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-

These children in Ecuador are learning how to brush their teeth, thanks to MEDLIFE.

mental organizations (NGOs). In the wake of January's earthquake in Haiti, criticism was leveled at some groups' short-term, medical mission model of aid. Dr. Paul Farmer—the United Nations deputy special envoy to Haiti and a founder (with Dartmouth President Dr. Jim Yong Kim) of Partners in Health, an NGO that got its start in Haiti—has been especially critical. "There's graffiti all over the walls in Port au Prince right now saying 'Down with NGOs'" Farmer said in a speech last spring. "I think people in the NGO world need to read the writing on the wall." What NGOs ought to do in such situations, according to Farmer, is focus on sustainable solutions that address the populations' long-term needs.

"MEDLIFE is unique in several ways," explains Colin Pile, the group's director of finance. "We're trying to reform the traditional medical mission into something more comprehensive, something longer lasting."

As part of that effort, the group tries to maintain a year-round presence in communities where they send volunteers and to follow up on the care provided by volunteers.

MEDLIFE now has several paid employees, but all the time Ellis has devoted to the group has been on a volunteer basis. In fact, he spread his DMS fourth-year requirements over two years so he'd have more time to spend on MEDLIFE. "It's a cliché, but if you love what you do, it doesn't feel like work," he says.

The organization has expanded rapidly and now has chapters on over 20 college campuses nationwide. Two chapters are currently being established in England. In the 2009-10 academic year, MEDLIFE sent 18 student groups to Ecuador and Peru and worked with 90 communities. This past summer alone, volunteers served over 5,000 people.

Useful: Ellis is now deciding what specialty to do his residency in. He's wavering between general surgery and emergency medicine, both of which he feels would be useful in the developing world. He also plans to continue to expand MEDLIFE.

But in the long term, his goal is actually for MEDLIFE to leave Ecuador. To that end, the group is cooperating with the ministry of health and education and with medical personnel in rural communities. "That's how you get to sustainability," Ellis says. "If we make sure communities own these projects . . . , 10, 20 years down the road, it doesn't require us being there."

Sarah Schewe

FACTS & FIGURES

All over the map

Number of hospital beds per 1,000 people

13.9
In Japan, highest of the 30 industrialized nations in the Organization for Economic Cooperation and Development (OECD)

3.8
Average in the 30 OECD nations

3.1
In the United States

2.2
In New Hampshire

1.7
In Mexico, lowest of the 30 OECD nations

Health-care spending per capita

$8,235
In New Hampshire

$7,290
In the United States, highest of the 30 OECD nations

$2,964
Average in the 30 OECD nations

$823
In Mexico, lowest of the 30 OECD nations

SOURCES: OECD HEALTH DATA (2007 OR MOST RECENT AVAILABLE FIGURES), NEW HAMPSHIRE HEALTHCARE DASHBOARD (2008 FIGURES), STATEHEALTHFACTS.ORG (2008 FIGURES)