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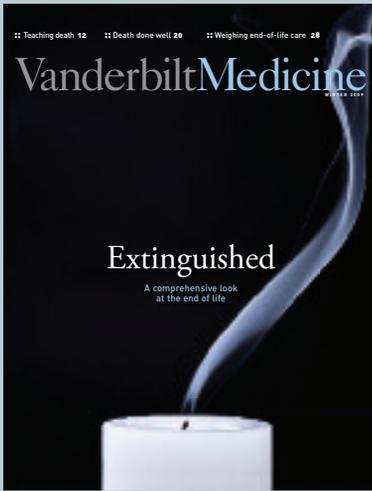
VanderbiltMedicine

WINTER 2009

Extinguished

A comprehensive look
at the end of life





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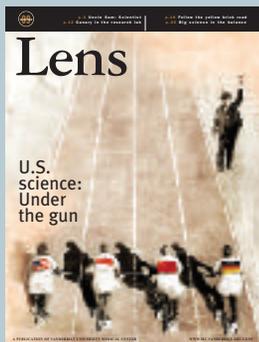
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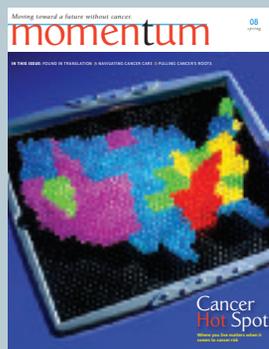
On Their Way, a publication of the Monroe Carell Jr. Children's Hospital at Vanderbilt.

www.vanderbiltchildrens.com/ontheirway



Vanderbilt Nurse, the alumni publication of the Vanderbilt University School of Nursing.

www.nursing.vanderbilt.edu/nurse



Momentum, the magazine of the Vanderbilt-Ingram Cancer Center.

www.vicc.org/momentum

:: on the cover

“The idea of death, the fear of it, haunts the human animal like nothing else; it is a mainspring of human activity — designed largely to avoid the fatality of death, to overcome it by denying in some way that it is the final destiny of man.”

— Ernest Becker



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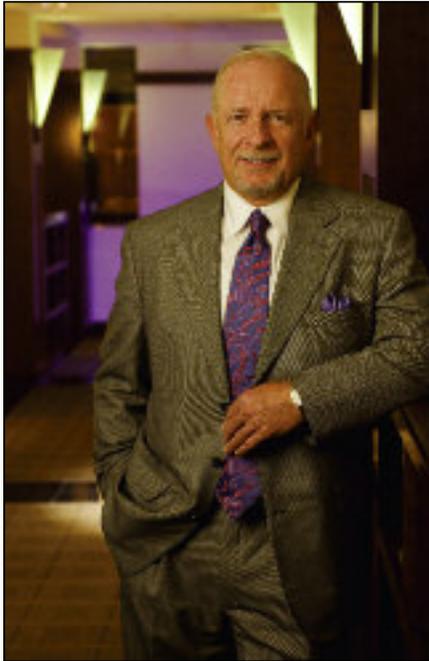
Gail Addlestone, M.D., MD'97, had a vision.



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

On any given day at Vanderbilt a handful of souls



DEAN DIXON

leave their mortal selves behind. We would hope that we had done everything we could to keep them with us. Most could not have been saved with the means we have at our disposal today. Some simply decide on their own that it is their time. And some die through simple human error. Medicine has focused ferocious attention on identifying the source of error, on designing systems that protect against those errors and in producing Six Sigma error reduction that matches Toyota's and GE's.

The record Vanderbilt has achieved in mortality and error reduction is nothing short of stunning. The severity-adjusted death rate among our patients is among the lowest in the nation. Our physicians and surgeons believe we can achieve death rates that are half the national average even as the national average is markedly improving. No matter how impressive this reduction in mortality – it is only half the job.

Doctors are geared to cure illness and injury. It is a focus that has helped us extend life by 40 years since the turn of the century. Still, the end point of life, no matter how long and how productive, is death. We fight to save lives. We need to work just as hard to make the transition

from life to death a meaningful and powerful experience for the people who are dying and the family they leave behind. Jonathan Gitlin, M.D., our chairman of Pediatrics, reminds us every day that there are children in our hospital who will never go home again. What obligation do we have to those children, to their parents, to their brothers and sisters? When our tools to cure fall short, what then is our mission?

In the pages of this issue of *Vanderbilt Medicine* we begin to answer these questions. And we begin to answer them with an affirmation that death is a process at least as important as healing – and may be even more profoundly and deeply meaningful. It has been said that the single most important distinguishing characteristic between human beings and the rest of the animal world is our awareness of death. Medicine needs to make that awareness as much a part of its ethos as “do no harm” and as much a part of its approach as diagnosis. **VM**

Antibodies from 1918 flu resurrected

Ninety years after the sweeping destruction of the 1918 flu pandemic, researchers at the Monroe Carell Jr. Children's Hospital at Vanderbilt have recovered antibodies to the virus — from elderly survivors of the original outbreak.

The study, led by James Crowe Jr., M.D., professor of Pediatrics and director of the Vanderbilt Program in Vaccine Sciences, and colleagues at the Mount Sinai School of Medicine, was published in the Sept. 25, 2008, issue of the journal *Nature*.

The influenza pandemic of 1918 killed nearly 50 million people worldwide, many of whom were young, healthy adults.

In 2005, researchers from Mount Sinai and the Armed Forces Institute of Pathology in Washington, D.C., resurrected the 1918 virus from the bodies of people killed in the outbreak.

When the investigators approached Crowe, whose lab had developed methods of making antibodies, to try to make antibodies to the 1918 flu, he was skeptical, but agreed to try.

The researchers collected blood samples from 32 survivors age 91-101 years and found that all reacted to the 1918 virus, suggesting that they still possessed antibodies to it.

Crowe's team was then able to isolate exceedingly rare B cells — the immune cells that produce antibodies — from eight of those samples and grow them in culture.

Seven of those samples produced antibodies to a 1918 virus protein, suggesting that their immune systems were waiting on standby for a long-awaited second outbreak.

In addition to revealing the surprisingly long-lasting immunity to such viruses, these antibodies could be effective treatments to have on hand if another virus similar to the 1918 flu breaks out in the future.

And the technology could be used to develop antibodies against other viruses, like HIV. **VM**

—MELISSA MARINO

News and happenings at Vanderbilt Medical Center

\$20M gift launches Children's Hospital expansion project

Three generations of the family of the late Monroe Carell Jr. have pledged a gift of \$20 million to the fundraising effort for a new facility to care for children and mothers.

The Campaign for Children and Mothers, with a goal of \$45 million, will support the building of a 400,000-square-foot facility, adjacent to and connected with the Monroe Carell Jr. Children's Hospital at Vanderbilt.

"This is truly a family gift from three generations," said Julie Stadler, the eldest daughter of Ann and Monroe Carell Jr. She and her husband, George Stadler, are chairing the Campaign for Children and Mothers. "My father inspired many by his example. He believed if you felt passionate about a cause, you should support it with your time, energy and financial resources to the best of your ability.

"That's why this gift is from all of us: my mother, Ann Carell; my sisters and their husbands, Kathryn and David Brown and Edie and David Johnson; and from George and me and all of our children. Our family felt it was important to demonstrate our own support in a significant way as we ask others throughout the community for their generosity."

Stadler joined John Stein, chair of the Board of Directors for Children's Hospital; Kevin Churchwell, M.D., CEO of the Children's Hospital; and Harry Jacobson, M.D., vice chancellor for Health Affairs for Vanderbilt Medical Center, as they announced the gift to the hospital's board of directors on Sept. 11, 2008.

"The generosity of the whole Carell family is a thing of legend," Jacobson said. "A gift of this magnitude has the possibility of transforming the way we view care for mothers and the babies they carry. But just as important, the generosity of the Stadlers, the Browns, the Johnsons, and Ann Carell will allow us to expand our Children's Hospital to meet the needs of our growing region, to expand our services, and to broaden our mission and build this wonderful new facility."

Monroe Carell Jr., who died on June 20, 2008, was a noted philanthropist and chaired the campaign that built the Children's Hospital that now bears his name. **VM**

—CAROLE BARTOO



On hand for the gift announcement were, from left, Kevin Churchwell, M.D., George and Julie Stadler, co-chairs of the Campaign for Children and Mothers, and Harry Jacobson, M.D.

DANA JOHNSON

Medical students span globe for Emphasis Program projects

Vanderbilt University School of Medicine students usually complete their Emphasis Program projects in a Vanderbilt lab, but during the summer of 2008 several performed research at various spots around the globe.

"The opportunity to work abroad is a wonderful gift to students and not just because of the exposure to different cultures," said Denis O'Day, M.D., who directs the Emphasis Program, which gives students the chance to engage in scholarly research during their first two years of medical school.

Here are a few of the students' stories:

- Matt Kynes and his wife, Ansley, traveled to Nimule, Sudan, a town on the border of southern Sudan and Uganda that has seen a rapid and alarming increase in HIV.

Kynes' Emphasis project involved interviewing more than 20 religious leaders about their opinions and attitudes toward HIV/AIDS and the current prevention, counseling and support programs their congregations were offering.

- Chris Estopinal worked for two months at Macha Mission Hospital, a 208-bed facility in Zambia that provides free HIV care and treatment to more than 3,000 patients, many of whom must travel hours or even days to reach the hospital.

Estopinal evaluated the hospital's home-based HIV care program by comparing outcomes such as death and drug adherence between those patients who live in communities with home-based care and those who do not.

- David Silvestri also traveled to Zambia, where he partnered with a short-term mobile clinic comprised of Zambian and American medical providers, including Jeff McKinzie, M.D., a Vanderbilt professor of Emergency Medicine. **VM**

- BRENT MCNEW

Blood pressure drug combo may cut heart attack deaths: study

Thousands of patients with high blood pressure could benefit from changing their drug treatment regimen to reduce their risk of cardiac death.

The current U.S. hypertension treatment guidelines recommend using a thiazide diuretic — a drug that increases the volume of urine — alone as the initial drug therapy for high blood pressure. But a new analysis of existing clinical trials of diuretic drugs calls into question the current guidelines.

Vanderbilt Medical Center researchers found that combining a thiazide diuretic with a "potassium-sparing" drug to treat hypertension reduced both sudden cardiac death and total coronary mortality by 40 percent.

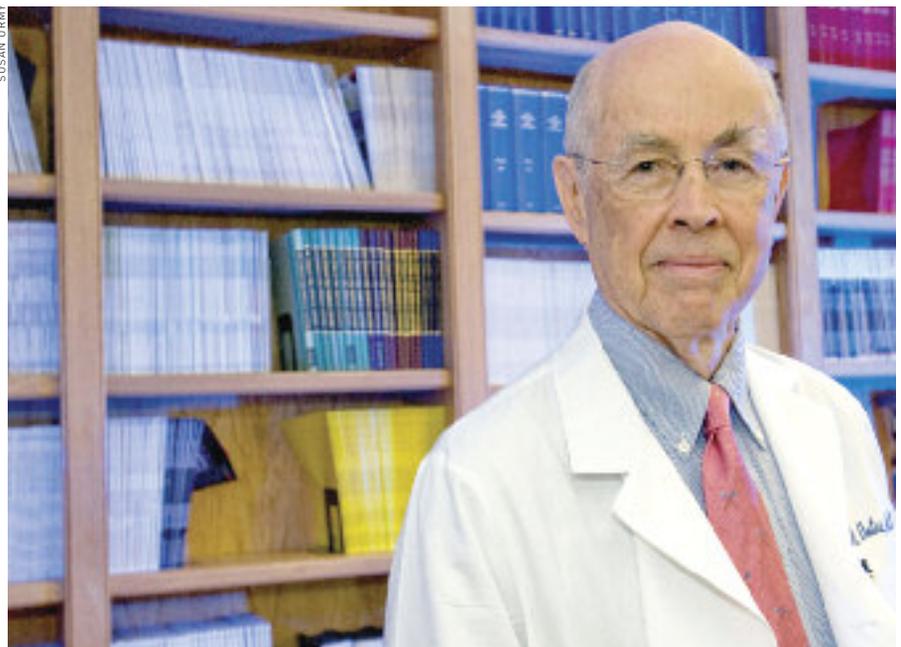
"The recommendations can now be re-examined in light of these new findings," said John Oates, M.D., senior author of the study published in the September/October 2008 issue of the *Journal of the American Society of Hypertension*.

Thiazide diuretics successfully reduce blood pressure for many patients, but they are also known to deplete potassium, said Oates, a professor of Medicine and hypertension specialist. This potassium "wasting" has sparked concern over the years with studies suggesting a link between potassium loss and sudden cardiac death. The new findings — that combining a potassium-sparing drug (ENaC inhibitor) with a thiazide diuretic reduces sudden death — beg the question of whether thiazide diuretics given alone actually increase the risk of sudden death in patients with high blood pressure. It's possible, Oates said.

"There's biologic plausibility for an adverse effect of the thiazides," he said. "If it's true, it's probably the largest adverse effect in the history of modern pharmacology. The number of individuals affected over the last 50 years would be staggering."

The Joint National Committee, under the direction of the National Heart, Lung, and Blood Institute, publishes clinical practice guidelines for hypertension — new guidelines are expected in 2009. **VM**

- LEIGH MACMILLAN



John Oates, M.D., is studying a hypertension therapy that may reduce coronary mortality rates.

Sullivan Pardee is being treated for congenital glaucoma at the Vanderbilt Eye Institute.



Sights set on easing congenital glaucoma

Parents of newborns often are told that their baby has big, beautiful eyes.

It's a common compliment, but it's one that a Vanderbilt ophthalmologist cautions could be a warning sign for congenital glaucoma.

"When the pressure in the eye is high, the eyes enlarge," said Karen Joos, M.D., Ph.D., associate professor of Ophthalmology at the Vanderbilt Eye Institute. "A child may also show signs of light sensitivity and a cloudiness of the cornea. Sometimes these are subtle changes that can easily be missed."

Congenital glaucoma is a rare condition affecting one in 10,000 births. Sullivan Pardee, 8 months, is one of those cases. Thankfully his mother, Tracy, noticed a change in his eyes when he was about 3 months old.

According to Joos, the best prognosis is found in patients whose symptoms develop between the age of 3 and 12 months, while those occurring earlier than 3 months typically experience more severe signs of the disease and a tougher outcome.

Sullivan was quickly scheduled to see Joos, but before making that appointment he was whisked to the emergency room at Monroe Carell Jr. Children's Hospital at Vanderbilt.

"We woke up the next morning and my husband, Tyson, looked at Sullivan," said Pardee. "His eye was totally clouded over. It looked like someone had spilled milk in it. The pressure in his eye had built up so high, it burst the membrane that covers and protects the iris."

Within three days, Sullivan underwent a goniotomy in both eyes to remove the fluid buildup caused by the improper development of the eye's drainage channels. Because the channels were defective, fluid was continually produced with no way to exit. This caused high pressure inside the eye.

A second surgery was performed a few weeks later because the pressure in Sullivan's eye did not decrease as much as Joos hoped.

"Sullivan has clear, clear eyes," said Pardee.

Nearly 75 percent of congenital glaucoma cases occur in both eyes and is most often seen in boys (65 percent). The success rate for congenital glaucoma is about 90 percent for up to five years. **VM**

-JESSICA PASLEY

National spotlight shines bright on Medical Center

In addition to being named to *U.S. News & World Report's* "honor roll" of the nation's best hospitals, Vanderbilt Medical Center's ongoing efforts to improve quality of care and patient safety were featured in the magazine's annual "America's Best Hospitals" issue, published in July 2008.

The 12-page article, told in a time-stamp format, is titled "America's Best Hospitals — Vanderbilt's special mix of skill, passion, and Southern comfort hits all the right notes in Nashville," and kicks off with a two-page photo of LifeFlight offloading a patient.

What follows is an account of some of the events that happened the week of June 9-14, 2008, as witnessed by *U.S. News* staff writers Sarah Baldauf and Lindsay Lyon and photographer Jim Lo Scalzo during their six-day visit.

The article's content was shaped in part from a lengthy menu of suggestions that were received and compiled in response to an e-mail sent by Harry Jacobson, M.D., vice chancellor for Health Affairs, prior to the *U.S. News* team's pending visit. More than 200 suggestions from people at all levels throughout the organization who wanted to show their work were received and then carefully reviewed.

In part from these suggestions, a 14-page list of story suggestions was created and used by News and Public Affairs personnel as they showed the reporters numerous programs, initiatives and protocols.

"One of the more gratifying aspects of this project with *U.S. News* was receiving these e-mail suggestions from people throughout the Medical Center," Jacobson said.

"From these e-mails it is readily apparent our workforce is proud of what we do, and they really understand how their role within the organization serves a common goal. I want to thank everyone who offered their input and assistance with this project." **VM**

-JOHN HOWSER

Trauma Center celebrates a decade of saving lives

In August 2008, the Vanderbilt Trauma Center celebrated its 10-year anniversary.

The acute care unit, located on 10 North in Vanderbilt University Hospital, opened on Aug. 13, 1998, with then Nashville Mayor Phil Bredesen on hand to help cut the ribbon.

Since its opening, the Trauma Center has treated a broadly diverse patient population from all walks of life, and has also cared for highly visible patients such as country music superstars, pro football players and elected officials on several occasions.

As the region's only provider of Level 1 trauma care, the Vanderbilt Trauma Center's staff of 16 physicians, 108 nurses and 42 staff has treated more than 33,000 acutely ill patients since the unit's opening.

Since 1998 the Trauma Center's number of annual admissions has risen from 2,000 to nearly 4,000 per year. During this same period, more than 16,000 motor vehicle accident victims, 3,100 gunshot victims and 5,000 uninsured Middle Tennesseans have been treated by Trauma Center staff. **VM**

—JOHN HOWSER



NEIL BRAKE

Carlos Arteaga, M.D., directs VICC's Breast Cancer Research Program, which received renewed funding from the National Institutes of Health.



JOE HOWELL

Breast cancer research gets \$12 million boost from NCI

Vanderbilt-Ingram Cancer Center's Specialized Programs of Research Excellence (SPORE) in Breast Cancer has received a new round of grant funding from the National Cancer Institute (NCI).

The NCI will provide \$12 million over the next five years to support and expand Vanderbilt-Ingram's translational research efforts in breast cancer.

"We are grateful that the NCI has recognized the high quality of our research program and rewarded our team for the novel and promising avenues of research we are pursuing," said Carlos L. Arteaga, M.D., director of the Vanderbilt-Ingram Breast Cancer Research Program.

The NCI initiated organ-specific SPORE grants in 1992 to encourage translational research, which is designed to speed discoveries from the laboratory into treatment options in the clinic. This patient-centered research platform encompasses work by basic scientists, epidemiologists and clinicians and encourages collaboration.

Vanderbilt-Ingram received its first SPORE grant in Breast Cancer in 2002.

The grant brings together 15 co-investigators from seven departments in the School of Medicine, spanning a breadth of basic science and clinical disciplines.

"Working as a team we want to make an impact on breast cancer research, treatment, detection and prevention worldwide," said Jennifer Pietenpol, Ph.D., director of Vanderbilt-Ingram and a Breast Cancer SPORE researcher.

"The SPORE grants are critical to our mission of making a difference in the lives of cancer patients."

All three of Vanderbilt-Ingram's SPORE grants — in breast, lung and gastrointestinal cancer — have now been renewed by the NCI, which is a remarkable accomplishment among cancer centers. **VM**

—DAGNY STUART

School of Medicine alum chosen as new dean

BY LYNNE HUTCHISON

Jeff Balser, M.D., Ph.D., is the new dean of Vanderbilt University School of Medicine.

Balser served as interim dean before his appointment in October 2008, and is a newly elected member of the Institute of Medicine and an alumnus of the school. He becomes the 11th dean of VUSM since its founding in 1875.

In addition to his responsibilities as dean, Balser is associate vice chancellor for Health Affairs with continued oversight of the Medical Center's research enterprise.

"Dr. Balser has earned the respect of his colleagues in the School of Medicine, and throughout Vanderbilt, for his keen intellect, sound judgment and high ethical standards," said Chancellor Nicholas Zeppos. "I have great confidence that Jeff will continue to advance the School of Medicine to new heights of excellence, both nationally and internationally."

"Jeff has proven himself as the chair of Anesthesiology, the associate vice chancellor for Research and as the interim dean," said Harry Jacobson, M.D., Vanderbilt's vice chancellor for Health Affairs. "He is a leader, a clinician, a researcher and a mentor with the energy and insight to lead the School of Medicine to an even greater level of achievement in the years to come.

"I'm proud to be entrusted with this honor," Balser said.

"As an alumnus of our Medical Scientist Training Program, I am deeply committed to the lives and careers of our faculty and staff, and our growing number of students and trainees in the sciences and health care."

Balser was born in Indianapolis, Ind., in 1962 and received his M.D. and Ph.D. in Pharmacology from Vanderbilt in 1990. He trained as a resident and fellow in anesthesiology and critical care medicine at Johns Hopkins, where he joined the faculty in 1995. He returned to Vanderbilt in 1998 as associate dean for Physician Scientists. In 2001 he was appointed the James Tayloe Gwathmey Professor and Chair of Anesthesiology.

In 2004 Balser became associate vice chancellor for Research, heading a period of significant expansion that moved Vanderbilt into 10th place among U.S. medical schools in funding from the National Institutes of Health.

Balser also is a member of the American Society for Clinical Investigation, the Association of American Physicians, the AAMC Advisory Panel on Research, and has recently chaired the NIH Director's Pioneer Award Committee.

His studies in the journals *Nature*, *Proceeding of the National Academies of Science* and *Nature Structural and Molecular Biology* have



ANNIE BARNER

established new paradigms for how the chambers of the heart contract and relax, and are yielding new targets for arrhythmia control.

Balser and his wife, Melinda, are the parents of three children: James, 18, Jillian, 16, and Madeline, 12.

Balser succeeds Steven Gabbe, M.D., who left Vanderbilt in June to become senior vice president for Health Sciences and chief executive officer at Ohio State University Medical Center.

Daniel Beauchamp, M.D., director of the Section of Surgical Sciences, headed the selection committee, which chose Balser from a group of nationally prominent candidates.

"While each applicant had an impressive academic record of leadership and accomplishment, Dr. Balser was the applicant who most impressed the committee with his energy and enthusiasm, his breadth of knowledge and interests spanning basic sciences to clinical practice, his diplomacy and his vision for the future of the School of Medicine and Vanderbilt University in its entirety," Beauchamp said.

"The School has enjoyed remarkable progress over the past decade, increasing in its local, national and international stature," Balser said. "While nurturing our atmosphere of cooperation and collegiality, we are now called to leadership in shaping the future of biomedical science and academic medicine. This will be an exciting period in the history of the Medical Center. I'm thrilled to have the opportunity to work with so many friends and colleagues in advancing our goals in health care, education and research.

"I recall sitting in Light Hall as a student in 1984, listening to Dean Chapman give a talk about the contemporary challenges in academic medicine," Balser added.

"I remember thinking at that time how exciting it must be to be dean of the School of Medicine at Vanderbilt. I still feel exactly the same way, and I am extraordinarily grateful for this opportunity." VM

Full Circle

Levi Watkins Jr., M.D., is well known for a host of firsts.

He was the first African-American student ever enrolled at Vanderbilt University School of Medicine. When he graduated four years later, he was still the only one.

He was the first African-American to serve as chief resident in cardiac surgery, as professor of cardiac surgery, and as associate dean of the School of Medicine at Johns Hopkins.

He defined the role of the renin-angiotensin system in congestive heart failure, which led to the use of angiotensin blockers. In 1980 he performed the world's first implantation of the automatic implantable defibrillator.

He even graduated first in his high school class.

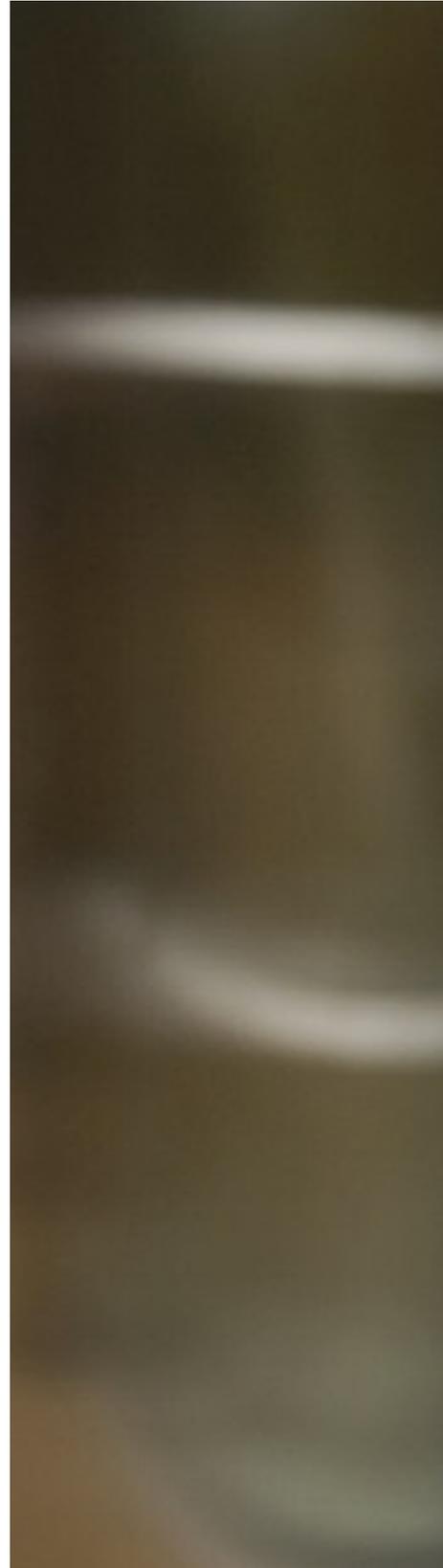
In October 2008, Watkins, MD'70, associate dean of the Johns Hopkins University School of Medicine and professor of cardiac surgery, was awarded Vanderbilt University's Distinguished Alumnus Award, which recognizes a graduate whose contributions have had a broad, positive impact on humankind — and who has chosen to do something of even greater benefit to the universal community.

"Dr. Watkins' career has been an inspiration to legions of physicians and scientists in this country and around the world," says Jeff Balser, M.D., Ph.D., Vanderbilt's associate vice chancellor for Health Affairs and dean of the School of Medicine. "His courage in overcoming adversity and racial prejudice is inspirational."

"I'm deeply honored by this," Watkins said. "It reminds me of something my grandfather said at my Vanderbilt graduation. He'd never been to Vanderbilt — he thought it was just for whites — but he came, saw the people, the stage, the robes. Then he said 'Boy, this is really something.'"

Watkins' warm, rich voice pauses, then drops deeper. "I feel the same way — this is really something. It's full circle."

WRITTEN BY **LYNNE HUTCHISON**
PHOTOGRAPH BY **JOE HOWELL**



LEVI WATKINS JR., M.D.



LEARNING BY EXAMPLE

Watkins was born in 1945 in Parsons, Kan., then moved with his family to Montgomery, Ala., when he was still a baby. His father was a business administrator and later was named president of Alabama State University.

Montgomery was ground zero for the early Civil Rights movement and Watkins was involved from childhood.

“Growing up in a segregated society was tough,” he recalls. “Movie theaters, stores, neighborhood, buses, train stations — they were all segregated. But black families and churches and communities were strong and spirited. That helped balance the negativity of segregation.

“Daddy and Dr. Martin Luther King Jr. were good friends,” Watkins continues. “So we joined the Dexter Avenue Baptist Church, where Dr. King was the preacher. He used to bring us boys to his home to keep us from being violent during those tough days. He was a wonderful man and greatly influenced my life.”

Even more influential was Watkins’ father — a kind man who led by example, demonstrating the virtues of hard work and love of people. “Folks said I looked and smiled like him. But he didn’t have any special children — we all got the same whippin’,” Watkins says with a chuckle.

After graduating from high school in 1962, Watkins took his father’s advice and headed to Tennessee State University in Nashville. Although he had intended to follow in his father’s footsteps and become a college professor, Watkins soon had a change of heart.

“I had an adviser and mentor — Dr. John Mallette — who was a biologist,” Watkins explains. “He saw talent in me that I did not see. He suggested the possibility of me being a doctor.”

Watkins took the challenge and in May 1966 became the first African-American ever to be admitted to VUSM. He learned of his acceptance from a front-page headline in the *Nashville Tennessean*.

“It was a complex experience with incredible beauty, but also challenges and

These days, the cardiac surgeon’s heart lies with improving postdoctoral training and diversity in medical education.

some negativity,” Watkins says of his Vanderbilt years. “The beauty was meeting people like John Tarpley (a classmate), and faculty who were great teachers, who embraced me in a way you’d never forget. It was academically challenging. I barely passed my first biochemistry exam.

“There was also negativity,” Watkins adds. “I remember the use of the ‘N’ word by occasional patients and occasional students. Also by occasional faculty.”

Worse, Watkins had water and feces thrown on him from the fourth floor of Curry Hall, where he kept a picture of Martin Luther King Jr. on his dorm room door. His saddest memory of that time was returning to Curry Hall the day Dr. King was assassinated.

“Not all the students in Curry Hall were as disappointed and devastated as I,” Watkins says. “I could tell by what they wrote on the door — ‘We finally got the coon.’”

By the time he had earned his M.D., however, Watkins had made many friends. He considered staying at Vanderbilt for residency, but the chief of surgery provided him with a strong recommendation to Johns Hopkins. Watkins arrived there in the fall of 1970.

Three years later Watkins interrupted his training at Johns Hopkins to do cardiac research at Harvard Medical School. There, after months of investigation, he defined the role of the renin-angiotensin system in congestive heart failure. His research ultimately led to the use of angiotensin blockers in the treatment of heart failure.

Watkins credits VUSM with his love for research.

“Vanderbilt had a lot of research faculty,” Watkins explains. “I liked their quest for new knowledge in addition to

the clinical knowledge. Research is important because that’s the way people push the cutting edge of understanding disease, genes, devices, drugs.”

In 1978 Watkins joined the Hopkins faculty as an assistant professor of Surgery. Within months he embarked on the groundbreaking work that launched his career and has saved the lives of thousands of patients who suffer from cardiac arrhythmia.

LIFE’S WORK

On Feb. 4, 1980, Watkins performed the world’s first surgical implantation of an Automatic Implantable Defibrillator (AID) in a 54-year-old California woman who would otherwise have died from cardiac arrest.

The AID automatically detects irregular rhythms and shocks the heart back to life. Its inventor, Israeli cardiologist Michel Mirowski, brought the device to Johns Hopkins for research and testing. Although Watkins was a junior faculty member at the time, his mentor recommended that he work with Mirowski on the project.

“I did the early animal work,” Watkins says. “Then in 1980 the FDA approved the implantation of the device in a human. That first operation sure was something.”

Watkins explains that after implanting the AID, he had to stop the patient’s heart to see if the device would work. “We’re taught to restart the heart, but here we had to stop it. It took what seemed a long time. The device was supposed to fire in 20 seconds, but it took 30 to 35 seconds. We almost used external defibrillation, but finally it fired and started. People almost cheered.”

Watkins notes that there have been problems over the years with AID leads

Left: Levi Watkins, M.D., in his 1966 class composite; Right: Watkins, left, greets NFL quarterback Bart Starr in 1998. Looking on are Harry Jacobson, M.D., (second from left) and former VUSM dean John Chapman, M.D.



and infection, and that fellow cardiologists once criticized the procedure, thinking it would kill patients. “But we overcame all that,” he says. “The AID is implanted in several million people and its success is well known. I’ve gone full circle in that area, too.”

Balsler, now VUSM’s dean, trained as a cardiac anesthesiologist under Watkins and counts himself among those fortunate individuals to benefit from Watkins’ mentoring and friendship. “His willingness to take the extra time to truly know and elevate those of us who cross his path is very special,” says Balsler. “He is always there when you need him ... sometimes before you even realize he is watching.”

COMMITMENT TO DIVERSITY

These days, the cardiac surgeon’s heart lies with improving postdoctoral training and diversity in medical education. He travels the country every year in an intensive drive to locate and recruit the best men and women from backgrounds under-represented in medicine.

“I do recruiting at all levels — students, postdocs and faculty — every chance I get,” Watkins says. “While African-Americans have felt the brunt of segregation, we recruit African-Americans, Native American, Latinos — a host of minorities.”

According to VUSM’s Associate Dean for Diversity, George Hill, Ph.D., Watkins has made a tremendous difference in medical education by stressing the national importance of a diverse physician pool.

“He represents the leadership necessary to make progress,” Hill says. “You have to be prepared to work hard, sometimes against all odds to be successful. He is willing to take a stand on what he believes.”

As a member of the Board of Trust, Watkins was proud that the VUSM Class of 2012 was the most diverse ever admitted, with 20 of the 105 students belonging to minorities underrepresented in medicine and 12 hailing from 10 foreign countries. But Watkins feels the nation still has a long way to go in improving diversity.

“I’m very happy with Vanderbilt,” he says. “It took leadership and commitment, and I hope other schools will emulate Vanderbilt in this. When I saw those admission numbers I felt back once again — full circle.”

Watkins’s commitment to racial equality prompted him to initiate an annual birthday tribute to Martin Luther King Jr. at Johns Hopkins. The program, which honors King and focuses on global humanitarian issues, has featured such leaders as Desmond Tutu, Coretta Scott King, Rosa Parks, former Atlanta Mayor Andrew Young, and singer Harry Belafonte. Not surprisingly, Watkins counts them all among his close friends.

The surgeon chuckles when asked which of his famous friends has impressed him the most. “They all impress me equally,” he says with admirable diplomacy. “Bishop Tutu impressed me when I met him in Africa. We got to be great friends. Coretta Scott King, I knew all my life. We

had a great friendship. Rosa Parks, we were friends. I oversaw their health once I became a doctor. Andrew Young and Belafonte — they’re all equal — but brought different spices to my pie.”

Watkins lives in Baltimore, where he was named “Best Citizen” by the city’s mayor. He has been awarded four honorary doctorates and numerous other accolades, and in 1993, PBS showcased his life and work in a New Explorers series episode called “A Dream Fulfilled.”

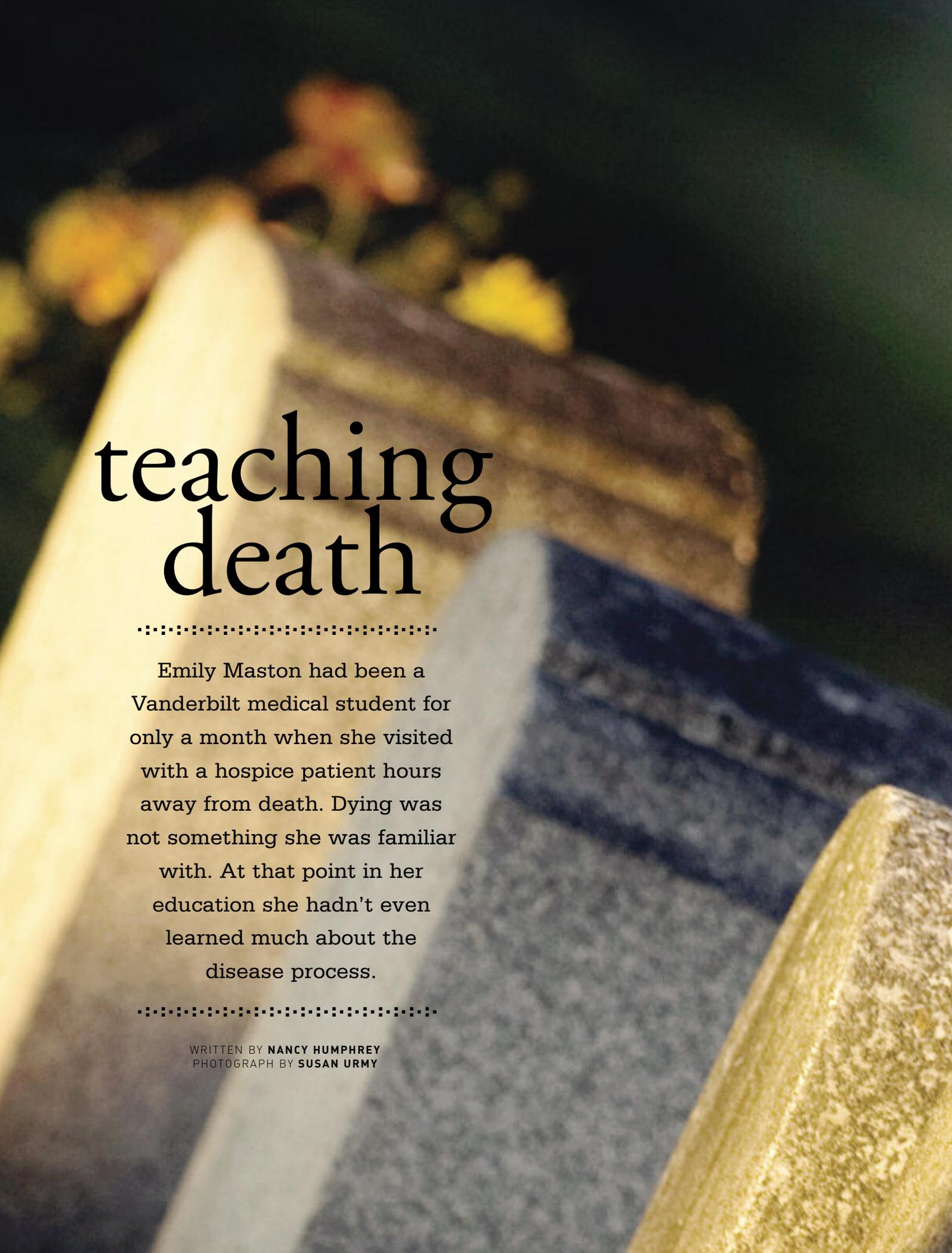
A life full of honors, hard work and travel has left Watkins little time for one of his loves: the water. “I had a boat until my life got so busy I had to sell it,” Watkins says. “The boat’s name was Amandala. I got the name when I went to South Africa and met Desmond Tutu. It means ‘power to the people.’ Most people thought it was a girlfriend’s name,” he adds a laugh.

Music also is important to Watkins. He played alto sax in his medical school days, then sold the instrument to buy a microscope.

But his greatest love is people, including numerous friends around the world and “a whole herd of non-genetic children” that he mentors. “My family is a larger family,” he explains. “Traveling, friendships, music, non-genetic children — all occupy a space in my life.”

Watkins says he’ll retire when he can. But even then, he says, “I’ll continue to serve. I’ll try to have fun, and to talk and touch and change people’s lives.”

May the circle be unbroken. **VM**



teaching death

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Emily Maston had been a Vanderbilt medical student for only a month when she visited with a hospice patient hours away from death. Dying was not something she was familiar with. At that point in her education she hadn't even learned much about the disease process.

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WRITTEN BY **NANCY HUMPHREY**
PHOTOGRAPH BY **SUSAN URMY**



Maston, 28, was participating in Vanderbilt University School of Medicine's Patient, Profession and Society course, and was on a rotation at Alive Hospice Residence Nashville with Melinda Henderson, M.D., one of the nonprofit agency's medical directors.

The patient, in his late 40s, had long gaps between each breath and was showing many of the impending signs of death. Despite the labored breathing and the immediacy of death, the room was peaceful, Maston recalls. She observed as Henderson spoke with the man's mother about his last days — that he had been lucid, able to enjoy his family, and do the last things he wanted to do, pain free. The doctor talked easily with the man's mother about her son's life that was being cut short.

"To me, in that environment, death didn't seem frightening, it seemed human," Maston said. "It was at the same time heartbreaking and hopeful, a celebration of life just as much as it was a mourning of death. The totality of life was acknowledged: the beginning, the end, the good, the bad, and that's something we all know. We're all human," the Southern California native said.

"I left feeling honored to have been there, and incredibly grateful for my life. It just put things into perspective," she said, adding that her experience prompted an extemporaneous visit to see her parents that weekend. "I was surprised at how deeply the experience affected me. I don't think I'll ever forget it actually."

Death — specifically how physicians should break bad news, process the information themselves, and relate to dying patients — is not a particular class at VUSM, but is instead woven throughout the curriculum and into teaching rounds by faculty members who believe that students should learn early that death and loss are an everyday part of the physician experience. Lessons learned early on can help the physicians-in-training be better at both breaking bad news to patients and their families and caring for a dying patient. The lessons can also help them learn how losing a patient will affect them, and what they can do to emotionally protect themselves.

"We in the hospice profession have accepted death as a natural extension of life," Henderson said. "Just like birth, it's commonplace. We grieve, of course, but in some cases we rejoice because suffering has ended," Henderson said.

When she explains what she does to others, they often ask if it's depressing, she said. "I tell them it's not. It's very rewarding," she said, recalling a conversation with a Vanderbilt third-year student who had witnessed a dying patient at Alive Hospice. "We left the room to discuss the patient's case. I could tell he (the

medical student) was taken aback by what we just saw. I was getting ready to go on with the medical details, but I saw his face, and we stopped and talked about it and how we do this work. I told him if we measure ourselves as physicians as death being failure, we'd always be unhappy and never measure up, because mortality is 100 percent. Death is not a failure because it's the ultimate end for all of us."

Henderson, who says she wasn't exposed to death in a medical setting until her geriatrics fellowship at Vanderbilt under James Powers, M.D., tells students it is OK to be emotional. "Just like the science we learn, this will be a learned process, too. How much emotion depends on the physician, the circumstance, the day," she says. "I can't think of an emotion that isn't acceptable. All of my physician partners have cried with families. We have some long-term patients who have become part of our family here. You may connect to someone because of their age or because of similar life experiences. And sometimes you don't even know why it touches you, but if it does, it's better to let that emotion show. Families are having those emotions too and they appreciate knowing that grieving is OK."

Frank Boehm, M.D., rounds with residents at Vanderbilt Hospital (top); Melinda Henderson, M.D., speaks with Alive Hospice patient Betty Butin, 77, as first-year medical student Emily Maston observes.

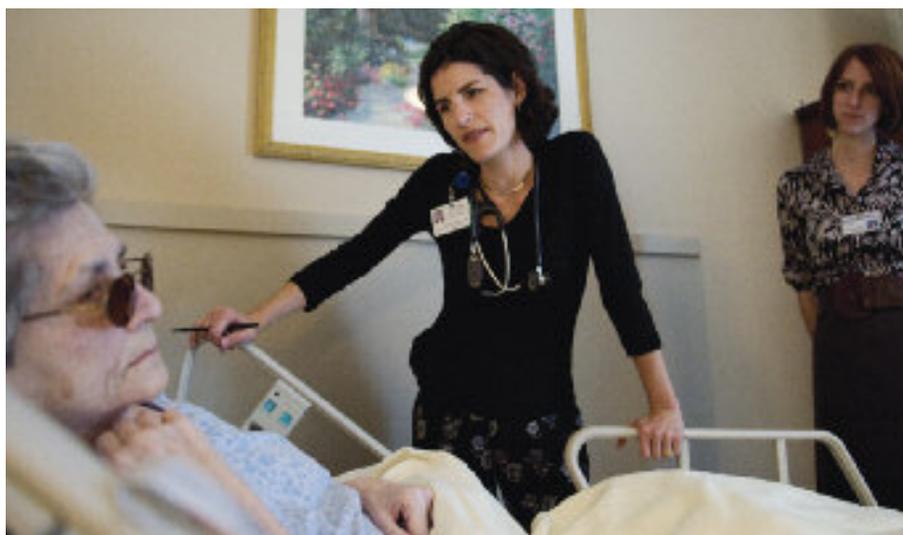


JOE HOWELL

Breaking bad news

Frank Boehm, M.D., admits he's emotional. He has felt things intensely since he was a child, he says. In his book, "Doctors Cry Too," he recalls an experience as a 26-year-old intern in obstetrics that has stayed with him throughout his career. During an emergency Caesarean section, both the mother and child died. As Boehm accompanied the woman's attending physician down the hall to deliver the bad news to the woman's husband and mother, he felt a lump forming in his throat. He no longer remembers what the physician said to the family, but he clearly remembers the "stunned expressions and chaotic disbelief" in their eyes as the dry-eyed attending delivered the bad news.

Although he tried not to, Boehm began to cry, and the woman's mother put her arm around him and thanked him for caring, reassuring him that the medical team had done all they could. "She had just lost her daughter and grandchild, and she was comforting me," Boehm recalls. He left the waiting room and retreated to the doctor's lounge where he was surprised to hear muffled sobbing — the attending physician had been able to hold back his tears around the family, but freely let go when alone.



JOE HOWELL

"It occurred to me that physicians show their grief in different ways, but I believe patients and their families really care how we feel about what happens to them," he said.

Boehm frequently has a "teaching moment" with residents by offering tips on how to break bad news to patients and their families. It's not a formal talk or lecture, but instead a note card he keeps in his pocket. "I'm not sure you can teach compassion, but at least you can teach showing compassion."

The tips:

- Prepare. Before you deliver bad news, select a private area. Turn your beeper and phone off. "Nothing is more

important at this time than the discussion you are about to have."

- Watch your body language. Boehm suggests breaking bad news sitting on the edge of the bed and looking the patient in the eye, or sitting down, facing a family, leaning forward making eye contact.
- Once the bad news has been broken, don't try to comfort with words. "You won't be able to do it," Boehm said. "The only thing that really works is 'I'm so very sorry.' Saying things like 'I know how you feel' doesn't work, because you don't know how they feel even if you've had a loss."

“I’m not sure you can teach compassion, but at least you can teach *showing* compassion.”



- It’s OK to touch patients, to give them a hug, to put your arm around them. “They want to know that you care what is happening to them.”
- Use “speak back.” Ask the patient, “What did you hear me say?” not “Do you have questions?” Frequently patients stop listening after they hear statements like “You have cancer of the ovary. It’s spread to the lungs.”
- Finally, try to leave patients and their families with hope. Not hope for a cure, necessarily, but with the reassurance “I’ll be there for you.”

Weaving loss throughout the curriculum

Students at VUSM begin thinking about the end of life in the first-year “Patient, Profession and Society” course and through small group discussions following this course, said Bonnie Miller, M.D., associate dean for Undergraduate Medical Education. Electives in palliative care are offered, and students also spend some time discussing death and dying during the first two weeks of medical school in the Foundations of the Profession course.

Second-year students will learn to address quality of life issues in their Patient, Profession and Society course and more content is being added. Third-year students have intersessions in pain management and palliative care.

And with the help of Vanderbilt’s new standardized patient program, third-year students learn how to counsel

patients and their families. Working with standardized “actor” patients, the students practice discussions about complicated end-of-life issues, and then evaluate their own performances.

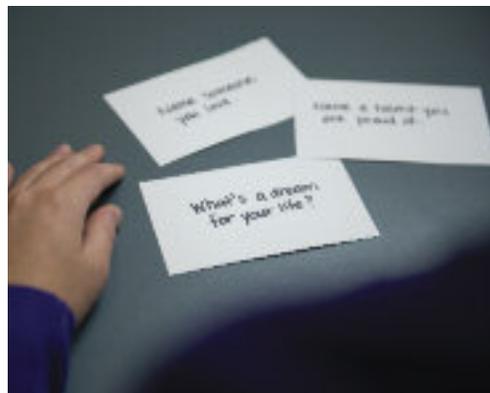
There are also small group discussions every six weeks in the third-year curriculum where students can meet to talk about difficult cases. “This allows students to process care episodes that are difficult to deal with,” Miller said. “Sometimes they don’t understand why certain decisions were made. Sometimes patients make decisions that go against the student’s own personal values. We hope these discussions allow our students to gain an understanding of these situations and also give them the opportunity to examine their own coping mechanisms when they are distressed by such episodes. Ultimately, these end-of-life decisions are the patients to make and we must learn to be supportive even when we might disagree.”

Miller said she has been asked by first-year students how they can protect themselves from the emotional havoc that losing patients can cause. “They’ve said that they’re afraid of getting so involved with patients that they get hurt over and over again, and they ask how they can avoid that without going too far to the other extreme, which is feeling nothing,” Miller said. “I tell them I’m far more concerned about them feeling nothing.”

Looking inward

Students in the second-year neuroscience course start the year in an unusual fashion for a course designed to address the cellular and anatomic description of the brain — on the first day they are asked to look inward.

Jeanette Norden, Ph.D., professor of Cell and Developmental Biology and a Master Science Teacher at VUSM, gives the students three index cards and asks



Notecards with questions like these play a role in Jeanette Norden’s second-year neuroscience course.



Jeanette Norden, Ph.D.

JOE HOWELL

them to write the name of a person they love on the first card, a talent they have on the second, and on the third, a dream they have for their life.

Norden tells them to put the cards face down on their desks, and to shuffle the cards, then to draw one. “I want them to imagine that whatever is on that card is gone and gone forever. I tell them that every day people walk into Vanderbilt Hospital and are either diagnosed with a terminal disease or they are accompanying a loved one who is. Either someone is

taken away from them, a talent is taken away, or dreams are changed in a profound way. Sometimes, people lose all three at the same time.”

Norden tells the students to think about assumptions they have for their own lives — that they will become a doctor, that they will marry and have children, that they will live long lives. “And they need to appreciate that other people have assumptions like that, too, and that they have responses to grief and loss which are very profound. They need to

think, ‘how would I feel if I were given this diagnosis,’ and that gives them at least a little insight.”

The second part of the exercise is that they are asked to call, e-mail or write the loved one they named on their index card. “One of the more surprising things is the name they put on the card is often someone they are estranged from — a sibling, a parent or a friend. When they imagine that they might not ever have the opportunity to see the person again, to say they’re sorry, it has a real impact on them.”

In neuroscience, she says, there are many kinds of loss, ranging from disability to death. Some people die suddenly, like from stroke, and others suffer from ailments where there is a slow decline, like Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), or Alzheimer's disease.

As often as possible Norden tries to bring in individuals or their family members whose lives have been affected by neurological disease. In the past the visitors have included two sets of parents who lost children to brain tumors, and a wife who tirelessly cared for her husband with Alzheimer's disease for six years.

"Students learn that we're all human beings facing death; we're all human beings facing loss. It happens to everybody — the poor, the good, the bad," Norden said. "This becomes more than doctor/patient. It brings it down to one human being coming in, telling their story to other human beings."

The speakers tell the students both the good and the bad they experienced with the medical profession during their loved ones' illness. "These aren't lectures from me on what they ought to do," Norden said. "These are multiple human beings coming in and saying 'we needed respect from doctors and nurses, for them to look at us when spoken to, for them to respond with kindness.'"

Norden reminds the students when breaking bad news or caring for dying patients, they will forever be part of the memory of the family members left behind.

"I simply say to the students, 'it is your choice to be either a good memory or a bad memory, but a memory you will be.'" **VM**

The four rules

by Biren Kamdar, M.D., PGYIII

WHEN I FIRST STARTED MEDICAL SCHOOL, I was aware that death would inevitably be a part of my day-to-day profession, but was clueless about physicians' interactions with real-life dying patients. As a third-year student caring for patients on the wards, critical end-of-life discussions and the death of patients seemed to occur behind the scenes while I attended mandatory medical student lectures or after I had already gone home.

The reality of what I would face as a physician became more evident during a risk management course during my final year of medical school. This lecture series provided us an overview of medical pitfalls including medication error, improper documentation, and malpractice litigation. Interestingly, I learned that practitioners with the most effective communication skills were sued the least — not necessarily those who graduated at the top of their class or with the strongest clinical acumen. This lesson was especially true in the setting of death or when breaking bad news, where the rules were simple: 1) choose a quiet location without disturbances — i.e. close the door and turn off your pager, 2) be a straight shooter — i.e. deliver the news honestly and without vagaries, 3) use simple phraseology — i.e. say "he is dead" rather than "he is not with us anymore," which can be easily misinterpreted, and 4) pause early and often to allow all news delivered to "sink in."

These four simple rules have guided me through my residency, not just in breaking bad news, but in almost all of my doctor-patient interactions. As an overworked house officer, it seems that the most grave, urgent situations find me at the most inopportune times. Regardless of the circumstance or outcome, these rules serve as a simple mantra and to this date have not let me down.

One such incident occurred soon after completing my internship, as a new resident rotating through the Medical Intensive Care Unit at the Nashville VA Hospital. A young veteran in his early 40s with newly diagnosed acute promyelocytic leukemia, a form of bone marrow cancer, was admitted to the ICU with signs and symptoms of shock. Although the patient was cheery and conversant with staff on arrival, he quickly developed multi-organ failure and slipped into a coma, his death imminent despite maximal medical therapy. His family members were in the hall outside the ICU, waiting for an update from his doctor — me. They had never met me, and worse, had no idea what fate just befell this person whom they loved so much.

As my intern scampered to place orders, recheck lab results, and



prepare for the inevitable, I was mentally preparing myself to talk with his family. “Remember the four rules,” I thought. I found a large, smiling group including his parents, two sisters, and brother eagerly awaiting my arrival. I introduced myself and settled into a quiet spot in the waiting room, telling them point blank that our patient had taken an unexpected turn for the worse and would surely die barring a miraculous turnaround. After processing the shocking news, his mother simply asked, “Can we see him while he is still alive?” “Of course,” I replied, promising to summon them in 15 minutes, just as soon as his room was tidied up by the nursing staff.

To my dismay, the patient lost a pulse and flat-lined the moment I returned to the ICU. In some futile clinical situations it would have been appropriate to let the patient pass peacefully, but since he was relatively young and previously healthy, he deserved every possible chance of survival. Moreover, I could not let his family down. We performed several cycles of CPR for 30 minutes, but he never regained a pulse. He expired less than two hours after his arrival in the ICU. His family would never be able to say their goodbyes.

I have had to break bad news several times, but never to the same people twice in a thirty minute time span. My head was swimming, but I once again retreated to my four rules. I took a deep breath and walked toward the waiting room. There his parents stood, composed, eagerly awaiting my permission to see their son. Instead of taking the family to the chaos of the ICU, I took them to the nearest conference room, my hands shaking on the doorknob, thankful that it was unlocked. The family knew something was wrong, but I fought to maintain my composure. After sitting them down I told them in my most

earnest demeanor that their loved one had arrested minutes after my previous conversation with them. Despite our efforts to revive him, we could not save him. He was dead.

To no surprise, the patient’s sisters fell to the ground, crying loudly in anguish, holding each other. The reaction of his parents surprised me. Using his cane, the patient’s father pulled himself up, walked over to me, and held out his hand. “Thank you for everything you did,” he said, shaking my hand. “You fought hard for our son. This must be very hard for you, too, and we appreciate your honesty.” I was shocked and impressed by this man’s strength. After hearing such tragic news about his son, he was thanking me? My overwhelming feelings of guilt and powerlessness were overcome by a sense of relief. At that point, everything and nothing made perfect sense.

I would be lying if I said I have not dealt with tragedy since that fateful day in the VA MICU — after all, it is a part of the job. Regardless of the scenario, I continue to have meaningful experiences when approaching these situations with compassion, strength, and, most importantly, honesty. Incidentally, after I complete my residency I will specialize in pulmonary and critical care medicine, a field where morbidity and mortality is the norm. While I look forward to using my training to save lives, I feel comfortable being the bearer of bad news in times where families are seeking compassion the most. To my amazement, I find that the most gracious patients and families are those dealing with bad news and loss. In the end, it is not the type of news that is delivered, but how it is delivered and by whom. As long as I stick to the four rules, the result is always a positive one. **VM**



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*The caged bird sings with a fearful trill
of things unknown but longed for still
and his tune is heard on the distant hill
for the caged bird sings of freedom.*

- Maya Angelou

Death Done Well

WRITTEN BY **KATHY WHITNEY**
ILLUSTRATION BY **CHRIS McALLISTER**

Life can change in the blink of an eye.

For Debbie Atkinson, that moment came Sept. 2, 2006. An accomplished equestrian, Atkinson, 49, was participating in the Kentucky Classic horse trials at Kentucky Horse Park in Lexington.

She was competing in the open intermediate division, galloping on the cross-country course, achieving that adrenaline rush she loved. As she approached a jump, her horse, Melancholy Blues, caught his legs at the welding wall and somersaulted. Atkinson fell from the horse and landed on the ground. She lay motionless and unconscious. Emergency Medical Technicians immediately tended to her, starting intravenous fluids on the course while waiting for a medical transport helicopter to arrive.

Physicians at the University of Kentucky Medical Center in Lexington recognized the severity of her condition shortly after she arrived — a high C-2 spinal cord injury. They placed Atkinson on a mechanical ventilator to keep her alive, and they waited for the swelling in her spine and neck to go down. Within a few days, her prognosis became clear. Atkinson, beloved riding instructor and coach, renowned competitor, proprietor of her own boarding and training stable, was now a quadriplegic. She had no feeling in or the ability to move anything below her neck. She could not breathe on her own. Her life had changed in an instant.

In October 2006

Atkinson left Lexington for Shepherd Spinal Center in Atlanta where she endured months of rehabilitation. She was discharged from Shepherd in January 2007 and headed home to Columbia, Ky., and a life full of new challenges.

For two years Atkinson and her devoted live-in companion of 17 years, Mike Wright, tried to enjoy the life they had. They lived on a large farm, enjoying the peace and serenity of their surroundings, along with their dogs and sheep. They placed Debbie's horses with other trainers. They kept up with friends as best as they could.

Atkinson said at first she was hopeful and willing to try this new life of hers.

"But it became pretty miserable," she said.

Confined to a wheelchair, with around-the-clock care, she and Wright had no privacy. Someone was in the house with them at all times. Hired help tended to her most basic needs, whether it was to make sure her ventilator breathing tube didn't pop out, which it did once, or to brush her teeth for her. Aides would come and go, some more reliable than others.

In the spring of 2008 Atkinson developed a fever and a urinary tract infection (UTI). Wright immediately took her to the doctor, who started her

on antibiotics and fluids. He stayed up with her all day and into the night. They both fell asleep around midnight. Wright awoke to find Atkinson in a coma.

"Someone in her condition is so fragile. You always have to worry about UTI; you always have to worry about respiratory infections; you always have to worry about bedsores. You have to be super diligent 24 hours a day," Wright said. "You can never fold your hands and rest and say, 'I've done a good job.' When something starts, it's a cascade of events, like an avalanche."

Atkinson developed sepsis, a life-threatening illness, and was transferred to Vanderbilt University Medical Center where she was admitted to the Medical Intensive Care Unit (MICU) on 7 South and given a 50/50 chance of surviving the first 24 hours. Robert Miller, M.D., assistant professor of Clinical Medicine, was on call that week and was responsible for her care. Atkinson survived, and she left the MICU 10 days later and returned home to Kentucky. That would not be her last visit to 7 South.

The right decision for her

Atkinson said she considered going off life support an option "from day one." After her brush with death, in late summer, she began to consider it more seriously. She and Wright had long discussions about it. They consulted her brother, Frank Miller, Ph.D., a bioethicist at the National Institutes of Health.

"As her brother, I was not surprised at the decision. As a bioethicist it was important for me to understand her reasoning and to make sure that she was not making an impulsive decision and that she had thought about what she might possibly do to make her life seem worth living," he said. "I was fully satisfied that she was making the right decision for her, given her circumstances. It was also important for me as a brother and bioethicist to do what I could to help her develop and implement a reasonable plan."

In August, Frank Miller, Atkinson and Wright contacted their local hospice and relayed Atkinson's wishes to have the ventilator removed so she could die.

"If I was able to get better or there was some miracle, I would go on and try. But there isn't, and it's more frustrating every day not to be able to do what I want to do," Atkinson said.

After several discussions with hospice, which ultimately was unable to fulfill Atkinson's request, Frank Miller placed a call to Vanderbilt.

Atkinson's brother remembered Robert Miller, M.D., from when he took care of his sister in the MICU. He called Miller at his office in Medical Center East and asked if Vanderbilt would consider taking his sister's case. Would Vanderbilt allow his sister to die when she wanted, the way she wanted?

"I encouraged them to come to Vanderbilt because I knew that we could make sure this process was done right," said Robert Miller. "I felt that if any institution could do it well, it would be here."

So began the exchange of e-mails, phone calls and meetings among physicians, ethicists, lawyers and members of the Palliative Care Team at Vanderbilt. No one could recall a specific case of admitting a patient to the hospital for the sole purpose of removing a ventilator to allow that patient to die.

"This was the first time I had ever been involved in a case like this," said Mohana Karlekar, M.D., assistant professor of Medicine and medical director of

VUMC's Palliative Care Team, a multidisciplinary approach to pain and symptom management as well as quality of life improvement for patients at the end of life.

From a legal standpoint, Vanderbilt was in the clear.

"The right to refuse treatment, even if it means that you die as a consequence, is such a well-established principle in law and in ethics that people don't think an awful lot about it," said Larry Churchill, Ph.D., Stahlman Professor of Medical Ethics. "Most of the issues come up because a family is conflicted about it or divided or someone on the staff has a problem about it. It's not ethically new ground."

On Sept. 24 and 25, Miller, Karlekar and Churchill met with the nurses and residents on the MICU to tell them that Atkinson would be coming to the unit.

"We were going to do this up front," Miller said. "We were not going to lie about her admission or her reason. She was coming in to the hospital, and we got the ICU bed reserved."

There were very few questions from the staff, but a nurse raised her hand and asked the one that was on the back of everyone's mind: how is this different from physician-assisted suicide?

"If you go on life support, you have the right to come off," Miller said. "This is not suicide. You use life support for a defined purpose. It's either to save a life or to preserve the quality of life that you expect. If it doesn't meet that need, you're not obligated to stay on it. That doesn't mean it's easy for you or for your family or for your physician to take you off it, but that's part of our obligation."

Karlekar further clarified the difference.

"What is unique about Debbie's case is she was in her steady state of good health given her injury, and she chose to take back control. The horseback riding accident was her fatal injury, and she would have died two years ago if we [health care] hadn't intervened."

In their meeting with the staff, Robert Miller and Karlekar laid out a plan. Having worked in the MICU for years, Miller knew that the final days of a



(Left) Debbie Atkinson on her horse, Melancholy Blues. Atkinson suffered a spinal cord injury in an equestrian accident. (Right) Atkinson and her husband Mike Wright at their home in Columbia, Ky.



patient's life could go horribly awry if the family does not have consensus or if the medical team is not properly prepared. The team would leave nothing to chance.

The final weeks

Atkinson, on her last full day of life, reflected on what life has been like since she made her decision.

"Actually, a lot better. Because I sort of became confident about what I decided, that it was right for me," she said. "We used to have around-the-clock care, and I didn't really like it. I knew I had to have it. We cut down on that."

With limited time left, she let most of her aides go. For two months, Wright was Atkinson's primary caregiver from 5 in the afternoon until 7 in the morning and on the weekends.

"We've had a lot to talk about and discuss. That aspect of it (the past two months) has been good," Wright said.

Family members, including Atkinson's brother, Frank, visited in early September. Two close friends came to the farm to say goodbye.

"It was good and it was hard at the same time," Atkinson said.

There was just one more thing Wright wanted to do. He asked Atkinson for a favor. She complied. On Friday,

Sept. 26, four days before her life was to end, and after 17 years together, Wright and Atkinson were married.

"We've probably been more married for a much longer time than most couples who have the certificate are. This lady is my soul mate. My hero. My everything all in one," Wright said.

Making sure

On Monday, Sept. 29, Wright and Atkinson made the two-hour drive from Columbia to Nashville. They stopped at a favorite restaurant to enjoy a last meal together. They arrived on 7 South in the early afternoon. They got settled in room 11 on the MICU.

Residents and the attending physician performed a medical evaluation. Amanda Wilson, M.D., assistant director of the Consultation Psychiatry Service, met with Atkinson to assess her capacity to make the decision to discontinue ventilator support.

"This assessment was as a vital part of providing her care as it was crucial to determine whether or not her decision making ability was being impaired by outside forces, psychiatric disease, or other psychosocial stressors," Wilson said. "One very important thing Dr. Karlekar and I wanted to exclude was

whether depression was influencing her decision making.”

If Wilson concluded Atkinson lacked capacity, for whatever reason, to make this decision, then the medical team would not have been able to move forward with the plan of discontinuing ventilator support.

“I found Debbie to be a fiercely independent woman who felt that her quality of life was extremely limited,” Wilson said. “She did not meet criteria for any major psychiatric disease and was not depressed. Her intentions were clear — she no longer wished to live with the assistance of a ventilator and appreciated that without it, she would not live.”

Wright and Atkinson spent the evening alone in room 11 on 7 South. She lay in the hospital bed, and he on the pull-out bed beside her. It was quiet save for the whoosh-whoosh of the ventilator.

On Tuesday morning, Karlekar and the MICU team met with Atkinson and Wright again and discussed with her how the morning would progress.

At 11:30 a.m., Chris Webb, R.N., administered the first doses of morphine and Versed, a sedative. Wright stroked his wife’s hair and held her hand. Within a few minutes, Atkinson was asleep.

Confident that she was comfortable, in no pain, third-year internal medicine resident, Joshua Fessel, M.D., Ph.D., pressed the button on the ventilator, and turned it off. He gently disconnected Atkinson from the ventilator. Wright sat down in the chair by the bed and waited. Atkinson died peacefully at 11:55 a.m.

“It was seamless, it was peaceful,” Karlekar said, still emotional two days later. “I know that day we freed her of the body that stopped working for her. We set her free the right way.”

When do we stop?

VUMC is a leader in palliative care, a specialty still in its infancy that focuses on patients who are facing life-threatening illness or injury, at any stage in the continuum of disease.

American hospitals are historically about rescue medicine — saving people. As early as the 1950s, doctors working with ventilators were asking if it was morally permissible to stop using life support. In the 1960s, as intensive care unit technology evolved, the question of “when do we stop?” became an important one to both health care providers and, to a lesser extent, policymakers.

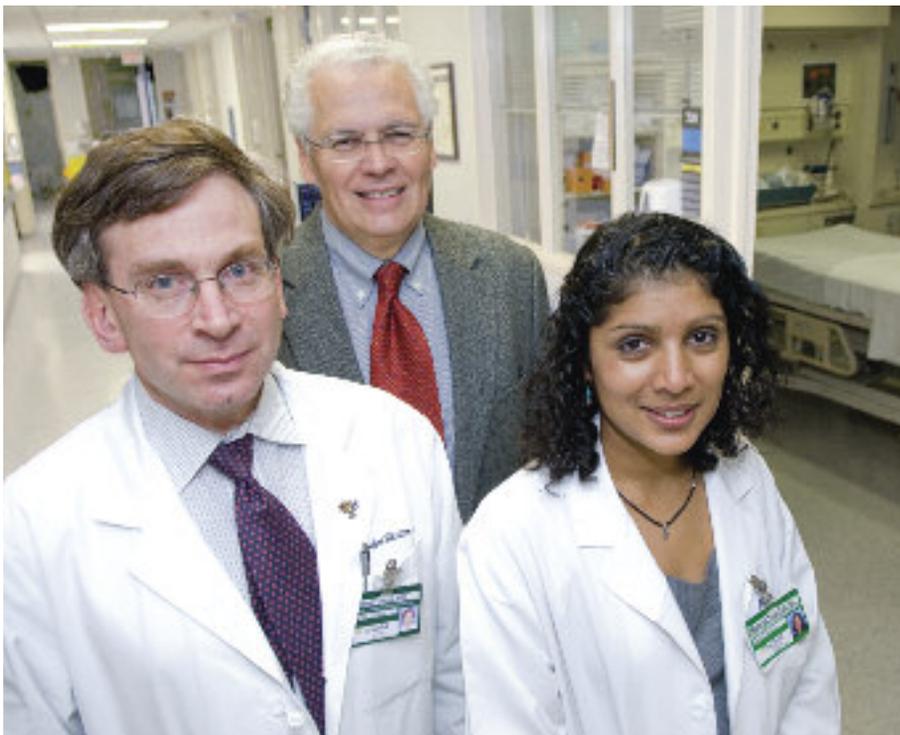
“Lawyers got pulled in to the discussion because of the question of whether it was legal to stop treatment if stopping it meant someone was going to die. Is it legal not to use treatment you have available to keep someone from dying?” said Elizabeth Heitman, Ph.D., associate professor of Medicine in the Center for Biomedical Ethics and Society and co-chair of the VUMC Ethics Committee. “This push to use available technology became known as the technological imperative: if the machine is there, we need to use it. Ventilators are a prime example.”

A mechanical ventilator can save your life, perhaps prolonging it for a week, a year, or 20 years. “It will save your life” became the mantra of end-of-life care in many ways, she said.

“The technological imperative in the hospital said you can never stop until you’ve run out of options. At the same time, there were an increasing number of options, so there was always one more thing that could be done for a dying patient.”

Health care providers are trained to save lives. Hospitals advertise their low mortality rates and compare them to other hospitals. The fewer people who die in the hospital, the better, goes traditional thinking.

“Saying that life support saves lives is false advertising with regards to end of life care. Ultimately, the life you save is going



Robert Miller, M.D., Larry Churchill, Ph.D., and Mohana Karlekar, M.D., consulted on the medical and ethical issues of disconnecting Debbie Atkinson’s ventilator.

to end and planning for that end is part of good medicine for people who have serious chronic illnesses,” Heitman said.

Many of the technological questions that health care providers were raising became patient-based in the 1970s when families began to watch loved ones die in the intensive care units, unable to get off life support. Patients and families increasingly challenged medical decisions to treat terminal illness indefinitely. The introduction of advance directives created legal documentation of patients’ refusal of life support. Today, many Vanderbilt patients have directives that help ensure they get the kind of end-of-life care they want when they are too sick to express their wishes.

In the 1980 Florida case of Satz vs. Perlmutter, a terminally ill, ventilator-dependent patient sued to have his ventilator disconnected. The patient suffered from amyotrophic lateral sclerosis (ALS) and was unable to remove the ventilator himself, so he asked a physician to do it for him. The Florida Supreme Court ruled in favor of the patient.

The court decided that this was not suicide because the cause of death was ALS, not the actions of the patient and doctor.

“This is something every health care institution ought to be willing to do if it has the skill to do it,” Churchill said. “Every case has to be considered on its own merits. Every person’s situation is very different. The fact that this (Atkinson’s death) was so carefully done, so professionally done, makes me feel really good about working at Vanderbilt.”

Has Vanderbilt found itself on a slippery slope? It’s irrelevant, according to Karlekar.

“As physicians it would be wrong to say, ‘we could help you, but we’re not going to.’ We have to be willing to do these really difficult things,” Karlekar said. “We didn’t just say we’d do it and then write the orders and let it go. We really spent the time to look at every variable to make sure this was the best transition for Debbie.” **VM**

TOO YOUNG TO DECIDE

Medical ethics, as it relates to the end of life, takes on a different meaning when it comes to pediatric patients.

Legally, children don’t have the autonomy to make decisions about their care until they reach the age of 18. As is usually the case where ethics are concerned, there is a grey area. Once a child understands what death means and has an adult perception of death, which usually happens around 8 or 9 years of age, health care providers begin to listen to them as they express their concerns about continuing treatment.

“We want a child who is going through treatment after treatment to have a say about his needs,” said Mary Jo Gilmer, Ph.D., M.B.A. “We involve parents in that discussion. We talk to parents about the most loving thing they can do for their child. Is it prolonging his life even though it is a difficult and tortuous life, or is it providing one special thing the child wants to do before he dies?”

“In talking with parents and other family members, hopefully, we can help the family come to a consensus about what is the most loving thing to do.”

Gilmer was a co-leader in development of the Pediatric Advanced Comfort Team (PACT) at the Monroe Carell Jr. Children’s Hospital at Vanderbilt and a professor at Vanderbilt School of Nursing. She is currently director of the Clinical Management Program.

She helps guide families as they decide whether to continue with treatment when a child’s prognosis is poor. It is a difficult process, at best.

Kimberly and Dave Barboza faced a lot of stress when deciding on their infant son Joshua’s treatment options. Joshua was diagnosed in utero with hypoplastic left heart syndrome, a condition that is not compatible with life without three complex, invasive heart surgeries. Each surgery carries a 50/50 chance of survival.

“We wanted advice from nurses, the palliative care team and family members, but in the end, it was our decision whether to pursue treatment or not for our son,” Kimberly said.

They opted for treatment. Joshua passed away in the Neonatal Intensive Care Unit at the age of 3 months, following his first heart surgery, but Kimberly and Dave are satisfied with the decision they made and appreciate the support they received from Gilmer and PACT.

“When health care can fix something, everyone is happy. But there are a number of things we just can’t fix, and then we feel like failures as health care providers,” Gilmer said. “In a great children’s hospital like Vanderbilt’s, there still are times when we can’t fix something. That’s when we need to walk with families down that path on their difficult journey.”

- KATHY WHITNEY

“ Tomorrow, and tomorrow, and tomorrow,
Creeps in this petty pace from day to day
To the last syllable of recorded time,
And all our yesterdays have lighted fools
The way to dusty death. Out, out, brief candle!”

– William Shakespeare

Tomorrow

by Erin Brady Worsham

I have procrastinated all my life.

There always seemed to be plenty of tomorrows to get things done.

Like in high school, when I put off writing my senior term paper until the week before it was due. Or in college, when I hopped between majors before settling on Theater and German just months before graduation.

But in 1994, when a doctor told me I was going to die, I couldn't put it off. I had run out of tomorrows. I was diagnosed with amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) and given maybe three years to live. I was 36.

Ironically, I had really started to get my life together. I was going to art school and felt I had found my real calling as an artist, like my mother. With a dear priest friend I was doing some much-needed housecleaning of ancient emotional baggage. I had accepted the possibility that I wasn't meant to be a mother, since my husband, Curry, and I had tried for six years to have a baby without success. I was nearing a place of peace in my life.

My newfound peace flew out the window on Sept. 7, 1994. I looked at my life and saw an endless series of wasted yesterdays. It was too late to change that. I went home to die.

That was 14 years ago and I'm still here. The ALS has ravaged my body. I'm paralyzed below the neck and have only minimal movement above. I eat with a feeding tube. I breathe with a ventilator. I drool.

But my spirit is strong. I believe the reason for my longevity is threefold; I love my God, I love my husband, and I love and cherish our son, Daniel Curry Worsham, who was born exactly nine months after my diagnosis.

It was never my intention to use a ventilator until I learned I was pregnant. Then I was like any other mother. I wanted to be a part of my child's life and I was willing to make concessions to do it. Daniel was 2 when I stopped breathing on Thanksgiving Day in 1997.

Choosing to live with the ventilator did not ensure that my family and I lived happily ever after. Our lives have been full of challenges, which come with the territory when concessions are made. Living life on your own terms is not free.

While the ALS has affected me physically, it has impacted Curry and Daniel equally in different ways. Some have been painful for me to see, knowing that I



Erin Brady Worsham with her husband, Curry, and son, Daniel.

am the cause. I have had ALS friends who chose not to go on the ventilator, because they didn't want to be a burden on their families. I am not that noble.

Curry has not had a full night's sleep in 14 years. I have seen it take its toll on his body. At the end of the day he is physically and mentally exhausted.

When Daniel was small, Curry could not work because he was taking care of both of us. Our growing debt weighed heavily on him, but he never considered putting me in a nursing home.

When I went on the ventilator in 1997, we fought for and eventually won nursing through the state. It wasn't full-time, but it allowed Curry to leave the house and work. He could sleep without worrying about not hearing my ventilator alarm, which could be fatal.

It's hard enough making the transition from boyfriend-girlfriend to husband-wife. It's even harder to transition from husband-wife to caregiver-patient. I have had to accept that Curry needs time away from me. This was difficult because he's my best friend.

Sometimes he gets an alumni newsletter from his high school. Many of his classmates went on to become prominent people in their different fields. I know he thinks about what he could have done had our lives been different. But in the great scheme of things, in those things that really matter with God, Curry Worsham is the most successful person I know.

It was bittersweet for me to watch Daniel grow in the realization that his Mom was not like other mothers. When he was very young, we would pick up some Whitt's Bar-B-Q on Whitt-nesday and take Daniel to the park.

One day Daniel played with his two newfound pals until it was time for us to go. I heard him say, "Don't you want to meet my Mom?" They took one look at me sitting in my wheelchair with the trachea tube coming out of my neck and ran the other way. "She's a nice girl," Daniel called after them. My heart broke, but I was filled with love for my son.

In kindergarten some of the boys were laughing about me in front of Daniel. The teacher wisely took them out

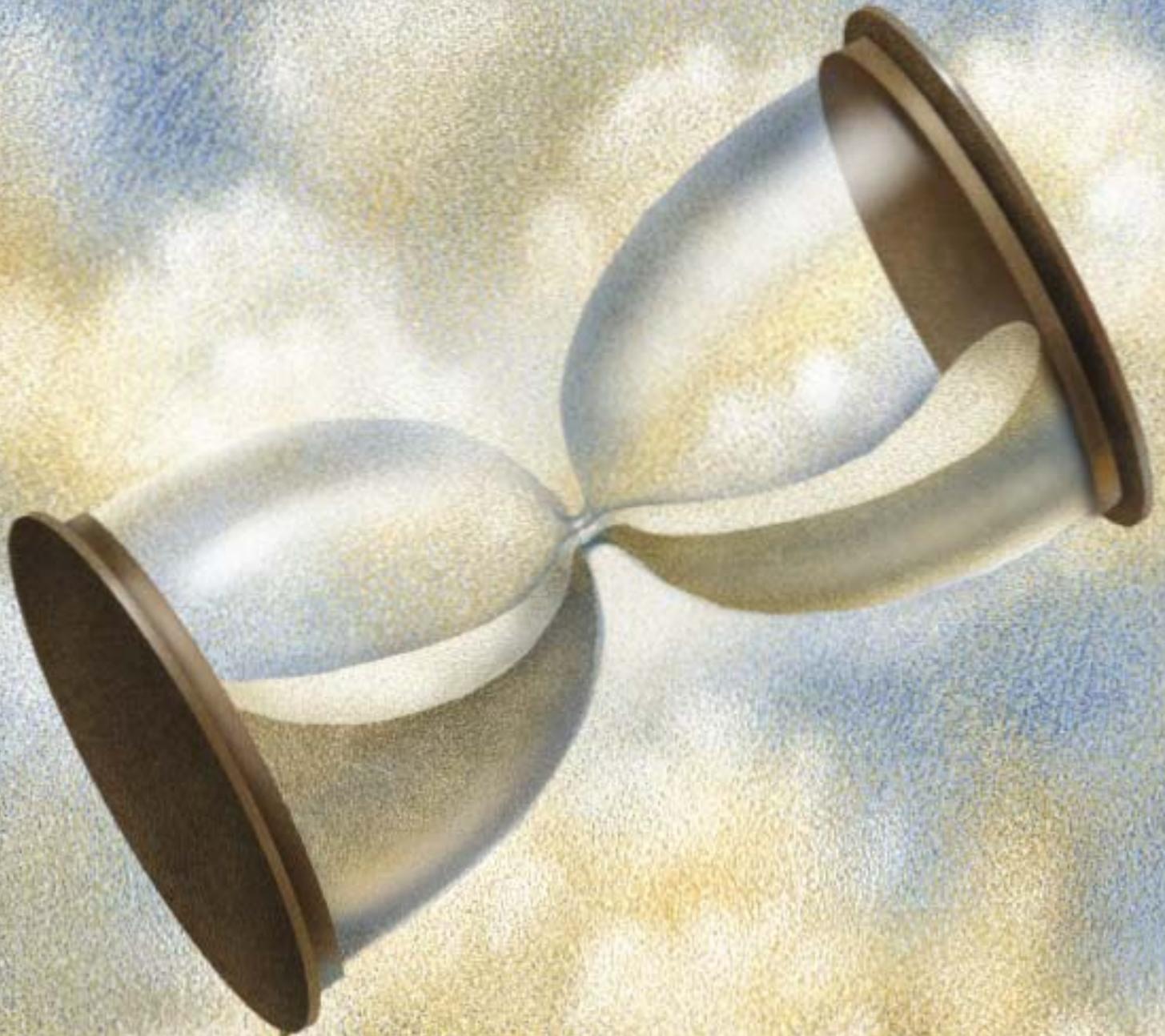
into the hall and let him talk to them. He told them I was like them and they should ask him if they had any questions.

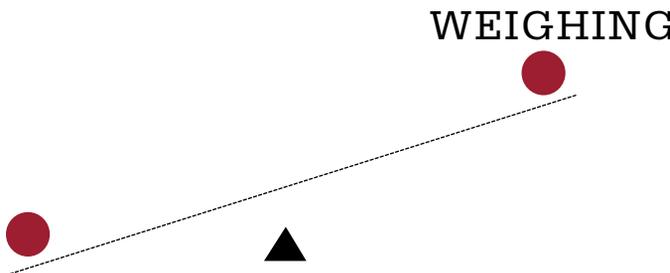
Daniel is 13 now. He doesn't cut me any slack or treat me any differently than anyone else. Growing up with a mother with a disability has made him a more accepting person. I will never regret that.

What has been more difficult to deal with is the loss of friends. I have often said that ALS won't kill you, the loneliness will. When your death seems imminent, people flock to offer support, but when you keep on living, they drift away. It's not mean-spirited. It's just human nature.

I thank God for the Internet, which has enabled me to be a freelance artist and writer. I've made some good friends through e-mail, as well as on SkiSpace and MySpace. They have enriched my life.

Strangely enough, I have been able to come to terms with this greedy disease after it hit me with everything it had. There are no more unknowns. And, at least metaphorically, I am still standing. Standing and eager to face whatever tomorrows lie ahead. **vm**





WEIGHING

end-of-life care

For the chronically ill, health care can become an unending maze of expensive interventions with certain risks and uncertain benefits

Health care researchers are questioning whether more is better and suggesting that standardizing care for the chronically ill in the last two years of life will reduce expenditures without sacrificing patient outcomes or satisfaction. So as the health care system faces decades of growth in the number of aged patients, Americans might be asked to respond to this sobering question: How do we want to live, and how do we want to die?

“I think it’s very important that we leave cost out of the equation in considering how we care for people at the end of life,” says Roy Elam, M.D. The health care community must never support choices that appear to hasten death in order to save money, he says.

Instead, Elam believes runaway expenditures might be tamed by this undervalued health care intervention: a sincere conversation. Physicians and other

health care professionals need to take more time to talk with seriously ill patients about all their options, he says, including pain management and end-of-life comfort care — instead of more tests and treatments — when they feel the time is right.

“We find that palliative care for hospitalized patients definitely saves money, and the patient satisfaction is frequently higher than on other units of the hospital,” Elam explains. Studies that show only marginal cost savings from hospice care usually fail to compare appropriate time periods, he contends. Hospice care is most common in the last days of life, and comparisons that reflect that, show it costs less than other interventions and is embraced by patients and their families at the same time, he explains.

“Better care costs less — that’s important,” observes Elam, an associate professor of Medicine.

WRITTEN BY **ELIZABETH OLDER**
ILLUSTRATION BY **DAVE CUTLER**

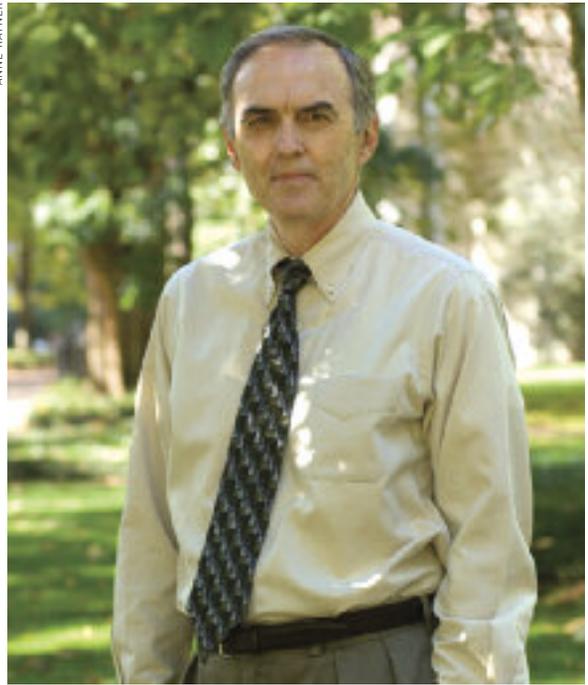
● **Too much of a good thing?**

That assertion — that better care costs less — is the seemingly counterintuitive research outcome of the Dartmouth Atlas Project. The 2008 study found that for chronically ill Medicare patients more health care interventions — doctors’ visits, hospital stays and the like — increased spending but did not produce better patient outcomes or satisfaction. Two-thirds of patients in the study were diagnosed with one or more of these diseases — cancer, congestive heart failure and chronic lung disease.

“The extent of variation in Medicare spending, and the evidence that more care does not result in better outcomes, should lead us to ask if some chronically ill Americans are getting more care than they or their families actually want or need,” said Risa Lavizzo-Mourey, M.D., M.B.A. Lavizzo-Mourey is president and chief executive officer of the Robert Wood Johnson Foundation, which provided principal funding for the research project done by the Institute for Health Policy and Clinical Practice at Dartmouth Medical School.

The Dartmouth Atlas Project found huge variations in dollars spent on chronically ill Medicare patients in the last two years of life, from a high of \$59,379 per patient in New Jersey to a low of \$32,523 per patient in North Dakota. In Tennessee, expenditures hit \$42,478; the U.S. average was \$46,412. The number of services patients received was driven by the number of health care providers and facilities in the area. One-third of annual Medicare dollars are expended on chronically ill patients who are in the last two years of their lives, the study says. Spending on Medicare and health care overall is predicted to skyrocket in the next decade as the baby boomers age.

ANNE BAYNER



W. Kip Viscusi, Ph.D.

“We need to benchmark the best systems and use policy to drive providers toward the benchmark by holding them accountable for the volume of services they deliver,” asserted study co-author Elliott S. Fisher, M.D., M.P.H., and director of the Center for Health Policy Research in the Dartmouth Institute. The study suggests academic medical centers and federal agencies need to lead the way by conducting research on when chronically ill people should be hospitalized, referred to specialists and recommended for other tests, treatments and services.

● **The health care cost-benefit conundrum**

As the outsized baby boom generation moves through the health care system in the next few decades, some observers suggest that studies like the Dartmouth Atlas Project could be used to promote health care allocation in America. People develop more chronic health problems and use more health care dollars as they age; life expectancy has continued to climb in the United States

to a record high of 78.1 years. By 2030, the number of Americans age 65 and older is expected to double to 71 million, which will account for 20 percent of the U.S. population.

Government policymakers already balance the cost of saving lives against the benefit gained based on economic models that weigh identified amounts of risk against people’s willingness to pay to contain it. Vanderbilt economist W. Kip Viscusi, Ph.D., has done a lot of these analyses, which rely on input from people who will be affected to quantify the trade-off between money and small risks of death. He understands that might make some people uncomfortable.

“When people hear that economists are putting a dollar value on human life, they imagine how we are conceptualizing that number,” observes Viscusi, the co-director of Vanderbilt’s new Ph.D. Program in Law and Economics and the first University Distinguished Professor.

“All the numbers I use are based on the preferences of people who actually face risk,” explains Viscusi, one of the world’s leading experts on cost-benefit analysis whose estimates of the value of risks to life

and health have been used extensively by the Environmental Protection Agency, the Federal Aviation Administration and other government regulators. “What matters is people’s preferences, what they say, their willingness to pay for risk reduction. You ask the people who are affected.”

While health care economic models often use “quality-of-life” adjustments that reduce the value of saving the lives of older people because they have more health problems and less time to live, Viscusi

thinks this methodology is misguided and without theoretical basis. Research shows that neither patients with a chronic illness nor older individuals are willing to take big risks with their personal safety, an indication, Viscusi says, that they continue to place a high value on their lives regardless of physical limitations or aging.

“There’s a danger that people would get shortchanged if you do the raw calculation based on remaining life expectancy,” he says.

And Viscusi points out that health care studies that look backward two years from when patients die — as the Dartmouth Atlas Project does — don’t account for any positive results of expenditures or for how physicians would even know their patients had only 24 months to live when care decisions were being made.

“For decades economists have cited expenditures in the last two years of life as a sign of wasteful medical expenditures,” Viscusi observes. “Raising this issue has

No longer a death sentence

When Ken Lucero was diagnosed with human immunodeficiency virus (HIV) in 1988, he prepared to die. Two decades later, his story shows how treatment advances have changed what once were terminal diseases into chronic illnesses that people live with for years, often until they die from other causes.

“Back then HIV or AIDS was a death sentence,” recalls Lucero. “I had friends dropping like flies.”

In 2007, after struggling for several years with health problems and consulting with 12 specialists, Lucero’s prognosis turned grim: six months to live. He moved from Dallas back to Lawrenceburg to be near family and within three weeks was treated at Vanderbilt University Medical Center by Comprehensive Care Center Medical Director Stephen Raffanti, M.D., associate professor of Medicine.

“He said, ‘I think there’s something else going on with you,’” Lucero recalls. He had

lost vision in his left eye, one clue that informed a diagnosis of infection at the base of the brain and a related partial blockage of the carotid artery. After a delicate surgery Lucero improved, but other health hurdles — including a PICC line infection — brought him to Vanderbilt again early this year.

“Nobody knew if I was going to live or die,” he says. “I couldn’t feed myself, I couldn’t dress myself, I couldn’t bathe myself.”

That’s when Raffanti asked him if he wanted to go home, and if he wanted to continue liquid nutrition. His answers were “yes” to going home, and “no” to liquid nutrition.

Back in Lawrenceburg, Tenn., Lucero continued on antibiotics and regained strength as he was cared for by his mother and two nurses — one his sister. By his April appointment at the Center, everyone was amazed at his condition.

In 1994, the year the Comprehensive Care Center opened, Raffanti says he lost 350 patients.

“It was really just a chronically progressive illness,” he recalls, and about the best doctors could do was to get to know their patients and understand their wishes for deathbed care.

“We got very good at diagnosing the complications of AIDS,” he says, many of which were relatively rare until then. “We got much better at treating them.”

Then, in 1996 new drug treatments aimed at controlling the underlying virus became available; unexpectedly, patients’ immune systems grew stronger with this intervention. Mortality rates plummeted. Today, with proper medication, HIV/AIDS patients can expect to survive for decades.

“The bottom line is most of our patients will not die of HIV disorders,” says Raffanti. Patients still must come to terms with a chronic illness that requires lifetime medication and limits lifestyle choices, while doctors have to refocus on treating these patients’

aging-related illnesses, some of which are caused and exacerbated by treatments, Raffanti explains.

It is imperative to help patients “chart that very dangerous course through the final stages of an illness,” preferably by collaborating and not simply through crisis intervention. Some patients will choose hospice care, to “die in control,” he says.

When he’s talking and listening to patients, Raffanti says some days he is keenly aware the waiting line is getting longer on the other side of the door.

“It’s extremely time-consuming and energy-consuming to do it right,” he says. But doing it right is what the patients want. “Some doctors are recognizing that patients have knowledge, that they are comfortable making choices,” Lucero says. “Why not allow them that?”

—ELIZABETH OLDER



R. Lawrence Van Horn, Ph.D.

the benefit of forcing people to think about the efficacy of the expenditures, but the fact that the expenditures are made in the last two years of life doesn't necessarily imply that they are wasteful."

While medical treatment for the chronically ill could be calculated using some kind of cost-benefit approach, Viscusi thinks that would present unique challenges.

"I just think it's a much harder area, a much more sensitive area, because you're dealing with much larger probabilities of death, and because they are identified lives, as opposed to anonymous lives," he explains.

Health care management and economics expert R. Lawrence Van Horn, Ph.D., M.P.H., M.B.A., echoes that observation.

"You can put a value on life, and policymakers do this all the time in terms of evaluating interventions," says Van Horn, who is faculty director of the Health Care MBA Program in the Owen Graduate School of Management. "But here's the key...everything is different when you look at it from a societal perspective as opposed to an individual perspective."

Van Horn says it difficult to imagine how policymakers would be able to justify health care decisions that keep treatments that carry even a small chance of success from seriously ill patients.

"How do you take that away from them? I think that's very difficult to do," he observes. "I think we need to recognize there is a limited amount of resources. As resources are committed here, they're not committed there."

Because of this reality, Van Horn says physicians and other medical professionals need to be out in front of the discussion of what he calls a "societal, cultural resource problem."

"Clinicians should be the people involved in making that decision, not economists," says Van Horn, an associate professor of Management.

"Despite our insatiable demand for technology, we are not in the position to commit unlimited resources to everybody in the last years of life," he adds. "I don't want economists to be the guiding force in what care is provided at that point."

This is really the "big talk"

As the debate looms about who should get what share of America's limited health care resources, Roy Elam has a proposal that would put the people most likely to be affected in the middle of the conversation: require every 65-year-old American signing up for Medicare to discuss their preferences about medical interventions and end-of-life care.

"Death is not an event. Death is a process," Elam explains. "We should begin the discussion about death at the age of 65 for everybody and every five years have the discussion again...If we begin talking about this as a culture, we can know what people really want."

People diagnosed with a life-threatening illness at any age could be assigned a nurse, a social worker or another trained professional — a coach, as Elam sees it — to help them deal with evolving medical issues, but also to listen to concerns and talk about sensitive topics like when to stop treatment. Other changes would be needed to support this societal discussion, he adds, like instituting a reimbursement system that rewards doctors for time spent counseling seriously ill patients and finding new ways to talk about palliative and hospice care so patients don't hear "as far as we're concerned, you are going to die."

Elam has forged a personal connection with that dilemma as a longtime student of medical ethics, board chairman of Alive Hospice and a husband who was caregiver for his dying wife. But he is optimistic that medicine today is shifting more toward caring for the whole person, rather than focusing on fixing body parts. And he believes helping patients and families make peace with declining health and demise is part of that.

"We want them to know that doctors have heard the story of their illnesses and the larger story of their lives," Elam explains. "We want them to know we genuinely care about their pain and suffering." **VM**

Specialized service provides caring touch for elderly

Senior patients require a particularly deft and caring touch from their medical team.

Vanderbilt University Medical Center's new Geriatrics Consult Service offers just that type of expertise and specialized treatment for the elderly and their families, too.

"We can make a difference in these patients' lives, even if it's for just one day," said Laurence M. Solberg, M.D., chief of the service. "We can give them a better quality of life near the end of their lives."

Doctors from any hospital department can request a consult for patients age 65 and older. About 65 percent of those patients have three or more geriatric syndromes, which include conditions such as dementia, incontinence, malnutrition, frailty and delirium.

Since its inception earlier this year, the service has seen an average of four new patients per week.

The multidisciplinary approach includes physical and mental health assessments; details of the patient's social and economic status, such as family support and home safety issues; a review of medications; and development of a care plan.

The experiences of two recent patients reveal the need for the specialized service.

An 86-year-old woman who lives a few hours away came to Nashville after fainting in church.

When seen by the Geriatrics Consult Service, the patient was on 14 medications and "feeling very weak," Solberg said. It turned out she'd recently seen a new cardiologist, and he'd put her on six additional medications.

Like many seniors, she was worried about the cost of those medications.

"Many doctors in the community just don't think about the fixed income that seniors are on," he said. "They forget about it, or think it's going to be covered."

The cardiologist "put her on all of the latest, greatest medications, and they all cost a ton of money," Solberg said. "None of them were cheap. To me, that's always a concern. There may be a generic that will do the job very well and not force the patient to choose between medicine and food."

The patient left Vanderbilt on four generic medications, which cost a total of \$16 per month.

"Here was a woman who was doing fine," Solberg said. "She didn't need all of these new medications. There was no thought to how her lifestyle would be affected by this."

Another important role is also one of the most difficult: dealing with families, many of whom are agonizing over how to care for their aging loved ones.

A 92-year-old patient with Alzheimer's lived at home with his 87-year-old sister until he suffered a fall recently.

"He really needed more supervision," Solberg said. "He needed to be in a structured environment. His sister and her children were adamant that he not be placed in a nursing home."

Despite community services and social work intervention at home, the patient kept returning to the hospital.

"We finally approached them with a real team approach, with therapists and social workers," Solberg said. "We said, 'We just really can't let him go home again. It's not in his best interest.'"

The team discussed with the family their fears of nursing homes, and set up tours of three facilities to help them choose.

"We were able to talk to the family about end-of-life issues and about getting the best care for him, even though it wasn't them caring for him," Solberg said. "It was better for their mother to see her brother well-cared for and not worry about him all of the time."

"That's a success story from the geriatrics team, because it made his quality of life better. And it helped his sister, too, because now she doesn't have to worry about him."

An added benefit comes from teaching young physicians about the needs of older patients. All internal medicine residents at VUMC now undergo a geriatric rotation.

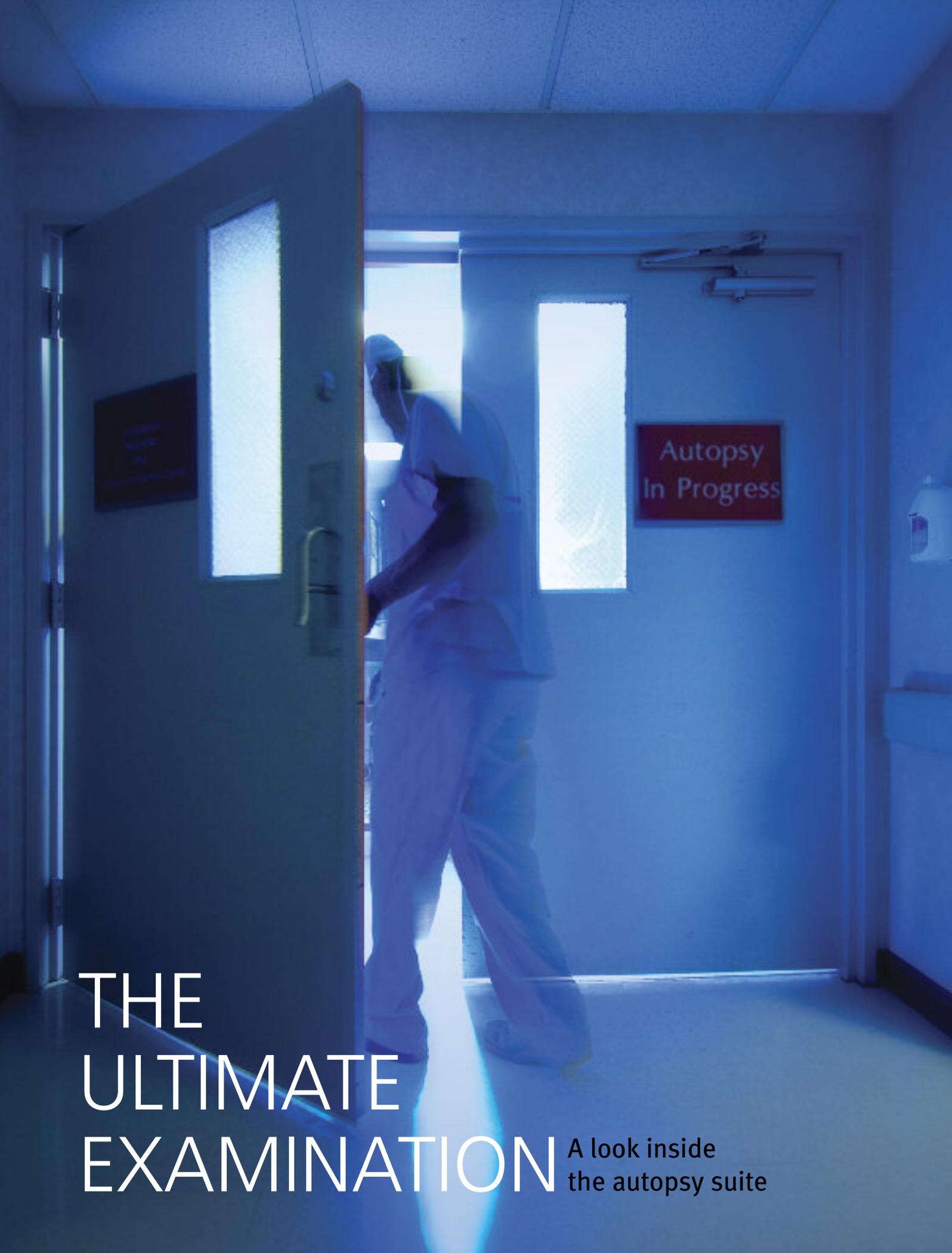
"The best thing we get to do is show the younger doctors in training that this is a part of elderly care that they never saw before and didn't understand," Solberg said. "Now they get to see it as a real extension of care. They help keep people functional."

"But also, if we can't keep them functional, we teach them how to deal with family members as they come face-to-face with the reality that their loved one is at the end of their life."

— LAURIE E. HOLLOWAY

Senior citizens participate in a tai chi class at Vanderbilt's Dayani Center.





Autopsy
In Progress

THE ULTIMATE EXAMINATION

A look inside
the autopsy suite

Leonardo da Vinci's Vitruvian Man is perhaps the most iconic anatomical drawing, capturing the ideal human proportions. But da Vinci is also notorious for how he gained his knowledge of anatomy — by digging up bodies to dissect them. In the 15th century, that was the only way to see what is under the skin, to examine the bones, muscles and ligaments, supplying da Vinci the knowledge of human anatomy necessary for masterpieces like the Mona Lisa and Last Supper. Fast forward five centuries, and post mortem examination is still the gold standard for discovering what is happening under the skin. Marcia Wills, M.D., director of the autopsy service at Vanderbilt University Medical Center, calls autopsy the “ultimate examination.” It's a chance for pathologists to explore the body in ways not possible during life, to examine every organ inside and out and to see things that may not be discovered on an X-ray or in lab results.

WRITTEN BY **LESLIE HAST**
PHOTOGRAPHY BY **DEAN DIXON**

Popular imagination would put the autopsy suite in a dark dungeon with stainless steel walls and dim lights. It is in fact located on the fourth floor of The Vanderbilt Clinic; its pale blue walls actually give it an airy, well-lit feeling.

But it is also cluttered with reminders of what goes on inside. Plastic tubs with unidentifiable tissues swimming inside are stacked around the room. Countertops are filled with scalpels and clamps, and an electric saw rests on the floor.

And in the middle of the room, on a steel table, is the body of a 64-year-old male with a history of cardiovascular problems.

“The beginning of an autopsy features sadness, reverence and a respect for each person’s dignity,” Wills said. “The family has very generously given us the opportunity to figure out what we couldn’t during life. It’s sad to know that the individual was once living and breathing, and know many people cared about this person. You have to realize this person has been through a great deal and they deserve the highest level of respect with the invasive procedure we are about to perform. Then the pathologist uses the techniques we were trained in to find answers.”

Declining numbers

Wills estimates that approximately 200 autopsies are performed at VUMC each

year. But just a few decades ago, there were more than 500 autopsies per year. Wills, however, says there is no magic number.

“We should do enough to serve the purpose of the community and hopefully move knowledge forward,” she said. “An older pathologist would say ‘absolutely do more autopsies,’ but it’s different in these financial times. We need a purpose to perform a test.”

An autopsy is offered as a service to the families of Vanderbilt patients at no cost. Because a hospital must recover the cost of this test, the number of autopsies, both at smaller hospitals and hospitals like Vanderbilt, has declined. Another reason for the decline is the fact that there aren’t as many unanswered questions because of modern diagnostic technology.

Wills said that future patients benefit from the accrued knowledge of autopsies, and even the patient’s family members can be helped if medical problems are illuminated that could help them as well.

“We hope that reading and discussing the autopsy report with the clinician will help them understand the disease process of their loved one. Once the disease

process is diagnosed and put into context for the family, they can seek genetic counseling.”

After a patient dies, the clinician discusses the autopsy option with their family. Decedent Affairs ensures that consent is properly completed, and contacts the first-year pathology resident about the new case. The resident then picks up the patient records, reconfirms proper consent and contacts the clinician about clinical treatment questions to investigate, depending on the patient’s health history and cause of death. The answers help physicians understand what went wrong and how to prevent it in the future.

The 64-year-old male had a history of right ventricle dysfunction and died during open heart surgery. The pathologists have been asked to investigate the cause of the dysfunction and why the patient had such difficulty with a defibrillator.

Before the procedure, the staff involved in this case is gathered around a desk in the corner littered with papers and files and boxes of supplies. Jessie Britton and Leavy McCoy, the technicians involved in every autopsy, are ensuring that all the necessary tools are ready and everyone has the proper gear.

During the autopsy, the first-year resident is assisted by a second-year charge while an attending physician looks on. But perhaps the most important teachers are Britton and McCoy.

“They have about a combined 70 years of experience,” Wills said. “They’ve seen everything, and they know everything.”

Britton has assisted with VUMC autopsies for more than 40 years, and McCoy for 28.

McCoy said that medical students have the book knowledge, but he and Britton teach the practical knowledge.



Marcia Wills, M.D.

“I know anatomy as well as the professors,” he said. “I don’t know all the terminology, but I have practical knowledge as good as anyone. I can do it in my sleep.”

McCoy has a degree in mortuary science and has also worked at the Medical Examiner’s office. After 28 years, McCoy said facing death is just another facet of going to work.

“Either you can do this or you can’t,” he said. “You have to like it, and I think it’s interesting to get to solve a problem for a family and discover unknown diseases. Every case presents something new.”

The process

To begin the gross dissection, first-year resident Sam James, M.D., presents the patient history to Wills while the second-year charge, Jason Tedesco, M.D., looks on. This is James’ fourth autopsy,

and Tedesco’s job is to oversee James’ work and help teach the procedure.

“Teaching is challenging,” Tedesco says. “You have to have patience. A lot of first year residents haven’t done too many autopsies before and need time and opportunity to learn.”

After a final verification of toe tag and hospital wrist tag, the first incision is made, a Y-shape, with branches from the shoulders meeting at the abdomen and continuing down around the navel in a single line.

Next, the breast plate is removed. McCoy picks up the striker saw, which has an oscillating blade that will cut bone and soft tissue but not the person operating it. He does the left side of the rib cage, then hands the saw to James and advises him on how to do the right side.

Every autopsy is treated as a contaminated environment, so the staff wears

paper gowns covered with plastic aprons, shoe covers, hair nets, face masks and a plastic face shield. Those wielding the scalpels wear a pair of Kevlar gloves sandwiched between two pairs of rubber gloves.

To remove the breast plate, McCoy and James position themselves on each side of the body, grip it with both hands and make three quick coordinated tugs down toward the abdomen.

“An autopsy is very physical,” Wills said. “I’m a small person, and I have to stand on a stool to get the right angle.”

The next important step is to tie the carotid artery with a piece of string to prevent it from retracting during the autopsy, giving the funeral home easy access for injecting embalming fluid.

Wills said the needs of the family and funeral home are always top priority during autopsy. They will accommodate all cultural and religious requests, like the

Threefold mission

In the 21st century, the purpose of an autopsy is vast, but can be broken down into three general categories:

1. Better understanding of the disease process for the family — depending on the findings of the autopsy, genetic counseling and further testing may be necessary for the family members of the deceased.
2. Continued education of the medical community about the patient and the concepts of the general disease — medical education can be enhanced for medical students, residents, pathologists and various teams of physicians.
3. Research is also strengthened by access to tissue for ongoing projects. The tissue of the deceased can help answer questions being asked by the medical community at Vanderbilt, nationally and internationally.

Jewish practice of burying the body before sundown, or the Native American practice of returning the organs to the body for burial.

“He will look perfectly normal after embalming,” Wills said. “We never touched the face, and we take out what we need while preserving the integrity of the body. We do autopsies in a very sensitive way. We do take great care, and we specialize each case in an attempt to answer the questions being asked.”

Once the organs are exposed, cultures can be taken. In a scene that could be out of the 19th century, a scalpel rests on an open flame from a small glass kerosene burner. McCoy presses the hot scalpel to the lung, and with a hiss and a puff of smoke, the area is sterile and James can get a germ-free lung tissue sample. He also uses a needle to collect urine from the bladder and blood from the aorta.

Next, the organs are separated from the surrounding tissue. McCoy, Tedesco and James each hold a flap of fat in one hand, while making quick sweeping strokes with the other, slowly peeling it back to reveal the smooth shiny organs underneath.

The atmosphere is relaxed but focused. There’s no rock music playing or talk of weekend plans, but there’s also no pressure or anxiety. The smell is simultaneously dirty and clean, like a very stinky bathroom being scrubbed with very strong cleaner.

Vanderbilt uses the Rokitansky technique, which dissects organs in place to better examine their relationships. Once the organs are cut free, they are removed from the body in two blocks — a heart and lung block and an abdominal block — to a parallel table for dissection. James gathers each block into his arms like a baby and rushes over to the other table before the slippery organs can slip out of his hands.

Although there have been amazing technological advances in medicine, autopsy technique has remained remarkably static with pathologists still making

the same incisions their forbearers did centuries ago.

The part that is changing, Wills said, is what can be done with the tissues once they are dissected. Pathologists now have access to genetic testing, microbiology, cultures and toxicology screening that can find answers not possible even five years ago.

Once the organs have been fully examined, they are placed into plastic tubs filled with formalin, a clear liquid that fixes cells in static positions, thus “stopping the organ at that moment in time,” Wills explained.

Although the evisceration only takes about an hour, it can take another two to four hours to examine the organs.

“The body can already be at the funeral home while they’re still dissecting organs,” McCoy said

McCoy sprinkles the inside of the body cavity with drying powder and then sews it up with a baseball stitch.

“The funeral home will pack the inside with newspaper or cotton so it doesn’t cave in,” McCoy explained.

He washes the body with soapy water, then puts it in a plastic biohazard bag to prevent any leaks in transport to the morgue. Then it is put in a zippered body bag, placed on a gurney and covered in a shroud to disguise what it is. McCoy has a key that will lock the elevator and prevent anyone else from getting on.

The findings

Within 48 hours of completing the dissection, the resident is required to complete the Preliminary Anatomical Diagnosis, which communicates to the family and clinician what was found in gross autopsy.

Then there are 30-60 days to do the microscopic examination and create the final report, combining findings from gross autopsy with what is discovered in conferences with attendings and from histology and other ancillary studies.

The resident meets with the attending in what Wills calls “a time to teach and collaborate and think about hypotheses.”

The residents repeat their findings in front of other attendings and develop the ability to present efficiently.

“Our job is to make it all make sense,” Wills said. “I don’t know all the answers and can’t figure out all the cases, but the interaction is so valuable.”

Medical students are also involved in autopsy. From August to December, they are required to see one autopsy, write up the report and formally present it.

As director of the autopsy service, Wills’ role is, in her words, “to make sure each autopsy is to the benefit and safety of its users.” That includes ensuring the safety of the pathologists, especially during infectious cases, and overseeing any research that is conducted. She also manages the report to the patient’s family.

“They have very generously given the opportunity to figure out what we couldn’t during life,” Wills said. “I ensure the residents write the discussion in language accessible to the patient’s family.”

But pathology isn’t just autopsy. The doctors are also involved in procedures for living patients, and Wills acknowledged she is often torn between serving the living or dead.

“I’m absolutely conflicted,” she said. “I cover cytology, pediatric pathology, among other things, and it’s a constant juggle of time and effort, as any clinician knows. Yes, the patient is dead, but the thrust of the autopsy is for the family and clinician. Being dead doesn’t make them any less important.”

Wills admits that autopsy was not the primary reason she chose pathology, but says it is a necessary part of the field and she enjoys solving the puzzles it brings.

“Autopsy is the opportunity that families have given us to do the ultimate examination on their loved one,” Wills said. “We can try to do all the appropriate detective work to find the answers to clinical questions while educating and participating in research.”

Wills said there’s also an element of surprise in autopsy, and one can never anticipate what will be discovered.



Leavy McCoy

“We all have stories about what we’ve seen, from massive hemorrhage to balloons of drugs in the stomach. That one went right to the Medical Examiner,” she said.

The Medical Examiner actually performs the majority of autopsies from deaths at VMC. In Tennessee, the ME receives all trauma deaths, homicides, suicides, drug overdoses and unwitnessed deaths, pretty much anyone who expired on 10 north or in the emergency room,” said Marie Williams, program coordinator for Decedent Affairs.

Of the 100 deaths VUMC averages each month, Williams estimates that 50-60 go straight to the funeral home, at least 30 go to the ME and 10-12 are autopsied.

Wills said there will always be a need for autopsy.

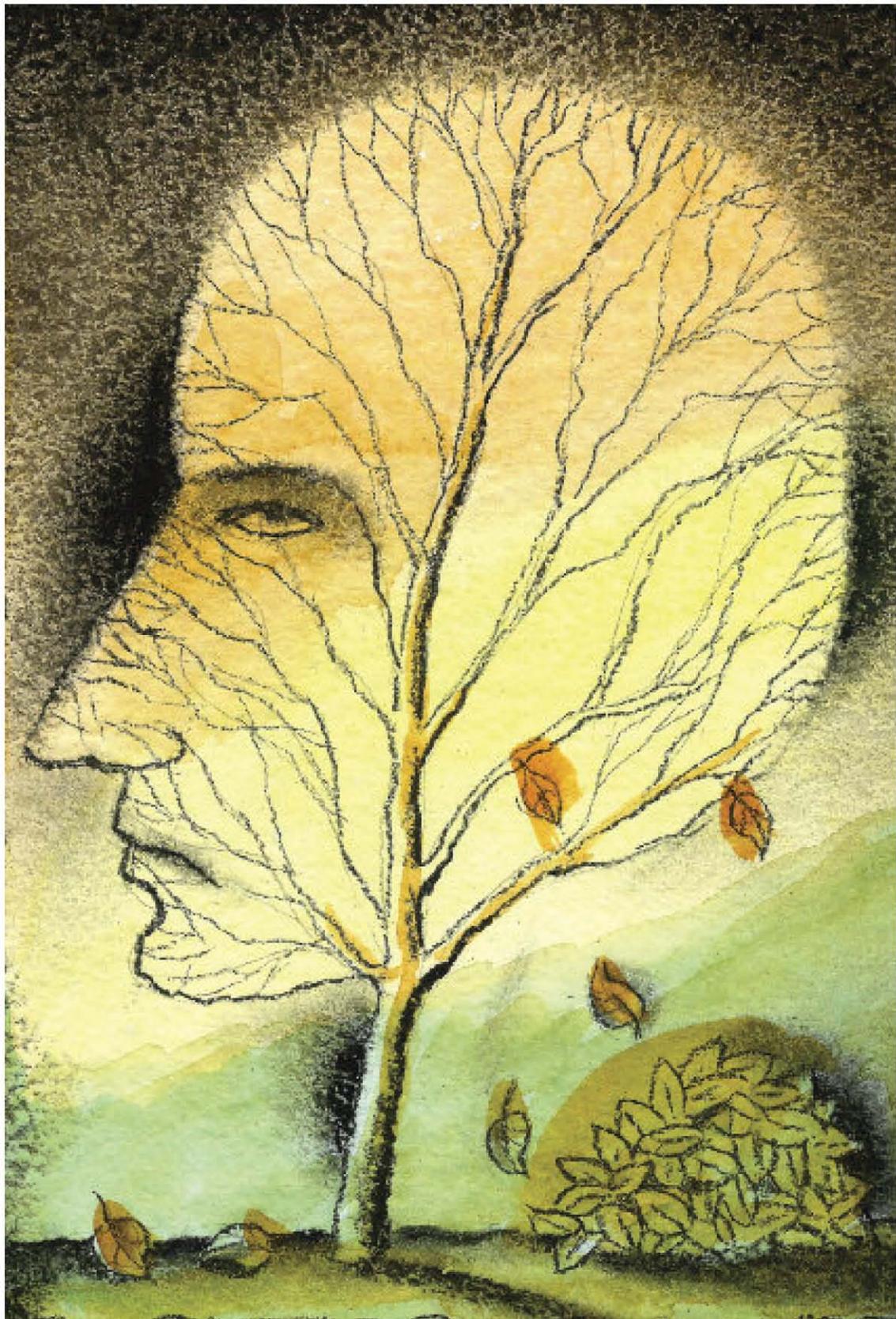
“We will always serve a purpose,” she said. “Autopsy is the only way to answer certain questions. It is the most complete exam that can be performed on a person.” **VM**

The Science *{and Art}* of Dying

WRITTEN BY JESSICA PASLEY
ILLUSTRATION BY LEON ZERNITSKY



In 1798 Benjamin Franklin had it right when he penned a letter stating: “in this world nothing can be said to be certain, except death and taxes.” The problem is — Americans want nothing to do with either. ¶ “Americans are not used to nor are they comfortable with the process of death,” said Roy Elam, M.D., associate professor of Medicine and medical director of the Center for Integrative Health. ¶ Elam said that many cultures approach death as part of the natural cycle of life, while in the United States there is a tendency to tuck it away on a shelf. ¶ “We try to assume that death doesn’t exist. We deny that it can happen to us. Of course it happens to every one of us.”



JOE HOWELL



The art of dying has been around for centuries. Finding what is right for each person requires one thing — listening.

Mohana Karlekar, M.D.



The science

For something as certain as death there is no way to pinpoint when someone is going to die, but there are indicators or stages of death — dying, active and imminent.

- Dying patients are those who have a limited life expectancy or who recently learned of their illness.

- Actively dying patients will exhibit physiological changes. Sleeping and eating patterns increase, while activity regimes decrease. These patients have days to weeks to live.

- Imminently dying patients show clear signs of end of life. A patient has cold and clammy hands, their legs are bluish, red in color or mottled from the lack of blood flow and their breathing patterns are slow and shallow (agonal).

These are indicators that a person will die in the next hour.

“As a person physically gets closer to the end of life the body begins to shut down,” said Mohana Karlekar, M.D., director of Palliative Care at Vanderbilt. “You eat less, drink less and eventually you stop eating and drinking all together. By this time, you’re not making as much urine or having as many bowel movements. You get sleepier and sleepier. And at some point what will happen is that the amount of time spent asleep is more than the time awake.

“Eventually, you sleep and you sleep and your breathing patterns change... You breathe and breathe and pause. That pause stretches out and stretches out and eventually there isn’t a next breath. That is the natural progression of death.”

Although the majority of deaths

follow this natural progression, about 10 percent to 15 percent experience terminal delirium, an agitation that occurs at the end of life. Medications are provided to calm the patients, allowing them to sleep.

“There is a real science to managing someone’s pain, fatigue and insomnia,” added Elam. “We are learning more and more about the anxiety people experience and how best to help them. There is much more science developing around stress management and the molecular biology of stress.”

Another area of scientific interest is the wasting away process often seen in cancer, end-stage organ failure and burn patients. Cachexia causes severe weight and muscle loss due to severe protein and calorie malnutrition.

“Fatigue, loss of energy, decreased muscle and strength make up cachexia,”



{ Grief Resources }

said Karlekar. “One predictor for survival is functional outcome or performance status. So if your cancer is really bad, but you have great functional status — you can eat, drink, bathe, walk 100 feet — you are going to do better with your cancer and someone is more apt to treat you.

“But let’s say that your cancer is not as aggressive and you can’t get out of bed and your functional status is poor, someone is less apt to treat you.

“If you can find something to treat cachexia ... you might be able to make some really big changes and people will feel better. If you can offer a treatment early on in the disease where it can make an impact — whether that is on a patient’s quality of life, treatment or nutritional status — if it makes the patient stronger, then it’s probably worth doing,” she said. (*See sidebar on cachexia on page 44*)

The art

The art of dying has been around for centuries, said Karlekar. Finding what is right for each person requires one thing — listening.

“If you listen to what patients and families are saying about their values and beliefs, then you can formulate a plan that is consistent, that makes medical sense, and is not going to over treat someone,” she said. “But you have to listen and that takes time. And in this day and time, it is a lot easier to order a test and do something than to have that conversation.

“For most patients, it actually allows you to live better,” she said. “Imagine being so worried about what is going to happen at the end of your life that it consumes you. Then you figure it out and you can actually focus on what you want — those things that give you the most meaning.”

Dana Allen, of Nashville, knows what it’s like for someone to live their last days with meaning. She knew when she

Alive Hospice of Nashville offers a number of support groups to the community. Groups provide participants the opportunity to receive grief support with others who may be experiencing similar thoughts and feelings. The groups are offered several times a year. All groups are free of charge.

Spouses Group: for those who have experienced the death of a spouse

General Grief Group: for adults grieving the death of a family member or friend

Bereaved Parents Group: for any parent who has experienced the death of a child, regardless of the child’s age

Children’s Group (ages 8-10) and Pre-Teen Group (ages 11-13): for young people who have experienced the death of a family member or friend

Grief in the Schools: an onsite support group at schools for high school students who are grieving the loss of a loved one

Camp Evergreen and Camp Forget-Me-Not: two-day summer camps for children who have experienced the death of a family member or friend

Holiday seminars: support sessions offering helpful strategies for coping with the intensified sense of loss during the holiday season

Additional support groups: additional support groups such as

Loss of a Same-Sex Partner offered as community needs arise

In addition, Alive Hospice recommends the following printed resources to those experiencing the loss of a loved one. This list was compiled from an extensive bibliography provided by Alive Hospice.

■ Clemons, H., “Saying Goodbye to Your Grief. Macon,” GA. Smyth & Helwys, 1994.

■ Grollman, E., “Living When a Loved One Has Died,” 3rd ed. Boston, MA: Beacon, 1995.

■ Heegaard, M., “Grief: A Natural Reaction to Loss”

■ Hickman, M., “Healing after Loss: Daily Meditations for Working through Grief.”

■ Johnson, J. & M., “Grief: What it is and what you can do.”

■ Ferguson, D., “When Winter Follows Spring: Surviving the Death of an Adult Child.”

■ Goodman, S., “Love Never Dies: A Mother’s Journey from Loss.”

■ Johnson, J. & M., “Children Die, Too.”

■ Kifer, C., “Left Behind: A Mother’s Grief.”

■ Klass, D., “The Spiritual Lives of Bereaved Parents.” Taylor and Francis Philadelphia, PA 1999.

left Tennessee for a trip to Maine last year with her husband, John, that it was the last time they'd vacation together. His battle with cancer was coming to an end.

"It was a vacation from the chemo," said Allen. "But we both knew that there was not going to be any more chemo. We never talked about it. Deep down we both knew (it was the end). It was unspoken.

"When he came out to sit with me that last full day of our vacation, I knew," Allen said. "There was nothing medical or scientific. It was just a feeling I had."

Throughout their five-day stay, the signs of death were increasing. His episodes

of withdrawal grew. He would sit for hours watching TV with his eyes closed. He ate less and less. He grew more fatigued.

"I had read all the books. Right before we left the hospice doctor said to me — 'You understand that he won't be coming back with you.'"

John died that week.

Soon after praying with a minister at his bedside, Allen told her husband that she loved him. He mumbled he loved her too. Although they were his last words, he lingered.

Then Allen spoke one last time to her husband of eight and one-half years.

"I told him that his girl was going to be OK," she said. "He didn't want to die without knowing I was going to be all right. I would never lie to him. I made a promise."

Within minutes, John Allen, 67, died. According to Karlekar, that is a very common scenario.

"You won't find this information in medical literature," said Karlekar. "But if you look at it clinically, people need permission to die, just as they need the will to live. Your will plays a very strong role in when you die.

"There are those who wait for either



{ *Wasting Away* }

One of the biggest challenges when treating life-threatening diseases is a syndrome called cachexia, the wasting away process. This extreme form of malnutrition leads to profound fatigue and muscle loss and is oftentimes seen in patients with diseases like cancer and AIDS.

For years physicians have tried treatment after treatment to improve a patient's nutrition in hopes of increasing muscle mass. GTx, Inc., founded by Mitch S. Steiner, M.D., recently completed a Phase II trial of a drug called Ostarine, a selective androgen receptor modulator or SARM, designed to increase muscle mass.

Results show that patients treated with Ostarine built muscle mass and climbed stairs faster with more power than patients taking the placebo.

"If we can create a drug that builds muscle and can impact the quality of life or a person's ability to respond to chemotherapy, for example, that would be wonderful," said Steiner, a Vanderbilt University graduate and former fellow. "When a patient is suffering from severe cachexia and does not have enough protein stores that increase in muscle mass may improve quality of life and survival.

"We're not certain where we would fit into the treatment process to make the most impact. It could be anywhere in the entire spectrum. If a patient feels better and comes to the dinner table because he has an appetite, then from a social and well-being standpoint he is part of the family. But when a patient has no appetite, lies in bed most of the time and begins to waste away, it completely affects the family dynamics."

Steiner's foray into the world of drug discovery came after successfully re-tooling a breast cancer drug, toremifene citrate, to

reduce the estrogen deficiency side effects of androgen deprivation therapy for prostate cancer.

Steiner earned his BS in molecular biology from Vanderbilt in 1982 and his MD from the University of Tennessee. He completed his surgery and urologic training at Johns Hopkins Hospital. He later returned to Vanderbilt University Medical Center as an assistant professor of Urology, Cell Biology and Pathology during a fellowship under Hal Moses, M.D., and Jay Smith, M.D., in 1993. He then joined the University of Tennessee at Memphis as the endowed chair of Urologic Oncology in 1995 and served as the chair and professor of Urology.

GTx, formed in 1997, is a biopharmaceutical company dedicated to the discovery, development and commercialization of small molecules that selectively target hormone pathways to treat cancer, osteoporosis and bone loss, muscle wasting and other serious medical conditions.

Aimed at treating cachexia in cancer patients, the Ostarine study enrolled 159 patients with non-small cell lung, colorectal, non-Hodgkin's lymphoma, chronic lymphocytic lymphoma and breast cancer. Thirty-five sites in the United States and Argentina participated in the randomized, double-blind, placebo, controlled study.

"Literature has suggested that lean body mass correlates with survival," Steiner said. "This is not a curative therapy. If we can minimize many of the side effects of cancer treatments — fatigue, nausea (loss of appetite) — then quality of life is impacted.

"When you think of terminal diseases, it doesn't mean you don't want to live. It just means you need to think about how you want to live."

— JESSICA PASLEY



DANA JOHNSON

*We try to assume that death doesn't exist.
We deny that it can happen to us. Of course
it happens to every one of us.*

Roy Elam, M.D.



a specific family member to arrive or to tell them it's OK (to die). Or they wait for news that certain things are in order," she said. "Then there is a whole group of people who wait for that one moment in time where they get a break from family members. It has a lot to do with their emotional preparation. It's different ways to control when they die. The human spirit plays a strong role whether you are awake and alert or lethargic."

Acceptance

In her nearly 10 years of practicing medicine, Karlekar has observed dying patients looking for ways to accept what is happening and make peace so that they can live.

"Preparing for death doesn't mean you can't keep living," she said. "The initial process is not that you are going to die, rather it is that you are no longer healthy."

At the time of diagnosis a patient begins to grieve, she explained. For instance, patients might lose the ability to work, drive, be active or even take care of themselves. These are all issues of loss that a patient needs to talk about and share with their family, friends or medical team. But concerns about family, finances, work and other daily tasks can impede the process.

"Emotionally everybody has things they want to figure out," Karlekar said. "As people begin to hone in on what they can do to make peace in their lives, they get to a place where they begin to accept what is going on.

"It is that emotional acceptance of what you are going through, where you are going, having the courage to talk about it, and having people around you who are willing to engage in the conversation... the truth is, if you are dying you want to talk about it because then you can sort things out and move on to what matters in life."

Elam and a growing number of physicians agree that the more readily a person accepts the fact that they are dying, and begins to focus on their life's meaning and purpose, the better death they will experience.

"For many of our patients today, hope lies in the search for the cure," Elam said. "When there is no more chemotherapy or no further treatment options, a person feels like it's all over. But what



JOE HOWELL

All of us will die. Some know when and why and some of us will never know.

Dana Allen



they don't realize is that there is much more to hope for before they die.

"Curing and healing are very different things," he said. "Curing is taking the disease away. Healing is really about caring for the whole person. Our relationships provide healing even as one is dying."

Palliative Care

According to Elam and Karlekar, palliative care has played a big role in educating both patients and medical professionals about living in the face of

either a life-threatening or terminal illness. A relatively new specialty in medicine at Vanderbilt, palliative care focuses on patients who are facing life-threatening illness or injury, at any stage in the continuum of disease. It is not just for the patient who is about to die. Vanderbilt's program has been around since 2006.

"We want to enhance the care that is given as well as provide all the information and resources a patient needs (when dealing with life-threatening issues)," said Karlekar. "Death is a part of life and at some point we are all going to face it. If I

can get you to an emotionally better place with what you are going through, perhaps you will do better with treatments or you will be more inclined to prepare for what might be down the road."

Early studies have shown that palliative care patients are the most satisfied patients in a hospital, Elam added.

"The outcome might be death, but the patient satisfaction is higher than it is for some other areas in the hospital," he said.

What experts have found is that patients facing a life-threatening or terminal illness need guides to help coach them along the journey.



{ *Planned Giving* }

“They need someone to walk with them who not only helps them think about dying, but helps them celebrate living, which can improve their quality of life,” said Elam. “That alone can help them hang onto hope. Hope doesn’t have to be that they are going to live forever. The hope might be that they get their pain under control. It might be that their nausea subsides or that their daughter is going to arrive the next day.

“It helps to have a relationship with someone who is able to help a patient relieve their fears which can allow them to let go at an appropriate time and die a more peaceful death,” Elam said.

See you later, mosquito

For Dana Allen, a year has passed since her husband died. The man she waited her entire life to find. The man who still brings a wave of giggles to his wife as she recounts their quaint greetings of “hello mosquito” based on an old commercial.

“We really had fun together,” she said. “We acted goofy and he was a wonderful, wonderful man.”

As Allen reflected on his death, she discovered something about herself.

“When he sat down that day with me on the patio, I told him how pissed off I was that this was happening to him,” Allen said. “When John died, it was like having my own arm cut off.

“But now I have put it all in perspective. All of us will die. Some know when and why and some of us will never know. I am not afraid to die now, because I will be with him again. It used to be something I was terrified of. No matter what road my life takes, I will be with him again.

“I couldn’t say goodbye — just see you later, mosquito.” **VM**

■ ■ To learn more and see a video of Dana Allen talking about her experiences, please visit www.mc.vanderbilt.edu/vanderbiltmedicine and click “The Science and Art of Dying.”

Many people create a personal or family legacy by partnering with a charitable organization such as Vanderbilt University Medical Center. Some donors make an outright gift or multi-year pledge, but there are also “Planned Giving” options.

Planned gifts include:

- Bequests under wills
- IRA beneficiary designations, and
- Life income gifts (charitable gift annuities and charitable trusts where the donor or family members receive income in exchange for a gift, usually for life).

Benefits of planned giving:

- It provides peace of mind. For example, an individual who does not feel comfortable giving away \$25,000 or more during life, may be open to the idea of leaving such an amount as a bequest.
- It makes gifts possible. Consider a donor who feels that she cannot afford to give away \$10,000 to charity. She may be able to make a gift if it will mean that she receives 6 percent of \$10,000 paid to her quarterly for her lifetime, guaranteed.

Other options:

- Bequest under a will: There is no cost to the donor during his lifetime, yet the gift is valuable to the charitable program and can be for a fairly high amount. The donor retains control of his assets and has access to principal in emergency situations.
- Designating a charity as beneficiary of your IRA: This is easy to do — the donor can add the charity’s name online or by calling the IRA manager (TIAA-CREF, Fidelity, Vanguard or other). Depending on the donor’s situation, the IRA to charity can simplify the estate administration and benefit survivors (Idea: Leave taxable IRAs to charity, non-taxable property to family.)
- Charitable Gift Annuities: A donor (at least age 65) makes a gift (minimum \$10,000) and receives income for life. A tax deduction is available immediately and the payments are partially tax-free. Payout rates are based on age: Age 65 — 5.7 percent; age 70 — 6.1 percent; age 80 — 7.6 percent, and so on.

Gifts of Stock and Securities

When making an outright gift to charity, remember to think about appreciated stock you may have in your accounts. If you have held the stock for more than one year and it is worth more than you paid for it, use that stock for your charitable giving. Stock gifts can provide valuable tax advantages.

Memorial Gift

A gift made in memory of an individual is a special way to remember a friend or loved one and express sympathy to their family. A public obituary request may advise friends and families how to honor a cherished life.

For more information about these and other giving options, please contact Timothy A. Kaltenbach at (615) 343-3113, (888) 758-1999, or by e-mail, plannedgiving@vanderbilt.edu. For more information, visit VUMC’s Planned Giving Web site, www.vanderbilt.edu/alumni/plannedgiving.



{ Gilda's Gang }

When Gail Addlestone, M.D., (MD'97) was 18, she lost her mother to ovarian cancer. Years later, as a newly established Nashville pediatrician, Addlestone became a long-term volunteer at Gilda's Club Nashville, a place where patients and those near to them find free support for living with cancer.

In her early 30s and pregnant, Addlestone was diagnosed with breast cancer at a time when she had continued to lead a Gilda's Club bereavement group for children and adolescents. Under the care of neonatologists, her cherished daughter, Eleanor, was delivered early and safely.

When illness and side effects of treatment eventually left her unable to maintain her pediatric practice, Addlestone instead joined the staff at Gilda's Club. There she conceived and launched Gilda's Gang, an annual program marrying volunteer fundraising with a 16-week course of fitness training, including regular sessions with personal trainers, weekly group workouts and complimentary gym access, culminating in group participation in the Country Music Half Marathon. In 2007, its second year, Gilda's Gang drew 60 volunteers who together raised \$150,000. Of that total, Addlestone herself raised about \$50,000.

Addlestone died from cancer in July 2007, three months after completing the Country Music Half Marathon with other Gilda's Gang participants.

In a non-residential, homelike setting near Music Row at 1707 Division St., the organization Addlestone helped nurture continues to serve men, women, teenagers and children with all types of cancer, as well as their family members and friends, offering a varied program of support groups, workshops, recreational opportunities, information and referrals.

With Vanderbilt providing more uncompensated care than all other Nashville hospitals combined, the Medical Center is generally too busy raising money for its own programs to consider giving funds to other organizations. Gilda's Club remains an important exception. The program counts Vanderbilt University Medical Center as a major corporate benefactor.

Faculty and staff at Vanderbilt-Ingram Cancer Center have found a close partner in Gilda's Club. Neurosurgical oncologist Reid Thompson, M.D., vice chair and associate professor of Neurological Surgery, began referring more patients and families to Gilda's Club after visiting the facility some years back.

"I suddenly came to realize it's a very important resource, one that's much broader than I had realized," Thompson said.

With a new brain cancer diagnosis, "not just the patients themselves, but family members, as well, may find themselves struggling quite suddenly with something they never thought they would have to deal with. Beyond coping with the medical complexities, people may be facing other difficulties — spiritual, emotional, interpersonal, vocational and so on. Gilda's goes a long way toward addressing those needs. It's an unbelievably positive place," he said.

"They've been a great partner to work with," said Vanderbilt pediatric hematologist Jim Whitlock, M.D., Craig-Weaver Professor of Pediatrics. Whitlock said emotional support figures greatly into treatment of childhood cancer.

"It's huge. It's hard enough to be a kid these days, but add to that losing your hair, bearing scars from surgery, walking around with a central line hanging out of your chest: to have a place where people understand what that's about and freely provide informed support is so essential."

The Gilda's Club calendar is replete with sessions devoted to yoga, pilates, tai chi, art activities, writing workshops and cooking classes. Support groups for patients and for family and friends each meet weekly. More specialized support groups meet monthly, including groups for teenagers, young adults and diagnosis-specific groups. Support groups are facilitated by on-staff social workers.

"For our support groups, our philosophy is that the wisdom is in the room. The experts are the folks who are living it," said Felice Apolinsky, L.C.S.W., a cancer survivor

and staff member at Gilda's Club.

Jule West, M.D. (MD'97), assistant professor of Medicine, met Gail Addlestone during their first year of medical school at Vanderbilt. The two became close friends.

"Gail was really a magnanimous soul. She had this amazing gift — she was the type of person who lit up the entire room, and she was fully engaged whenever she was with you. And she was very selfless, thoughtful and brave," West said.

"From the time of her diagnosis onward, it was clear that she was not going to be a person with breast cancer. She was going to be a person — period. There's nothing more amazing than watching someone who's dying from an illness live, and live fully.

"I know Gail's connection with Gilda's Club empowered her tremendously."

Gilda's Club Nashville is one of 22 affiliates of Gilda's Club Worldwide. All programs are free of charge. For more information, visit www.gildasclubnashville.org. — PAUL GOVERN

Gail Addlestone, M.D., left, with her friend and fellow Gilda's Gang participant, Danielle Gilbert.



President's Corner

The Canby Robinson Society is as strong as ever and poised for another successful year in 2009.

There are currently more than 2,500 members who were responsible for \$23,439,702 in giving to the Medical Center in FY 08 compared with \$17,038,817 in FY 07. The dollars raised support chairs, scholarships, research, facilities and departmental programs at the Medical Center.

We have been very busy this fall welcoming our new Canby Robinson Society Scholars (*see article on page 50*) and beginning the selection process for next year's scholars. We hosted two outreach tours: the LifeFlight/Trauma Program with John Morris Jr., M.D., director of Trauma and Surgical Care, and a program that updated us on expansion plans for the Monroe Carell Jr. Children's Hospital at Vanderbilt and the challenges

facing pediatrics with Jonathan Gitlin, M.D., chair of Pediatrics, and Kevin Churchwell, M.D., CEO and executive director of Children's Hospital. This program was followed by a tour of the NICU. We also provided several opportunities to attend organ recitals with the medical students in the Pathology Lab.

In September the CRS co-hosted a regional dinner in Atlanta with Medical Alumni Affairs, and we have other dinners planned in Birmingham and Chattanooga in early 2009. The CRS Board met in October and toured the new Anatomy Lab as part of the meeting's agenda.

In November we launched an exciting new initiative, the Coalition for the Canby Robinson Society, which will be a wonderful vehicle for recruiting new members and increasing support to all areas of the Medical Center (*see article on page 51*).

Please visit our Web site at www.mc.vanderbilt.edu/crs/ to access all

Medical Center publications and to stay informed on CRS activities.

We are grateful for your continued support and encourage you to let us know if there is anything we can do to better serve you and your families.



Missy Eason
Executive Director

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; www.mc.vanderbilt.edu/crs/

Class of 1978 halfway to goal of fully endowed scholarship

The Vanderbilt University Medical School Class of 1978 is working to fund an endowed scholarship in honor of their 30th reunion, held in October 2008, and the class is well under way to reaching its goal.

Classmates Stinson Humphrey, M.D., and Thomas Nygaard, M.D., co-chaired the campaign to raise the necessary \$600,000 for an endowed scholarship.

Members of the Class of 1978 at their 30th reunion.



By reaching out to the class members, Humphrey and Nygaard had a goal of raising \$100,000 by this year's 30th reunion. The class responded to the request and has committed more than \$320,000 thus far with almost half of the class pledging contributions for the scholarship.

"The response of our classmates to date has been truly remarkable," Humphrey said. "We have an unusual class that was close when we were students, and many have stayed involved through contributions to the School of Medicine throughout the years since graduation. The high level of participation is due to the support we received as students from faculty, administration and staff."

Scholarships fulfill a critical need and have a powerful impact on the lives of many students in the School of Medicine. By providing endowed scholarships, such as the Class of 1978 Endowed Scholarship, Vanderbilt can continue to

attract students of the highest caliber regardless of their ability to pay.

"A lot of us financially struggled to go to medical school," Nygaard said. "It was not easy on us. We want young people to be able to attend medical school and we want to attract the best students possible to Vanderbilt. The more students who come to Vanderbilt and succeed, the better it is for them and for Vanderbilt."

Humphrey agrees and is proud of his class's mission to fund a scholarship. "The cost of medical education and obtaining a medical degree is expensive and costs continually rise," he said.

"I believe that an endowed scholarship that will cover the tuition for one student per year is a very significant contribution for a single class to provide."

After graduation Humphrey remained at Vanderbilt as a house officer, first as a general surgery first-year resident and then as a resident in Oral and Maxillofacial Surgery. Following

(continued on page 50)

CRS scholarships expand education, careers of deserving students

Five new Canby Robinson Society scholars are among the 105-member Vanderbilt University School of Medicine Class of 2012.

Rajshri Mainthia graduated from Virginia Commonwealth University/ Medical College of Virginia, participating in an eight-year Honors Medical Program and majoring in chemistry. She also studied abroad at Oxford University in Great Britain before choosing VUSM.

"I ultimately decided to attend Vanderbilt based on its unique collegial environment, faculty support network, and rising focus on translational and international research," Mainthia said.

Receiving the CRS scholarship will help Mainthia pursue her goals of becoming a surgeon and collaborating closely with financial consultants, scientists, lawyers, and community workers to improve health care in low-income areas.

"In the future, I'd love to form a multi-disciplinary team that works synergistically to create sustainable surgical care models for poor, underserved populations," she said.

Sarah Bourne attended Harvard University, majoring in neurobiology,

where she conducted neuroscience research and completed an undergraduate honors thesis studying the role of the insulin pathway in *C. elegans* olfactory learning.

The Ottawa, Canada, native chose to attend Vanderbilt for several reasons.

"The CRS scholarship was the final deciding point in my decision to attend Vanderbilt because of the flexibility it will allow me in choosing a specialty and in deciding whether to practice in the U.S. or back in Canada," she said. "The CRS scholarship allowed me to make the decision to attend an American rather than Canadian medical school without having to take financial considerations into account."

She was impressed by how invested faculty is in medical education and their genuine concern for student well being. "I also liked that the emphasis program builds the opportunity for students to do research into the curriculum," she said.

She is considering careers in neurosurgery, neurology, or psychiatry after graduating from Vanderbilt.

Ravi Parikh majored in anthropology, focusing on medical and cultural anthropology, at City University of New York Brooklyn College in Brooklyn.

He chose Vanderbilt due to its transformative educational experience and student-focused component. "The emphasis program (a two-year research program that is part of the curriculum), the stellar global health institute, as well as a business school with a health care management component



Canby Robinson Society scholars, left to right, are: (front row) Rajshri Mainthia and Sarah Bourne; (back row) Obi Umunakwe, Peter Knowlton and Ravi Parikh.

all allow me to further explore my interest in international health care management and economic development," he said.

"The CRS scholarship will allow me to follow an unconventional career path of pursuing an M.D./M.B.A. to work in international health and health care development without the burden of debt hindering my career goals," he said.

Peter Knowlton graduated from Duke University with a B.S. in biology before deciding to attend VUSM.

"As a hopeful physician-scientist, I was strongly attracted to Vanderbilt by the access to terrific medical training and world-class research," he said. "Apart from that, I was deeply struck on my visits to Vanderbilt by how happy and grounded its students seemed, as they appeared far more focused on actually learning quality medicine than on memorizing every fact within a textbook."

(continued from page 49)

residency he entered private practice in Los Gatos, Calif., and practiced until retiring in 1997. He is spending his retirement on such projects as the scholarship campaign and an endowment he created and helps administer to help medical and theological education in Nigeria, West Africa.

Nygaard is board certified in cardiovascular disease and interventional cardiology. After graduating from VUSM, he served his internship and residency in

internal medicine at Johns Hopkins Hospital, and later completed his fellowship in cardiovascular disease at the University of Virginia. He stayed on the faculty at the University of Virginia as an interventional cardiologist and director of the coronary care unit. In 1986 he and his family relocated to Lynchburg, Va., where he served as director of the cardiac cath labs at Stroobants Heart Center Lynchburg General Hospital until 2001. He now serves as director of

Cardiology for the Heart Center and chairman of the Heart Board. He is president of the Centra Cardiovascular Group and vice chairman of the board of Centra, Inc., a regional health system with approximately 5,000 employees.

- JON COOMER

“The recent completion of such facilities as CELA (Center for Experiential Learning and Assessment) and the new anatomy lab ensured me that Vanderbilt not only was a technologically advanced institution, but also one that would go the extra mile to provide for the needs of its students.”

Knowlton believes the CRS scholarship will have a tremendous impact on his career. “Forming bonds with other CRS scholars, donors, and faculty will hopefully provide me with an opportunity to network with some of the past, present and future medical leaders of America,” he said.

Obi Umunakwe knew that Vanderbilt would provide him with a medical education that few other schools could match.

The M.D./Ph.D. candidate graduated from Howard University in 2008 with a B.S. in chemistry. He looked at current Vanderbilt research and determined it was in line with his interests. “What really sealed the deal for me was the people, both faculty and students, who I met from Vanderbilt during the application process,” he said. “They really gave me the feeling that Vanderbilt was very focused on the well-being of the students and that they would use whatever resources they could for student support. I felt as though I would be happier at Vanderbilt than any other school I was considering.”

Receiving the CRS scholarship will expand Umunakwe’s academic circles. “The Canby Robinson Society will provide me with an extra layer of support, should I ever need it,” he said. “It will also be an avenue to interact with some of the people who keep Vanderbilt Medical Center running.”

- JON COOMER

The Canby Coalition

For 30 years, the Canby Robinson Society has encouraged and honored those who support Vanderbilt

Medical Center. On Nov. 10, a new group, the Coalition for the Canby Robinson Society, launched with the goal of continuing the success of CRS.

The Coalition is made up of 26 alumni and community members with a wide range of associations to the medical center. The Coalition will be charged with recruiting new members to CRS and broadening the scale of support for the Medical Center.

The Coalition is led by Robert Collins, M.D., professor of Pathology, Robert McNeilly Jr., and Judson Randolph, M.D. The troika began to meet 10 years ago to build a scholarship program for Vanderbilt medical students, and their commitment led to the development of the Coalition.

All three attended Vanderbilt as undergraduates. Randolph and Collins were medical students together, and Randolph and McNeilly are past presidents of CRS.

“The Canby Robinson Society has a great reputation and has grown mostly on its own through that reputation. This is a push to increase that. It will bring more intentional recruitment of additional members,” McNeilly said.

Once the idea was proposed, similar models from other universities and medical centers were studied.

The leaders are especially passionate about reducing the debt of medical school students.

“Our working with the CRS through the Coalition is a natural extension of our interest in scholarship,” Collins said.

“Students generally borrow inordinate amounts of money to complete their schooling, and we want to reduce that debt burden,” McNeilly said. “As a result, their choice of specialty would be much freer, and it would attract to Vanderbilt even more first-class candidates. And ultimately, many will return to Nashville to practice, which builds up the community and maintains the tremendous accomplishments of the Medical Center.”

“I still think of medicine as a calling, and I refuse to think of it as an enterprise. I want them to be able to follow their

calling,” Randolph said.

“The Coalition will be a wonderful vehicle for increasing support to all areas of the Medical Center and to further engage donors about what matters most to them. The Canby Robinson Society reflects giving to all areas of the Medical Center from scholarships to chairs to facilities, research and departmental programs,” said Missy Eason, director of the Canby Robinson Society.

- LESLIE HAST

Giving back

Glenn and Barbara Merz have shared many triumphs and tears at Vanderbilt. The couple met at Vanderbilt as their late spouses were battling lung diseases after receiving transplants. Barbara helped establish a family/spouse support group where she and Glenn became close friends throughout the recovery process.

Barbara’s first husband, Vernon Rosser, was diagnosed in 1997 with Idiopathic Pulmonary Fibrosis (IPF), a lung disorder with no known cause and no cure, and was placed on a national waiting list for a transplant, along with 3,000 other hopeful patients.

In June 1997, a lung became available for Vernon. The complicated surgery at Vanderbilt was a success, even though Vernon faced many challenges during the long recovery and spent nine weeks in intensive care. Vernon recovered and he and Barbara enjoyed five years before he died in December 2002.

Glenn’s first wife, Joyce, also suffered from IPF and received a transplant in 1998. According to the Pulmonary Fibrosis Foundation, there are 5 million people worldwide who are affected by this disease. In the United States there are more than 200,000 patients with Pulmonary Fibrosis, with about 50,000 new cases diagnosed each year. As a consequence of misdiagnosis the actual numbers may be significantly higher.

(continued on page 52)

WHERE ARE THEY NOW? KENT K. ISHIHARA, M.D.

Kent K. Ishihara, M.D., and family are moving west.

In June, Ishihara will join the faculty at the University of California, Davis in the Division of Endocrinology, Clinical Nutrition, and Vascular Medicine.

Ishihara remained at Vanderbilt for internship and residency in internal medicine after graduating from VUSM in 2001, then relocated to Washington University in St. Louis for an endocrinology fellowship. After finishing his fellowship training in 2007, he joined a small endocrinology private practice, Hellman and Rosen Endocrine Associates, in Kansas City, Mo.

The former CRS scholar is grateful for the opportunity that the scholarship allowed him personally and professionally. "The CRS scholarship was, and continues to be, an amazing blessing," he said. "The scholarship helped me choose a path in medicine without the influence of a large burden of debt. Therefore, I was able to choose a less lucrative career in Endocrinology, where the needs are great because so few choose to spend the extra years in training for what amounts to essentially no financial reward."

The scholarship also allowed him to consider returning to a career in aca-

demics, where he can use the skills and experiences of his Vanderbilt education to provide care for patients with both simple and complex endocrine disorders, while helping to train the next generation of doctors.

He and his wife, Abigail (VUSN 2005), married in 2005 in Nashville, and their first baby, MaryJane Ruth, was born in 2008 in Kansas City. The couple both joined the Vanderbilt Medical Campus Outreach on a medical mission trip to the Philippines in 2006, and he again joined the team on a trip to Ghana in 2008.

- JON COOMER

Kent and Abigail Ishihara with MaryJane Ruth.



CRS members participated in a recent LifeFlight outreach tour.



TOMMY LAWSON

(continued from page 51)

Vernon and Joyce became very close friends during the transplant. Joyce died in February 2003, only nine weeks after Vernon.

"Joyce had been very ill prior to this and I think once Vernon was gone, though his passing was totally unexpected, she was ready also," Barbara said. "We both said they had something to do with us getting together."

Glenn and Barbara maintained their friendship after the deaths of their spouses, and eventually began dating. They married in January 2004.

As a way of giving back to the institution that means so much to them, that helped care for their spouses and brought them together, they have established the Glenn and Barbara R. Merz Scholarship for Medical Education and the Barbara and Vernon Rosser Endowed Fund in Lung Transplant Medicine.

The Merz Scholarship for Medical Education will fully endow a medical school scholarship fund, and the Rosser Endowed Fund will endow an unrestricted fund in the Department of Medicine supporting transplant medicine.

"Vanderbilt has impacted my life several times," Barbara said. "I was born there and developed a very serious disease myself. They used an experimental drug that helped save my life. It is known as penicillin."

Barbara recalls the care and compassion she and her husband received while being treated at Vanderbilt. "When Vernon was a transplant patient he did not do well the first few days and was put into a drug-induced coma," she added. "During those long nine weeks, doctors, nurses and even people I did not know came by his room in ICU to encourage and talk to me. I was not a spouse but a member of the Vanderbilt family."

- JON COOMER

save this date

CRS Dinner
May 16, 2009

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



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Vanderbilt Medical Alumni Reunion 2008

For those of you who attended Reunion 2008 on October 23-25, I hope you enjoyed your time on the Vanderbilt campus. A big thanks to our class chairpersons, class gift chairs and class party hosts for making this a truly wonderful event. If you were not able to make it to Reunion 2008, please refer to the back two pages of this issue for photographs from various Reunion festivities.

VMAA Board of Directors

Dr. Warren F. McPherson (HS '66-'72), VMAA President 2006-2008, presided over the VMAA Board Meeting, introducing Dr. Wyatt E. Rousseau (MD '69) as the next president of the VMAA to serve a term from Reunion 2008 to Reunion 2010, in tandem with the newly elected VMAA President-Elect, Dr. David W. Patterson (MD '85).

In addition, Dr. McPherson welcomed to the VMAA Board Dr. Brock L. Schweitzer, the current Post-Doctoral Organization representative, and installed the following medical alumni to serve as Specialty Society representatives from Reunion 2008 to Reunion 2012: Dr. Sam S. Chang (MD '92, HS '92-'94), Urology Society representative, Dr. James W. Felch (MD '77, HS '77-'81), Savage Society representative, Dr. Benjamin P. Folk III (HS '81-84, FE '86-'87) Friesinger Society representative, Dr. Alan H. Fruin (MD '67, HS '67-'73) Meacham Society representative, Dr. Thomas T. Dovan, Orthopaedics Society Representative (HS '97-'00), and Dr. Richard F. Treadway (MD '64, HS '64-'65) Luton Society representative.

Reunion 2008 VMAA Alumni Awards

During the Reunion 2008 festivities, the VMAA Award winners were honored at the Grand Evening Dinner held at the Loews Vanderbilt Hotel Symphony Ballroom. The 2008 VMAA Distinguished Alumni Award, VUSM's highest alumni honor, was bestowed upon Dr. Richard B. Johnston Jr. (MD 61, HS '61-'63) and Dr. Harold L. Moses (MD '62, HO '62-'65, FAC '68-'73, '85-present), the 30th and 31st recipients of this prestigious award. Dr. Clifton K. Meador (MD '55, HS '59, FE '60, FAC '73-'80, '82-Present) and Dr. Robert Sanders (MD '55, HO '55-'58, awarded posthumously) were honored with the VMAA

Alumni Achievement Award, an award that recognizes outstanding personal achievement and/or professional accomplishments by a VUSM alumnus or alumna. Mrs. Annette Eskind was the worthy recipient of the VMAA Distinguished Service Award, an award that recognizes an individual of exceptional merit whose dedicated and distinguished volunteer service has furthered the aims and goals of VUMC.

VMAA/ProQuest Health and Medicine

Due to positive feedback from our recent yearlong Vanderbilt Medical Alumni Association (VMAA) ProQuest Database trial, the VMAA is now opening enrollment to our VMAA/ProQuest Health and Medicine Complete users group. ProQuest Health and Medicine Complete is a 24/7 online resource offered through the VMAA at no charge for our medical alumni. ProQuest Health and Medicine Complete's online database provides access to almost 1,500 publications, including medical journals for most disciplines as well as consumer and health administration titles. User Group slots are currently limited by contractual agreement with ProQuest. We will enroll alumni on a first come/first serve basis until our group is filled. If you are interested in joining our VMAA/ProQuest Health and Medicine Complete users group, e-mail ann.price@vanderbilt.edu to check availability and learn more about this resource.

Worthy of Note News

Please take a moment to submit new submissions for our alumni news section in *Vanderbilt Medicine*. Please send announcements and digital photographs to medalum@vanderbilt.edu; fax to (615) 936-8475; or mail to VUMC Medical Alumni Office, 21st Ave South and Medical Center Drive, MCN D-8212, Nashville, TN 37232-2106.

Ann H. Price

KEY

- MD - Medical School Graduate
- HS - House staff
- FE - Fellow
- FA - Faculty
- CF - Clinical Faculty

* Indicates CRS member

40s

G. B. Hodge, M.D., MD'42, who helped found what is now USC Upstate, has chronicled the history of the campus and its leadership in his memoir, "Reflections on Building an Institution: The University of South Carolina-Spartanburg." A Spartanburg native and retired surgeon, Hodge helped establish the campus in 1967, when Spartanburg needed a nursing program to train students to work in a hospital setting.

John C. McGill, M.D., MD'46, retired from family practice after 44 years and sends his regards to his classmates.

David G. Stroup, M.D., MD'48, HS'48-'49, practiced obstetrics and gynecology in Atlanta from 1952-1992, and served as past president of the Atlanta Obstetrics and Gynecology Society and as chief of staff at South Fulton Hospital. He and his wife, Betty, have three children: David Jr., Susan and Betty Anne.

50s

Burton R. Bancroft, M.D., MD'58, retired from practicing surgery in St. Cloud, Minn., and is providing medical care at free clinics sponsored by St. Cloud Hospital and res-

idency program. He and his wife have two daughters, a son and three grandchildren — all live close by.

***Paul H. Barnett, M.D., MD'58**, and his wife, Paula, have recently returned from a trip to Israel, and have added both a bearded collie puppy and an eighth grandchild to their list of accomplishments. Grandson Phillip Daniel Lashinsky was born in August.

***Newton Bramblett Griffin, M.D., MD'57**, HS'57-'58, '60-'63, retired in September 1997, but still continues to earn enough CME credits to qualify for the AMA Physicians Recognition Award, which he has earned since 1969. He and his wife still travel in the United States and abroad.

Paul Huchton Jr., M.D., MD'58, HS'58-'59, presented a course on "China Today" at the University of Texas at El Paso. The course includes dynasties, other history, modern politics, current problems and events, the economic situation, and other pertinent facts about China.

John Owsley Jr., M.D., MD'53, was chosen as one of the Distinguished Professor Emeriti to be honored at a special Department of Surgery Grand Rounds at the University of California San Francisco, in August. He continues in an active plastic surgery practice in San Francisco, and is director of the Aesthetic Surgery Fellowship at the Aesthetic Surgery Institute at California Pacific Medical Center. In 2005, he was awarded a special citation for excellence in education by the Educational Foundation of

book focus



John H.K. Vogel, M.D., HS'57-'60, is practicing cardiology in Santa Barbara, Calif., and co-edited "Integrative Cardiology-Complementary and Alternative Medicine for the Heart." The text contains contributions of more than 40 authors. It can be obtained from www.amazon.com.

the American Society for Plastic Surgeons. His wife, Sharon, holds a law degree from the University of San Francisco Law School, and is a prosecuting attorney in the office of the San Francisco District Attorney.

Gerald E. Stone, M.D., MD'57, HS'57-'58, has been married to Lois Stone since 1956. They have 14 grandchildren, the oldest of whom, David Clay, is a pre-med senior at Vanderbilt.

60s

***John H. Dixon, M.D., MD'67**, HS'67-'70, reports that his son, John Trent, married Anne Benedetto in May 2008.

Gordon Nelson Gill, M.D., MD'63, HS'63-'64, emeritus professor of Medicine and Cellular and Molecular Medicine, has been appointed Dean for Scientific Affairs-Health Sciences at the University of California, San Diego. Prior to that, he was Dean for Translational Medicine. He and his wife, Patricia, vacationed with their family of 17, including four children, their spouses and seven grandchildren on Lake Martin in Alabama in 2008.

Joseph F. Lentz, M.D., MD'63, HS'63-'64, '67-'68, retired two years ago after practicing pediatrics in Nashville for 38 years. "A great time had by all," he reports. He and his wife, Betty, are staying busy, spending time with their four sons, their spouses, and 10 grandsons, age 2 to 15.

Rebekah Naylor, M.D., MD'68, was the first woman to graduate from the surgical residency program at the University of Texas Southwestern Medical Center in 1973. She then spent 30 years in India at the Bangalore Baptist Hospital serving as a doctor and hospital administrator. Naylor's classmate from Baylor University, Camille Lee Hornbeck, is the author of "Rebekah Ann Naylor, M.D.: Missionary Surgeon in Changing Times," which describes Naylor's experience improving and developing the hospital. This past June, Naylor received the 2008 Distinguished Alumnus award from the Parkland Surgical Society in Dallas.

Michael B. Seagle, M.D., MD'67, HS'71-'72, is chief of the Division of Plastic Surgery at the University of Florida College of Medicine.

***James A. Settle Jr., M.D., MD'68**, retired in 2006 as head of Atlanta Pulmonary Associates and medical director of Select Specialty Hospital in Atlanta. He is now practicing primary care at the Eglin V.A. Outpatient Clinic and lives in Niceville, Fla.

***Robert A. Sewell, M.D., MD'68**, HS'68-'70, HS'72-'76, reports that his son, Nathan, and wife, Leigh, live in Richmond, Va., where

worthy of note



Irv Heimburger, M.D., MD'57, HS'57-'58, (left), won the top award in the annual American Philatelic Society's 2008 Champion of Champions Competition in Hartford, Conn. His exhibit, titled "The U.S. Pictorial Issue of 1869 and its Usage," was judged the best of over 30 Grand Award exhibits from APS-certified national-level stamp shows from the preceding year. The American Philatelic Society is the largest organization for stamp collectors in the world, with nearly 50,000 members in 110 countries.

Nathan practices plastic surgery. A son, Malcom, a veterinarian, and his wife, Frances, live in Nashville with their son, Sewell's first grandchild, Charlie.

K. Shannon Tilley, M.D., MD'64, HS'64-'68, retired after practicing ophthalmology for 26 years, including more than two years in the U.S. Army in Hawaii. He also performed disability evaluations for 10 years. His wife, Gwen, retired as department chair for Business Technologies at Nashville State Technical Community College.

70s

Ralph I. Barr, M.D., MD'72, HS'73-'76 has practiced psychiatry in Columbia, Tenn., since 1980, and currently serves as the regional medical director for Centerstone in the Columbia region, continuing to pursue his interest in early music playing recorders. His wife, Donna, continues volunteer work for Maury County Library; son, Evan, is the principal percussionist with the Arkansas Symphony Orchestra in Little Rock; and daughter, Rachel Chandler, is a school librarian in Williamson County, Tenn.

***Janis Jones, M.D., MD'78**, has been practicing general pediatrics in West Palm Beach, Fla., since completing her residency at the University of Miami. She has a practice that encompasses private practice, public health pediatrics and hospitalist services. In July 2008, she became chief of staff of St. Mary's Medical Center and the Children's Hospital at St. Mary's. Her husband, Amos Talley, is retired from the Veteran's Administration and is now a real estate investor. Their daughter, Janine, is the business manager for her mother's medical practice, Children's Healthcare Associates.

***Ben Kibler, M.D., MD'72, HS'73-'77, FE'73-'74**, is the medical director of the Shoulder Center of Kentucky. He received the Jack Hughston Award from the American Physical Therapy

Association for lifetime contributions to sports medicine. He was featured in *Forbes Magazine's* annual baseball edition as a "catalyst for change" in baseball.

John H. Nading, M.D., MD'77, reports that his daughter, **Mary Alice Nading, M.D.**, graduated from VUSM in May 2008.

Kenneth Nix, M.D., HS'77-'80, is Internal Medicine Program Director, associate dean of the Mayo School of Graduate Medical Education, and vice-chair of the Department of Medicine at Mayo Clinic in Jacksonville, Fla. He was named a Mayo Distinguished Educator in 2001. His son, David, is a Fulbright fellow at Tohoku University in Sendai, Japan, studying the origins and trajectory of contemporary Japanese sustainable architecture. Daughter, Elizabeth, is a veterinarian in Atlanta.

Don Schweiger, M.D., MD'72, HS'72-'74, recently completed his fourth year as chairman of the Board of Low Country Medical Associates, a primary care organization of internists, family practitioners and pediatricians. He has been in private practice for 31 years and currently resides in John's Island, S.C., with his wife of 25 years, Susan.

Frederick Turton, M.D., HS'77-'80, is chair-elect of the American College of Physicians (ACP) Board of Regents. He has served on the board since 2003 and has held the position of chair of the ACP Ethics, Professionalism and Human Rights Committee since 2006. He is also vice chair of the ACP Services Political Action committee as well as the vice chair of the ACP Finance, Strategic Planning, and Health and Public Policy committees.

80s

Mike Blood, M.D., MD'81, and ***Steven O'Sheal, M.D., MD'81**, led a group of 19 Americans to Pwoje Espaw in southern Haiti



Aubrey Hough, M.D., MD'70, HS'70-'75, (seated), received the **Drs. Mae and Anderson Nettleship chair in Oncologic Pathology at the University of Arkansas for Medical Sciences**. Hough, a distinguished professor in the UAMS Department of Pathology, chaired the department for more than 21 years, served two terms as UAMS Medical Center chief of staff, and chaired the internal advisory committee of the Winthrop P. Rockefeller Cancer Institute. He is associate dean for translational research and special projects in the College of Medicine and has been named the College of Medicine Distinguished Faculty Scholar, the highest honor a faculty member at the UAMS College of Medicine can receive.

last March, to an orphanage of more than 600 children. They held a series of clinics and prescribed treatment including reading glasses and medications from their pharmacy. They have seen both quotidian and grave diseases such as pufferfish sting, malaria and HIV. Blood

has worked for three years with their organization, Medical Mission South Haiti, and has completed his ninth trip. He and his wife, June, have adopted Jacob Baptiste, a student, who asked Blood to be his best man at his wedding. Blood and O'Sheal thank their classmates



John Boldt Jr., M.D., MD'82, HS'82-'85, and his wife, Carla, worked in Quito, Ecuador, from 1992 — 2004, training national Ecuadorian physicians how to teach and take care of their own people. They have four children and are currently residing in Chattanooga, Tenn., where he is an assistant professor of Medicine at the University of Tennessee Medical Program at Erlanger Medical Center. He teaches residents, who hail from 14 different countries, in the critical care service.



***Sarah Samaan, M.D., MD'88, is a partner with Legacy Heart Center, a 15-member cardiology practice in Plano, Texas. Her book, "The Smart Woman's Guide to Heart Health," will be published by Brown Books in January. She and her horse, Helio, were ranked third nationally for their dressage division in 2007. She and her husband, Gary Cooper, have two dogs, one cat and four horses.**

for the generous donations, which help provide not only medical aid but also sports equipment, shoes and other necessities to the orphanage. They encourage and welcome alumni to participate in this project and have a Web site undergoing construction, mmshaiti.org.

John D. Gazewood, M.D., MD'87, was appointed Residency Program Director at the University of Virginia Department of Family Medicine and has been named to the "Best Doctors in America."

Alan List, M.D. FE'84-'87, has been appointed executive vice president, physician-in-chief of Moffitt Cancer Center in Tampa, Fla. Before joining Moffitt in 2003, he served as the head for the Leukemia and BMT Programs and the associate center director for clinical research at the Arizona Cancer Center.

Anthony Martin, M.D., FE '87 - '89, completed his second tour in

Iraq in June 2008. He served as the Deputy Commander for Clinical Services for the 325th Combat Support Hospital located in Tikrit, Iraq. He was awarded the Bronze Star Medal for service.

Paul Pearigen, M.D., MD'87, is a captain in the U.S. Navy Medical Corps. He has served as program director and chairman of Emergency Medicine and as group surgeon for two deployments in support of OEF/OIF. After completing a tour in Washington, D.C., as the executive assistant to the Surgeon General of the Navy, he began his current post as Deputy Commander, Naval Medical Center, San Diego. He is serving as chief operating officer of this large, teaching and referral military treatment facility with more than 6,200 staff and expenditures of more than \$500 million.

Eric Senn, M.D., MD'88, is the chief of staff at Grand Stand Regional Medical Center. He is also the secretary of the board of directors for the Carolinas Center for Medical Excellence and secretary of his corporation, Carolina Health Specialists, the largest, private multi-specialty group in South Carolina. He and Angelika have a 4-year-old son, Aleks.

***Ghodrat Siami, M.D., FE '81-'83** is president of the International Society for Apheresis and celebrated 50 years of service from the American Medical Association and the Nashville Academy of Medicine in 2005. His grandson is in medical school and will be the fourth generation physician in the family. His great grandson was born July 16, 2008.

90s

Felice Adler Shohet, M.D., MD'93, HS'93-'96, specializes in pediatric infectious diseases at Children's Hospital in Orange County, Calif.

***Bryan Becker, M.D., FE'92-'95,** has been appointed president of the National Kidney Foundation. Becker, professor of Medicine at the University of Wisconsin School of Medicine and Public Health, serves as vice-chair of the Department of Medicine, Physician-in-Chief and head of the section of Nephrology. A volunteer with the NKF for a decade, Becker hopes to increase awareness of kidney disease and the need for early detection through the expansion of the NKF's Early Evaluation Program that provides nationwide free screening for those at risk.

Thomas Boeve, M.D., MD'93, will complete 11 years of Otolaryngology private practice in Bristol, Tenn., this year. He and his wife, Jolene, have been married for 20 years and have four children. They are relocating to Kenya, East Africa, for full-time medical missions.

Elizabeth Cato, M.D., MD'92, clinical instructor in Nursing, has been appointed associate medical director of AmeriChoice by UnitedHealthcare. Cato, an internist by training, has extensive experience as a practicing physician in Nashville and as a health plan executive. AmeriChoice serves more than 180,000 TennCare beneficiaries in Middle Tennessee and manages TennCare services for an additional 83,000 members in East Tennessee.

Anderson Collier III, M.D., MD'98, returned to Vanderbilt after seven years of training in pediatric hematology-oncology at the University of Texas Southwestern Medical Center. He has been an assistant professor of Pediatrics for three years. He and his wife of four years, Rachel, celebrated the birth of their first child, Harrison, in June.

Brendan J. Collins, M.D., MD'99, has joined the Plastic and Reconstructive Surgery Center

Dirk Hamp, M.D., MD'91, HS'91-'94 and his wife, Paige Holland Hamp, have a new addition to their family of six. They recently traveled to Uganda, East Africa, to adopt 9-year-old Jane, and to help create "Embrace Uganda." In June 2008, they revisited Uganda to help finish a Vocational School building, engage in orphan outreach, conduct medical clinics and help create library resources.



at Mercy Medical Center in Baltimore.

Sara Dann, M.D., MD'92, is in private practice in Miami, treating children, adolescents and adults for psychiatry medical management and psychotherapy. She recently remarried and lives with her husband, Bob, and their six children.

Sarah Gladstone, M.D., MD'98, welcomed daughter Charlotte on Dec. 6, 2007. She joins big sister, Ellen.

Bassam Helou, M.D., MD'98, works with the Surgical Clinic in Nashville. He is married to Kris, and they have two children, Matthew, 5, and Gracie, 2.

James N. Johnson, M.D., MD'93, was named chief operations officer for Nashville Orthopedic Specialists, P.C. He and his wife, Catherine, have a son, James, 2.

Adam Kremer, M.D., MD'97, HS'97-'01, joined a private practice in Holland, Mich., at the Brain-and-Spine Center.

Laura Lawson, M.D., MD'98, HS'98-'03, FE'03, recently started a new practice, Tennessee Breast Specialists, in Nashville and is serving as a co-director of the Saint Thomas Health Services Breast Program. She has two sons – Wade, 4, and Luke, 2.

Kenneth Leone, M.D., MD'92, completed his neurology residency training and fellowship in EMG/Neuromuscular disease at the University of Virginia in 1997. He was in private practice for 10 years in Savannah, Ga., before recently joining the faculty in the Department of Neurology at UVA as a clinical associate professor. He is enjoying his new role as director of neurological outpatient services and becoming reacquainted with the area.

Robert Lowe III, M.D., MD'98, lives in Nashville, where he practices orthopaedic spine surgery. He has been married for six years and has four sons under 5.

Susan Massick, M.D., MD'97, lives in Columbus, Ohio, with her husband, Doug, 7-year-old son and 4-year-old daughter. She is a dermatologist at Ohio State University.

David Myers, M.D., MD'97, is finishing up his pediatric nephrology fellowship at Seattle Children's Hospital with a Master's of Epidemiology degree with an emphasis in clinical trials.

George Robinson II, M.D., MD'93, is enjoying a satisfying career as a general orthopaedist. He and his wife, Sara, have two daughters and spend their time attending their soccer, basketball, t-ball and volleyball games.

2000-

Ryan Bayley, M.D., MD'08, and **India Landrigan, M.D., MD'08**, were married on May 17. They met at and graduated from Harvard University.

John Matthew Conoyer, M.D., MD'03, HS'03-'08, has joined Midwest ENT Centre PC in St. Peters, Mo., where he is working alongside his father, ***Michael Conoyer, M.D., MD'75**. John Conoyer has also joined in the medical staff at Barnes-Jewish St. Peters Hospital. He and his wife, Ellen, are expecting their third child in May. They have two sons – Michael, 3, and James, 1.

Kara Danner, M.D., MD'02, has been employed by the Center for Women's Health and Specialty Services since January 2007 and was voted Gerald Champion Regional Medical Center's 2007 Physician of the Year. She and her husband, Mark, have two children – Aleah, 2, and Weston, born June 8, 2008.



Ron Wells, M.D., MD'00, and his wife, Elizabeth, welcomed Catherine Victoria Wells on June 29, 2008. She joins older sister Caroline, 2. They live in Germany where Ron is a pediatric cardiologist at Landstuhl Regional Medical Center.



Mark DeJong, M.D., MD'01, HS'04, (right) and **Jeffrey Smithers, M.D., MD'03**, practice together in St. Louis, Mo., at Southern Illinois Sports Medicine. They are taking care of primary care sports medicine and non-surgical orthopaedic issues for adults and children. DeJong completed his internal medicine residency at Vanderbilt in 2004 and his primary care sports medicine fellowship at Duke. Smithers completed his internal medicine/pediatrics residency in Phoenix, Ariz., and his primary care sports medicine fellowship at Arizona State University.



The VMAA hosted a dinner in San Francisco in conjunction with the Scott Society's annual meeting in October 2008. Pictured here are VUMC's current Chief Residents of Surgery (left to right) **Eric Castaldo, M.D., M.P.H.**, **Joseph A. Greco, M.D.**, **Truman M. Earl, M.D., MSCI**, **Aaron W. Eckhauser, M.D., MSCI**, and **Clinton A. Marlar, M.D., MD'04**.

Matthew Harris, M.D., MD'02, will be leaving the U.S. Navy and starting a radiology residency at the University of Florida, in the summer of 2009.

Jon Heavey, M.D., MD'03, is currently on active duty in Kadamiyah, Baghdad, at a forward trauma station. He and his colleagues set up a small 501(c)3 non-profit foundation there and have been evacuating children to the United States for surgery. He has finalized agreements with Amazon.com, Lowe's and Gap brands to help raise money to transport these children to academic medical centers. For more information, visit www.hope.md.

Susannah Quisling Longmuir, M.D., MD'03, is an assistant professor of Pediatric Ophthalmology at the University of Iowa Department of Ophthalmology. She and her husband welcomed their first child, Charlotte, on Feb. 29.

Morgan McDonald, M.D., MD'03, moved back to Nashville and accepted a faculty position with the Med-Peds program at VUMC to establish a community health

curriculum. She and her husband, Brent, have an 18-month-old son, Whit.

Milton Ochieng', M.D., MD'08, and his younger brother, Fred Ochieng', a third-year VUSM student, have established a clinic in their home village of Lwala in Kenya. The clinic sees 100 patients a day since opening in April 2007. Benefiting from a U.S.-based nonprofit, the Lwala Community Alliance, the clinic is trying to expand with a maternity ward and HIV/AIDS wing. The U.S. dollar stretches far there. An emergency surgery for an ectopic pregnancy would cost at least \$10,000 in the U.S. but was \$250 at their clinic, Ochieng says. Donations and awareness are being raised as they continue to receive more patients.

Lynn Bunch O'Neill, M.D., MD'02, is an assistant professor of Geriatrics at Mount Sinai School of Medicine and co-director of the Integrated Palliative Medicine Fellowship at the Hertzberg Institute of Palliative Care. She and James O'Neill Jr., were married July 12 in New York City.

Emily Stoneman Shuman, M.D., MD'03, married Andrew Shuman in December 2007. She is a fellow in infectious diseases at the University of Michigan.

Elizabeth Atkinson Zow, M.D., MD'02, and her husband, Mark, welcomed their second son, Lucas, on Sept. 19, 2008. He joins his two-year-old brother, Adam.

worthy of note



Dear Dr. Price,

On behalf of our 3rd Grade Class at Gilbert Elementary at Harlandale ISD - San Antonio, TX, we want to thank you for allowing us the opportunity to represent Vanderbilt University School of Medicine this year! We have had an amazing year that offered many wonderful challenges.

Our 3rd grade students have been extremely motivated and hard-working individuals. This year has been exceptional. We are an Exemplary Campus, the only one in our district! As third graders, they must pass their TAKS tests in order to be promoted to the next grade. I am proud to inform you that our Commodores came out with 100% passing in Reading and Math! This is quite an accomplishment!

As we finish this school year, and prepare ourselves for next year, let me just say that representing Vanderbilt has been a truly wonderful experience. Representing Vanderbilt has given us the opportunity to do a little research on our school, mascot, and colors. I am proud to say that our class is representing the only medical school on our campus!

I would like to take this opportunity to thank you Dr. Price for the t-shirts that you've sent our students. They wear them proudly on our College Bound Pep Rally Days.

Raquel M. Zepeda
 Science Teacher-3rd-5th grade
 E.H. Gilbert Elementary, Harlandale ISD - San Antonio, TX
 TEA Exemplary Campus



Esther Maksymovitch Penn, M.D., MD'98, and **Dan Penn, M.D., MD'98,** had a baby girl, Misha Elle, on Oct. 6, 2008.

Colleen Brophy, M.D., joined Vanderbilt Medical Center's Department of Surgery in July 2008. She is Vanderbilt's only female physician professor of Surgery and the only female surgeon in the Division of Vascular Surgery. She is also the first female chair of the Bioengineering, Technology and Surgical Sciences Study Section at the National Institutes of Health, a two-year term she recently accepted. Brophy comes to Vanderbilt from Arizona State University where she was a research professor of Kinesiology at the Center for Metabolic Biology and an adjunct professor of Bioengineering and Cellular and Molecular Biology. She was also chief of Vascular Surgery at the Carl T. Hayden VA Medical Center in Phoenix and a clinical professor of Surgery at the University of Arizona.

Roger Chalkley, Ph.D., has been elected by the National Academies of Science as chair of the Committee to Study the National Needs for Biomedical, Behavioral, and Clinical Research Personnel. Over the course of two years, this task force will conduct a review and prepare a report to the National Institutes of Health (NIH) and the Agency for Quality Research (AHRQ) on issues regarding research personnel needs. The focus of the committee will be gathering and analyzing information regarding the employment and education trends of research scientists in the biomedical, behavioral and clinical sciences, as well as oral health, nursing and health services research. Chalkley, who came to Vanderbilt in 1986, was also named president-elect of the American Association of Medical Colleges group on Graduate Research Education and Training.

***Kevin Churchwell, M.D.**, CEO of the Monroe Carell Jr. Children's Hospital at Vanderbilt was recently named one of *Nashville Business Journal's* 2008 Health Care Heroes. The publication said Churchwell was selected because of his ability to balance personal relationships with the business demands of running Children's Hospital. The list honors the innovators, strategists and pioneers whose work is helping to grow the region's health care industry.

***Jayant Deshpande, M.D.**, anesthesiologist-in-chief at Children's Hospital, is serving as president of the Society of Pediatric Anesthesia (SPA), a national organization dedicated to improved pediatric perioperative care. In this role, Deshpande is overseeing "Wake Up Safe," a quality improvement initiative to collect and probe causes of negative events during anesthesia in children. This is

the first comprehensive study of its kind ever conducted in pediatric anesthesiology.

Roland "Ron" Eavey, M.D., of Harvard University, will become the new chair of Vanderbilt's Department of Otolaryngology and director of the Bill Wilkerson Center for Otolaryngology and Hearing and Speech Sciences, effective February. Eavey, director of ENT Pediatric Services at Massachusetts Eye and Ear Infirmary at Harvard since 1981, succeeds founding chair ***Robert Ossoff, M.D.**, who announced last year that he would transition into a new role at Vanderbilt in December. The nationwide search also yielded a strong addition to the Monroe Carell Jr. Children's Hospital at Vanderbilt, as Eavey's wife, **Sheila Desmond, M.D.**, also a faculty member and pediatrician at Harvard, will join the Vanderbilt faculty. Desmond is currently Unit Chief of Adolescent and Pediatric Medicine at the MGH Chelsea HealthCare Center in Boston.

Kathryn Edwards, M.D., and ***Jeff Balsler, M.D., Ph.D.**, dean of VUSM and associate vice chancellor for Health Affairs, have been elected to the Institute of Medicine (IOM) of the National Academies. Edwards and Balsler join 17 other Vanderbilt faculty members elected to the IOM in previous years. Edwards holds the Sarah H. Sell Chair in Pediatrics and serves as vice chair for Clinical Research for the Department of Pediatrics.

Peter Giammalvo, Ph.D., chief learning officer at Vanderbilt Medical Center, was named a fellow of the American College of

Healthcare Executives, the nation's leading professional society for health care leaders. To obtain fellow status, health care executives must fulfill requirements including passing a comprehensive exam, meeting academic and experiential criteria, earning continuing education credits and demonstrating professional and community involvement. Fellows commit to ongoing professional development and are recertified every three years. The American College of Healthcare Executives is an international professional society of more than 30,000 members dedicated to improving health care delivery.

Brent Graham, M.D., has been named director of the Division of Pediatric Rheumatology at the Monroe Carell Jr. Children's Hospital at Vanderbilt. Graham previously served as clinical director of the Division of Pediatric Rheumatology at Cincinnati Children's Hospital Medical Center. He joined the faculty there in 1998 after serving a three-year fellowship. Graham, who grew up in Nashville and graduated from Vanderbilt's School of Medicine, is the son of ***Thomas Graham, M.D.**, professor of Pediatrics, Emeritus. Graham's research interests include musculoskeletal imaging and juvenile fibromyalgia.

***Frank Harrell Jr., Ph.D.**, chair of the Department of Biostatistics, delivered the keynote speech last summer at the Statistical Science Awards Ceremony, Centers for Disease Control and Agency for Toxic Substances and Disease Registry in Atlanta. In May 2008, he spoke at the annual meeting of statisticians of the Cleveland



***Jason Morrow, M.D.**, chief of the Division of Clinical Pharmacology in Vanderbilt Medical Center's Department of Medicine, died on July 8, 2008. He was 51.

Dr. Morrow received his bachelor's degree from Vanderbilt University and his M.D. from Washington University in St. Louis, his hometown. He served his medical internship and residency at Vanderbilt, and was chief medical resident from 1987 to 1988, when he joined the Division of Clinical Pharmacology as a research fellow.

In 1990, he and Jackson Roberts, M.D., discovered a series of compounds called isoprostanes that help researchers reliably detect and monitor free radical damage. Also called "oxidative stress," this damage has been implicated in the development of atherosclerosis, age-related macular degeneration and neu-

rodegenerative diseases.

Dr. Morrow joined the Vanderbilt faculty in 1994, and later was named the F. Tremaine Billings Professor of Medicine and professor of Pharmacology. In 2005, he became the fourth chief of the Division of Clinical Pharmacology, which currently has 190 employees and a \$33 million annual budget.

He is survived by his wife, Lisa, and their children, Jeremy and Stephanie.

Clinic, Case Western Reserve University, and Ohio State University and was also the invited keynote speaker for the Biostatistics Annual Talk at the Medical College of Wisconsin. Harrell also recently was named the 2008 Mitchell Lecturer for the Department of Statistics by Glasgow University, Scotland.

***Billy Hudson, Ph.D.**, project leader and director of the Center for Matrix Biology, heads a group of researchers at VUMC who have been awarded a Program Project Grant (PPG) to study the kidney's filtration mechanism. The grant, funded by the National Institute of Diabetes and Digestive and Kidney Diseases, awards \$6 million over five years.

Tina Iverson, Ph.D., assistant professor of Pharmacology, received a Young Investigator Award from the National Alliance for Research on Schizophrenia and Depression (NARSAD), the world's leading mental health research charity. The two-year, \$60,000 awards are given to early-career scientists who study psychiatric disorders. Iverson will study the sensing of the neurotransmitter dopamine.

***James Johns, M.D.**, professor of Pediatric Cardiology at Monroe Carell Jr. Children's Hospital at Vanderbilt, has been appointed to the TennCare Pharmacy Advisory Committee by Tennessee Gov. Phil Bredesen. Johns will serve as the pediatric representative on the advisory committee, which meets quarterly to make evidence-based recommendations to the TennCare Bureau regarding medications to be included on the Preferred Drug List. The appointment runs through July 31, 2011.

***Pat Levitt, Ph.D.**, director of the Vanderbilt Kennedy Center, is stepping down after six years at Vanderbilt to pursue other opportunities. Levitt, the Annette Schaffer Eskind Chair, has accepted a position at the Keck School of Medicine, University of Southern California. He will be director of the Zilkha Neurogenetic Institute, chair of the Department of Cell and Neurobiology, and Provost Professor of Neuroscience, Psychiatry and Pharmacy. Associate Director

***Elisabeth Dykens, Ph.D.**, will serve as VKC interim director while a nationwide search is conducted for Levitt's successor.

***Lawrence Marnett, Ph.D.**, professor of Biochemistry, Chemistry and Pharmacology, has received the first Founders' Award from the American Chemical Society's Division of Chemical Toxicology. The award recognizes Marnett's contributions to the field of chemical toxicology. Marnett received the award during the fall ACS meeting. Marnett is the founding and current editor of the ACS journal *Chemical Research in Toxicology*, which just celebrated its 20th year. He was also one of the founders of the ACS Division of Chemical Toxicology. He is the director of the Vanderbilt Institute for Chemical Biology and the Mary Geddes Stahlman Professor of Cancer Research.

***Michel McDonald, M.D., M.B.A.**, director of Cosmetic Dermatological Surgery, has won the Nashville Emerging Leader Award for medical and health care services. These awards, sponsored by the Nashville Area Chamber of Commerce and the 20/20 Leadership Alliance, cover 13 categories and are given to young professionals under the

age of 40 who show outstanding commitment to their community. McDonald is a founding member of the Blade and Light Society, which provides volunteer surgical care to underserved communities around the globe. She has been appointed to the Governor's Council on Physical Fitness and Health and currently sits on the boards of Fifty Forward and Friends of Nashville Ballet. In dermatology, McDonald has special expertise in Mohs micrographic surgery.

John McPherson, M.D., assistant professor of Medicine, medical cardiology director, and John Selby, M.D., professor of Clinical Anesthesiology and Clinical Surgery, accepted the surgical director post in July – teaming up to care for Vanderbilt Heart's sickest patients on the Cardiovascular Intensive Care Unit (CVICU). This unique approach to dual leadership reflects the overall vision of Vanderbilt Heart and Vascular Institute (VHVI), which is collaboration between cardiologists and cardiac surgeons, two groups historically separated by professional differences of opinion.

***Bonnie Miller, M.D.**, associate dean for Undergraduate Medical Education, is heading a research project that received a \$199,000 grant from the Arthur Vining Davis Foundation to study the effects of moral distress on medical students.

***Harold (Hal) Moses, M.D.**, professor of Cancer Biology and Director Emeritus of Vanderbilt-Ingram Cancer Center, has been designated a National Associate, an honorary title given in recognition of extraordinary service to the National Research Council in its role as adviser to the nation in matters of science, engineering and health, by the authority of the Council of the National Academy of Sciences and the Institute of Medicine. Membership in this group is offered as a lifetime appointment. Moses is the Founding Director of Vanderbilt-Ingram and current director of the Frances Williams Preston Laboratories. He is well known for his work on the transforming growth factor-beta family of growth regulatory peptides.

***Jeanette Norden, Ph.D.**, professor of Cell and Developmental Biology and a Master Science Teacher at Vanderbilt University School of Medicine, recently received a Compassionate Friends Professional Award from The Compassionate Friends (TCF), a national support group for families who have lost a child. The awards are given to a professional psychologist, counselor or other practicing professional who has contributed in the area of supporting, assisting and edu-



Brent Polk, M.D., chief of the Division of Pediatric Gastroenterology, was recently honored as the division was renamed in his honor – the Brent Polk Division of Pediatric Gastroenterology, Hepatology and Nutrition. Since becoming chief, Polk has built the division from just three full-time faculty to 12. The division is now one of the largest of its kind and is among the top three in grant awards from the National Institutes of Health. Polk has also taken leadership

of the Digestive Diseases Research Center. Along with associate director Richard Peek, M.D., director of the adult Division of Gastroenterology, Hepatology and Nutrition, Polk is guiding the center through unprecedented growth.

cating others about dealing with loss. Norden, a neuroscientist, incorporates first-person accounts of dealing with brain-related illnesses into the neuroscience course for medical students.

Thomas Oeltmann, Ph.D., associate professor of Medicine and Biochemistry, has been elected president-elect of the Society for Glycobiology, an international association that brings together scientists studying “glycans” — sugars and sugar-containing molecules. He will serve as president in 2009. Oeltmann served on the board of directors and as secretary of the Society for Glycobiology from 1993-2006 and was also on the editorial board of the society’s journal, *Glycobiology*, for 10 years. As president-elect of the Society for Glycobiology, Oeltmann will chair the committee responsible for awarding up to \$50,000 in travel grants to graduate students to attend the annual meeting. In 2009, as president, Oeltmann will have responsibility for all organizational aspects — scientific program, social program, location and logistics — for the society’s 2009 annual meeting.

Christopher Olsen, Ph.D., research instructor in Molecular Physiology and Biophysics, received a Young Investigator Award from the National Alliance for Research on Schizophrenia and Depression (NARSAD), the world’s leading mental health research charity. The two-year, \$60,000 awards are given to early-career scientists who study psychiatric disorders. Olsen will investigate physiological changes in a rarely studied population of neurons (dopamine neurons within the A10dc region) following repeated stress.

Beth Price, M.B.A., has been named to the newly created position of chief executive officer of the Vanderbilt-Ingram Cancer Center. Price has served as oncology operations strategist for Vanderbilt-Ingram and Vanderbilt Medical Group since June 2007, where she assisted in the development and implementation of the regional market oncology strategy and served as interim business officer for the Cancer Center. As CEO Price will be responsible for expanding quality cancer services in the Middle Tennessee market and the Southeast, enhancing Vanderbilt-Ingram’s status as a top 15 National Cancer Institute-designated Comprehensive Cancer Center and providing administrative and business leadership.

Baxter Rogers, Ph.D., research assistant professor of Radiology and Radiological Sciences, received a Young Investigator

Award from the National Alliance for Research on Schizophrenia and Depression (NARSAD), the world’s leading mental health research charity. The two-year, \$60,000 awards are given to early-career scientists who study psychiatric disorders. Rogers will use functional magnetic resonance imaging (fMRI) to determine how different parts of the hippocampus interact with cognitive networks in other parts of the brain. Studying these subdivisions may help contribute to understanding the functional roles of the hippocampus and how it breaks down in psychiatric disorders.

***Mace Rothenberg, M.D.**, HS ‘82-’85, chaired the 2008 GI Cancer Conference at the Opryland Hotel in Nashville in October.

Uchechukwu Sampson, M.D., assistant professor of Cardiovascular Medicine, has received a grant from the Robert Wood Johnson Foundation. He was selected for the Harold Amos Medical Faculty Development Program, a four-year postdoctoral research award. The Harold Amos Medical Faculty Development Program was created to increase the number of faculty from historically disadvantaged backgrounds who can achieve senior rank in academic medicine. Sampson, who is based at Meharry Medical College and VMC, will perform studies of inflammation in abdominal aneurysms.

Kim Smith, M.D., clinical fellow in Nephrology, has received a grant from the Robert Wood Johnson Foundation, being named to the Clinical Scholars Program, which provides postdoctoral training for young physicians interested in research and leadership careers in health policy and academic medicine.

Luc Van Kaer, Ph.D., professor of Microbiology and Immunology, was recently named deputy editor of the *Journal of Immunology*. He will serve a five-year term as one of 10 deputy editors for the journal. He previously served as an associate editor for the journal from 2002 to 2006 and as a section editor since 2006. As a deputy editor, Van Kaer will make editorial decisions about approximately 400 papers per year, handle rebuttals from authors, nominate manuscripts for the “In This Issue” section of the journal, and suggest topics and authors for the “Brief Reviews” and articles for the “Pillars of Immunology” sections of the journal.

David Wasserman, Ph.D., the Ron Santo Chair in Diabetes Research and professor of Molecular Physiology and Biophysics, has



***Karen Summar, M.D.**, has been named medical director of the Down Syndrome Clinic at the Monroe Carell Jr. Children’s Hospital at Vanderbilt. The clinic provides comprehensive

medical evaluations for individuals who have Down syndrome.

received a coveted MERIT (Method to Extend Research in Time) award from the National Institutes of Health for his research on metabolism. Less than 5 percent of NIH-funded investigators are selected to receive MERIT awards, which reward consistently high grant performance with up to 10 years of continuous funding without competitive review. The extended grant duration will “make it possible to conduct high-risk research with a high scientific impact,” said Wasserman. With the funding, his group will investigate the mechanisms that control carbohydrate and fat metabolism in the liver and the conditions that cause the liver to accumulate fat, an early sign of type 2 diabetes and metabolic syndrome.

Elizabeth Yang, M.D., Ph.D., has received a \$50,000 grant for her genetic research. Yang’s research project will study how SHP2 (a cancer-causing gene found in childhood leukemias) causes B cell leukemia.

Amy Mayes Becker, M.D., MD '44, HS '44-'46, died Oct. 23, 2008. She was 90. Dr. Becker graduated summa cum laude from Carson Newman College and was one of two women to graduate from VUSM in 1945. She lived in Knoxville, Tenn., and was a pediatrician. She is survived by her second husband, Felix G. Line, M.D.; three children Amy, Chris and Stephen; and 12 grandchildren.

Janet Kay Boyles M.D., MD '95, died Dec. 22, 2006. She was 59. In 1995 Dr. Boyles was a postdoctoral Fellow and research associate in cell biology for Yale University school of Medicine. She worked as a staff physician in occupational medicine for Barnes Jewish Hospital in St. Louis from 1998-2001. She is survived by her brother Bradley Boyles; sister, Julie Fuller; and Kenneth Boyles.

James Henry Brown M.D., HS '49-'52, died May 3, 2008. He was 84. After serving as clinical instructor and associate professor at Tulane University School of Medicine, from 1956-1965, he formed his own practice in psychoanalysis in New Orleans for

more than 39 years. Dr. Brown gave more than 50 years of service to the American Psychiatric Association and was one of the founding members of the Louisiana Psychoanalytic Association. He is survived by his wife, Carol Brown; sons Dr. Thomas Brown III and Dr. James Brown; and 11 grandchildren.

Catherine Bell Brummett, M.D., MD '38, died July 17, 2008. She was 94. She practiced as a pediatrician in Middlesboro, Ky., and Aberdeen, Miss., and later held well-baby clinics for the Tennessee Public Health Department in Nashville and the Alabama Public Health Department in Birmingham. She lived in Mountain Brook, Ala., for 48 years. Dr. Brummett was active in volunteer medical missions to India, Nigeria and Israel. She is survived by five children, Jane, Betty, Chester Jr., Catherine and Grant; six grandchildren; and eight great-grandchildren.

William J. Callison M.D., MD '53, HS '57-'60, died May 11, 2008. He was 79. Dr. Callison was an orthopaedic surgeon who spent

35 years practicing medicine in Asheville, N.C. In 1982, he began a solo practice of foot and ankle surgeries, which he continued until his retirement in 1995. He is survived by his wife, Patricia Callison; three children, Anne Stokely, William and Frank; and seven grandchildren.

Henry Coppolillo, M.D., FA '71-'76, died Aug. 26, 2008. He was 82. He was born in Calabria, Italy, and his family settled in Chicago. He held medical school posts at the University of Michigan and Vanderbilt. In 1976 he became the chair of the new training and clinical programs in child psychiatry at the Colorado University Medical Center. Dr. Coppolillo then resumed private practice, acted as consultant to several area hospitals and psychiatric societies, and continued to write for assorted psychiatric and medical journals. He is survived by his daughter, Catherine; two sons, Pete and Rob; and two grandchildren.

Paul Fatum, M.D., MD '58, died August 7, 2008. He was 78. Fatum served the West Michigan community for 44 years as a kind and compassionate anesthesiologist at Butterworth Hospital. He served as chief of the Department of Anesthesiology for 14 years and as a member of the Butterworth Hospital Board of Trustees for eight years. Dr. Fatum is survived by his wife of 50 years, Shirley; his children, Mary Ann, Mark, Teresa and Monica; and 10 grandchildren.

Maurice Fox, M.D., MD '57, HS '57, FE '60, died July 31, 2008. He was 76. From 1964 until his retirement in 1990, he practiced internal medicine and endocrinology at the Palo Alto Medical Foundation and was a clinical professor of Medicine at the Stanford University School of Medicine. He was one of the first endocrinologists to practice in the area and was a leader and innovator in the treatment of diabetes. Dr. Fox is survived by his wife, Ellen; their children Susan,

Arthur, Maggie, Peggy and John; and seven grandchildren.

•John D. Franklin, M.D., HS '67-'77, died Sept. 16, 2008, from injuries sustained in an automobile accident. He was 65. A Chattanooga plastic and reconstructive surgeon for 26 years, he was chairman of the Department of Plastic Surgery, Chattanooga Area Unit, University of Tennessee College of Medicine, and president and aesthetic and plastic surgeon with Specialists in Plastic Surgery, Chattanooga. Dr. Franklin was instrumental in the development of the microsurgical free deltoid flap in 1981. He is survived by two sons, Joe David and Timothy Lee, and four grandchildren.

John Alexander Galloway II, M.D., MD '62, died at his home in East Cornwall on Aug. 21, 2008. He was 71. A surgeon, he was associated with many different hospitals including Charlotte Hungerford Hospital where he was a pioneering director and founder of the Cardio-Pulmonary Lab and chief of the Department of Surgery. Dr. Galloway spent the last six years working as a locum tenens in surgery at Johnstown Memorial Hospital in Johnstown, Pa., and Jackson Memorial Hospital in Jackson, Tenn. He is survived by his wife, Laurel; children, Laura, Ellen, Julia, Alexandra, Kyle and Christopher; and eight grandchildren.

Leo Gibson M.D. MD '61, died June 15, 2008. He was 72. Dr. Gibson served as an Ob/Gyn for 36 years in Picayune, Miss., before retiring five years ago. He is survived by his wife, Lisa Gibson; his daughters, Laura Anne, Karen Leigh and Kristy; two grandchildren; stepchildren, Jodi, Rachel, Angie and Matthew; and nine step-grandchildren.

***Alvin F. Goldfarb, M.D., MD '47,** of Center City, Pa., a professor of obstetrics and gynecology at Thomas Jefferson University and a pioneer fertility researcher, died



Allan F. Moore, M.D., MD '03, the Young Alumnus Representative on the Vanderbilt Medical Alumni Association Board of Directors, died in July 2008 in Philadelphia from injuries sustained in a motor vehicle accident. He was 31.

Dr. Moore, a fellow in endocrinology at Massachusetts General Hospital, was researching the prevention and complications of diabetes there and at the University of Pennsylvania School of Medicine and was also working toward a master's degree in medical science at Harvard Medical School.

His wife, Rebekah Gee, M.D., who was also seriously injured in the accident, is an obstetrician-gynecologist and a Robert Wood Johnson clinical scholar at the University of Pennsylvania Medical School. She is the daughter of former VU chancellor Gordon Gee.

A native of Danville, Va., Dr. Moore was a member of Alpha Omega Alpha and a Canby Robinson Society Scholar while a student at Vanderbilt and received the Albert Weinstein Prize in Medicine from Vanderbilt, given to a student who has demonstrated high scholastic attainment and qualities.

on Nov. 1, 2008. He was 85. Dr. Goldfarb joined the faculty at Jefferson in 1959, where he taught generations of doctors in reproductive endocrinology until 2006. He founded the North American Society for Pediatric and Adolescent Gynecology and the Adolescent Wellness Through Access to Resources to Education (AWARE) Foundation in 1998, which provides confidential online interactive help at (www.awarefoundation.org). Dr. Goldfarb is survived by sons Michael, Robert and Daniel; a daughter, Lisa; and five grandchildren.

***Noel C. Hunt III M.D.**, MD '61, HS '61-'66, died May 15, 2008. Dr. Hunt was a U.S. Air Force veteran and a founding member of the Chattanooga Heart Institute. He is survived by his wife, Trisha Hung; three children, Noel, Peter and Claire; stepdaughters Wendi and Aimee; and 10 grandchildren.

***E. Palmer Jones, M.D.**, MD '43, died Oct. 5, 2008, in Nashville. He was 88. Among the first class at Vanderbilt to graduate in uniform during World War II, he began his medical career at Saint Thomas Hospital in 1951, and was one of the first anesthesiologists to set up practice in Nashville. From 1951-1967, Dr. Jones served as director of the Saint Thomas Department of Anesthesiology. An avid Vanderbilt sports fan, his family reports that he watched the Commodores football team improve their record to an undefeated 5-0 the night before his death. Following his retirement in 1991, he archived the history of his life and catalogued his memorabilia into 50 books. He is survived by his wife of 65 years, Dorothy; four children, Pamela, Elizabeth, E. Palmer Jones Jr., and Marjorie; six grandchildren; and five great grandchildren.

Otto Morse Kochtitzky, M.D., MD '50, died June 26, 2008. He was 87. Dr. Kochtitzky was chairman of Nashville's Park View Hospital and Chief of Medicine at Baptist Hospital. In the mid-'70s,

he was named chairman of the Board of Trustees and president of the Tennessee Medical Association. He also served as an officer of the Tennessee Public Health Council of the Tennessee Public Health Department and as President and chairman of the board of the Middle Tennessee Heart Association. He is survived by his son, Rodney, and two grandsons.

Archie Louis Lester, M.D., MD '50, HS '50-'51, died Sept. 8, 2008. He was 86. He practiced internal medicine in Lake Charles, La., from 1956 until 1987. Dr. Lester is survived by his wife, Mary Edith; four daughters, Shevawn, Dedrah, Mariet and Kerry; and nine grandchildren.

***Charles H. Marks, M.D.**, MD '51, died June 30, 2008. He was 80. He and his family moved to Ocala, Fla., where he was Ocala's first board certified surgeon in 1957. Dr. Marks practiced as a surgeon for 33 years until retiring and volunteering at the Marion County Public Health Department Surgical clinic for 14 years. He is survived by his wife, Kay Marks, five children, and 12 grandchildren.

***Myron Morris M.D.**, MD '58, died June 28, 2008. He was 83. A volunteer for the Tucson Interfaith HIV/AIDS Network (TIHAN) for 12 years, Dr. Morris established the auction, "Treasures for TIHAN," which has raised more than \$1.4 million for the network.

John T. Rawlings, M.D., MD '53, died May 12, 2008, at his home in Frankfort, Ky. He was a general surgeon practicing in Frankfort for 25 years before retiring in 1994. He also served for many years as a medical consultant at Disability Determination Services for the Commonwealth of Kentucky. He is survived by his wife, Carol; a son, John Thomas Jr.; daughter, Cynthia; and four grandchildren.

***John Salyer, M.D.**, MD '38, HS '38-'39, died July 25, 2008. He

was 96. Salyer performed what is believed to be the first open-heart surgery in Orange County in 1961 when he repaired a hole in the heart of a 5-year-old boy. He also performed Orange County's first cardiac pacemaker implant in 1963. Dr. Salyer served 20 years in the U.S. Army, attaining rank of colonel, before establishing his practice in Santa Ana in 1959. He is survived by his wife, Jill; daughter, Barbara Yagi; son John M. Salyer Jr.; two grandchildren; three great-grandchildren; two stepchildren; and two stepgrandchildren.

Joseph Steranka, M.D., MD '60, HS '60-'63, died Sept. 5, 2008, at his home in Dickson, Tenn. He was 87. He practiced pediatric medicine in Nashville for 15 years, then in Dickson from 1977 until his retirement in 1992. Dr. Steranka is survived by his wife of 68 years, Irene; sons, Joseph Jr., and Larry; five grandchildren; and five stepgrandchildren.

***Joseph Garland Stroup, M.D.**, MD '54, HS '54-'57, died Sept. 12, 2008, at his home in Napa, Calif. He was 78. Establishing a practice in 1962, Dr. Stroup was the first board-certified pediatric allergist in the Sacramento, Calif. His practice eventually expanded to include offices in Carmichael, Yuba City, Auburn, Grass Valley, Elk Grove and Lodi. He had a love of travel, food and music. He preferred France and Italy, but took family and friends with him on trips to every continent. He is survived by his wife, Kathy; children, Jane, Joe, Ruth, Lee and Elizabeth; and six grandchildren.

Lucian L. Tatum, Jr. M.D., MD '61, HS '61-'62 died April 27, 2008. He was 72. A member of the American Urological Association, the Southeastern Section of Urology, the American College of Surgeons, and the American Medical Association, he spent 42 years practicing medicine and served as Chief of Staff and on the Board of Spalding Regional Medical Center. Dr. Tatum is survived by his wife, Nora; daughter,

Anna; sons, Lucian III, Alex and Coleman; and eight grandchildren.

William Wehunt, M.D., MD '72, died June 10, 2008. He is survived by his wife, Sandra; sons, Wesley and Tad; and daughter Wendy.

***Pearl Zink, M.D.**, MD '37, HO '37-'39, died July 21, 2008. She was 95. She was the first female to serve on the house staff at Vanderbilt University Hospital. In 1939 Zink opened her practice in the treatment of allergic diseases in San Antonio. She was a pioneer in the field of allergy and was a recognized authority throughout the Southwest and Mexico. After retiring, she wrote an autobiography, "Maybe if I Hurry," and a compilation on the changes that occurred during her lifetime, "On Borrowed Time." She is survived by two nephews; adopted family Sue McCrory, Maudine Brown and Olivia Quiroga; and many wonderful friends.

Reunion 2008 Photo Gallery

Pictured here:

1. Judson G. Randolph, M.D., (MD'53); Kitty Murfree (CRS President), and George W. Holcomb Jr., M.D., (MD'46, HS'46-'49), gather at the Loews Hotel Symphony Ballroom for Medical Alumni Reunion 2008's Grand Evening Dinner.
2. Members of the Class of 2003 gather for a Reunion photo.
3. John Thomas West, M.D., (MD'51) and his wife, Ruth, enjoyed the live music and dance floor post presentations at the Grand Evening Dinner at Loews Vanderbilt Hotel ballroom.
4. Newly inducted Quinq Medical Society members from the Class of 1958
5. Newly inducted Quinq Medical Society members from the Class of 1959
6. Distinguished Alumnus winner Hal Moses, M.D., presents a lecture during Reunion.
7. VMAA Distinguished Alumni Award 1986 winner Henry C. McGill Jr., M.D., (MD'46, HS'46-'47), left, congratulates Harold L. Moses, M.D., (MD'62, HS'62-'65, F'68-'73, '85-present), one of this year's Distinguished Alumni Award winners, at the annual Quinq Society Luncheon.
8. Marvin H. Schwartz, M.D., (MD'55), and his wife, Ellen, enjoy the opening celebration at the Country Music Hall of Fame.



TOMMY LAWSON



ANNE RAVIER



SUSAN URRY

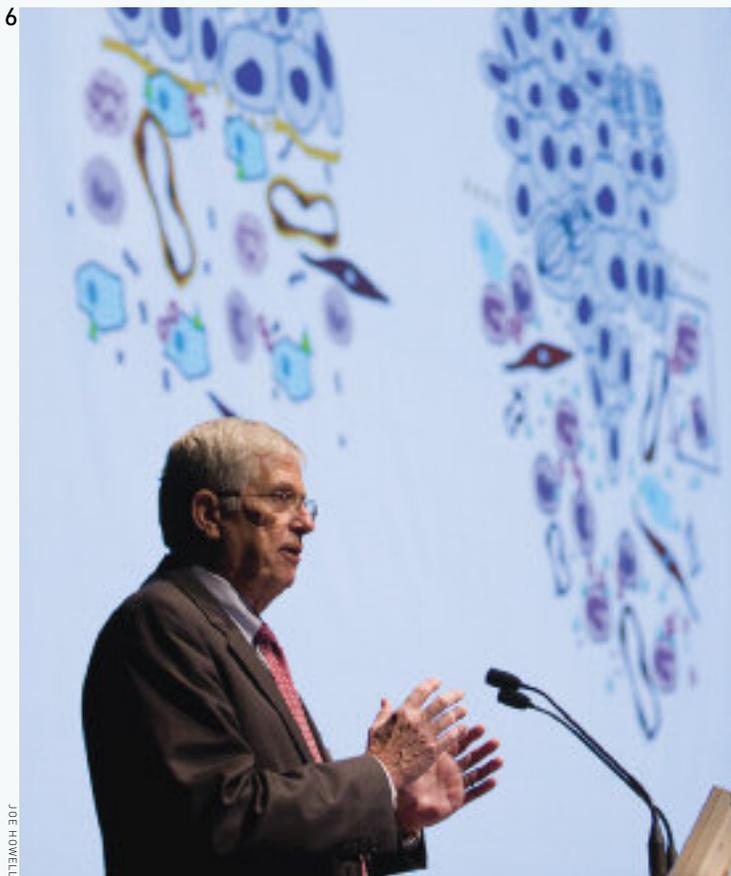


TOMMY LAWSON



TOMMY LAWSON

6



JOE HOWELL

7



TOMMY LAWSON

8



SUSAN UPTON

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