If question on grads’ minds is “Got match?” answer is “You bet!”

Jeffrey Barrett and Sue Ann Hennessy couldn’t stop grinning. They hugged, exchanged excited chitchat, and hugged again—looking more like a couple of teenagers than a fourth-year medical student and an assistant dean.

Barrett, originally from Jamaica, had just learned that he had been assigned by the National Resident Matching Program (NRMP) to do his psychiatry residency at Montefiore Medical Center in the Bronx—his first choice. “We’re so proud of the accomplishment he’s made,” Hennessy, assistant dean for student affairs, said later. “Dr. Martha Regan-Smith, myself, and a lot of other deans at the Medical School, we’ve been his family away from home.”

Incredible: When Barrett received his “Match Day” envelope—and the letter inside telling him where he would be doing his residency—he also sought out Dr. David Nierenberg, senior associate dean for medical education, to shake his hand and give him a hug. “He has been a mentor and incredible teacher to me,” said Barrett of Nierenberg.

The hugs, smiles, and exclamations of Barrett and his mentors were actually not the exception but the norm for DMS students on Match Day 2005 in mid-March. Students and their spouses, partners, and friends, as well as numerous professors and administrators, filled the chairs and overflowed into the aisles of Auditorium G at DHMC for the Match ceremony. Given the importance of residency in a physician’s training, the excitement was understandable.

Hugs: Match Day is “a highlight of [students’] medical education. . . . It’s everything that they have worked for,” said Hennessy, by way of explaining the emotion in the room. “You know, when you’re happy you usually hug the people you love or you care about. . . . And generally,” she adds, “students are very, very happy with their matches.”

This year, more than 25,300 medical students participated in the NRMP, which uses a computer algorithm to match medical school graduates with openings in more than 8,000 accredited U.S. residency programs. Nationally, the most popular specialty choices this year were dermatology, emergency medicine, and several surgical disciplines; DMS graduates, however, once again showed a commitment to primary care, with family practice, internal medicine, and pediatrics topping the list.

Practice: Dale Ross is one of the ’05s who chose family practice. Originally from northern Idaho, he is particularly interested in rural family practice and “getting out in the community.” His wife, Angel, and their two children donned black cowboy hats for Match Day, and the whole family is looking forward to moving to Casper, Wyo., where Ross will be training at the University of Wyoming.
“We’ve enjoyed our time at Dartmouth—it’s been a great place for us,” says Ross. But “we are looking forward to heading back out West.”

Ross is the only DMS graduate bound for Wyoming, Massachusetts (where 11 students are going), California (10), and New York (7) proved the most popular destinations; three ’05s will remain at DHMC next year.

The Match placements for all DMS ’05s, plus placements for the ’05 graduates of the Brown-Dartmouth Program, are listed in the adjacent box.

DMS’s dean, Dr. Stephen Spielberg, applauded the students’ achievements but added, “It’s also a little bit sad because it’s kind of the beginning of the end of us having you all here.”

Welcome: While Match Day is a time to say goodbye to graduating students, it’s also a time to welcome incoming residents. In July, more than 100 new residents from all over the country—and the world—will arrive at DHMC. In addition, the New Hampshire-Dartmouth and Maine-Dartmouth family practice residency programs will welcome 18 new residents. “This year we had the strongest class of interviewees to date,” says Dr. Gail Sawyer, director of the New Hampshire-Dartmouth program. “We are very excited to welcome the Class of 2008.”

Perhaps Dr. Susan Harper, DMS’s assistant dean for medical education, summed up this year’s Match best when, at the beginning of the ceremony, she described the results as “awesome!”

Jennifer Durgin

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Results from Match Day 2005

**DMS ’05s are entering these residency programs this year:**

**Anesthesiology**
- Jessica Holland, Maine Med Ctr (UVM)
- Christian Renaud, Dartmouth-Hitchcock

**Emergency Medicine**
- Jennifer Boyle, Maine Med Ctr (UVM)
- Paul DeKoning, U North Carolina Hosp
- Catherine Lenkoski, Los Angeles County-Harbor-UCLA

**Shannon Lucas, Hosp of U of Pennsylvania**

**Family Practice**
- Trevor Braden, Central Maine Med Ctr (Boston U)
- Rachel Eckkema, UCLA Med Ctr-Santa Monica

**Lisa Holland, Allina Family Residency Prog**

**Michael Kim, Northridge Hosp Med Ctr (UCLA)**

**Benjamin Mailloux, Virginia Commonwealth U**

**Dale Ross, University of Wyoming-Casper**

**Mary Smith, Sutter Health (UC Davis)**

**Tara Thacker, Kaiser Permanente-Los Angeles**

**Kristen Thornton, Mayo**

**Matthew Weitzel, Lancaster Gen Hosp**

**Internal Medicine**
- Kelly Bodio, Beth Israel Deaconess (Harvard)
- Marilena Calderasusa, Rhode Island Hosp (Brown)
- Rebecca Cogswell, UC SF Med Ctr

**Laura Nodding, Beth Israel Deaconess (Harvard)**

**Hadas Shuran, U Michigan Hosp**

**Katherin Sprout, Dartmouth-Hitchcock**

**Geoffrey Walford, Brigham & Women’s Hosp (Harvard)**

**Charles Wicks, Hosp of U of Pennsylvania**

**Internal Medicine (Preliminary)**
- Jose Carrillo, St. Joseph’s Hosp (U Arizona)
- Joa Carter, Beth Israel Deaconess (Harvard)

**Carey Couto, Rhode Island Hosp (Brown)**

**Kristen Elias, St. Vincent’s Hosp (NY Med Coll)**

**Erin Salcone, Canarias St. Elizabeth’s Med Ctr (Tufts)**

**David Wartman, Beth Israel Deaconess (Harvard)**

**Internal Medicine (Primary Care)**
- Evan Doverin, Brigham & Women’s Hosp (Harvard)

**Obstetrics-Gynecology**
- Sum Cheung, Loma Linda U
- Kathleen DeGrosso, Georgetown U Hosp

**Cara Mathews, Women & Infants Hosp (Brown)**

**Orthopaedic Surgery**
- Patrick Donard, Oregon Health & Science U
- Bryan Mitchell, Strong Mem Hosp (U Rochester)

**Nikhil Thakur, Rhode Island Hosp (Brown)**

**Pathology**
- Bryan Coffing, U Michigan Hosp

**Thomas Kirn, Hosp of U of Pennsylvania**

**Jonathan Marotti, Beth Israel Deaconess (Harvard)**

**Pediatrics**
- Malinda Danforth, Baystate Med Ctr (Tufts)
- Jaclyn Davis, New York Presbyterian Hosp (Cornell)

**Tobias Hays, Children’s Hosp-Oakland (UCSF)**

**Linda Lee, Georgetown U Hosp**

**Jennifer McGuire, U Colorado Sch of Med**

**Jaime Walford, McGaw Med Ctr (Northwestern)**

**Stanley Weinberger, U Minnesota**

**Patricia Wurster, New England Med Ctr (Tufts)**

**PEDIATRICS (MEDICAL GENETICS)**

**Benjamin Solomon, NIH/Childrens National Med Ctr**

**PEDIATRICS (PRELIMINARY)**

**Orville Hartford, U of Louisville**

**Plastic Surgery**
- Anthony Ferrone, Strong Mem Hosp (U Rochester)
- Matthew Stanwix, Johns Hopkins/U Maryland Preg

**Psychiatry**
- Jeffrey Barrett, Montefiore Med Ctr (Albert Einstein)

**Thaddeus Shattuck, Brown U**

**Julie Young, UC Davis Med Ctr**

**Anthony Wolf, U Michigan Hosp**

**Surgery (General)**
- Rebekah Kim, St. Luke’s-Roosevelt (Columbia)

**Franklin Margaron, Virginia Commonwealth U**

**Nicholas Osborne, U Michigan Hosp**

**Surgery (Preliminary)**
- John Gachiania, Louisiana State U Health Sci Ctr
- Brian Kowal, Dartmouth-Hitchcock

**Sylvan Maginlaw, Basset Healthcare (Columbia)**

**Alaka Pellock, Beth Israel Deaconess (Harvard)**

**Hussein Samjii, Stanford U Med Ctr**

**Nwamaka Tabwo, Washington Hosp Ctr**

**Yousef Tanagho, U Hosp (Case Western Reserve)**

**Transitional**
- Christine Haughey, Hennefin County Med Ctr (U Minn)

**Asef Khwaja, St. Barnabus Med Ctr**

**Brown-Dartmouth ’05s are entering these residency programs:**

**Family Practice**
- Elizabeth Morcan, U Arizona Affil Hosp
- Justin Wheeler, Oregon Health & Science U

**Internal Medicine**
- Matthew Frances, UC Davis Med Ctr
- Michelle Morreale, New England Med Ctr (Tufts)

**Louai Razzouk, Mt. Sinai Hosp Sch of Med**

**Internal Medicine (Preliminary)**
- Charles Chia, St. Vincent Hosp (NY Med Coll)
- Felicia Chu, Beth Israel Deaconess (Harvard)

**Kristen Koconis, Hershey Med Ctr (Penn State)**

**Internal Medicine (Primary Care)**
- Amy Noack, San Francisco Gen Hosp (UCSF)

**Radiology**
- Dorothy Shum, Kaiser Permanente-Los Angeles

**In addition, these 2005 graduates have been accepted into advanced programs that they will start in July of 2006:**

**Anesthesiology**
- Alaka Pellock, Beth Israel Deaconess (Harvard)

**Child Neurology**
- Jennifer McGuire, Children’s Hosp of Philadelphia (UPenn)

**Dermatology**
- Joa Carter, Dartmouth-Hitchcock

**Charles Chia, U Washington Med Ctr**

**Orville Hartford, Fletcher Allen Health Care (UVM)**

**Christine Haughey, U Minnesota**

**David Wartman, Rhode Island Hosp (Brown)**

**Neurology**
- Jose Carrillo, Los Angeles County-Harbor-UCLA
- Felicia Chu, Beth Israel Deaconess (Harvard)

**Neurosurgery**
- John Gachiania, Louisiana State U Health Sci Ctr

**Ophthalmology**
- Erin Salcone, Massachusetts Eye & Ear (Harvard)

**Otolaryngology**
- Hussein Samjii, Stanford U

**Radiology**
- Corey Couto, Rhode Island Hosp (Brown U)

**Kristin Elias, NYU Med Ctr**

**Asef Khwaja, U Maryland Med Ctr**

**Kristen Koconis, Hershey Med Ctr (Penn State)**

**Urology**
- Brian Kowal, Dartmouth-Hitchcock

**Nwamaka Tabwo, Washington Hospital Ctr**

**Yousef Tanagho, U Hosp (Case Western Reserve)**

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VITAL SIGNS

**Dartmouth Medicine**

**Summer 2005**
Hugs and high-fives were clearly the order of the day when the DMS ’05s got their residency assignments. Pictured are 1 Joi Carter and Laura Noddin—both of whom are headed for Harvard’s Beth Israel Deaconess Medical Center; 2 Jeffrey Barrett—sharing with Senior Associate Dean Dave Nierenberg the news that he’s going to Montefiore Medical Center in New York City; 3 Kathleen DelGrosso and Ben Solomon—upon finding out they’re both bound for the D.C. area, she to George-town and he to the National Institutes of Health; and 4 Geoffrey Walford (left, who matched at Harvard’s Brigham and Women’s Hospital in Boston) and Tobias Hays (right, who’s heading west to UCSF’s Children’s Hospital), celebrating with a friend.

**VITAL SIGNS**

Julie Suzumi Young, DMS ’05, is adept at putting words together on paper but can’t find a nice way to say that she “hated” the first two years of medical school. “How can you say that nicely?” she asks. “Every single thing I did, everything I learned, was completely alien.”

**Zone:** Young was in her late thirties when she decided to leave an established career as a dietitian and start all over again as an M.D. student. She felt out of her comfort zone.

One major enjoyment missing from her life was writing, which had been a constant ever since college, when she had dreamed of becoming a journalist. But that dream fizzled once she got to know the daily grind of journalism as an intern for the Los Angeles Times.

She kept writing, though, for employee and professional society newsletters and for Japanese newspapers. It wasn’t until medical school had consumed her life that she realized how much she missed working with other writers and editors. So when she heard that the *Journal of the American Medical Association* (JAMA) had editorial openings in its student section—Medical Student JAMA (later Student JAMA)—she applied for and landed one of the positions.

“I think it’s safe to say that [Student JAMA] really changed my medical school experience,” says Young. She spent three years as the student section’s deputy editor, spreading out her clinical rotations to accommodate the extra work. Interacting with her fellow student editors was a pleasure for Young. For the first time since entering medical school, she was working with people who were “speaking the same language—the same editorial language” she did.

Although Student JAMA was a small section—appearing once a month within the larger weekly journal—and was run by students, it was no less rigorous in its editorial standards. “Even though this was sort of a student publication,” explains Dr. Stephen Lurie, former senior editor at JAMA who worked closely with Young, “there was the expectation that it would be up to JAMA’s usual standards.”

Contributing authors were often surprised by this and put off by the numerous revisions requested by the student editors, Young explains. “They didn’t understand that JAMA was telling us, ‘Look, if you don’t change this, we’re not publishing it.’”

Grateful: Yet despite the struggles with authors and the long hours (and her dismay when JAMA discontinued the student section last year), Young is grateful for the experience. “I feel, now, a lot more confident that if I want to publish a paper, I have a pretty good idea of what’s required,” she says.

In addition, Student JAMA “totally changed” Young’s residency application. “Every interview that I went on, that’s the first thing they’d ask me about—the JAMA experience,” she recalls. “And it actually deter-
Julie Young spent the last few years helping to edit JAMA’s student section.

VITAL SIGNS

From the left, tile artists Simon, Wikoff, and Eisenhardt.

Julie Young spent the last few years helping to edit JAMA’s student section. Julie Young knew that she wanted to enter the psychiatry residency at the University of California at Davis after she corresponded with the chair of psychiatry there, Dr. Robert Hales, who is also editor-in-chief for the book arm of American Psychiatric Publishing. After that interaction, UC-Davis “was the only place I wanted to go because of the opportunity to work with Dr. Hales,” says Young.

Mutual: The feeling seems to have been mutual, since Young was accepted to the program and, even before arriving in California, already had gotten a few assignments from Hales.

“Right after the Match,” says Young, “I e-mailed him, ‘Hey! I’m coming to UC-Davis!’ So then he e-mails me back, ‘Okay, I’ll give you a project.’” While some students might have rued the extra work, Young’s assessment was: “It’s just fun!”

Jennifer Durgin

A Godzilla-like creature opens its large, toothy mouth. Nearby, streaks of light from a blazing sun bounce off a rocky landscape. These are just two examples of 104 beautifully detailed clay tiles made by DMS students, faculty, and staff. The tiles have been assembled into a collage-like work of art that was recently mounted in the stairwell of Chilcott Auditorium on DMS’s Hanover campus.

The idea for the project came about when Elizabeth Eisenhardt, now a third-year student, met Naj Wikoff, director of the Healing and the Arts Project at DMS’s Koop Institute. They wanted to reinforce the presence of the arts and beautify the Medical School’s facilities. They decided on a group tile-making project as their first effort, seeing it as a perfect way to involve lots of people. Taking a simple carving tool and creating an image in a square of wet clay is also fairly easy to teach.

Clay: At tile-making workshops in the DMS Student Lounge, they invited passers-by to come in and render something important to them—nature scenes, faces, hobbies, or cultural icons. Eisenhardt’s passion is ballet (she danced professionally before medical school), so her tile has a silhouette of a leaping ballerina.

“Naj was a great teacher,” says second-year student Laura Simon, who took over the project this year and oversaw the installation. “A lot of students started off saying, ‘I don’t know how to do this. I don’t know anything about art.’ But working with clay is such a great medium that they started using their hands and getting into it.” Simon’s tile features a bright sun against an impressionistic landscape. “Sitting in the lounge with friends and classmates really does inspire you and gives you a sense of community,” she says. “This made me think of a sun.”

The tiles were arranged as a single, dramatic work with two large parts—a beige diamond and a blue diamond—each made up of many distinct, small parts. Rather like the big institution that the construction now beautifies. M.C.W.
Richard Reindollar is named chair of ob-gyn

He expected to follow in his parents’ footsteps and become a schoolteacher. Instead, in September, Dr. Richard Reindollar will follow in Dr. Barry Smith’s footsteps and become chair of the DMS Department of Obstetrics and Gynecology.

Funding: Internationally recognized for his work in reproductive endocrinology and infertility, Reindollar has been on the faculty at Harvard since 1997. He is also director of reproductive endocrinology and infertility at Beth Israel Deaconess Medical Center and principal investigator for the two largest clinical infertility studies in the nation; he’ll bring oversight of the trials (and their funding) with him to Dartmouth this fall.

The studies, which are looking at the cost-effectiveness of different approaches to infertility care, are being run with several Boston organizations; DMS’s Department of Community and Family Medicine and Center for the Evaluative Clinical Sciences will join the collaborative and analyze the data when the studies are completed.

“We are studying whether conventional infertility treatments are appropriate as the first line in moving toward in vitro fertilization, or whether it’s cost effective to move rapidly into in vitro fertilization,” Reindollar explains. About 500 couples are enrolled in the FASTT (Fast Track and Standard Treatment Track) trial, for women 40 to 43.

Reindollar received his M.D. from Bowman Gray, did his residency at York (Pa.) Hospital, and completed a fellowship in reproductive endocrinology and genetics at the Medical College of Georgia. He stayed on the faculty there for five years, never expecting to one day specialize in infertility, let alone run clinical trials. “We trained in pure reproductive endocrinology—sexual ambiguity, delayed and precocious puberty, and menstrual abnormalities,” he says.

In 1986, he was hired as director of the Division of Reproductive Endocrinology at Tufts New England Medical Center; he also set up a molecular biology lab at Tufts Medical School. Ten years later, he moved across town to Harvard.

Reindollar now looks forward to moving north. “It will be really exciting for me to leave the hustle of a very competitive but large patient base and come to a more rural community,” he says. He’s impressed with the collaborative spirit that “permeates throughout the entire Medical Center and Medical School.”

In his new role, he hopes to strengthen local and regional clinical care; build the teaching and research programs; establish fellowships in reproductive endocrinology, maternal-fetal medicine, and urogynecology; and expand the reproductive medicine network in northern New England. “Barry Smith put together this very, very strong program and really developed strong ties throughout the region and especially the southern part of the state,” Reindollar says. He also looks forward to collaborating with Dr. Emily Baker, who as interim chair “continued to grow the department and to lead in a fashion that I’ve just not seen for interim chairs.”

Leadership: Reindollar is a delegate to the American Board of Obstetrics and Gynecology, the specialty’s certifying organization, and has held leadership roles—including as president—in several other national and regional specialty societies.

His parents may have been teachers, but his family now includes a couple of doctors. His wife, Dr. Ann Davis, is an ob-gyn who specializes in pediatric and adolescent gynecology; she is currently on the faculty at Tufts and may join the DMS faculty next year. And his identical twin brother is a gastroenterologist in North Carolina. But it’s too soon to tell in whose footsteps his two teenage sons will follow.

Laura Stephenson Carter

DHMC symposium: Health-care data should be made public

A mericans know more about the safety, quality, and efficiency of the cars they drive than of the places they seek medical care. Why? Because over the years not many hospitals and clinics have collected data about their performance—such as the number of inpatients who die from a heart attack or the satisfaction of patients upon discharge—and only recently have a select few made such data available to the public. (See page 16 for news on DHMC’s actions in this regard.)

But measuring and reporting outcomes is just what’s needed to improve U.S. health care and stymie skyrocketing costs, said six national health-care leaders who gathered for a symposium at DHMC in late May.

“We have made a commitment to transparency, a commitment to making the information that patients need . . . available, and using that information for improvement,” says Paul Gardent, executive vice president of DHMC, after the event. But “we don’t want to simply look within the walls of our medical center,” he adds. He and other Dartmouth-Hitchcock leaders want to “think more broadly and more strategically about the health information needs” of the future.

Ideas: To bring forth new ideas, Gardent and Dr. Thomas Colacchio, president of the Dartmouth-Hitchcock Clinic, hosted a symposium titled “Med-
icne, Metrics, and Transformation: Making the Important Choices.” More than 250 clinicians and administrators from regional hospitals, clinics, and organizations, as well as government officials, attended.

**Keynote:** The keynote speaker was Dr. Kenneth Kizer, who as undersecretary for health in the Department of Veterans Affairs was largely responsible for transforming the ailing VA medical system into one of the best in the world. “Modern health care is the most information-intensive enterprise that human beings have ever engaged in,” Kizer told the audience. “Yet we’re trying to manage it, and trying to operate in many cases, the same way we did 100 years ago. We simply can’t get to where we need to go today without bringing health care IT [information technology] into the 21st century.”

But getting “where we need to go” is about more than computers and data, Kizer and the other speakers said. “The other piece . . . is leadership and commitment and understanding of the direction in which [the data] can take you,” said Dr. Louise Liang, senior vice president of Kaiser Permanente, a nonprofit HMO and the nation’s largest. “I think it’s very clear,” she added, “that [DHMC], this community, has [that] other piece.”

Dr. Donald Berwick, CEO of the Institute for Healthcare Improvement, also praised DHMC, reminding attendees to stay focused on patients—“a reminder you don’t need at Dartmouth.”

DHMC is indeed a national leader in outcomes reporting and quality improvement, as recent articles in the Wall Street Journal, the New York Times, and the Washington Post have attested. Faculty in Dartmouth’s Center for the Evaluative Clinical Sciences (CECS)—such as Dr. John Wennberg, the first person to draw attention to regional variations in care—have been studying the delivery of care for more than 20 years.

Two CECS faculty members, Dr. Elliott Fisher (whose research suggests that 30% of U.S. health-care dollars go to unnecessary treatments) and Dr. Gerald O’Connor (who cofounded the Northern New England Cardiovascular Disease Study Group) also spoke. Both talked about how data can change clinical outcomes. O’Connor, for example, described a collaboration among five hospitals that has dramatically cut their combined mortality rate for heart-bypass surgery.

Fisher and O’Connor also urged academic medical centers to lead the way. “If we . . . look at how we compare to other academic medical centers,” pointed out Fisher, “we can teach our residents and our students about reflective practice.”

“We have gotten a lot of recognition for our efforts,” Gardent says later. But he’s careful not to exaggerate DHMC’s accomplishments nor to diminish the challenges that remain. It’s the combination of “science plus measurement plus reporting,” adds Gardent, “that will lead to much higher levels of quality and reliability.”

**Cost of services is part of transparency at DHMC**

If you put the word “transparency” into the news search engine LexisNexis, virtually all the hits have to do with international affairs. But that was the word chosen by the Institute of Medicine (IOM) in a 2002 call for an overhaul of the domestic health-care system. The IOM’s “Crossing the Quality Chasm” report challenged hospitals to improve the quality of care, reduce medical errors, and increase “transparency” about their performance.

Dartmouth-Hitchcock not only didn’t have to ask what the IOM meant by transparency but was poised to respond. “DHMC and DMS have a long history,” says executive vice president Paul Gardent, “of measuring performance in the interest of quality improvement.”

This approach, based on work at Dartmouth’s Center for the Evaluative Clinical Sciences (CECS), rests on the underlying principle of informed patient decision-making. “Given our historic interest, and the call by the Institute of Medicine,” Gardent continues, “we needed to embrace transparency and to become a national leader in transparency.” (See page 15 for a story on a related effort.)

**Post charges:** The latest step in that process came a few months ago, when DHMC became one of the first medical centers in the country to post charges for its services on its Web site.

But back to the beginning: After the IOM report came out, DHMC set three goals—to provide better information to patients to help them make health-care decisions; to increase trust in DHMC’s role as a charitable, nonprofit organization; and to stimulate improvement in the quality of care. “We define quality broadly,” Gardent says, “to include clinical outcomes, as well as patient satisfaction and cost of services.”

Putting flesh on the bones of those simple-sounding goals took some time, however. Melanie Mastanduno, a clinical measurement analyst at DHMC, says that administrators spent about 15 months answering the question “How would transparency look?” Based on information and opinions from national consultants, patient interviews, and focus groups, DHMC decided to create a Web site that would give patients accurate and honest data about the Medical Center’s performance. “Our mission is to continually improve the science of clinical practice,” she says, “and we believe that publishing both health information and quality reports is a valuable tool in that mission.”

**Quality reports:** The site, which can be reached by going to www.dhmc.org and clicking on “Featured Section: Quality Reports,” went live a year and a half ago. Most recently, in February of this year, charges for services—including office visits, diagnostic tests, and surgical procedures—were added to the site. DHMC is not only one of the first institutions to publish its charges, Mastanduno points out,
Transforming Medicine Campaign goes public

The mood was celebratory. The sun was shining. The news was great. On Saturday, May 21, Dartmouth Medical School and Dartmouth-Hitchcock Medical Center announced to the world that they were launching a $250-million campaign—the largest in their history—that aims to transform the way medicine is delivered both in their own backyard and around the world.

**Endowment:** The appropriately named Transforming Medicine Campaign will raise funds to increase endowment for faculty support and program development; to advance research, academic, and clinical initiatives; and to build new facilities.

"Together we will transform not just medicine, but lives, here in the Upper Valley, in the regions of New Hampshire and Vermont, and throughout our country and our world," said Alfred Griggs, chair of both the DHMC and Mary Hitchcock Hospital Boards, in officially launching the campaign.

The previous record for a DMS or DHMC campaign was $95 million, raised as part of the Dartmouth College Will to Excel campaign, which ended in 1996. Although Transforming Medicine has just gone public, it's been accepting advance gifts for senior faculty and endowments for junior faculty development. Scholarships for DMS students are also being sought.

- $85 million for support of faculty, primarily through the establishment of endowed chairs for senior faculty and endowments for junior faculty development.
- $98 million for key clinical research facilities at DHMC, in including a Translational Research Center, the Children's Hospital at Dartmouth, and the Center for the Evaluative Clinical Sciences, as well as research in areas such as neuroscience, cardiovascular research, immunology and infectious diseases, orthopaedics, and genetics.
- $67 million for new research facilities at DHMC, including a Translational Research Building and a Center for the Evaluative Clinical Sciences building; renovations to the Vail and Remsen research buildings on DMS's Hanover campus; and a $2-million contribution to the...
new Norris Cotton Cancer Center-North in St. Johnsbury, Vt.

Lead gift commitments made during the quiet phase of the campaign included $5 million from Dean LeBaron to build a commons to connect Borwell Research Building to future research facilities; $5 million from Jennifer and Peter Brock for the genetics department; $5 million from the Theodora B. Bets Foundation to study brain tumors at Norris Cotton Cancer Center; $3 million from Johnson & Johnson for a psychiatry department project to help people with severe mental illness gain independence by obtaining community-based employment; and $2 million for scholarships from Dr. Norman Payson, a 1973 graduate of DMS.

**Difference:** Payson, former CEO of Oxford Health Plans as well as a DMS Overseer, also spoke at the launch. “Today,” he said, “in heath-care policy, practice, medical education, patient empowerment, understanding of disease, advances in diagnosis and treatment, this medical center and medical school are making a difference.”

“What we export from the Upper Valley are the ideas, the models, the practices,” noted DHMC’s senior nurse executive, Nancy Formella, who rounded out the slate of speakers. “The care and the innovations in care, the improved treatments and therapies—they start right here in this community and they work every day to benefit the patients of our region” . . . and, ultimately, the world.

Laura Stephenson Carter
Aviation-themed gala gets capital campaign off the ground in style

Ladies and gentleman, we will begin boarding in a moment,” said a voice over a loudspeaker—an appropriate announcement to any passengers at any airport. But these weren’t just any passengers; they were party guests in tuxedos and ball gowns. And this wasn’t just any airport; it was a private hangar in Lebanon that had been transformed into an elegant banquet hall, complete with crystal chandeliers.

Garb: The “passengers” were guests at a black-tie fund-raising gala to celebrate the Transforming Medicine Campaign (see page 17 for a related story). As they arrived, the 500 guests were greeted by “stewardesses” in vintage garb and serenaded by barbershop and doo-wop quartets. Then they sipped on cocktails; chatted with actors dressed as aviation pioneers Wilbur and Orville Wright; bid on silent auction items; and admired antique aircraft. “This is a fabulous event,” said Dr. Ira Byock, director of DHMC’s Palliative Medicine Program. “It’s unique . . . a little history and a great deal of fun. It’s amazing to see everybody here supporting this remarkable effort. And we are indeed here to transform medicine.”

During dinner, historical images of DMS and DHMC flashed on giant screens, while swing dancers jived and bands played. Later, a voice announced, “We are about to begin our in-flight movie.” After a short film celebrating institutional successes, there were brief remarks by emcee Susan Dentzer, DC ’77, health correspondent for PBS’s NewsHour, a DHMC Trustee, and a DMS Overseer; campaign cochair Dr. Peter Williamson, DC ’58 and a DHMC neurologist; and retired NBC correspondent Bob Hager, DC ’60. Hager spoke of ways that Dartmouth medical pioneers are transforming medicine, just as the Wright brothers transformed flying.

Memorable: Finally, as everyone departed, they stopped at “Baggage Claim” to pick up mini-suitcases filled with mementos of a memorable evening.

Laura Stephenson Carter
THE BIRTH OF A NOTION

Medical opinion in the U.S. regarding water births runs . . . well . . . hot and cold. As of 2001, the latest year for which figures are available, about 140 hospitals offered the procedure, but many did not. Dartmouth Hitchcock-Keene/Cheshire Medical Center strongly supports the concept and has done over 1,000 water births since starting a program in 1998. DHMC in Lebanon offers underwater labor, but not water births. In England, though, feelings are far from lukewarm. In 1992, the House of Commons passed a resolution that all maternity services provide women the option of labor or delivery in water. In a recent grand rounds presentation at DHMC titled “Water Births: Dolphins and Whales Do It—Should Humans?” Dr. Kisha Destin described complications associated with underwater births, such as neonatal waterborne infectious disease and cord rupture with neonatal hemorrhage. It’s assumed that the rates of these complications are low, said Destin, but she noted that no large randomized controlled study has ever been done on the process.

BOOK DEBUT HAS DMS ROOTS

Though patients’ experiences often end up in papers for medical journals, it’s rare that they play a role in a literary career. But not impossible. Several years ago, Catherine Tudish—then a member of the DARTMOUTH MEDICINE staff and now one of the magazine’s regular freelancers—visited the Norris Cotton Cancer Center infusion suite to write a story about a patient being treated there. “I was given a tour of the suite and was particularly struck by the children,” Tudish recalls. “Those impressions stayed with me, becoming more powerful with time, until I had no choice but to write a story about a child with leukemia. That story was published in Green Mountain Review and read by Nat Sobel, who is considered one of the top New York agents.” Sobel took Tudish on as a client; encouraged her to build a collection of stories around that first one—“The Infusion Suite”; and found a publisher for the book—titled Tenney’s Landing.

“So DARTMOUTH MEDICINE played a key role in launching my literary career,” Tudish adds, “though it’s much too soon to actually claim a ‘literary career.’” Hardly. The book was just released by Scribner, and a review in Publishers Weekly called it an “eloquent, emotionally authentic debut.”

Surgeon leads aneurysm screening campaign

Just below the kidneys runs a section of the abdominal aorta, a blood vessel about the size of a small garden hose. It’s a workhorse, delivering blood to the whole lower half of the body. But after 50 or 60 years of use, its walls can weaken, sometimes creating a dangerous bulge known as an aneurysm. If the aneurysm gets too big and too weak, it can rupture.

Huge: “That’s a calamity that most people don’t survive,” says Dr. Robert Zwolak, a vascular surgeon at DMS. “Of those lucky enough to get to the hospital alive, there is a huge emergency surgery,” and about 50% of those who undergo emergency surgery don’t survive. Some 15,000 people die each year in the U.S. of ruptured aortic aneurysms.

Zwolak was tired of seeing patients die from aneurysms that could have been detected by ultrasound and treated before they ruptured. So in February 2004, he helped the Society for Vascular Surgery found the National Aneurysm Alliance (NAA), an organization dedicated to reducing deaths from abdominal aortic aneurysms (AAAs). As the head of the NAA, Zwolak has been lobbying Congress since mid-2004 to require Medicare to cover ultrasound screening for those at risk of AAA—which includes everyone over 55 who smokes or has smoked, has high blood pressure, has evidence of atherosclerotic vascular disease, or has a family history of AAA.

Though screening for many diseases, especially cancer (see page 40), remains controversial, the benefits of AAA screening are conclusive. “If we find an aneurysm before it’s ruptured, we have a 95% to 98% cure rate,” says Zwolak. And unlike cancer, there are clear benchmarks for what size aneurysms are likely to cause problems. “If it’s a ‘baby’ aneurysm, you might follow it once a year with an ultrasound because that’s how slowly they grow,” Zwolak says. “If it’s medium, say between four and five centimeters in diameter when it’s discovered, you’d look with an ultrasound every six months. And then when it gets above five—in men we think five and a half is the magic number—that’s the point at which the risk of the thing rupturing is significant enough that it’s worth undertaking a fairly large-magnitude surgery to fix it.”

Fix: AAAs can be “fixed” with open surgery or with a newer, less-invasive procedure. In open surgery, a piece of synthetic tubing is sewn in place of the weak segment. “In concept, it’s incredibly simple,” says Zwolak. But in practice, it’s a “very big operation”; even when done on a nonemergency basis, 3% to 4% of patients don’t survive.

The less-invasive procedure has much better outcomes—just 1% to 2% mortality. It involves only a small incision in an artery in the leg. A device about the diameter of a pen is then fed up into the abdominal aorta. Once in place, the device deploys a stent graft that spans the length of the aneurysm and descends...
into the iliac arteries. Now, says Zwolak, “more than 50% of [elective AAA surgery] patients at Dartmouth—and I think that’s pretty representative of major medical centers across the country—are getting these minimally invasive grafts.”

Though lobbying is a new role for Zwolak, he’s found it relatively easy because, he says, he “can obviously speak with great sincerity and experience.” He and the NAA got a boost in their campaign when earlier this year the U.S. Preventive Services Task Force endorsed AAA screening for men aged 65 to 75. DMS recently established a nurse shadowing program that aims to help medical students build strong relationships with nurses, so they can collaborate more effectively.

The elective course was started by Joseph O’Donnell, M.D., senior advising dean at DMS, and Ellen Ceppetelli, R.N., director of nursing education at DHMC. They got the idea when they co-taught a session of a DMS course called Health, Society, and the Physician. “One of the things that we realized as we were talking to the fourth-year students,” says O’Donnell, “was that they really didn’t have a good picture of what nurses did and how they added to the health-care team.”

Caring: “I started thinking in my mind how could we get these wonderful, caring, holistic young people to think about what role a nurse plays in health care,” adds Ceppetelli.

O’Donnell and Ceppetelli wanted the program to be as collaborative as a real doctor-nurse relationship should be. So it was left to the nursing directors, nurses, and participating DMS students to determine how best to structure the shadowing experience. “I think we were afraid of somehow?” recalls Julie Young, DMS ’05.

Initially, the group intended to honor just a few clinicians, but when they opened the idea up to the entire class, the nominations swelled. Not wanting to turn it into a competition, the students chose to honor all of the nominees—25 attending physicians, four residents, and one optometrist. “Thank you for your part in our educations,” the students wrote in a memo explaining their Outstanding Physician Role Model Award. “Due to your efforts, we have had plenty of wonderful people who have shown us how to become ‘good docs.’” J.D.

### TEACHING TECHS IN THE LAB

There’s a day I go home that I can’t say I learned two new things,” says Jill Polito. A technical specialist in DHMC’s clinical laboratory, she’s speaking to a group of University of New Hampshire (UNH) students who are visiting DHMC. Next, Polito helps the students gaze through a multiheaded microscope, so they can see slides of spinal meningitis and acute leukemia. Playing an important role in patient care by helping to make such diagnoses is what Polito “loves about being a med tech,” she adds.

Polito was one of several DHMC technologists who met recently with UNH sophomores to cultivate their interest in the field of medical laboratory science. The two institutions collaborate to offer a degree in the field, with UNH providing the classroom work and DHMC the clinical training in a six-month internship. During the internship, students complete rotations in the four subsections of the clinical pathology lab—the blood bank, hematology, chemistry, and microbiology—and become integrated into the often hectic workflow. “‘Stat!’ is one of [the students’] major words,” Polito noted. J.D.
it being too structured—that it would almost be a barrier,” Ceppetelli says.

In the course’s first offering, this past spring, each medical student had six shadowing experiences—one each lasting between two and four hours. After every two experiences, all parties involved met to share information and reactions.

“The biggest asset a physician has is a wise nurse by their side,” says Donna Brown, R.N., nursing director of medical specialties, who helped recruit nurses to take part in this initiative. “The nurses were extremely thrilled to know that young med students would be interested in learning about the work of a nurse.”

**Side by side:** Students observed the range of duties that a nurse performs, from monitoring the condition of patients to ascertaining when a palliative-care team should be brought in. “The medical students were encouraged to work side by side with the nurse and to ask as many questions about what was happening with the patients as well as [about] the processes . . . involved in nursing,” says Brown.

Students had a variety of reasons for enrolling in the elective. First-year student Laura Shively was aware of poor doctor-nurse relationships. “I come from a family of doctors and nurses so I wanted to be able to interact with patients,” says Shively’s classmate Rusty Phillips. Normally, first-year students don’t have a chance to work with hospitalized patients.

Upon completing the six experiences, all participants attended a dinner hosted by emeritus professor Frances Field, M.N. “She was the first nurse on the faculty at DMS and has always been a great advocate of nurses and doctors working together to produce good outcomes,” says O’Donnell. “At the dinner, I was blown away by the comments the nurses and students made.”

“There was no negative, absolutely no negative—they were just delighted because they had this opportunity to work together,” says Ceppetelli.

“I thought it was very useful. I would like to see it as a part of a [required] class versus part of an elective,” says Shively.

The nurse shadowing experience will be offered again next year as an elective. “You cannot collaborate with people unless you see them as competent,” says Ceppetelli. “This is an opportunity to communicate with people and develop trust.”

**Sateia, in yellow, and Link pause amid the crowd after the service in Rollins Chapel.**

**DMS memorial service makes the news on NPR**

Each spring at Dartmouth Medical School, first-year students hold a memorial service for the families of the cadavers they’ve studied all year. It’s a way of honoring the body donors who’ve become the students’ silent teachers. The voice saying these words was familiar—Scott Simon, host of Weekend Edition on National Public Radio (NPR), was introducing a segment reported by Susan Keese of NPR’s Vermont affiliate.

“During the months they spend dissecting the cadavers,” Keese explained, “the students know only their age and cause of death. In the spring, when the cremated remains are returned to the relatives, they learn more.”

Held in Dartmouth’s Rollins Chapel, the service was attended by students, faculty, and friends and families of the donors. “This memorial service is in recognition of your loved ones’ generosity and in celebration of their lives,” read the program. “We encourage you to remember your loved one by lighting a candle at the front of the chapel.” As family members filed up to light candles, the evocative sounds of Pachelbel’s Canon in D Major echoed through the chapel.

“I cannot put into words how much we have all learned, benefited, and grown from the contributions of your loved ones,” began Nathaniel Link, a first-year student. Next at the lectern was Dr. Martha McDaniel, chair of anatomy. She told the families a little about the students, pointing out that although the service is obviously meaningful to the families, it’s amazing how important it is to the students, too.

**Poignant:** Heather Sateia, the first-year student who organized this year’s ceremony, read a work by Henry David Thoreau. The poignant words told of completing a cycle and returning to something greater—like a blade of grass to the earth.

Next was a time for reflec-
tion. The students had encouraged family members to submit memories of their loved ones ahead of time. Six students came forward to read excerpts. Some passages were light-hearted recollections of feeding birds and handcrafting rugs, while others told of fleeing the Nazi regime and traveling the globe. The students interspersed these tales with mentions of their own experiences, their gratitude, their admiration for the donors.

"You opened your heart and home to many Dartmouth students and gave them the ultimate gift, your remains, to help them in their life work. You will be with us always," said Sateia.

Then the donors' names were read aloud, one by one, before a moment's silence in their memory. Again music swelled and everyone sang "Amazing Grace" as the candles burned brightly.

"After the service," reported Keese, "the future doctors and the families mingled and talked. The students recalled how hard it was at first to take apart a human body."

As the NPR segment ended, music filled the airwaves. "The students say that knowing that the donors wanted their bodies to be used in this way makes the lab work easier, but often a hint of red nail polish or a tattoo reminds them that someone special is in their hands. For NPR News, I'm Susan Keese."

"A lot of my friends," recalled Sateia a few days after the event, "went into the ceremony not expecting to become emotional—but found themselves crying."

Sion E. Rogers

**Joint class on law and lead looks for solutions**

Say the words "lawyer" and "doctor" and most people probably think "malpractice." But law and medicine intersect for other reasons, too, often in the public's interest.

"We look to the public-health community in my profession to tell us what's wrong," Boston attorney Neil Leifer told DMS and Vermont Law School (VLS) students at a joint class during spring term. (Leifer, of the law firm Thornton and Naumes, is best known for leading Massachusetts's successful fight against the tobacco industry.)

**Cases:** Litigation "doesn't start with the lawyers. We don't dream up the cases—despite what the doctors are taught in medical school," he joked.

For several years, Leifer and Dr. James Sargent, a Dartmouth pediatrician, have co-taught a class on lead poisoning for VLS environmental law students. More recently, Sargent began lecturing on the topic in a course on environmental and occupational health for Dartmouth M.P.H. students. By combining the lectures into one joint session, Sargent reasoned, VLS and DMS students would have a chance to interact and gain more from the experience. The course directors at both schools agreed, and the session was combined for the first time this past spring.

"I hope this becomes an annual event to go back and forth and look for ways to build on the really rich aspects of this topic for public health and environmental law," noted Dr. Carolyn Murray, chief of occupational medicine at DHMC and codirector of the DMS course.

Leifer lectured the class on the history of lead paint in the United States from the late 1800s through the 1970s, when it was finally banned. He is currently representing Rhode Island in a lawsuit against the paint industry, which continued producing paint with lead long after its toxic effects on children were known. The difficulty of such litigation, Leifer explained to the students, is proving causation—that children's disabilities are a direct result of the industry's actions, or lack thereof. To do this, Leifer must rely on medical experts like Sargent.

"The goal of a medical expert is not to impress jurors with credentials," Leifer explained, "but to educate them."

Sargent then talked about the toxicity of lead; the effects of lead poisoning—such as anemia, abdominal pain, brain damage, and, in extreme cases, encephalopathy; and the first national lead-screening programs.

In the 1970s, when the Centers for Disease Control and the Public Health Service "started screening kids, they found out that lead was pervasive in the cities, especially in the ghettos—the inner cities of the eastern seaboard," Sargent told the class. Today, the average human lead concentration is about 2 micrograms per deciliter. "Why was lead so pervasive?" Sargent asked. Substandard housing with lead paint was partly to blame, but the bigger culprit was the lead being added to gasoline to increase octave counts. It took 23 years, from 1973 to 1996, for the U.S. Environmental Protection Agency to completely phase out leaded gasoline for on-road vehicles.

"Now lead poisoning is not a pervasive exposure; it's a point exposure," said Sargent. "It's the exposure of a kid that happens to live in a house where the lead paint's deteriorating."

**Exposure:** When Sargent has a patient who tests positive for lead poisoning, he counsels the parents on how to reduce or eliminate the child's exposure to lead paint. Sometimes, the best solution is for the family to move, but many families cannot afford to do so. Even though in most states, lead poisoning is a violation of sanitary codes, enforcement programs often lack sufficient funding, so property owners are rarely pressured to...
abate the hazard, noted Leifer. “Frankly,” explained Sargent, “the reason I became interested in lead poisoning is because it wasn’t a problem that I could solve in the office. I was frustrated by it. These kids would get lead poisoning, I’d send them back out to the house, they’d get poisoned again. I knew that there had to be a bigger solution to this. I wanted to make a difference in a bigger way than I could in the office.”

**Linked:** “The big picture,” he added, “is that lead poisoning is a public-health problem... and it is inextricably linked with corporate behavior, the legal system, and the political system. ... Neil’s taught me that.”

**Jennifer Durgin**

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**Former combat pilot is still in the hunt for excitement and challenge**

“I’m kind of into the danger and excitement sorts of fields,” says Dr. Elizabeth Weber, chief resident in orthopaedics at DHMC. One could also add “male-dominated” and “fiercely competitive” to her list of adjectives. Before medical school, Weber spent six years in the Air Force, three of them as a combat pilot. And as of June, she’ll be only the third woman to complete DHMC’s orthopaedics residency.

**Exciting:** “You may have some ideas about what you want to do, both in medicine and in the military, when you start,” Weber explains, “but if you tend to be a competitive person—which I am—then you very quickly figure out what’s the most prestigious and exciting thing to do.” Weber was the only woman in her pilot training class of 60 and one of only about 20 who graduated. While in the Air Force, she flew all over the world, transporting generals and dignitaries on Lear jets and then, during the Gulf War, flying combat missions on KC-135s, which are used to refuel other planes in flight.

“I think the biggest problem with being a woman in the Air Force... was [when] we were based in Riyadh, Saudi Arabia,” during the Gulf War, says Weber. As commander of a combat plane, she was responsible for her craft and crew, but she couldn’t perform many of her duties because of Saudi attitudes toward women. “They wouldn’t give me gas because women can’t talk to men there,” Weber recalls. “It’s one thing not to respect a gender because that’s the way you were brought up, but not to respect the rank of a military officer... it was very bothersome.”

She hasn’t encountered any such obstacles at DHMC. “My peers in this program are absolutely amazing,” she says. “They are well-spoken, articulate, smart, fun, funny... just a great group of guys. I haven’t felt any animosity about my gender.” She does admit that at times “it’s a little socially challenging.” But challenge is clearly what Weber thrives on. Come July, she’ll be starting a new challenge—a pediatric orthopaedics fellowship in Australia.

**J.D.**

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**Novello keynotes Women in Medicine conference**

To those who live with glass ceilings, let’s start teaching them how to throw stones!” challenged Dr. Antonia Novello, former U.S. surgeon general and the keynote speaker at Dartmouth Women in Medicine, a conference held this spring.

Women have come a long way since Elizabeth Blackwell became the first female physician in the U.S. in 1849 (and since her sister Emily was rejected by DMS, in 1852, on the basis of her gender).

But still more needs to be done before women achieve true equality with their male colleagues, Novello insisted. “We must demand that women be encouraged by schools, propelled into academic excellence by universities, recognized by their male counterparts, and appointed to positions of distinction—on their merit—equal to those of men.” Novello, the first woman and first Hispanic surgeon general, is currently health commissioner of New York State.

**Passion:** Inspired by Novello’s passionate talk, the nearly 150 attendees, mostly women, went on to participate in sessions on such topics as career strategies, leadership skills, burnout, mentoring, and personal/professional balance. Among the 25 presenters at the day-and-a-half-long conference were a career development coach, a medical historian, DMS faculty members and alumni, spouses of female physicians, and even a current DMS student.

Career development and executive coach Janet Bickel, a former executive at the Association of American Medical Colleges, counseled participants on ways to recognize and develop leadership skills and to achieve success in their careers.

But attendees were also cautioned to avoid letting their jobs...
Laura Flashman, Ph.D.
Associate Professor of Psychiatry

Flashman uses a combination of cognitive testing, anatomic imaging, and functional magnetic resonance imaging to understand the brain and behavior. Her work focuses on schizophrenia and other psychiatric diseases, mild cognitive impairment, early Alzheimer’s, and traumatic brain injury.

How did you decide to go into your field?
Before graduate school, I took a fantastic course in Behavioral Neurology at the Harvard Extension School. Each week the professor presented a case with the person present—one week someone with aphasia, one week someone with temporal lobe epilepsy, one week someone with spatial neglect. I was hooked and knew that I wanted to study neuropsychology.

If you weren’t a scientist, what would you like to be?
I would like to be an actress (I have been accused of being overly dramatic!), but I get stage fright. I think I probably would be an accountant.

Are there misconceptions people have about your work?
I deal with really basic misconceptions all the time when I talk to people about both neuropsychology (“Does that mean you can read my mind?”) and schizophrenia (“Isn’t that having multiple personalities?”).

What's your favorite nonwork activity?
I really like taking photographs and doing things outside (hiking, skiing, walking on the beach). I have enjoyed doing these activities with my children and watching them become more independent each year.

What famous person, either living or dead, would you most like to meet?
I’d like to meet John Nash, the Nobel-Prize-winning mathematician [and the subject of A Beautiful Mind] who also suffers from schizophrenia.

What about you would surprise most people?
I am something of a thrill seeker—I have jumped out of an airplane and white-water rafted and enjoy scuba diving.

What do you admire most in other people?
Integrity, intelligence, ability to share knowledge in a way others can understand, productivity, and a sense of humor.

What's the hardest lesson you ever had to learn?
In research, you have to develop a thick skin, because papers and grants get rejected often. Learning to move past that, and to benefit from reviewer criticisms and get your work out there anyway, is a hard but important lesson.

What do you ultimately want to discover?
A way to improve the quality of life for people who suffer from severe mental illness.
It’s hard to decide if they’re more unlikely as researchers, matchmakers, or TV personalities, but Dr. Nancy Beck and Bridget Decker are all three. In the lab, Beck, a postdoctoral fellow in microbiology, and Decker, a graduate student in biochemistry, work “mostly with men, who complain that they can’t find anyone to date in the Upper Valley.” And they also happen to have a friend who works at Hanover’s public-access television station. So the pair, who were looking for something to do with their creative energies, put one and one together and came up with a TV show for singles.

**Joke:** It’s not quite like any show you’ve ever seen. Beck—who is dark and glamorously made-up—and Decker—who has a goofy laugh and a more than passing resemblance to actress Drew Barrymore—sit on a brown velvet couch in a vintage clothing store and giggle at their own and each other’s jokes as their interviewees, mostly men, answer questions about themselves.

The production values remain solidly in the cable-access realm, though there’s some mildly adventurous camera work and viewers occasionally get to see the studio audience, which includes people standing on chairs, beers in hand, to get a better view.

**Mate:** “What we study has nothing to do with dating,” Decker says. “Except occasionally, you do get the yeast to mate.” Which may be even harder than encouraging Upper Valley residents to do the same. M.M.
In this section, we highlight the human side of clinical academic medicine, putting a few questions to a physician at DMS-DHMC.

Kristine Karlson, M.D.  
Assistant Professor of Community and Family Medicine and of Surgery

Karlson joined the faculty in 1997. Winner of two world championships in rowing, she was also team physician for the U.S. National Rowing Team at the 2000 World Championships.

What made you decide to become a physician?  
I can’t remember actually making the decision. Since high school, it seemed somehow the right place for me and nothing ever changed my mind.

What are your clinical interests?  
I trained as a family physician first, then did a fellowship in sports medicine. I see both primary-care patients and sports-medicine patients. I enjoy the challenges and joys of following people over time but also am happy that I can combine my medicine and athletic backgrounds in providing care for athletic people of all ages.

What books have you read recently?  
Alice Sebold’s books The Lovely Bones and Lucky are two I’ve read recently. In both she addresses violence from interesting perspectives.

What’s your favorite nonwork activity?  
Since 1997 I have really gotten excited about cross-country skiing, particularly skate-skiing. It’s such a joy to be out in the woods on a clear winter day in a fast, fluid workout.

What’s your favorite nonwork activity?  
Since 1997 I have really gotten excited about cross-country skiing, particularly skate-skiing. It’s such a joy to be out in the woods on a clear winter day in a fast, fluid workout.

What about you would surprise most people?  
I was not an athlete until college. My mother still says that if she had to pick which one of her five kids would have made an Olympic team, it definitely would not have been me. (I was on the 1992 Olympic rowing team and on four national rowing teams in the years prior to that.)

What do family and friends give you a hard time about?  
Patience. When I decide I want to get something done, I usually want to do it now.

Of what professional accomplishment are you most proud?  
Having been board certified in sports medicine in only 1999, I was asked in 2002 to be on the committee that writes the board exam and was subsequently asked to chair the committee. It was a major honor and I think happened because I studied very hard for the exam and did very well on it. A smart colleague who I respect had failed the exam, which got me scared, so I studied harder than I would otherwise have—but it paid off!

What advice would you offer to someone contemplating going into your field?  
Students interested in family medicine and other primary-care specialties are given a hard time by specialists who say they are wasting their talents. But where else do people come in with a variety of complaints and undifferentiated problems, asking you to figure it out? By the time a patient reaches a specialist, somebody else has often already made a diagnosis and decided which specialist should see the patient. But we juggle a lot of potential diagnoses and start the process to find the right one.

What’s the hardest lesson you ever had to learn?  
That hard work and wanting something badly don’t necessarily mean you’ll get it. After my sports fellowship, I trained again for rowing and tried but failed to make the 1996 Olympic team. I have no regrets—it was worth trying, but it was a disappointment.

If you could live in any time period, when would it be?  
Maybe turn the clock back 30 to 40 years. It’s tempting to yearn for simpler and safer times. However, in almost any other time period my opportunities as a woman in both medicine and sports would have been significantly more limited or nonexistent.
Worthy of note: Honors, awards, appointments, etc.

Jay Dunlap, Ph.D., a professor and chair of genetics, received the first Robert L. Metzenberg Award from the Genetics Society of America, for his contributions to understanding the genetics of the fungus Neurospora; the award was presented at the annual Fungal Genetics Conference.

Allen Dietrich, M.D., a professor of community and family medicine, received the 2005 Curtis G. Hames Research Award. The award honors dedication to research in family medicine; the recipient is selected by the Society of Teachers of Family Medicine, the American Academy of Family Physicians, the North American Primary-Care Research Group, and the Hames Endowment.

Surachai Supattapone, M.D., Ph.D., an assistant professor of biochemistry, was named a member of the Clinical Neuroimmunology and Brain Tumors Study Section of the National Institutes of Health.

Nancy Speck, Ph.D., a professor of Medicine and ABC News.

That pattern leaves many people even at DHMC, there was the reported, “but the av....

...’s research colleagues also aimed to temper such hype, in an ABC report about ways to prevent breast cancer and heart disease: ‘It’s important that we not say more than we know,’ said Lisa Schwartz, M.D.” The team also writes a regular series of articles for the Washington Post; their latest piece was titled “Overstating Aspirin’s Role In Breast Cancer Prevention: How Medical Research Was Misinterpreted to Suggest Scientists Know More Than They Do.”

A recent Dartmouth study about the relationship—or the lack thereof—between malpractice awards and insurance premiums drew press from all over the country, including the Boston Globe, the Philadelphia Inquirer, the Associated Press, National Public Radio, and the Los Angeles Times. “Physicians and insurers may fear multimillion-dollar jury awards,” the LA Times reported, “but the average court judgment in 2003 was $461,000, said Amitabh Chandra, a Dartmouth College economist and one of the authors. And 96% of malpractice cases that year were settled out of court for an average of $257,000, he said. . . . The researchers concluded that malpractice payments had risen in line with medical care costs, while doctors’ insurance premiums grew far faster—by double-digit percentages for some specialties. They suggest that recent malpractice premium increases may have had more to do with insurers’ documented losses in the bond market from 1998 to 2001.”

A recent feature in the New York Times Magazine about the importance of autopsies in assessing “diagnostic and treatment routines” and catching “mistakes and bad habits” said few hospitals today value autopsies. But “hospitals that do—teaching hospitals like New York’s Mount Sinai; Dartmouth-Hitchcock Medical Center, in Lebanon, N.H.; and Baylor University Medical Center, in Dallas—manage to absorb the costs [and thus] have a
much better idea where their errors are" and how to improve the care that they deliver.

In a story about the steps hospitals are taking "to prevent one of the most surprising and dangerous hazards facing patients: falls that can lead to severe injury or even death," the Wall Street Journal interviewed DHMC’s director of nursing research. “Surgical patients can be at special risk, notes Suzanne Beyea, Ph.D. . . . In cases she studied, falls occurred moving patients onto operating beds or when staffers weren’t clear on who was supposed to be watching the patient after safety straps are removed,” wrote the Journal. “Patients may also try to get up and walk after surgery before they are steady on their feet,” Beyea also noted.

“When Lloyd Kasper [top photo] and his colleague Randolph Noelle [bottom photo] set out in the 1990s to invent a new drug,” an article in the Financial Times of London began, “they were exploring the frontier between research and business . . . The Dartmouth researchers thought they had found a way to block the biochemistry that spurs MS [multiple sclerosis].” The Times went on to recount the struggles the researchers have faced during their 14-year quest to bring a new drug to market. A similar but more in-depth piece by the same writer also appeared in Science magazine: “The Dartmouth pair, still convinced their discovery can transform the lives of MS patients, are beside themselves with frustration . . . But not enough [frustration], it seems, to prompt either Noelle or his friend of 20 years to capitulate, even as their options for reviving the drug dwindle.”

To find out “what, exactly, are Americans paying for” when it comes to health care, Forbes consulted “Eliott Fisher, a professor of medicine in Dartmouth’s influential health costs group, [who] says that the two most expensive decisions a doctor makes are to send a patient to the hospital and to schedule a new appointment. Yet the benefit of more doctor visits is pretty much unproven, he argues. In fact, switching from specialist to specialist may just provide more opportunities for doctors to ‘drop the ball,’ he says. Areas with more intensive health care often wind up with patients who are less healthy,” Forbes said. “The U.S. could theoretically send one-third of the health-care workforce to Africa,’ says Fisher, ‘and improve the health of both continents.’”

In a New Yorker piece about doctors’ salaries, Dr. Atul Gawande cited the work of a DMS physician-researcher. "William Weeks . . . found that, if you view the expense of going to college and professional school as an investment,” wrote Gawande, "the payoff is somewhat poorer in medicine than in other professions. Tracking the fortunes of graduates of medical schools, law schools, and business schools with comparable entering grade-point averages, he found that the annual rate of return by the time they reach middle age is 16% per year in primary-care medicine, 18% in surgery, 23% in law, and 26% in business. Not bad, in any of these fields, but the differences are there.”

The New Yorker also recounted a now-legendary DMS story: "In the 1970s, a doctor named John Wennberg conducted a study in his home state of Vermont and found that, even in his small and relatively homogeneous corner of the country, doctors in different areas adopted wildly different approaches.” The article updated the story, too: “A recent set of Dartmouth studies, led by Wennberg, looked at the way top teaching hospitals treated elderly patients in the last six months of their lives. . . . At ‘high-intensity hospitals’ patients saw doctors, consulted with specialists, and were given tests far more often than at low-intensity ones.” And all that care “did little but drive up the cost of treatment.”

Referring to the notoriously corrupt 15th-century Borgia family, a DMS pharmacologist responded cleverly to a question posed by National Geographic in a story on toxins. “Is arsenic a poison or a drug?” the writer asked. “It’s both,” says Joshua Hamilton. “It depends: Are you talking to a Borgia or are you talking to a physician?” The article also recalled the tragic death of “Karen Wetterhahn, a professor of chemistry at Dartmouth, [who] spilled a drop, a tiny speck, of dimethylmercury on her left hand,” and later died as a result of the exposure.

“Doctors may no longer make house calls,” the New York Times said, “but they are answering patient e-mail messages—and . . . medical groups around the country are now beginning to pay doctors to reply by e-mail, just as they pay for office visits.” Among those quoted was DHMC’s senior medical director. “ ‘Patients love this stuff; I love this stuff; the staff loves this stuff,’ said Dr. Barbara Walters. One benefit of online messaging—perhaps because it can be done in a setting less harried than a doctor’s office—is that it gives patients a greater degree of control. ‘Patients can describe what’s going on with them,’ [Walters said,] ‘if given the chance and given the time.’"
biochemistry, was appointed chair of the Hematopoiesis Study Section of the National Institutes of Health.

Gilbert Fanciullo, M.D., an associate professor of anesthesiology, was elected to the board of the American Pain Society.

James Bernat, M.D., a professor of medicine, testified before the U.S. Senate Committee on Health, Education, Labor and Pensions about end-of-life issues and advance directives. He is former chair of the American Academy of Neurology’s ethics committee.

Ronald M. Green, Ph.D., an adjunct professor of community and family medicine, was recently awarded a fellowship by the John Simon Guggenheim Memorial Foundation. The fellowship will support his examination of ethical, religious, and literary perspectives on genetic enhancement.

Patricia Ernst, Ph.D., an assistant professor of genetics, received a Kimmel Scholar Award from the Sidney Kimmel Foundation.

Nicholas Shworak, M.D., Ph.D., an assistant professor of medicine, was selected as the American Heart Association’s Lobby Day representative for New Hampshire. One researcher was chosen from each state to exemplify the objectives of the association’s funding process.

Andrew Pomerantz, M.D., an associate professor of psychiatry, based at the White River Junction, Vt., VA, was honored as Manager of the Year and Federal Employee of the Year by the Federal Association of Vermont.

Dean Seibert, M.D., an associate professor of medicine emeritus, was elected to the DMS chapter of Alpha Omega Alpha (AOA), the national medical honor society. Three third-year DMS students were also elected to AOA: Lisa Ernst, Greg Fuhrer, and John Raser.

Jeffrey Barrett, a fourth-year medical student, was awarded a Minority Medical Student Travel Scholarship by the American Psychiatric Association.

Karen Skalla, A.R.N.P., received the Oncology Nursing Society Pat McCue/New Orleans Chapter End-of-Life Nursing Career Development Award. She is an oncology nurse practitioner at the Claremont, N.H., Valley Regional Hospital, part of DHMC’s Regional Cancer Program.

Dartmouth Medical School was again ranked among the top 50 medical schools in the nation by U.S. News & World Report. DMS was 35th in the research category and 34th in a category that factors in the percentage of graduates who go into primary care. DMS was also 17th in the “Rural Medicine” specialty category. The rankings are based on reputation, research funding, student selectivity, and faculty/student ratios.

The DHMC Adult Diabetes Self-Management Program was recently accorded recognition as an “outstanding program” by the American Diabetes Association.