Blood Pressure

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products. Chemically modified hemoglobin has a short half-life, only 12 to 24 hours, which may be enough to keep someone alive while being transported to an emergency room. But once there, the patient would need regular red cells.

AuBuchon, who was the medical officer of blood services at the American Red Cross's national headquarters prior to coming to DHMC in 1990, says he has “the utmost respect for the Red Crossers we deal with.” Yet something in the system isn't working as well as it used to, he believes.

“The long-term implication I can see is the decentralization of the blood supply,” AuBuchon predicts. “That's not necessarily good. In my opinion—this was an opinion I had formed when I worked for the Red Cross and I still believe it—donor recruitment works best when there is a single recruiting organization within one community. So donors don’t get confused, they get a single message. Donors want to donate because they are helping patients. They don’t want to get caught in the cross-fire of two organizations that are competing for their allegiance. So we have been very careful about how we have begun recruiting by trying to make the message a very individualized one, and trying to focus on those people the Red Cross . . . is not fully utilizing as donors. As we go further down this pathway, we will see even more competition for donors.”

What does AuBuchon see for the future? “The Holy Grail is for a pathogen-inactivated universal red-cell unit,” he says. “Pathogen reduction is a couple of years away, and toxicity concerns are still significant.” He doesn’t expect to see artificial blood or hemoglobin solutions being widely used any time soon—they don’t work long enough and the cost is huge, he says.

“For the time being, there's only one place to get oxygen-carrying capacity, and that's from the arm of a human donor,” AuBuchon says—as he holds his right arm high and presses a gauze pad to the inside of his elbow against a spot where there was a needle just a few minutes before.

Worthy of Note

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ications, and the quality of an institution's child-life programs.

Peter Silberfarb, M.D., a professor of psychiatry and of medicine, was appointed a Distinguished Life Fellow by the American Psychiatric Association.

Constance Brinckerhoff, Ph.D., the Nathan Smith Professor of Medicine and of Biochemistry and the associate dean for science education, was recently selected by her undergraduate alma mater as a recipient of the Smith College Medal. The medal is presented to Smith alumnae who “exemplify in their lives and work the true purpose of a liberal arts education.”

Peter Williamson, M.D., a professor of medicine and the medical director of the DHMC Epilepsy Program, received the 2002 J. Kiffin Penry Award for Excellence in Epilepsy Care from the American Epilepsy Society.

Kathleen Allden, M.D., an assistant professor of psychiatry, received the Martin Luther King Jr. Social Justice Award from Dartmouth College. The award honors members of the Dartmouth community who have contributed significantly to peace, civil rights, public health, or social justice. Allden serves as medical director of the International Survivors Center in Boston, which aids refugees, asylum-seekers, and victims of torture; she has developed mental health training programs for the International Rescue Committee; and she was the U.S. delegate to a United Nations international conference on refugee resettlement.

Candice Monson, Ph.D., an assistant professor of psychiatry, received a Clinical Research Career Development Award for her work in clinical trials of mental health treatments.

Lisa Adams, M.D., an instructor of community and family medicine, was awarded the 2002 Doctors of the World USA Volunteer Award for her service as a volunteer physician with the organization.

Steven Atkins, Psy.D., a clinical associate in psychiatry, was the recipient of a Parents' Choice Award for Teaching Your Children
End-of-life care at Dartmouth-Hitchcock

Dartmouth Medical School also offers several electives, such as “The Healer’s Art” and “Literature in Medicine,” that deal with death and dying and other aspects of the emotional side of medicine. And under the auspices of a Schweitzer Fellowship, Kristen Thornton, a DMS ’05, is organizing a hospice experience for medical students.

In addition, Fanciullo and the palliative-care team are continually educating students, residents, and other health-care providers through daily interactions as well as through formal presentations. Anesthesia residents do a rotation in palliative care and some internal medicine residents choose palliative care as an elective.

A variety of research initiatives are under way, too. Dartmouth’s Center for Psychosocial Oncology Research conducts studies and offers counseling to cancer patients. Critical-care specialist Thomas Prendergast, M.D., received a faculty scholars award in 1999 from the Project on Death in America to develop a curriculum on end-of-life care in an intensive care unit (ICU). His research on the withdrawal of life support in an ICU was recently published in the Journal of the American Medical Association.

And in February of 2003, internist Elliott Fisher, M.D., M.P.H., reported in the Annals of Internal Medicine that regions that provide more aggressive (and therefore expensive) end-of-life care do not achieve any better patient outcomes than do regions that spend less (see page 3 in this issue for more about this study).

O n the clinical front, DHMC has an interdisciplinary palliative-care team that includes physicians and nurses who are board-certified in palliative medicine; a pain management specialist; a hospice/home-health liaison; a social worker/case manager; a psychologist; and a pastoral caregiver. Among services they provide are:

- Advanced, multidisciplinary treatment options for pain and symptom management, addressing patients’ spiritual, social, and emotional needs.
- A 24-hour on-call service for providers caring for patients facing end-of-life issues.
- An inpatient palliative-care clinic.
- Hospice home care.
- Family education to help patients’ relatives cope emotionally and to assist them in the medical treatment of their loved ones.
- Bereavement services to help survivors deal with pain and loss.

Exhuming Bonaparte

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Forshufvud argued that Napoleon’s death was most likely a political assassination—carried out with meticulous control, over a long period of time, in full view of innocent physicians in order to allay suspicion. If it was politically inspired, the crime must have been planned in Paris, not London, for the Bourbon monarchy had much more to lose than the English government had the emperor escaped and been restored to power.

Most likely the story is not yet finished. No medical case and no criminal case can be considered closed for all time. Whether one accepts or rejects the hypothesis that Napoleon was poisoned, the record of his last illness remains a puzzle to challenge present-day imagination and ingenuity.