

April 2004

# Clinical Center News

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- Celebrating our volunteers
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## Director highlights past achievements, future plans

The Annual Director's Awards held last month recognized more than 100 employees and U.S. Public Health commissioned corps members for their outstanding participation and work throughout the Clinical Center.

The ceremony, held last month in Masur Auditorium, was also an opportunity for Clinical Center Director John I. Gallin to highlight past achievements and future plans for the Clinical Center and Mark O. Hatfield Clinical Research Center.

"This year promises to be a landmark year," said Dr. Gallin as he highlighted accomplishments expected in 2004.

On the top of the list of new events is the opening of the Mark O. Hatfield Clinical Research Center. Several sections of the one million square-foot building have already been turned over for occupancy, which means that architects and engineers are reviewing the structure. Once they give their approval, then various Clinical Center staff will have an opportunity to review the space and make sure that everything is in working condition.

The creation of a separate campus entrance for patients, located off of Cedar Lane, will help minimize stress and the burden of security

clearance for patients. The patient entrance will also provide easy access to the CRC, which will be a short distance from the Cedar Lane entrance.

According to Dr. Gallin, all departments and offices are scheduled to move into the CRC by September 2004. The patient move will take place December 2004. A ribbon-cutting ceremony is scheduled for September 2004.

### *Other important highlights:*

- The number of inpatients enrolled in protocols has increased from 19,299 in 2002 to 20,836 in 2003. That increase is expected to rise to 23,000 by the end of 2004, according to Dr. Gallin.

- The Edmond J. Safra Family Lodge, scheduled to open in fall 2004, will provide a home away from home for family members of Clinical Center patients. The Lodge will have 34 guest rooms, family gathering areas and telecommuting facilities. The lodge was primarily funded by a \$3 million donation from The Edmond J. Safra Philanthropic Foundation. An additional \$1 million was donated by the foundation for landscaping and maintenance. A ribbon cutting for the Family Lodge is scheduled for November 2004.

- The new addition to the Children's Inn is scheduled to open this month.
- Due to the federal outsourcing mandate, the Clinical Center was required to reduce 50 positions. This was successfully completed without anyone losing their job.

## CRIS implementation set for July

The Clinical Research Information System designed to replace the Medical Information System currently in place, is slated for implementation on July 31.

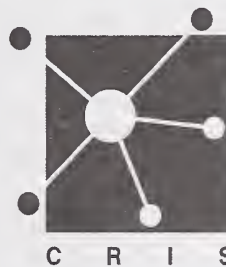
"The build and configuration of CRIS so that it works here at NIH is, with few exceptions, complete and has been extensively reviewed by our users," said Dr. Stephen Rosenfeld, CRIS project manager and acting chief information officer for the Clinical Center. "Project focus over the next few months will be on testing to ensure that what we've built works in the way we expect it to and on training efforts."

The July implementation covers the patient care aspects of CRIS, the functions now handled by the

Clinical Center's 28-year-old Medical Information System (MIS). It is a critical component to complete before the move to the new Mark O.

Hatfield Clinical Research Center later this year. "Our goal is to bring up this core system to support clinical care at least on the level we are now with MIS, and incrementally upgrade with new capabilities the organization needs and wants."

So that testing can proceed most



See **CRIS**, page two

## MIS services reduced for CRIS implementation

Keeping MIS, the current Medical Information System, functioning will be a critical challenge as work on the Clinical Research Information System (CRIS) intensifies in the months before its mid-summer implementation.

"In preparation for CRIS, we've had to reduce some of the services we provide on MIS," said Dr. Stephen Rosenfeld, CRIS project manager and acting chief information officer for the Clinical Center. "We appreciate everyone's patience. The new capabilities in CRIS will be worth this temporary inconvenience."

Here's a summary of what will and won't continue in MIS.

### What will continue:

- Additions, deletions, and modifications to lab, pharmacy and radiology tests.
- Updates from First DataBank (pharmacy/drug interaction database).
- Additions, deletions and modifications of Institute/Branch designations.
- Reassignment of physicians and patients when protocols are terminated.
- Correction of duplicate patients.
- Data extractions related to patient care or patient safety.
- User code creations and deletions (new MIS users will be trained).

### What has been discontinued:

- New personal order sets. CRIS will not support personal order sets. Physicians who currently use them in MIS are being contacted so that their personal order sets can be moved into protocol or service order sets.

## CRIS implementation continued from page one

effectively, changes to CRIS will be controlled through a new configuration management program.

"This is how we'll do business from now on," said Dr. Rosenfeld. "There will be a formal process through which changes identified during testing and training—and after implementation—will be considered and prioritized. Critical changes can still be made before we go live." With MIS, changes essentially were handled on a first-come, first-served basis.

CRIS training is slated for June and July; close enough to the introduction of CRIS to be most effective. "It's important that training be conducted as close as possible to the time CRIS will be introduced," said Dr. Rosenfeld. What users will learn in the CRIS classroom will be based on their role in patient care. Formal training will be conducted in

- New interfaces to ancillary systems.
- Extractions of data unrelated to patient care or patient safety.
- Creation and modification of clinical documentation. Users may enter new assessments by selecting "type" on the current screen.
- Creation of new protocol order sets.
- Modifications of protocol order sets. If the changes you require are substantive, DCRI will break the link in MIS so there's no confusion about correct orderables. Order using the master guides.

**Note:** New protocol order sets and modification of existing ones can be accommodated in CRIS. Contact Melanie Retzke in DCRI for more information.

the Department of Clinical Research Informatics. Three classrooms, with a capacity for up to 50 students will serve as CRIS training headquarters.

"Watch for the early-April opening of our CRIS practice lab, which will offer a place you can come for hands-on experience using the new system," said Rosenfeld. The CRIS practice lab will be located in the Clinical Center's first floor lobby near the admissions desk.

CRIS project teams will provide more information about implementation specifics and application details during the next few weeks.

For more information about CRIS visit <http://cris.cc.nih.gov>; email: [cc-cris@mail.cc.nih.gov](mailto:cc-cris@mail.cc.nih.gov); or participate in CRIS town meetings. The next town meeting is April 7, 1:30-2:30 pm in Lipsett Amphitheater. To view the February and March CRIS town meetings visit <http://videocast.nih.gov/>.

—by Sara Byars

To be evaluated case-by-case by DCRI and/or the CC Deputy Director for Clinical Care:

- Addition of resources for new satellite clinics
- Unit changes (additions, modifications, deletions)
- MIS user class creation
- System-wide changes that affect all MIS users.

If you have questions about protocol order sets and other phase out of MIS work, contact Melanie Retzke in DCRI at 301-496-6576 or email: [mretzke@cc.nih.gov](mailto:mretzke@cc.nih.gov).

If you have questions about personal order sets, contact Sue Martin, DCRI at 301-496-4240 or email [smartin@cc.nih.gov](mailto:smartin@cc.nih.gov).

For more information on CRIS, go online: <http://cris.cc.nih.gov>.



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## Matthew Corley: enjoying life despite the setbacks

You may know Matthew Corley and not even know it. He's often found at the hospitality desk near the main elevators with a smile, kind word and help for all who pass by. Many who enter day to day hardly notice him unless he's gone. Then things seem different.

Corley, 52, a hospitality services coordinator, learned that he had Hepatitis C five years ago. There were no symptoms. But there it was in his blood work; dormant in his liver. As long as there were no symptoms, Corley was happy to remain at his post assisting patients, visitors and employees. But as he passed the 50-year mark he became concerned that his luck might run out.

His doctors concurred. He could have joined an NIH protocol, but ended up going to a private sector protocol approved by NIH.

"I have medical insurance that will help me," he said, "and even though I'm a taxpayer, I didn't want to take a place away from someone who didn't have insurance."

The treatments were brutal, but effective. He was given Interferon, Pegasys and Riboviron. He receives a shot of Pegasys once a week during the 48-week protocol. At the end of the protocol, he hopes to be completely free of the disease.

"I don't think I'd ever do it again," he said, shaking his head. "The treatments have robbed me of a lot of energy and, frankly, a lot of my smiles. But I'm encouraged when I come here because it gives me a boost. I just enjoy being here. It makes me feel better."

It also makes a considerable number of Clinical Center employees feel better, too. "It's been unreal," he said. "The compassion, the concern, the phone calls and cards...I've

always had plenty of reasons to love this place, but now it's more personal. People have really made me feel loved and appreciated. I tell my wife that it's nice to receive flowers while you can still smell them, and it feels good to know how people feel about you."

He was especially touched to receive a card from Clinical Center Director Dr. John I. Gallin.

Not only was he lavished with attention, doctors, nurses and others—some he didn't even know—donated nearly 700 hours of leave to Corley. He began the treatments in June 2003 and expects to complete them by May 15 of this year. Already he feels better and his viral load is dropping.



Matthew Corley

After May 15, he'll be monitored every three months. Until then, he continues to love his job and, most of all, he loves helping people.

So the next time you pass his desk and he's there, take a moment to introduce yourself. It could brighten the rest of your day.

— by John Iler

### 2004 National Nurses Week 'Who We Are, Where We Are Going' A Celebration of Nursing

Whether it is embracing change for the new Mark O. Hatfield Clinical Research Center, conducting and supporting research or providing high quality patient care, nurses at the NIH Clinical Center work collaboratively with all members of the multidisciplinary healthcare team. The 2004 celebration of National Nurses Week at NIH, "Who We Are, Where We Are Going"—A Celebration of Nursing, will focus on the current clinical areas where nurses practice.

National Nurses Week begins May 6 and ends on May 12, Florence Nightingale's birthday. The week will kickoff with a keynote speaker Thursday, May 6 in Lipsett Amphitheater from 10 to 11 a.m. Throughout the week research being conducted by NIH nurses will be highlighted. On Tuesday, May 11, inpatient care units and outpatient clinics will showcase their contributions to clinical research during a special program to be held in the 14th floor auditorium.

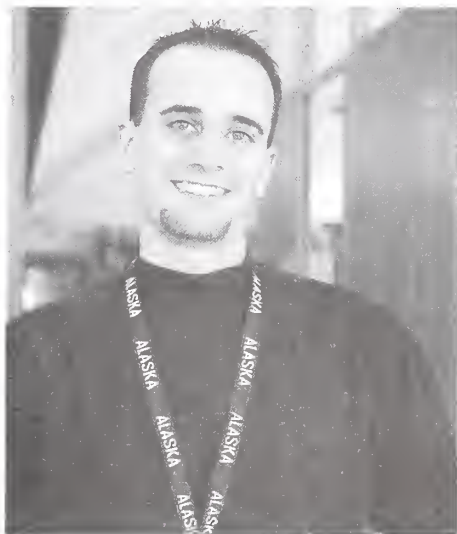
There is no better time of year to show nurses how much they are appreciated. There are nearly 2.7 million registered nurses in the United States and Clinical Center nurses are among the best and brightest in the nation. Mark your calendars for May 6-12 and be sure to celebrate them. The mission of the Clinical Center could not be carried on without them.

## Celebrating Our Volunteers Volunteer Week – April 18-24

### Fellows gain valuable experience volunteering

Nelly Bardenwerper and Ryan Corrick came to NIH as Intramural Research Training Award (IRTA) fellows wanting to learn more about medical research. When they leave, they will take with them a richer understanding of patient care and a healthy respect for family members who care for their sick loved ones.

As volunteers in the Family Friend program at the Clinical Center, both Nelly and Ryan make themselves available to play and take care of sick children or siblings of sick children, while the parents consult with doctors or are being treated themselves.



Ryan Corrick

“Many times parents have to bring their children to the Clinical Center with them, or if the child is the patient, sometimes the siblings are with them and they need something to keep them occupied while the family member is being treated,” said Andrea Rander, director, Volunteer Services, Social Work Department. “We developed this program to allow an outlet for the children, and it also gives them someone to talk to and form a relationship with while they are here.”

The program began in 1994 as a

result of parents needing a respite from their children who were being treated. Parents would practically live in a room with their children on a pediatric unit for days at a time.

“Now that many patients are being served on an out-patient basis, the program has changed its focus,” said Rander. Currently, there are four active volunteers who work with the program, along with several others who are on-call.

Ryan and Nelly joined the program looking for volunteer opportunities that allowed them to work directly with patients. Both called Rander and she suggested the Family Friend Program.

“This has been an enormous benefit to us,” said Ryan, an IRTA fellow in the Laboratory of Cell Biology, NCI. “Seeing the resilience and strength of these children in spite of serious illness reminds me why I want to pursue a career in medical research – to give them hope.”

Nelly agrees that the opportunity has exceeded her expectations. “It puts a smile on my face,” said Nelly, an IRTA fellow in the Genetics of Development and Disease branch, NIDDK. “I enjoy working with kids and their families. You begin to build a relationship with the kids. They make little notes and drawings for me that I display on my desk. It’s something I look forward to every week.”

Nelly and Ryan are called on at least once a week to volunteer. Approval is given by their supervisors to leave the lab for about an hour to take the kids to the 14th floor playroom. If the playroom is unavailable, they walk around the Clinical Center, show the kids their lab area, or sit and talk.

“This just reaffirms my desire to work with patients,” said Nelly, who has been accepted into two medical schools and wants to be a primary

care physician. “I’m happy to be getting as much clinical experience as I can and being at NIH allows me to discover the rewards of brightening the days of young patients and their families in addition to exploring the complexities of molecular biology.”

Even though each hour spent



Nelly Bardenwerper

with the kids can be tiring, Ryan said it’s worth it.

“During one visit, I had to watch three siblings. The youngest child was sick and I watched the three healthy children,” said Ryan. “By the time the doctor finished talking to the parents, the kids had my hair standing on end; my new glasses were bent and they had hidden some things from my backpack. I was drained by the time I left, and it was only 9:30 in the morning.”

Despite the experience, Ryan said he understood that the siblings had frustration they needed to express in response to their sibling being sick. “As I was leaving, the doctor who was working with the family approached me and told me how much he appreciated my help,” said Ryan. “That totally made my day.”

—by Tanya Brown



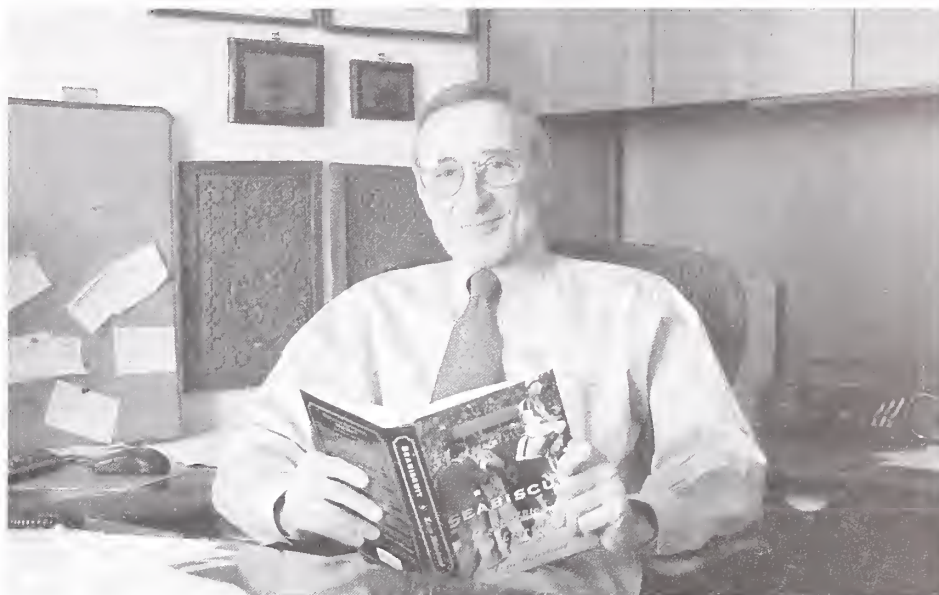
## 'Academy award' for inspiration, compassionate medicine

The role of empathy in clinical medicine can't be overstated. A sick patient who feels miserable and worried needs a doctor with clinical acumen and medical knowledge, but a doctor who also cares how the patient feels should be greatly valued. In Dr. Fred Gill, Laura Hillenbrand found both compassion and skill.

Dr. Gill leads the Clinical Center's Internal Medicine Consult Service. Hillenbrand battles Chronic Fatigue Syndrome (CFS). It happens that she authored the book-turned-movie *Seabiscuit: an American Legend* while suffering from CFS. It also happens that when in private practice Dr. Gill also treated many CFS patients referred to him by NIH. Hillenbrand credits him for being the first physician to really pay attention to all of the symptoms she was experiencing. Her CFS had been diagnosed by the time she met Dr. Gill but it was his ability to listen and provide superb medical care—that often elusive comprehensive bedside manner—she claims helped her endure her illness.

By the time she met Dr. Gill, she'd seen more than 20 doctors. She said, "So many of them, their face hardens, and they dismiss you. My experience with him was so different. He listened for over an hour and said, 'I don't know the cause of your illness, or exactly how to treat it, but I will do my best to help you.'"

Dr. Gill brings this same compassion to patients referred to him through the Internal Medicine Consult Service. When asked about his empathetic demeanor with patients he said, "It's a natural thing, not something that is easily taught. It is especially important in situations



Dr. Fred Gill receives accolades from author of *Seabiscuit* for being a compassionate doctor.

when you don't readily have the answer to a particular medical problem such as in the case of those with CFS and other patients with questionable diagnoses."

Through the years many of the people in his private patient population came from NIH, employees and their families. In 1998 he was asked by NIH leadership to begin the Internal Medicine Consult Service for inpatients and outpatients participating in research studies at the Clinical Center. He did so part-time for two years and began a full-time schedule in 2000. "In this job one must be able to understand medical problems in the context of the research study and facilitate positive interaction with all the multidisciplinary teams in intramural research in the clinical program," he said. He finds the uniqueness of clinical research stimulating and intriguing, but still genuinely loves the patient care aspect of his role—devotion to this day that Hillenbrand finds remarkable.

"Although I am no longer a patient of his I can't forget how much he helped me. A lot of physicians seem to construct a firewall; they want the facts and they want you out of the office quickly. Dr. Gill doesn't have that. I get the sense that because physicians deal

with illness every day of their career, they get inured to it and they get detached. Somehow Dr. Gill is able to be emotionally involved without it grinding him down and wearing him out. I don't know how he does it," she said.

Hillenbrand is one of the 800,000 U.S. adults and countless children suffering from CFS, a serious and complex illness characterized by incapacitating fatigue, memory and concentration problems, severe pain, body weakness, and persistent flu-like symptoms. After more than a decade of research, the cause is not yet known; there is no definitive diagnostic test and no standard treatment.

As Hillenbrand's 16-year struggle with CFS continues Dr. Gill holds her in mutual esteem. The writing of *Seabiscuit*, while experiencing the physical challenges of CFS, was no small feat for Hillenbrand, according to Dr. Gill. Her experience has been described in several interviews as "...the incredible toll it would take on her body. At times the fatigue was so crushing, the vertigo so fierce, that she would write flat on her back with her eyes closed."

"I was thrilled when she became

See **Seabiscuit**, page seven

# Breakthrough in fight against sickle cell disease

A new study reveals that nearly one third of adults with sickle cell disease develop high blood pressure in their lungs and that the condition, pulmonary hypertension, causes a much higher mortality rate in patients than those without it. Researchers led by Dr. Mark Gladwin, Critical Care Medicine Department, found that the rare, deadly lung condition is so common among people with sickle cell anemia that testing for and treating it could help many patients live longer, healthier lives. The findings demonstrate, the researchers claim, an urgent need to diagnose this complication in adults with sickle cell anemia as it is a major risk factor for death. The study was conducted as a multi-center collaboration between NIH and

the Howard University Center for Sickle Cell Disease. The report was published in the February 26 edition of the New England Journal of Medicine (<http://content.nejm.org/cgi/reprint/350/9/886.pdf>).

Sickle cell disease is a chronic, often fatal anemia that is classically characterized by severe attacks of pain from blood vessels being blocked by red blood cells that become rigid and form a sickle shape when deoxygenated. In the U.S. this genetic disease occurs mainly in African Americans, and is accompanied by episodic severe pain in the joints, leg ulcers, jaundice and

multi-organ failure.

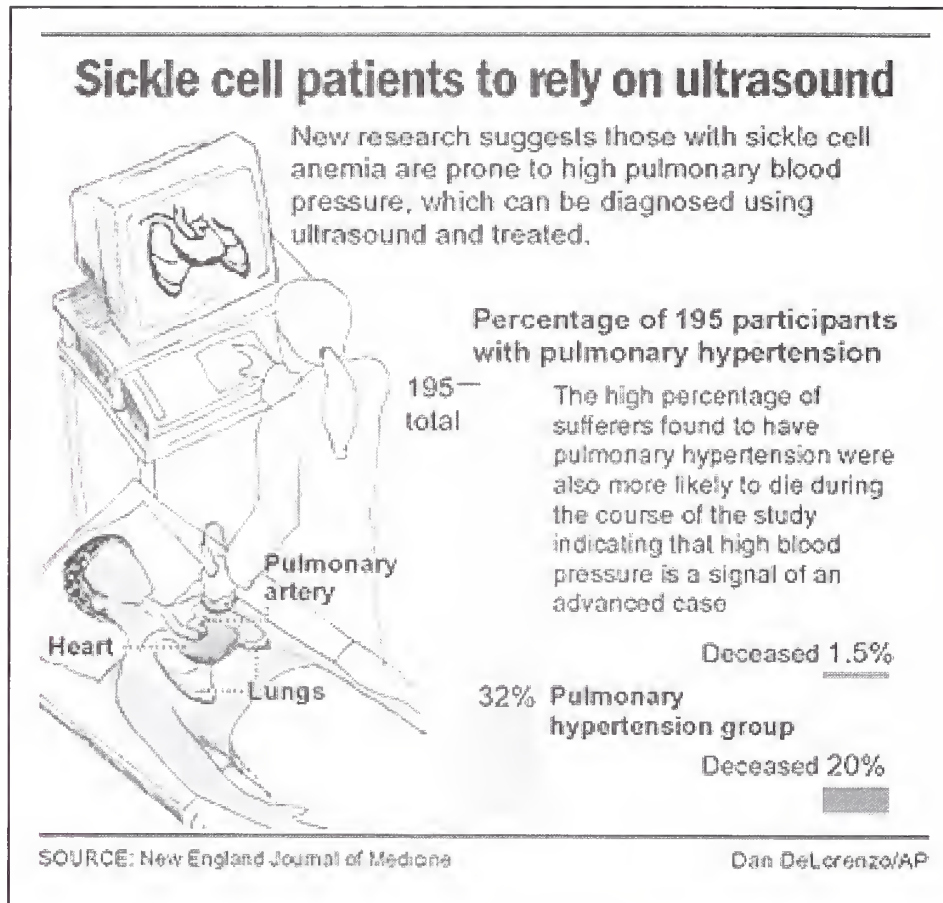
Pulmonary hypertension is high blood pressure in the arteries that supply the lungs (This is not related to high blood pressure measured by a cuff on the arm). The blood vessels that supply the lungs narrow and their walls thicken, so they can't carry as

evaluated in the NIH project.

"Secondary pulmonary hypertension develops in most types of hereditary and chronic anemias that are caused by hemolysis, the destruction of red blood cells. This suggests that there is a distinct syndrome of hemolysis-associated

pulmonary hypertension, a complication that has been reported with increasing frequency in sickle cell patients," said Dr. Gladwin.

The research project followed 195 patients, 82 men and 113 women, with an average age of 37, over two years. Doppler echocardiography, a test that uses sound waves to "see" the heart, was performed on each person to assess their pulmonary-artery pressures. Doppler-defined pulmonary hypertension occurred in 32



much blood. Like a kinked garden hose, pressure builds and backs up. The heart works harder, trying to force the blood through. If the pressure is high enough, eventually the heart can't keep up, and is unable to pump enough blood through the lungs to pick up adequate amounts of oxygen. Patients become tired, dizzy and short of breath. When an underlying cause can't be found, the condition is called primary pulmonary hypertension. When a pre-existing disease such as sickle cell triggers high blood pressure in the lungs, doctors call it secondary pulmonary hypertension. This is the type of pulmonary hypertension

percent of the patients. Of the 195 individuals in the study, 20 percent with pulmonary hypertension died and all but two of the patients with the condition survived. Even patients with a mild arterial pressure in the lungs had a high rate of fatality.

Since the study identified those sickle cell patients at the highest risk of death, certain therapies targeting pulmonary hypertension could improve survival rates. "Several types of interventional therapies are now available but so far have been tried in only a few sickle cell patients, said co-investigator Dr. Oswaldo Castro,

See **Sickle cell**, page seven



## Sickle cell continued from page six

acting director, Howard University Center for Sickle Cell Disease. He referenced inhalants such as oxygen and nitric oxide; blood exchanges through transfusions; and use of vaso-dilators such as Viagra that open the blood vessels of arteries.

Detection of high blood pressure in the lungs may also account for the

unexplained or mistakenly explained sudden deaths in adult patients with sickle cell disease. "We see a high frequency of sudden death in those with sickle cell and this study helps to clarify what is causing those fatalities; particularly in the absence of coronary artery disease as the cause," explained Dr. Gladwin.

The co-authors agree that this study's findings represent an opportunity to address a major cause

of disability and death in the adult sickle cell disease population—pulmonary hypertension. They believe the research data supports universal screening of individuals with sickle cell disease for this condition and clearly shows the immediate need for clinical trials to further investigate therapies that may combat a serious complication of sickle cell disease that is associated with an ominous outcome.

The research team included collaborators from the Critical Care Medicine Department, CC; Cardiovascular Branch, NHLBI; Hematology Branch, NIDDK; and the Center for Sickle Cell Disease, Howard University College of Medicine.

—by Dianne Needham

For more information on Sickle Cell Disease clinical studies contact the research team at 301-435-2345.

## Better breathing means longer life

Gardens evoke passion, excitement and joy. Annie Brown's girlhood garden patch of greens and vegetables did much more. It helped her, in some manner, to physically feel better—important for Annie who was born with sickle cell anemia. Some 70,000 to 100,000 Americans have the disease and an estimated 1,000 babies are born with it each year, the vast majority from African American families.

Sickle cell anemia is an inherited disease in which the red blood cells, normally circular-or-doughnut-shaped, become crescent shaped. As a result, they function abnormally and cause small blood clots. These clots give rise to recurrent painful episodes called "sickle cell pain crises."

Growing up in Rowland, North Carolina, Brown's parents told her that the doctors said "she wouldn't live past age 18 and that she would never have children." Brown, now 53, is the mother of two grown kids and has surpassed both those doctors' beliefs as well as general statistics regarding the lifespan of sickle cell patients. The median age of death for people with sickle cell anemia is 42 for men and 48 for women.

Her own little garden was only one way Brown, a lively woman with a quick smile, stayed healthy. "Eating right is just part of it. Don't give up, do whatever you can to feel better and help ease the pain of sickle cell disease," she said.

Like most individuals with sickle cell anemia Brown has many



Annie Brown

of the complications caused by the disease. One complication, pulmonary hypertension or high blood pressure in the arteries that bring blood to the lungs, is why she came to the Clinical Center. Researchers have found (see "Breakthrough in fight against sickle cell disease," page six) that normal blood pressure in the lungs for people with sickle cell disease is defined as 2.4 meters per second or less; a reading of 2.5 or higher is evidence of pulmonary hypertension in these individuals; and a reading of three meters or more indicates severe pulmonary hypertension. When Brown came to NIH her level was 3.9. She is now being treated with Sildenafil (generic) more commonly known as Viagra.

"I am stronger. Have more energy. Once I passed out but now I don't feel as faint or out of breath," said Brown. "It's just better to feel good."

The medication keeps her lung blood pressure regulated. Her positive attitude fuels her life.

## Seabiscuit continued from page five

a best-selling author; especially when she was able to produce that wonderful book while being ill. She is a bright, splendid person," said Dr. Gill.

The movie *Seabiscuit*, nominated for seven Oscars by the Academy of Motion Picture Arts and Sciences, relates the true-life tale of a heroic 1930s racehorse by that name and the men who handled him. Making it through tough times is really what the story is all about. Something Dr. Gill believes parallels Hillenbrand's own experience in overcoming the hardship of CFS to write the book.

*The Internal Medicine Consult Service functions within the Clinical Center. The team is consulted by other NIH institutes or centers for problems that arise in research study patients. The service also helps to manage patients with complex medical problems and coordinates all necessary testing and referrals for comprehensive work-up and management of the problem. Call 301-496-9490 for further information. To learn more about CFS visit <http://www.cfids.org> or call 704-365-2343.*

—by Dianne Needham

# Russell Leonard retires after 43 years

On March 11, 1961, Russell Leonard came to the Clinical Center with no intentions of staying long.

"I got used to being here and I didn't want to just sit around doing nothing," said Leonard. Forty-three years later, at age 74, Leonard decided last month that it was time to retire.

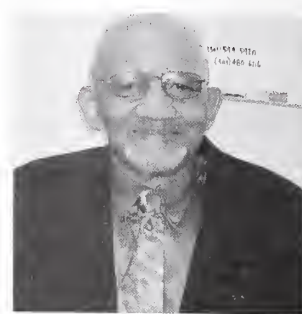
"I'm doing the best thing by retiring now," said Leonard, who

worked for the Housekeeping Department. "I still have my health and strength, and I'm grateful for that."

Leonard spent the last four years in the Clinical Center working on the third floor in the processing lab, Laboratory of Host Defenses. At one time, he was reassigned to another part of the hospital, but employees in the

lab rallied to get him back.

"Russell Leonard is one of those rare individuals whose soundness of character



Russell Leonard

and commitment to his job may be overlooked at a place like NIH, where the primary focus is pioneering research and caring for critically ill patients," said Dr. Sharon Jackson, investigator, Laboratory of Host Defenses. "For those able to recognize these attributes in Mr. Leonard, he serves as an inspiration and a constant reminder that we should all aspire to a work ethic that reflects his humble dedication and integrity."

Dr. Jackson added that his attitude and common sense approach to life is what set him apart as a role model. Leonard said he never looked at himself as a role model, but takes great pride in doing his job and encouraging the people he works with everyday.

"The people here are so nice and nice to work with," said Leonard, who added that he has worked in just about every area of the Clinical Center since joining the hospital. "I've covered the whole territory, but that's my job. Whatever I do, I try to do my best."

He disposed of trash, made beds and cleaned floors with pride. "Someone once asked me why I took the time to spread the bed sheets smooth and make sure the corners were straight," said Leonard. "I told them that it could be me in this hospital bed, and if it were, I would want somebody to put as much effort into making it perfect."

Leonard said he doesn't have any definite plans during his retirement, but he said he will help out his friends that aren't able to help themselves by cutting their lawns and doing whatever else needs to be done. The one thing Leonard knows he won't be doing during retirement is working. "I definitely don't plan on finding another job," he said.

## april

\* Lectures can be accessed on the NIH videocast at <http://videocast.nih.gov>

**7** **Grand Rounds**  
12-1 p.m.  
**Lipsett Amphitheater**  
**Ethics Grand Rounds**  
*Is It Ethical To Conduct Research With Individuals Who Have No Access to Standard Treatment?* \*  
Ruth Macklin, Ph.D., Albert Einstein School of Medicine

**Wednesday Afternoon Lecture, 3 p.m.**  
**Masur Auditorium**  
*Transmission of Prions*  
Charles Weissmann, M.D., Ph.D., University College, London

**CRIS Town Meeting**  
1:30 p.m.  
**Lipsett Amphitheater**

**14** **Grand Rounds**  
12-1 p.m.  
**Lipsett Amphitheater**  
**Contemporary Clinical Medicine: Great Teachers**  
*The End of Life* \*  
Richard Payne, M.D., Pain and Palliative Care Services  
Anne Burnett Tandy, Memorial Sloan-Kettering Cancer Center

**Wednesday Afternoon Lecture, 3 p.m.**  
**Masur Auditorium**  
*Antiviral Immunity and Vaccines*  
Rolf M. Zinkernagel, M.D., Ph.D., University of Zurich

**19** **Vounteer Awards Ceremony**  
5-8 p.m.  
**Strathmore Hall, 10701 Rockville Pike**

**21** **Grand Rounds**  
12-1 p.m.  
**Lipsett Amphitheater**  
**50th Anniversary Celebration of Clinical Research**  
*Hospital Epidemiology: 1979 to 2004* \*

David Henderson, M.D., CC  
*Blood Safety: The Last 50 Years* \*  
Harvey Klein, M.D., CC

**Wednesday Afternoon Lecture, 3 p.m.**  
**Masur Auditorium**  
*Genome Architecture, Rearrangements, Evolution and Genomic Disorders*  
James R. Lupski, M.D., Ph.D., Baylor College of Medicine

**28** **Grand Rounds**  
12-1 p.m.  
**Lipsett Amphitheater**  
**50th Anniversary Celebration of Clinical Research**  
*Biomedical Imaging in the Genomic Era: Studying System Biology at the Whole Organism Level* \*  
King C. Li, M.D., M.B.A., CC  
*Screenting for Colon Cancer Using Virtual Colonoscopy* \*  
Ronald Summers, M.D., Ph.D., CC

**Wednesday Afternoon Lecture, 3 p.m.**  
**Masur Auditorium**  
*Dissecting Disease Biology and Advancing Medicine with Small Molecules*  
Stuart L. Schreiber, Ph.D., Harvard University