



WELL-HEALED: The Norris Cotton Cancer Center ran a series of five Healing Tapestry workshops in April. Cancer survivors were invited to work with a visiting artist to create personal, expressive “tapestries” of textured, handmade paper.

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 under 40 years old. About 450 will be enrolled in FORTT (Forty and

OveR Infertility Treatment 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 trails. “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 bustle 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 pro-



BRUCE WAHL / BETH ISRAEL DEACONESS MEDICAL CENTER

Richard Reindollar, new ob-gyn chair.

gram 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

Americans 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-



WASTE NOT, WANT NOT: DHMC received one of only eight national Environmental Leader Awards from Hospitals for a Healthy Environment. The awards recognize efforts to cut waste, phase out toxic substances, and eliminate the use of mercury.

icine, 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.”

JENNIFER DURGIN

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 pro-

vide 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,