



# Practically Speaking

NUMBER 21, WINTER 2006

## Blazing the Trails of Bioethics

*A Conversation With Daniel Callahan*

**T**he oft-quoted, -consulted and -published Daniel Callahan is perhaps the nation's leading thinker on bioethics issues. The bridge between philosophy and medical science barely existed, in fact, before Callahan and Willard Gaylin, MD co-founded The Hastings Center in 1969 to bring research discipline and critical thinking to a host of ethical concerns emerging from rapidly advancing medical technologies — such as end-of-life care, patient safety in research, and equitable distribution of health care. The Donaghue Foundation first crossed paths with Dr. Callahan in the mid-1990s, when the Trustees asked him to undertake a special study to help guide Foundation grantmaking priorities. His direction on critical issues surrounding bioethics over the years have helped to inspire other Trustee initiatives in this area.

We recently caught up with Dan Callahan in his Garrison, NY office to learn more about The Hastings Center and discuss topics from his recent books.

### **Dan, how did The Hastings Center get started?**

In the mid-1960s I got a PhD in Philosophy from Harvard, and spent some time as a magazine editor in New York. During that period I decided that I didn't want to teach at a university, but at the same time I became interested in the whole field of medical ethics and the great changes going on in medicine and biology. That combination led me to the idea of creating a research center to deal with these contemporary problems. I then recruited a neighbor of mine, psychiatrist Willard Gaylin. I was always

the full-time person and he was part-time, but we made a very good working pair. We felt at the time that the developing problems in medicine and biology were generating all sorts of ethical dilemmas, but at the time nobody was looking at them in any organized fashion. So we decided that's what we should do.



Daniel Callahan, PhD has written three dozen books on bioethics subjects, including end-of-life care, embryo research and patient safety in research.

### **How were you funded in those early years?**

We were funded by some small grants from the National Endowment for the Humanities, from the Rockefeller Foundation, and from some individual supporters. We were in a field that was not yet a field — later it became known as bioethics — but

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**The Foundation's Purpose, from Article Fourteenth of the Will of Ethel Donaghue:** The Foundation established hereunder is created and shall be operated solely for the purpose of providing financial assistance for research in the fields of cancer and heart disease and/or other medical research to promote medical knowledge which will be of practical benefit to the preservation, maintenance and improvement of human life.

## Important Dates

### **Clinical and Community Health Issues Program**

Letters of Intent  
reviewed:

February 28, 2006

April 28, 2006

June 30, 2006

August 31, 2006

Applications due:

September 7, 2006

### **Donaghue Investi- gator Program**

Applications due:

April 20, 2006

### **Donaghue Founda- tion Annual Meeting**

May 10, 2006

8:30 a.m. - 2:00 p.m.

at the Connecticut

Convention Center,

Hartford

## FROM THE TRUSTEES

# A silver lining, a singular thinker on medical priorities

This issue of *Practically Speaking* departs from our recent practice of organizing each newsletter around a single specific theme. It's more of the mosaic we frequently think the Foundation itself constitutes: a bit of this and a bit of that, some news, some views, some comings and goings, a few announcements and other bits of housekeeping. And then, of course, there's this letter — this opportunity for the trustees to share some of what's going on in our minds as 2006 gets underway.

With the recent departure of long-time staffer **Jacque Daniel** — now comfortably settled at the University of Virginia — and the arrival of **Nancy Yedlin** — an MPH with lots of background in marketing and communication — our executive director, **Lynne Garner, PhD** has “seized the moment” and refashioned both the priorities and the practices of the Foundation to take full advantage of the skills Nancy has brought to us. We regretted the loss of Jacque's rare talents but were determined to find a silver lining to the cloud of her leaving. We found it in thinking, as we always try to do, about ways to be opportunistic and jump the Foundation to a new level in perhaps a new direction. Jacque was irreplaceable, so we didn't try. Instead we used the personnel change to give real impetus to the translation/dissemination work we've wanted for so long to emphasize. Already we're beginning to see signs of advancement of that agenda as Lynne and Nancy redesign the format of our next annual meeting and brief us on other works in progress. We're confident they will bolster

the uniqueness of Donaghue and contribute to a transformation of attitudes and priorities in the role of research in actually benefiting people in need.

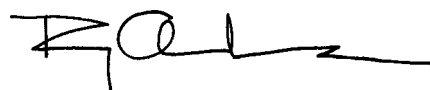
The feature article in this issue merits a comment or two. It spotlights a gentleman who has been a true trailblazer in bioethics for almost four decades and who has been a

big help to Donaghue in our embedding of ethics in our work.

**Daniel Callahan, PhD** has authored many insightful and eminently readable books on death, dying, and end-of-life care and priorities, both personal and societal. As much as any single bioethicist, he has prompted all of us to think realistically and responsibly about life and death and each other. In the early days of Donaghue's searching for its own priorities in research grantmaking, he was instrumental in opening our eyes to both the possibilities

and the problems in the work we were setting out to do. We're grateful to him for the insights he has given us and for his inspiring example of perseverant pursuit of right answers. Those familiar with Donaghue who read the Callahan interview will find ample evidence of his influence on our thinking. ▣

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Ray Andrews



Sheilah Rostow

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## EXECUTIVE DIRECTOR'S REPORT

We had an unexpected outcome in the 2005 Donaghue Investigator program this year — no grants were awarded. Since the beginning of the program, 25 Connecticut scientists have received a Donaghue Investigator award, with nearly \$14 million going to four Connecticut institutions to support their research. So in our eighth year of the program, we were unpleasantly surprised to receive only four applications that fit the program criteria.

Trustees and staff share in some degree of excitement about the Donaghue Investigator program during the selection of finalists and announcement of the new award winners. This program is more selective than the Clinical and Community Health Issues program — about ten percent of applicants receive an award — and we feel the high degree of flexibility provided investigators with this funding mirrors the flexibility the Foundation has to fulfill its mission. The selection process includes an interview with finalists, which allows us to get to know these high-caliber health-related researchers and learn about their interesting work. By the time the Trustees have made their difficult decision about which investigators to select for this award, we feel connected to the finalists. Our annual reunion with the entire cadre of Donaghue Investigators reinforces this connection with the grantees.

So when the decision was made that four applications — regardless of their quality — didn't provide a competition that would be as rigorous as the previous years and therefore no awards would be made, we all were disappointed. And stumped. What happened?

We have given that question a good deal of thought and have a few theories but no conclusion. Two years ago we narrowed the scope of research topics allowed within the program; did that create confusion about the program and inhibit prospective applicants? Possibly, although the first year of that change produced a robust field of finalists and made the Trustees' decision quite difficult. The narrowing of research topics away from basic sciences to more applied clinical and public health research limits the number of potential applicants; are there simply not enough investigators in those fields at the particular career point required for this program? Certainly the research enterprise supports fewer people in these areas — one reason that Donaghue is now favoring them — but surely with two medical schools in Connecticut that shouldn't be a barrier. Are there a lot of eligible researchers who simply are not aware of the program? Quite possibly. A random event? Maybe.

Covering our bases, Nancy Yedlin and I have been making a concerted effort to communicate with prospective applicants about the program, its purpose and application process and hopefully informing more people about this funding opportunity. The application materials have been revised with an eye to improving our communication about the program, but anyone considering applying to this or any other Donaghue program should feel welcome to call and discuss with Foundation staff any questions they may have about the program parameters. We welcome your questions about the Donaghue Investigator program and look forward to receiving many packages on April 20, the program's application deadline. ▀

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### Donaghue Advisers and Grantees Recognized

Two Foundation advisers and three Donaghue Investigators have recently received recognition for their academic or research accomplishments:

**Howard Tennen, PhD**, Professor of Community Medicine and Healthcare at the University of Connecticut, was named University of Connecticut Board of Trustees Distinguished Professor. This

is the highest honor bestowed on a University of Connecticut faculty member, and is reserved for individuals with a long-term record of superior teaching, research and service at the University. Dr. Tennen has been a member of the Foundation's Clinical and Community Health Issues review committee since 2004.

*(cont'd on page 9)*

## New Practical Benefit Initiatives

■ After a two-year hiatus on new Practical Benefit Initiatives, Donaghue has recently established a new PBI at the University of Connecticut Health Center. The **“Donaghue Nutrition Competition Program”** was started in October and will run for five years at a cost of \$550,000.

The purpose of The Donaghue Nutrition Research Competition is to support new and meritorious clinical research on the impact of nutrition to prevent or reduce disease and to achieve and maintain optimal health. The program will solicit, evaluate, and fund studies from Connecticut research institutions intended to produce promising pilot studies leading to the submission for larger grants to other external funding agencies; conduct smaller but highly innovative and possible risky hypotheses; and support faculty who are new to the field of nutrition research.

Applications to the competition will be reviewed by the GCRC Science Review Committee, and a four-member advisory panel, including a member from a research institution other than the University of Connecticut and a member appointed by the Donaghue Foundation, will select grants to fund from those judged meritorious from the UCHC's General Clinical Research Center review process. For further information about this program, contact Anne Kenny, MD,  
(cont'd on page 5)

## Callahan (continued from page 1)

we managed to persuade people that the issues were important and they gave us money.

### **Has the Center's structure changed over time?**

It has not really changed over time, although we certainly grew in size. We started with a staff of about four or five people when we opened our offices in 1970, and now we have a staff of about 30. But we've been a staff of 30 for at least 15 years now.

### **Give us a brief overview of the Center's principal activities.**

We think of our work as falling into different categories. Our main activity is to put together research projects on what seem to us to be the interesting and important problems of contemporary biomedicine. But we also have two publications, one called *The Hastings Center Report*, which has articles on bioethics, and another called *IRB*, a journal for people interested in human subject research. We have also done a number of educational things over the years, such as workshops, cooperative programs with universities, and a visiting scholar program.

Our work is both national and international. After I retired as president [Callahan was president of the Hastings Center from 1969-1996], I took on the title of Director of International Programs, and we have tried over the years to do more internationally as well as domestically.

### **What has been the focus of the Center's research?**

The topics have ranged widely over the years, everything from the beginning of life to the end of life. But we started with a handful of core issues that remain with us, including ethical problems in the care of the dying; ethical problems generated by reproductive medicine and biology; issues surrounding genetics; and the use of scientific techniques to manage or control human behavior. We've also worked on a variety of other topics as well, including human subject research, the problems of health care reform and health policy, the just allocation of health care resources, and the like.

### **Is the Center today the organization you envisioned it to be 35 years ago?**

When we started we had no expectations that the field of ethics research would develop the way it has — or that the Hastings Center would develop as it has. When we started, for instance, there were no courses taught in medical ethics in medical schools, with the exception, say, of some Catholic medical schools. And that was one of the things we worked on. Now every medical school has courses in medical ethics.

We were the very first in the world to be a research organization on these issues. Now there are any number of other centers concerned with it as well, though most of them are at the universities, not free-standing as we are. And, of course, there's a great deal of media interest in our issues, and national commissions on our issues, so the field really went beyond anything we envisioned. By the mid-'70s some people were saying that these issues were just going to blow over, that ethics research was just a fad. But it didn't turn out that way.

### **Donaghue's trustees approached you in the mid-1990s to conduct a somewhat unusual research project for the Foundation, which up to that time had been in the habit of giving money to much more technical basic science or clinical kinds of investigations. What was the focus of that project?**

At the time, one of my interests in health policy was setting priorities. The Hastings Center had been conducting a project on the goals of medicine — one objective of which was to deal with the question of priorities — and [Donaghue Trustee] Ray Andrews asked if we would help the Foundation develop some guidelines in setting priorities for their own work. And so we did that, as we were simultaneously trying to think about priorities in health care more generally. One result is that Donaghue became interested in the field of bioethics and decided that they would do more work in that area.

**In addition to your work at the Hastings Center, you are also a lecturer at the Harvard Medical School and a senior fellow at the Yale Institution for Social and Policy Studies. Tell us about your work at Yale.**

It's a very informal relationship. I have no formal duties and I receive no income. The idea was not that I would go up there to teach. Instead, I take part in projects that the bioethics program runs from time to time where there is mutual interest. My interaction is mainly with the faculty. At the moment I have one project underway at Yale, working with a geriatrician, Margaret Drickamer, MD. Last year I took part in an ongoing end-of-life project there.

**You have edited or written more than three dozen books. Your most recent book, *What Price Better Health?* (2003), is subtitled *Hazards of the Research Imperative*. Tell us about that.**

I was really operating on two levels in that book. First, there's a great deal of discussion these days on what's called "research ethics." The common meaning of that phrase centers on the use of human subjects for research, or sometimes on the integrity of research — manipulation of data and so forth. I wanted to expand the concept of research ethics to encompass a much broader scope: What are the appropriate goals and priorities of research? What are the appropriate limits on research? How should controversies be dealt with?

Secondly, I became very interested in the question of embryo research. As with the recent stem cell issue, most of the debate was centered on the question: how do we balance the value of embryos against the value of research to save future lives? But it became increasingly clear that all of the debate focused on the embryos, and the notion of the obligation to carry out research was being analyzed by...nobody. I thought that was very strange. If you're trying to balance off these two potential areas of value, what kind of imperative is there to carry out research?

In the book I mention that Dr. Joshua Letterberg, a well-known Nobel Laureate,

said to me 30 years ago that if we don't carry out research on disease, the blood of those who will die will be on our hands. I remember asking myself at the time if this were really true. I forgot about it for many years until the recent stem cell debate, where people were saying we have a moral obligation to carry out this research because it might save all kinds of lives. And then I asked, well *is it* a moral obligation? For instance, if a legislator decides he wants to take some money from the research budget and move it into elementary school education, he's not going to be accused of killing people who might have been saved by the research. So it becomes a question of how to allocate resources. Essentially, I conclude that I don't believe that there is a moral obligation to carry out medical research, with one exception — an epidemic or pandemic where large numbers of people are at risk. A disease

like AIDS, where you have a large number of younger people being killed, would be a perfect case. I call it a high moral good, but not a binding obligation. It is one of many goods a society can provide, but not an overriding good.

For instance, you have to ask the question that economists ask, namely: what is the opportunity cost? What else might you spend the money on? At the time of the California debate on a \$3 billion bond issue for stem cell research, newspapers were report-

ing that there were some 2.5 million adult illiterates in southern California. As I wrote at the time, it seemed to me that given the highly speculative nature of stem cell research, \$3 billion would have been better spent educating the illiterates who have no future at all in our society unless they learn to read and write. Stem cell research may be important, but it can't trump everything else.

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## Practical Benefit (cont'd)

at the University of Connecticut Health Center.

■ Building on the success of the St. Francis Hospital and Medical Center's **SisterTalk Hartford** project, Donaghue and the Connecticut Health Foundation are joining to fund a \$172,000 supplemental year for this study. SisterTalk was funded by Donaghue in 2002 for three years to test the efficacy of a weight loss intervention focused on women in Hartford's predominantly African America churches. Judith Fifield, PhD, is the Principal Investigator. The original phase of the project demonstrated that the intervention, which integrates issues of spirituality into its healthy life-style message, has been successful in reducing weight and blood pressure in the intervention group. The added fourth year will investigate whether women sustain their weight loss several months after the intervention ended. It will also track how the program is sustained in the churches and whether and how it moves to other churches.

The Connecticut Health Foundation is the state's largest independent, non-profit grant-making foundation and is dedicated to improving the health of people in Connecticut. Donaghue is pleased to be collaborating with the Health Foundation to discover successful ways to improve health and health care in Connecticut. ▀



## Research Ethics Symposium

The Donaghue Initiative in Biomedical and Behavioral Research Ethics, in collaboration with the University of Connecticut Health Center and the Connecticut Hospital Association, held the 3rd annual Institutional Review Board (IRB) Educational and Networking Symposium on November 3, 2005.

This series has developed into a mainstay of educational activities for IRB members serving Connecticut institutions conducting research. The format for these symposia is interactive, with key presentations on current controversial topics by nationally acknowledged experts and facilitated case-study workshops for further exploration of the issues. The topics that were discussed at the most recent symposium included centralized review of clinical trials, effect of litigation on the informed consent process, and research involving adolescent subjects.

The morning session featured three presentations on these topics. **Dr. Lowell Schnipper**, Professor of Medicine at Harvard Medical School, discussed the pros and cons of centralized, as opposed to local, human subject protection review, especially in light of the increasing number of complex multi-site studies. In a provocative presentation, **Barbara Mishkin**, of Hogan and Hartson law firm, analyzed the extent to which recent litigation trends may

*(cont'd on page 7)*

**Callahan** (continued from page 5)

**As you point out in the book, standards surrounding human subject research establish an interesting ethical imperative of sorts.**

Yes, the whole debate of human subject research going back to the postwar years and Nazi experimentation — actually going back over a hundred years — asks: how do you balance off all the lives that can be saved by research against the harm that might be done to the human beings you used as your research subjects? The international standard we essentially have now is that unless you get informed consent from research subjects, you cannot carry out the research. We don't care how many lives you might save, you still can't do it. I found that to be a really important precedent — a moral standard that trumped any supposed research obligation.

So my main point was that research is a good thing to do, but we shouldn't use the language of a moral obligation, except under very unusual circumstances.

**You also suggest in the book that we redefine the term "medical progress" to be less focused on conquering disease and more focused on improving the way we care for people with disease; less focused on extending a life poorly lived and more focused on reducing premature death.**

The idea of medical progress is probably one of the most sacred of all American values, and certainly a sacred value in medicine. But in recent years progress has usually meant technological innovation of one kind or another, whereas there is a lot of good evidence that something like 60 percent of health improvements come from socioeconomic conditions — not organized medical care. We spent \$3 billion for the human genome project, for instance. We should now spend \$3 billion to better understand why we have obesity, why people don't exercise as much now as they once did, and why people smoke and do other things harmful to their health. One estimate is that 50 percent of all deaths in the U.S. can be traced to unhealthy behavior. Yet that hasn't triggered the kind of research excitement enjoyed by, say, genetic research. But clearly, if you're trying to save lives, you're going to make a huge difference

in health outcomes if you can reduce obesity and get people to exercise more.

As to the question of human life span, I have long thought the appropriate goal is what's sometimes called the "compression of morbidity." The aim is to have people live reasonably long lives in good health and, if possible, die rather quickly. The idea of the compression of morbidity is to keep people healthy until late in life and hopefully avoid a long period of decline and suffering.

But medicine is very confused about death. On the one hand you have a palliative care movement based on the acceptance of death, and on the other you have a research community that doesn't like death at all and is going after every cause of death. The line between living and dying is very fuzzy these days. There's an enormous technological drive among the doctors. No matter what condition the body is in, the doctor can always try one more thing. Most people receiving hospice care start only a week or so before they die, though they probably should have started it months before they died. But the doctors don't want to tell the families that the patient is dying, and the families don't want to talk about the patient dying, because death is considered defeat.

This raises some fundamental questions: How should we think about death in research? How should we balance quality of life and length of life when we form our research priorities? How should we define progress?

**Have the major funders of research begun to lift their eyes in this direction?**

It's a very hard sell. The tendency now is to confuse medical progress with technological innovation. So you're constantly hearing about new drugs that are going to improve things, or fancy new technologies that are going to extend lives. And, of course, there's a lot of money involved.

**Shouldn't medical advances allow us to start allocating resources to other areas?**

One of the real puzzles to me is that by every standard American health is improving — people are living longer lives, mortality rates from almost all diseases are declining — but the funny thing is that the healthier we're getting, the more we end up spending on

health care. We don't say, "Well we're getting healthier, let's spend some money on other things." It doesn't work that way. Instead, we've raised the standards of what counts as good health. If you're 75 and having erectile dysfunction, for instance, there's now a pill for it. People's expectations for their health advance as fast as the research. This is true of practically everything else in our society. We expect more from our automobiles than we did 20 years ago, and so on. A very interesting study from the late 1980s found that objectively people are in better health now than they were 40 years ago, but subjectively they complain that they're in worse health. They have different standards of what they call good health.

**Another theme of your book concerns the cultural forces at work shaping the scope and expectations of research.**

Yes, how culture shapes our views has been of long-standing interest to me. This country has had a long tradition of belief in scientific progress and technological innovation. It has been one of the things we pride ourselves on. When surveys are done about research in America, about 80 percent think it's absolutely terrific. They are willing to pay higher taxes for even more research. And you have an awful lot of people who make money

from research — pharmaceutical companies, companies that make instruments or diagnostic devices. And Americans don't want to get sick. So there are both altruistic and self-interested factors at work in our society.

**Is the public involved in the discussion of the role of research and setting priorities? Or does it take place only in the halls of research?**

There really isn't that much of a discussion in the scientific community about these issues. You have the NIH, which does most of the basic biomedical research in this country — and which, interestingly, gives more money to lethal diseases than it does to diseases that affect quality of life — and then of course you have the medical companies which base decisions on whether they can sell something. Their aim is not the common good, it is profit to shareholders. And you don't get any real priorities that way.

So there is no real discussion of priorities within the research community or in the marketing community of health care, and so it's hardly surprising that the public is not caught up in it as well.

I think it would be wonderful to find out what people think is comparatively more or less important. It's not easy to even frame

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**Research Ethics (cont'd)**

have an undermining influence on the ethical spirit of informed consent. Ethical aspects and regulatory guidelines pertaining to research with adolescent subjects was discussed by **Audrey Rogers** of the National Institute of Child Health and Human Development of the National Institutes of Health.

During the afternoon, the speakers each facilitated a working group to give participants an opportunity to explore in greater depth the topic of their presentation. The symposium was attended by 72 participants representing 16 Connecticut institutions. ▢

In October the **Clinical and Community Health Issues** Committee convened to review the Fall 2005 applications. The Trustees are pleased to announce their decision to fund the following grants:

Principal Investigator	Institution	Research Topic	Grant Amount
Rafael Perez-Escamilla, PhD	Associate Professor of Nutrition, University of Connecticut	Breastfeeding Education & Support Trial for Obese Women	\$239,696 for three years
Ludo Max, PhD	Assistant Professor of Communication Sciences, University of Connecticut	Neurological Bases of Stuttering: Motor Learning & Control	\$217,902 for two years
Yifrah Kaminer, MD, MBA	Professor of Psychiatry, University of Connecticut Health Center	Contingency Management Reinforcement for Adolescent Cannabis Use	\$240,000 for two years
Linda Mayes, MD	Professor, Yale University Child Study Center	Minding the Baby: Home Visiting for Young Parents	\$240,000 for three years
Anne Kenny, MD	Associate Professor of Internal Medicine, University of Connecticut Health Center	Effects of Omega-3 Fatty Acids on Bone & Frailty	\$240,000 for two years

“If a legislator takes money from the research budget and moves it into elementary school education, he’s not going to be accused of killing people who might have been saved by research. So it becomes a question of how to allocate resources.”

the issues. How do you compare some genetic diseases, which are awful and eventually kill — but only affect a relatively small number of people — to, say, heart disease? Or how do you compare relieving mental illness — which doesn’t kill people, just makes them miserable — to spending money on cancer? Even technically it’s a very complicated discussion to have.

**Whose job is it in our culture to lead the charge on this discussion?**

It’s nobody’s job — which is why it’s not taking place.

**You’re about to publish a new book. What’s the focus there?**

The new book is called *Medicine and the Market: Equity v. Choice*. I got interested some years ago in the use of market practices in health care systems and how to assess them. Do we go the way of universal health care as Europe and every developed country except ours has, or do we bring in more market forces and encourage competition? In

our country we have no price controls on drugs because the drug industry is very powerful and this country believes in the market more than other countries. In Europe the drug prices are controlled because the government says we’ll pay you 28 cents per pill — take it or leave it. In this country we let drug companies charge whatever the market will bear.

**Do you make any conclusions in the book about which model is the better system for health care?**

We concluded that, by just about every standard, the universal care countries provide superior care for their citizens. We should envy them. Yet the intriguing thing we learned in this study is that basically every country in the world is having a health care cost problem. Ours is one of the worst because of our market practices, but the Europeans are all complaining about health care costs too. They are very much committed to universal care, and are wary of market activities. On the other hand, the market is government’s

## Donaghue Working With Other Foundations To Fund Research

Eye-eyed readers of Donaghue’s annual reports surely have noted a statement on the financial page that says the Foundation facilitates research grants for other organizations. This brief statement refers to an ongoing collaboration between Donaghue and the Hartford Foundation for Public Giving and the Connecticut office of the Bank of America’s Foundation and Philanthropic Services.

Through its scientific review process, Donaghue facilitates medical research funding by the Hartford Foundation for Public Giving to research scientists in the Hartford area. The Hartford Foundation has a small number of its funds that specify medical research as their target. Because its work is focused primarily on arts and culture, education, housing and economic development, and social services, the Hartford Foundation has used Donaghue’s science review process for the past eight years to provide high-quality, peer-reviewed research grants for its donors. Each year Donaghue notifies the Hartford Foundation of grants from institutions within the Capitol region that have been reviewed by Donaghue scientific advisory committees as meritorious for funding. The Hartford Foundation then decides which grants are the best matches for its funds ac-

cording to their individual purposes. “We are pleased to partner with the Donaghue Foundation to ensure that our donors’ resources are used to discover ways to improve the health for people in this community,” said Richard Porth, vice president for grantmaking at the Hartford Foundation.

A similar process is used by the Connecticut office of the Bank of America’s Foundation and Philanthropic Services in carrying out a trust established by Ethel Donaghue during her lifetime. This trust is different in two ways from the Foundation established by her will. First, it was an inter vivos trust — begun during her lifetime rather than establishing a mechanism to fund research after her death. And second, it has a very specific and narrow focus — “medical research for the cause and cure of cancer.” Our review process saves the Bank from having to establish one of its own, and the dollars increase what is available for research.

These collaborations incidentally free up some Donaghue money for more grantmaking, and they join with the National Patient Safety Foundation and the Connecticut Health Foundation (see article on page 4) as organizations that Donaghue has worked with creatively to benefit medical research in Connecticut. ■

big escape valve in Europe. In this country, when things get really tough, we tend to look to the government instead of the market.

**How does a smaller funding organization like Donaghue navigate some of these issues and figure out their research priorities?**

Donaghue tries to support research not readily funded by NIH and I think that

makes a great deal of difference. The Foundation should continue to be supportive of innovative things, and of research on diseases that are not going to command a lot of public attention. And of course I appreciate their interest in the ethical and social problems of medical research and progress. There is far less money for inquiries of that kind than for the research itself. **D**

**Advisers (cont'd)**

**Harlan Krumholz, MD** was named as the Harold H. Hines Professor of Medicine at Yale University School of Medicine last November. Dr. Krumholz received one of the Foundation's "New Investigator" grants in 1995 and is now a member of the Policy Advisory Committee.

**Elizabeth Bradley, PhD**, 2002 Donaghue Investigator, was awarded "Teacher of the Year" in the Yale University School of Public Health in May 2005.

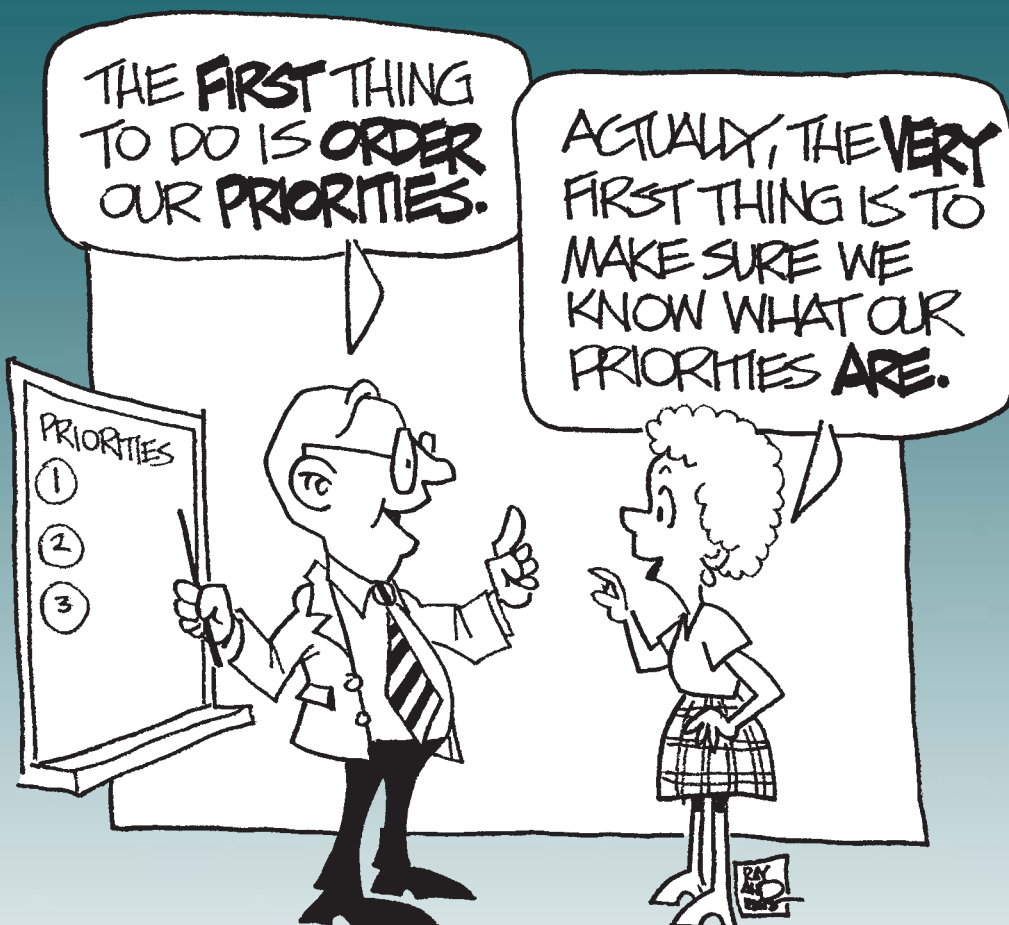
**Stephen M. Strittmatter, MD, PhD**, 1998 Donaghue Investigator, received the Senator Jacob Javits Award in Neuroscience from the National Institute of Neurological Disorders and Stroke. This award is presented to investigators who have demonstrated exceptional scientific excellence and productivity.

**Francisco Sylvester, MD**, 2003 Donaghue Investigator, created the Kids Center for Bone Health, which opened at Connecticut Children's Medical Center in October 2005, and is its director. The center has a state-of-the-art Lunar Prodigy bone densitometer and works with the CCMC Research Department to design projects with clinical divisions. **D**

## DONAGHUE DICTIONARY: pri·or·i·ty

**A** priority for this issue is addressing Donaghue's take on the idea of priority. According to a standard dictionary, a priority is something that is given or deserves attention ahead of competing alternatives. When resources are limited, it's important to identify which alternative uses merit preferential treatment — to focus on the ball one should be keeping one's eye on. A pretty fundamental question is, "Whose priority are we talking about?" This is so because different folks will surely have different ideas about how best to apply the same resources.

For the Foundation trustees, Miss Donaghue's intent, as expressed in her will, is always Priority One. And the trustees' reading of that intent — the application of her resources to promoting useful health knowledge through research — becomes our oft-recited mantra: "Practical Benefit." Recognizing that priorities differ among people and organizations, Donaghue often places a priority on just those things others relegate to a back seat. Hence our "but for" test, which focuses our attention on worthy projects that without our support might not move forward because they're not high on someone else's list of priorities. **D**



## New Foundation Employee

Starting in September, **Nancy C. Yedlin** has joined the Donaghue Foundation staff as Director of Program Communications & Management. She has responsibility for managing two of the Foundation grant programs: Clinical and Community Health Issues and the Donaghue Investigator Program. In addition, Nancy is responsible for developing strategies and approaches to improve the dissemination of promising research results for use in the health care practice and policy worlds.

After obtaining her undergraduate degree from Brown University in Anthropology, Nancy received her Master's degree in Public Health from the Yale School of Medicine in 1981. For most of her career, Nancy worked in the managed care and corporate benefits arena. She held leadership positions at PHS/HealthNet and in the health benefits strategy group at Pitney Bowes Corporation.

When family members were experiencing significant health issues which demanded her time and attention, she took a break from the corporate work force in favor of the greater flexibility of being a self-employed consultant. "This change provided me an unexpected opportunity to look at my life in a different way, and when the time came to head back to full-time employment, I knew I wanted to do something that I would find more satisfying.

In addition to learning the ins and outs of the Clinical and Community Health Issues and the Donaghue Investigator programs, Nancy has been laying the groundwork for Donaghue to go the next step in taking greater responsibility to connect research findings to practice. For example, Donaghue's 2006 annual meeting will be a half-day conference and will explore several topics related to knowledge transfer from "the research world" to "the real world." Nancy has been taking the lead in designing this conference and its agenda and in selecting the speakers.

"I've truly enjoyed my first few months at the Foundation. It may be a cliché, but its small size gives us the opportunity to do it all — from licking stamps to strategic plan-

ning." And she jokingly adds, "In all of the jobs I've had before this one, I either had to make money or save money for someone else. This is the first job where the main purpose is to give money away. That's a lot more fun." ▣

## Jacqueline Daniel Update

Many of our *Practically Speaking* readers have had the opportunity to speak with or meet **Jacqueline Daniel**, the Foundation's cheerful and steadfast employee for the past eight years. Jacque began at the Foundation as an administrative assistant from a temp agency, and through the years she consistently gained new skills and demonstrated her value to the Foundation. When she recently fulfilled a long-held dream of moving her family to Virginia, Jacque was the Foundation's Program Administrator. In that position, she was the go-to person for the Clinical and Community Health Issues and Donaghue Investigator programs, assisted with the Foundation's newsletter and website, functioned as the office manager, and was the personable "front door" of the office.

After arriving in Charlottesville, Jacque began working in the University of Virginia's newly established Office of Equal Opportunity Programs. She arrived just in time to join a staff retreat in the Shenandoah Mountains. Her duties include administering some of the office's programs, oversight of the office's budget and financial records, and working with the newsletter and website — "right where I left off with Donaghue," Jacque wrote in a recent email. She will also be overseeing and monitoring the faculty recruitment process, ensuring compliance with the University's diversity procedures for all faculty positions, and editing office reports.

Jacque's new office is in the historical "Academic Village," the original University of Virginia campus designed by Thomas Jefferson and based on the concept of faculty and students living together as an intrinsic part of academic life. Jacque says she loves the beauty of the Charlottesville area and the historic campus.

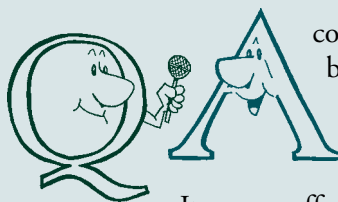
We miss Jacque, but are happy for her and her family in their new home. We hope she will stay in touch with Donaghue and let us know of her progress and adventures. ▣



"In all of the jobs I've had before this one, I either had to make money or save money for someone else. This is the first job where the main purpose is to give money away. That's a lot more fun."

## ASK THE TRUSTEES

### QUESTION: How did you become a Donaghue Foundation trustee?



**EDITOR'S NOTE:** *Trustees charged with executing a trust are either named in the trust document itself or appointed by a court. Trustees may be either individuals or corporations having trust powers (e.g., banks) or, as in the case of Donaghue, both. If a vacancy exists in a trustee position for a trust created in a will, the appropriate probate court fills the vacancy. Miss Donaghue's will named Connecticut Bank and Trust Company (her long-time bank) and Alexander Goldfarb (one of her conservators) as trustees. CBT was taken over in a series of corporate steps leading ultimately to Bank of America, and Attorney Goldfarb died before Miss Donaghue, so a vacancy resulted in the individual trustee position.*

#### Ray Andrews replies:

My involvement with Donaghue is a classic illustration of the adage “Life is what happens to you while you’re making other plans.” The job came looking for me while I was gazing in other directions. The answer to the question posed above has two distinct parts:

- 1) Why was I asked to take on the assignment? and
- 2) Why did I agree to do so?

In early 1993 the probate judge having oversight of the trusts set up in Miss Donaghue's will asked me to interview for the trustee position he had the responsibility of filling. I'm sure it was my extensive background in health care and trust law, combined with the fact that I was free of professional entanglements that might compromise my independence of judgment, that prompted the judge to appoint me trustee. The fact that I didn't seek the job but was willing to volunteer for it probably commended me to him.

Perhaps more interesting than why I was asked are the reasons I accepted the court's appointment. First, there is a tradition among lawyers that prompts us to willingly accept an assignment when asked by a judge. Second, I believed that I could repair some of the damage to the public's perception of lawyers that had been caused by scandals that swirled around Miss Donaghue in her last years. Third, when I read Miss Donaghue's will — my marching orders-to-be — I saw an extraordinary opportunity to accomplish something for human health if I were to make Donaghue a top personal priority during my tenure as a trustee. Miss Donaghue's inspiring words offered me the resources, the power, the latitude and the challenge to build something that

could have great and lasting impact — and be a proper tribute to her and her family in the bargain. And the structure of the trust — having a capable bank co-trustee — would allow me to focus on mission.


It was an offer I couldn't refuse. It was a humbling honor to be selected. And I've derived enormous personal fulfillment from working at the mission I undertook.

Under Miss Donaghue's will, I now have the responsibility of selecting my successor. After 12 years as trustee, I consider that a matter of highest priority because, having signed on as “the Irish woman's lieutenant” in 1993, I will always be committed to the enduring effect of her legacy.

#### Sheilah Rostow replies:

The short answer to the question is that I did not become a trustee. My employer, Bank of America, serves as one of the two co-trustees, having succeeded to the position to which Connecticut Bank and Trust Company was named in Miss Donaghue's will. As an officer of Bank of America, I was selected by the Bank to represent it in overseeing the Foundation. My actions and decisions are taken on behalf of the Bank as co-fiduciary of the Foundation and, like Ray Andrews, I am bound by the terms of the will and the requirements of fiduciary duty and responsibility. As a senior philanthropic service officer, I was assigned to the Donaghue Foundation because the nature of the trust requires someone with extensive experience and the ability to make decisions on behalf of the Bank.

A question that is often asked is why someone might name a bank as a trustee. There are many answers to this question that may reflect the preferences of the person setting up the trust. Among these might be the desire to provide expertise in fiduciary and investment management, to provide an objective third party, or to provide longevity and continuity (unlike humans, banks have a permanent existence). In the case of Bank of America and Donaghue, we also provide significant operational assistance that enables the Foundation's staff to focus on fulfilling the mission of the Foundation. Bank of America is a leader in the field of philanthropic management both locally and nationally, and it therefore has the ability to provide expertise in all aspects of the management of private foundations such as Donaghue, as well as all manner of charitable relationships.

The combination of an individual trustee and a corporate trustee has proved to be a fortuitous partnership which I believe has served and will continue to serve the Foundation well. 

**GRANT IN PROGRESS**

## Connecticut Collaboration for Fall Prevention in Conference Call to Seniors

“Hello, this is Genesys Conferencing. I have Angela on the line.” And another of the Plainville Senior Center’s monthly conference calls to home-bound senior begins. The “Party Line” is a program to provide social interaction and information to seniors who cannot get to the other of the Center’s programs. “We currently have only four to six people on the call, but in the past we have had as many as 15,” explained Ronda Guberman, Assistant Director of the Plainville Senior Center. The first half hour of the call features a presentation of information or something that is simply interesting or entertaining. Past phone calls have featured talks on hypothermia or diabetes; a local librarian read poems during the call near Valentine’s Day; and a member of the Plainville Historical Society told the stories of local history. The second half of the call is spent playing bingo — and winners do receive prizes.

So, what does this have to do with Donaghue, you may ask. The featured speaker of a recent call was Margaret Gottschalk, Program Coordinator of the Donaghue Foundation-funded **Connecticut Collaborative for**

**Fall Prevention.** CCFP is one of the Foundation’s Practical Benefit Initiative programs, started in 2000 to test whether falls in the elderly can be prevented. The staff at the senior center discussed the topic with call members, having sent out in advance of the call some of the CCFP’s materials. Mrs. Gottschalk discussed the CCFP, explaining risk factors for falls and what individuals can do to reduce their chance of falling. “I went well past my half hour, and they didn’t complain about missing bingo, so I guess they found it interesting.”

Mrs. Guberman confirmed that information about falls is a big topic at the Center. “The Fall Prevention program has been a tremendous asset to the Center. People are talking about falls in a different way. They used to say, ‘so and so fell,’ but now they are more aware of what they can do to prevent falls and the repercussions of falling.”

This is music to the ears of the CCFP Principal Investigators Mary Tinetti, MD and Dorothy Baker, PhD, who have been working with the entire CCFP team to embed fall prevention practices in the intervention area of their quasi-experimental study. The project is currently doing process evaluations and will begin its outcome evaluation next year. ▀



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