October 2004

Clinical Center News

In this issue:

CRIS goes live: activation brings bigger, better electronic hospital system

by Pat McNees

It's Friday evening, August 21, 2004. Normally all of the inpatients' medical orders are printed out at midnight; tonight, no orders are to be entered after 10. At midnight, the Clinical Center is turning off the electronic medical information system (MIS) it has used for 28 years. If all goes well, at 7:30 Saturday morning the staff will turn on the first part of a new, bigger, better electronic hospital information system—the core of the CC's new clinical research information system (better known as CRIS).

For seven weeks, from 7 a.m. until 11 p.m, staff have been training on the system. Inevitably, many have waited until the last minute.

When MIS went live for inpatient documentation in 1976, it did so one nursing unit at a time, starting with 5-West. Most institutions going from paper to electronic records come on one physical area or one function at a time. Because the CC is changing from one electronic system to another and can't maintain data in both systems, CRIS was to be introduced in a "big bang"—turning the core hospital system on everywhere, all at once. When the original go-live date of July 30 was changed, the CRIS team turned on the subsystem for retrieving historic (not live) data to give users experience with part of the system.

Ultimately CRIS will include two dozen different systems around one clinical and one research hub. The part of CRIS scheduled to go live Saturday morning is the first part of the core hospital information system, focused on patient care. A week earlier, all the laboratory results and most clinical documentation from MIS were transferred to CRIS, so staff could see how they looked in the new system.

Clinical Informatics has set up a lounge for breaks, with a large-screen television and enough food to sustain

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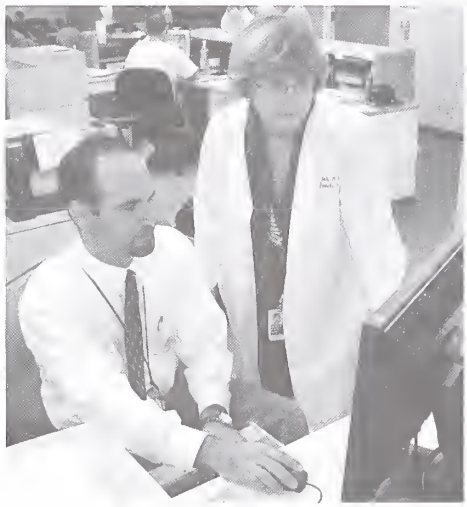
It's been years in coming, but on Wednesday, September 22, the new Mark O. Hatfield Clinical Research Center was dedicated in the name of the senator from Oregon, Mark. O. Hatfield (inset). Look for the special issue of CCNews this month.

CRIS activation
Continued from page 1

dozens of people, some working through the night. One can sense the combined fatigue and high energy that come with difficult but important team deadlines. Close to 200 people (CC and NIH staff and contractors) have worked long hours for weeks to get the system ready. Many work into Friday night—some until Saturday morning, many for more than 24 hours at a stretch. All day Friday and into the evening prescribers have been entering patients' current medical orders into the new system.

At 11:30 the overhead announcements begin all over Building 10: "The MIS system will be down in one half hour." Another message comes at 15 minutes before, then 5 before, then at midnight: "MIS is shutting down." On cue, technical staff and contractors begin connecting all the interfaces. Some of the staff catch a few winks in patient beds reserved for the occasion on the twelfth floor.



Dr. Scott Solomon, of the Hematology Branch, NHLBI, and nurse Laura Wisch, familiarize themselves with CRIS data input.

Friday night and Saturday morning they encounter two obscure software problems. Identifying the problems takes longer than solving them, but a CC employee finds a report about one on the Internet; nobody present has ever heard of it and the symptoms provide no clue to the problem (a bug in the operating system which, combined with troubleshooting other problems, creates totally unpredictable behavior).

Saturday at 6 a.m., a team of extremely tired technical and medical staff and contractors convene to decide whether CRIS should go live as scheduled. They delay for hours, with Dr. Steve Rosenfeld, the Clinical Center's chief information officer and associate director for clinical research information systems, periodically giving status reports to all staff. Finally, Rosenfeld calls together key parties and asks for recommendations. The decision: Postpone a full day, get things worked out as best we can and make the go-live Sunday morning. This gives the exhausted team a chance to sleep, and all day Saturday people keep entering documentation and getting used to the system.

Sunday morning, August 23, 2004, CRIS goes live.

"There was a very strong feeling of NIH community during those few days," says Dr. Cliff Lane (NIAID), chair of the CRIS project steering committee. "I didn't see people losing their tempers or getting angry or frustrated. There was frustration with not getting the system in, but I think everyone bonded as an NIH community, because everyone knew how important this is, particularly to the safety and the care of the patients."

"Other than the fact that we were all exhausted, I don't think we lost anything by waiting till Sunday," says Rosenfeld. "And when we finally did go live everybody was rested. Since Sunday morning, the system has been up and running smoothly."

Not that there weren't problems, including a problem with printers—some not printing at all and some printing far too much. But the worst problems were in the outpatient pharmacy. Many new pharmacy options were built into CRIS, but they weren't completed by the go-live, so some people who hadn't had enough practice on the system were entering orders incorrectly and not getting feedback—still to be incorporated is a system of alerts about user errors. The pharmacy was extremely busy for well over a week.

"Walking through the hospital, you saw a lot of busyness in the nursing units, and a lot of people helping each other with the new system," says Rosenfeld. "The one place where CRIS had an unacceptable impact was in the outpatient pharmacy," where patients had to wait far too long. "We're still not back to where we were."

Problems were inevitable and there are details still to be worked out. But there have already been big gains. Reviewing patient data is almost a different experience, the improvement over MIS is so dramatic. The screen design is more efficient and user-friendly, and the system offers more decision support. The core system was repackaged to provide a standard clinical desktop with pull-down menus, icons, more easily read fonts, and other features familiar to computer users. As physician Peter Crompton, an NIH fellow, said after trying the new system, "A bad day with CRIS is better than a good day with MIS."

With MIS you could pull out data for one patient only. With CRIS, you

Clinical Center News

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can retrieve much more data. Looking at a list of all the patients under your care, you can see flags for orders or results you haven't reviewed yet, so you know at a glance what work you have to do. You can show trends in data, create customized patient lists (all inpatients, all consults, etc.), retrieve all the data on one patient in different views, and retrieve data across patients and across protocols.

Writing orders and retrieving data is easier and more logical now, says Lane. "With MIS, for example, let's say I wanted to order a drug. I'd have to go to the master screen, go to the pharmacy screen, go to an alphabet screen, find the drug, go to the drug, and then (depending upon the drug) probably go through another three to seven screens. With CRIS I can type in the first three letters of the drug I want and that order will appear to me immediately. Depending upon how much I want to change it, two or three screens and I'm done."

"I think we did a good job," says Rosenfeld. "We were as prepared as we could be. And I have to say, everybody really rose to the occasion—from the nursing department to the doctors, from the lab technologists and diagnostic radiology to the pharmacists. We were ready to have help available all over the place, but it was still a huge inconvenience to people, and everybody accepted it and dealt with it extremely well."

"The response of the NIH patient care community to CRIS activation was extraordinary," says Clinical Center Director John I. Gallin. "I thank the entire CRIS team for their special work and I am delighted that the initial phase of activation has been completed successfully. In the next few years the system's clinical research component will mature with the development of a new data warehouse to store and merge clinical and research information. We look forward to CRIS's continued development." ❖

Lecture on insulin resistance to be held November 3

Dr. Gerald M. Reaven will deliver the Astute Clinician Lecture, "Insulin Resistance and Metabolic Syndromes: Different Names, Different Concepts, Different Goals," on Wednesday, November 3, at 3 p.m. in Masur Auditorium.

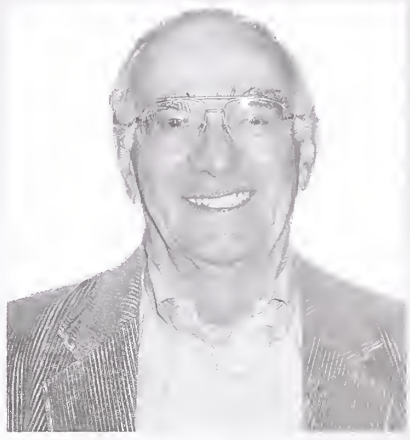
Reaven, a professor of medicine at Stanford University School of Medicine's Division of Cardiovascular Medicine, has been on Stanford's faculty for more than 40 years. His research has advanced the understanding of diabetes and related disorders, including insulin resistance.

Insulin resistance is marked by high levels of insulin in the blood. Although this tends to keep blood sugar levels down, it can eventually lead to type II diabetes; the pancreas becomes overtaxed and cannot continue to produce such high insulin levels. It also leads to other medical conditions, including heart disease.

Abnormalities associated with insulin resistance were first recognized in the late 1980s. Since then much new information has come forth about insulin resistance and disease. This has led to two approaches in thinking about the condition. One approach has been to recognize that the abnormalities associated with insulin resistance have broadened and to change the way physicians view the clinical syndromes associated with the condition.

The second approach is to establish criteria to diagnose this metabolic syndrome as a way to identify those at risk for developing heart disease. The lecture will explore the implications of these two approaches.

Reaven earned his MD and completed his internship at the University of Chicago. After a residency in internal medicine at the University of Michigan in 1959, he went to Stanford, where he has been since. He served as instructor (1960), associate professor (1965), professor



Dr. Gerald M. Reaven

(1970), head of the division of endocrinology and metabolic diseases (1974-1977), head of the division of gerontology (1977-1990) and director of Stanford's General Clinical Research Center, which he established (1977-1990). A longtime professor of medicine at Stanford, he has been professor emeritus since 1995.

He has published more than 500 articles in scientific journals and numerous textbook chapters and other scholarly works and has received the highest awards for research from the American Diabetes Association, the British Diabetes Association, and the European Association for the Study of Diabetes.

The Astute Clinician Lecture was established through a gift from Haruko and Dr. Robert W. Miller. Each year it honors a U.S. scientist who has observed an unusual clinical occurrence and, by investigating it, has opened an important new avenue of research.

The Astute Clinician Lecture is an NIH Director's Wednesday Afternoon Lecture Series event. It is hosted by the Clinical Center. For information and accommodations, contact Hilda Madine, 301-594-5595.

Clinical Center and NIAID lead West Nile Virus treatment trial

by Dianne L. Needham

The Clinical Center and NIAID have responded to the West Nile Virus (WNV) epidemic that has swept across the nation by developing a multicenter study seeking to find safe treatments for encephalitis, one of the most severe symptoms of WNV. Researchers are testing the safety and preliminary effectiveness of using WNV antibodies to treat people in whom the virus has reached, or threatens to reach, the brain.

"The high death rate seen among persons with WNV encephalitis—swelling of the brain—and the long-term consequences of the disease among survivors provide impetus for this research," said study chair Dr. Amy Agrawal, of the Clinical Center's Critical Care Medicine Department.

WNV is a mosquito-borne virus that can cause encephalitis, spinal cord damage and other serious problems. Only 1 to 3 percent of human infections cause this clinically important disease, but that 1 to 3 percent can have devastating and long-term consequences. Elderly and immunosuppressed individuals are those most likely to experience the virus's devastating complications. In 2003, more than 9,000 cases in the U.S. were reported and in 2004 virtually every state reported multiple cases of WNV.

According to Agrawal, events in a WNV outbreak in Israel in 2000 provided the rationale for this specific trial. One Israeli patient had low antibody levels, developed WNV-induced encephalitis and per routine medical practice was given intravenous immunoglobulin (IVIG). Her recovery was dramatic. This IVIG preparation was then analyzed to see if it had any WNV antibodies; the preparation had very high concentrations, by contrast with American IVIG, which contained no antibodies.

"This is because WNV has circulated in Israel since the 1940s and their population has a high level of antibodies to the viral infection," explained Agrawal. "This long-term exposure creates immunity to WNV in a large proportion of the population. When you pool the blood from multiple donors and formulate the IVIG, it will then have many antibodies directed against West Nile virus." By contrast, only a small percentage of the U.S. population has antibodies against West Nile virus.

Currently, clinicians have few treatment options aside from providing supportive care for treating people sick with severe WNV symptoms. If the Israeli IVIG compound being tested in this trial is proven safe as a treatment for these complications, researchers will have a better understanding of WNV, develop treatments for it and possibly prevent it, Agrawal said. The compound is pooled antibodies obtained from Israeli donors with high levels of the antibodies.

"To have any effect this IVIG agent needs to be given early," Agrawal explained. Animal models have shown that the Israeli IVIG product provides therapeutic benefit if given promptly after infection. Alpha interferon is being assessed by another group of investigators, although animal data are not as promising with alpha interferon as with the IVIG.

This protocol represents an intramural/extramural NIH alliance. Dr. Richard Whitely and Dr. John Gnann, of the University of Alabama at Birmingham, who lead the NIAID-funded Collaborative Antiviral Study Group, have worked closely with Agrawal and with Dr. Walla Dempsey (NIAID) to develop this national, multicenter project. More than 60 sites nationally, in addition to the Clinical Center, are now prepared to study West Nile patients on this protocol.

Agrawal believes this study could serve as a prototype for researching outbreak-type diseases and bioterrorism-type events. "The challenges posed by trying to 'chase the outbreak' are complicated by delays as institutional review boards at each center review the protocol. It is difficult to move quickly into an area as the outbreak occurs and to be ready to enroll patients before the outbreak is over. This creates difficulties for anyone trying to do rigorous studies on these emerging diseases. Efforts to respond to, or treat, bioterrorism-related events' diseases would likely be hampered by similar constraints."

The nationwide trial can enroll up to 110 patients 18 years and older who have WNV-related encephalitis or who are at risk of developing the complication. Trial participants will receive a single dose of the Israeli IVIG compound or a dose of one of two placebos.

The study represents collaboration among NIAID's Division of Microbiology and Infectious Diseases; the NIAID-funded Viral Studies Group; and the Clinical Center's Critical Care Medicine Department. ❖

For more information about the trial visit the **NIAID Collaborative Antiviral Study Group**, University of Alabama, Birmingham website at: www.casg.uab.edu or www.clinicaltrials.gov. For information about participating at the Clinical Center site call **1-800-411-1222**; TTY **1-866-411-1010**. "IVIG – West Nile encephalitis: Safety and Efficacy" is the formal name of the trial.

Pain and Palliative Care Service accredited by ABHPM

by John Iler

The Clinical Center's Pain and Palliative Care Service has just joined an exclusive group of pain facilities accredited by the American Board of Hospice and Palliative Medicine (ABHPM). It is one of only nine in the United States to have attained such a distinction.

Based in Glenview, Ill., ABHPM was formed in 1995 to establish and implement standards for the certification of physicians practicing hospice and palliative medicine.

"ABHPM creates and administers the certifying examination, works to implement high standards for training, and contributes to setting the standards for excellence in palliative medicine," said Dr. Ann Berger, chief of the service. "So we're thrilled to be part of such a small group to have gained accreditation."

"We're delighted to be one of the first nine accredited palliative fellowship programs in the country."

Dr. Daniel Handel

To receive accreditation, pain centers must demonstrate "substantial compliance" with all requirements in the voluntary program standards jointly adopted by the Palliative Medicine Review Committee (PMRC) and ABHPM. Developed through a three-year consensus process, the program was funded by the Robert Wood Johnson Foundation and The Open Society Institute's Project on Death in America.

The program standards require at least 12 months of training in the key knowledge and competencies needed to be a successful specialist physician in hospice and palliative care.

Training programs must arrange for fellows to care for patients in inpatient settings, community settings (including Medicare-certified hospices), and ambulatory care settings. Consultation services, longitudinal care and exposure to bereavement support also are part of the training experience.

From left to right: Andrew Mannes, Jacques Bolle, Diane St. Germain, Donna Pereira, Ann Berger, Eva Cummings, Daniel Handel, Wendy Wiser, Marcus Walker, Karen Baker and Chad Sawyer.

"We're delighted to be one of the first nine accredited palliative fellowship programs in the country," said Dr. Daniel Handel, director of the fellowship. "Our growing medical specialty, devoted to symptom management in incurable and terminal illnesses, coupled with a holistic, patient and family centered approach, relies upon a specific body of knowledge that is both scientific and experiential in nature, which is taught through our interdisciplinary team."

Getting the accreditation was more than a mere formality. The requirements led many of the staff through training they'd never before received.

"The accredited training programs are the training ground for the next generation of physician leaders in palliative care," said Dr. Steven Radwany, PMRC chairman.

"Fellows in these programs learn to work in interdisciplinary teams and to value the contributions of other disciplines, to focus on relieving the suffering of both patient and family members, to respond to the physical, emotional, and spiritual dimensions of life-threatening illness, to communicate effectively and compassionately about very difficult issues with patients from many cultural backgrounds, and to help families and health care teams deal with ethically difficult choices."

These are all skills that are too often neglected during earlier phases of a physician's education, Radwany added. "Graduates of these newly accredited training programs will go out into the community and help their colleagues with challenging palliative care situations."

Other ABHPM members include Beth Israel Medical Center, New York City; Cleveland Clinic Harry R. Horvitz Center for Palliative Medicine; Marshfield Clinic/St. Joseph's Hospital, Ministry Health Care, Marshfield, Wis.; Massachusetts General Hospital, Boston, Mass.; San Diego Hospice and Palliative Care, San Diego, Calif.; University of Pittsburgh, Pittsburgh, Penn.; UT MD Anderson Cancer Center, Houston, Texas.; and VA Palo Alto Health Care Service and Stanford University School of Medicine, Palo Alto, Calif. ❖

Inhaled nitrite may help babies suffering in a low-oxygen state

by Dianne L. Needham

Inhaling a simple nitrite spray may help babies diagnosed with persistent pulmonary hypertension of the newborn (PPHN), according to a joint study conducted by scientists at the Clinical Center and Loma Linda University School of Medicine (Loma Linda, Calif.). Premature newborns and those with pneumonia or heart problems often develop PPHN. This often-fatal disease causes high blood pressure in an infant's lungs and places the baby in a low-oxygen state.

The collaborative study findings are reported in *Nature Medicine* (September 12 online version; October, print edition).

Nitrite, a simple salt in the blood that dilates the blood vessels in the lungs, reacts with de-oxygenated hemoglobin (respiratory protein of the blood) and converts to nitric oxide when the human body is in a low-oxygen state. Nitric oxide, a short-lived gas produced by cells lining the blood vessels, plays an important role in regulating blood flow. The NIH–Loma Linda research team theorized that the naturally occurring conversion of nitrite to nitric oxide might help babies with high blood pressure in the lungs. They correctly predicted the nitrite conversion mechanism would lower lung blood pressure and raise oxygen levels.

The NIH–Loma Linda team studied the effect of nitrite inhalation in an animal model of PPHN. They compared the administration of nitric oxide with the administration of plain nitrite.

"Nitrite inhalation rapidly reduced pulmonary pressures by 65 percent," said Dr. Christian Hunter, a fellow in the NIH Clinical Research Training Program for Medical and Dental students, a fourth-year Loma Linda medical student and lead author of the study. "The nitrite had a much longer effect than the nitric oxide. In one case, we administered the inhaled nitrite for 20 minutes and the high blood pressure levels were reversed for an hour."

Delivering nitrite mixed with plain saline through a plastic inhaler holds great potential for becoming a much simpler and more economical way to treat newborns, according to principal investigator Dr. Mark Gladwin, Critical Care Medicine Department, Clinical Center. "The current clinical standard for treating these infants is to administer nitric oxide gas every day through a complex delivery system requiring high-level monitoring not available in small community hospitals or developing countries," he said. "This approach costs thousands of dollars a day and the delivery systems run tens of thousands of dollars. Our findings demonstrate this has potential to be done in an easier and more cost-effective manner."

"This research shows that a common agent found in nature can have profound health benefits worldwide," said Dr. John I. Gallin, Clinical Center director. "It emphasizes the importance of persistent, ongoing clinical research to life and health."

Nitrite also is available for human use as an antidote for cyanide poisoning and is used in meat curing, as well.

Further research is necessary to determine the safety and efficacy of inhaled nitrite for human use. Plans are under way to begin clinical trials by early 2005. Scientists from NHLBI and NIDDK at NIH, and from the Center for Perinatal Biology and Division of Neonatology, Loma Linda University School of Medicine, also participated in this study.

The full text of the study report may be found in *Nature Medicine* online at: http://www.nature.com/cgi-taf/DynaPage.taf?file=/nm/journal/vaop/ncurrent/abs/nm1109.html. ❖

A Sound of Thanks

Deon Baptiste, left, listens as his twin brother Ian explains how thankful he is for the successful outcome of the blood stem cell transplant procedure he underwent at the Clinical Center.

During one of his dance shows 24-year-old Ian Baptiste of Point of Spain, Trinidad and Tobago, began feeling ill. Tired all the time, he was routinely waking up with a mouth full of blood, a headache and dizziness.

The family doctor and a specialist confirmed a diagnosis of severe aplastic anemia, an acquired bone marrow disease. His physicians referred him to the Clinical Center for further evaluation.

By November 2003 doctors realized the only way to help Ian was to perform a peripheral blood stem cell transplant. Fortunately, his brother Deon was the willing—and best suited—donor because he is Ian's identical twin.

"When I heard how sick Ian was I started crying. I wanted to help. I didn't need an explanation. I just wanted to get it done," said Deon. "Ian is my brother, my buddy."

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Daniels leaves Clinical Center for the University of California, San Diego

by John Iler

Pharmacy chief Dr. Charles ("Chuck") Daniels left the Clinical Center in September to become professor of clinical pharmacology and associate dean of the School of Pharmacy and Pharmaceutical Sciences at the University of California, San Diego. He also is pharmacist-in-chief in the university's health system.

Daniels had been pharmacy chief at the Clinical Center for nine years. During that time, he has seen "growth in patient-oriented pharmacy services and safety improvements in the administration of medication in the Clinical Center" as his greatest accomplishments. "Collaboration in pharmacy research also has grown substantially and has increased the number of highly qualified staff at all levels," he said.

"A number of things are still being improved, such as the pharmacy's physical plant, which is in need of significant upgrades," he added. Both of these have already been addressed in the building of the new Clinical Research Center and future enhancements in the Magnuson Center.

"The Clinical Center leadership has provided strong support for high-quality pharmacy services since I arrived at NIH. Personnel and budgetary issues always influence how much can be done and how fast," said Daniels. "But I have never had a good idea rejected outright, even though some, concerning pharmacy automation and space, have had to be placed in queue for practical reasons."

Before coming to the Clinical Center, Daniels spent 15 years at the University of Minnesota College of Pharmacy and University Hospital. Bob DeChristoforo has been named acting chief until a Pharmacy Department chief is selected. ❖

Dr. Charles Daniels

Sound of Thanks

Continued from page 6

A peripheral blood stem cell transplant was performed on Christmas Eve 2003. Slowly Ian's health improved. One year to the day from when Ian first came to the Clinical Center, he and Deon gave NIH a very special gift.

The twins' passion is music and dance. They perform with Jeunes Agape ("young unconditional love"), a Point Fortin, Trinidad and Tobago-based musical-drama group. On September 2 Jeunes Agape performed a memorable concert of uplifting music, song and dance in the Masur Auditorium.

"This was really a morale boost for us to see that what we do does make a difference, said Hematology and Transplant Clinical Nurse Specialist Nonniekaye Shelburne. "Ian and Deon gave back to us, too, not just in research but in friendship." ❖

2004 Flu Vaccine Schedule

The flu vaccine clinic is being held on the B1 level of the Clinical Center (Building 10, Visitor Information Center, Little Theater) to serve NIH employees.

Some things to remember: *Do not* go to the OMS 6th Floor Clinic. The clinic will administer vaccinations based on the first letter of the employee's last name. Employees showing up on the wrong day can expect to wait. Wear a short sleeve shirt or jacket/sweater that can be quickly removed to expose your upper arm. Finally, this program is for NIH employees only.

For flu vaccine information, log on to www.nih.gov/od/ors/ds/flu
On campus location: Building 10/ Visitor Information Center/Little Theater

First Letter of Last Name		Date	Morning	Afternoon
EFGH		Monday, Oct. 18	7:30-11:00	1:00-3:30
IJKLM		Tuesday, Oct 19	7:30-11:00	1:00-3:30
NOPQRS		Wednesday, Oct 20	7:30-11:00	1:00-3:30
TUVWXYZ		Thursday, Oct 21	7:30-11:00	1:00-3:30
ABCD		Friday, Oct 22	7:30-11:00	1:00-3:30
IJKLM		Monday, Oct 25	7:30-11:00	1:00-3:30
NOPQRS		Tuesday, Oct 26	7:30-11:00	1:00-3:30
TUVWXYZ		Wednesday, Oct 27	7:30-11:00	1:00-3:30
ABCD		Thursday, Oct 28	7:30-11:00	1:00-3:30
EFGH		Friday, Oct 29	7:30-11:00	1:00-3:30
Off Campus	**Location**			
RKL I	Rm 5054	Mon./Tues., Nov 1 and 2	8:30-11:00	1:00-3:00
Poolesville		Tuesday, Nov 2	8:30-11:00	1:00-3:00
EPN	Rm 103	Wed./Thur. Nov 3 & 4	8:30-11:00	1:00-3:00
TW2	Rm 200F	Friday, Nov 5	8:30-11:00	1:00-3:00
NSC	Conf Rm 3103	Mon./Tues. Nov 8 and 9	8:30-11:00	1:00-3:00
Make-up Dates On Campus, Building 10, Room 6C306–OMS		Nov. 10,12,15,16,17	7:30-11:00	1:00-3:30

Beginning November 18, influenza vaccinations will be by appointment only. Please call OMS at (301) 496-4411 to make an appointment.

Medicine for the Public

Medicine for the Public features the latest developments in medicine. Physician-researchers working in the frontiers of medical discovery at NIH relate stories of science to the lay public. The lecture series, now in its 28th year, will cover the following topics for the 2004 season.

October 5

Dietary Supplements: What Do You Know? What Should You Know?

Dr. Paul M. Coates, director, Office of Dietary Supplements, National Institutes of Health

October 12

Through the Looking Glass: The Future of Medicine and the Building of the Mark O. Hatfield Clinical Research Center

Dr. John I. Gallin, director, Clinical Center, National Institutes of Health

Dr. Robert Frasca, partner-in-charge of design, Zimmer Gunsul Frasca Partnership

October 19

Evidence-Based Education: Preventing Reading Failure in America

Dr. G. Reid Lyon, research psychologist and chief, Child Development and Behavioral Branch, Center for Research for Mothers and Children, National Institute of Child Health and Human Development

October 26

The Biomechanics of Human Movement: Could Leonardo da Vinci Fly?

Dr. Steven Stanhope, director, Physical Disabilities Branch, Rehabilitation Medicine Department, NIH Clinical Center and National Institute of Child Health and Human Development

November 9

Addiction to Medications: What Are the Risks and Who Is Vulnerable?

Dr. Nora D. Volkow, director, National Institute on Drug Abuse

November 16

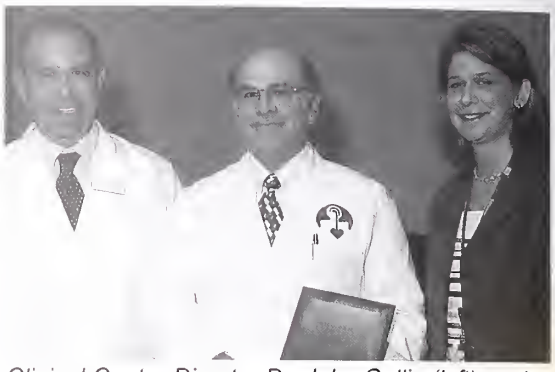
Viruses, Vaccines and Emerging Health Threats

Dr. Gary J. Nabel, director, Vaccine Research Center, National Institute of Allergy and Infectious Diseases

Lectures are held Tuesdays at 7 p.m. in the Clinical Center's Masur Auditorium and are free and open to the public. For more information, call 301-496-2563 or visit http://clinicalcenter.nih.gov/about/news/mfp.shtml.

Goldstein is 2004 Distinguished Clinical Teacher

NINDS researcher Dr. David Goldstein was recently named the 2004 Distinguished Clinical Teacher. He was recognized as an exemplary clinical mentor and outstanding teacher who played an important role in the professional development of clinical fellows.



Clinical Center Director Dr. John Gallin (left), and Dr. Melinda Merchant, present Dr. David Goldstein with the 2004 Distinguished Clinical Teacher Award.

"The DCT award is given to an NIH faculty member who exemplifies the ideal of a mentor, teacher, clinician, and researcher," said Dr. Melinda Merchant, senior clinical fellow in the Pediatric Oncology Branch, NCI, and Felcom subcommittee chairman for the award. "The award is given by the fellows to a role model of the clinical teacher they one day would like to become." The 2004 DCTA winner, she added, is "indeed a fantastic role model and exemplary mentor."

Goldstein is chief of the Clinical Neurocardiology Section, Clinical Neuroscience Program, NINDS. He has conducted pioneering research on the autonomic nervous system and is the author of hundreds of papers on the topic. He has an international research reputation and has been awarded the NIH Merit Award and the Laufberger Medal of the Czech Academy of Sciences.

"There has never been a time when I could not contact him or sit and ask him questions of him, even when he has been very busy," said one fellow. "He creates a working environment in which he leads by consensus. This quality makes him a true mentor."

For all his accomplishments, the 2004 Distinguished Clinical Teacher winner has not lost the personal touch with either his patients or with those he mentored. "He excels in all the criteria that were listed as a mentor," said one, "and with all my heart I confirm each and every one of them. He has touched lives including mine." ❖

October Grand Rounds, Events

6 *Wednesday, 12 noon – 1 p.m., Grand Rounds for Fellows*
How Far Away Is the Future for Patients with Lupus?
Dr. Bevra H. Hahn, professor of Medicine, Department of Rheumatology, David Geffen School of Medicine, UCLA

13 *12 noon - 1 p.m. – Contemporary Clinical Medicine: Great Teachers*
IL-1 and IL-18 as Targets of Inflammatory Diseases
Dr. Charles Dinarello, professor of Medicine, University of Colorado School of Medicine

20 *12 noon - 1 p.m.– 4th Annual John Doppman Memorial Lecture for Imaging Sciences*
Molecular Genetic Reporter Strategies for Imaging Protein Function and Protein-Protein Interactions in Living Animals
Dr. David Piwnica-Worms, professor of Radiology and professor of Molecular Biology & Pharmacology, director, Molecular Imaging Center, Washington University School of Medicine

26 *12 noon - 1 p.m.* – NCCAM Lecture
Reverse Herbology: Predicting and Preventing Adverse Herb-Drug Interactions,
Dr. Steven A. Kliewer, professor Molecular Biology and Pharmacology
Nancy B. and Jake L. Hamon Distinguished Chair in Basic Cancer Research
University of Texas Southwestern Medical Center, Dallas.

27 *12 noon - 1 p.m.*–Ethics Rounds,
The Ethics of Altruistic Organ Donation, Dr. Baruch Brody, director, Center for Ethics and Public Health, Baylor College of Medicine

Lectures can be accessed on the NIH videocast at http://videocast.nih.gov