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Vanderbilt **Medicine**

WINTER 2005



Targeting
the malpractice
crisis

Distinguished Alumni 2004

The Distinguished Alumnus Awards were given to Irwin B. Eskind, M.D., class of 1948, J. Donald Gass, M.D., class of 1957 and, posthumously, to George R. Burrus, M.D., class of 1955.



Donald Gass, M.D.



Irwin Eskind, M.D.



George Burrus, M.D.
1931-2004

Vanderbilt **Medicine**

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:: on the cover

The crisis surrounding medical malpractice has become larger than life. The system is broken. It needs to be fixed. But how?



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BY HARRY R. JACOBSON, M.D.
Vice Chancellor for Health Affairs

Get a roomful of doctors together and then whisper,

DEAN DIXON



“I’ve been sued.” There is no surer way of focusing the attention of our profession than to talk about the place where medicine and law rub together - often combustibly. Caps on liability, tort reform, no-fault malpractice insurance, specialized courts – the policy alternatives burst forth like daffodils in spring. To listen to the political debate, one might imagine that setting caps on pain and suffering will balance the budget, allow for universal health care coverage and lead to world peace.

Interestingly enough, our experience with the growing malpractice malaise is a result not of a failure in medicine but a result of its great success. Medicine at the dawn of the last century was cheap, safe and largely ineffective. Medicine at the dawn of this century is powerful and effective, but is also expensive and dangerous. In 1905, a doctor often had no choice but to watch a patient die because medicine simply had no tools to assist. Today there are few occasions that a doctor has no tools to assist. Each intervention is an opportunity for error and each intervention carries risk that might lead to a malpractice claim.

Many in our profession look first to reform in law, in the courts and in policy. Pursuing those remedies is appropriate but not sufficient. We must look within medicine for a solution. We cannot con-

tinue to insist that government protect us from the courts unless we are trying our best to address medicine’s contribution to spiraling malpractice claims.

First, we must practice evidence-based medicine. The first defense in a malpractice claim is to demonstrate that the care provided meets the community standard for care for all similar patients. We would help ourselves enormously by setting national standards for care that are continually refreshed to reflect the latest in peer-reviewed research. Then we should use advanced process control techniques and informatics to ensure that we follow our standards with every patient.

Next, we need to construct an environment that encourages medicine to look carefully at its own mistakes so that we can continually improve our own performance, safety and effectiveness. Our reluctance to do so in order to avoid a single malpractice claim assures that we will continue to see more malpractice claims, not fewer. Blame free reporting of adverse events and near misses will let us see our mistakes and systematically correct them. The lessons we are learning at Vanderbilt from the aviation industry will make us a better provider presenting fewer risks to our patients and ultimately demonstrating a liability profile as thin as it can possibly be.

Once we have reformed ourselves, our pleas to seek regulatory or legal relief will carry far more weight. **vm**



Shape the Future campaign reaches historic \$1 billion mark

Vanderbilt University has crossed the \$1 billion mark in gifts and pledges in its multi-year "Shape the Future" campaign. The funds have already been put to use to transform the university and the people it serves.

"It's gratifying to be able to announce this achievement, not only because it signals great success to date in a very ambitious campaign, but also because of the impact we have already seen as a result of this giving," said Monroe Carell Jr., chairman and CEO of Central Parking Corporation and chair of the "Shape the Future" campaign. Carell is also a member of the Vanderbilt Board of Trust, the Medical Center Board, and an alumnus of the School of Engineering. "This milestone figure is a first in the history of the institution, and it represents the generosity of many people."

The goal for the campaign is \$1.25 billion. According to *The Chronicle of Higher Education*, only 20 other institutions in the country are currently attempting a fund-raising campaign with a goal of \$1 billion or more. No other campaign of this size has been undertaken in Tennessee.

The major projects that the campaign is helping fund at the Medical Center include: Monroe Carell Jr. Children's Hospital at Vanderbilt, Vanderbilt-Ingram Cancer Center and Frances Williams Preston Building, Vanderbilt Eskind Diabetes Center, Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences, Vanderbilt Orthopaedic Institute, School of Nursing Godchaux Hall renovations, faculty chairs, Medical School scholarships and research initiatives. **VM**

-SUSANNE HICKS AND JESSICA HOWARD

News and happenings at Vanderbilt Medical Center

Food on demand

"When you are feeling bad, familiar things are better," said Gloria Rader, grandmother to 2-year-old cancer patient Logan Catron.

Those words are at the heart of a major change implemented by Nutrition Services at the Monroe Carell Jr. Children's Hospital at Vanderbilt. Families can now order room service meals from a new child-friendly menu, delivered within 45 minutes of their call.

"We have chicken nuggets shaped like dinosaurs, and fish sticks shaped like anchors or star fish and colored blue or green," said Karen Raffey, a registered dietitian and director of Nutrition Services for VCH.

A survey and suggestions from the Pediatric Advisory Council (PAC) led to a new menu that included food items that could be quickly prepared at the Children's Hospital and delivered by hosts/hostesses specially trained for customer service.

The service started with a pilot program on the sixth floor. With the new system, patients can order just for the next meal, or they can make choices for the whole day or even several days in advance.

"There is this legendary story about a teen-ager who brought a hamburger to a PAC meeting, and the hamburger had been re-heated twice in the microwave while he was out getting tests," said Terrell Smith, the administrative director in charge of family-centered care at Children's Hospital. "As only a teen can do, he twisted the rubbery meat in front of the group, and knocked the roll on the table. Then he waved the plastic baggie around saying it looked like a piece of police evidence. He wanted to know if Pizza Hut can get a pizza to his house, hot and fresh in less than an hour, why couldn't nutrition services do the same thing just three floors up in the same building?" **VM**

-CAROLE BARTOO



**Logan Catron, 2, with
an order from the new
child-friendly menu.**

Protein to the rescue

KSR1 could be therapeutic target for inflammatory bowel disease

In the inflamed intestines of a patient with inflammatory bowel disease (IBD), the body's own immune system commands the cells lining the intestinal tract to commit suicide.

Recently, Vanderbilt University Medical Center researchers identified a life-preserving protein that seems to rescue these cells from an almost certain death.

The protein, called kinase suppressor of Ras-1 (KSR1), protects the intestine by turning on survival pathways inside the cells. This discovery suggests that KSR1 could be a novel therapeutic target for inflammatory bowel disease as well as certain types of gastrointestinal cancers.

The study, led by D. Brent Polk, M.D., professor of Pediatrics and Cell and Developmental Biology, was published in the November issue of the *Journal of Clinical Investigation*.

Inflammatory bowel disease, a group of conditions that includes Crohn's disease and

ulcerative colitis, affects nearly 1 million Americans. These conditions are characterized by chronic inflammation (redness and swelling) of the digestive tract. In IBD, an overactive immune response churns out heaps of pro-inflammatory proteins, which prompt the epithelial cells lining the intestines to commit suicide.

"Clearly, not all the intestinal cells die (in IBD)," Polk said. "The question that we were asking is 'what are the factors that regulate intestinal cell survival in an inflammatory environment?'"

One pro-inflammatory protein that is produced in large amounts is tumor necrosis factor (TNF). TNF can act as either a survival or death signal depending on the activation of other cellular proteins, including KSR1.

Polk and colleagues used several different animal models to investigate the role of TNF and KSR1 in the fate of intestinal cells.

Polk first examined KSR1 activity in mice that lack an anti-inflammatory protein called interleukin-10 (IL-10) — a standard model of IBD. These mice produce high levels of TNF and show increased inflammation and death of intestinal cells.

"When we looked at those mice which had IBD, KSR1 was activated," Polk said. "Not only was KSR activated, but the cell survival pathways were also activated with inflammation." This showed that KSR1 likely jump-starts the cell survival machinery, in order to protect the cell from impending death.

In another model, Polk injected TNF into mice that lacked KSR1. The cell survival pathways did not become active. However, the cell death pathways were fully activated, again suggesting that KSR1 regulates the life-or-death decisions prompted by TNF.

In a final set of experiments, Polk bred the two mutant strains of mice together to form a genetic cross lacking both IL-10 and KSR1.

"Our thinking was that ... if we had exaggerated TNF production (as in the IL-10 deficient mouse) and also lacked KSR1, we would expect to see increased cell death. And that's what we saw."

With the results of the three experiments, Polk and colleagues have provided mounting evidence that KSR1 is a master switch that promotes cell survival in the face of inflammation. Thus, activating KSR1 with drugs could protect intestinal cells from inflammation-induced death, providing a novel approach to treating IBD.

Since proteins like KSR1 are activated by the addition of phosphate groups, a process called (phosphorylation), Polk is currently working on identifying these phosphorylation sites within KSR1.

Other Vanderbilt authors on the study were Fang Yan, Sutha K. John, Guinn Wilson, David S. Jones and M. Kay Washington. The research was funded by the Crohn's and Colitis Foundation of America and the NIH. **VM**

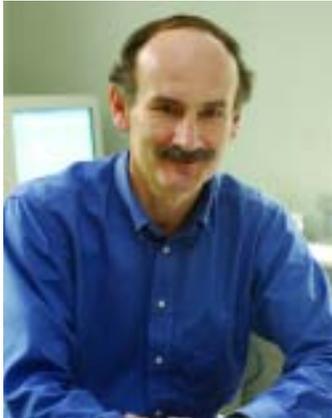
—MELISSA MARINO

D. Brent Polk, M.D.



ANNE RAYNER

Wayne A. Ray, Ph.D.



DANA JOHNSON

Antibiotic interaction boosts sudden death risk

The widely used antibiotic erythromycin — prescribed for common ailments like sore throats and ear infections — increases the risk of sudden cardiac death.

A team of Vanderbilt University Medical Center investigators reported in September in *The New England Journal of Medicine* that patients taking oral erythromycin in combination with other medicines that increase its levels in the body were five times more likely to die from a sudden cardiac arrest.

The findings sound a cautionary note for patients and their physicians, said Wayne A. Ray, Ph.D., professor of Preventive Medicine and lead author of the study.

“For physicians, the message is to avoid giving erythromycin with drugs that inhibit its breakdown,” Ray said. Such drugs include the calcium channel blockers verapamil and diltiazem, used in the management of high blood pressure, and antifungal medicines like ketoconazole and fluconazole.

And it’s not just drugs, Ray added. Grapefruit juice also slows the breakdown of erythromycin, causing higher than expected blood concentrations and posing a potential risk.

“Patients and their physicians need to be aware of these potentially harmful combinations and avoid them whenever possible,” Ray said.

Oral erythromycin taken alone is still considered a safe drug.

The new study is the first to systematically address whether or not erythromycin increases the risk of sudden cardiac death. There were rare case reports suggesting an increased risk in patients receiving intravenous erythromycin, said co-author C. Michael Stein, M.B., Ch.B., associate professor of Medicine and Pharmacology.

“But generally people assumed that oral erythromycin, which is very widely used to treat all kinds of bacterial infections, didn’t have this risk,” he said.

Ray, Stein and colleagues studied a group of Tennessee Medicaid enrollees who died suddenly from cardiac causes between 1988 and 1993. The study group is considered one of the best-characterized cohorts of sudden death available, Stein said, because all of the medical records were carefully reviewed by Ray and his team. The cohort included 1,476 cases of sudden cardiac death.

In the small subgroup of these patients who had taken erythromycin along with one of the drugs known to slow its breakdown, there were three deaths. Though the number is small, Ray said, it is statistically unlikely that those deaths were due to chance.

“It is an unacceptably high risk,” Ray said. **VM**

—LEIGH MACMILLAN



Patient satisfaction at heart of VUMC quality initiative

Leaders are opening a new chapter at Vanderbilt University Medical Center, renewing and sharpening the institution’s commitment to service and operational excellence. Among their chief aims is to improve the experience of patients in Vanderbilt hospitals and clinics.

And while they’re at it, the leadership team plans to refine how work in general is directed at VUMC. In what leaders say will be a two- to four-year process, new goals and accountability for patient satisfaction will be matched with goals and accountability for clinical quality, financial results, staff and faculty satisfaction and growth in patient volume.

“Our work to help patients overcome sickness and injury and live healthier lives is extremely valuable, and the people who work here are great at what they do,” said Vice Chancellor Harry R. Jacobson, M.D.

“There’s every reason to insist on uncompromising customer service,” Jacobson added. “Vanderbilt is poised to help improve and reshape health care, but if we’re to hope to fulfill any part of this promise, the experience of our patients needs to figure more strongly in how we do our work. The best in customer service coupled with our already incomparable clinical care will help us reach our goal of being the health care provider of choice in our entire region.”

Sweeping efforts toward change at VUMC will be focused into a program that will be known as “Elevate.” The program is assisted by the Studer Group, and takes an approach of treating staff and faculty satisfaction as the key to patient satisfaction and overall success. Led by former health care executive Quint Studer, the company has worked with top-performing organizations such as The Cleveland Clinic and Sisters of Mercy Health System. **VM**

— PAUL GOVERN

Procedure eases vein harvesting

A new vein harvesting technique performed at Vanderbilt University Medical Center is making coronary artery bypass surgeries more appealing to patients by reducing pain and shortening recovery times.

Traditionally, the greater saphenous vein, located in the leg, is used as the conduit to bypass blocked coronary arteries, and until recently, patients undergoing this type of heart surgery would require a lengthy incision along the inside of the leg to retrieve the vein.

Now, physicians have developed a less invasive technique — endoscopic vein harvesting — that typically requires only two small (2cm) incisions to remove the leg vein for use in the heart.

It's an improvement that patients will be happy to see.

James Greelish, M.D., assistant professor of Cardiac Surgery and one of the physicians supervising the new technique, said the traditional procedure of filleting the leg open for vein harvesting is problematic for several reasons, including increased infection rates, pain and poor aesthetic appeal.

"This new minimally invasive technique is of great benefit for our patients," Greelish said. "There are many advantages — less pain, lower infection rates and improved mobility leading to quicker rehabilitation. It is exceedingly rare to see a patient return with a wound infection due to these smaller incisions. This in turn results in a cost savings to Vanderbilt."

Since beginning the new technique in September, Vanderbilt has performed more than 50 cases.

Vanderbilt is using the new Vasoview technology by Guidant Corp. to harvest veins. The steps of the procedure are as follows: an incision is made at the knee;

a camera and dissector are inserted through a cannula (the device through which all the instruments are inserted into the leg) which is then inserted into the incision; another device called the trocar is also inserted, which allows for CO2 to be injected into the site and create a tunnel, or cavity, so that the medical team can manipulate the surgical instruments and remove the vein. **VM**

- JESSICA PASLEY

Pot smoking could increase tubal pregnancies

Marijuana use may increase the risk of ectopic (tubal) pregnancies, researchers at Vanderbilt University Medical Center recently reported.

The researchers studied CB1, a "cannabinoid" receptor that binds the main active chemical for marijuana, delta-9-tetrahydrocannabinol (THC).

In pregnant mice that lacked the gene for the receptor, or in which the receptor was blocked, the embryo failed to go through the oviduct — the tube leading from the ovaries to the uterus. The same thing happened in normal mice when the receptor was over-stimulated.

The study, published in the Oct. 1, 2004 journal *Nature Medicine*, describes for the first time how the CB1 receptor in the mouse regulates muscle contraction to move the embryo down the oviduct.

It is not known whether drugs that block or, in the case of marijuana, over-stimulate the CB1 receptor can cause ectopic pregnancy in humans. However, "our results raise caution for women of reproductive ages regarding the chronic use of marijuana for recreation or pain alleviation," the researchers concluded.

The report's senior author, S.K. Dey, Ph.D., Dorothy Overall Professor of Pediatrics, said he also was concerned about the potential impact of an anti-obesity drug, now in clinical trials, that suppresses appetite by blocking the CB1 receptor. Such a drug, if approved, would likely be taken by young women of reproductive age.

"What will happen if they consume anti-CB1 drugs?" asked Dey.

Marijuana exerts its effects in the brain and peripheral organs through two cannabinoid receptors, CB1 and CB2. Lipid molecules made by the body, called "endocannabinoids," activate these receptors, and are involved in several important physiological functions, including memory, pain and appetite.

The study was supported by the National Institute on Drug Abuse and the National Institute of Child Health and Human Development. **VM**

-BILL SNYDER



MATT GORE

seeing clearly

Study 'eyes' alternative to LASIK



LASIK, a surgical procedure intended to reduce a person's dependency on glasses or contact lenses, has reached such a level of familiarity that most people don't even know that LASIK stands for Laser-Assisted In Situ Keratomileusis. The procedure, however, isn't for everyone. Besides the cost and risk factors associated with the procedure, there's a group of people who aren't even candidates in the first place – those with severe nearsightedness.

A new investigational procedure, however, could provide clearer vision for those who couldn't see LASIK surgery in their future. Instead of altering the cornea with a laser beam,

Instead of altering the cornea with a laser beam, the new procedure is intended to correct vision with a surgically inserted lens.

the new procedure is intended to correct vision with a surgically inserted lens. "For many patients with severe nearsightedness, their only option is to wear glasses or contacts, because their corneas are too thin for LASIK surgery," said Jeffrey Horn, M.D., assistant professor of Ophthalmology and Visual Sciences and surgeon for the new clinical study.

"We hope this procedure will give these patients another possibility." Patients enrolled in the clinical study of the Acrysof phakic intraocular lens will have a small lens surgically inserted into one eye. Because the investigational lens is pliable, the surgery requires a very small incision similar to the size used in today's cataract surgeries and most likely will not need stitches. In about the same time it takes to perform LASIK or cataract surgery, the investigational lens can be placed in the eye in front of the iris.

"The investigational lens is made from a soft, gentle acrylic material. This same Acrysof material is also used in lenses that treat cataracts and was implanted in approximately 175,000 patients nationwide who underwent cataract surgery last year. Close to 20 million of these cataract lenses have been implanted globally since it was first developed for medical use," Horn said.

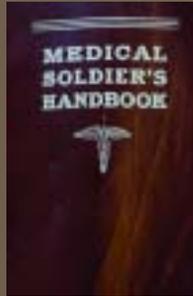
"Because we are not altering the corneal curvature, as is done with laser vision correction, but rather inserting a new investigational lens into the eye, the quality of vision should be preserved and in some patients in the study, it has even improved," Horn said.

Recently the Food and Drug Administration approved the use of a similar type of lens and will review the performance of this investigational lens at the conclusion of this clinical study.

"I am very proud and excited to be in this study," Horn said. "More so, I feel being chosen to participate in this clinical study is further evidence that the Vanderbilt Eye Institute is one of the nation's premier eye and refractive surgery centers."

Healthy patients, age 18 to 49, with stable, severe nearsightedness, and who can tolerate their contact lenses are being recruited for this clinical study. Participants will receive the consultation, lens and follow-up visits free of charge, but will be responsible for certain operative fees. The study will last about three years. **VM**

– LISA PEPPER



THE 300TH GENERAL HOSPITAL, Vanderbilt Hospital's unit in World War II, was formed in 1942. Hugh Morgan, M.D., was the first commanding officer. When he was transferred to Washington, the unit was placed under the command of Col. George Reyer, a Vanderbilt medical school graduate. After training at Camp Forrest in Tullahoma, Tenn., and many false alerts, the group left for overseas in August 1943. They were expecting to establish a hospital in North Africa, but were reassigned to the Fifth Army and sent to Italy. After the entire unit arrived from Africa in November 1943, 25,000 patients were treated during the first year and the hospital's bed capacity was increased from 2,000 to 3,000. In one 24-hour period in 1944, 130 surgeries were performed. In 1945, some of the 300th returned home and some departed for the Pacific. The unit was awarded a meritorious service unit plaque for superior accomplishment.

From current display in the Eskind Biomedical Library Historical Collection.

The Fighting 300th

1.



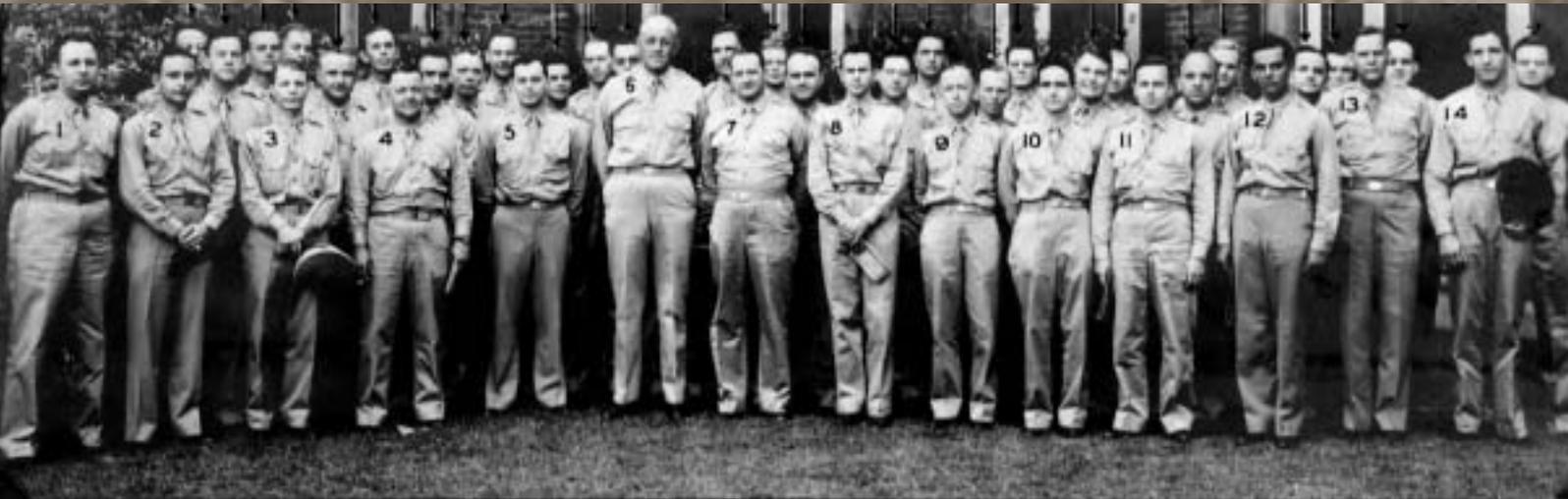
2.



3.



4.



Pictured here:

1. The Fighting 300th arrives in Italy
2. Col. George Reyer
3. The nurses in the Vanderbilt Unit, September 1942
4. An official portrait of The Fighting 300th
5. Benton Neil Jr., a dentist, fills canteens

5.



a whirlwind *of* research

While many of his fellow medical students were focused primarily on understanding the pathophysiology of disease, Gerald B. Hickson had a growing interest in a rather unusual area of research – how patients and physicians communicate. Even as a young medical student, he realized that successful communication was crucial to successful medical care.

“I WAS STRUCK BY HOW CERTAIN OF MY PROFESSORS could link effectively with families, and how others didn’t do so well,” said Hickson, associate dean for Clinical Affairs. “For my own career, I wanted to figure out how to best connect with families in a way that ensured the appropriate flow of information – ultimately to be able to offer the best care that I could.”

Hickson’s interest led him to Vanderbilt, and eventually to his current role as director of the Vanderbilt Center for Patient and Professional Advocacy.

Hickson began his education in his home state, earning a B.S. at the University of Georgia in Athens. He went on to receive his medical degree from Tulane University School of Medicine in New Orleans. When Hickson came to Vanderbilt in 1978 as a Pediatric intern, he realized it was where he wanted to spend his career.

“I found a unique environment at Vanderbilt, where there is a degree of collaboration and professionalism that I always wanted,” Hickson said. “After completing my fellowship, I turned down what seemed to be a pretty impressive long-term offer from another institution to stay at Vanderbilt, where I only had a one-year appointment. I thought it would be best in the long run, and a few years later I knew it was the right decision.”

In Pediatrics at Vanderbilt, Hickson quickly moved up the ladder, and in 1990 he was named chief of the Division of General Pediatrics. Although his days were filled with patient care and the responsibilities

WRITTEN BY LISA PEPER
PHOTOGRAPHY BY DEAN DIXON

Hickson translates
volumes of malpractice
research into better
patient care



“Patients and their families often judge the quality of medicine based on aspects of interpersonal care, and if they don’t feel respected or weren’t treated properly or didn’t get answers, they assume the care was substandard.”

of running the division, Hickson remained steadfast in his research.

He continued to pursue his interest in communication skills that was sparked in medical school, but he began taking it in a new direction, studying medical malpractice issues.

“I became interested in malpractice in part because of my observation of the impact being sued had on certain house staff when I was running the Pediatric Residency Program,” Hickson said. “I began reviewing the medical literature at the time and was disappointed at the relative lack of empirical studies about a major part of our medical care delivery system – something that greatly influences our care.”

Hickson sought to understand the litigation process and began research projects with colleagues throughout the University.

“Every time we finished a study, we would have additional questions,” he said. “The ultimate challenge, which we began thinking about in the mid-90s, was how do we translate all that we’ve learned, not only into additional research, but to address the malpractice risk that exists in medicine.”

Hickson wanted to provide physicians with empirical data regarding medical malpractice – to define who was at risk and what measures physicians could take to lessen that risk.

“There is this dogma out there that malpractice risk is based on the complexity of care delivered, the patients seen or even just luck. But research suggests a very different answer. It’s actually very logical,” Hickson said.

Through his research, Hickson has learned risk can be defined by three factors: a physician’s chosen specialty, the number of patients seen, and the level of patient dissatisfaction based on the patients’ perceptions that no one has time for them, will answer their questions, and that they are not respected as humans.

Of these factors, Hickson said, controlling patient dissatisfaction is the most practical way to lessen malpractice risk. Patients who are unhappy with their treatment are more likely to sue, even if

the bad outcome they experienced has nothing to do with medical negligence, he said.

“Patients and their families often judge the quality of medicine based on aspects of interpersonal care, and if they don’t feel respected or weren’t treated properly or didn’t get answers, they assume the care was substandard,” Hickson said. “Physicians can choose how they will deal with risk. But it behooves them to examine how their practices make some people unhappy,” he said.

Hickson and his team have determined that unsolicited patient complaints are a very good proxy for malpractice risk. The Vanderbilt team has identified that 4 percent to 6 percent of physicians by hospital site will generate 35 percent to 50 percent of all complaints. These physicians are the ones with the most lawsuits, perhaps 20 percent to 40 percent of all claims. According to Hickson, these physicians can lower their risk by addressing what it is about their practice or their behavior that makes patients and their families upset.

First, he said, dissatisfaction can be generated by the practice itself – a physician in high demand can be perceived by patients who must wait months for an appointment as “too busy” to see them. Medical professionals can be cast in a negative light before they even see the patient.

Second, a physician can have behaviors that are perceived in a negative light.

“For example, one physician we worked with had great communication skills, but he chose never to sit down in the presence of a patient,” Hickson explained. “He found he could get through his day faster by never sitting. This was a behavior that was perceived negatively by some families who thought he didn’t care enough to sit down with them. Sometimes doctors make a value decision about how to act and that leads to unintended consequences.”

Hickson said that some physicians may put themselves at risk with a mindset that their only job is to do the right thing technically, but that a large segment of society expects more from a medical professional. Lastly, at risk are those

malpractice risk at a glance

- 4 percent to 6 percent of physicians by hospital site will generate 35 percent to 50 percent of all complaints.
- These physicians are the ones with the most lawsuits, perhaps 20 percent to 40 percent of all claims.

physicians who are impaired in one way or another – with addictions or even personality disorders.

“It’s important to note that the vast majority of physicians are kind and want to do the right thing,” Hickson said. “Our goal is to help those physicians be reflective, so they don’t get caught up in lawsuits.”

This quest led Hickson to his current position, a full time effort of trying to identify and address risk, not only at Vanderbilt, but at other institutions across the country.

Hickson began a program at Vanderbilt to review unsolicited complaints, identify high-risk physicians, and work with these physicians to understand how they can lower their risk for lawsuits. The program began to draw interest from other institutions, and Hickson and his team began initiating the program at medical centers across the country.

“We have found great results from most physicians we have worked with,” he said. “Once you provide them with data – if they are willing to reflect on it – they respond in a positive way and want to know what they can do to lessen their risk.”

For many physicians, the solution is learning how to engage the patient, to express concern and care, and to properly disclose information when there is a bad outcome. It all comes back to Hickson’s initial interest – communication skills.

“I hope that as a result of our process of identifying and addressing risk that we will make the institutions that we’re working with safer and care experiences more satisfying for our patients,” Hickson said. “With the prime focus on addressing risk, providing education and continuing to pursue, ask and answer questions about the system of litigation, we hope to really influence the culture here at Vanderbilt and across the country.” **VM**



Quiet phones mean happy patients

John McCauley hopes for the day when he can be like the Maytag repairman – sitting by the phone with no one calling. It’s not only because callers usually aren’t happy. More so, it’s because when the phone

rings it usually means someone thinks they’ve had a bad experience at Vanderbilt.

“I would be happy not to be needed, because that would mean that the safety measures Vanderbilt is putting into place are working, and patients are experiencing better results,” said McCauley, assistant vice chancellor for Risk and Insurance Management.

But the phones are still ringing and McCauley continues his role, leading the office that tries to quickly and carefully deal with adverse events. Beyond post-event management, the Office of Risk and Insurance Management works to promote the delivery of quality health care, promote safety, identify and control hazards and injuries and protect the University’s resources.

While the office also buys and provides insurance and administers workers’ compensation, the area of the most activity is professional liability. As a self-insured medical center, Vanderbilt supplies professional and general liability coverage for VUMC, its employees, medical and nursing students, nurses, residents, fellows and full-time faculty.

“But beyond providing coverage for employees, we want to be a resource for medical professionals,” McCauley said. “Should a situation occur, we do the investigations and work with those involved to make the best decisions to reduce the risk of a lawsuit, but we also put a lot of manpower and resources into preventing risk.”

McCauley’s office has three nurses dedicated to working with the Medical Center, including a clinical risk manager who spends much of her time identifying potential risks before a patient is harmed. They also work closely with F. Andrew Gaffney, M.D., who serves as the chief quality and safety officer for VUMC.

Education is another way the office hopes to reduce risk. Through their Web site, requested presentations, the annual new employee orientation and personal counseling, McCauley and others in his office teach employees the ins and outs of medical malpractice, other medical risks such as patient privacy and safety reporting, and the steps medical professionals can take to prevent lawsuits.

According to McCauley, early intervention helps physicians protect themselves from unnecessary lawsuits, but also benefits those who are injured by giving them deserved compensation in a timely manner.

Although managing risk and insurance seems to imply that the priority is keeping money from leaving an institution, McCauley said Vanderbilt cares more about the patient’s best interest – even when that interest means a financial loss.

“We work as hard at prevention as we do at minimizing risk,” McCauley said. “I’m not aware of any other organization that puts as many resources into prevention.” **VM**

- LISA PEPPER



Like many topics thrust into the national spotlight through politics or a media frenzy, the crisis surrounding medical malpractice has become larger than life. 🎯 There is no doubt the medical malpractice system is broken. There is no question that it needs to be fixed. But there's also no consensus on how to fix it – and this may be the true crisis.

Targeting

THE MALPRACTICE CRISIS

THE CONCEPT OF MEDICAL MALPRACTICE and a doctor's legal duty to perform up to a professional standard is hardly a recent phenomenon. Even in ancient Rome doctors were held responsible for negligent treatment.

“There is a considerable body of Roman case law on the wrongful infliction of harm,” said Thomas A. J. McGinn, Ph.D., associate professor of Classics at Vanderbilt and an expert in Roman law. “There are legal rules, a legal standard for the duty of care, that insist a doctor must be appropriately careful in the exercise of his skill. Doctors are liable for careless treatment of any type; they are culpable for not having foreseen what a careful person could have foreseen.”

Today's medical malpractice laws are grounded upon similar principles. Although they can vary from state to state, in most states, malpractice law rests on three basic concepts: negligence, causation and damages.

“To win a suit in Tennessee, a plaintiff must prove that the health professional failed to provide the recognized standard of care, and that the substandard care led to the injury,” said John McCauley, assistant vice chancellor for Risk and Insurance Management. “Damages can include the medical costs associated with the injury, lost wages and pain and suffering.”

The legal system is supposed to help those who suffer from medical negligence receive compensation, and malpractice insurance is meant to protect medical professionals from claims made against them.

According to McCauley, insuring physicians used to be fairly easy for one simple reason – there weren't many malpractice claims.

WRITTEN BY LISA PEPPER
ILLUSTRATION BY DAVE CUTLER

Just the facts, ma'am

When attorneys send files of information on obstetrics and gynecology malpractice cases to Frank Boehm, M.D., for his review, he wants only the facts.

Boehm, who has been reviewing medical malpractice cases for attorneys for the past 23 years, has a different approach from many medical experts. He asks that he not be told whether he is reviewing the case for the plaintiff or defense.

"My attitude on this is that the facts should say what they say. They shouldn't change one way or the other after I've reviewed the facts and come to some overall impression," said the professor of Obstetrics and Gynecology and former director of the Division of Maternal/Fetal Medicine.

For nearly a decade after Boehm joined the faculty at Vanderbilt, attorneys would call his office, asking him to review notes from medical/legal disputes. He turned them down time after time.

"I was young, relatively inexperienced, knew nothing about the law, and consequently felt I needed to concentrate on my career, my research, my teaching and my clinical work rather than get involved in the arena of medical/legal disputes," he said.

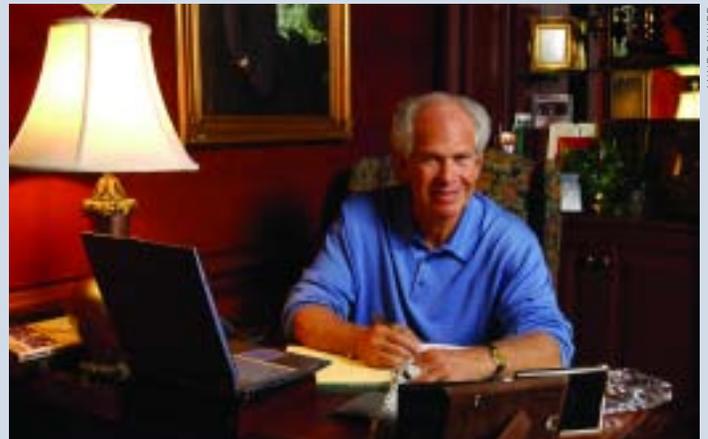
But in 1981 he changed his mind when he realized only a few obstetricians were doing this, and began professionally

reviewing cases sent to his office. He'd take them home and review them at night and on the weekends.

"The American College of Obstetrics and Gynecology and the AMA said it was our ethical duty to get involved and do it in a professional way, that we are the ones to help the courts answer these very difficult questions," Boehm said. "But I soon realized I was going to have to make up rules as I went along. It wasn't like you could read a book and learn how to do this. I didn't understand how to accept cases, if I should advertise or not, if I should only take cases for the plaintiff or only for the defense, if I should take cases from Nashville, how much I should charge, how I should conduct myself in a deposition, and what exactly was meant by terms like 'standard of care.'"

It was only after several years of reviewing cases that he re-thought his *modus operandi*. He decided he needed to be as objective as he could, to prevent either becoming an advocate for, or giving the appearance he was an advocate for one side or the other. So he decided two things: he would no longer accept cases from Vanderbilt's referral base: all of Tennessee, Southern Kentucky and northern Alabama. He didn't think it was proper as director of Maternal/Fetal Medicine to accept patients transported

Frank Boehm, M.D.



ANNE RAYNER

from other cities, then turn right around and help someone sue the doctors who trusted Vanderbilt to take care of their patients. He also made a decision not to speak to the attorney calling to ask for help. The calls are instead taken by an assistant, who asks the attorney to send the information.

Boehm says he doesn't review depositions at that point, just the facts of the case, and has never even been tempted to read the last page of the book, so to speak, to find out which side the attorney represents. "Every time I get one of these cases, it's like reading a Sherlock Holmes mystery. I'm thinking 'I hope this doctor will have done this or this nurse will have done that.' After he reviews the information, he calls the attorney and points out the strengths and weaknesses of both sides, before finally finding out which side the attorney represents and saying if he can help or not.

Boehm, who was sued once, but the case dismissed, says he learns something from each case he reviews. He said Vanderbilt also benefits from

the knowledge he gains from each case. But he admits being a medical expert isn't for everyone. "Each case is an indictment of the medical profession – a doctor, nurse or midwife being accused of negligence. To participate in these cases, you have to have a thick skin and enjoy the process of debate. You have to think ahead and understand where questions are going. It's easy to get tripped up in this business. Lawyers are good at finding holes in your argument. It's not something you can enter into lightly." **VM**

— NANCY HUMPHREY

“Up until the 1970s most hospitals were community, governmental or charitable entities and had a level of immunity. You really couldn’t sue these hospitals,” McCauley said. “And even more, there was a locality rule that in order to sue a doctor or nurse, you had to have another doctor or nurse testify what the standard of care was in that community. Back in those days, no one wanted to step forward and say that their colleague down the street was negligent.”

This protection began eroding as hospitals became private enterprises, medicine grew into big business and specialization removed some of the sense of community

and beginning in the late 1980s, you had a flood of companies offering malpractice insurance.”

Increasing competition for business leads to a declining price of insurance. And then something happens - prices go down, insurance companies begin losing money and some leave the market. Supply becomes limited, driving up the price of premiums and the process starts all over again.

“Insurance is cyclical. When there are fewer insurers, premiums are higher and insurance companies make money,” McCauley said. “More insurers buy in and eventually premiums go down. This

Hickson said plaintiff attorneys have also gotten better at arguing their cases.

“Lawyers are becoming more and more successful and are now winning more than they are losing in pregnancy-related cases,” he said.

Money and lawyers aside, perhaps the most disconcerting factor adding to the crisis is inefficiency of the system. Many argue that the courts don’t do a good job of sorting out which lawsuits are valid and which are not.

“Those who deserve compensation don’t always get justice,” Hickson said.

Many families indicate that they sue only to find out “what really happened”

“Medicine has been de-mystified, and we actually began educating the public about medical mistakes.”

from the industry. Hospitals became perfect targets for lawsuits and insurance companies didn’t know how to handle it.

“There wasn’t much history to base malpractice rates on. Insurance companies were charging low prices, but then all of a sudden they were seeing real claims,” McCauley said. “If they weren’t paying them, then they were defending them, and either way, they weren’t making any money.”

Insurance companies had to adjust – some insurers left the market, malpractice insurance premiums skyrocketed, medical professionals struggled to afford insurance, and the first medical malpractice crisis was born.

Over time, the insurance market became more stable. The higher premiums were leading to profits, and more insurers began writing medical malpractice policies.

“It’s like any free market activity,” said Gerald B. Hickson, M.D., associate dean for Clinical Affairs and director of the Vanderbilt Center for Patient and Professional Advocacy. “You have soft markets and you have hard markets. It’s the notion of supply and demand economics. When insurers can make a lot of money, other insurers become interested,

was the case in the mid-80s, when the market burst again. And it’s the case now.”

Fanning the malpractice fire

While today’s insurance crisis may have its roots in free market activity, there are other factors adding insult to injury: verdicts are getting bigger, plaintiff attorneys are getting better, and sorting out who deserves what is getting harder.

“Juries have become more generous,” Hickson said. “If you look at the judgments from 1992 to 2002, median awards tripled. Why? Well, individuals may be angry as medicine has become more complicated and they have had more hoops to jump through, related to managed care. Jury members may sympathize with the patient more and physicians less. Medicine has been de-mystified, and we actually began educating the public about medical mistakes.”

According to McCauley, most people’s idea of what is fair compensation has also changed.

“With the lottery, \$1 million doesn’t seem like that much anymore,” he said. “Now we’re seeing \$60 to \$80 million verdicts.”

or because they don’t feel their doctor listens to them, answers their questions or warns them of the risks. And statistics show that for every valid suit, there are five to seven times as many invalid suits.

“At the end of the day, the public feels that no one is looking out for them – and no one is happy,” Hickson said.

Medicine’s prescription for medicine

For as many problems as have been identified in the medical malpractice system, there are an equal number of suggested solutions. With the nation divided and with policymakers split, there is no sure answer in sight. Medicine may be left to pull itself out of a state of crisis.

“If you go through the newspapers and the magazines, and you look at all the suggestions for malpractice reform, it’s lowering the percentage that lawyers get; it’s capping punitive damages. There’s a whole series of things aimed at tort reform and perceived abuses. Nowhere do you find reducing the errors that hurt patients,” said F. Andrew Gaffney, M.D., associate dean for Clinical Affairs. “What if we just don’t hurt as many people? Then we won’t get sued as much, and

Resting in the jury's hands

Seth Scholer, M.D., is one of many physicians who's defended an unwarranted medical malpractice lawsuit. Scholer said he knew he had made the right medical decision, calling the Tennessee's Department of Children's Services (DCS) to report that he suspected a patient was the victim of abuse.

The mother of a young patient of Scholer's complained her child suffered from various symptoms. But after a full examination and testing, Scholer could find nothing wrong with the child. He consulted the physicians who had treated the child before and his colleagues at Vanderbilt who had examined and tested the child, who concurred that they also could find no medical problems. Scholer brought the case to Vanderbilt's Child Abuse Referral and Evaluation Committee.

"I was concerned that the mother was fabricating the symptoms, leading to unnecessary tests and procedures," Scholer said. "If this was the case, the mother was causing the medical professionals to put the child through the pain of the tests and procedures and was mistreating her child."

Scholer and his colleagues suspected the child was a victim of a condition called Munchausen's Syndrome by Proxy, an illness in which the caregiver fabricates or induces symptoms in a child.

"The law is clear, when you have a concern that a child is being abused, you have to report it to DCS," Scholer said. So he did.

Soon after DCS began investigating the case, Scholer, two other doctors and Vanderbilt University Medical Center were sued for medical malpractice. It's not uncommon for those with Munchausen's to pursue litigation. But the case was dismissed.

"I was fortunate to have a good result and to have the full backing of my institution," Scholer said. "It was difficult, and I wish there was a better system, but I had to do what was best for the patient, and I'd do it again if I had to." **VM**

- LISA PEPPER

everybody wins. That's what we're trying to do."

Though it may be a hard reality to face, Gaffney said, medicine has not kept pace with most other high tech industries in terms of establishing, implementing and adhering to safe practices.

"Event rates and mistake rates in medicine compared to other high-risk, high-danger industries such as airlines and nuclear power are mind-boggling. These other industries operate with people who are certainly no better trained, no more dedicated, and no more hardworking, but the difference is that medicine has not yet adopted standardized, industry-proven safety measures," Gaffney said.

The challenge is to convince the medical industry that it is possible and to

malpractice risk by working to reduce the number of lawsuits generated by dissatisfied patients. Programs such as Hickson's can help medical professionals identify their own malpractice risk, based on unsolicited patient complaints, and to address behaviors that may be contributing to the complaints.

"We also teach physicians how to face the challenges of conveying bad news to patients and families," Hickson said. "Families often express to researchers that no health professional expressed any sympathy for what they experienced. In our classes, we teach how to express concern and provide answers in ways to meet the families' needs."

If patients understand why a bad outcome occurred, if questions are answered, and they perceive their caretakers

In addition to reducing errors in practice, medicine can influence its malpractice risk by working to reduce the number of lawsuits generated by dissatisfied patients.

change the culture to one where safety is everyone's priority.

"The model everybody uses is Swiss cheese – that it's an accident when all the holes in the whole stack of slices of Swiss cheese line up. Each person involved in the process controls one of those pieces of cheese," Gaffney explained. "If they're observing, speaking up, and catching mistakes, they can pull their piece out of the way, and the accident can't happen. That's what it takes – a see it, say it, fix it mentality."

Gaffney leads the effort at Vanderbilt to instill these safety principles through an aviation-based training program – Crew Resource Management. By working to educate all levels of the medical staff on the signs of potential problems and effective ways to communicate problems, Vanderbilt has already experienced a decline in safety-related errors.

In addition to reducing errors in practice, medicine can influence its

to be genuinely concerned about them, they are less likely to file suit, Hickson said.

The final step is quickly doing the right thing for patients who have been injured by negligence (see risk management story on page 13). Early intervention enables the health care provider to treat the patient fairly, which can prevent lawsuits that escalate the cost of a settlement and delay the payment to those injured.

When taken together, reducing errors, reducing dissatisfaction and working to settle more cases quickly could help the medical industry pull out of the current state of malpractice crisis.

"When I look at the headlines about malpractice, I think 'yes, it's a big problem.' But a big part of the solution is in our hands," Gaffney said. "And I'm really proud that Vanderbilt is taking a lead in this – they're doing it." **VM**

The no-fault option for reforming medical malpractice

During the 2004 presidential campaign, medical malpractice got its 15 minutes of fame, but only two reform options found their way into the spotlight. One candidate promoted a reform based on capping pain and suffering damages, while the other endorsed a process to weed out invalid claims.

Another proposed reform, the “no-fault” system, didn’t make it into the limelight, yet it’s considered a viable option by many in the medical field. Unlike the other reform options, the no-fault system seeks to take medical malpractice out of the realm of tort law all together.

Similar to the workers’ compensation program, a no-fault system is set into motion when patients file a claim. Their claim, which states they have received negligent care or avoidable or preventable medical injuries, is sent to a panel of medical experts and jurists for review. The claim and the physician’s report are used to determine if in fact the patient did receive such substandard care. If the decision is affirmative, the panel awards the patient an amount determined by a fixed benefits schedule. If the patient is not satisfied, there is an appeals process.

Proponents of the no-fault system say it will better ensure those injured actually receive the compensation they deserve, and will increase safety because when the

prospect of litigation is removed, physicians will be more willing to admit and learn from their mistakes. Critics say it would cost too much and it could be too difficult to determine which bad outcomes are compensable and which are not.

F. Andrew Gaffney, M.D., associate dean for Clinical Affairs, has firsthand knowledge of how the no-fault system has worked in another country, and how it can be a starting point to improve safety. Through an adjunct professorship with Karolinska Institute in Stockholm, Sweden, Gaffney was able to use data collected through their no-fault system of medical malpractice.

“Because there is only one medical malpractice insurer for all the physicians in Sweden, this insurer had a database of all the malpractice claims filed,” he said. “I was able to receive access to this database, along with the hospital discharge registry that all hospitals report into.”

Gaffney had more than five years of data to merge, and for the first time, was able to compare the “numerator and denominator of medical malpractice.” With this information, Gaffney was able to look at the claims rates by hospital, department, procedure, age, type of hospital, city and/or region.

“We were able to take this data and analyze the performance

of different groups, giving the hospitals and physicians a true measurement of their performance in comparison to their peers,” Gaffney said. “The results challenged some traditional beliefs and gave a starting ground for improvement.”

By comparing the claims to the number of procedures done at a particular hospital, Gaffney discovered that the traditional belief “the more you do something, the better you are” isn’t always true.

For some procedures, such as thyroid surgery, practice did seem to make perfect, but for others, such as hysterectomies, there was no statistical difference among those hospitals that performed numerous procedures and those who only did a few.

“This data can be used to help patients choose a hospital for their procedure, which could help lower the number of those suffering bad outcomes,” Gaffney said. Measures such as these can

also show hospitals where serious deficiencies lie.

“Because there isn’t a fear of being sued, doctors and hospitals are much more forthright about errors that are made,” Gaffney said. “In fact, doctors will often recommend their patient fill out a claim and will help them through the process. Admitting you made a mistake is the first step to fixing a problem and making health care a safer system.” **VM**

— LISA PEPPER

F. Andrew Gaffney, M.D.



ANNE RAYNER

CAST in a new LIGHT

**Ellen Wright Clayton takes a
fresh look at genetics**

In the mid 1970s scientists and the government were at odds over new recombinant DNA research techniques and their unknown potential effect on public health. It was at ringside of this protracted controversy that Ellen Wright Clayton found her path.

WRITTEN BY PAUL GOVERN
PHOTOGRAPHY BY DEAN DIXON



SHE WAS STUDYING AT Stanford toward her master's in biochemistry, and it happened that the professor teaching first-year graduate biochemistry was at the center of all the ruckus. Paul Berg didn't discuss the public controversy much in class, yet it was all over the press. (Berg later won the Nobel Prize in chemistry for studies of the biochemistry of nucleic acids with particular regard to recombinant DNA.

"I just realized that was where my heart was, in the social response to science," Clayton said.

And although that sounds like a complicated area for a person to take on. Clayton appears to have just the sort of universalist bent that her calling would demand.

As she neared graduation from high school in her native Houston, Texas, she looked for a college that was strong in both science and religion. "Even back then, I understood science as being situated in society and affecting people in real life," she said. She chose Duke, where she majored in Zoology and sang in the choir on Sundays. Clayton later became both a lawyer and a pediatrician, and today she teaches in both the Schools of Medicine and Law.

Introducing herself socially as a pediatrician and a law professor tends to be too much of a show-stopper, so at parties when someone asks what she does, she will usually say only that she is the director of the Center for Genetics and Health Policy at Vanderbilt. Along with appointments in Law and Pediatrics, she is the Rosalind E. Franklin Professor of Genetics and Health Policy. Her work takes her into classrooms and patient rooms at Vanderbilt and Meharry, and to podiums and conference tables around the world. As a writer, educator, physician and policy expert, she's engaged with many of the ethical, legal and social issues that crowd the way between health care and the greater society.

She established the Center for Genetics and Health Policy in 2001 to promote, says the mission statement,

"interdisciplinary efforts to improve the use of genetic information and the delivery of health care."

The advance of genetics is in part a preamble to a discussion about human society, a discussion that Clayton appears uniquely poised to help direct. Society and health care face a welter of questions. Are certain genetic variations grounds for employment discrimination? How might genetic variation affect an individual's ability to learn and to fit into society, and should education take more genetic variations into account? Is genetic variation a criminal defense? Where do we draw the line on screening for heritable disorders in newborns? What constitutes a useful genetic test?

"The promise of genetics is enormous; it's enormous," she said. "But the overarching challenge is going to be recognition of the complexity of that information." An awful lot of heat and not very much light is how she characterizes current public discussion of genetics.

"The juicy story is the story that's scary on some level," she said. To pull in readers, headline writers are prone to equate genes with fate — you knew, didn't you, that your future was written in your genome? DNA is popularly characterized as the very book of life, when it's more like the orthography of the contract for the unfinished screenplay of life.

Along with all the fiction that surrounds genetics, there is history to contend with: for better and for worse, the subject of genetics is connected with the eugenics movement and Nazi genocide.

All the clamor notwithstanding, Clayton finds that most of the issues raised by genetics are in fact longstanding debates cast in a new light, and that there are any number of established social, ethical and legal standards available to help sort through and focus the discussion.

As a writer, her initial foray into questions of genetics and society was a paper written in law school on liability in reproductive genetic counseling (the paper was published, winning her an invitation

“I had decided if I was going to talk about the way law regulates medicine, I should learn more about medicine,” she said. “Attending medical school seemed the most efficient thing to do. Which is why I’m not an economist.”

to join the law review). A little later, between law school at Yale and medical school at Harvard, she clerked for Judge John C. Godbold of the 5th U.S. Circuit Court of Appeals, spending much of her time on a case concerning frozen bull semen.

Pediatrician-in-training

At age 6, as part of an X-ray procedure called a pneumoencephalogram, Clayton had to have the ventricles of her brain temporarily drained of cerebrospinal fluid and pumped full of air. The ordeal concluded, the first grader announced to her parents that she wanted to become a doctor. The toys her parents gave her suddenly all became doctor-related.

As a young law clerk, Clayton had long ago set aside intentions of becoming a doctor when she was invited to present legal issues for grand rounds at the Medical College of Virginia.

On the trip to Virginia she had with her a legal brief that upon her return to Montgomery needed to be dropped off at Judge Godbold’s house; Clayton thought it over during the trip and as she handed the packet to the judge she announced that she was going to go to medical school. “I had decided if I was going to talk about the way law regulates medicine, I should learn more about medicine,” she said. “Attending medical school seemed the most efficient thing to do. Which is why I’m not an economist.”

Her affiliation with both law and medicine has earned her much respect in both fields. She sits on boards or otherwise participates in committees and projects of the Institute of Medicine, the National Institutes of Health, the Food and Drug Administration, the American Bar Association, the American Society of Law, Medicine and Ethics (she’s a past president

and past editor-in-chief of the society’s journal), and a long list of other organizations. She and her husband, Jay, chair of Vanderbilt’s English department, came to Vanderbilt in 1988.

Asking the tough questions

“I only have an hour and a half, which is ridiculous,” she said. Introducing herself to a class of Vanderbilt graduate students, Clayton invites them to interrupt her lecture with their questions. “I’m easily distractible, which is a good thing, but I can also get back on task fairly readily.”

She leads the class through a rapid survey of the ethical, legal and social implications of genetics. Genetics is very powerful, she says toward the end of the session, “but it doesn’t determine what we should do as individuals or as a society. Whenever someone says, ‘The genetics are this so we should do this,’ we need to ask questions.”

Gerald B. Hickson, M.D., associate dean for Clinical Affairs, said medicine needs people like Clayton to ask questions. “She’s engaged in helping all of us, members of society and the medical field, think about some of the ethical challenges that we face now and will face as we learn lots more about the potential of the new genetics. It takes someone of her intelligence and thoughtfulness to consider some of the challenges.”

“She has a great talent for focusing the discussion, cutting to the crux of it,” said John Phillips Jr., M.D., David T. Karzon Professor of Pediatrics and director of the Division of Medical Genetics.

Among Clayton’s many concerns is the prospect that genetic variation may be misused to exclude people from employment or from other benefits of membership in society; and her corresponding concern is

that, instead of sensibly relying on existing anti-discrimination laws, governments may rush into new laws that create protected classes based on genetic variation alone, thus grossly unrecognized the role of environmental factors in forging human identity and health. She is also concerned that, while genetics supports the view that distinctions of race and ethnicity have tremendous cultural components, scatter-shot efforts by drug makers to develop new genetic therapies may wind up giving new life to the mistaken notion that racial categories have biological meaning.

And she believes doctors generally don’t have the background to sort through manufacturer claims about the growing number of unregulated genetic tests arriving on the market. In 2003, Clayton established the School of Medicine’s first required course in genetics.

When she started medical school Clayton wasn’t sure if she would do a residency and go on to practice medicine, but she quickly realized that a residency would be needed to establish more firmly her credibility with policy questions. Her husband said that when she finally held and worked with a patient for the first time she was relieved that it felt natural to her.

“Ellen really does view the need of the whole patient,” Hickson said, “and we talk about that all the time, but she models that behavior. She is always advocating the well-being of patients and families, not just physical well-being but more broadly.”

Clayton believes the new genetics is coming. A lot could go wrong with its application in health care and with its interpretation by society and our legal system.

“Neither the science nor the policy questions are readily reducible to sound bites,” Clayton said. “What will help people is to be able to convey a sense of the complexity along with a sense of the tractability.” She said she is hopeful that a growing number of people are informed enough to begin asking the right questions. **VM**

David Chooljian

Student pursues medicine and law in new joint degree program

Growing up, David Chooljian always knew he wanted to be a doctor. The only problem was everyone told him he'd make a better lawyer. So he decided to do both.

Chooljian is Vanderbilt University's first medicine/law joint-degree student, earning a M.D./J.D. in the course of six years. He's currently in his fourth year of the program. He explains his current standing as "having the 'M' and the 'J' and working on the 'Ds.'"

"I'm interested in medical ethics, so a joint degree will allow me to gain different perspectives on medical situations," Chooljian said. "Medicine and law often have two different ways of thinking and approaching a problem. I want to be able to understand both sides."

Chooljian decided he wanted to pursue a joint degree during his first year of undergraduate education at UCLA. "There were only six universities with established (medicine/law) joint-degree programs, and Vanderbilt wasn't one of them," Chooljian said.

"But Vanderbilt had a reputation to being very open to joint degrees, which made it easier for me to approach the administration. I began by applying to the Law School and School of Medicine separately."

When Chooljian visited the School of Medicine,

instead of going on a campus tour, he snuck away to the Law School and found someone he could talk to about starting a joint-degree program. He found that the two schools had already been discussing a possible joint program.

"One of the best aspects of that initial meeting is that, although the schools had already begun discussions of putting a program in place, I was asked for my input regarding the structure and implementation of the program," Chooljian said. "That really meant a lot to me and definitely influenced my decision to come here."

It didn't take long until the M.D./J.D. program was put in place, and Chooljian was signed up as the first candidate.

The M.D./J.D. joint-degree program is a six-year program, instead of the normal seven years it would require to do the degrees separately. The first two years involve School of Medicine coursework; the next two years are spent at the Law School. The fifth year is a full calendar year of clinical rotations, and the sixth year is split between the two schools.

The program was designed to allow students to become fully engrossed in each school separately, ensuring the development of two distinct viewpoints. Chooljian said it

DANA JOHNSON



has been successful thus far, but it's a "learn as you go" situation.

"Most of our other programs are 20 to 30 years old, and students enrolled in them have the benefit of advice from their predecessors and of refinements we've made over the years," said D. Don Welch Jr., associate dean for Administration for the School of Law.

"In David's case, all of the advice will be one-way, and the refinements will be because of what we have learned from him."

Though there have been some bumps in his road, Chooljian said he feels well on his way to the profession he desires. His ultimate goal is to practice medicine and be involved in clinical ethics.

"Being with patients is the most rewarding thing, and it's definitely the best part of the job," Chooljian said. "And ethics will never get old — there's always something that hasn't been thought of before and new problems that will arise."

Chooljian has already been able to use his dual degree

education in a practical setting. He traveled to University of Concepcion's Medical School in Chile last July to help set up the future undergraduate academic interchange with Vanderbilt.

"Joint degree programs are made for students like David," said Bonnie Miller, M.D., associate dean for Medical Students. "Before he began his law studies, he wrote a proposal for a longitudinal research project that will compare the professional and ethical development of medical students to that of law students. I think this is an early indication that he will find many ways in the future to combine his dual scholarly interests."

VM — LISA PEPPER



It turns out an ethicist's job is similar to the enchanted mirror's, absorbing a person's values by asking questions and reflecting back those values, framed in the context and focused on the situation, and adding a little learned wisdom into the deliberation process

WRITTEN BY CLINTON COLMENARES
ILLUSTRATION BY CURTIS PARKER

A license to think

STOP BY TO TALK WITH a group of medical ethicists sometime about what it is they do and you come away hours later with a good idea about it, but also with more questions – about yourself, about science, and about how you and science fit into the rest of the world. And when your head and chin have been rubbed raw by acts of contemplation, you'll realize: That's what they do best. They make you think.

Ethicists have no storefront, per se, and they don't produce widgets. Yet their work is

more than academic. With their careful, clear deliberation, they help you arrive at an answer, but one coupled with context and understanding. Their work is subtle, but it's woven into the warp and woof of life's fabric, and as cultural, social, economic and scientific worlds spin more collectively, their thread grows stronger, and its colorful hue begins to show through.

"The idea is about ethical deliberation," says Mark Bliton, Ph.D., assistant professor of Medical Ethics in the Center for Clinical and Research Ethics. "It's about people's experiences and helping them think through the complex problems that face them."

Medical ethics officially began at Vanderbilt in 1981 when Richard Zaner, Ph.D., a quintessential philosopher, arrived at Vanderbilt to plant the seeds of medical ethics. Zaner set to work, writing the book, literally and figuratively, for a fresh new field that was beginning to take root across the country, and over the next 21 years, growing a clinical program with a sterling national reputation.

About midway through the last century medical research got a bad name: the Nuremberg trials described Nazi wartime experiments that cruelly froze Jews; and poor rural black men in Alabama were studied for syphilis, but were never treated for or told about their disease; America cringed. Medicine redeemed itself with life-extending technology and death-defying, or at least death-delaying, procedures. But following the turbulent late 1960s and the free-living 1970s, Americans drifted away from the “paternalism of physicians,” Bliton says, and started making their own medical decisions. Add into the mix HIV and AIDS, and the rise of advocacy, and there are a lot of voices standing outside the ivory towers of medicine, wanting to be heard.

Zaner, who recruited Bliton and, later, Stuart Finder, Ph.D., brought topics that were once considered ethereal and academic – if they were considered at all – to patients’ bedsides and into research review committees.

Yet ethicists aren’t consultants, they’re not licensed counselors.

“A lot of people think medical ethicists decide, that we’re the ones who make the final decisions,” Finder says. “But really we help those who are the primary stakeholders (family, assigned physicians, primary investigators, etc.) make the best decisions for themselves. We try to identify and clarify the issues at stake, then facilitate.”

It turns out an ethicist’s job is similar to the enchanted mirror’s, absorbing a person’s values by asking questions and reflecting back those values, framed in the context and focused on the situation, and adding a little learned wisdom into the deliberation process Bliton mentioned.

So, it stands to reason that with more complex issues facing society (Medicare funding; Medicaid and, close to home, TennCare viability; genetic medicine, stem cell research; growth of diverse cultures; etc.), the more mirrors one has and the more perspectives brought to bear on an issue, the more detailed the questions, and the clarity, become.

In recent years, Vanderbilt has added greatly to its reflective powers.

Larry Churchill, Ph.D., Ann Geddes Stahlman Professor of Medical Ethics, replaced Zaner after his retirement. At the University of North Carolina Churchill earned a reputation as one of the nation’s policy virtuosos; at Vanderbilt he is helping shift gears into the next era of ethics, one of broader collaboration and deeper policy expertise.

“I see ethics as a basic science,” Churchill says, explaining, “just as a physician can’t practice unless you know enough chemistry, biology and anatomy, you shouldn’t practice unless you know enough about the value issues.”

Over the past year Churchill has recruited Elizabeth Heitman, Ph.D., a cultural diversity specialist, and Lucia Tanassi, Ph.D., from Cambridge, a cultural anthropologist who came to Vanderbilt specifically because she saw the opportunity to work with other specialists.

Ellen Wright Clayton, M.D., J.D., who brought her unique and powerful combination of legal policy, genetics research and pediatric clinical care to the mix at Vanderbilt in 1988, has added Josh Perry, an attorney with a master’s in religious studies, as a fellow in her Center for Genetic Health Policy.

The two centers – Churchill’s and Clayton’s – have begun working more closely, doing more together, they say, than they could separately.

“This allows us to have a broader, more robust discourse about fundamental ethics and policy issues facing medicine,” Clayton says. Their hope is to create “a space in the Medical Center in which the social context of health and health care is explored.”

And explore they have. Within the university, the teams of ethicists provide a resource for clinicians, families, students and researchers. When Vanderbilt obstetrician Joseph Bruner, M.D., and neurosurgeon Noel Tulipan, M.D., created the world’s first procedure for maternal-fetal surgical repair of spina bifida, Bliton

was the ethics shepherd, making sure families contemplating the surgery understood all the ramifications of the large step into a new medical frontier. Bliton’s work was used as a model for a national NIH study of the procedure, and Finder has begun similar work in another pioneering neurosurgical procedure.

As genetics becomes “genetic medicine,” tailoring pharmacology to specific traits, anchored in ethnic variability, indigenous groups and society at large confront new issues.

“What is a Hopi Indian?” Heitman asks. “Why is Halle Berry black instead of white? If you’re looking at genetics, you need to know where to start in order to get some kind of framework to begin your research.”

And when a group of scientists “parachute in” to study these groups, who speaks for the people being studied? In some countries, the governments do, raising new barriers to overcome.

At the bedside, Finder has faced queries as varied as helping families decide when to remove a loved one from a ventilator to whether or not it’s ethical to remove sperm from a brain-dead man for insemination later.

Churchill has expanded ethics’ presence in the medical school curriculum, directing the Ecology of Health Care course for all first-year students, but he sees the need to take it further.

The growth in depth and breadth of ethics at Vanderbilt parallels an interdisciplinary shift across campus, Clayton says, and the increasing collaboration between the centers allows the Medical Center to increase its presence outside the campus.

“Nuremberg taught us the need for understanding,” Finder says. “We have to ensure that people understand” when they participate in research, how they receive medical care and how science and health care fit into public policy. **VM**

Polar views in the embryonic
stem cell controversy

CLASH OF CONVICTIONS

Scott Wright's peaceful nights ended almost four years ago. That's when his now 6-year-old daughter Emma was diagnosed with type 1 diabetes, and a day-and-night routine of blood glucose checks and insulin injections began.

The mental strain is wearing, says Wright, who rises twice each night to prick Emma's fingers.

"I constantly think,
'is she going to be okay
tonight?'"

WRITTEN BY LEIGH MACMILLAN
ILLUSTRATION BY ELIZABETH LADA



DANA JOHNSON



Diagnosed with type 1 diabetes nearly four years ago, Emma Wright (pictured here) is doing well, but her parents worry about long-term complications.

What are embryonic stem cells?

Human embryonic stem cells are unspecialized cells derived from embryos that are typically four or five days old. These “blastocyst” stage embryos – hollow balls of cells smaller than a period on this page – have developed from eggs fertilized *in vitro*, not from eggs fertilized in a woman’s body.

For more information about stem cells, visit the National Institutes of Health’s Stem Cell Information Web site (<http://stemcells.nih.gov/>).

He and his wife, who just two years ago also was diagnosed with type 1 diabetes, worry about the long-term complications of the disease – the blindness, kidney disease, nerve disease, amputations, heart disease and stroke.

“I try to block those thoughts out, but they’re there,” Wright says.

Wright supports research aimed at better understanding diabetes – in fact, he works as a research assistant in the Vanderbilt Diabetes Center, hoping that the investigators there will find new ways to treat or even cure the disease. But when it comes to embryonic stem cell research, oft-cited as having the potential to cure diabetes, he hesitates.

“It feels...kind of unethical,” he says, then adds quietly, “but if it is a cure...”

This personal struggle for Wright – between a belief that research involving human embryos is wrong and the hope for therapies – is at the root of the national controversy swirling around human embryonic stem cell research.

“It’s sad to see the polarization of this issue, when it’s so therapeutically

promising,” says Mark A. Magnuson, M.D., director of the newly established Vanderbilt Center for Stem Cell Biology.

That promise, he says, is of regenerative medicine. “These cells offer the potential for deriving new tissues that could be used to treat certain diseases, like diabetes, Parkinson’s disease and heart failure, in a manner that we’ve really never done before.”

The idea is for scientists to discover how to direct embryonic stem cells to form specialized cell types, so that they can be grown in large quantities and used as “replacement” cells to treat patients.

So, what’s all the fuss about?

First, some definitions. “Stem cells” generally come in two sorts: adult and embryonic. Both share the unique qualities of being unspecialized and of living and dividing for long periods of time. Through cell division, they renew themselves and generate cells that can mature into specialized cell types.

A key difference between adult and embryonic stem cells appears to be in the specialized cell types they can become. Studies suggest that adult stem cells, present in certain tissues – the best known are the blood stem cells in the bone marrow – are more limited than embryonic stem cells, which give rise to every tissue in the body.

Twenty years worth of research using animal models has validated that embryonic stem cells retain their potential after being removed from the embryo and grown in the laboratory. Recent studies demonstrate their usefulness in treating diseases in animal models. Therein lies the hope.

But therein also lies the controversy. With the creation of an embryonic stem cell “line” comes the destruction of an early-stage embryo, and for some, the destruction of a human embryo at any point in development is unacceptable.

At the national level, this ethical struggle has played out in terms of dollars. Research that involves the destruction of human embryos is legal, but federal funds

The idea is for scientists to discover how to direct embryonic stem cells to form specialized cell types, so that they can be grown in large quantities and used as “replacement” cells to treat patients.

may not be used to support it. Private funds were used to derive the first human embryonic stem cell lines, reported in 1998.

The availability of these lines and their potential fueled demands from scientists, patient advocacy groups and others to make federal funds – the largest source of support for academic investigators – available for human embryonic stem cell research. On Aug. 9, 2001, President George Bush issued what he called a compromise policy: federal funds could support research using human embryonic stem cells already in existence as of that date (cells from embryos which had already been destroyed), but not research to create or study new lines.

Moving toward therapies

For proponents of stem cell research, the policy didn't go far enough. The number of “approved” human embryonic stem cell lines is limited and the cells, based on reports from scientists using them, “are not very robust,” Magnuson says.

“The approved cells offer only a limited selection of histocompatibility types, which is an important factor for tissue transplantation in order to limit immune rejection,” he adds. “And they've all been grown in the presence of mouse cells, which introduces unknown risks.

“I would certainly like to see more human stem cell lines be available.”

Those lines, he says, should come from donated embryos generated by *in vitro* fertilization (IVF) procedures – the major source of human embryonic stem cell lines to date. As many as 400,000 IVF embryos exist in frozen storage in the United States, according to a recent article in *Politics and the Life Sciences*. Some of these will continue to be stored indefinitely, most will be discarded.

“These frozen embryos are slowly dying,” Magnuson says. “Vanderbilt’s position is that it would be better to use these valuable tissues, with the consent of the parents who created them, in a life-affirming way. Stem cell research is precisely that.”

The 2004 election results appear likely to keep the restrictions on federal funding in place for now.

Even without federal support, the research will move forward in the United States – with private funds and with public funds in states like California where voters strongly supported a \$3 billion bond measure for stem cell research in November – and in other countries. In the long term, the restrictions could put the United States at a competitive disadvantage, especially if other countries succeed in developing and patenting new stem cell therapies, Magnuson points out.

Those therapies may seem a long way off, but they are not science fiction, says Magnuson, whose own interests are in directing stem cells to become insulin-producing cells. For now, he and other investigators at Vanderbilt are studying mouse embryonic stem cells to discover the molecular switches and methods that will make embryonic stem cell therapies a reality.

For families like the Wrights, managing the day-to-day routine of diabetes doesn't leave much time for contemplating the cures that embryonic stem cell research might bring.

“If that becomes an option, we'll have to think long and hard about it,” Wright says. **VM**

Vanderbilt launches stem cell center

Vanderbilt formalized its commitment to stem cell research last year with the creation of the Vanderbilt Center for Stem Cell Biology (VCSCB). The new center is designed to harness existing research strengths on campus and to stimulate growth in this promising scientific area, says Mark A. Magnuson, M.D., assistant vice chancellor for Research and director of the VCSCB.

“Stem cell research is obviously a very active and intense area, and if we want to be among those advancing the field, which we do, we need to be focusing on it,” Magnuson says. Investigators at Vanderbilt have been working on mouse embryonic stem cells for over 10 years. The VCSCB will develop a shared resource to facilitate research efforts utilizing human embryonic stem cells. **VM**

John Chapman, M.D.

Vanderbilt loses giant of American medical education

Vanderbilt University School of Medicine lost its biggest fan on Oct. 13, 2004, when its longtime dean John E. Chapman, M.D., died of complications of Parkinson's disease.

The former dean, who conferred degrees on two-thirds of the school's living graduates, was 73.

Dr. Chapman led VUSM for a quarter of a century, and stepped down in 2001 to assume a new role, associate vice chancellor for Medical Alumni Affairs.

While dean of the medical school, he conferred degrees on more than 3,000 Vanderbilt medical students, and, during his period as dean, grew the faculty by 789 faculty members.

"John Chapman was truly a giant of American medical education," said Harry R. Jacobson, M.D., vice chancellor for Health Affairs. "He worked long and hard to earn his title of 'Dean of Deans.' He guided the Vanderbilt University School of Medicine to the forefront of medical education programs in the nation."

Dr. Chapman accomplished much in his three-plus decades at Vanderbilt. He served as associate dean for Education; associate professor of Pharmacology; director of Continuing Medical Education; professor of Medical Administration; chair of the Division of Medical Administration; and dean of the School of Medicine from 1975 until 2001. By the end of his tenure as dean, he was graduating medical students who were the offspring of medical students he had graduated more than two decades before.

"The culture of our medical school and our medical education programs is largely a result of Dean Chapman's vision, and not only his vision, but his longevity," said Steven G. Gabbe, M.D., who replaced Dr. Chapman as dean in 2002. "Vanderbilt is known to be a place that supports students and prioritizes medical education. That's what Dean Chapman did."

From 1972 to 1974, Dr. Chapman served simultaneously as acting dean of the medical school, acting director of Vanderbilt University Hospital and acting vice chancellor for Health Affairs.

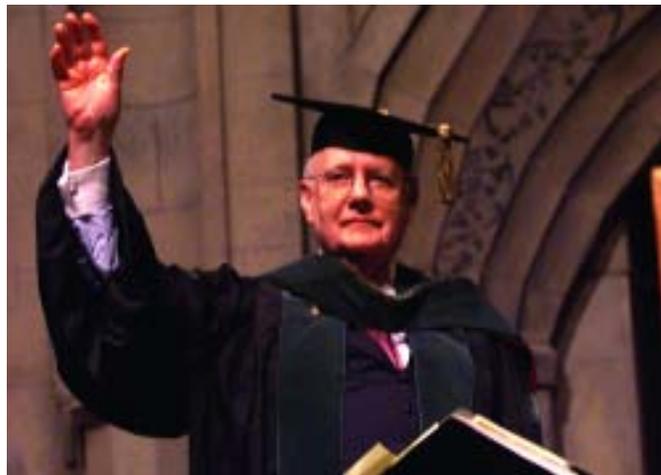
He was a member of virtually every major medical and medical education board or organization, locally, regionally and nationally. He chaired the nominating committee of the National Board of Medical Examiners, the Council on Medical Education Nominating Committee, the Association of American Medical Colleges (AAMC) Nominating Committee, the Southern Council of Medical Deans, the American Medical Association (AMA) section on Medical Schools, and the AAMC Committee on Student Finance. In 1992 he was named Foreign Adjunct Professor at the Karolinska Institute in Stockholm, Sweden, home of the Nobel Prize, which awarded Chapman an honorary doctor of medicine degree in 1986.

When he stepped down as dean at Vanderbilt, pledges from alumni, friends

throughout the United States and the Vanderbilt Board of Trust established the Dean John E. Chapman Scholarship, which is awarded to two deserving medical students every four years.

In 2000, Dr. Chapman received the Tennessee Medical Association's Distinguished Service Award, and in December, posthumously, he received the American Medical Association's 2004 annual distinguished service award, the only one given of its type. Dr. Chapman is survived by his wife, Judy Jean. **VM**

-NANCY HUMPHREY



DANA JOHNSON

Batson, former dean, vice chancellor, dies

O. Randolph Batson, M.D., who was dean of the Vanderbilt University School of Medicine and vice chancellor for Medical Affairs in the 1960s and early 1970s, died Dec. 6, 2004. He was 88.

Above all, Dr. Batson was a pediatrician, and it was during his time as dean and vice chancellor that Vanderbilt Children's Hospital was founded in 1970. He also oversaw several building expansions at the Medical Center, and gave research a renewed emphasis.

"Dr. Batson's leadership added faculty and space and brought this medical center to new heights," said Harry R.

Jacobson, M.D., vice chancellor for Health Affairs. "Those of us who are carrying on in his footsteps continue to build on the foundation he left us."

Dr. Batson, a native of Hattiesburg, Miss., earned both a B.A. and an M.D. from Vanderbilt, graduating from the School of Medicine in 1942. After a residency and fellowship in Pediatrics at Vanderbilt, he joined the faculty as an instructor. He had a longstanding research and clinical interest in poliomyelitis, and he served as director of the Vanderbilt Poliomyelitis Clinical Study Center for a decade. He was director

of the Vanderbilt Clinical Study Center for Chronic Diseases of Childhood from 1960 to 1963, the year he was named Dean of Medical School and Director of Medical Affairs (later vice chancellor for Medical Affairs). He remained dean until 1972 and vice chancellor until 1973. Following his time in administration, Dr. Batson again took up the reins of clinical care, research and teaching in Pediatrics. He was named an emeritus professor in 1982.

Dr. Batson is survived by his wife of 54 years, Bennie Wells Shaw Batson, three daughters, a son and three grandchildren.

VM - WAYNE WOOD

President's Corner

2005 was still a very new year on Jan. 6 when a planning retreat for the Canby Robinson Society was held at Vanderbilt's Center for Better Health. As those of you who are members know, membership in the CRS results from a significant contribution to the Vanderbilt Medical Center.

The value of what the CRS members provide this Medical Center can hardly be

overestimated. Whether in support of facilities, technology, scholarships, faculty chairs or programs – such as the Vanderbilt diabetes program, the Vanderbilt-Ingram Cancer Center, the Monroe Carell Jr. Children's Hospital at Vanderbilt, and the Bill Wilkerson Center – the outcome is vital: enhanced research results, improved clinical care, and exceptional training of those who are dedicated to caring for us, and for others, tomorrow.

We know that charges will never be able to cover the

cost of the health care we provide and that we are dependent on philanthropy, which enables us to make significant advances in health care.

We invited approximately 60 leaders – both from the Vanderbilt family, and from the community at large – to focus on determining the best way to support those who make these advances possible. Discussions were held encompassing the mission and purpose of the CRS, ways to provide maximum value to members, the creation of access for CRS members to VUMC information, communications, growth of our membership base and the most effective use of events. Prior to the retreat, a survey was sent to the entire membership and we received a large response, which was most helpful – thank you!

We are grateful to those of you who attended the retreat, for sharing your time and yourselves with us in our efforts to increase the value of what the Medical Center is able to provide. We will continue to update you on our progress in this magazine.

CRS

Fran Hardcastle
President,
Canby Robinson Society



Fran Hardcastle

Following the Heart from Vanderbilt to Tibet

It starts in the flatness of south Texas and moves to the rolling hills of Nashville and leaps to the mountains of Tibet. No, not the latest film epic, but the story of a family legacy involving scholarship, a sense of mission, and Vanderbilt.

Ashley McAllen, M.D., (MD '87) is the Director of Medical Operations for the Tibetan Medical Foundation, a 501(c)3 begun by McAllen and a friend. The foundation serves the medical needs of nomads of the Tibetan plateau.

How did he get from south Texas to Tibet? Vanderbilt played an important role in this unique trip. There is a Looney-McAllen family legacy going back to 1883 when James Owen Looney graduated from Peabody. And part of this legacy has been the gifting of scholarship funds (the J.C. Looney and Myrtle Looney Scholarship and the McAllen-Looney Scholarship) and the journey of the heart in work.

McAllen, a CRS member, received his medical degree at Vanderbilt, but the irony is that he wasn't even planning to go to college. "I grew up in a small Texas town. My dad told me

I could either go to college or be a farmer." McAllen spent one summer on a farm and decided to explore the college option. "Vanderbilt was really an amazing place. Three of the five greatest men I've ever known were at Vanderbilt. So many people there influenced me to try to be a respectable human being. Really, my time at Vanderbilt was the main formative event in my life."

One lesson learned – "medicine is more than just a job; it's a larger way of looking at life and I was so encouraged in this and I blossomed at Vanderbilt." He received this encouragement from his mentor, William Schaffner, M.D., chairman of Preventive Medicine. McAllen always had a heart for international health and Schaffner affirmed him in this direction. One summer during medical school he worked on a Caribbean island and another he had a fellowship in Africa. He eventually found his way to the MPH program at Emory and with the enthusiastic support of his mentor, moved into the world of

(continued on page 34)

Dixon Burns, always a teacher

When Dixon Burns, M.D., was a young boy in Mississippi, he performed odd jobs in the office of his father and grandfather, country physicians who practiced medicine together. One of his duties was to unpack the big boxes of medicine they picked up on one of their trips to Memphis. After he unpacked them, he filled prescriptions for the patients.

Burns (MD'45) was 12 years old. His early exposure to medicine served him well, and at the age of 82, he continues to share his knowledge and love of medicine with medical students and residents in Tulsa, Okla.

After Burns graduated from medical school, he did a rotating internship at Detroit's Harper Hospital. In those days, 39 states required new physicians to have a rotating internship in order to obtain licensure. After two years in the Air Force, Burns returned to Vanderbilt for a four-year residency in ob/gyn. He practiced obstetrics and gynecology in Tulsa until 1986. Rather than retiring at the age of 64, he decided to go back to school.

"I always had an interest in several other things related to medicine like the history of medicine and medical ethics and medical economics," Burns said. "In 1986 there were 30 medical schools in America that had some or most of these programs. I wrote 30 letters and got 21 replies. I drove all the way from Tulsa up to as far north as Harvard, and I visited 12 medical schools so I could see which one I'd prefer to go. The one at Southern Illinois in Springfield was by far the best."

After he completed a fellowship in medical humanities he contacted the dean of the medical school in Tulsa and

asked him if they could form a program in medical ethics. He agreed and Burns started it in 1988. He still teaches an ethics class once a week. He also leads an ethics class for the ob/gyn residents.

"We ask them to submit their case histories, and we go over them and

"I have taught something all my life."

come to a reasonably clear message of what we would do if we were taking care of these cases. It is a practical addition to their reasoning process," Burns said. "I have taught something all my life. I started teaching Sunday school when I was 12 years old. Teaching requires me to increase my knowledge, understanding and background of this area. You have to do a lot of reading and studying and preparation. I've always enjoyed teaching. This is something I hope is useful and gives our students a background in medical ethics."

Burns credits his love of teaching to his medical school days at Vanderbilt.

He remembers fondly that department chairmen taught the third- and fourth-year medical students every day from 11 a.m. until noon. The professors concluded with a 10-minute presentation of the evolution of knowledge of particular diseases.

"That was terrific and added to the application of one's knowledge for other diseases," Burns said.

In recognition of his outstanding teachers and in honor of his

father, who graduated from Vanderbilt Medical School in 1915, and his son Bill, who graduated in 1978, longtime CRS member Burns gave Vanderbilt \$1.25 million in 1998.

"I learned that Vanderbilt has a closer attachment and interest in teaching their medical students than any other school I followed. This was possible because they had great teachers in all the clinical subjects. I wanted to repay in that regard too." **CRS**

- KATHY WHITNEY



Fran Hardcastle, right, leads a discussion group at the CRS retreat in January.

CRS Members Observe High Tech Procedure

Several members of the Canby Robinson Society were recently invited to watch a robotic surgical procedure in action and were amazed at the advances they witnessed

Bill Alford, M.D., Kitty Murfree and Fran Hardcastle watched via a monitor outside the operating room while Addison Scoville III actually went into the OR with Joseph A. Smith Jr., M.D., the physician who performed the prostatectomy using the \$1 million Da Vinci Surgical System.

"I watched Dr. Smith perform a prostate resection utilizing the robotic technique which was projected onto a large screen in the Alfred Blalock surgical conference room. The robot performed flawlessly as did Dr. Smith,"

Alford said. "The most impressive thing to me was the exposure of the prostate gland in its usually inaccessible location and how the robotic arms could be manipulated with precision to dissect, cut and suture in this limited space. Despite a few technical problems, the audience was enthusiastic about being allowed to view this new technique and hopeful that more such procedures could be seen in the future."

Viewing the operating field through a video monitor, Smith manipulated the instruments with the use of mechanical extensions. The Da Vinci robot uses three arms, one for the endoscope and two for the surgical instruments, each entering the patient through its own port.

"Dr. Smith was looking at a video screen and making the robotic arms do what they needed to do. The visual clarity he had was remarkable and the image he was looking at was in 3-D. The patient was 10 feet away from Dr. Smith and me," said Scoville. "I watched the procedure a month ago and I'm still amazed."

Missy Eason, director of the CRS, extended an invitation to the CRS board members to watch the innovative surgery "because it was a great opportunity for our board and prospective members to see first-hand one of the newest programs being offered here at Vanderbilt," she said. "The outreach tours are a way of educating our board so that they in turn will continue to be ideal spokesmen for our Medical Center." **CRS**

- KATHY WHITNEY



The Canby Robinson scholars gathered for a dinner recently at the home of Harry and Jan Jacobson. Pictured here are: bottom row, l to r, Elizabeth Eby, Lola Blackwell, Mica Bergman, Dana Guyer, Christina Shuman, Purvi Shan; middle row, l to r, Amanda Ackermann, Jennifer Rosenbluth, Ana Luisa Perdigoto, Haritha Bodduluri, Diana Lemly, Laura Altom; back row, l to r, Kevin Elias, Alexander Eshaghian, Stephen Settle, Donna Vleugels, Katie Cox, Cassie Gyuricza, Kristina Collins.

CRS welcomes new board members:

Lonnie S. Burnett, M.D.,
president-elect, January 2006
Karla J. Christian, M.D.
Mrs. John R. Ingram (Stephanie)
Mrs. Robert O. Rolfe (Kathy)

Glynis A. Sacks, M.D.
John D. Sergent, M.D.
Marta Hernanz-Schulman, M.D.
Mrs. George B. Stadler (Julie)
Blair J. Wilson

And extends thanks to the following board members who are rotating off the board:
Julia Breyer-Lewis, M.D.
John H. Dayani, Ph.D.

Mrs. Richard E. Francis Jr.
Aubrey B. Harwell Jr.
Harry L. Page Jr., M.D.
William H. Tate
John A. Zic, M.D.



Julie Thwing

You don't have to look far to find former Canby Robinson Society Scholar Julie Thwing, M.D. She remained at Vanderbilt after graduating in 2002 to do an internal medicine/pediatrics residency.

She clearly remembers getting "the call" from Dean (Gerald S.) Gotterer in her dorm room at Harvard, where she earned an A.B. degree in Biology. He was calling to tell her she had been chosen to receive the Canby Robinson Scholarship.

"I was ecstatic," she said. "I definitely would not have gone to Vanderbilt without the scholarship."

Thwing said what really sticks out in her memory about Vanderbilt is its collegial atmosphere. "It is very nurturing and encouraging. The faculty is very approachable. They had students over for dinner. Aside from the high quality education, it was also a really good experience overall."

Thwing was born in Seattle, grew up in West Africa where her parents were missionaries and went to high school in Dallas. Her hobbies include running, reading, gardening and international gourmet cooking. She recently did a monthlong rotation in Cameroon, Africa where she shadowed a pediatrician who cares for children with HIV. She hopes to go back to Africa one day to run a mission hospital and to spend time with her family who still live and work there as missionaries. **CRS**

- KATHY WHITNEY



Julie Thwing

DANA JOHNSON

Following the heart . . .

international health. He also met his wife, Zemfira, in Tajikistan; along with their two children they have traveled the world.

McAllen wants to continue the family legacy and assist students in following their hearts. When approached for a gift to support medical scholarship, he took this as a perfect time to look at his own estate planning. After discussion with his mother, Margaret Looney McAllen, he decided to honor her with the Margaret Looney McAllen Bridge Scholarship, offering scholarship support for the last two years of a Vanderbilt student's undergraduate program and the four years of medical school.

"This is the first step to the realization of a dream of one of my mentors, where everyone could be on a scholarship, giving people the opportunity to pursue the kind of medical education they wanted and it wouldn't be economically driven." McAllen adds, "I know how much medical education costs and it's frustrating for students to come out of school with this huge amount of debt. They feel like they've got to follow the money rather than their heart."

Vanderbilt was a catalyst in Ashley McAllen being able to follow his heart as a physician. He is providing the opportunity for others to do the same.

The Scholarship Campaign is a vital component of the University-wide Shape the Future Campaign and is co-chaired by Robert Collins, (MD '51), Judson Randolph, (MD '53), and Robert McNeilly, (A&S, '54.) **CRS**

- JUDSON RANDOLPH, M.D.

For more information about the Canby Robinson Society, contact Missy Eason, Director of Donor Relations, Vanderbilt University Medical Center, D-8223, Medical Center North, Nashville, Tenn. 37232-2106, (615) 343-8676 or 8677, fax (615) 343-0809, e-mail: missy.eason@vanderbilt.edu

ANN H. PRICE, M.D.
Executive Director
for Medical Alumni Affairs



Reunion 2004

Reunion 2004, Nov. 4-6, was celebrated by almost 1,000 alumni and friends, including participants in the concurrent Brittingham and Burnett Societies meetings. While the weekend had many “highlights,” my personal favorite was the Qinq Induction Ceremony for the VUSM Classes of 1954 and 1955. Fifty-three members of these two classes were on hand to

receive the traditional bronze medallion and Qinq Medical Society pins from Vice Chancellor Harry Jacobson and Dean Steven Gabbe.

VMAA Board

Many thanks go to Dr. Lawrence K. Wolfe, (MD 60), for his service to the Vanderbilt Medical Alumni Association (VMAA) as the VMAA Board President from 2002-2004. Under Dr. Wolfe’s leadership the Board significantly revised its bylaws, by adding the “Associate Member” category to include all current VUSM students and house officers. In addition, Dr. Wolfe was instrumental in expanding the VMAA Board membership to include representatives from all medical alumni constituencies, including a graduate student representative, the president of the post-doctoral organization, and eight departmental/divisional medical specialty society representatives.

The VMAA Board installed the following new voting members at Reunion 2004.

Jean R. Anderson, M.D., Regional Representative, Baltimore; William J. Anderson, M.D., Regional Representative, Nashville; Clifton R. Cleaveland, M.D., Regional Representative, Chattanooga, Tenn.; Steven J. Eskin, M.D., Scott Society Representative, Nashville; Meredith A. Ezell, M.D., Savage Society Representative, Nashville; Kenneth Bruce Jones, M.D., Regional Representative, Jonesboro, Ark.; Allen B. Kaiser, M.D., Brittingham Society Representative, Nashville; Amy C. Moore, Ph.D., Post-doctoral Representative, Nashville; Susan Niermeyer, M.D., Regional Representative, Denver; Steven F. O’Sheal, M.D., Regional Representative, Birmingham, Ala.; David W. Patterson, M.D., Regional Representative, Washington, D.C.; Rachel H. Roberts, Graduate Student Representative, Nashville; William S. Stoney, M.D., CRS Past President, Nashville.

These new Board members joined the following medical alumni whose terms of office on the VMAA Board will extend for another one to four years.

William A. Altemeier, IV, M.D., Regional Representative, Seattle; Gilbert E. Boswell, M.D., Regional Representative, San Diego; Teresa S. Bratton, M.D., Regional Representative, Greensboro, N.C.; Roy O. Elam, III, M.D., Regional Representative, Nashville; Jeffrey B. Eskin, M.D., At-Large Representative, Nashville; Lesley French, VMS IV, VUSM Student

Representative, Nashville; Steven G. Gabbe, M.D., Dean, VUSM; Robert E. L. Gotcher, M.D., At-Large Representative, Hillsborough, Calif.; Harry R. Jacobson, M.D., Vice Chancellor for Health Affairs, VUMC, Nashville; Trey Lee, M.D., House Officer Representative, Nashville; Warren F. McPherson, M.D., Regional Representative and President-Elect, Murfreesboro, Tenn.; Anne-Marie Oelschlager, M.D., Young Alumnus/Alumna Representative, Seattle; Ann H. Price, M.D. Executive Director, Medical Alumni Affairs, Nashville; Wyatt E. Rousseau, M.D., Regional Representative, Richardson Texas; John K. Shaver, M.D., Regional Representative, San Juan Capistrano, Calif.; Melissa K. Thomas, Ph.D., M.D., Regional Representative, Boston.

“Worthy of Note” News

We need the help of all our medical alumni. Have you published a book or article, received an academic promotion, been elected to a professional society post, served on a community board, finished a marathon, had a new addition to the family, moved to a new practice setting, worked on a medical mission team, passed your boards, etc.? All your good news is worthy of note and of special interest to those with whom you studied and trained. Do not hold back. Since modesty continues to be our worst enemy in ferreting out “Worthy of Note News,” classmates, friends, and spouses are invited to submit praiseworthy pieces about their favorite medical alumni for inclusion in one of our next issues of Vanderbilt Medicine.

VMAA Host Program Update

The VMAA Host Program’s password-protected Web site became available to VUSM IV’s in October. Seniors are beginning to schedule visits with medical alumni host families as they travel across the country searching for the perfect internship match. Many thanks to all of you who are participating in this fledgling program. If you live in close proximity to an academic teaching program, and have not yet signed up to participate with this program, please consider volunteering for this effort. Please e-mail me at ann.price@vanderbilt.edu to indicate your interest.

Various Alumni Discounts/Special Offers

Cingular Wireless, TPAC, Regal and Carmike Cinemas, and Avis are among those vendors offering discounts or special offers to Vanderbilt alumni. For an updated list of discounts and special offers visit: www.mc.vanderbilt.edu/alum-affairs/ and click on “Alumni Benefits.”

Ann H. Price

worthy of note



***Joseph A. Cook, M.D., MD'64**, retired from the International Trachoma Initiative in March 2003. He will continue his interest in international health, but with more leisure time than before. He authored a summary of his work aimed at trachoma, the world's leading preventable cause of blindness, in the November 2003 edition of *Lancet*. In May 2003, he received the prestigious Trachoma Gold Medal at a ceremony in Paris. The medal is awarded each year to a person who has advanced the cause of trachoma

control and was presented by Gabriel Coscas, M.D., (shown here, left, with Cook), president of the International Organization Against Trachoma, and by La Ligue Francaise Contre Le Trachome in association with the 109th Congress of the French Society of Ophthalmology. Cook says he is sorry to have missed his 40th class reunion. He and his wife, Betty Anne, were celebrating their 40th anniversary with their three daughters, spouses and grandsons in Mexico.

School of Music at Vanderbilt, in charge of development.

50s

Oliver Massengale, M.D., HS'58, retired in 1995 after 35 years of pediatric practice in Portland, Ore. Since then, he and his wife have been in the scenic Pacific Northwest enjoying summer hiking and backpacking and winter downhill skiing. They have three daughters and six grandchildren, all healthy and happy.

Ellis A. Tinsley, M.D., MD'59, HS'59-60, '63-'66, retired in 2002 from his practice of general and thoracic surgery of 35 years and moved with his wife, Betty, to Wrightsville Beach, N.C. Now married for 47 years, they have three sons and a daughter and eight grandchildren. Their son, Ellis Jr., is now president of his father's former practice.

60s

Edward E. Anderson, M.D., MD'61, HS'61-'62, after a three-year hiatus in the corporate world as medical director of a health maintenance system, has gone back to a full-time internal medicine practice with his office based at Saint Thomas Hospital in Nashville.

Daniel C. Geddie, M.D., MD'63, HS'67-'69, CF'74-'89, is assistant clinical professor of Radiology at Vanderbilt and is board certified in Diagnostic Radiology. He and his wife, June, have been married for 40 years.

***John M. Leonard, M.D., MD'67, HS'71-'72, F'73, FA'74-'04**, has been named chief of medicine at Saint Thomas Hospital in Nashville. Before joining Saint Thomas, he was vice chairman for education and the residency program director for the Department of Medicine at Vanderbilt University School of Medicine. He also served as an attending physician and as a consulting physician in the division of infectious diseases at Vanderbilt Hospital.

40s

***Fred Allison, Jr., MD'46, HS'46, FA'87-**, professor emeritus of Internal Medicine, was recognized at the August 2004 dedication of the Fred Allison Jr. Research Laboratory at the University of Mississippi Medical Center.

***W. Faxon Payne, M.D., MD'48, HS'48-'53, '57-'60, FA, CF'80-'89, FA'86-'00**, is currently retired and professor emeritus of Radiology at Vanderbilt. Payne reports that his younger daughter, Virginia, is now associate dean at the Blair

* Indicates CRS member

***Richard B. Johnston, Jr., MD'61, HS'61-'62,** has been named Executive Vice President for Academic Affairs at the National Jewish Medical Research Center in Denver, a research hospital in immunology and pulmonary medicine, which *U.S. News and World Report* has named "Best Respiratory Hospital in the United States" for the past seven years. He is also Associate Dean for Research and Development at the University of Colorado School of Medicine.

70s

***A. Everette James, Jr., M.D., FA'75-'89,** has a collection of quilts created in the African-American community of North Carolina exhibited at the Charlotte Museum of History until March, then moving to the North Carolina Museum of History. He has also produced a new book, *Collecting American Paintings, Identification and Values*, focusing on collectible American paintings. The book is available through www.collectorbooks.com.

Peter Rawlings, M.D., MD'79, continues to practice with Gary Meredith, MD'74, HS'78, in Chattanooga. He is the secretary/treasurer of the Chattanooga-Hamilton County Medical Society. He has served on the Board of Directors of the Chattanooga Ronald McDonald House Charities for more than 10 years and on the vestry at his church. He also serves as a member of the board of the Children's Nutrition Program of Haiti (www.cnphaiti.org), runs a nutrition program in Haiti, and regularly runs medical missions in and around Leogane, Haiti.

80s

***Jan L. Brandes, M.D., MD'89, HS'89-'92, CF'93-**, of Nashville, was recently elected as president of the American Council of Headache Education (ACHE), a non-profit partnership dedicated to advancing the treatment and management of headache and to raising public awareness of



worthy of note

***Susan Andrews, M.D., MD'78,** has become a recognized leader in the implementation of the electronic medical record in the private practice office setting and is enjoying encouraging and helping others get started with an EMR. Her family practice group in Murfreesboro has been the subject of several articles on the paperless environment including one in American Medical Association's online amednews.com and another in the American Academy of Family Practitioner's online e publication. She and her colleagues at Family Practice Partners started using an EMR in October 2000 and use wireless laptops to document patient encounters. To view both publications, visit www.ama-assn.org/amed-news/2002/10/14/bisa1014.htm and www.aafp.org/fpr/20041000/1.html

headache as a valid, biologically-based illness.

Robert T. Means, Jr., M.D., MD'83, F'86-'88, FA'88-'92, effective July 1, 2004, became chief of the Medical Service at the Lexington Veterans Medical Center, professor of Medicine in the Hematology/Oncology Division and the Vice Chair for Research in the Department of Internal Medicine at the University of Kentucky. His wife, Stacey McKenzie, MD'85, HS'85-'88, F'88-'90, FA'90-'92, is working for Lexington Infectious Disease Consultants.

***Jeffrey Sippel, M.D., MD'89,** is a clinical faculty member in the pulmonary and critical care division at the University of Colorado and is board certified in internal medicine, pulmonary medicine and critical care medicine. He also has a Masters of Public Health degree from the Oregon Health and Science University School of Public Health. He and his wife welcomed their second child, Mari Elizabeth, in 2003.

John W. van Wert, M.D., MD'84, has enjoyed a busy obstetrics and gynecology practice at Premier Obstetrics and Gynecology of Orlando since 2003. He practices with two other physicians and two nurse practitioners and plans to

take his wife, Anne, a pediatrician, along with their two children, on their first two-week mission trip to Ghana in West Africa in June 2005, to operate in a clinic there.

90s

Elizabeth L. Cato, M.D., MD'92, has left private practice after nine years to be medical director of Tennessee for HealthSpring community health plan.



worthy of note

Christopher U. Cates, M.D., MD'82-'84, F'86-'88, published a commentary in the December 22/29 issue of the *Journal of the American Medical Association*, pointing out that virtual reality training is a better, faster and safer way for physicians to learn endovascular procedures like carotid stenting than the traditional training route. Cates is Director of Vascular Intervention at Emory University Hospital and Emory Crawford Long Hospital in Atlanta. Carotid stenting is a new technology that offers high-risk patients a less invasive option to carotid endarterectomy. The U.S. Food and Drug Administration approved the new technique in September 2004. Emory is one of 30 national training centers for the procedure.

Laura Ray, M.D., Ph.D., HS'96-'99, started her own practice in Montrose, Ala., Fairhope Internal Medicine, PC, with another Vanderbilt graduate, John Douglas, M.D., MD'58. She, Delene and the cats love living in Montrose, a very small town on Mobile Bay.

Major Thomas Benton Repine, M.D., MD'98, is presently serving in Baghdad, Iraq with the Army's 31st CSH Unit (Combat Support Hospital). He is assistant chief of hematology/oncology at Brooke Army Medical Center.

George Gaylord Robinson II, MD'93, is director of Total Joint Care at Providence Medical Center in Kansas City, Kan.

Omer Shedd, M.D., MD'98, and his wife, Kelly, are living in Gainesville, where Omer is a postdoctoral fellow in cardiovascular medicine at the University of Florida, Gainesville. They welcomed a child, Ashlee Elizabeth, on Oct. 11, 2004.

***Robert W. Steele, M.D.,** MD'93, has been named chairman of the Advisory Board for Childhood

Immunizations for the state of Missouri. He and his wife, Renee, have three children – Ryan, 11, Mitchell, 9, and Dora Jean who turned 1 in December.

2000-

Meri Murphy Todd Harper, M.D., MD'01, married Sean Harper, M.D., in Portland, Ore. on May 30, 2004, following the completion of her residency in Pediatrics at Oregon Health and Sciences University. They have moved to Salt Lake City where she is practicing general pediatrics.

Robert (Sandy) Neblett, M.D., MD'02, is a third year resident at the University of Kansas School of Medicine-Wichita Family Medicine Residency Program at Via Christi Regional Medical Center in Wichita.

Laura Stobie Winterfield, M.D., MD'01, and her husband, Jeffrey Winterfield, M.D., welcomed their first child, James Roland, on June 29, 2004. Laura is chief resident in Dermatology at the University of Texas Southwestern in Dallas.

Scott Baldwin, M.D., has been named director of the Division of Pediatric Cardiology in the department of Pediatrics and Vanderbilt University School of Medicine. Baldwin replaces the former chief, Thomas P. Graham Jr., M.D., who stepped down after 33 years of service. Baldwin, who joined Vanderbilt in 2002, has served as the Katrina Overall McDonald Professor of Pediatrics and professor of Cell and Developmental Biology, working as vice chair for Laboratory Sciences in Pediatrics.

***Frank H. Boehm, M.D.,** who has been credited with bringing modern obstetrics to Vanderbilt, Nashville and Middle Tennessee, was honored in December at the 30th Annual High-Risk Obstetrics Seminar at Vanderbilt University Medical Center for his commitment to the practice of obstetrics over the past 32 years. Boehm, professor of Obstetrics and Gynecology, who co-directs the seminar, stepped down recently as director of the Division of Maternal-Fetal Medicine. He is remaining on the faculty half-time to concentrate on teaching, research and writing a second book. He published a collection of essays, *Doctors Cry, Too* in 2001. **Cornelia Graves, M.D.,** associate professor of Obstetrics and Gynecology and assistant dean for Diversity in Medical Education, has been appointed interim director of Maternal-Fetal Medicine.

***Nancy Brown, M.D.,** has been named the Robert H. Williams Professor of Medicine. The newly created professorship was named in honor of Robert H. Williams, M.D., who received his training in internal medicine at Vanderbilt and was Vanderbilt Chief Medical Resident in 1939. Brown has earned national recognition and numerous awards for her research on blood pressure regulation, including the 2001 Young Scholar Award from the American Society of Hypertension and the 2002 American Federation for Medical Research Outstanding Investigator Award.

Nancy C. Chescheir, M.D., from the University of North Carolina at Chapel Hill, has been named chair of Obstetrics and Gynecology at Vanderbilt University School of Medicine. She is the first woman to chair a clinical department in the medical school's 129 years. Chescheir, 49, Charles Hendricks Professor of Obstetrics and Gynecology and the Medical Alumni Teaching Professor at UNC, received both her undergraduate and medical degrees from UNC, then served her residency there, including a year as chief resident and a fellowship before joining the faculty there in 1988. At Vanderbilt, Chescheir, a perinatologist, succeeds **Stephen S. Entman, M.D.,** who is stepping down after 10 years as chair of the department. He will remain on the faculty.



worthy of note

Charles H. Griffith, M.D., MD'88, associate professor of Internal Medicine and Geriatrics at the University of Kentucky College of Medicine is one of four medical school faculty members from across the nation to receive the 2004 Alpha Omega Alpha (AOA) medical honor society's Robert J. Glaser Distinguished Teacher Award from the Association of American Medical Colleges. The award is presented annually to two clinical and two basic science medical school faculty members in the nation. He joined the UK College of Medicine faculty in 1994. Griffith has received more UK teaching awards and recognitions than any other faculty member in the history of the UK College of Medicine. In the 11 years he has served as director of the internal medicine clerkship, the course has been awarded the Clerkship Excellence Award eight times, including seven years in a row. Also receiving the prestigious AOA honor was Vanderbilt faculty member Art Dalley, Ph.D. (see faculty news).

***Art Dalley, Ph.D.**, professor of Cell and Developmental Biology and Master Clinical Teacher, received the prestigious Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award Nov. 6 at the Association of American Medical Colleges annual meeting in Boston. Dalley was one of four in the nation to receive the award, which honors "tireless efforts to provide the nation's next generation of doctors with an outstanding educational experience," according to the AAMC. Dalley joined the Vanderbilt faculty in 1998. He previously served on the faculty at Creighton University School of Medicine in Omaha, Neb., for 24 years. He earned his Ph.D. and B.S. from the University of Utah.

***Raymond N. DuBois Jr., M.D., Ph.D.**, and **Walter J. Chazin, Ph.D.**, have been elected as fellows of the American Association for the Advancement of Science (AAAS), an honor bestowed upon them by their peers. They are among 308 scientists from around the country who have been elevated to this rank because of their efforts to advance science or its applications that are deemed scientifically or socially distinguished.

***Steven G. Gabbe, M.D.**, dean of the Vanderbilt University School of Medicine, has been appointed chair of the second Association of American Medical College's Task Force on Clinical Research. The task force will spend 12-18 months addressing the issues confronting clinical research endeavors, with a focus on institutional infrastructure that supports research.

***S. Julian Gibbs, M.D.**, professor of Radiology and Radiological Sciences, Emeritus, was named Diplomate of Honor at the recent awards ceremony of the American Board of Oral and Maxillofacial Radiology in Denver. The award, the highest presented by the board for a career of contributions to the profession, had not been presented since 1982. Gibbs, one of the four living holders of the award, was a charter diplomate and past-president of the board.

Thomas P. Graham Jr., M.D., has stepped down as director of the Division of Pediatric Cardiology after 33 years. He built the division as its first and only chief, and is being replaced by **Scott Baldwin, M.D.** Graham will still play a vital role in the division and will continue his focus on improving the care and management of adults with congenital heart disease.

Pat Levitt, Ph.D., professor of Pharmacology and director of the Vanderbilt Kennedy Center for Research on Human Development, received

the 2004 Friend of Children Award from the Tennessee Chapter of the American Academy of Pediatrics. The award recognized Levitt's contributions at the local, state and national level to the healthy development of children.

Daniel R. Masys, M.D., an oncologist and a leading biomedical informatics expert who currently directs the biomedical informatics program at the University of California, San Diego School of Medicine, has been appointed chair of Vanderbilt University School of Medicine's Department of Biomedical Informatics and chief academic officer of the Informatics Center. Masys is a 2001 electee to the Institute of Medicine of the National Academy of Sciences. Prior to joining UCSD in 1994, he was director (from 1986 to 1994) of the Lister Hill National Center for Biomedical Communications, a research arm of the National Library of Medicine.

***Randolph (Randy) Miller, M.D.**, has been named the Donald A. B. and Mary M. Lindberg University Professor of Biomedical Informatics. The namesake, Donald A.B. Lindberg, M.D., honored Miller in a ceremony during celebrations for the Eskin Biomedical Library's 10th anniversary. This is the first named chair in the department. Miller came to Vanderbilt in 1994, which doubled the size of the innovative program, at the time, from one to two.

***Robert H. Ossoff, D.M.D., M.D.**, associate vice chancellor for Health Affairs, has been chosen as president-elect of the Society of University Otolaryngologists — Head and Neck Surgeons (SUO-HNS). He will begin his term as president in November 2005. The SUO-HNS is made up of more than 600 ear, nose, and throat specialists who are faculty members of otolaryngology departments across the United States and Canada.

Richard M. Peek Jr., M.D., has been named chief of the Division of Gastroenterology, Hepatology and Nutrition and Mina Cobb Wallace Associate Professor of Medicine. He succeeds **Raymond N. DuBois, M.D., Ph.D.**, who recently left the position to head the Vanderbilt-Ingram Cancer Center as its new center director. Peek is no stranger to Vanderbilt and the Division of Gastroenterology. Peek came to Vanderbilt in 1992 for his fellowship in the Division of Gastroenterology after earning his M.D., with distinction, from the University of North Carolina School of Medicine, then serving as chief medical resident at the University of North Alabama School of Medicine. He joined the faculty in 1996 and has risen through the ranks to associate professor and director of research in the division.

Scott Rodgers, M.D., a psychiatrist in the Division of Child and Adolescent Psychiatry, has been appointed assistant dean for Medical Student Affairs. He replaces Bonnie Miller, M.D., who is vacating the position to serve in the new office of Medical Education as associate dean for Undergraduate Medical Education. Rodgers joined the Vanderbilt faculty in 2000 as assistant professor of Psychiatry and took on the additional responsibilities of directing the second-year psychiatry course, directing the third-year medical student clerkship in psychiatry, and heading up the Pediatric Consultation/Liaison Service. He said it was his experience working with the students that attracted him to the assistant dean position.

Christianne Roumie, M.D., instructor in General Internal Medicine, and Harvey Murff, M.D., assistant professor of Medicine, have been selected as the first Veterans Affairs Clinical Research Scholars. Through the VA Clinical Research Center for Excellence, the investigators will be supported by a \$400,000 per-year grant awarded by the U.S. Department of Veterans Affairs.

***William Stead, M.D.**, associate vice chancellor for Health Affairs and director of the Informatics Center, has been elected chairman of the board of regents of the National Library of Medicine, one of the National Institutes of Health and the world's largest medical library. The NLM is the primary source of funding for biomedical informatics research grants, providing a total of about \$60 million in funding, all of which relates in some way to biomedical informatics, the specialty Stead is largely credited with helping pioneer.

***Norman Army**, executive vice president for Clinical Affairs and CEO and executive director of Vanderbilt University Hospital, has been recognized by the Tennessee Hospital Association with one of its top honors. Army was presented with the Meritorious Service Award for Chief Executive Officer at the organization's 66th annual meeting held in Nashville Sept. 29-Oct. 1. The award is presented to a hospital chief executive who has demonstrated leadership and exemplary service to the health care field.

William Cleveland, M.D., MD'50, HS'51, died Sept. 14, 2004 in Miami of bone cancer. He was 83. Cleveland, a world-renowned endocrinologist and chairman of the Department of Pediatrics at the University of Miami School of Medicine for two decades, made medical history as part of the team that performed the world's first successful thymus gland transplant in 1967. He was a founding member of the American Southern Society for Pediatric Research and also helped establish the Department of Children's Medical Services for the State of Florida. Cleveland retired in 1989, but remained a professor and chairman emeritus of the department, continuing to see patients until the onset of his illness in June. He is survived by two children.

Joseph Russell Cook, M.D., MD'34, died Nov. 16, 2004 in Huntington, W. Va. He established a practice in internal medicine in Huntington, and established the Huntington Internal Medicine Group. He retired in 1994 after 56 years of medical practice. He is survived by three children, three grandchildren, and three great grandchildren.

Eric L. Dyer, M.D., MD'76, HS'76-'78, F'82-'84, CF'85-'00, of Brentwood, Tenn., died Sept. 15, 2004. He was 56. Dyer, a pulmonologist at the Frist Clinic in Nashville, was also a published poet and Civil War enthusiast. He is survived by his wife, Cheryl, two children, and a stepdaughter.

Horace Rainey Frierson, M.D., MD'46, died Aug. 18, 2004 at his home in Malibu Canyon, Calif. He was one of two founding physicians of the Sepulveda Boulevard Medical Center in Los Angeles, and is survived by a sister and other family members.

***John C. Gillen, M.D.**, MD'56, of Xenia, Ohio, died Nov. 2, 2004. He was 72. He was a family physician in the Fairfield, Ohio area before serving as the director of the Family Medicine Residency

Program at St. Elizabeth and the department chair of the Family Medicine Program at Wright State University School of Medicine. He is survived by his wife, Faye, five children, 12 grandchildren and four great-grandchildren.

John Powell (Jack) Glover, M.D., MD'50, died Dec. 14, 2004 at his home in Nashville. He was in general family practice in Ashland City and established the first medical clinic in Cheatham County. He later joined the National Life and Accident Insurance Company where he subsequently became the medical director. He is survived by his wife, Mary Frances, three daughters, six grandchildren and six great grandchildren.

Harvey P. Groesbeck, M.D., HS'39, died June 30, 2004. He was 90.

Willis M. Hendricks, M.D., HS'41, died May 15, 2002. He was 85. He began an ob/gyn practice in LaGrange, Ga. in 1948 where he remained in practice until 1986 at the Clark-Holder Clinic. He is survived by his wife, Thelma, nine children, 18 grandchildren and two great-grandchildren.

Joe Hampton Henshaw, M.D., MD'51, died Oct. 13, 2004 in Sarasota, Fla., He was 80. He practiced until the late 1970s in Sweetwater, Tenn., when he semi-retired, then practiced medicine, specializing in emergency medicine in Michigan, Illinois and Florida. He retired in Knoxville in 2000. He is survived by his wife, E. Ann, three children, three stepchildren, eight grandchildren and one great-grandchild.

Granville Allen Lawrence Jr., M.D., CF'57-'87, died in September 2004 in Nashville. He was 87. He began his Nashville medical practice in 1948 and served on the staffs of Vanderbilt, Saint Thomas, Baptist, Nashville General and Parkview hospitals and was a founder of the Middle Tennessee Lions Sight Service in 1956. He is survived by his wife, Rebecca, three children and three grandchildren.

Curtis W. Rainy, M.D., MD'49, died Dec. 13, 2004 in Rochester, Minn. He was 84. He was a general practitioner at the Elma (Iowa) Hospital and St. Joseph Hospital in New Hampton and assisted with general surgery in Waterloo for 33 years, retiring in 1987. He is survived by two children and four grandchildren.

L.J. Spitz, M.D., MD'35, died on Oct. 10, 2004. He was 93. After serving in World War II as a front-line physician, he entered private practice and was an attending physician to the New York City Department of Hospitals and the New York Infirmary. He was also an assistant physician at Sloan-

Kettering Memorial Hospital and New York College and was instrumental in establishing the Strang Clinic, a cancer care facility. He moved to New Mexico in 1972 and worked as a consultant to the University of New Mexico Cancer Research and Treatment Center. He is survived by his wife of 61 years, Alice, and three children.

Beverly Jean Triplett, M.D., MD'50, died on Sept. 18, 2004. She practiced in Las Vegas.



R. Michael Rodriguez, M.D., HS '80-'82, '84-'85, who served as associate professor of Medicine for Vanderbilt University School of Medicine, died Dec. 21, 2004. He was 53.

Dr. Rodriguez spent most of his career in private practice, but turned his focus to teaching medical students in 1997. In less than a decade, he became one of Vanderbilt's most beloved instructors.

Dr. Rodriguez was born in Kingsville, Texas, and earned his B.A. in Biology from Southwest Texas State University in San Marcos, Texas. He received his medical degree from Tufts University School of Medicine in Boston in 1980, and came to Vanderbilt University Medical Center as an intern in the Department of Medicine that year.

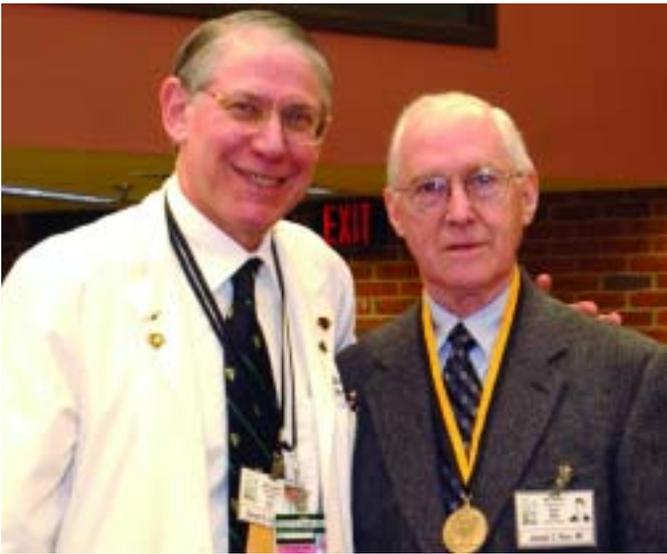
He went on to serve a residency and postdoctoral fellowship in the Department of Medicine and entered into private practice at Saint Thomas Hospital in 1985. He added an academic appointment at Vanderbilt University School of Medicine in 1989 and was named medical director of the Department of Respiratory Care at Saint Thomas in 2000 and associate professor of Medicine at Vanderbilt in 2001.

Dr. Rodriguez specialized in pulmonary medicine and was a member of various thoracic societies. He also developed and patented the Pleurex catheter.

At Vanderbilt, Dr. Rodriguez served as director of Minority Affairs from 1998-2002 and until his death was a member of the admissions committee and the academic programs committee. He was one of the first faculty members to be named a Master Clinical Teacher, which is designated based on teaching excellence and is accompanied by funding which encourages the continued pursuit of excellence in teaching.

Dr. Rodriguez was the recipient of various teaching awards, including the Hugh Jackson Morgan Award for Inpatient Teaching, the Thomas Brittingham Teaching Award, the Shovel Award, the Housestaff Teaching Award, and the Housestaff Distinguished Teacher Award. He was also honored with the Affirmative Action Award, the Grant W. Little Award for exemplary leadership in the promotion of scientific research, and the Healthcare Foundation of New Jersey Humanism Award.

Dr. Rodriguez is survived by his wife Missy and two children, Jonas and Sara. - LISA PEPER



1

Reunion 2004

Photography by Dana Johnson

Pictured here:

1. Dean Steven Gabbe with Quinq inductee Joseph Ross, M.D., class of 1954. The Quinq ceremony marks the 50th anniversary of receiving a medical degree at Vanderbilt.

2. From left, Patty Malloy, Jean Cortner, M.D., Class of 1955 and Carl Grote, M.D., Class of 1954 at the 2004 Quinq Ceremony.

3. Herbert Burke, June Foley and James Gross, all of the Class of 1955, at the Quinq ceremony.



2



3

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