

Network Newsletter Archives

Network Newsletter
Home

Sign Up for an E-Mail
Notification Alert

Archives

About the Newsletter

Resources & Links

SPOEs

Network: A Quarterly Newsletter from the Anderson Network

Spring 2002

- **Melodic Modalities: Cancer treatment and “the sound of music”**
- **Psychiatrist studies physician-patient communication**
- **Doctor, doctor**
- **Friends of MPD Houston Golf Classic and Auction**
- **Director of Anderson Network-and cancer patient-retires**
- **Long-term survivors of childhood & adolescent cancers invited to reunion**
- **New Anderson Network head brings special talents**

Melodic Modalities: Cancer treatment and “the sound of music”

When you're alone at home, at work or in the car, do you ever throw inhibition to the wind and start to sing? Maybe it's some show tune or pop song whose melody rings out. Maybe you find yourself rapping with a rapper, or humming with the symphony's strings. Maybe your feet start tapping or your fingers snapping.

All the while you are singing, rapping or humming, tapping or snapping, you may actually be experiencing a sort of music therapy – relieving pent-up stress and anxiety and bringing a healthy calmness into your day.

This is a possibility that researchers who use music therapy with cancer patients are studying with increasing interest.

Not that the idea of music having therapeutic value is a new one. The Bible tells of how young David relieved the torments of King Saul by playing his harp. Greek mythology recounts how Apollo, who gave Orpheus music to charm the wild beasts, was god of both music and medicine. And in the sixth century B.C., the Greek philosopher Pythagoras not only wrote about music's therapeutic power, but also prepared specific harmonies for various diseases.

Today, the use of music therapy is widespread and crosses national borders. At an international conference in 1999, 2,500 music therapists from 44 countries assembled to share their clinical experience. And there are some 8,000 members of the American Music Therapy Association in the U.S. and Canada today.

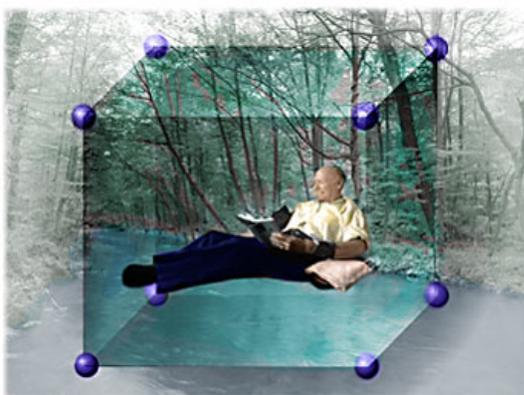
But exactly what is music therapy?

According to Deforia Lane, Ph.D., a board-certified music therapist and recognized leader in the field, “Music therapy is the systematic application of music in the treatment of the physiological and psychosocial aspects of an illness or disability.”

Dr. Lane, director of music therapy at the University Hospitals of Cleveland, Ireland Cancer Center/Rainbow Babies' & Children's Hospital in Cleveland, Ohio, claims, “Music has been shown to reduce blood pressure, heart rate and respiration rate, to decrease pain perception, to increase feelings of self-worth, to positively affect the immune system and to reduce levels of fear and anxiety related to hospitalization. Other benefits include positive changes in patient compliance and mood, as well as uplifting the morale of staff.” (Journal of Oncology Management, January/February 1993).

In their work, music therapists offer a “menu” of alternatives that can include using cassette tapes for relaxing or energizing; using music before, during and after surgery or painful procedures; singing during family visitation; developing musical skills on some instrument; using music for a visualization experience; helping patients write their own songs; or simply playing or singing what the patients would like to hear.

In the last few years, M. D. Anderson has taken a closer look at how melodic modalities could be used in the care of cancer patients – first with Octaphonic Sound (a concept developed and produced by Yamaha) for patients receiving chemotherapy; second with traditional music therapy as an integral part of programming in the Department of Pediatrics; and third as a pilot study with patients in the intensive care units under the auspices of Place...of wellness.



Octaphonic Sound is a new technology that combines music and nature in a surround sound.

Octaphonic Sound and Chemotherapy

Octaphonic Sound is a new technology in which music and nature sounds are digitally processed and delivered through eight speakers to create a surround-sound environment with realistic three-dimensional quality. M. D. Anderson's Pain Research Group, under the leadership of Dr. Charles Cleeland, is studying the effects that this sound has on a patient's treatment-related distress.

Patients in the study have four choices of sound: classical music; classical music with nature sounds; sounds of a calm sea with gentle waves breaking on the beach; and sounds of nature with wind, rain, birds and sea. Margaret Harle, the oncology research nurse who carefully chose the music and nature selections, admits to its limitations. "It would be good if we could just pop in someone's CD, to allow them a personal preference, but the system doesn't work that way."

It is also Harle's job to recruit appropriate patients for the study, to administer several tests, including the Brief Profile of Mood States to determine anxiety and vigor, the Octaphonic Selected Feelings Survey, and the M. D. Anderson Symptom Inventory, as well as to collect anecdotal reactions.

In the first phase of the study, 27 chemotherapy patients agreed to participate and were studied for two visits. They were randomly selected to receive one hour of Octaphonic Sound on the first or second visit.

This was done to eliminate "sequence effect," the possibility that listening to the music first or second might influence the responses of the other visit. The sound visit was in a room equipped with the Octaphonic Sound system. Following each treatment they were asked to rate their feelings and make comments.

After the session with sound, some of their reactions were: "The music puts you in a state where all pain and worries are almost non-existent." "Gave greater peace of mind – soothing – really relaxing. I fell asleep at one point during the music and nature sounds." "I have trouble staying still or seated for long periods of time. The music seemed to help that." "Any stress or uncertainty was taken away with the relaxing music." "I like the music, but I also like something livelier – country and western would be OK." "I am pleased with myself with volunteering for this study. It made the same routine of chemo different."

"We really don't have sound scientific evidence at this point," says Dr. Cleeland, "that stress or distress is necessarily related to how well people do or perhaps how effective their therapy is. It does make a difference in how they feel, and that's where we're focusing."

In the second phase of the study, Harle will compare the responses of patients listening to Octaphonic Sound with those of patients listening to the same content on a CD with a portable CD player. She and the research group will then decide which is most effective for stress reduction.

"We know that Octaphonic Sound helps the patient be more relaxed, calmer, less tense," she says. "And it has the most effect on patients with higher levels of distress. It's also our experience that patients who want to try Octaphonic Sound do the best. They like music for the way it enhances their life. And of course, if we can give them their preferred music, that is best."

Music and Pediatric Patients



Three days a week, Michael Richardson, a board-certified music therapist, brings his skills to pediatric patients at M. D. Anderson. Using his intuition and years of experience to guide him, he arrives with a variety of instruments, CDs and ideas for song writing. But his major goal is to help the children and adolescents with self-expression and socialization.

"I might say to the children, 'Let's hear what you're mad about,' and then encourage them to see how loud they can beat the drum," he says. "That allows them to deal with anger in a controlled way. Then, sometimes they write songs

about what it's like to die, what they're afraid of, what they want to say to their parents, the doctors or the staff."

Music also offers a way for the children to get to know more about each other. They can make songs about their names and the kinds of food they like, their favorite colors, their feelings and moods. Music is a way of coaxing some children out of their rooms while bringing activity to children who must stay alone in isolation.

"Most important in this work," he says, "is that it needs to be their music, culturally appropriate for each individual person and age. A teen-ager doesn't want to listen to something from the Wizard of Oz, especially if he/she is from Turkey!"

Richardson, who has been working with pediatric patients at M. D. Anderson for 10 years, is supervised by Dr. Donna Copeland, professor of pediatrics and section chief, Behavioral Medicine, Pediatrics.

Music in the Intensive Care Units

Place...of wellness began its study with patients in M. D. Anderson's medical and surgical intensive care units in 2000. In the pilot program, a music therapist saw patients who had been recommended either by families or nurses, for sessions of approximately 15 minutes.

The goals of the music therapy program were pain reduction and/or pain distraction, relaxation, increase in adaptive coping, socialization and/or normalization and palliative care. The sessions offered patients in a hospital setting the opportunity to make choices, take an active role, express emotions, draw on their abilities and normalize their environment.

Before each session, the therapist recorded whether the patient was awake, asleep or sedated. If possible, the patient was asked to rate his or her pain on a 10-point numeric scale with "10" signifying the most pain. This information was recorded again after the session, along with anecdotal comments by the patients and observations by the therapist.

The session consisted of music sung in the preferred style of the patient – if the patient could communicate. If not, the family or nurses were consulted. Patients and any family were encouraged to sing along or to actively participate in some way by clapping, toe-tapping or any other rhythmic body movement.

The mean score for patients' self-report of discomfort or pain before the session was 3.46 compared with 2.88 after the session, which has been enough of a decrease in pain to encourage interest for further studies. Plans are under way to continue this program.

Future Plans

Other areas of the hospital are considering the attributes of music therapy and whether it would be feasible in their particular settings, among them the Blood and Marrow Transplantation unit and Palliative Care. Place...of wellness is hoping to help these areas develop practical and appropriate programs.

As for Octaphonic Sound, after the study is finished, the system will remain indefinitely in the Infusion Therapy area of the Ambulatory Treatment Center. It is available on a first-come, first-served basis to patients receiving chemotherapy there.

And Michael Richardson continues to sit down with the kids in Pediatrics three mornings a week and bring out the music in them.

Research using music therapy with cancer patients still has a long way to go. Developing medical models for collecting scientific data is a challenge that people like Dr. Deforia Lane are trying to meet. In the meantime, anecdotal evidence shows that it can, at least, affect the quality of life.

"Music can be as immediate as hitting a brick wall," says Richardson. "It's that powerful if it's the kind of music the patient likes. It can bring tears to grown men's eyes as well as children's. It's what makes people cry or smile with joy when they hear a certain hymn at church. It can create an incredible connection to oneself – and others."

Related Links: M. D. Anderson's [Pain Research Group](#) and [Place...of wellness](#).

[Back to Top](#)

The other side of the stethoscope: A psychiatrist studies physician-patient communication



Most of us experience the flat end of the stethoscope, the side the doctor places on our chest. But what is it like to be the one who wears the stethoscope, the one who listens to our heart and lungs? What is it like to be the one who cares for numerous patients each day, the one who may miss a child's soccer game because he or she still has patients to see? And even more challenging, what is it like to be the one to deliver bad news?

These are issues that have occupied Dr. Walter Baile during a good part of his professional life. As professor of neuro-oncology and section chief of Psychiatry in the Department of

Neuro-Oncology at M. D. Anderson, his special interest has been training oncologists in physician-patient communications and studying issues of death and dying. He has led workshops on these subjects, written papers, carried out research and developed a six-step protocol for disclosing difficult information to patients. Now, he has finished recording a video,

"Being an Oncologist," with actors William Hurt ("The Doctor") and Megan Cole ("Wit") that invites doctors to reflect on the personal aspects of cancer care.

During the 45-minute presentation, Hurt and Cole assume the personas of various doctors. Using dialogue gathered by physician focus groups, they sit before the camera as though they are two doctors having coffee at the end of a long day. Informally and anecdotally they share their feelings about the stress of caring for patients with life-threatening illness; the time pressures; the challenge of breaking bad news; the need to keep hope alive; the balancing of sympathy and empathy and keeping personal boundaries, as well as dealing with both the patient's and their own emotional reactions.

Along with a growing number of colleagues in the U.S. and Canada, Dr. Baile addresses an important need in medical care today: helping to remove barriers that prevent doctors from talking about how patients affect them, and teaching skills not covered in medical school.

"Oncologists naturally focus on technological solutions to medical problems," he says. "Patients with serious illness, however, may benefit also by knowing the truth about their disease and their options rather than from being given false hope. And yet many medical students never hear a lecture on skills such as how to communicate bad news to patients."

He admits that it's a balancing act to try to maintain some control over emotional involvement with patients. "It's a challenge to take care of people and have them die if we've invested time, energy and emotion in them. That's why we need to look at the role patient loss plays in the doctor's life. Because no matter how good a doctor is, he/she can't save everyone."



According to Dr. Baile, a doctor needs to learn how to help patients die well, how to give appropriate hope, how to respond to patients emotionally, and how to deal with family members who are disappointed in the care received. A doctor can't help others without coming to some understanding of his/her personal issues around death and dying.

Because disclosing unfavorable information to patients is a complex communication task that goes beyond words, Dr. Baile and five colleagues have developed and published "SPIKES – A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer" (The Oncologist, August 2000). In it, they write that being able to break bad news well can affect patients' understanding of what the doctor is saying, as well as their satisfaction with medical care, their level of hopefulness and their subsequent psychological adjustment. It may also help patients make difficult decisions about treatment.

The reward for physicians is that they may be subject to less stress and burnout, especially prevalent in oncology where physicians work closely with patients who have life-threatening illnesses and therapy often has only a limited impact.

Very few studies have yet looked at the patient's preference for disclosure of unfavorable medical information. However, in a study done by J. T. Ptacek and John J. Ptacek, published in the November 2001 issue of the Journal of Medical Oncology, findings suggest that special attention should be given to making the environment comfortable, taking plenty of time with the patient and attempting to empathize with the patient's experience.

Most important, this increasing emphasis on communication assures that more research will be done in this area, and that both physicians and patients will benefit from the findings.

[Ed. Note: "Being an Oncologist" is a collaborative effort with M. D. Anderson's Public Education Office and Faculty Development, and is funded by the University Cancer Foundation. A workbook accompanies the video.]

[Back to Top](#)

Doctor, doctor



Dr. Roy Herbst

Cancer research is currently undergoing a fundamental shift that can best be described as a change from "seek and destroy" to "target and control." Dr. Roy Herbst, M.D., Ph.D. – chief, Section of Thoracic Medical Oncology – discusses two of the directions this research is taking: anti-angiogenesis therapy (studying drugs that have the potential to starve cancer tumors by preventing them from forming the new blood vessels they need for survival) and research into the epidermal growth factor (EGF) receptor (which promotes cell growth, cell proliferation and cell invasion).

What is the role of biology in the treatment of cancer, and specifically lung cancer?

In the last decades, we have made significant progress in the treatment of lung cancer using standard chemotherapy agents. In fact, in 2002 we have four drugs that are approved by the U.S. Food and Drug Administration (FDA)

for the treatment of non-small cell lung cancer (NSCLC). However, while these agents are useful and provide improved survival compared to prior agents, they are still rather non-specific. They kill tumor cells but also attack normal tissues. This is the reason why patients being treated for lung cancer lose their hair, have low blood counts making them prone to infection, and have diminutions [a decrease] of their mucus membranes.

Clearly, if we are going to do better in this disease, we need newer, more specific agents. We need a paradigm shift to develop more targeted therapy for NSCLC. The way this is being approached is to better understand the molecular biology of lung cancer tumor cells, then to apply this understanding to the development of new, more effective and specific treatments.

Unfortunately, there is often as much as a 10-year lag from when something is discovered in the laboratory until it reaches clinical trial. However, it is a very exciting time in lung cancer research since we have identified numerous new biologic targets, all of which are becoming candidates for therapeutic intervention. This has become a major thrust of our therapeutic program at M. D. Anderson.

How do biologics differ from chemotherapy drugs?

Chemotherapy drugs work by interfering with basic cellular processes, such as DNA replication. They can also impair cell division. These drugs are not selective for tumor cells and will have the same effect on all dividing normal cells. In an adult, most of the cells dividing are in fact tumor cells; however, the cells of the hair, bone marrow, nerves and mucous membrane are also dividing. This is the reason why chemotherapy drugs can be quite toxic, and this limits their use and dose.

Biologic therapies are specific for a molecular process for a given tumor. In a sense, they are "smart bombs" – meaning that they target only the cells that have a specific biologic receptor or process, which is hopefully more predominant in tumor cells than in normal cells. The use of this treatment does not exclude, however, chemotherapy. It is becoming quite obvious, in fact, that these biologic agents work very well in conjunction with chemotherapy. Two aspects of research into biologic therapies are in angiogenesis and the epidermal growth factor (EGF) receptor.

What is anti-angiogenesis and why is research into it so important?

One of the important new developments in cancer treatment in the last 30 years has been the realization that tumors can only grow to a certain extent until they form their own vascular supply. Agents that specifically target the blood vessels can interfere with tumor growth with very little toxicity to normal tissues. These agents can be quite specific and offer the opportunity to treat a large number of different tumors because they are treating, not the tumor cell, but the blood vessels in the normal host. In early trials, these agents have been very easy to use with minimal toxicity and represent the emphasis on important new targets for cancer therapy. What we are trying to do here in our department is to study anti-angiogenic drugs like endostatin, SU6668 and LY317615 in Phase I trials to better assess their safety and dose in lung cancer patients so that we can begin rationally to combine them in clinical trials.

What is the epidermal growth factor (EGF) receptor and why is research into it so important?

Some of the most exciting advances in the last several years in the treatment of advanced NSCLC have been therapies directed against the EGF receptor – a chain of events that affect cell growth, cell proliferation and cell invasion. Blocking the binding of EGF to its receptor – which is often over-expressed on lung cancer cells and expressed at very low levels on normal cells – would prevent a crucial molecular step involved in cancer cell proliferation. This would be a very specific way to target lung cancer tumors.

We are very fortunate that molecular biology has helped us develop several agents that block this receptor. The most work in lung cancer to date has been done with a drug known as ZD1839 or Iressa. In some of the earliest Phase I trials, which we conducted here at M. D. Anderson, we showed that this drug is relatively safe, producing very few of the side effects of low blood counts and mucositis that is seen with current standard chemotherapy. The main toxicity is a mild facial rash that one might expect in a drug that is targeting the EGF receptor which is present at high levels in skin.

We have seen in early trials that patients with lung cancer respond to this agent in the most advanced settings – for instance, patients who had failed multiple prior chemotherapy regimens. These agents have the potential to help improve response and prolong survival in patients with advanced disease. Two randomized trials of chemotherapy with the epidermal growth factor have ended, one of which was led in accrual by our group here at M. D. Anderson. The results are under review and, hopefully, will be presented some time this year.

How is the efficacy of these methods assessed?

In all our trials, we are always looking for tumor response and patient benefits. Yet, with all these many agents in clinical trial, not every one can be studied in a randomized placebo-controlled Phase III study. Clearly, we need to have some indication in early trials that we are having some effect on the blood vessels, the EGF receptor, or perhaps on both. One way to do this is through the use of non-invasive imaging, such as PET (positron emission tomograph) scans that allow us to measure blood flow through tumors and to track tumor metabolic growth. This is a way of determining if in fact the agent is working at an early time point and allows us to determine what dose is required. In many cases, we're using tumor biopsies and skin biopsies as well to identify whether there is an effect on a particular tumor target.

How long have scientists been looking in this direction for cures to cancer?

Angiogenesis has been studied as a therapeutic target for at least 30 years. The theory was first proposed by Dr. Judah Folkman in Boston back in the early '70s and is now well regarded

by most members of the oncology community. The EGF receptor has been a target almost as long. In fact, Dr. John Mendelsohn, president of M. D. Anderson, is one of the people credited with first identifying therapeutic monoclonal antibody approaches to the EGF receptor.

Where does research go from here?

This is a promising time in lung cancer research, but we have a long way to go. There's still not a single anti-angiogenesis inhibitor that is FDA approved, and currently the most advanced trial in lung cancer, with an agent that blocks the EGF receptor, is at least one year away from bringing a drug to the clinic on the frontline if the trials turn out positive. I can tell you from my experience that even this agent, Iressa (which as a single agent could be available this year), still only benefits approximately 30 percent of lung cancer patients who have stable disease for more than three months. In fact, only about 10 percent of patients on average have a response to this agent. That leaves 90 percent of people whose tumors don't shrink, though still about 30% will benefit with stable disease and improved quality of life. We need, therefore, to better understand who are the patients that do best and then find ways to export this to all patients. Studies along this line are now under way.

I actually don't believe any one of the biologic therapies is going to work for all patients. Rather someday we'll probably need to do a molecular profile on each patient (i.e. take a tissue biopsy), run it through a gamut of scientific tests, and determine the two or three or maybe four different biologic processes that are driving the growth of that given tumor. We will then need to take these new agents, combine them in the proper cocktail (perhaps also with chemotherapy), and use them together to have the best response and benefit for our patients and to prolong their survival with good quality of life.

[Back to Top](#)

Friends of MPD Houston Golf Classic and Auction

On Monday, May 6, Friends of MPD (Myeloproliferative Disorders) Houston will host its first Golf Classic at the Deerwood Country Club in Kingwood, Texas. The event will be a five-person Florida Scramble and the field is limited to the first 144 golfers. Each foursome will be joined by an NFL Alumni Association "celebrity" guest. Proceeds will help establish an MPD research grant for the Leukemia Department at M. D. Anderson.

Friends of MPD was started by Robert Pena, a patient at M. D. Anderson who was diagnosed with myelofibrosis in June 2000. He has been joined by a dedicated group of "Friends" who are committed to raising funds for medical research into this group of rare bone marrow disorders. MPDs are diseases in which too many of certain types of blood cells are made in the bone marrow. The resulting scarring or fibrous marrow hinders the proper production of red and white blood cells as well as platelets. The exact cause is not known and there is no known cure. It can be progressive, evolving into more serious forms of leukemia.

For more information call 281-209-7849 or e-mail robert.pena@bakerhughes.com.

[Back to Top](#)

Learning the meaning of words Director of Anderson Network – and cancer patient – retires

For almost 13 years, I've heard you say such words as: "I wouldn't wish cancer on anyone, but it was the best thing that ever happened to me"; "I've met some of the nicest people since I was diagnosed with cancer"; "cancer has changed everything in my life – certainly my priorities"; "once diagnosed with cancer – life is never the same again."

I've heard those words and even though they didn't always resonate within me as "valid," I accepted them as words coming from those who were living them. If they're being lived out, they must be true ... for them ... for those living with cancer.

About a year ago, I found myself being haunted by those words while I was screaming out others, i.e. "I don't want to be a part of this cancer community." "I'm NOT ready to be a member of this family." "I feel so alone." But, the diagnosis of stage II colon cancer and six months of chemotherapy treatments informed me every day that, like it or not, I am a member of a community that speaks a language that before I only heard, but now somehow I must live.

I can't say that I'm yet prepared to agree that "cancer is the best thing that ever happened to me." Those words don't yet freely flow, maybe because I'm not yet in remission, or maybe because I haven't totally learned how to cope with this new paradigm. Whatever the reason, I have to believe that most reading this article have been, or are still, where I am right now. But what I am prepared to say is I have met some of the nicest people since my diagnosis. Well, I guess even that's not totally true, because I knew many of you before I was diagnosed. However, now I know you as fellow sojourners, sisters and brothers in common expression, friends ... as I've never known friendship before.



For the past 12 1/2 years, I've had the privilege of serving as the director of the Anderson Network at M. D. Anderson. The Network is a group of volunteers of M. D. Anderson, all persons living with cancer. Our purpose is to reach out to all others with help, support, understanding and hope. We make this mission manifest through a number of programs including this quarterly publication, Network. In the years I've been with the Anderson Network, you have permitted me to hear your stories, walk with you on your journey, share your life, cry with you and celebrate with you. Now you are the ones who hear my story, walk with me, and understand each emotion I live through.

Life will never be the same again. I remember several years ago quoting that to a reporter who was writing a story on survivorship. He reacted by saying "I can't write that. I want this to be an upbeat story." I responded, "You're assuming that means life is never good again. Life will never be the same again, because it can be so much better." I said that then as the "voice of the survivor." Now, when it's my own voice...do I believe it?

I'm working on that just as I'm working on this priority thing! I'm working on it because I see and hear you all living it – reaching out, holding another's hand, walking that journey side by side, sharing your smile, a tear, a shoulder.

In three months time, I was diagnosed with cancer, had surgery, began chemotherapy, turned 60 and got engaged to a wonderful, understanding man. Two weeks after the completion of chemo, we got married, had a big celebration party, and shortly after that, I announced my retirement from M. D. Anderson and the Anderson Network. My life will never be the same again.

You have gifted me with so much these past 12 1/2 years. Our work together and the stories and lives we have shared will remain with me forever as life-giving and as constant reminders of life's priorities. You have no idea what a difference you make in so many lives. You have no idea what a life-changing difference you have made in mine.

Just about everything in my life has changed – and you have allowed me to see just how good it can be.

My dear friends ... for teaching me the meaning of the words ... I thank you. – Judy Gerner Biffle

[Back to Top](#)

Long-term survivors of childhood and adolescent cancers invited to reunion

M. D. Anderson's Division of Pediatrics is hosting a reunion and conference of long-term survivors of childhood and adolescent cancers who were treated at M. D. Anderson. Celebration of Life: A Reunion for Survivors of Childhood and Adolescent Cancers will be held May 31-June 1, in M. D. Anderson's Hickey Auditorium, 11th floor, R. Lee Clark Clinic, 1515 Holcombe Blvd., with Dr. Lee Ellis, associate professor of Surgical Oncology, and Dr. Eugenie Kleinerman, head of the Division of Pediatrics, among the featured speakers. Registration fee for the two-day event is \$5. For more information, contact Felisha Estelle at (713) 745-0083.

[Back to Top](#)

To be of service to others: New head brings special talents



With the departure of Judy Gerner, the Anderson Network has undergone some important changes. First, it has become part of the Department of Volunteer Services at M. D. Anderson, a partnership that brings greater visibility and resources to the Network as it continues its mission of providing hope and support patient-to-patient, caregiver-to-caregiver. Second, Laurie Albrigo, who joined the Anderson Network in January 2001, assumes leadership as assistant director of Volunteer Services, managing the Anderson Network.

Laurie brings great energy and enthusiasm to her new role. With an M.A. in behavioral science, specializing in health and human performance, and a B.A. in education, specializing in teaching the hearing impaired, Laurie says that the theme of her life has always been to be of service to others.

Never was that more apparent than at the Anderson Network annual "Living Fully with Cancer" patient conference last September. She signed as nearly 700 patients and caregivers sang "Circle of Life," from the popular Disney movie, "The Lion King," which also served as the conference theme.

During the 14 years she lived in Alaska, where she raised her two sons Shane and Seth (now 24 and 21 respectively), Laurie worked in several capacities with the speech and hearing impaired. One of her most interesting jobs was at Headstart. As a contract consultant, she flew into Indian and Eskimo villages to train native teachers in methods of dealing with speech and language problems. On these trips, she lived among the natives, eating their food and staying in their homes or schools.

She has also been a health promotion coordinator in patient education at Kelsey-Seybold Clinic and director of Medifit, a center for preventive medicine at San Jacinto Methodist Hospital. In her new capacity, she plans to enhance the programs offered by the Anderson Network and to serve its mission: Sometimes the best help comes from someone who has been there.

[Back to Top](#)

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