatments to New Hampshire adolescents and their families who have experienced traumatic events, have developed related emotional problems, and are served by the state’s 10 community mental health centers. Called the Project for Adolescent Trauma Treatment (PATT), the initiative is funded by a four-year, $1.6-million federal grant—one of only 19 given out in 2005 by the U.S. Substance Abuse and Mental Health Services Administration. PATT is operated out of the Dartmouth Trauma Interventions Research Center (DTIRC), which Rosenberg heads.

PATT will be implemented first at West Central Behavioral Health, an agency with offices in Lebanon, Claremont, and Newport, N.H. Then the evidence-based practices will be disseminated to the other nine centers. Establishing a new model of care can be tricky, since historically mental-health clinicians have chosen from a variety of treatments that haven’t been tested head-to-head.

Evidence: “We have a system where clinicians kind of do what feels right to them,” says Rosenberg. “It has a lot to do with training [and] regional variation. . . . We really want to shift that thinking, saying, ‘Look, we have to refer to the hard evidence and prioritize care based on what the science shows us is most likely to work.’” Because West Central has worked with DTIRC from the beginning of the grant process, “they absolutely buy into the principles,” Rosenberg says. “They are great partners.”

The treatment Rosenberg’s team selected is trauma-focused cognitive behavioral therapy (TF-CBT). Thanks to the grant, DTIRC was able to join the National Child Traumatic Stress Network, which did initial training in TF-CBT for West Central clinicians. DTIRC supervisors are continuing the process, using a train-the-trainer model.

Now, adolescents who come to West Central fill out an online screening survey, developed by DTIRC, which assesses them for trauma and PTSD symptoms. “What you want to see are the cases in which [teens] aren’t going to get over their symptoms. So you want to target them first—the ones who really need help,” says Harriet Rosenberg, M.A. She is a coadministrator of the PATT grant and a longtime research partner of Stan Rosenberg’s, as well as his wife.

Trauma-focused cognitive behavioral therapy has two aspects: exposure therapy and cognitive restructuring. The exposure aspect involves creating a coherent narrative of the traumatic event to overcome associated painful feelings. The idea behind cognitive restructuring is that “thinking influences your feelings, and life experiences influence that thinking, and the thinking is not always accurate,” explains Kim Mueser, Ph.D., a coinvestigator on the grant.

Trust: For example, an adolescent who was physically abused five years ago may still be holding on to certain no-longer-accurate beliefs and thus feel unable to trust anyone in authority. The treatment involves “figuring out what the thinking is you’re doing, examining the evidence behind it, challenging it, and when it’s not accurate changing it,” says Mueser.

DTIRC chose cognitive behavioral therapy because “it has the most research support behind it of any other trauma treatment out there for adolescents,” according to Mary Kay Jankowski, Ph.D., director of PATT.

The grant actually has both a short-term and a long-term goal, says Stan Rosenberg—to “transform systems so that [the centers] know and use these models,” but also to transform “the whole mindset . . . such that eight years from now, when we’ve made evolution in treatment technologies and when new models come on board, that they’re also going to use those.”

Matthew C. Wiencke
In this section, we highlight the human side of clinical academic medicine, putting a few questions to a physician at DMS-DHMC.

Patricia Glowa, M.D.
Assistant Professor of Community and Family Medicine

Glowa, who’s been at Dartmouth since 1995, was named Family Physician of the Year in 2005 by the New Hampshire Academy of Family Physicians. She specializes in women’s and children’s health and child sexual-abuse evaluations.

How did you decide to become a doctor?
After leaving school halfway through my bachelor’s in English, I was working in New York and got the flu—genuine, sick-for-a-week flu. I found myself thinking about medicine. I had always enjoyed science and math and wanted to be in a helping profession, but it had never crossed my mind before to consider medicine—which I think was part of the gender legacy at the time.

When did you choose family medicine?
When I was at Harvard Medical School—which is the farthest thing from a proponent of family medicine one can imagine. My image of medicine was my family doctor from childhood in Springfield, Vt. When I spent a rotation with a family doc in Gardner, Mass., it became clear that was what I wanted to do. And when I went to Rochester, N.Y., for residency, the program director was my childhood family doctor!

Are there any misconceptions that you find people have about family medicine?
Primary care, and family medicine in particular, tend to be at the bottom of the medical hierarchy in terms of respect. In family medicine, you have to stay competent with a very wide variety of medical issues. There are some particular skills required in family medicine, such as learning your limits, coping with uncertainty, and navigating the boundaries of almost all the specialties. It is a complex job. I think a lot of other folks in medicine don’t quite get some of the complexities and so don’t give us credit for what we do.

What advice would you give to a medical student who is considering family medicine?
Figure out if you enjoy a good deal of what family docs do. If there are a variety of things you enjoy that only partially mesh with another field, maybe you want to be a family doc.

What have been the most fulfilling aspects of your career?
I love obstetrics. Obstetricians take care of people during pregnancy and delivery, and pediatrics pick up the babies afterwards; I get to do both. I also enjoy some things nobody else likes to do, such as child sexual-abuse evaluations. It’s high emotional intensity and has high potential for burnout, but I really enjoy being able to do that work—helping kids have non-traumatic exams after they have been in terrible circumstances and advocating for child health.

How do you avoid getting burned out on that work?
Because it’s only a part of what I do.

What about you do you think would surprise most people?
I’m a mildly obsessed amateur potter. And, as Garrison Keillor puts it, I am a recovering shy person. I don’t present as being particularly reserved, but I’m pretty introverted really.

What bores you?
I don’t do things that are boring. I don’t have time. I can’t remember being bored in a very, very long time.

Not even doing paperwork?
Oh, that’s aggravating. That’s not boring. It’s got to be done. I plow my way through it. Most of it requires some thought process.

Is there a famous person, living or dead, whom you would like to meet or spend a day with?
Probably one or more of the early suffragists.

Putting relationships at the center of medical education

It sure wasn’t your run-of-the-mill, speaker-at-a-lectern professional meeting. As the official program got under way, deans and faculty members from nine medical schools engaged in animated conversation, told stories, shared their feelings, and got to know each other—and themselves—a lot better. They also learned how to practice “appreciative inquiry” by framing questions in positive rather than negative terms.

Concept: The attendees had been invited to Indiana University School of Medicine for what was billed as an immersion conference on relationship-centered care (RCC). An outgrowth of a movement known as patient-centered care, RCC expands on that concept. Its basic premise is that patient care is affected by a physician’s relationships not only with patients and their families, but also with other healthcare professionals and with the community at large.

Medical students learn how to conduct themselves in an organizational culture largely by means of what’s come to be called the “hidden curriculum”—the attitudes and values that get transmitted outside official classes. Dartmouth’s Dr. Joseph O’Donnell, senior advising dean at DMS and one of the attendees at the conference, wants to shed a lot more light on the process. He sees a gulf between what students are taught officially about...
ON TARGET: Dr. Edward Merrens, chief of hospital medicine at DHMC, got to tour Turin as a physician for the U.S. Olympic biathlon team. Biathlon is cross-country skiing combined with rifle sharpshooting; Merrens was a cross-country skier in college.

Joe O'Donnell, left, has recruited especially articulate patients like Holly Field, right, to talk with medical students, as one of many ways to help them realize the power of relationships.

The conference came on the heels of DMS's preparations for a reaccreditation site visit last year, in which all aspects of medical education were evaluated.

Lack: The School had learned from a student-run survey that below the surface, students feel surprisingly high levels of loneliness, isolation, and inadequacy and a lack of approachable role models. DMS is known for having a collegial and supportive atmosphere and a humanistic faculty and student body, so administrators were surprised by these findings. O'Donnell was determined to respond—to become “the best in the world” at caring for those who study and work within its walls.

Students say they don't know “who to go to,” says O'Donnell. “There’s no place for them to show vulnerability.” This is not unusual for medical students at other schools, but O'Donnell knew Dartmouth could do better.

The meeting in Indiana could have been called a physician-heal-thyself session, since one precept of RCC is that caregivers need to themselves experience self-knowledge, appreciation, a sense of belonging, and values in their own lives before they can transmit these qualities to students, each other, and their patients.

The DMS team brought to the meeting ideas gleaned from many years of experience working with students. Those who joined O'Donnell in Indiana were Dr. Lori Arviso Alvord, associate dean of student and multicultural affairs at DMS; Sue Ann Hennessy, assistant dean of student affairs at DMS; Tommy Woon, associate dean of pluralism and leadership at Dartmouth College; and Dr. Nan Cochran, an associate professor of medicine who has worked on RCC efforts with O'Donnell.

The challenge of implementing RCC is a huge one, yet success is measured in small, human ways. The DMS team returned to campus with ideas they hope to implement soon. They range from the broad and formal—for example, to get the whole School to adopt the values of RCC—to the informal and personal—to show joy in their work, to show empathy everywhere, to know each other better, to say thank you.

The team has decided to use three new student societies, formed to foster cooperation across all four years, to carry the RCC message. O'Donnell and the other mentors of these societies hope that will give students the “feel-safe place” they lacked.

“Bringing RCC into the societies,” O'Donnell says, “brings more connectedness to each other and to the School . . . We've got our feet in the water, but we have to go a little deeper.”

Lessons: Armed with stories, poems, and life lessons, the Indiana conferees summed up their experiences by writing about the difference this unusual conference had made in their commitments to each other and to their profession.

One wrote this: “I sat and looked at the microphone at the end of the meeting, flooded with thoughts and feelings. Joe just used the word ‘ripple waves’ as I felt this flood. Tom talked about bringing our whole self into life and our work life. . . . I have been a reflective and emotional person, I guess forever. In my professional life I have adopted a ‘quiet’ life. . . . Often I tell myself I am satisfied with my quiet accomplishments, but in some ways the concept over the past few days has made me realize that I can take my ‘quiet’ skills and inject them into the culture of medicine . . . take the risk and hope that I can leave an impact that will be ‘heard.’”

Rosemary Lunardini

A reminder of the pace of change, and of timeless truths, from the Spring 1986 issue of this magazine:

Dr. Ross McIntyre, then director of Dartmouth’s Norris Cotton Cancer Center, wrote about a 1985 visit to the Soviet Union: “I learned that there were more than twice as many hospital beds per capita in the U.S.S.R. as in the United States . . . but that the percentage of the gross national product devoted to health was about one-fifth that of this country. The apparent discrepancies in statistics were resolved by the comment made by one observer that hospitals in the Soviet Union were ‘dormitories’ for people who didn’t feel well.”

Today, Russia spends 6.2% of its gross domestic product on health care, compared to 14.6% in the United States.
TEEN TIME: Through the Rural Health Scholars program, DMS students have been volunteering weekly at Lebanon, N.H., High School. They discuss health issues the teens will face as they become independent of their parents, such as health insurance.

**Then & Now**

A reminder of the pace of change, and of timeless truths, from the 1970 Mary Hitchcock Memorial Hospital annual report:

In 1970, the MHMH Business Office had “close to 40 people taking care of” all financial services, using “machines that turn out hundreds of thousands of punch cards, giving us information we once had to write by hand.” Especially in the area of patient accounting, the report explained, “we’ve come a long way. . . . When private insurance was first introduced, it caused a flurry! . . . It has taken a lot of ingenuity to keep up with the paperwork required by third parties.”

Health-care finances, and the institution, are far more complex today; the same functions require 220 full-time-equivalent positions.

**Policy-makers get a look at how decisions play out**

In January, nine New Hampshire policy-makers donned white medical coats and spent a day learning what it’s like to be a doctor at DHMC. They weren’t allowed to actually treat patients, of course, but they got to shadow physicians during inpatient rounds, outpatient visits, and even in the operating room. They were participating in Project Medical Education (PME), designed to give legislators and other policy-makers a better understanding of the complexities of academic medicine.

“One of our key goals in doing this is really demystifying the process of medicine,” said Dr. Stephen Spielberg, DMS’s dean, at the program’s welcoming dinner. At a post-dinner “graduation,” the policy-makers were all given a white coat, a statement of their medical school “loan debt,” and a “residency assignment” for the following day.

The participants were excited and a bit nervous as they began their nearly three-hour clinical experience the next morning. But the real medical residents who were their hosts quickly put them at ease. Afterward, the policy-makers were eager to offer feedback about PME to DHMC officials.

**Watching:** “I expected maybe they wouldn’t be too happy to have a politician watching them,” said New Hampshire State Senator Robert Clegg. “It was just the opposite. Of course, surgery was interesting. The attending physician was more than happy to treat me like I was really a resident and explain everything he did.”

“The one thing that stood out for me is how much attention these patients were getting,” said Darwin Cusack, chief of staff to one of New Hampshire’s U.S. Congressmen, Charles Bass. Cusack was also impressed with how well the physician he shadowed explained a patient’s situation to a family member. “He went over it in technical terms first and then went over it all again in terms she could understand and made sure that she knew exactly what the state of play was and answered all of her questions.”

**Code blue:** “I learned that you don’t take the elevator” when responding to a code blue, said New Hampshire State Representative Fran Wendelboe. She described needing to hustle up the stairs as her team rushed to the aid of someone who had gone into cardiac arrest.

In addition to shadowing residents, the policy-makers learned about the complexities of financing graduate medical education, visited several labs, heard from physician-scientists about the important role research plays in patient care, and were introduced to the daunting process of diagnosing a puzzling case.

**Act:** DHMC’s PME was based on a program of the same name run by the Association of American Medical Colleges (AAMC). It’s designed to give policy-makers information so they can make insightful decisions on issues that affect academic medical centers. The AAMC program began in the wake of the Balanced Budget Act of 1997, “which posed the most serious threat to federal support for our missions in recent memory and which heightened a long-standing concern about the meager understanding most policy-makers have of academic medicine,” according to Dr. Jordan Cohen, the president of the AAMC.

Legislators and government officials typically underestimate
the years of education and training required to become a physician, for example; have little appreciation of the degree to which educators are involved in research and patient care; don’t understand how research improves patient care; and don’t realize how much care academic medical centers and teaching hospitals provide for underserved and uninsured patients.

Without a full understanding of what such institutions do, legislators have no way to anticipate the impact that their budget cuts may have on academic medical centers.

Funding: In New Hampshire, funding for DHMC is in jeopardy partly because people don’t understand what graduate medical education is, explains Gina Balkus, DHMC’s director of government relations for New Hampshire. Balkus organized the PME program along with Dr. Worth Parker, DHMC’s director of graduate medical education, and Frank McDougall, vice president of government relations for the Medical Center. It was such a success that they plan to offer it again in June.

“Legislators who took part in the program now understand the challenges we face as an academic medical center,” says Balkus.

In fact, Senator Clegg, who is the chamber’s majority leader, has expressed an interest in establishing a loan forgiveness program for DMS graduates who agree to practice in New Hampshire’s underserved areas. “This is a direct result of his participation in the PME,” says Balkus.

Laura Stephenson Carter

---

**INVESTIGATOR**

In this section, we highlight the human side of biomedical investigation, putting a few questions to a researcher at DMS-DHMC.

**Michael Beach, M.D., Ph.D.**

Associate Professor of Anesthesiology

Beach, a medical statistician as well as an anesthesiologist, studies the impact that movie exposure has on adolescent smoking behavior. His other research interests are pediatrics sedation safety and screening in underserved populations.

What made you decide to go into statistics?

It’s fascinating—it has just the right amount of complex mathematics, computer programming, and application to real problems. And while many people think that statistical techniques haven’t changed since the publication of Euclid’s Elements, the field is quite dynamic. The analysis of longitudinal data and techniques for computing missing data are two of the more recent advances. Deleting from a statistical analysis patient records in which only some of the relevant data is missing can lead to errors of bias and loss of precision.

What clinical areas do you specialize in?

I spend some of my clinical time involved with pediatric anesthesia and some involved with ultrasound-guided regional anesthesia.

If you hadn’t become a medical scientist, what would you like to be?

Probably a high school math teacher. I was a telephone solicitor for a summer, and I know that I wouldn’t do that again.

What’s the last book you read?

I recently read *Flyboys* and *Flags of Our Fathers*, both written by James Bradley. I am in awe at what those men did and what they endured as pilots and soldiers in World War II.

---

**INSIGHT**

If you could travel anywhere you’ve never been before, where would it be?

Either Mongolia or Bhutan. I’d like to do some horseback riding in Mongolia and also see some of the festivals there.

What is the toughest lesson you’ve ever had to learn?

The one I haven’t been able to learn is not to put off tasks until the very last minute.

What about you would surprise most people?

Not much, I hope.

Who was your scientific mentor?

As a statistics graduate student, I did my dissertation with Paul Meier. He was a pioneer in the development of tools to analyze censored data. The Kaplan-Meier curve is his most well-known contribution to the field.

What professional accomplishment are you most proud of?

I have had the good fortune to volunteer with Interplast ([www.interplast.org](http://www.interplast.org)), an organization that provides plastic surgery to patients in developing countries. I help provide the anesthesia care for children who primarily are having cleft lip or cleft palate repairs. These are children who potentially would grow up as adults with a facial deformity that we just don’t see in this country because every child who has it gets it repaired. With Interplast, I have traveled to Nepal, Bangladesh, Timbuktu, and Vietnam.

What advice would you offer to someone contemplating going into your field?

I think the ability to read the medical literature critically demands that every physician have an understanding of some basic statistical concepts—not advanced methods. Almost all “statistical” mistakes are in the interpretation of the particular model that was used or test that was performed on the data of interest.

What’s your favorite nonwork activity?

I’ve been trying over the last two years to get my private pilot’s license. It’s been a slow go, but I’m almost there. I also like to scuba dive, but I prefer very warm oceans rather than very cold lakes.
Among the people and programs coming in for prominent media coverage in recent months was Dr. Jonathan Ross. In the “Diagnosis” section of the New York Times Magazine, the DHMC internist—“a tall wiry doctor with large silver-rimmed glasses and a gentle manner”—solved a medical mystery. “I think this is scurvy,” the magazine quoted Ross as saying to his medical team, which was taking care of a patient crippled with a puzzling illness. “He said they needed to start treating her immediately,” the magazine recounted. “The team was skeptical. . . . [But] by Day 5 [of treatment with vitamin C], the patient was able to walk again, though she had to use a walker.”

In Peter Jennings’s last documentary for ABC News before he died of lung cancer, he interviewed DMS physician-researcher Elliot Fisher. “Dr. Fisher and his fellow researchers at Dartmouth Medical School studied the relationship between how much is spent on health care and how beneficial that health care is,” said the narrator of the documentary. “The findings were pretty consistent,” Fisher told Jennings. “More medical care did not result in better medical care. In fact, it goes the other way, if anything.” Fisher’s work was also mentioned in a recent Wall Street Journal editorial and in a feature in the Economist.

Nightmares aren’t the only sleep problems that affect kids. In an article in the Pittsburgh Post-Gazette, “Dr. Michael Sateia, [former] president of the American Academy of Sleep Medicine, noted that the American Academy of Pediatrics now recommends that pediatricians screen all children for snoring, which can be a sign of sleep problems. ‘This is part of a growing recognition of the importance of healthy sleep and sleep disorders in childhood,’ said Sateia, a professor of psychiatry at Dartmouth. ‘Pediatricians are beginning to recognize how common sleep-related problems of all kinds are during childhood and what impact these disorders have on . . . children.’”

In January, after Israel’s Ariel Sharon suffered a stroke, National Public Radio’s All Things Considered interviewed a DHMC expert about medically induced comas. “Dr. James Bernat is a professor of neurology at Dartmouth Medical School,” the show’s host said. “He says the goal of a medically induced coma is to reduce the work of the brain cells and protect them from increased pressure inside the skull or after an event such as stroke.” Another NPR show, Weekend Edition, also talked with Bernat, to get his opinion on an unusual case in Massachusetts. One day after a court decided that an 11-year-old girl in a coma should be allowed to die, the girl awoke. The debate over the case “echoed that over Terri Schiavo,” observed the NPR reporter. “But Dr. James Bernat says the two cases are different. ‘Mrs. Schiavo was in a vegetative state for 15 years,’” he pointed out.

“A funny thing is happening to hypnosis,” according to Prevention. “It’s becoming respectable.” In an article titled “The Healing Power of Hypnosis,” the magazine featured a DHMC nurse who was having trouble getting pregnant until she underwent hypnosis by “Da-Shih Hu, M.D., a psychiatrist and an assistant professor at Dartmouth Medical School.” Among the many medical centers—and the many different hypnotic treatments—also mentioned in the article was “Dartmouth-Hitchcock Medical Center, [where] doctors use hypnosis to reduce pain and nausea” during certain epilepsy diagnostic procedures.

Major newspapers in Boston, Washington, D.C., Baltimore, Seattle, Ottawa, and London, as well as radio and TV stations worldwide, consulted a DMS epidemiologist about a fiber study that appeared recently in the Journal of the American Medical Association. “In an editorial in the same

New on the bookshelf: Recent releases by DMS faculty authors


 Principles of Physiology. By Matthew N. Levy, M.D.; Bruce M. Koeppen, M.D., Ph.D.; and Bruce A. Stanton, Ph.D., professor of physiology at DMS; Elsevier Mosby; 2006 (fourth edition). This textbook, designed as a text for medical students, shows how advances in molecular biology and genetics affect understanding of human physiology. It includes new insights into the cardiovascular, respiratory, and endocrine systems—such as the mechanisms of hormone action and the regulation of energy storage. Each chapter relates the abstract physiological concepts to specific clinical conditions.

VITAL SIGNS

MEDIA MENTIONS: DMS

Among the people and programs coming in for prominent media coverage in recent months was Dr. Jonathan Ross. In the “Diagnosis” section of the New York Times Magazine, the DHMC internist—a tall wiry doctor with large silver-rimmed glasses and a gentle manner—solved a medical mystery. “I think this is scurvy,” the magazine quoted Ross as saying to his medical team, which was taking care of a patient crippled with a puzzling illness. “He said they needed to start treating her immediately,” the magazine recounted. “The team was skeptical. . . . [But] by Day 5 [of treatment with vitamin C], the patient was able to walk again, though she had to use a walker.”

In Peter Jennings’s last documentary for ABC News before he died of lung cancer, he interviewed DMS physician-researcher Elliot Fisher. “Dr. Fisher and his fellow researchers at Dartmouth Medical School studied the relationship between how much is spent on health care and how beneficial that health care is,” said the narrator of the documentary. “The findings were pretty consistent,” Fisher told Jennings. “More medical care did not result in better medical care. In fact, it goes the other way, if anything.” Fisher’s work was also mentioned in a recent Wall Street Journal editorial and in a feature in the Economist.

Nightmares aren’t the only sleep problems that affect kids. In an article in the Pittsburgh Post-Gazette, “Dr. Michael Sateia, [former] president of the American Academy of Sleep Medicine, noted that the American Academy of Pediatrics now recommends that pediatricians screen all children for snoring, which can be a sign of sleep problems. ‘This is part of a growing recognition of the importance of healthy sleep and sleep disorders in childhood,’ said Sateia, a professor of psychiatry at Dartmouth. ‘Pediatricians are beginning to recognize how common sleep-related problems of all kinds are during childhood and what impact these disorders have on . . . children.’”

In January, after Israel’s Ariel Sharon suffered a stroke, National Public Radio’s All Things Considered interviewed a DHMC expert about medically induced comas. “Dr. James Bernat is a professor of neurology at Dartmouth Medical School,” the show’s host said. “He says the goal of a medically induced coma is to reduce the work of the brain cells and protect them from increased pressure inside the skull or after an event such as stroke.” Another NPR show, Weekend Edition, also talked with Bernat, to get his opinion on an unusual case in Massachusetts. One day after a court decided that an 11-year-old girl in a coma should be allowed to die, the girl awoke. The debate over the case “echoed that over Terri Schiavo,” observed the NPR reporter. “But Dr. James Bernat says the two cases are different. ‘Mrs. Schiavo was in a vegetative state for 15 years,’” he pointed out.

“A funny thing is happening to hypnosis,” according to Preventon. “It’s becoming respectable.” In an article titled “The Healing Power of Hypnosis,” the magazine featured a DHMC nurse who was having trouble getting pregnant until she underwent hypnosis by “Da-Shih Hu, M.D., a psychiatrist and an assistant professor at Dartmouth Medical School.” Among the many medical centers—and the many different hypnotic treatments—also mentioned in the article was “Dartmouth-Hitchcock Medical Center, [where] doctors use hypnosis to reduce pain and nausea” during certain epilepsy diagnostic procedures.

Major newspapers in Boston, Washington, D.C., Baltimore, Seattle, Ottawa, and London, as well as radio and TV stations worldwide, consulted a DMS epidemiologist about a fiber study that appeared recently in the Journal of the American Medical Association. “In an editorial in the same
journal,” reported the BBC, “Dr. John Baron of Dartmouth Medical School in New Hampshire said short-term studies appeared to suggest there was no effect from high dietary fiber intake on bowel cancer risk.” (See page 11 for more on Baron’s JAMA editorial.) Baron was also quoted about a trial showing that calcium and vitamin D supplements don’t protect against colorectal cancer. The study was “probably not long enough to observe an effect on colorectal cancer,” Baron told USA Today.

For each day of February, Black History Month, the Indianapolis Star featured a black individual “who made a difference.” Among the honorees was “Dr. Mae Jemison . . . the first black female astronaut in space” and an adjunct professor of community and family medicine at DMS. “After graduating from medical school, she joined the Peace Corps,” explained the Star, “serving as a medical officer in the West African countries of Sierra Leone and Liberia. ‘Having been an astronaut gives me a platform,’” she told the paper, “‘but I’d blow it if I just talked about the shuttle.’ Instead, she brings attention to what she sees as unacceptable disparities in the quality of health care in the U.S. and in Third World countries.”

“The hospital industry has spent nearly $100 billion in inflation-adjusted dollars in the past five years on new facilities, up 47% from the previous five years,” noted a recent USA Today article. For perspective, the paper turned to a DMS expert. “These hospitals are loaded with technology to intensively treat chronically ill patients right up to death,” says physician John Wennberg, director of the Center for the Evaluative Clinical Sciences at Dartmouth. “We know from research that does not improve outcomes, but it does drive up costs.” A Washington Post editorial by Steven Pearlstein and a Wall Street Journal article also cited Wennberg’s work. “We know from John Wennberg and his associates at Dartmouth that as much as half of all health care consumed in some regions is medically unnecessary,” Pearlstein wrote.

“For the first time, the federal Medicare insurance system will pay for certain people over 65 to get an ultrasound screening test to detect abdominal aortic aneurysms, a dangerous ballooning of the body’s main artery that can burst with lethal results,” began an article in the Wall Street Journal. “Robert Zwolak, a Dartmouth Medical School vascular surgeon who has campaigned for the new law,” the Journal continued, “called it ‘a tremendous step forward and a great victory for patients at risk.’” (For more on Zwolak’s campaign, see page 20 of the Summer 2005 DARTMOUTH MEDICINE.)

Countless commuters listened in as “Dartmouth Medical School’s Dr. James Weinstein, one of the nation’s leading experts on back pain,” was interviewed on NPR’s Morning Edition in early March. Featuring two of Weinstein’s patients who were considering back surgery, the segment described how “Weinstein wouldn’t tell his patients what to do,” but rather gave them the best information available about the current treatment choices. “Weinstein is heading a federally financed study . . . to compare the benefits of surgery and nonsurgery,” NPR explained. “Results are due this summer.” Weinstein’s name also cropped up in a Wall Street Journal article about baby slings. The trendy carriers are functional as well as hip, the Journal said, “because they distribute the baby’s weight” better and “allow mom or dad to switch sides periodically. ‘If you can change loads and positions, that’s good for the body,’” Weinstein advised.

Also providing baby-related advice, in the magazine Parenting, was “Jennifer Shu, M.D., director of the newborn nursery at Dartmouth-Hitchcock Medical Center.” Regarding baby sleeping positions, she told Parenting, “I tell my patients: You should still put them down on their backs, but what babies do in the middle of the night is their business.” Later on in the article—titled “Is My Baby Ready To . . .?”—she offered a word of caution about attachable crib toys. “Some [babies] will push the buttons repeatedly until they get sleepy. Other kids will just get more and more wired,” says Dr. Shu, the mom of a four-year-old.

The Kansas City Star recently interviewed Dr. “Lori Arviso Alvord, a Navajo who grew up on a reservation in New Mexico. Today she is a surgeon and an associate dean at Dartmouth Medical School,” the Star said. The article also reported on several talks that Alvord gave in Kansas City. “Her remarks touched on Navajo beliefs, ceremonies, and cultural practices and how they relate to healing,” the Star explained. “For example, she said the traditional Native American lifestyle included a lot of physical activity and a diet rich in fruits, vegetables, grains, and nuts. Meat depended on good hunting and was not a daily staple. Such a lifestyle reflects modern-day exhortations for exercise and low-fat diets.”
Worthy of note: Honors, awards, appointments, etc.

Victor Ambros, Ph.D., a professor of genetics at DMS, received the 2006 Genetics Society of America Medal for outstanding contributions to the field over the past 15 years. Among Ambros’s discoveries was the identification in 1993 of a new family of small genes involved in the orchestration of development and behavior. Ambros’s lab now studies the roles of microRNA-mediated regulatory pathways in animal development and human disease.

Lynn Butterly, M.D., an assistant professor of medicine, was the recipient of the American Cancer Society’s 2005 Sandra C. Labaree Volunteer Values Award in recognition of her efforts to raise colon cancer awareness and screening rates. She headed New Hampshire’s Colorectal Cancer Screening Community Outreach Project and Comprehensive Cancer Collaboration.

James Platt, M.A., an instructor of psychiatry and director of the Dartmouth Faculty and Employee Assistance Program, was recently chosen as the president-elect of the International Association of Employee Assistance Professionals in Education.

David Glass, M.D., a professor and the chair of anesthesiology, received the Accreditation Council for Graduate Medical Education’s John C. Gienapp Award in recognition of his leadership in overseeing the implementation of new national work-hour standards for medical residents.

Sean Hunt, M.D., an assistant professor of anesthesiology, was elected president of the New Hampshire Society of Anesthesiologists.

James Varnum, M.H.A., the president of Mary Hitchcock Memorial Hospital, was chosen to receive the American Hospital Association’s Award of Honor, as well as the Distinguished Service Award of the Regent for New Hampshire. See the feature on page 38 in this issue for more about Varnum’s 28-year career at Mary Hitchcock.

Jennifer Bomberger, Ph.D., a research fellow in physiology, and Emily Cordas, a graduate student in physiology, received the Caroline tum Suden/Frances A. Hellebrandt Professional Opportunity Award from the American Physiological Society. Selected from a nationwide pool of early-career researchers who were first authors on studies, they will present the results of their work at continued on page 60

AN ACT OF GENEROSITY

The Norris Cotton Cancer Center isn’t a museum, but an important piece of history is now on permanent display there: an original copy of the 1971 National Cancer Act (pictured below). The ground-breaking act, signed by then-President Nixon, provided the funding and authority for the National Cancer Institute to lead the nation’s fight against cancer.

The Cancer Center was given a copy of the act—one of only two in existence—by Marilyn Cole, widow of former Nixon administration official Kenneth Cole, who is credited with shepherding the Cancer Act through Congress.

“Our family felt that this was the perfect place for this document,” explains Brady Cole, Ken Cole’s brother; he is a counselor at the VA Medical Center in White River Junction, Vt., as well as a member of the Friends of Norris Cotton Cancer Center. “The Cancer Center embodies the spirit and intent of the act and is a place my brother would have loved,” Brady Cole adds, “because of its sense of inclusion, family, and community.”

CELEBRATING HUMANITY

Noted author and environmental activist Terry Tempest Williams, a recent Montgomery Fellow at Dartmouth, was an unusual choice of speaker for the Norris Cotton Cancer Center’s weekly grand rounds. She’s neither a scientist nor a clinician, but she has lost several family members to cancer. She’s best known for her book Refuge: An Unnatural History of Family and Place, which juxtaposes the 1983 rise of Great Salt Lake, the flooding of a bird sanctuary, and her mother’s struggle with ovarian cancer. Tempest Williams thanked “the nurses, the physicians, the technicians, and health-care providers” who care for cancer patients. “Your honesty, your professionalism, and your humanity have a trickle-down effect on the family,” she said.

“We live dignity, honesty, service, hope, every day, but we rarely talk about it,” said Dr. Mark Israel, director of the Cancer Center at the end of Tempest Williams’s presentation. “And we even much more rarely celebrate it.”

GOING FOR GOLD: As the annual Audrey Prouty Bike Ride, which raises funds for Norris Cotton Cancer Center, got ready to mark its silver anniversary, James Gold was the top fund-raiser (really!). The 25th Prouty, on July 8, has a goal of $1 million.
Worthy of note

continued from page 22

the annual Experimental Biology conference in San Francisco.

KC Wright, M.S., R.D., a registered dietitian in DHMC’s outpatient cardiology clinic, was selected as an evidence analyst by the American Dietetic Association.

The ALS Clinic at DHMC was recently certified as an ALS Center of Excellence by the national ALS Association. ALS is amyotrophic lateral sclerosis, commonly known as Lou Gehrig’s disease. DHMC’s ALS Clinic was only the 24th to be certified by the national association.

The Bone Marrow Transplant Program at DHMC was recently accredited by the Foundation for Accreditation of Cellular Therapy.

The Midwifery Service at DHMC was presented with the “With Women, For a Lifetime” Gold Commendation from the American College of Nurse-Midwives. The award recognizes midwifery services that have provided innovative and compassionate care to women and their families, expanded access to women’s health care, engaged in community outreach, and educated midwifery students.

Errata: An article in the “Discoveries” section in our Winter 2005 issue, about Lee Witters’s work with an enzyme known as AMPK, misstated the degree that he holds. Although Witters is primarily a researcher rather than a clinician, he has an M.D., not a Ph.D. Dartmouth Medicine herewith also grants him a G.S.H. (Good Sense of Humor), since his message informing us of the error read as follows: “Thanks for the . . . story and the awarding of a Ph.D. degree to me (always thought I deserved one!).” And we assign ourselves to a refresher course in fact-checking—especially since, more seriously, there was an error in a “Vital Signs” article in the same issue. A story about a new approach to treating pancreatic cancer stated, “So far, the cancer has not returned in patients who had surgery.” The passage should have stated that there had been no local recurrences of the cancer in those patients—in other words, no further evidence of pancreatic tumors, although there may have been metastases elsewhere. We regret all errors, but especially one of such substance.

Letters

continued from page 27

fall of 2006. While I was in Hanover for my interviews, I was given a copy of Dartmouth Medicine and I loved it.

I wonder—am I eligible to receive a subscription at my home here in Arizona? If so, I would love to get on your mailing list.

Many thanks!

Mark Tyson
Tucson, Ariz.

Article aficionado

I am the father of a premed student at Colgate and also make quarterly visits to my neurologist, Dr. Thomas Ward, at DHMC, where I have often enjoyed the articles in Dartmouth Medicine.

I notice that it’s possible to be added to your mailing list. May I please subscribe?

Frederick R. Lofgren
Lyndeborough, N.H.

We are happy to add to our subscription rolls anyone who is interested in the subjects we cover. See the box on page 25 for details.

Consider… Baynes Road at Meriden Village!

• New homes in a “Village Main Street” setting
• Historic New England facades
• Small town “rural” character
• Strong sense of community
• Highly regarded elementary school
• Views, common land, open fields and woods
• Adjacent to Kimball Union Academy
• Quick commute to Dartmouth and DHMC
• Several homes under construction and available for immediate purchase.
• A limited number of individual lots available as well.

HANOVER • 603/643-6400
W. LEBANON • 603/298-5155
GRANTHAM • 603/863-3838

McLaughry REAL ESTATE

www.mclaughry.com

NORWICH • 802/649-3830
FAIRLEE • 802/333-4701
WOODSTOCK • 802/457-8100