

Vanderbilt Medicine

SPRING 2004

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The new epidemic of childhood obesity

• escaping the
prison
of eating disorders

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Reunion 2004 will be held Nov. 4, 5, and 6 reuniting graduates of class years ending in 3, 4, 8, and 9, and the Quinq classes of 1954 & 1955.

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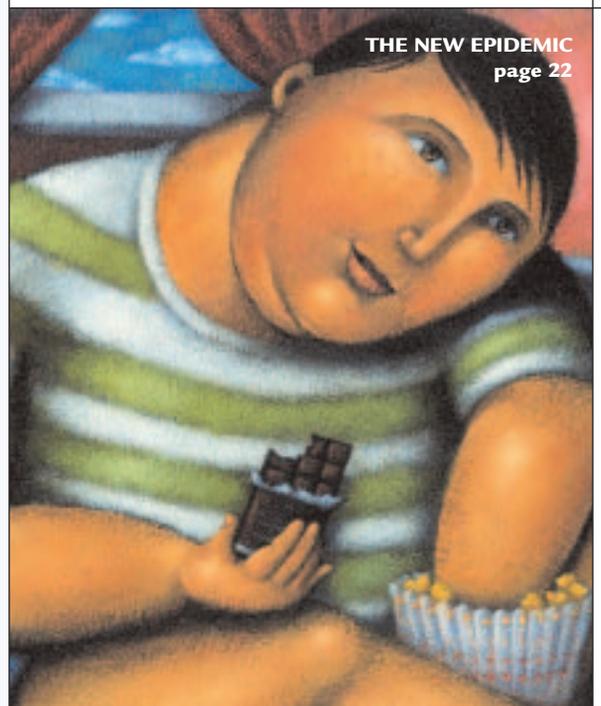
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DEAN DIXON

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

An international reputation in managing eating disorders

Food. As living beings, each of us is hard-wired to seek food, store it in good times and live off the stores in lean times. In earlier issues we've explored some of the biological consequences of this genetic hard wiring in the epidemic of obesity sweeping across the country. The increasing incidence of obesity and the diseases it causes – diabetes, cardiovascular disease, gastric disorders and even cancer – are well understood.

But food is not just the grist of our genes. We have soft wiring about food as well. We learn eating habits, develop taste preferences and build our personal histories around important moments at the family dinner table. Food is elevated to the level of icon in our psyche and takes on meaning and importance far beyond the purely physiological. Sometimes our soft wiring about eating also goes haywire.

Eating disorders like anorexia and bulimia are on the rise. Our tools for the diagnosis and treatment of these disorders

seem wholly inadequate. Our efforts to prevent them are even poorer. For some young women, the disorder begins in early adolescence and continues throughout their adult life with devastating physical and emotional consequences. No single behavioral disorder has a higher mortality rate than eating disorders.

What to do about eating disorders? First, we need to build tools for prevention – tools that push back against the fashion model/movie star culture and tools that help to give young girls a sense of self-worth and control over their lives. Second, we need to develop better diagnostic and therapeutic approaches that help us identify young women at risk and treat those who develop the disorders more effectively.

GirlForce is a program developed here at Vanderbilt to begin addressing root causes of a wide variety of health behaviors influenced by self-image. It is a program whose time has come, and one that has

established affiliates all across the United States, in Australia and Ireland.

With our longtime supporters in the Junior League of Nashville, we have expanded our eating disorders program under the direction of Ovidio Bermudez, M.D. Dr. Bermudez has built an international reputation in managing these disorders through medical, behavioral and social interventions.

We're making headway in helping young people escape the prison of eating disorders. We need to do more to make sure fewer girls are sentenced to this prison in the first place. ●



All moved in

The move of 112 patients from the old Vanderbilt Children's Hospital on three floors of Vanderbilt Hospital to the new freestanding Monroe Carell Jr. Children's Hospital at Vanderbilt began 30 minutes before schedule, at 7 a.m. Sunday, Feb. 8.

Dedrick Woodard Jr., 1, and his mother were wheeled out of the pediatric emergency department attached to the Vanderbilt Clinic. Accompanied by four ED staff members, Vanderbilt Children's Hospital's Medical Director Arnold Strauss, M.D., and CEO Jim Shmerling, the group took an elevator up to a fourth-floor connector, and over to the new eight-floor, 206-bed, 600,000-square-foot hospital.

By 7:30 a.m., the original time set for the move of the ED, there were six patients, and things were running smoothly. Dedrick and his mother rested comfortably, as staff were waiting patiently for the patients and families to fill the rooms.

By 10:30 a.m., the time planned to move all inpatients, the first four patients were lined up ready to go. Media, family, volunteers and staff all looked like they were leaning into the wind, ready for the gates to open so they could charge across the connector.

There was no "charge," it was all very controlled, but the energy was high all the way. Staff members burst into applause as the first patient, Gary Ellis, was wheeled onto the eighth floor by Harry Jacobson, M.D., vice chancellor for Health Affairs, Shmerling and the hospital's name-sake Monroe Carell Jr.

The whole day was like that. Patient after patient made the move over the connector on the fourth floor, to be met by staff members, have their photograph taken with Champ, the Children's Hospital mascot, and finally settle into beautiful new rooms on brand new floors.

At 4:30 p.m., an hour and a half before the earliest expected time of completion, it was all over. While 140 patients had been prepared for the move, several went home just before or during the move. By final count, 112 actually crossed over the connector between VUH and VCH on this historic day.

The new hospital, at the corner of 24th Avenue and Capers, is the largest building project in Vanderbilt University's history and one of the largest in Nashville.

- CAROLE H. BARTOO

VUMC study: Smallpox vaccine poses low risk

Results of the most comprehensive United States smallpox study to date — conducted at Vanderbilt University Medical Center — prove that people inoculated with the smallpox vaccine pose a low risk of infecting others if proper bandaging and hand-washing techniques are followed.

Study results, published in the Feb. 15 issue of *Clinical Infectious Diseases*, may put to rest concerns over the risk of health care workers, or others such as military or emergency workers, vaccinated for smallpox of passing the disease along to at-risk members of the population like children, pregnant women, and people with immune disorders or certain skin conditions.

"Hopefully, this study has helped reassure individuals about the transmission of smallpox," said Thomas Talbot, M.D., assistant professor of Medicine and the study's lead investigator. "The risk of transmission is vastly reduced if those vaccinated against smallpox keep the vaccine site bandaged and practice good, thorough hand-washing with soap and water, or an alcohol-based product, after changing the bandage."

About eight or nine days after receiving a smallpox vaccine, individuals develop an open wound that sheds live vaccinia virus, (the actual virus used in the vaccine) for several days. The potential risk of spreading vaccinia virus to patients, particularly to those in an at-risk group, led many U.S. health care workers to choose not to participate in President George Bush's national smallpox vaccination campaign.

Children, pregnant women, people with eczema or other exfoliative skin disorders, and those with immune disorders can be at serious risk if exposed to the vaccinia virus.

For VUMC's study, 148 individuals were vaccinated. None had ever received the vaccine. Each participant went through an average of 9.6 bandage changes during the study, and 2,843 cultures were obtained from vaccine sites, outside of vaccination site bandages, and participants' hands for laboratory analysis. Vaccinia was recovered from only 0.65 percent of the bandage specimens (six of 918) and from only 0.22 percent of the hand specimens (two of 926), an extremely low frequency of recovery of the live vaccinia virus outside of the protective bandage. There was also no evidence of transmission of vaccinia to volunteers during the study.

Talbot says he sees no need for everyone to be vaccinated against smallpox. Thanks to civilian and military vaccination campaigns there now exists a backstop of individuals who could step in during a bioterrorism crisis.

"If someone were to intentionally release smallpox, we have our first wave of health care responders protected," he said. "The vaccine can be effectively administered for as long as three or four days after exposure, so health care workers who have been vaccinated could take care of patients and help vaccinate everyone else in the days following an attack."

- JOHN HOWSER

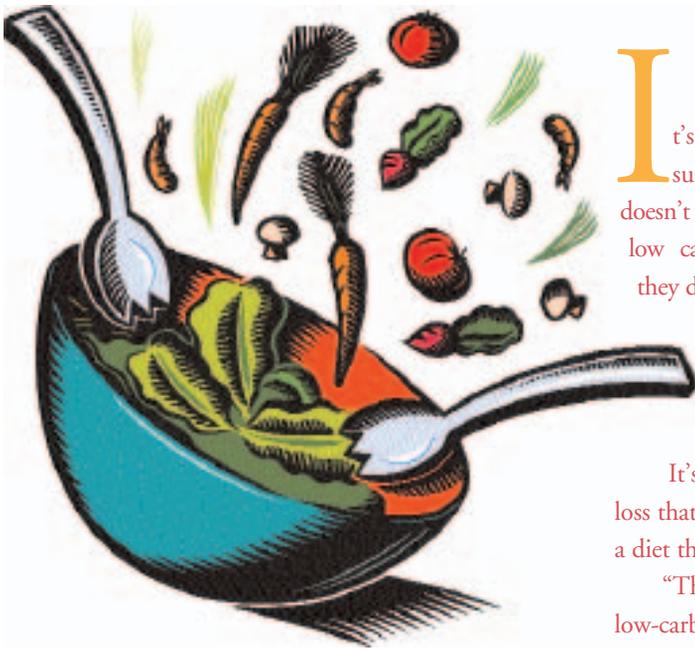


DANA JOHNSON

low carb

does it work? is it safe?

by Nancy Humphrey



It's hard these days to pick up a consumer-oriented magazine that doesn't tout the latest information about low carbohydrate diets. They work; they don't. They're safe; they're not.

Fast food restaurants now offer low-carb entrees in addition to the traditional high-carb choices.

It's a popular approach to weight loss that has been around for years, and a diet that works for many.

"The bottom line is that people on low-carb diets can lose weight if they reduce their calories, and this weight loss may result in an improved metabolic profile," said Chris Biesemeier, registered dietitian and assistant director of Nutrition Services at Vanderbilt University Medical Center. "However this approach to weight loss does not meet nutritional needs and requires use of nutrient supplements," she said.

"I would say if the low-carb diet allows you to lose weight and keep it off, then I would recommend using this approach," she said. "I say this because weight loss is hard work and if you've found something that works for you, that's great. However, the low-carb diet would not be my first choice of diet. Instead I'd recommend that you eat a

low-calorie, moderate-fat, balanced-nutrient diet, since you can lose weight with this approach and meet your nutritional needs.

Biesemeier offered the following guidelines from an article entitled "Popular Diets: A Scientific Review," published in the March 2001 journal *Obesity Research*.

- Diets that reduce caloric intake result in weight loss.
- All low-calorie diets result in loss of body weight and body fat.
- People who lose weight on low-carb diets do so because they're eating fewer calories.
- High-fat, low-carb diets are low in vitamins E, A, thiamin, B-6, folate, calcium, magnesium, iron, potassium and dietary fiber.
- Low-carb diets that result in weight loss may also result in decreased blood lipid levels, decreased blood glucose and insulin levels and decreased blood pressure.
- High-fat, low-carb diets result in ketosis.
- Long-term compliance is likely a function of psychological issues rather than macronutrient composition, i.e., not how much carbohydrates or fat is in the diet.

Biesemeier said for keeping weight off, based on the National Weight Control registry data, she recommends eating a low-calorie, low-fat diet that includes breakfast and limits fast food meals to fewer than once a week; reducing sedentary activities, like watching TV and sitting for long periods of time at the computer, and increasing your activity level to meet the goal of 60 minutes of total activity a day.



Death of longtime special events director leaves void at Vanderbilt

Andrea Williams Carroll, Vanderbilt University Medical Center's longtime director of Special Events, died on Sunday, Jan. 11 at her home.

A native of Dallas, Texas, Ms. Carroll created the Special Events office when she came to Vanderbilt in 1975. As director, she coordinated events ranging from the medical center's annual holiday turkey toss, where employees receive a free turkey, to alumni trips in cities throughout the United States, the medical school's biennial reunion and elaborate dinners for hundreds, held both on and off campus.

Ms. Carroll, 54, known for her upbeat personality and joyful sense of humor, was a caring person who worked with the richest citizens of Nashville, but knew no class boundaries. She was motherly to younger staff who worked with her, sent flowers to a friend each year on the anniversary of her husband's death, and had a knack for the finishing touches on the events she planned.

"There are few people who have contributed as much to our family and this university as Andrea Carroll," said Harry R. Jacobson, M.D., vice chancellor for Health Affairs. "No one could ever match her ability to give others joy — through the work that she did and through her very presence. We will miss her. We will miss her uniqueness, her grace and the buoyancy she gave us all."

Survivors include her husband, Tim Carroll; a sister, Barbara Williams of Charlotte, N.C.; a brother and his wife, Kent and Beth Williams of Naperville, Ill.; and brother and wife, Drew and Jo Williams of Arlington, Texas; sisters-in-law and husbands, Linda and Don Earnhart of Dallas and Donald and Louise Carroll of Naucelle, France; mother-in-law, Miriam Carroll of Dallas, nephew and niece, Kent and Mary Kate Williams, and niece and nephew, Allison and Eric Earnhart of Dallas.

"I loved Andrea Carroll," said Roscoe R.

Robinson, M.D., who worked closely with Carroll during his 16 years as vice chancellor for Health Affairs at VUMC. "She was bright, creative, classy and wonderfully supportive of everything I tried to do as vice chancellor. We were fortunate to have her on the team."

Robinson said he traveled with Ms. Carroll to many medical alumni dinners from 1981-1997. "She was a gracious hostess who knew just how to create a perfect environment in which we could get to know our alumni better," he said.

Donations can be made to the Andrea Williams Carroll Fund at Vanderbilt University Medical Center, Gift Processing, VU-Station B #357727, Nashville, Tenn., 37235-7727. — NANCY HUMPHREY



Andrea Carroll

Interpreters ensure understanding

There's no denying that communication is key in patient-doctor relationships. And communication becomes essential when the patient speaks little or no English.

Take this real-life snafu for example: When one Spanish-speaking patient came to Vanderbilt University Medical Center, a staff member who spoke some Spanish attempted to communicate pre-surgery instructions to the patient. Unfortunately, the patient understood that he was not to eat or drink for two weeks prior to the surgery. After several days of not eating and sneaking food at night, he couldn't keep up with the fasting "orders." On the way to his surgery, he stopped and ate. Once he arrived at the hospital, the surgery had to be cancelled because he was only supposed to refrain from eating several hours prior to the surgery, not days.

It's the job of Johannie Resto, coordinator

for Interpreter Services, to make sure such incidents don't happen.

"Just because someone speaks another language, it doesn't mean they can be an interpreter. You can't just use anyone," said Resto. "It's more than just communicating word for word — it's interpreting the message."

Resto said language barriers and cultural factors often make a difference in communication between a doctor and a patient. Sometimes the interpreter needs to clarify or educate patients and patient families on a particular subject. The job requires good listening skills and sometimes even becoming an advocate for the patient.

When the Office of Interpreter Services was created in March 2001, Resto became its only staff member, a number that has just increased with the recent addition of a part-time and full-time interpreter.

For the past four years, she's provided more than just an essential service to those who speak little or no English; she's gone beyond the "call of duty" to build relationships with patients in order to



Johannie Resto (left)

help ease at least one aspect of a very stressful situation.

Vanderbilt University Medical Center is the only hospital in Tennessee to provide interpreter services 24 hours a day, seven days a week. And it's free of charge.

While Resto and her newly hired interpreter can provide only Spanish interpretation and translation, the office has an agency they can call on to provide on-site interpretations for any language needed. The language line can be utilized and has more than 140 languages available for phone interpretation.

"But it's much better to provide the service on-site, obviously," Resto said. "The language line is good for check-in patients, appointments, or last minute requests."

— JESSICA HOWARD

a different medicine

by Lisa Dubois

Christopher Greeley, M.D., remembers it like an epiphany. A young mother had brought her 1-month-old baby into the Angkor Hospital for Children in Siem Reap, Cambodia. The baby was having difficulty breathing, getting sicker by the minute, and a chest X-ray showed an enlarged heart surrounded by excess fluid. Greeley was certain the baby was experiencing congestive heart failure – until he began asking the mother questions.

The mother said she was having problems of her own – numbness and tingling in her hands and feet, and difficulty walking. The woman, Greeley discovered, was extremely malnourished and had no thiamin in her system. Both she and her child were suffering from the vitamin deficiency disease, beriberi. Greeley gave the baby thiamin and within a day her condition had improved. In three days, she was well enough to go home.

“That was the first time I realized that this is different medicine. This is not United States medicine,” says Greeley, assistant professor of Pediatrics at Vanderbilt. “I had to go to a World Health Organization website and learn about infantile beriberi, because I’d never even heard of it.”

Every fall for the past three years, Greeley has returned to Cambodia to teach and practice medicine among one of the world’s most impoverished populations. He usually takes a resident or medical student with him, and although he pays his own

way, the month spent at Angkor Hospital is considered a sanctioned international rotation, enabling Vanderbilt to establish a liaison with a medical center in Southeast Asia. His rotation is arranged through the Japanese-based organization, Friends Without A Border, a secular, not-for-profit agency dedicated to the support of the children’s hospital. Aside from the unique medical experience he gains, Greeley goes to Siem Reap, he says, “to show [the Cambodian] people that there are others out there who care about them. It’s amazing to go there and within a few weeks to introduce hope into a community.”

Greeley is one of an estimated 25 Vanderbilt physicians who travel to underserved areas of the world to provide, to teach, to bring supplies, and to offer their medical expertise.

John Tarpley, M.D., associate chief of surgical services at the Nashville Veterans Administration Hospital, spent 13 years working in a referral hospital in Oromoso,



This page:

Top photo: Christopher Greeley, M.D., plays with a local boy on one of his “house calls” in a Cambodian village.

Bottom photo: James Netterville with Gift Grevibe, who suffers from Burkets Lymphoma of the jaw.

Next page:

James Netterville, M.D., and his brother, David Netterville, M.D., back row, fifth from left, pose with the team of doctors and nurses from Vanderbilt and St. Thomas hospitals and local hospital staff in Ikot Ekpene, Nigeria.

Photos courtesy of Christopher Greeley, M.D., and James Netterville, M.D.

Nigeria. He says that a physician may participate in medical missionary work for a number of reasons – humanitarianism, idealism, a quest for adventure, and for some, because of religious or spiritual motives.

“People enter medical school with a great deal of idealism, which may be lost during the arduous years of medical school and residency training,” Tarpley said.

Some doctors have discovered they can recapture their original passion and idealism by periodically returning to the basics – to non-technologically dependent medicine, to medicine almost completely based on physical diagnosis and history, where they are required to find creative solutions to profound problems. The obstacles to practicing 21st Century medicine in third-world environments are often transcended by the personal rewards.

For James Netterville, M.D., director of Head and Neck Surgery in the department of Otolaryngology, a chance reintroduction to a man he’d met in college sparked his desire to journey to Ikot Ekpen, Nigeria. While an undergraduate student at David Lipscomb University, Netterville had attended a lecture by Henry Farrar, M.D., who spoke about his work at a bush hospital in Africa. Many years later, out of the blue, Netterville received a referral for a patient with head and neck cancer from Farrar. He called the older physician, who mentioned that he was still doing medical missionary work and, by the way, he desperately needed a head and neck team to go to his little hospital in Nigeria.

“It seemed like a far-flung idea to take a group over there,” Netterville recalls. He first telephoned his brother, who is a cardioanesthesiologist at St. Thomas Hospital and convinced him to come along. It took two years to pull together the requisite team of nurses, nurse anesthetists, residents, and anesthesiologists to make the journey to Africa. A Vanderbilt/St. Thomas group, led by Netterville, has continued to return to

Ikot Ekpen for two weeks every year since 1999, lugging 70-pound suitcases packed with sutures, scalpels, equipment and bandages, and sometimes driving through the jungle on roads so poor that it takes four hours to travel nine miles.

The hospital is a rudimentary, open-air structure. Many patients with head and neck tumors may wait for up to a year until the Vanderbilt surgical team arrives. Notified that the Americans are coming,



they and their families will walk for miles, carrying beds, linens and food – everything they will need for their stay except medicine, which the hospital supplies – because in this village the family is responsible for the care of the patient.

Netterville recalls entering the female ward his first day and being struck by the rows of women, sitting on cots, all of whom had large, visible tumors protruding from their neck or face. During the night, members of the patients’ families – hundreds of brothers, sisters, fathers, mothers, children – slept around their loved ones on the hospital’s concrete floors.

Typically, the Vanderbilt team will operate for nine days, in a single operating room with two operations going on simul-

taneously on two OR tables six feet apart.

“It sounds crowded but in reality it is the most efficient operating theater I have ever been in,” said Netterville whose team averaged 8 to 10 major operations a day in this single room. Some of the tumors they see may be seven inches wide. During the first two years with no pathology or laboratory, Netterville says they often diagnosed tumors this way: if it was slow growing, they considered it benign, if fast-growing, it

was considered malignant.

The major limitation of Nigerian medicine is the lack of technology and equipment that is taken for granted in the United States, Netterville said. For example, when one patient failed to restart breathing after the surgery, with no ventilator and no regional referral hospital nearby, a 12-member team acted as her ventilator, taking shifts bagging the patient in the corner of the operating room for 48 hours until she could breathe on her own.

Two years ago, out of 80 operations, three patients died. The team became very discouraged because these were deaths that might have been prevented in the United States. But the local Nigerian doctors told Netterville, “you’ve helped 80 people and

Vanderbilt resident Jeremy Vos, M.D., with a Nigerian baby and his family.



only three have died. To us, this is a wonderful success.”

Netterville said the visits each year help not only the impoverished people they serve, but themselves as well. “It is such a joy to observe the profound effect it has in the lives of the nurses, the residents, and the students who get to go and share their lives with these wonderful people.”

In 1996, Anderson Spickard Jr., M.D., director of Vanderbilt’s Center for Professional Health, received an e-mail from Russia, inviting him to be the principal speaker at a conference for alcohol addiction counselors. An expert in drug and alcohol addiction and treatment, Spickard traveled with his wife to Moscow to introduce the Russians to a 12-step treatment program known as OPORA. The Protestant-based OPORA program adheres to the concept of the Triune God (Father, Son and Holy Ghost) as the “Higher Power.” More than 100 people from across the country arrived to participate, some having sojourned for two days from the outer reaches of Siberia. Today, more than 4,000 people in 40 communities in Russia have trained to become OPORA counselors.

government officials in charge of health and education. The programs he began are now expanding beyond alcohol addiction into counseling for drug addiction, and physical and sexual abuse. “We are reaching into the matrix of pain,” Spickard says.

The most effective medical missionary work centers around teaching. Building a system of health care in an impoverished region requires patience and perseverance, the fruits of which may not be seen for generations. Tarpley cites an old adage, “If you’re planning for a year, plant seeds. If you’re planning for a decade, plant trees. If you’re planning for 100 years, educate the people.”

The international exchange program at Angkor Hospital for Children focuses on just that concept. When Greeley rotates through the hospital, he spends three or four days lecturing the doctors there and the rest of the time involved in patient care, rounding with the physicians on inpatients and patients in the clinic.

“Our goal is to train the local doctors and have them take more and more responsibility for the administration, outreach and running of their hospital,” Greeley says. “We illustrate to them how to think about

Spickard said an alcoholic Russian general who went through the program was in charge of the missiles directed at the United States during the Cold War. Today, the general who held his finger over the infamous “little red button” is in recovery.

After years of continual long-distance correspondence, in 2000, Spickard returned to Moscow to consult with the

complex cases and how to organize the care of very sick children. Over the few years I’ve been going there, I’ve seen a dramatic improvement in their professionalism and the caliber of medicine they practice.”

Many of the problems medical missionaries encounter stem not from the less-than-ideal conditions of the hospital, but from political upheavals and the lack of infrastructure that pervades many developing nations. Netterville’s team has taken tremendous advantage of American programs that donate used hospital equipment to needy countries. He had an ultrasound machine sent to Nigeria, for instance. A year later, it’s still sitting on the dock. Just as frustrating, when a piece of equipment does eventually reach its intended destination, often no one there knows how to set it up or to fix it should it break. Bush hospitals all over Africa are littered with broken, nonfunctional hospital equipment donated by well-intentioned Westerners.

Netterville believes the answer lies in “telemedicine.” Each year he brings laptop computers to the Nigerian physicians. His goal is to set up a telecommunications network between the African hospital and Vanderbilt, so the Nigerians could download an image of a slide or an X-ray, for example, and a Vanderbilt pathologist or radiologist could read it, and help them formulate a diagnosis and treatment plan.

“They are days away from us by travel, but only seconds away by telemedicine,” Netterville explains.

For Tarpley, Greeley, Netterville and Spickard, these unique excursions into other cultures have enabled them to redefine and appreciate the passion, if not the idealism, they felt on that first day of medical school.

“Every day that I’m in Cambodia,” says Greeley, “I think what I’m doing and learning is worth all the trouble it took to get there.”

A Heart that Spanned the World

George R. Burrus, M.D. {1931-2004}

The life of George Burrus, M.D., centered around the heart. On the one hand, he devoted his career to the fragile physical organ that keeps a body alive – which sometimes falters and needs repair. Yet, just as important to him was the heart that forms the essence of one's soul, the spiritual pump that generates love and kindness, generosity and caring. In George Burrus, both hearts were inextricably bound together, and they defined him as a man.

Born in Nashville in 1931 and raised in the Methodist church, he grew up listening to stories told by Damien Mumpower, M.D., who had served in Africa as a medical missionary. Burrus, MD'55, HS'55-'56, CF '66-04, chose to follow the same career path. At age 21, he married his girlfriend Barbara Howard. In 1955, he completed medical school at Vanderbilt and later accepted a surgical residency at the Baylor University Medical System in Houston, Texas, where he trained under famed cardiothoracic surgeons, Michael DeBakey and Denton Cooley. In 1961, he and his wife returned to Nashville, four children richer.

Burrus' sights, however, were on overseas medical missionary work – which he began at the Methodist Mission Hospital in Nadiad, India. Burrus' stint in Nadiad lasted less than a year, however, cut short when his daughter Ellen

was born with Schilder's disease, a disorder that eventually forced the family to return to the States where she could receive better medical care. Ellen died at the age of 5.

Back in Nashville, he joined a surgical group practice with his friends, William Stoney, M.D.'54, HS'54-'55, HS'58-'61, and William Alford, M.D. '56, HS'56, HS'59-'62. Still, his heart was pulling him elsewhere. In 1971, the Burrus family, now eight members strong, traveled to Bosobe, Zaire, a remote jungle village, to restart a bush hospital that had been abandoned by Swedish Baptists a decade earlier during a period of tribal turmoil.

"After we landed in Kinshasa, it took us two days in a 4-wheel drive vehicle to get to Bosobe," Burrus recalled in a recent interview. "When we got to the hospital, the folks who were supposed to have been there for two years, the people I was taking over for, had never come. It wasn't a hospital, it was just a dispensary with two Swedish nurses and no doctor."

Determined to fulfill his obligations, he approached the tribal chief and explained that he would put up the cash if the chief could find people to build an airplane landing strip to transport and receive supplies and medicines for the promised hospital.

"The chief told me the workers would be there on Monday," Burrus said. "Lo and behold, come Monday morning



George Burrus, M.D. in Bosobe.

500 ladies, each with a hoe and many with babies strapped to their backs, began clearing off a 50- by 1,000-meter landing strip. And it's still there today."

Frustrated by the lack of progress on the building of the hospital, Burrus finished his commitment and then resumed his medical practice in Nashville. But memories of Africa continued to shadow him. In 1980 he returned to Bosobe, and later began returning twice a year, each trip lasting about a month.

"We (he and Alford) didn't look on these month-long departures as any kind of problem," Stoney said. "It was a part of George being George. He was a genuinely good person all the way through. And he would give his all to everything he cared about."

For every trek Burrus would pack as many as 40 boxes filled with food and medical supplies, and he constantly solicited the aid of equipment suppliers and pharmaceutical companies,

church groups and scout troops. He donated to the hospital a microscope, a chemical analysis machine, and even a portable X-ray machine. He and his wife traveled with books, boots and soccer balls for the local children.

On Valentine's Day, 2004, Burrus died of a heart attack, leaving behind a wife and a large family of children, grandchildren and friends. No one is certain what will happen to his colleagues and patients in Africa now. No one can say if the little bush hospital in Bosobe can survive without Burrus' dogged determination and support.

Only this much is known: For nearly 30 years an American doctor touched the lives of the residents of one far-away, all-but-forgotten village in a dangerous African nation. He gave these people his heart, and they, in turn, gave him theirs.

– LISA DUBOIS



escaping the

PRISON

of eating disorders

Sometime during the third grade, a boy in Sarah Laughren Tucker's class turned around in his chair, looked her squarely in the face, and bluntly told her she was fat. That's the first time the Clarksville High School junior remembers feeling like she was overweight. There are other factors, of course, but it was one of the defining incidents the 16-year-old painfully recalls when she talks about her struggle with her weight, a struggle which eventually became anorexia nervosa.

The name-calling incident is one that she kept from her parents until she was receiving treatment at Vanderbilt Children's Hospital's eating disorders program, one of about 300 individuals, mostly adolescents and teen-age girls, who are treated at Vanderbilt each year. Vanderbilt's program, which accepts patients from 8 to 24 with an average age of 17, provides medical treatment, patient education and family support. The program works closely with practitioners in the community who provide mental health services for these patients.

BY NANCY HUMPHREY

DANNA JOHNSON



Ovidio Bermudez, M.D., and Susan Beightol, R.N.

According to the National Eating Disorders Association about 5 to 10 million girls and women and 1 million boys and men in the United States struggle with eating disorders at any given time. About 20 percent to 25 percent of regular dieters progress to partial or full-syndrome eating disorders and anorexia has the highest mortality rate of any mental illness, with 10 percent to 20 percent dying due to their eating disorder.

There are three recognized categories of eating disorders – anorexia nervosa, an

obsession with the process of eating by people who see themselves as overweight, even though they are dangerously thin; bulimia nervosa, which is characterized by a secretive cycle of binge eating following by purging; and Eating Disorder Not Otherwise Specified (NOS), atypical presentations of patients with eating disorders who don't fall into the other two categories. A fourth category, binge eating disorders (or compulsive

overeating), has been proposed.

“With the explosion of the information age, we've seen an explosion in the number of patients with eating disorders,” said Ovidio B. Bermudez, M.D., associate professor of Pediatrics and program director of the center. “Rather than being a rare illness, like it once was, it's becoming common.”

A LIFE OF THEIR OWN

According to the National Institute of Mental Health eating disorders aren't due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which

certain maladaptive patterns of eating take on a life of their own. They normally occur during adolescence or early adulthood, but more frequently cases are being seen at Vanderbilt and other institutions in children and even later in adulthood.

The family-focused, outpatient-based eating disorders program at Vanderbilt helps patients move toward readiness for change in the context of their family dynamics.

“It's an intensive relational approach with a strong emphasis on honesty and trust,” Bermudez said. “It's a team effort to understand the psychodynamics, the relational and emotional weavings of their lives.”

The program has experienced recent growth thanks to a gift from Nashville's Junior League. Bermudez and his group will be taking a look at expanding the current clinical services in the new Junior League Eating Disorders Center in the Monroe Carell Jr. Children's Hospital at Vanderbilt. The plan is to make the current program into a comprehensive center that will include inpatient treatment and day treatment as well as the outpatient program that is already in place. Currently, medically compromised patients are admitted to the adolescent unit for medical care. Part of becoming a comprehensive center is including research, teaching and advocacy along with clinical care.

“Eating disorders are complex to address,” Bermudez said. “It would be nice if it was as simple as the patient chooses not to eat, or the patient chooses to eat and throw up, and we could get them to stop that. But it's much more complex both in what gets them there and in what needs to occur for them to be able to successfully leave those behaviors behind,” he said. “Because eating disorder behaviors actually serve a need for the patient, it's important to understand how all that works, and it's important to be able to switch, to offer them better coping skills and more positive

History of Eating Disorders

There are detailed historical accounts of eating disorders dating back to the 13th century – young women who starved themselves in an effort to make a statement or to find a purpose in their lives.

“Back then, having anorexia was not about

being skinny,” said Ovidio B. Bermudez, M.D., associate professor of Pediatrics and medical director of Vanderbilt's eating disorders program. “It was about denying oneself of basic needs, making a statement, and sometimes to address or highlight family or church issues.”

In the 1800s, in the post industrial revolution, a drive for thinness came into the picture. Fashion was important, increasing the desire to be thin.

– NANCY HUMPHREY

alternative coping mechanisms, rather than just say ‘cut it out.’”

“They come here wanting to change,” said Susan Beightol, R.N., nurse case manager for the eating disorders program. “They just don’t know how.”

A SCARY PLACE TO BE

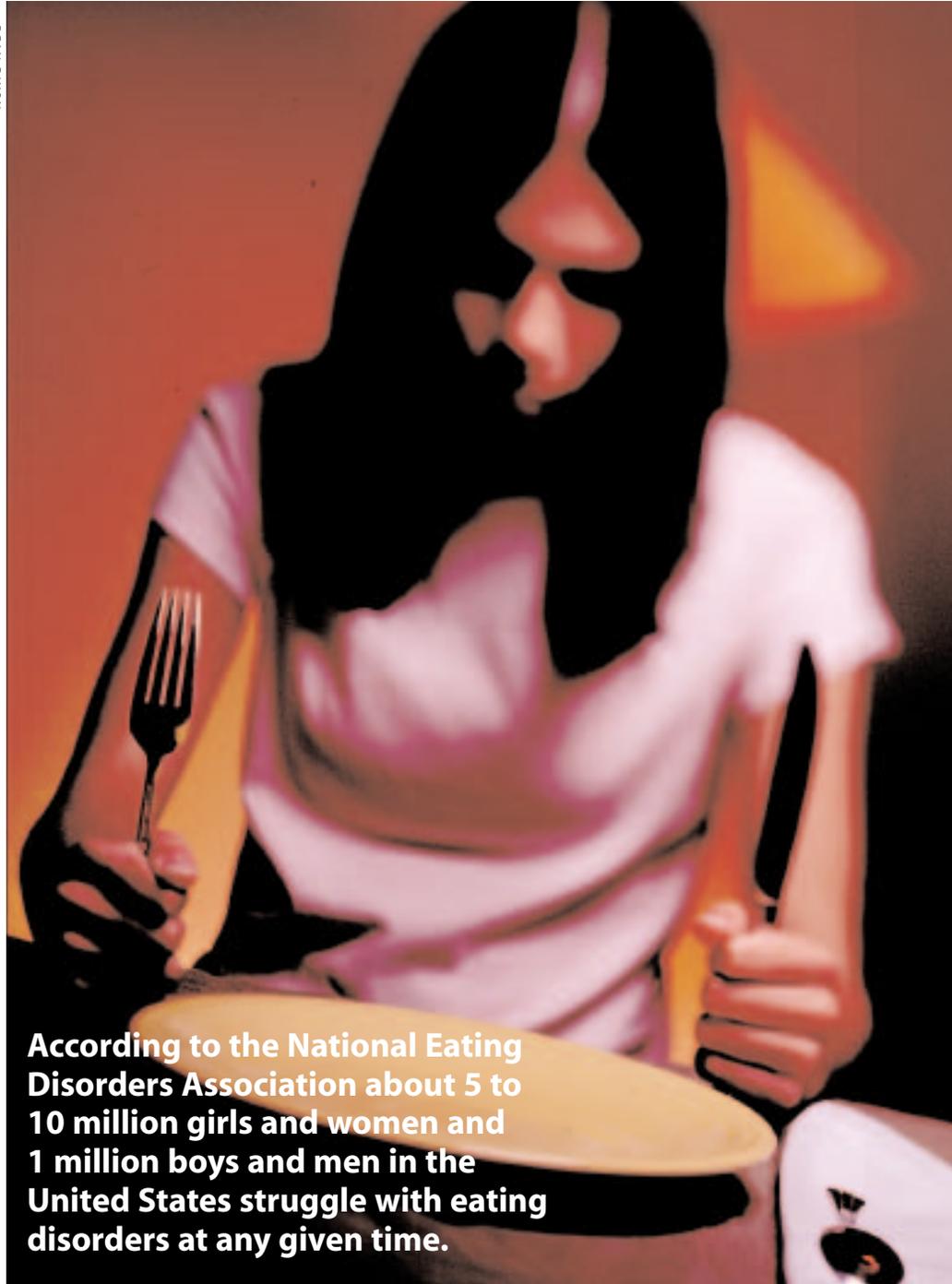
Sarah Laughren Tucker has been a patient of Bermudez’ for the past two years. She went through most of her childhood heavier than she wanted to be. In the eighth grade, she was 5 foot 3 inches and 192 pounds and told her mother she didn’t want to enter high school overweight, so the two joined a popular weight loss center.

“As she lost weight, she started to feel so much better about herself, but I never knew she felt so badly about herself in the first place,” said her mother, Laughrie.

Over a five-month period, by the time Sarah Laughren entered ninth grade, she had dropped to 130 pounds.

“She looked fabulous and was elected to the homecoming court. I thought she was doing great,” said her mother, who describes her teen-age daughter as “naturally sweet-mannered and kind.” Tucker said she is also a “high achieving perfectionist,” personality traits that are often linked to patients with eating disorders.

By Christmas of that year, she thought otherwise – Tucker noticed that her daughter was eating very small amounts of food, pushing her food around on her plate and chewing every morsel of food numerous times. She was exercising excessively (sometimes up to three hours a day), yet was winded as they shopped together for Christmas gifts, and often stumbled. Soon after that she developed a stomach virus and was hospitalized. Normally a girl with lots of friends, she started isolating herself from her friends, turning down invitations to sleepovers because they usually involved eating pizza and lots of junk food. It was shortly after the bout with the stomach flu that



According to the National Eating Disorders Association about 5 to 10 million girls and women and 1 million boys and men in the United States struggle with eating disorders at any given time.

Tucker told her daughter’s pediatrician she suspected something was wrong. Soon after, upon the recommendation from a good friend, Sarah Laughren, in a move unusual for patients with anorexia, was open about her illness, telling her parents “I think I have a problem. I can’t fix this. I’m scared.” The pediatrician referred the Tuckers to Vanderbilt and Bermudez where the treatment of anorexia involves both the patient and the family.

“Anorexia is a very private disease, and people who have it aren’t usually so honest,” Tucker said. “Most are in fact dishonest and

want to hide it. Most won’t even admit it to themselves. But Sarah Laughren is different in that respect. We know. All of her friends know. She talks to other girls who she thinks could be headed that way and tells them not to go down that road.”

When the 5 foot 5 inch Tucker first saw Bermudez at Vanderbilt she weighed about 120. She was hospitalized for about a week when she dropped to 102. Her body temperature had dropped to 95 degrees Fahrenheit. Her heart and pulse rates were weak. “It was horribly frightening,” her mother said. She weighed about 115 when

she left the hospital, and did well very well for about a year. Once again this year she began to struggle, and spent more time hospitalized at Vanderbilt in October 2003.

The second hospital stay was much different.

“The first time we stayed with her. Her room was full of flowers from her friends. It was a big party,” Tucker said. “This time Dr. Bermudez said ‘mom and dad, go home. She needs time to think about what she’s doing to herself.’”

Tucker says Sarah Laughren is doing better, still seeing Bermudez, a dietitian in Clarksville and a Christian psychologist in Hendersonville. But she thinks it will be a battle she could fight for the rest of her life, like alcoholism. The disease, the family calls “the monster,” is a maddening illness that affects the entire family.

Sarah Laughren wrote about her disease, “it’s a scary place to be when you look in the mirror and know you’re slowly but surely killing yourself, but you can’t do anything about it.”

And it’s not easy for family members to sit by and wait for things to get better.

“I sit and listen but I don’t understand. I’ve had to learn the hard way that I can’t fix it. As much as I want to fix it, I won’t be able to. It’s the ‘monster’ that sits at the table with you and goes to bed with you, and is constantly in the back of your mind. I don’t know if she’ll ever walk away from it. I can wish it away and pray and yell. I’ve done all those things. Until she wants to fix it, it’s not going to happen.”

Bermudez said one of the hopes with the new eating disorders center is that the hospital will one day be able to better meet the psychiatric and psychological needs of patients with eating disorders. The first step of an expansion would be adding a day treatment program where the patients are in the Vanderbilt program environment for five to six days a week, at least for two meals of their day. There might also be an outpa-



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- SARAH LAUGHREN TUCKER

tient program with fewer days, and an after school program for local patients where they could go to school in the morning, then spend two to three afternoons in the Vanderbilt treatment program each week.

“We need to be able to treat our patients not just when they’re medically compromised but throughout the spectrum of their eating disorder,” Bermudez said. Currently Vanderbilt patients are referred

out of state to programs such as the eating disorders program at an out-of-state residential facility. “Young people from the state of Tennessee should get the care they need here rather than having to go out of state,” Bermudez said.

Tucker said one thing she would like to see added to the Vanderbilt program is a support group for family members of those with eating disorders. “When I bring Sarah

Laughren in to the clinic, I'll see another mom in the waiting room with her teenage daughter, and our eyes will lock, and I'll ask her how old her daughter is, and we'll talk, and it's obvious that she needs somebody to listen, somebody who can understand. There's a real need for a group where we can get together and talk."

"I HAVE TO RECOVER"

The incidence of bulimia nervosa is much more common, especially among women on college campuses. Around 2 to 5 percent of the population suffers from bulimia, Bermudez said. The disorder is characterized by recurrent episodes of binge eating, with a lack of control over eating during the episode, and then self-induced vomiting or misuse of laxatives, diuretics, enemas or other medications, to get rid of the food.

Heather Smith, 22, and a senior at Cumberland College in Lebanon, Tenn., has been concerned about her weight since she was 12. But she has never been overweight, said her mother, Susan. She began to binge and purge when she was in the 10th grade, but her parents didn't find out until two years later, at a point where she was purging four to five times a day. "She looked thinner than normal, and didn't have a lot of energy. We took her to her doctor, and she confronted her. That's when we found out," Smith said.

"It's a difficult thing," Heather said. "You get trapped. People see you are thin, and say 'you need to eat. Have you eaten?' You feel forced to eat, then what are you supposed to do once you've eaten, and it's 9 at night, and you can't exercise?"

Once the bulimia began, Heather said she felt mixed emotions. "I'd cry and yell at myself inside, but then I also felt 'why didn't I figure this out sooner? Wow, I can do this.'"

Heather saw a psychologist, and for about a year after, gained weight. "Much to our naiveté, we thought she was getting bet-

ter," her mother said. Then she admitted it had not gone away and she was referred to Bermudez.

"When we first found out about it, I felt physically sick," her mother said. I was in so much shock, and felt hurt because she had hid it from us so long. Now I'm angry, after being around this for five years. I keep wondering when this is going to get better, or if I'm frustrated and scared. Is she going to live?"

Due to the frequency of her purging, Heather's jaw is misaligned. She has had a feeding tube in her nose, twice, and it was in July, during a hospital stay, Bermudez told her that he would no longer be able to take care of her if she wasn't going to be truthful with him and with her family, her mother said. Her weight is currently stable, and she will soon have a stomach tube inserted in hopes that she can gain some weight on her 97-pound frame.

Bermudez said convincing a patient with an eating disorder that gaining weight is in his or her best interest is hard.

"It's difficult to take someone who is almost always guarded at best and resistant to any outside influences and try to turn that around and get them to buy into the idea that somebody really can be on their side while attempting to change their behaviors," Bermudez said. "It's easy to be on their side if you sanction their behaviors and it's easy to be on the opposite side if you are going to attempt to ask them to give up their behaviors. The real challenge is having them perceive you're on their side, while still trying to change their behavior. We try not to ask patients specifically to eat, or to stop throwing up. We work with them to

Sarah Laughren Tucker (front) with friends and family at a bowling alley.



understand what restriction and bingeing and purging have done for them and why those are not the best coping behaviors."

That's why family cooperation is essential in the treatment of a patient with an eating disorder, Bermudez said. "Families need to understand the basic concepts of what got the patient here in the first place, and we also assist and guide families through the treatment process."

"It's like there are two people inside your head," Heather said. "Now, I'm on the edge of my recovery, after being in the prime of my eating disorder for the past seven years, but there's a huge voice inside me saying 'you can't do something. You've gotten to where you need to be.' It's a constant battle. Do I need to recover? Do I want to recover? I have to recover." 

For more information

Academy for Eating Disorders/www.aedweb.org

Eating Disorders Coalition for Research, Policy and

Action/www.eatingdisorderscoalition.org

EDCT (Eating Disorders Coalition of Tennessee)/ www.edct.net

NEDA (National Eating Disorders Association)/www.nationaleatingdisorders.org



Sheree Wedding

No Looking BACK

(AN ESSAY BY SHEREE WEDDING)

What is your passion in life? Why do you wake up in the morning? Every person has a goal they work toward or hobbies and passions that fill their days. Looking forward to doing an activity creates joy in our lives. I grew up outdoors. I was a tomboy and loved to rough it out with the guys down the street. I played as hard as they did. I had wrestling matches with my brother and never attempted to play dolls with my sister. My passion in life involved a basketball and a 10-foot goal. My neighbors came to my house and we played in my driveway for hours upon hours. It was fun even though the boys won the majority of the games. I played on the school team and loved stepping on the court, warming up before a game. The smell of the popcorn from the concession stand and the crowd settling in their seats to watch us play brought joy to my heart. The same passion appeared with softball. I had a summer and winter activity to look forward to every year. My confidence shot through the roof when I walked out on the field to begin an inning. The best part was the compliments I received after the games on my performance. My dad and I chatted about the areas of my game that needed improvement as well as the areas of the game I played well. I enjoyed every second I played sports. I dreamed of going to college and continuing sports. I envisioned myself on a WNBA team.

The teams I played on became my family. The crowd knew my name and cheered me on every time I was at bat or when I had possession of the basketball. I felt important and a part of something special. The team members liked me and enjoyed having me on their team. We would hang out together at school, sit at the same table at lunch, and talk with each other in the hallway. Belonging to a group of friends created a comforting feeling inside.

eating disorders

Sheree Wedding in her early basketball days.



Along with the sports, I enjoyed finishing schoolwork on time and neatly. I loved to receive a report card with good remarks. Pleasing the teacher remained a top priority. My parents rewarded my good work. I set a goal to go to college and worked hard in school to be able to fulfill that wish. My parents encouraged me at home to focus on school although I also had a passion for sports.

My goals were set in stone in my mind. I couldn't imagine anything altering the process leading to my goals. What do you do when events uproot your plans in life? Where do you turn? How do you set new goals when you have been so adamant about the ones already established? One little event can change your course in life.

My goals changed at 15. I tried out for the basketball team and did not make the list. I was crushed. I felt that the coach was saying my skills were worthless. My dreams shattered the moment I saw the list of the new team without my name on it. As time went

on, I noticed I belonged nowhere. I had a boyfriend, but no group to hang out with or talk to about plans after the game. How was I going to fit in? The one thing I felt confident at was stripped away. Wait a minute, I still had softball season. Well, that year wasn't so good for softball either. I spent more time warming the bench than playing the field. I needed to fit in somewhere, with some group. What does it take to be liked by the groups I see hanging out together?

Well, I observed and saw that skinny girls with beautiful skin and hair received attention from their peers and especially the guys. The girls even turned my boyfriend's head. I began to think I could lose a little weight and maybe wear some makeup. I began to eat a little less and count calories of

down and always stayed with me. It created a sense of control in my life. I moved to another state and a new school at sixteen and lost all control over the decisions in my life. My parents made them without consulting me. The eating disorder put me in the driver's seat of that area in life. I could control how much I ate and the number of calories I had each day. The compliments now came from my eating disorder. It told me I accomplished something when I didn't eat, stayed hungry, and ate less than other people did. I enjoyed the compliments. I felt proud to be disciplined enough to keep track of the calories and lose weight. I lost 35 pounds in three months during the first bad spell of the disorder. My weight dropped to around 93 pounds.

I ENJOYED EVERY SECOND I PLAYED SPORTS.
I DREAMED OF GOING TO COLLEGE AND CONTINUING SPORTS.
I ENVISIONED MYSELF ON A WNBA TEAM.

the foods I ate. I wanted the attention and to be liked by people. The eating decreased each week. The calorie counting became mandatory for each meal. I received compliments from others on how good I was looking. I thrived on those compliments. I felt proud of myself again because I was good at something. I could diet well. I possessed the discipline needed to keep at it and lose the weight. It became a passion in my life. I revolved my activities around the passion. If friends asked me to go out with them and food was involved I had to come up with some excuse not to eat or just not go with my friends. Soon the compliments turned into worry. People said I was too thin and worried about the little amounts of food I put in my mouth. My eating disorder loved to hear the worry in others voices. I sure had their attention. That was my goal: attention and people talking to me.

As time passed, my eating disorder became my best friend. It never let me

I stabilized my weight when I began at a new school. I still counted calories and compared my body image to every girl I encountered. I hated the image I saw in the mirror. I functioned in life and hid the disorder from everyone. I continued to succeed in school and even played basketball at my new school. I played softball in the summer on a league associated with the city. I regained some passion towards sports, but nowhere near the same degree as before.

My parents separated and the disorder resurfaced. Emotions flew back and forth because one minute they were together, the next they were apart. Anger and hurt feelings increased the intensity and time spent on a treadmill. I exercised till I hurt and ate little portions. Another move occurred where my mother and I moved into a smaller house in the same town. I now was in my second year in college. The eating disorder grew larger with each angry feeling I had or any disappointment in life. My body

always hurt, I was sensitive to cold temperatures, and I still felt like I needed to lose more weight. If I didn't exercise, the eating disorder did not allow me to eat. I knew my thoughts were irrational at this point, but my logical thinking became subservient to the eating disorder. I lost control again in life and the disorder controlled my every move and thought.

I could not live each day like this anymore. I heard about a doctor in Nashville, two hours away, that specialized in eating disorders. My parents and I traveled to Nashville on Dec. 18, 2003 to beg for help. I dropped to 90 pounds during this extreme spell of the disorder. I couldn't sleep, barely could do schoolwork, and only concentrated on how much exercise I put in that day. I was screaming inside for help.

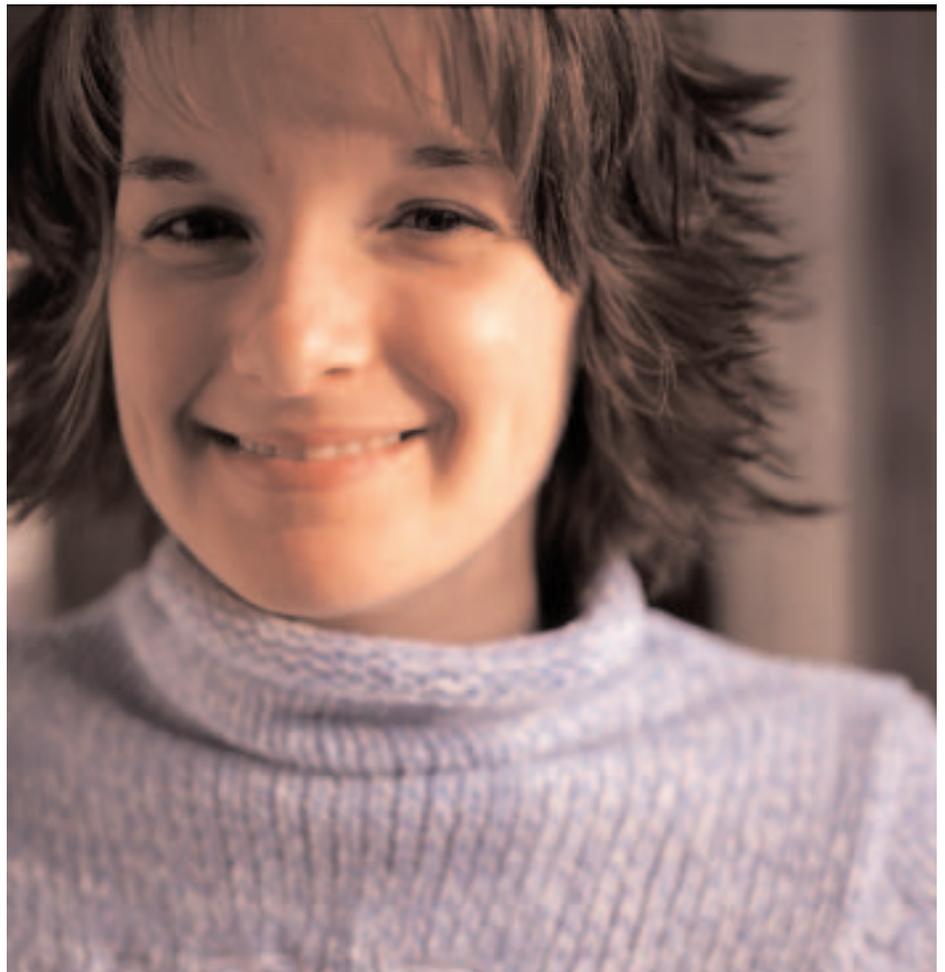
The doctor came into the office, looked at me, asked a little about my situation, and laid out an option. Prior to the doctor coming in a resident took all the background info of how I reached this point. The doctor's options were admittance to the hospital, followed by residential care and then outpatient or continuing life as I knew it. I went into shock and experienced the worst panic attack. I felt tingly all over and couldn't breathe or stop crying. Fear ran through me. The doctor said I had to trust him fully or the process would not work. Even though I felt scared, I knew in my heart I must take this step. I remembered the many nights when I fell asleep wondering if I would wake in the morning. I felt like I was going to die and I knew I couldn't continue that way of life. I agreed to the treatment process and the doctors began to find a room and take care of all the paper work. I calmed down, but still did not fully trust the doctor. I thought he was going to pump me with calories and make me huge. I expressed my fears and that I did not fully trust him yet. The doctor understood and helped me with those feelings. A

“I HAVE COME A LONG WAY SINCE DEC. 18, 2003,
BUT A LONG ROAD STILL REMAINS AHEAD.
I AM NOT LOOKING BACK, ONLY FORWARD.”

whole team worked with the doctor and became my support system. They each showed kindness and concern towards me. They listened to every word I said and comforted me during the bad days at the hospital. Vanderbilt University Hospital saved my life. I consider the support team of doctors as my family.

Wonderful help exists for those individuals already wrapped up in the disorder. The help can give a person the strength to fight the disorder and win. I have come a long way since Dec. 18, 2003, but a long road still remains ahead. I am not looking

back, only forward. The doctors guide me down the road smoothly and are there when a bump appears. After you pass the bump, strength and power grows inside and the disorder loses. To win against the disorder is the greatest feeling. If you asked me when I was 15 where I saw myself in five years, you would not have heard recovering from an eating disorder. My vision would have been on a basketball court, warming up to play a college game. Goals and dreams change, sometimes out of your control, in life. Mine sure did. ♡



TIM EVANS

the SKINNY on weight loss surgery

by Lisa Peper

Last year, more than 80,000 obese Americans chose bariatric surgery as the solution to their weight problem.

Bariatric surgery, also called gastric bypass surgery, is a weight loss procedure that reduces the size of the stomach and reroutes the small intestine. There are various bariatric procedures, but the Roux-en-Y procedure is the most common method.

“The Roux-en-Y procedure is one of the most effective types of weight-loss surgery with limited side effects,” said Vanderbilt’s Sattar Hadi, M.D., assistant professor of Medicine, division of Gastroenterology, Hepatology and Nutrition. “This makes it a popular choice.”

During the Roux-en-Y procedure, which is often done laparoscopically at Vanderbilt, surgeons separate the upper part of the stomach. Next, they cut the small intestine, pulling it up to the new stomach and reattaching it. The new stomach is about the size of a thumb after the surgery, and over time, it will stretch to the size of a lemon, able to hold approximately three-fourths a cup of food.

But there’s more at work than just the restricted stomach. Malabsorption, caused

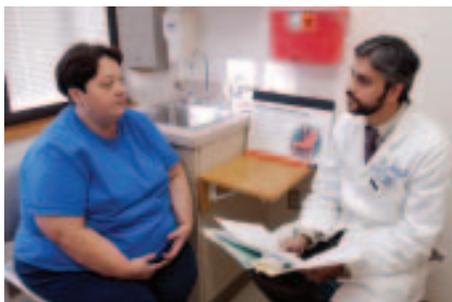
by the missing link of small intestine, also leads to weight loss. Hormonal changes have also been credited with decreasing appetite and helping patients shed pounds.

These three components make bariatric surgery an effective weight loss procedure. Patients can lose 30 percent to 50 percent of their weight in one year. In turn, the effectiveness has many insurance companies covering the costs and thousands signing up for the life altering surgery.

Based on National Institutes of Health (NIH) guidelines, bariatric surgery is available to patients with either a body mass index (BMI) of 35 to 39, who have two co-morbid health conditions, such as hypertension or diabetes, or a BMI of 40 or higher. For example a 5-foot-5-inch woman weighing 210 pounds would have a BMI of approximately 35. Partner this obese status with two other conditions and she would be through the first round of qualifications for the surgery at Vanderbilt. So would a 5-foot-6-inch man weighing 270 pounds, who would have a BMI of about 40.

At many facilities offering the surgery, the qualifications do not go much farther.

Dr. Sattar Hadi talks with Jo Ann Ford, of Hanson, Ky.



According to Gordon Jensen, M.D., director of Vanderbilt's Center for Human Nutrition, this is not enough.

"A good bariatric surgery program involves much more than just the surgeons," he said. "It needs dietitians, psychiatrists or psychologists, nurse practitioners, and support groups – ensuring the patients have what they need each step of the way."

Patients who come to Vanderbilt interested in the surgery must go through a health risk evaluation, which includes being seen by a doctor, dietitian and psychologist. They must also complete four educational sessions concerning their nutrition.

"Going through this surgery is a major life change, and we want to make sure all patients understand this," said Alice Buchanan, dietitian for Vanderbilt's Center for Human Nutrition. "It requires self-control and learning how to get as many nutrients as possible in a very small amount of food. If patients continuously overeat, over time they can stretch their stomachs and begin regaining weight."

After being approved for the surgery, Vanderbilt patients generally must wait three to 12 months before having the operation. During this time, they work with the staff to maintain their weight by diet, exercise and medication, halting the process of weight gain until surgery.

After the procedure, the surgeons and nutritionists continue to work with the patient, in part because of the potential complications. Surgical complications can include intestinal leaks, injuries to other organs, infection, and blood clots, among others. Nutritional complications after bariatric surgery can include dumping – abdominal pain, vomiting and diarrhea from high sugar, high calorie, or high fat intake – vitamin deficiencies, gallbladder disease, anemia, and more.

Though there are many possible complications from bariatric surgery, some side effects are determined by the level of expertise

and experience of the surgeon performing the procedure, according to Hadi.

When things get complicated

Linda is an unfortunate example of how surgical problems and insufficient follow-up can lead to life-threatening complications.

Linda and her primary care physician decided she was a candidate for weight loss surgery. She was 58 years old, 5 feet tall, 200 pounds and suffered from hypertension and diabetes.

"I thought it was my last chance to be healthy," Linda said. "I have grandkids and wanted to be able to play. So I went through with it."

Prior to the surgery, performed at another hospital, Linda was required to see a psychologist and a cardiologist. Her surgery was set for one month later. During this month Linda, dreading her upcoming life without full access to food, ate everything she could. She gained 48 pounds before the date of her weight loss procedure, unknowingly putting herself at an increased risk for surgical complications.

Linda went into surgery, hoping for a new chance at life. Linda came out fighting for her life. After the surgery, she went into respiratory failure, suffered a heart attack and developed a staph infection. Linda spent the next two months unconscious in a hospital bed.

After 107 days in the hospital, Linda came home – hungry.

"I was told I wouldn't be hungry for six months to a year, but I was starving," she said. "But I couldn't keep anything down."

In fact, Linda was starving to death. It was after moving to Murfreesboro, Tenn. to be closer to her daughter that Linda received help at Vanderbilt.

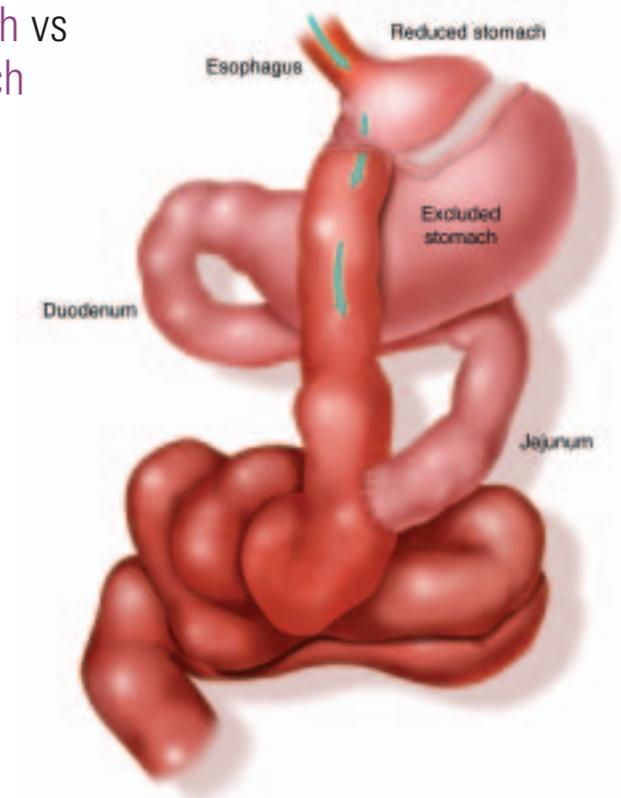
"I met with Dr. Jensen who recognized immediately that I was malnourished," Linda said. "If I hadn't found him, I wouldn't have been here to tell this story."

Linda began IV feedings and moved to a feeding tube, then to solids. Though she's still recovering, she's lost 130 pounds and no longer has diabetes and hypertension.

"I'm just grateful to have found the help I needed at Vanderbilt," Linda said. 

Reduced stomach VS Excluded stomach

Illustration by Dominic Doyle



the new epidemic of childhood **obesity**

Stephanie Shirley-Brown loved music and playing piccolo in the Franklin County High School marching band, so it came as quite a shock when she abruptly quit after her sophomore year. It wasn't that she was tired of band, as she told her friends and family, it was because at 5-foot-6 and 200 pounds, she already wore the school's largest uniform.

by Lisa Peper

“My grandma even had to alter it to make it fit,” she said. “I knew that the next year there wouldn't be a uniform big enough for me. I thought there wouldn't be a band uniform in the state that would fit.”

It was easier for Shirley-Brown to simply avoid trying on the uniform than to face the embarrassment of finding the uniform too small, and the possibility that she wouldn't gain weight over the approaching year didn't even cross her mind. She had accepted her label as the “fat girl.” After all, she had been dealing with the limitations of her weight since she was 7. But inside, being the “fat girl” still hurt, and she still dreaded the attention her weight problem could bring her.

Shirley-Brown covered up her size with jokes, and made people laugh to be part of the group. Though she had a lot of friends,

she learned early on that she was not like the rest of the kids.

“It was just like having a handicap,” she said. “People could see my fat just like you could see a child's crutches or wheelchair.”

And like a child with a disability, Shirley-Brown can list the missed opportunities of her youth.

“I was scared of athletic activities and felt sick before each and every P.E. class. My first bra was a woman's bra, because no training bra would fit me. I couldn't wear girl's tights; instead I had to wear women's pantyhose. I couldn't fit in the desks as school; I'd squeeze in with the side bar cutting me in half around my middle. I had a frumpy woman's jacket when all the other girls had cute little girl coats. At camp I was always afraid to sleep on the top bunk, fearing the bed would break and hurt the girl beneath me. And boys were always a letdown. I didn't have a single date all through school.”

Even as an adult, the hurt hasn't gone away. Instead, Shirley-Brown is reminded of

being the “fat girl” every time she sees an overweight or obese child. And these days, when 30 percent of all children are overweight and 15 percent are obese, she often feels that familiar twinge of sadness and guilt.

Obesity in children is not a new problem, but it's a growing problem in the United States that has been called a new epidemic.

“Childhood obesity is a major public health problem,” said Stephen Callahan, M.D., assistant professor of Adolescent Medicine at Vanderbilt University Medical Center. “We're seeing a substantial increase of overweight and obese children and adolescents – the prevalence has quadrupled over the past 25 years. This dramatic increase stems from changes in eating habits and activity levels.”

Callahan admits genetics play a role in obesity, but he said, “The vast majority are having problems with weight because of less daily activity. Children are spending more time in front of TV and computer screens and less time being active. At the same time, more of the foods they're eating are nutritionally poor and portion sizes have doubled and tripled.”

“It's not just lifestyle or genetics, it's both,” said Vanderbilt dietitian Alice Buchanan. “We start developing habits as children, and parents play a large role in





Stephanie Shirley Brown as: (top to bottom) a child; before bariatric surgery, with her dog, Daisy; and post-surgery in February.

this. A 5-year-old is not driving himself to fast food restaurants. He's not stocking the cupboards with junk food."

"We're teaching a whole new group of children to eat unhealthily and be inactive," said Callahan. "American adults have become increasingly more overweight, and we are passing on poor nutrition and exercise habits to our children."

This was Shirley-Brown's life. As a child, both of her parents were overweight, and created an environment in which overeating and being inactive were normal. She was 2 years old when her father had triple bypass surgery, and when she was 18, he died in her arms from a heart attack.

"With weight, people will argue whether it's heredity or environment," Shirley-Brown said. "I would say both. If your parents are overweight, you may be prone to gaining weight more easily, but you're exposed to a lifestyle of poor habits. You train children to mind their manners, be courteous, do the right thing, but what about training them to eat properly? Lifestyle and education can help overcome almost any 'fat' genes."

But instead of teaching her healthy habits that they didn't have, Shirley-Brown's parents had put her on a diet at age 10, on Dexatrim at age 12, in aerobics classes and on every latest weight loss fad all through high school. Nothing worked.

"My mother would drive me to the classes and pick me up afterwards," Stephanie remembered. Her mother never attended the class with her.

"Childhood obesity is a family and societal problem," Callahan said. "We evaluate individual patients, but positive change is most likely to occur when families get involved and work together. Ultimately,

until communities and society changes, childhood obesity will only get worse."

Statistics show the problem is getting worse, but it's not just children's self-esteem at risk – overweight children are putting their health at risk.

"An increase in the number of obese children means that many more children and adolescents are suffering from 'adult' diseases," said Callahan.

Many conditions that were rarely seen in children are becoming more commonplace, such as Type 2 diabetes, hypertension, high cholesterol, orthopaedic complications and sleep apnea.

"Ninety percent of overweight teens continue to be overweight as adults," Callahan said. "That's why it's especially important to help children and teens change the way they eat, exercise and cope with psychological stigma, to achieve a healthier future."

Shirley-Brown continued to gain weight beyond high school, becoming an obese adult. By age 30 she was over 300 pounds.

"In my early twenties I just gave up on my weight," she said. "I envied those who had lost a lot of weight and kept it off – I was jealous. But I knew it would never happen to me. I was in denial of who I was."

"It's pretty common for most of my patients to have been overweight since their childhood," said Buchanan, who works with high-risk overweight patients. "It's habits started as children – upbringing, life events, what we learn as children. We need to address and understand these issues behind the problem. We need to approach it as seriously as any other disease."

Vanderbilt takes a comprehensive approach to treating obese children. Callahan encourages healthy eating and activities to each family he sees.

"We talk about healthy eating habits for all children, because regardless of size, everyone needs to develop a healthy lifestyle. And for our patients who are overweight (about

"Nothing tastes as good as thin feels."

one out of every five patients), we evaluate for medical problems that may develop because of their weight – like diabetes or hypertension,” he said. “We work with the children and their families on how to eat better and find ways to increase activity. And we also address the common psychological components, such as depression or social isolation.”

Other hospitals are offering another means of treatment for obese adolescents – bariatric surgery, the weight loss procedure that restricts the amount of food the stomach can hold. Though VUMC has an extensive adult bariatric surgery program, the hospital will not perform the surgery on minors.

“This surgery involves a lifelong commitment, immediate risks and long-term risks,” Callahan said. “The long-term safety of the procedure in growing children is unknown, so we’re not ready to offer it as a treatment option.”

“How can children really decide that they are willing to only be able to eat six ounces of food forever, or commit to never eating sugar again?” Buchanan said. “Beyond this, questions arise – are they even finished growing? Will it give them osteoporosis if they cannot absorb enough calcium? Emotionally are they ready? With all of these questions, surgery is not an option for children.”

Yet many wonder – can children really go from being obese to a normal weight without surgery, but through healthy eating and exercising alone?

“Though the best results would come from a change in our society and popular culture, communities and families can make a difference in their children’s lives,” Callahan said. “Children can lose weight and keep it off if they learn new, healthier habits. It takes planning and a commitment on behalf of the entire family, but it’s achievable.”

Vanderbilt offers a family-centered program, ShapeDown, which has seen successful results by working with the entire

ShapeDown

There’s a saying – Parents shouldn’t ask their child to do anything they wouldn’t be willing to do themselves. This is the principle behind ShapeDown, a family-centered approach to weight loss.

Vanderbilt University Medical Center offers the 10-week program to help children and families plan more active lives and establish good eating habits.

“Parents learn how to encourage their children to build healthier

habits, and they learn how to set limits. Children learn to take responsibility for eating and staying active,” said Heather Holden, a clinical dietitian and coordinator of Vanderbilt’s ShapeDown program.

ShapeDown involves weekly two-hour meetings and homework for both parents and children.

The program begins with a questionnaire that covers medical, mental and physical health.

“This helps everyone involved learn which areas are in good health

and which need more attention,” Holden said.

ShapeDown promotes a gradual approach to gain healthy eating habits and encourages children and parents to participate in physical activities that build endurance, flexibility and strength.

“The goal is to make activity fun, downplay dieting, and get parents and children on the same track when it comes to their health,” Holden

said. – LISA PEPPER

family to develop healthier lifestyles. (*See above for more information*).

Though Shirley-Brown looks back and wishes for a thinner childhood, she agrees that bariatric surgery is not the solution for most obese children. Stephanie underwent the surgery in March of 2002, at age 32, and she knows all the procedure entails.

“Very few children could handle the weight loss surgery,” she said. “The smaller stomach is a tool, but getting the weight off is up to the individual. Yes, you can regain the weight, and then you’re out of options. And for a child or a teen to make that lifelong commitment, to use a ‘last chance’ at such a young age, would be too much for the most of them. I hope more and more children can learn how to change their bad habits and avoid ever having to think about surgery.”

Shirley-Brown considered bariatric surgery her last chance to take charge of her life.

“As an adult, I wanted to take responsibility for myself and right the wrongs. That’s why I did gastric bypass. I knew if I didn’t do something, by the time I was 50, I would be 500 pounds and unable to walk. I had tried dieting and even had lost weight,

but I couldn’t stay disciplined long enough. I was not taught self-discipline. I know what it is now, but it’s taken a drastic surgery to teach me this,” Stephanie said.

Two years and 183 pounds later, she is grateful for having the surgery and is committed to staying thin for the rest of her life.

“My new motto is: nothing tastes as good as thin feels,” she said.

Shirley-Brown said that even though she could list her missed opportunities, she didn’t fully know how much she was missing out on as an obese child and as an obese adult. This is why her heart goes out to others who are overweight or obese.

“It’s the everyday things that someone who’s thin would never even think of. I can cross my legs now. I can ride roller coasters and fit through the turnstiles at concerts. I’m not afraid to travel or go to movie theaters,” she said. “I’m free – free from the bondage my weight was putting on me. And I’m making up for all the lost time, the 27 years of my life that fat claimed. I will die before fat claims another minute of my life.”

the person I was **meant** *to* be

AN ESSAY BY SHANNON NICOLE THOMAS

“You chastise yourself for being so stupid to actually do it again. You command yourself that it can’t happen again—no more bingeing, no more purging. But in the back of your mind, you know you’ll be back tomorrow. Back to punish and cleanse.

Perhaps this confession will be the necessary element that will stop this utterly disgusting and revolting behavior. What is it that keeps me from having self-control? What keeps pushing me to eat like a madman, purge like a drunk—worse actually? Food has no power—I give power to food rather than controlling it, or even controlling myself. I need the revulsion to food rather than the fatal attraction to it. Food is disgusting. I don’t need to purge it; I just need to stay away from the gross sh**. Stick to the safe, clean foods. Life will be much easier that way. When I feel the urge to eat and purge, I need to think of this—think of myself in that bathroom barfing my head off—looking at my pitiful reflection in the cloudy water. Ew.”



T

his was written the summer of 2002, during one of the bulimic episodes in my battle against anorexia and bulimia. I never would have admitted that these behaviors were bulimic; I wanted to be in control, have it all together, be uniquely thin. Within the eating disorders' subculture lies an understood hierarchy: anorexia is the ultimate display of self-discipline and willpower, having control over your own body and emotions, creating a sense of power. Bulimia means that you are "incapable of controlling yourself." Anorexia – purging type, my diagnosis during years of treatment, was stuck in the middle, mediocre, average, which I felt described my life.

From early childhood I'd been very compliant, eager to please, and desired to excel at everything I did. However, I never lived up to my own standards. I was a good violinist, but not the best; I was a good student, but not the smartest; I was thin, but not thin enough. By age twelve, this feeling had evolved into "I am fat." I stopped eating lunch to cut down on caloric intake and from that point on, I looked at food in terms of calories. Over time my food restriction became more severe, and I began purging in order to hide the anorexic patterns from others, who didn't understand my passionate pursuit of thinness.

During my junior year of high school, I doubted my Christian faith and questioned my identity; coupled with my restrictive diet, this threw me into a depression that

escalated quickly. By the end of the summer, I was severely underweight and suicidal. I began seeing Nan Allison, a nutritionist, and occasionally attended therapy, until a suicide attempt in November led me to Dr. Ovidio Bermudez. He immediately sent me to the Renfrew Center for inpatient treatment, and I clothed my fear with indignation at his "overreaction." Once I returned home, I started therapy with Dr. Jennifer White, who planted seeds of recovery I later embraced.

At Vanderbilt, I still found it difficult to deal with my eating disorders and depression, even with medications and continued treatment. Behaviors progressively worsened, and during my junior year, Dr. Bermudez and I discussed the possibility of going inpatient again. This felt like my only option if I wanted to find any relief from the hell I was living. Every morning I awakened to a haunting decision. Do I eat? Or do I get rid of the meals I can't avoid? I calculated how many calories I burned walking to class, practicing violin, and sitting at my computer. Regardless of what I was doing, I couldn't escape the fear of being "too much," feelings of worthlessness, and the frightening reality that I might be bound to my eating disorders forever.

In November, my life was falling apart in every area. One particularly eventful day, I broke down in my apartment, overcome by hopelessness. Afraid to leave me alone, my roommates insisted that I go to church with them. I didn't want to have anything to do with it, believing I was beyond help. But to appease them, I went. During the service, I realized I had two choices: God or death. This was my last time to choose; I knew that. Never before had I felt the weight of my decision to choose life or death. It was as if I was standing on the bridge, ready to jump, and God was calling me to choose Him instead, to turn around. Even when I had attempted suicide, I hadn't understood the magnitude of my decision



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in the way I did that night. God was giving me an ultimatum.

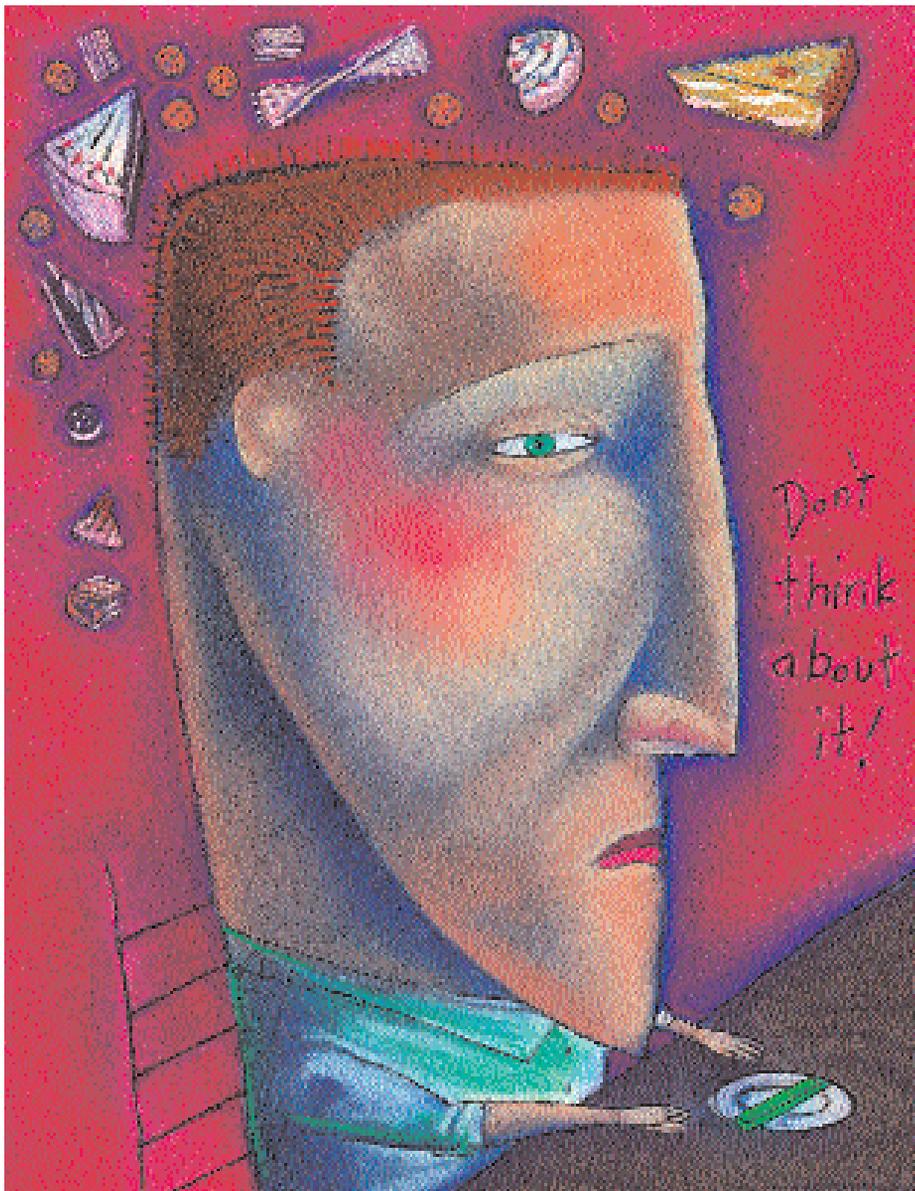
Although I didn't realize how emotionally difficult the next few months would be, I chose life. I began to open up more with my roommates and started attending Bethel World Outreach Center, where I witnessed living examples of God's love and power. Within the next couple of weeks, all eating disorder behaviors had stopped. Strengthened by newly found support and realization of my worth, I began to deal with the things I had tried to mask with my eating disorder: self-hatred, lack of identity, dependency, rebellion, and fear. As a result, I find I am now the person I was meant to be, not consumed by the eating disordered mentality. I have healthy relationships with my supportive parents and a group of friends, no longer isolating myself. I don't compare my body with those around me. I don't get anxious around food, constantly dwell on it, or find it necessary to make food journals. I don't calculate calories, measure food, or obsessively exercise. I don't try on six outfits every morning, trying to find one that "conceals my fat." I know, feel, and see that I am not fat. I share my story not for my own healing but to show that complete recovery – physical and emotional – is possible. 🍷

OPPOSITE PAGE AND ABOVE: Shannon Nicole Thomas

Vanderbilt students fight eating disorders

by Nancy Humphrey

Vanderbilt University is not unlike other top tier universities in the country – attracting high achieving and extraordinarily driven students who yearn to please their family and teachers.



Vanderbilt shares another distinction with those schools – a high incidence of students who suffer from eating disorders, particularly anorexia and bulimia.

The two – high achievers and eating disorders – often go together, said John Greene, M.D., director of the Zerfoss Student Health Center. “There’s a definite connection between high achievers from the upper socio-economic class, those with a high need to please their parents with their grades, their performance and their looks, and eating disorders,” he said.

To help combat the growing problem of disordered eating, Vanderbilt has developed a campus-wide effort to make its students more aware of the dangers of eating disorders and the importance of not dwelling on body image.

Students coming to Zerfoss have the opportunity to pick up one of many brochures and pamphlets about eating disorders. Some have been developed by Vanderbilt; others come from national organizations. The University also educates its resident advisors about how to recognize signs of eating disorders. It is not uncommon for a student with an eating disorder to be approached by a roommate, another student in their residence hall, or by a resident advisor who suspects the student has an eating disorder.

Becky Spires, wellness coordinator at Vanderbilt for the past five years, said when

she took at the job at Vanderbilt, she would see “skin and bones” students coming in to the Student Recreation Center, working out for more than two hours at a time. “I would think ‘they need help.’ I wanted to give them resources to help themselves, then I thought if these students have eating disorders and I don’t know what we have on campus, how are they supposed to know where to turn, and how am I supposed to be able to help them.”

Early in 1999 Spires began a fact-finding mission at Vanderbilt to find out if other people on campus were encountering students with suspected eating disorders and if they had advice on how to handle the situation.

“I had an overwhelming reaction from people. I knew then we had a problem on this campus. We all had ideas about what to do, but until that point we had no combined effort. We had wonderful resources on campus, but nobody really knew what the other was doing.”

By the fall of that year, a task force of about 25 people across campus had been formed and the group came up with a brochure on eating disorders that listed resources both on campus and off and hosted an eating disorders week to promote awareness.

“It’s a secret disease. Students want to hide it,” Spires said. “They want to control it. If people know about it, then it’s out of their control. I feel like we’re in a stew pot here. We have all the ingredients in the cauldron to have eating disorders rampant on our campus. Typically people with eating disorders are very type A, very perfection driven, very driven in academics, dedicated and organized, the kind of people we have here.

“We have a very beautiful campus in many ways,” Spires said. “There are beautiful people on our campus. Many of our students come from affluent or perfection-driven backgrounds – not only will you be your best, you’ll look your best.”

“It’s a secret disease. Students want to hide it. They want to control it. If people know about it, then it’s out of their control.”

Vanderbilt’s students are more willing to talk about their disordered eating behaviors than students at other institutions, Spires said. “That’s very encouraging.”

Elena Hearn, a counselor with student health on campus, said that students at Vanderbilt are very well versed in recognizing the signs because eating disorders are becoming more prevalent in high schools. “When they get here most have already known someone who has one,” she said.

There is too much emphasis on physical appearance on a college campus, Hearn said. “Many students think they should be skinny to be happy. It’s a prevalent view here and on campuses like ours. I’ve actually had students tell me they’re rather be dead than fat.”

IMAGE, a student organization, was born from the task force that Spires formed in 1999, dedicated to promoting positive body and self image for Vanderbilt men and women. The group meets weekly and is working to establish a clear protocol for students with concerns about body image to get the professional help they need, is creating a website that lists critical information and helpful resources at Vanderbilt, and hosts the IMAGE week in February, a week of awareness about body image. The group also hopes to establish a peer education group where students will be trained to talk to other organizations on campus about body image and eating disorders.

During IMAGE week, the group puts stickers on magazines at the student recreation center, saying that the images in the magazines aren’t attainable by most people, and congratulating students for being healthy and trying to maintain a healthy body. They pass out blue and green ribbons across campus and, with permission, cover mirrors across campus. “Some get torn



down immediately. Some stay up for weeks,” Spires said. “The message with that is, there’s more to an individual than meets the eye. They’re trying to get people to realize it’s about what’s inside.”

April Ann Salcido, a senior at Vanderbilt and president of IMAGE, got involved in IMAGE after she spent her high school years restricting food and exercising more than she should have – sometimes two hours in the morning and two in the afternoon. In her senior year of high school she lost a significant amount of weight and eating became “a central preoccupation that started to invade every aspect of my life,” she said. “I felt like everything revolved around food, but at first I didn’t think there was something wrong with me. I thought I was being healthy.”

About the same time, a close high school friend of Salcido’s was hospitalized with an eating disorder and nearly died. “That was kind of a wake up call, and when I got to Vanderbilt I got involved with IMAGE. We decided that there should be more than just the week devoted to body image awareness. I got here and saw that so many girls I know are fixated on image and that’s very unfortunate. I felt that right away.”

DEAN DIXON



ANNE RAYNER



DEAN DIXON



sending healthy messages

by Jessica Howard

A typical young girl probably goes through an ordinary day seeing hundreds of images depicting beauty.

Thumb through a beauty magazine and everything from the cover to the advertisements feature models with great figures, shiny hair and gorgeous, acne-free faces. Turn on the television or go to a movie, and not only will you see very attractive women on the screen, they're moving and talking, and often oozing with sex appeal.

The daily barrage of these images may even make the most self-confident girl take a second look in the mirror while sucking in her cheeks and stomach. It might make a girl consider getting cosmetic surgery, or exercise excessively or go on a diet. Poor body image can lead to all these things – the most drastic steps such as severe dieting or smoking to lose weight can threaten a girl's health or even her life.

But what the advertisers don't tell us is that the models in their ads are thinner than 98 percent of American women. While the average American woman is 5 foot 4 inches tall and weighs 140 pounds, the average model is 5 foot 11 inches tall and weighs 117 pounds, according to womensissues.com.

A group of women – including health and fitness professionals at Vanderbilt University Medical Center and the Nashville community – were worried about the media's unrealistic portrayal of what beauty should look like and the negative effect it had on girls. They felt it was crucial to get realistic and healthy messages to girls before the images got to them.

Six years ago, they developed a program called GirlForce, which addresses a whole range of interrelated health risks among adolescent girls including lack of exercise, obesity, smoking,

“The emphasis is on health and feeling good, not appearance.”



eating disorders, poor eating habits, and poor body image.

“We were all having the same discussion – that girls and women tend to have poor body image,” said GirlForce executive director Susan McDonald. “The problem is that poor body image is linked to some serious health problems like depression, disordered eating and smoking, particularly among young girls.”

The GirlForce health-risk prevention model promotes physical activity, healthy eating, smoking prevention, and positive body image. In half-day workshops, girls experience first hand the joy of movement, and how exercise and food choices affect the way they feel physically and emotionally.

“The emphasis is on health and feeling good, not appearance,” said McDonald, a certified fitness instructor.

The target age group for the intervention is fifth and sixth graders. “They are well aware of the issues at this age, but their ideas about body image and lifestyle are usually not set in stone. So, we have a better chance of influencing attitudes and behavior.”

VUMC has offered the GirlForce workshops as a community service in Metro Nashville schools since 1998. GirlForce has also trained more than 200 women to lead the workshops in other communities across the state and nation. The program made its international debut in Ireland, Mexico and Australia last year.

Mentoring is the key to the program's success, said McDonald. “Medical and nursing students have been the backbone of our workshops in Nashville. Ideally, we have one college mentor for every five kids, so each girl gets a lot of individual attention.”

High school students are also encouraged

to become mentors because young girls relate to them so well.

The workshops involve active participation. It's not a lecture about what girls should and should not do or believe.

“They get up and move; even the nutrition lesson is based on a relay game,” McDonald said.

If they are not up and moving around, girls are actively engaged in a dialogue with fellow students and their mentors. They are encouraged to speak their minds about a topic that has often been taboo – body image.

Girls explore and discuss how the ideals of beauty change over time and from one culture to another. In the 1600s, plump women were considered more affluent and attractive, as depicted in paintings by Peter Paul Rubens, for example. In the 1920s, the thin flapper look was fashionable – women even bound their breasts to appear flatter.



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“Being physically active throughout adolescence offers a big umbrella of protective benefits for girls.”

By the 1950s, Marilyn Monroe had become the voluptuous icon of beauty. Models have gotten progressively thinner ever since with today's supermodels being labeled “waifs” or the emaciated “heroin chic.”

“There's a huge pressure on girls to look like supermodels, which is totally unrealistic,” said McDonald. “Healthy bodies come in all different shapes and sizes, and that's our message.”

Even if weight is a problem, self loathing is not the solution,” she said. “The

only solution is lifestyle change and to do that you have to start from a place of self respect and self love.”

The GirlForce environment is a safe place for girls to open up and talk about self-image and the pressure they feel to conform to a narrow definition of beauty. “The girls find out other people feel the same way about it as they do. After the sessions, they tend to be more accepting of themselves and each other.”

Chelsea Gifford, 14, participated in GirlForce three years ago as a sixth grader at Eakin Elementary School in Nashville. She admits that she still looks at magazine cover models with a twinge of envy, but she keeps it to a minimum.

“At GirlForce, you realize you are fine how you are. I really think GirlForce helped a lot of people at my school,” said Gifford, who plays soccer and softball at the University School of Nashville.

Karen Dyer, an exercise specialist at the Dayani Center and fitness director of GirlForce, said that the program encourages exercise and participation in sports and helps all girls feel successful at exercise even if they aren't athletic.

The program offers a wide variety of exercise activities from street dances to rock climbing.

“We want girls to look at exercising as a regular and enjoyable part of their lives,” Dyer said. “It builds self-esteem and confidence.”

Dyer said that all aspects of the program naturally intertwine. “Girls are so complex, you can't hit these issues without the others. You can't really pull apart one without addressing the other.”

A segment on nutrition explores food choices based on nutritional needs and personal preferences. The “smoking mirror,” designed by Vanderbilt medical students, addresses the seen and unseen effects of smoking. Girls touch and compare a healthy lung with one deteriorated from years of smoking. To bring the message

home, girls get to see how they would look after 20 years of heavy smoking, for example, excessive wrinkling, tooth loss and pallor.

“I looked like a witch,” said Gifford, whose picture was one of those selected as an example. She said she has no desire to ever light up a cigarette after seeing her picture morphed that way.

Dyer is a firm believer in the program, not only because of her involvement, but also as a mother of two girls. Speaking to her daughter's third grade class, Dyer said she was shocked to learn children even that young had distorted opinions on body image. She asked a boy in the class what a girl should look like and he said “no thunder thighs.”

Apparently it's not uncommon as one might think. According to womensissues.com, 42 percent of elementary school students between the first and third grades want to be thinner, and 80 percent of children who are 10 years old are afraid of being fat.

“We may not be able to change the world,” McDonald added. “But we can help girls become more resilient. Being physically active throughout adolescence offers a big umbrella of protective benefits for girls. It improves their self-esteem, helps them socially and academically, and makes them happier and healthier. Active girls tend to become active as adults as well. Our goal is to help every girl discover the benefits of that umbrella for herself.”

GirlForce is a research-based intervention recognized by the American Alliance for Health, Physical Education, Recreation and Dance, The National Association for Girls and Women in Sport and the American Heart Association. 

President's Corner

The Canby Robinson Society is the umbrella encompassing many generosity to Vanderbilt University Medical Center. Contributions, whether they are to facility or program, or are unrestricted gifts, all result in the enhancement of education, research and patient care.

Unrestricted gifts provide full tuition and stipends for CRS scholars. Currently,

there are 26 scholars, five of whom are in the M.D./Ph.D. program, which takes six years to complete. Not only do these funds alleviate the burden of debt upon graduation, but make it possible for these exceptional students to pursue extraordinary areas of interest in the field of medicine while earning their degrees.

On May 13, the CRS will present a very special award, which is given annually to the fourth-year student who is voted by his or her classmates as having the

intangible qualities of common sense, knowledge, thoughtfulness, personal warmth, gentleness, and confidence that combine to make the "Ideal Physician," the person fellow classmates would most want to have as their personal physician.

Outreach programs and tours are available throughout the year allowing CRS members and prospective members to become acquainted personally with new projects and facilities at the medical center.

As of Feb. 8, the Monroe Carell Jr. Children's Hospital at Vanderbilt is up and running – a freestanding, state-of-the-art facility which is arguably the finest Children's Hospital in the country – an accomplishment of epic proportions. We thank the many CRS donors who have played

Fran Hardcastle



such a large part in making this possible, and particularly Monroe Carell for his tireless commitment.

We owe a debt of gratitude to Dr. Bill Stoney who has served as president of the CRS for the past two years, and has been a steadfast leader and an inspiration to us all.

The annual dinner will be held on May 22. We look forward to seeing you there.

CRS
Fran Hardcastle
President,
Canby Robinson Society

Fran Hardcastle

Nashville native and longtime Vanderbilt supporter, Fran Hardcastle, is the new president of the Canby Robinson Society. Fran took office in January and will serve in that capacity for two years.

A graduate of Vanderbilt University, Hardcastle has devoted most of her adult life to civic and volunteer duties. It was her involvement with the Junior League of Nashville that led her to Vanderbilt Children's Hospital many years ago. She was on the scene when the children from the old Junior League Home for Crippled Children were moved into the Children's Regional Medical Center at Vanderbilt. Hardcastle has been involved with the Children's Hospital on and off since then, serving as president of both the Friends of Children's Hospital and the Children's Hospital Board. She became involved in other aspects of the medical center like the CRS and has been a member of its board for three years. Hardcastle won the 2002 Mary Catherine Strobel Volunteer of the Year Award – her category was Community Volunteer – for her work with the Junior League,

Vanderbilt Children's Hospital and other community organizations.

"Just by being involved with one facet, your interests span out to the rest of the medical center," Hardcastle said. "The Children's Hospital is my first love, and I think once you get involved, it sort of wraps itself around you, and that's true for many people. You go do other things, and then somebody asks you to volunteer again, and before you know it, you're back at Vanderbilt. There have been critical times along the way, and I just happened to be there. I have a corporate memory and that helps, knowing why things were done the way they were. There are so many people who have a history with the place. When you see what the hospital does as a whole, all the people that are there are outstanding."

Hardcastle said that one of her goals as the president of the CRS is to increase awareness of the value of what the Vanderbilt Medical Center brings to Nashville. "We should recognize its importance to the world at large through its mission of education, research and clinical care," she said. **CRS** – KATHLEEN WHITNEY

New board members share love of Vanderbilt

The Canby Robinson Society recently announced its new board members for the 2004-2007 term. Several members have been actively volunteering at Vanderbilt for years, while others are new to Vanderbilt and to the CRS. What they all share is a love of the medical center and the recognition of its importance to Nashville.

Linda Curb is new to the CRS, but is a familiar face to the Vanderbilt Children's Hospital board, where she has served as a member for two years. "What really attracted me to the CRS is that it reaches out and helps with scholarships. That was exciting to me," she said. Curb and her husband, Mike, chairman of Curb Records in Nashville, have two daughters, both of whom are pursuing master's degrees from Vanderbilt.

Carla Davis, M.D., graduated from Vanderbilt Medical School in 1974. She received her residency training at the University of California in San Diego and returned to Nashville to finish her pathology training. She has been a pathologist on the staff of St. Thomas Hospital for 24 years. "When I was a medical student, I was from a small town, and Vanderbilt helped me significantly financially and allowed me to get a medical education, so I feel I should pay some of that back," she said. "Through the years, I have worked with students who received the CRS scholarships, and it was such a

benefit to know these people who otherwise might not have been able to come to Vanderbilt. I've been really impressed by the students who receive them. They have probably added more back to Vanderbilt than they received from the CRS."

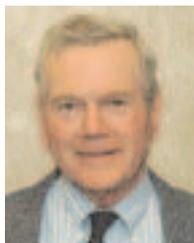
Kitty Murfree is the current chairwoman of the Children's Hospital board and is a returning CRS board member. Murfree initially became involved with the medical center through her work with the Junior League and soon became emotionally attached to Vanderbilt. "The CRS teaches you a lot about Vanderbilt Hospital, and I think that's very important. I was born at Vanderbilt. The medical center has treated all of my family for a lot of years. Vanderbilt has been a part of my family's life for a long time," she said. "It's been a wonderful learning experience for me. I've enjoyed every minute of it."

Paul Sternberg, M.D., the G.W. Hale Professor and chairman of the Department of Ophthalmology, is new to Vanderbilt and comes to the medical center from Emory University School of Medicine. He has encouraged his department faculty to become members of the CRS. "I asked everyone at a certain level to donate to the medical school, and everyone else to donate at least \$500 and I would match it. We got 100 percent participation from my department faculty," he said.

Jean Ann Banker's love of medicine and her family's dedication to health care make her a natural fit for the Canby Robinson Society. There are many doctors in her family, and as a family, they run a school for the mentally challenged. Banker became involved in Children's Hospital shortly after she graduated from Vanderbilt University. She was president of the Friends of Children's Hospital from 1991-1992 and has served on Children's Hospital board in ex officio positions. She is also the past president of the Junior League of Nashville and served on the CRS board some years ago. "I love the Medical Center and have loved watching it grow," she said. "I've watched it become a level one trauma center, a full transplant center, and a cancer center. I love what the medical center does. It is a top-rate medical school, and one key to continuing to be a leader in education is getting the best applicants, so it's important for them to be able to accept the students they want. The CRS scholars, in turn, have an opportunity to become an advocate for the medical school and medical center in the community."

Robert Collins, M.D., John L. Shapiro professor of Pathology, brings a sense of history and knowledge of VUMC to the CRS. "I have been at Vanderbilt for 40 years as a teacher and recognized a need to have scholarship support for students or we could be in danger of becoming elitist. To go from being a contributor in the form of a teacher to being involved in a major organization that raises support for scholarships is a natural progression," Collins said. 

- KATHLEEN WHITNEY



Robert Collins, M.D.



Jean Ann Barker



Paul Sternberg, M.D.



Kitty Murfree

Not pictured: Carla Davis, Linda Curb

Two degrees in one

Alex Eshaghian was born in Tehran, Iran, with coarctation of the aorta and aortic stenosis, a heart condition requiring him to have corrective surgery as a young boy. That early event, coupled with a love of science and the happiness derived from helping others, led Eshaghian to pursue an



M.D./Ph.D. degree at Vanderbilt University School of Medicine through the Medical Scientist Training Program (MSTP). The Canby Robinson Society helped him achieve his dream.

Eshaghian, 27, is one of eight M.D./Ph.D. Canby Robinson scholars (there are 18 other CRS scholars in the M.D. program alone) receiving full tuition, awarded on the basis of demonstrated leadership and scholarship activities.

Eshaghian, who moved to Los Angeles when he was only a few months old, said he is interested in incorporating research and possibly teaching into his career. "It has been a great honor and privilege for me to be one of the first M.D./Ph.D. students to be a CRS scholar.

Funding provided by the CRS allowed an expansion of the program."

Eshaghian's interests lie in the field of dermatology. He is doing his thesis work in the laboratory of James Sligh, M.D., in the department of Cell Biology, and is studying mitochondrial DNA changes in non-melanoma skin cancer.

Erik Musiek, another Canby Robinson scholar in the M.D./Ph.D. program, is in his fourth year of the six-to seven-year program. The first phase consists of the first two years of medical school, or the study of the basic biomedical sciences; students enter the graduate school (Ph.D.) part of the program after their second year of medical school. The third phase consists of the clinical rotations of the third and fourth years of medical school.

Musiek is working with Jason D. Morrow, M.D., in pharmacology, *(continued on page 36)*

Giving Back.....a Family Legacy

For as long as Elizabeth Craig Weaver Proctor can remember, her parents taught her that giving back was not an option, but a vital part of being a member of your community. Vanderbilt University Medical Center has always played an important role in the life of her family and friends.

Her late husband, Bill, served as a member of the Medical Center board and helped guide Vanderbilt during its move into the new hospital in 1981. After Bill's death, Roscoe R. Robinson, M.D., and his wife, Ann, encouraged Elizabeth to take a leadership role in the hospital. She, along with her daughter Becky, got to work. Becky became the president of the Friends of Children's Hospital and Proctor established the first chair in pediatric oncology. The Craig-Weaver Chair supports research and patient care and is held by James Whitlock, M.D.

In 1991, Proctor was elected president of the Canby Robinson Society and embraced the Society's goal of providing scholarships for medical students.

Proctor continues to embrace the need for scholarships today as a member of the Vanderbilt University School of Medicine Scholarship Committee and recently established the Elizabeth Proctor Endowed Scholarship Fund. This fund will provide scholarship support, in perpetuity, for one medical student every four years.

As a member of the VUSM Scholarship Committee, Proctor has asked members of the community to consider providing scholarship support. More than 50 percent of the physicians practicing in Nashville have received some portion of their education or training at Vanderbilt and Proctor sees her gift as an investment in the future of the community.

"Vanderbilt is the place where miracles happen and I feel lucky to be a part of

it," she said. "I have received so much more than I have ever given through my affiliation with this hospital."



The VUSM Scholarship Campaign Fund continues to grow as alumni and friends throughout the country provide support. To date the campaign has received almost \$14 million in documented bequests and over \$9 million in outright gifts and bequests, for a total of more than \$23 million in new funds. An additional \$25 million has been identified in existing funds to bring the total to more than \$48 million in scholarship and financial aid support. 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**

- SARAH REYNOLDS



Teresa Esterle, M.D.

Teresa Esterle stays busy with her eight-physician private pediatric practice in western Cincinnati. But she still makes time to lecture and teach at the primary care clinic once a month at Cincinnati Children's Hospital. She also recently completed her term as president of the Cincinnati Pediatric Society, and remains on the legislative issues committee of the Ohio Chapter of the American Academy of Pediatrics.

Still single, Esterle volunteers with the Leukemia and Lymphoma Society, and is helping organize events for the Cincinnati Chapter for the Vanderbilt Alumni Club. When she has spare time, she travels and gardens, and has recently been participating in marathons. She completed her first last year, for the Team in Training/Leukemia and Lymphoma Society, and is running the Flying Pig Marathon in Cincinnati in May.

"I have many happy memories of the closeness of the Vanderbilt family, and am grateful to the Canby Robinson Society for their generosity in allowing me to pursue my dream," she said.



Teresa Esterle, M.D.

Donor Spotlight Lawrence and Peggy West

Peggy West was the youngest of five children living in East Nashville when she developed pneumonia and wasn't expected to live. She spent about three months in Vanderbilt University Hospital.

"My mom always said Vanderbilt was responsible for me being here. But they never sent a bill. They knew we were a poor family, and I feel I owe Vanderbilt my life," said West, of Gallatin, Tenn.

After she married, she

told her husband she wanted to donate money as they could to Vanderbilt University Medical Center – and they did, \$1,000 here and \$10,000 there.

When a naming opportunity arose to name the business center in the new Monroe Carell Jr. Children's Hospital, a center that allows families to keep up with the outside world and their careers while their children are patients in the hospital, the time seemed right to donate more.

West and her husband, Lawrence, CRS members, used money from their foundation, the Peggy and Lawrence West Foundation, and made a \$250,000 donation. The business center was named in their honor.

"I think about my poor mom, spending time with me in the hospital when she had other small children. She never paid a penny for my care, but told me if I ever could give back something, that I should."

Two degrees (cont.)

studying free radical damage in the brain and how it contributes to Parkinson's disease.

"I came to Vanderbilt with an interest in Parkinson's and gained an interest in free radical damage once I got here. Once I got here, I became interested in the idea of how free radical damage causes aging, and more specifically how it relates to Parkinson's disease," Musiek said.

A native of Hanover, N.H., Musiek is a graduate of The College of William and Mary. He is married to Amy Musiek, who will graduate from Vanderbilt University School of Medicine this year, and stay at Vanderbilt for her residency.

Musiek said the CRS scholarship influenced his decision to come to Vanderbilt.

"I was very honored to have been selected to be a CRS scholar," he said. "Amy and I both wanted to come here, and the CRS sealed the decision. It's been a very positive impact in our lives. Both of us feel a huge debt to Vanderbilt, and the M.D./Ph.D. program is just phenomenal."

Musiek said he hopes to ultimately be a physician-scientist with his own lab, but also able to maintain a clinical practice. He said he hopes to have an 80/20 split – spending 80 percent of his time doing research and 20 percent seeing patients. "That would be ideal," he said. **CRS**

– NANCY HUMPHREY

Save
CRS DINNER
this
SAT., MAY 22, 2004
date!

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*

alumni journal

REMINISCING –

2004 CADAVER BALL

Student talent and creativity at Cadaver Ball-2004 truly ratcheted up the bar again. This year's Cadaver Ball, in a spin-off of the popular Matrix movies, chronicled the trials of "Neomycin" as he moved through medical school to finally take his place in the ranks of the "Intern Nation." Other highlights of the evening included Dean Steven Gabbe's excellent rendition of "Soul Dean" in a Blues Brothers take-off; a song praising "Yellow," the color of all things in anatomy; and a video clip touting "Light Hall's Greatest Hitz." Fourth year student J. P. Norvell received the Bucket Award (the student counterpart to the Shovel Award), and Dr. John Tarpley graciously accepted this year's Shovel Award.

MATCH DAY

Match Day is always a tense but thrilling day for our fourth-year students. This year's Match Day was no exception as a standing-room-only crowd filled 208 Light Hall on March 18 to find out where this year's graduating medical students would spend the next three to 10 years of their lives. For a list of our students' matches, visit our web site at <http://www.mc.vanderbilt.edu/alum-affairs/>.

MENTORING &

HOST PROGRAMS

Embarking on your residency is such an exciting period, but making the move to a new program, especially one in a distant city, can also be a time of anxious anticipation. The Department of Medical Alumni Affairs has created a new program, the Vanderbilt Medical Alumni Mentor Program, to match our graduating students with Vanderbilt medical alumni in the city or hospital in which they will continue their education. This program is a wonderful avenue for our more experienced alumni to share first-hand knowledge of their geographic area and professional climate with our newest medical alumni.

Another new program, the Vanderbilt Medical Alumni Host Family Program, is designed to help defray the cost of interview travel for our rising fourth year students. By opening your home to one of our medical

student "travelers" for a one-night stay, you will be continuing Vanderbilt's long tradition of collegiality and hospitality. If you missed the mailing calling for medical alumni participants for these two programs, please be sure to visit our Medical Alumni website at <http://www.mc.vanderbilt.edu/alum-affairs/>, where you'll find details about these new initiatives. We definitely need more volunteers in cities with major residency programs. If you are still training in a residency program, I hope you will make time to sign up to be a mentor and/or a host. Vanderbilt Medical Students will certainly be coming your way. ♥

Best wishes to all,

Ann H. Price, M.D.

Executive Director for Medical Alumni Affairs

reunion 2004

Our next Medical School Reunion will be Nov. 4-6, 2004. All alumni are invited to attend, but special anniversary class celebrants are:

5th	10th	15th	20th	25th	30th	35th	40th	45th	50th
1998	1993	1988	1983	1978	1973	1968	1963	1958	1953
1999	1994	1989	1984	1979	1974	1969	1964	1959	1954

Reunion social event highlights include a Thursday evening opening reception, the Friday evening Grand Dinner, and Saturday evening class parties. In addition, the Brittingham and Burnett Societies will be having membership meetings during reunion weekend. Please check our Medical Alumni Website for online registration and further information in April. We hope to see you there!

Faculty News • Alumni News

Faculty News

***Jeffrey R. Balsler, M.D., Ph.D.**, professor and chair of Anesthesiology and holder of the James Tayloe Gwathmey Physician-Scientist Chair, has been named associate vice chancellor for Research. He succeeds **Lee E. Limbird, Ph.D.**, who relinquished the position at the end of 2003, after leading the research enterprise since 1998.

***Gordon R. Bernard, M.D.**, professor of Medicine and chief of the division of Allergy, Pulmonary and Critical Care Medicine, has been named the assistant vice chancellor for Research.

Kenneth J. Gaines, M.D., associate professor of Neurology, has completed training at the second annual Donald M. Palatucci Advocacy Leadership Forum in Dana Point, Calif. The American Academy of Neurology established the forum in 2003 to empower neurologists to advocate on behalf of their patients for sensible health care reforms on local, regional and national levels. Participants are selected based on their leadership potential and passion for patient and professional advocacy.

Kathleen L. Gould, Ph.D., professor of Cell and Developmental Biology, has been appointed to another five-year term as a Howard Hughes Medical Institute (HHMI) investigator. Gould has been a member of this select group of investigators since 1984. HHMI currently employs about 350 investigators at universities and academic health centers around the country.

***Richard M. Heller Jr., M.D.**, professor of Radiology and Radiological Sciences and Pediatrics, was honored in January for 29 years of service and for his work as the founding chief of Pediatric Radiology at Vanderbilt.

***Allen B. Kaiser, M.D.**, professor and former vice chair of clinical affairs in the department of Medicine, has been named Hospital chief of staff and Vanderbilt Medical Center associate chief medical officer. As chief of staff, Kaiser is responsible for major improvement initiatives of the hospital and clinic; resolution of day-to-day problems; oversight for physician credentialing; and has a hand in the forming and promulgation of bylaws for physicians working in the hospital.

Kimberly D. Lomis, M.D., assistant professor of Surgery, has been named a Master Clinical Teacher for the Vanderbilt University School of Medicine, a program designed to enhance medical

education for the school's third- and fourth-year students. The program also protects the faculty member's time for teaching and improves the teaching skills of VUSM faculty members. Others named are Scott Rodgers, M.D., assistant professor of Psychiatry, Charles B. Rush, M.D., assistant professor of Obstetrics and Gynecology, and Adrian Jarquin-Valdivia, M.D., assistant professor of Neurology.

Eric Sumner, M.D., a third-year resident in internal medicine, and **Adrian Jarquin-Valdivia, M.D.**, assistant professor of Neurology, have been chosen as recipients of the Vanderbilt University School of Medicine CANDLE (Caring, Advocating, Nurturing, Determination, Leadership and Empathy) Award, a monthly award given by Vanderbilt medical students to individuals who have devoted themselves to teaching and mentoring.

***C. Wright Pinson, M.D.**, formerly H. William Scott Professor of Surgery and chair of the department, director of the Vanderbilt Transplant Center and chief of staff of Vanderbilt University Hospital, has been named associate vice chancellor for Clinical Affairs and chief medical officer. He succeeds ***John S. Sargent, M.D.**, who stepped down last July to become vice chairman for education in the department of Medicine. Pinson will oversee operational improvement of The Vanderbilt Clinic and VUH.

Alastair J.J. Wood, M.D., recently assumed the post of the newly created position of associate dean for External Affairs.

Alumni News

'40s

Gameel B. Hodge, M.D., MD'42, and a 1938 graduate of Wofford College received an honorary doctor of science degree from Wofford at the school's 2003 commencement. Hodge practiced general, thoracic and cardiovascular surgery in Spartanburg for more than 50 years before his full retirement in 2000. During that time he treated more than 65,000 patients and was one of the pioneers in the practice of heart, lung and brain surgery in the region. He practiced at both Spartanburg Regional Medical Center and Mary Black Memorial Hospital, and was an adjunct faculty member at the Medical University of South Carolina.

Robert M. Hall, M.D., MD'49, is featured in the American Academy of Orthopaedic Surgeons Legacy of Heroes online exhibit. Hall was a combat battalion/regimental surgeon in Korea and a hospital commander in Vietnam. To view the exhibit, visit legacyofheroes.aaos.org/hall.cfm

'50s

***John L. Sawyers, M.D.** HS'50, '53-'57, FA-61- was honored in September by the Centerville, Tenn., community at the 100th birthday of the Drake Free Public Library, an institution given to the city by his great grandfather, Gov. Francis M. Drake. Sawyers' accomplishments were noted at the event. He was accompanied by his wife, Julia, MD'60.

Paul A. Winokur, M.D., MD'51, has been retired since 1991. He was in private practice for 10 years, was chief of pediatrics at Muhlenberg Regional Medical Center in Plainfield, N.J., for 25 years, and was clinical professor of Pediatrics and Family Medicine at Robert Wood Johnson School of Medicine in New Brunswick, N.J.

***Frank A. Riddick Jr., M.D.** MD'54, chief executive officer emeritus of the Ochsner Clinic Foundation, received the American Medical Association's Distinguished Physician Award Dec. 6 during the organization's meeting in Honolulu. Previous recipients include renowned heart surgeon Michael DeBakey, M.D., and Alton Ochsner, M.D., one of the five founders of the Jefferson Parish-based medical colossus where Riddick spent his career. Riddick served as medical director and chief executive officer of Ochsner Clinic, a group practice of about 500 doctors from 1975 through 1992. He served as CEO of the Alton Ochsner Medical Foundation, when the clinic, hospital and research arms were merged, from 1990 until 2001. Riddick received the Vanderbilt Medical School distinguished alumnus award in 1988.

Gerald E. Stone, M.D., MD'57, a pioneer in chronic hemodialysis starting in 1963, recently retired from full-time private practice. He is doing Locum Tenens for the University of Rochester's Strong Health Primary Care and continues to have attending privileges at Strong Memorial Hospital in Rochester. He has been married since 1956 to writer and poet Lois Greene Stone. They have 12 grandchildren.

*Indicates CRS member

'60s

Bill Goodson, M.D., MD'60, is practicing psychiatry on a reduced schedule in Huntsville, Ala. He has recently published a novel, *The Bossuet Conspiracy*, with iUniverse publishing house. The story has strong Nashville and Vanderbilt connections.

'70s

Sidney W. Bondurant, M.D., MD'71, HS'80-'83 continues his gynecology practice and his work as a deputy sheriff one night a week in Grenada, Miss. In addition to his law enforcement and medical duties, he is also a state representative in the Mississippi State Legislature.

Charles D. Knight Jr., M.D., MD'79, is the new president of the Shreveport Medical Society. The Shreveport surgeon has been a member of the society since 1985, when he began his practice at the Highland Clinic, and has been a member of the medical society board for six years. He is also a past president of the Louisiana chapter of the American College of Surgeons and past president of the Surgical Association of Louisiana.

'80s

J. Allan Tucker, M.D., MD'81, has been appointed chair of the University of South Alabama Department of Pathology and the Louise Lenoir Locke Professor. Tucker, who served as the vice chair of Pathology for the past eight years and interim chair for almost two years, also serves as director of anatomic pathology and chief of surgical pathology for the USA Health System. Tucker is married to Jean Tucker, a senior attorney for USA Health System. They have three children, Rebecca, William and Catherine.

Chris Cates, M.D., HS'82-'84, F'86-88, was selected by the American College of Cardiology to present its case before the American Medical Association for approval of new reimbursement coding for the carotid artery stent new technology procedure. Cates is director of vascular intervention at Emory University and Director of the vascular program at Emory University Hospital and at Crawford Long Hospital. He is the Interventional Cardiology representative of ACC's Coding and Nomenclature committee.

'90s

Hani Ibrahim, M.D., MD'93, has been appointed to the staff of South Shore Hospital in Weymouth, Mass. He has joined South Suburban ENT Associates in Weymouth.

James C. Sloan, M.D., a urologist with Oak Ridge Urology Associates, has joined the staff of Methodist Medical Center of Oak Ridge. A native of the Pacific Northwest, he makes his home in Oak Ridge with his wife, Allyson.

Daniel Viner, M.D., MD'97, and his wife, Jessica, welcomed a son, Jacob Dimitry, on Sept. 22. He joins twin 2-year-old sisters, Rebecca and Gabrielle.

Trey Lee, M.D., now in his fourth year of training at Vanderbilt as a clinical fellow in Neurophysiology, after three previous years as a Neurology resident, received the American Medical Association Foundation Leadership Award at the AMA National Advocacy Conference in Washington, D.C.

In Memoriam

Crawford Williams Adams, M.D., CF '60-'89, died Dec. 13, 2003. He is a past president of the American College of Chest Physicians and founder and past president of the Nashville Cardiovascular Society. He served as president of the St. Thomas Hospital staff, vice president of the Tennessee Heart Association, and president of the Middle Tennessee Heart Association. He was preceded in death by his wife, Barbara, and is survived by four sons, eight daughters, 27 grandchildren and 10 great-grandchildren.

James Erwin Anderson, M.D., MD'59, HS'59-'60, CF'66-00, died Nov. 18, 2003. He was 69. He is survived by his wife, Carolyn, two sons, a daughter, and seven grandchildren. He was an associate in a private practice in Nashville.

R. B. "Sonny" Baird Jr., M.D., MD'46, died in Mooresburg, Tenn. on Nov. 15, 2003. He was 81. He practiced medicine for 54 years and was chief of staff at Pineville Community Hospital before moving to Rogersville in 1972. He served as chief of staff and chief of Surgery at Hawkins County Memorial Hospital, was a health officer and medical examiner for Hawkins County for many years, and was associate professor for Clinical Surgery at East Tennessee State University. He was preceded in death by his wife, Elsie, and is survived by four daughters, two sons, 11 grandchildren and four great-grandchildren.

Luthur Abner Beazley, M.D., MD'46, CF'59-'89, died on Aug. 25, 2003. Beazley practiced pediatric medicine for about 40 years in the Donelson area of Nashville and served as president of the Nashville Academy of Medicine, president of the Davidson county Pediatric Association and chairman of the Tennessee Chapter of the American Academy of Pediatrics from 1983 to 1986, the

organization that honored him with "Pediatrician of the Year" in 1989. Along with other local physicians, he helped establish Donelson Hospital, now known as Summit Medical Center, and was instrumental in the passing of legislation requiring that children ride in car seats in automobiles. He is survived by his wife of 36 years, Nelle, four children and 11 grandchildren.

John Connelly Bondurant, M.D., MD'48, died Jan. 2 in Portland, Ore. He was 81. He was a physician at Bess Kaiser Hospital in Portland for more than 25 years. He is survived by his wife, Marjorie, a daughter, two sons and two grandchildren.

Henry Murfee Carney, M.D., MD'33, HS'33-'36, died on Sept. 11, 2003 in Texarkana, Ark. He was 94. He was a member of Alpha Omega Alpha at VUSM, and served as chief resident of surgery, then as an instructor of surgery from 1937-1942. In 1946, he and a partner founded the Collom and Carney Medical Clinic in Texarkana, a private medical group practice that grew from four physicians to 70 physicians and several branch offices.

Billy L. Farmer, M.D., MD'54, died Oct. 22, 2003 in El Paso, Tex. He was 74. Farmer had lived in El Paso since 1963 and retired from his dermatology practice in 1987. He authored two books on the origins of the universe. He is survived by his wife, Rita, two daughters, two sons and 12 grandchildren.

John W. Frazier, M.D., MD'38, HS'39, died March 4. Frazier established the first M.A.S.H unit in the South Pacific theatre during World War II, after leading his troops on foot across the Owen Stanley Mountain Range of New Guinea. He had an internal medicine practice in Nashville and sat on the Adjudication Board of the Veterans Administration. He is survived by his wife of 63 years, Mary Louise, three sons, two daughters, 14 grandchildren and 14 great-grandchildren.

James E. Hanchett, M.D., HS'62-'63, F'64, died Sept. 29, 2003 in Oakland, Pa. He was a physician at Shadyside Hospital, Veteran's Administration Hospital and the Children's Institute. He is survived by his wife, Jeanne, three daughters, two sons and 11 grandchildren.

William Derrel Hazlehurst, M.D., MD'38, F'40, died Sept. 10, 2003 in Macon, Ga. He was 90. He was in private practice in Macon from 1947 until his retirement. He served as president of the Bibb County Medical Society, was on the staff of Middle Georgia Hospital, and served as chief of staff of the Medical Center of Central Georgia. He is survived by his wife, Harriet, three children, six grandchildren and a great-granddaughter.

J. Lynwood Herrington Jr., M.D., MD'45, HS'45, CF'57-'00, died Feb. 23 at home in Nashville. He trained Vanderbilt residents at St. Thomas Hospital and worked as a surgeon with the Edwards-Eve Clinic, now known as the Surgical Clinic. He retired from both in 1990. Herrington wrote more than 300 papers and 20 chapters in several textbooks over his 40-year career and was also a visiting lecturer and professor at more than 200 universities and medical schools. He served as president of the Southern Surgical Association in 1993. He is survived by his wife, Mary Alene, four daughters, three sons and 21 grandchildren.

Thomas Jefferson Holbrook, M.D., MD'41, HS'41-'44, F'47, died Jan. 15. He was 86. He was a member of the Alpha Omega Alpha honor society at VUSM and started the first neurosurgical practice in Huntington, W.V., where he practiced for 38 years. He was a founding member of the American Board of Electroencephalography, Neurosurgical Society of America, American Medical Electroencephalographic Association, the William F. Meacham Neurosurgical Society and the Neurosurgical Society of West Virginia. He was preceded in death by his wife of 49 years, Lois, and is survived by three sons and nine grandchildren.

Tetsuro Kono, Ph.D., professor of Molecular Physiology and Biophysics, Emeritus, died in Nashville Jan. 18 from pancreatic cancer. He was 78. His research over 30 years at Vanderbilt focused on insulin action, laying important groundwork for what goes awry in diabetes and obesity. He is survived by his wife, Seiko, a daughter and two sons.

***Virgil S. LeQuire, M.D.**, MD'46, F'49, FA'50-, died Dec. 13, 2003 in Nashville. He was professor of Experimental Pathology, emeritus at VUSM. During his tenure at Vanderbilt, he taught neuroanatomy and pathology, and was chair of admissions for the medical school from 1980 until 1991. He is survived by his wife, Louise, four children and eight grandchildren.

Wendy Anne Peterson Metzger, M.D., HS'77-'79, died from cancer on Jan. 25 in Tempe, Ariz. She was 53. She spent several years as a physician in the Indian Health Service in Mescalero and Zuni, New Mexico and at the Phoenix Indian Medical Center, then at the Student Health Service of the University of Arizona in Tucson, Arizona State University, Tempe, and finally, the Thomas-Davis Medical Center in Tempe where she retired in 1995. She is survived by her daughters, Anne and Kathryn.

Bernard L. Newton, M.D., MD'38, died Jan. 3 in Greenville, N.C. He began his general surgery practice in Catawba County in 1947 and retired after 36 years of practice. He also served as chief of staff at Catawba Memorial Hospital. He was

preceded in death by his wife, Celestine, and is survived by two daughters, two sons, seven grandchildren and four great-grandchildren.

John Christian Ransmeier, M.D., HS'40, died Jan. 19 in Asheville, N.C. He was 91. He was an internal medicine physician in Alexandria, Va., from 1963 until his retirement and worked at the Veteran's Administration Hospital in Oteen. He is survived by his wife of 54 years, Frances, a daughter, two sons and four grandchildren.

Robert L. Sells, M.D., MD'38, died in October 2003 in Santa Rosa, Calif. He was 91. He established a private practice in San Mateo County in obstetrics and gynecology and was a pioneer in the development of Planned Parenthood. He is survived by two daughters.

William R. Norman Jr., M.D. MD'52, died June 28, 2003. He was 76. Survivors include his wife, Lois, a daughter, two sons and four grandchildren.

Wilbourn Couperly Shands, M.D., MD'45, HS'45, died Sept. 30 in Jackson, Miss. He was 80. Adams, a member of Alpha Omega Alpha at VUSM, was a general surgeon at The Surgical Clinic in Jackson, Miss., served as chief of staff at St. Dominic Jackson Memorial Hospital and was clinical professor emeritus in the Department of Surgery at the University of Mississippi Medical Center. Adams is survived by his wife of 50 years, Janet, four daughters and several grandchildren.

George Merrill Shore, M.D., MD'71, died on Dec. 30, 2003 in Jacksonville, Fla. He practiced clinical pathology at St. Vincent's Medical Center for 21 years and is survived by his wife, Linda, two sons, a daughter and one granddaughter.

Grace Porterfield Teal, M.D., MD'86, HS'86-'88, F'90,'95, FA'96-'00, assistant professor of Medicine at Vanderbilt, died Feb. 17. She was 44. She is survived by her husband, Christian, and a daughter.

Charles F. Weiss, M.D., MD'49, died Jan. 13. He was 82. He was a pediatric pharmacologist and had been clinical professor of Pediatrics at the University of South Florida and professor of Pediatrics at the University of Florida. Survivors include his wife, Bernice, three sons and six grandchildren.

Barry E. Wind, M.D., MD'78, died last December in San Antonio after a battle with cancer. He is survived by his wife, Ginny, a son and a daughter.

Thomas Whitten Wright, M.D., MD'48, died in Huntsville, Ala., on Feb. 17. He was 79. Known to his friends as "Whit," he practiced surgery in Huntsville for 37 years. He was president of his first-year class at VUSM and was a member of the Canby Robinson Society. In Huntsville, he served as president of the Madison County Medical Society, and for 35 years, served as president of the Huntsville Clinic, and also practiced surgery in Scottsboro, Arab, Guntersville and Fayetteville, Tenn. He is survived by his wife, Evelyn, two daughters, two sons, and five grandchildren.

Communication/ Dore2Dore

Effective communication with our medical alumni is an ongoing challenge. We continue to move toward greater use of e-mail, but we have found that people change e-mail addresses more frequently than their street addresses. Do you know that all alumni are eligible for a permanent Vanderbilt e-mail address?

By using this free e-mail forwarding feature, you will never need to give your family and friends a new e-mail address, no

matter how often you change your e-mail account.

Establish an account with Vanderbilt's Dore2Dore program and create a permanent Vanderbilt alumni address (i.e.: yourname@alumni.vanderbilt.edu).

During the registration process, you will need to input the address you would like e-mail forwarded. Then, as you change e-mail addresses, all you have to do is log on to Dore2Dore and update your forwarding address.

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Ruth Ann Vleugels celebrates with classmate Elise Cornet.



Jonathan Kim hugs classmates, Jessica Chan, left, and Lillian Tseng, after finding out where they matched.



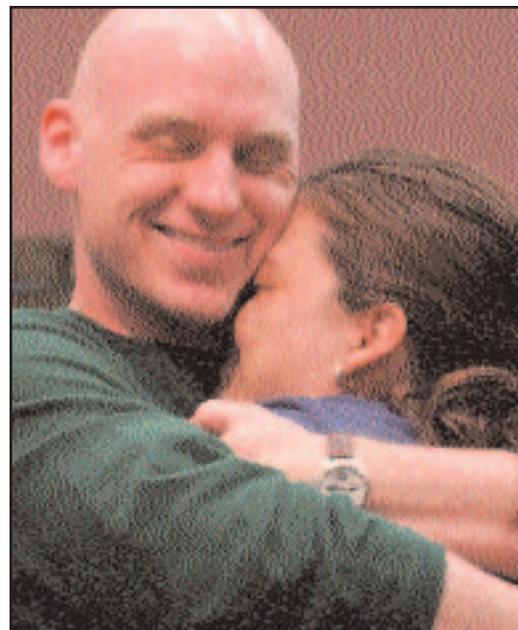
Jessica Chan reacts to her match at UCLA Medical Center as Bonnie Miller, M.D., associate dean for Medical Students, looks on.

match day 2004

PHOTOS BY DANA JOHNSON



Megan Thunder cheers for her classmates.



Jonathan Watson hugs his wife, Melissa, after finding out they're among six students heading to UCLA Medical Center for their residencies

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