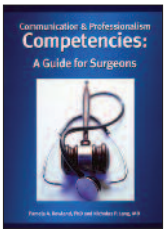
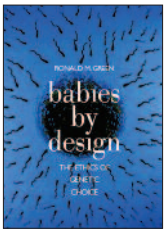
New on the bookshelf: Recent releases by DMS faculty authors

Communication and Professionalism Competencies: A Guide for Surgeons. Edited by Pamela A. Rowland, Ph.D., research associate professor of community and family medicine at DMS; and Nicholas P. Lang, M.D. CineMed, 2007.



Designed for surgeons, this book describes communication competencies in various situations, covering physician etiquette, professional image, and cultural adaptability. It discusses how to make oral presentations, disclose adverse outcomes, and request organ or tissue donations.

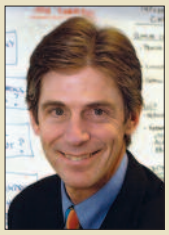
Babies by Design: The Ethics of Genetic Choice. By Ronald M. Green, Ph.D., adjunct professor of community and family medicine at DMS and director of the Ethics Institute at Dartmouth. Yale University Press, 2007. This book presents a scientifically and ethically informed view of human genetic modification and explains the possibilities for the future. It outlines new capabilities in genomic science; addresses questions of safety, parenting, and social justice; and explores religious implications of gene modification.



MEDIA MENTIONS: DMS

Among the people and programs coming in for prominent media coverage in recent months was the Dartmouth Institute for Health Policy and Clinical Practice, which in April published the newest edition of the *Dartmouth Atlas of Health Care*. The volume showed that the amount of money spent on end-of-life treatment varies widely depending on location, inspiring newspapers across the country—including the *Miami Herald*, the *St. Louis Post-Dispatch*, and the *Baltimore Sun*—to find out where their local hospitals ranked. The *New York Times* asked "Dr. **John Wennberg** of Dartmouth Medical School, the chief author of the study" about the findings. "'Some chronically ill and dying Americans are receiving too much care—more than they and their families actually want or benefit from,' Dr. Wennberg said."

Other authors of the *Atlas* were also in demand as the media covered the findings. "**Elliott Fisher**, the report's coauthor," told *USA Today* that "the big differences between hospital systems indicate there is room to improve efficiency, save money, and spare some patients from what may be unnecessary hospital stays. 'These are all high-quality medical centers, but it's amazing the differences in practices among them,' Fisher says." The *San Luis Obispo Tribune* spoke to "Dr. **David Goodman**. . . . Health care, he said, is like sunshine. There are limits to how much is good for you." And the *Wall Street Journal*, among other media outlets, reported on a plan by *Consumer Reports* to publish hospital ratings. "The index is based on work from the Dartmouth Atlas Project, a research effort developed by researchers at Dartmouth."



Not everyone agrees with the *Atlas*'s conclusions. In the *Washington Post*, one doctor argued that "to some, the Dartmouth data encourage the notion that if the supply of specialists and hospital beds were suddenly cut, doctors might reserve fancy care for patients who really needed it, and thus costs would fall. But . . . these cost controls will require hard choices—and, inevitably, haphazard rationing of health care." Others, however, were more convinced. "The Dartmouth researchers estimate that Medicare could save tens of billions of dollars annually," said a *New York Times* editorial. "That is a very good reason to change."

When a study in the *British Medical Journal* revealed that the use of terminal sedation in the Netherlands has risen since 2001, *Time* magazine turned to a Dartmouth expert for commentary.

Terminal sedation "may sound to many people as automatically hastening a patient's death. But that's not the case, says Dr. **Ira Byock**, chair of palliative medicine at Dartmouth Medical School. . . . 'This is a practice, when used correctly, that's only done in the final stages of life. . . . At that point, nutrition or antibiotics can usually do nothing to prolong life.'" But in *U.S. News & World Report*, Byock, "an end-of-life-care expert," warned that sedation can be misused. "'There is no distress you're going to have that I cannot alleviate with medications, but we don't want that to be a substitute for good, comprehensive medical care.'"

Reuters highlighted a study led by **Linda Titus-Ernstoff** on "women whose mothers were exposed to diethylstilbestrol (DES) in the womb. . . . DES, a synthetic form of estrogen, was introduced in 1941 as a drug that prevented miscarriage. An estimated 6 million women worldwide took the drug before its use during pregnancy was banned in 1971." Earlier research showed that DES could cause cancer in daughters of women who took it, "and now it seems that the hazard may have been passed to granddaughters." Titus-Ernstoff found that "although there was no overall increase in cancer, there were three cases of ovarian cancer in daughters of women exposed prenatally to DES—a figure higher than would normally be expected."

AND DHMC IN THE NEWS

The *New York Times* covered the use of "slow medicine" at the Kendal at Hanover retirement community. "The term slow medicine was coined by Dr. **Dennis McCullough**, a Dartmouth geriatrician, Kendal's founding medical director, and author of *My Mother, Your Mother: Embracing 'Slow Medicine,' the Compassionate Approach to Caring for Your Aging Loved Ones*. . . . Grounded in research at Dartmouth, slow medicine encourages physicians to put on the brakes when considering care that may have high risks and limited rewards for the elderly."

"**George O'Toole**, an associate professor of microbiology and immunology at Dartmouth," talked to *U.S. News & World Report* about antimicrobial minerals in mud. "'The effort to identify a new class of antibiotics is important, because most of the varieties we now use have been around for the last 40 years,' he noted. 'However, typically when people look for new naturally derived antibiotics, they focus on living biological material, like plants. So this is an interesting idea . . . that here they're looking instead at an inorganic source like mud.'"

U.S. News & World Report also covered a study led by **Yinong Young-Xu**, a researcher at the White River Junction-based National Center for Post-Traumatic Stress Disorder. His work "is the first observational study to examine the effect of anxiety or depression treatment on a heart patient's risk factors." People with coronary heart disease "who reduced or kept their anxiety level steady were as much as 60% less likely to have a heart attack or die compared to those who had an increase in anxiety level."

"Dr. **James Bernat**, a Dartmouth neurologist," spoke to the *Boston Globe* about organ donation and the definition of death. According to the *Globe*, "surgeons abide by a code known as the 'dead donor rule,' which forbids removing body parts from the living. Yet a few outspoken medical ethicists say the dead donor rule is broken all the time—and, perhaps even more surprisingly, that the rule itself should be abandoned." Bernat is not so sure. "The dead donor rule helps to uphold public confidence in organ transplantation, which is 'somewhat shaky,'" Bernat told the *Globe*. "And breaking the taboo, he worries, could eventually lead ethically challenged doctors to take organs without patient consent."

After the FDA approved the first generic drugs to treat restless legs syndrome (RLS), GlaxoSmithKline pulled all ads for Requip, its popular—and lucrative—RLS drug. To find out why that might be, an NBC station in San Francisco interviewed two Dartmouth researchers. "Dr. **Lisa Schwartz**, associate professor of community and family medicine at Dartmouth, [said], 'It makes you wonder whether there's a disease to be treated.' Schwartz and her husband, Dr. **Steven Woloshin**, also at Dartmouth, say that drug company promotions, combined with uncritical media reporting, have exaggerated the prevalence of restless legs syndrome and led to over-diagnosis and over-treatment with powerful brain-altering drugs."

According to a *New York Times* article about back pain, "for all the money sufferers spend on doctor visits, hospital stays, procedures, and drugs, backs are not improving." So is there anything a sufferer can do? "Dr. **James Weinstein**, editor of the journal *Spine* and chair of orthopaedic surgery at Dartmouth," told the *Times* that "'the best treatment for straightforward back pain without a specific diagnosis is reactivating yourself to what you normally do as fast as possible. . . . I think we are an overmedicated society, and I would not recommend narcotics for everyday back pain except for in most rare of circumstances.'"

The *Los Angeles Times* reported recently on the availability of individual genome scans. "Dr. **H. Gilbert Welch**, a professor of medicine at Dartmouth Medical School," told the *Times* that "he thinks genome scans will make matters worse, especially because most doctors have little genetics training. 'I think a broad-spread application of personalized genetic testing would create havoc and would likely lead to more harm than good,' he says. 'It will make people anxious, and it would probably push doctors to more aggressive interventions simply because of a lack of information and a feeling they had to do something.'"

"Hours in the sack may have more to do with your weight than hours in the gym," reported MSNBC.com. A study has shown that "those getting six hours or less of shut-eye nightly were more likely to become overweight or obese compared to those getting a solid eight hours of nightly slumber. And surprisingly, those getting nine or more hours of sleep were also more likely to become overweight or obese. . . . 'This is a warning to the public that sleep is critical to good health,' said Dr. **Michael Sateia**, chief of sleep medicine at Dartmouth."