THE DAILY CLIPS

February 15, 2010

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Safe Zone trains ECU staff on gay issues
Saturday, February 13, 2010

ECU News Services
As the student related his reluctance to go to certain places on campus and his troubles while shopping in Greenville, jaws dropped in surprise and nodded in acknowledgement.

“I think a lot of straight people don’t realize the issues we go through on a daily basis,” Chris Pentz, a 20-year-old junior, told his small audience. About a dozen faculty and staff members were gathered in a small conference room for Safe Zone, an East Carolina University program that makes it possible to easily identify people who are empathetic and have attended training on issues related to gay, lesbian, bisexual and transgender students.

Intended to be a visible example of ECU’s support for GLBT students, the Safe Zone program gives faculty, staff and resident advisers a chance to learn about what it’s like to be a GLBT student on campus. Participants talk with a panel of students about their campus experiences and get tips from students on how to make ECU a more welcoming place. After a two-and-a-half-hour training, participants earn a sticker they can display in their office that shows students they are in a “safe zone.”

Aaron Lucier, director of housing operations, was part of Safe Zone’s creation at ECU and leads the training today.

“Students would often come to me and say, ‘Who is the best person to talk to in this office?’” said Lucier, who advises the Gay Lesbian Bisexual Transgendered Student Union (GLBTSU) and did the same for its predecessor. “This was a number of years ago, and I think a number of years ago, they had to be more careful. Safe Zone meant students would not necessarily have to ask me or ask anyone else.”

This was back in the late 1990s, when similar programs were cropping up across the country. After the ECU program started, the Student Affairs Diversity Team adopted it until it fell into hiatus in the early 2000s. Its revival began in 2006, and now volunteers working with the Chancellor’s Diversity Committee manage it. More than 100 faculty, staff and resident advisers have completed the training.

Safe Zone’s presence is comforting for GLBT students, Lucier said. “It’s not that they would necessarily use it or take advantage of it, it’s just the fact that it’s there. Just that it’s there might make them feel more welcome on campus.”
The program also sends an important message to visitors, he said. “They’re finding that there is a GLBT-friendly presence on this campus. That’s really important.”

Lucier is quick to point out that the sticker only means that someone has gone through the training; its absence does not mean someone is not gay friendly. Nor does the sticker’s presence mean that the training participant is an expert on gay issues.

While the training tends to attract people who are already empathetic to gay issues, the presence of the stickers could spark helpful discussion in campus offices, he said.

“We often get, ‘Well, do I need to put one up for every group on campus?’” Lucier said. “Well, if you think a group feels marginalized we might need to do it for other groups, but I don’t think anybody feels as marginalized sometimes as our GLBT students do.”

Several UNC system schools have similar programs; among them are N.C. State University, University of North Carolina at Chapel Hill, University of North Carolina at Greensboro, University of North Carolina at Charlotte, University of North Carolina at Wilmington, Appalachian State University and Western Carolina University.

**Medical resident dies from cancer**

An ECU family medicine resident has lost her 41 1/2-year battle with cancer. Katherine Bray-Strickland, who was featured in this ECU Notes column in January, died Wednesday.

She was diagnosed with maxillary osteosarcoma, a cancer of the jaw, in 2005 and had two recurrences.

Strickland and fellow medical resident Anna Hudson, who is also battling cancer, benefited from the generosity of their peers during a silent auction held in December, which raised $3,800 from ECU and Pitt County Memorial Hospital employees and friends, toward the women’s medical expenses.

Strickland graduated from the Brody School of Medicine in May 2009. In a message to family and friends, her parents, sister and husband wrote, “Kati’s fighting spirit and courage throughout this time have inspired us all. Her big heart and sense of humor has created a huge ripple effect, and we are truly blessed by the outpouring of support and love we have already received from so many of you.”

A graveside memorial service is planned for today at 1:30 p.m. at Pinewood Cemetery.

At her request, in lieu of flowers, gifts in Bray-Strickland’s memory may be given to the Family Medicine Center Building Fund at the ECU Medical & Health Sciences Foundation, 525 Moye Blvd., Greenville, NC 27834.
Jazz pianist, retired professors to perform

Renowned jazz pianist and composer Lenore Raphael will perform on a double bill with ECU emeritus professors Ed Wheatley and Bob Muzzarelli as part of the “Jazz at Christine’s with TomtheJazzman” series at 8 p.m. on Feb. 26 at the Hilton Greenville. Raphael’s performance is co-sponsored by ECU School of Music and the Hilton Greenville.

A New York native, Raphael began playing piano at age 3, and by age 7 she performed at Carnegie Hall. She played in small clubs in New York and New Jersey until she earned performance opportunities in New York’s top jazz venues such as Birdland and the Metronome. Raphael hosts a weekly show, “Lenore Raphael’s Jazz Spot,” on Pure Jazz Radio.com at 8 a.m. and 8 p.m. on Sundays.

Sentimental Journey, eastern North Carolina’s premier easy listening trio, will open for Raphael. Sentimental Journey features vocal, keyboard stylist and trumpeter Wheatley; Bob Muzzarelli on percussion; and Mary Muzzarelli on bass. Sentimental Journey will play a tribute to lyricist/composer Johnny Mercer.

Seating is limited. Dinner is available starting at 5 p.m., and the musical performances start at 8 p.m. Call 355-9500 for dinner reservations. Show admission is $10 and tickets are available through the ECU Central Ticket Office at 328-4788 and at the door.

Ticket revenues for the series are used to support the ECU School of Music Jazz Studies Program.

Physician nominated for national award

Dr. Tae Joon Lee, a clinical assistant professor of family medicine at the Brody School of Medicine at ECU, has been nominated for the medical director of the year award presented by the American Medical Directors Association, a national group representing physicians involved in long-term care.

Lee is a geriatric specialist at ECU and medical director at Golden Living Center, a long-term care facility on MacGregor Downs Road. GLC Executive Director Hal Garland nominated Lee for the award.

The national recipient of the award will be announced at the March meeting of the AMDA in Long Beach, Calif.

Upcoming events:
Wednesday: Sallie Southall Cotten Lecture: “Little Old Ladies and the Last Word: An Exploration of Sassiness and Risque Behavior in African American Folklore,” presented by Trudier Harris, 7 p.m., Wright Auditorium. Part of the Voyages of Discovery lecture series. Tickets are $10 for the public and are free for ECU faculty, staff and students.

Saturday: Motown concert, 8 p.m., Wright Auditorium. Tickets are $10. Call 328-4788.

See www.ecu.edu/cs-ecu/calendar.cfm for times, places and more information on these events and other ECU upcoming activities.

THE ARTWORK, “Derelict Two,” which is cast iron, bronze, fabricated steel and aluminum made by ECU student Aaron Earley, is included in an exhibit of cast iron art on display at Mendenhall Student Center through Feb. 21. A reception will be held Thursday evening for ECU faculty and students and guest artists from the School of Art Institute of Chicago who created the featured pieces.

CLIFF HOLLIS
ECU NEWS SERVICES
Dr. Robert Shaw, lung specialist

Dr. Robert Shaw, a lung specialist, has joined the Brody School of Medicine at East Carolina University and its group practice, ECU Physicians.

Shaw joins the Department of Internal Medicine division of pulmonary and critical care medicine as a clinical associate professor. He comes to ECU from a local private practice. He also was an ECU faculty member in the early 1980s.

Shaw has bachelor’s and medical degrees from Duke University. He completed residency training and a fellowship in pulmonary medicine at Ohio State University Hospital. Shaw is board-certified in medicine, pulmonary medicine, critical care medicine and sleep medicine and is a fellow of the American College of Physicians and American College of Chest Physicians.

Shaw’s research interest is lung injury following cardiac surgery, and his clinical interests are patients with sleep-breathing disorders, chronic obstructive pulmonary disease and asthma.

Dr. William Bailey, cardiologist

Dr. William H. Bailey has joined the Brody School of Medicine at East Carolina University and its group medical practice, ECU Physicians.

A cardiologist who specializes in heart arrhythmias, Bailey comes to ECU from La Grange, Texas, where he was in private practice. He has a bachelor’s degree in biology and German literature from Tulane University in New Orleans and a medical degree from Baylor College of Medicine in Houston. He completed an internship and residency training in family medicine at Baylor and a residency in internal medicine at the University of Texas Health Science Center in Houston. He also completed a fellowship in cardiology at Texas and another in cardiac electrophysiology at Baylor.

Bailey is also a reservist in the U.S. Air Force and speaks German and Spanish. He sees patients at the East Carolina Heart Institute at ECU.

Dr. Tejas Desai, kidney specialist

Dr. Tejas Desai, a kidney specialist, has joined the Brody School of Medicine at East Carolina University and its group practice, ECU Physicians.

Desai has joined the Department of Internal Medicine division of nephrology as an assistant professor. He has a medical degree from New York University School of Medicine, completed residency training at NYU and Mount Sinai School of Medicine-Jersey City Medical Center and a fellowship in nephrology at Emory University.

Desai is certified by the American Board of Internal Medicine in medicine and nephrology. His clinical interests are nephrology and nephrology education.

He sees patients at the ECU Physicians Nephrology and Hypertension Clinic at 2355 W. Arlington Blvd.
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Twists Multiply in Alabama Shooting Case

By SHAILA DEWAN and KATIE ZEZIMA

HUNTSVILLE, Ala. — On Friday, this city of rocket scientists and brainy inventors was stunned when a neuroscientist with a Harvard Ph.D. was arrested in the shooting deaths of three of her colleagues after she was denied tenure.

But that was only the first surprise in the tale of the neuroscientist, Amy Bishop, who was regarded as fiercely intelligent and had seemed to have a promising career in biotechnology. Every day since has produced a new revelation from Dr. Bishop’s past, each more bizarre than the last.

On Saturday, the police in Braintree, Mass., said that she had fatally shot her brother in 1986 and questioned whether the decision to dismiss the case as an accident had been the right one.

On Sunday, a law enforcement official in Boston said she and her husband, James Anderson, had been questioned in a 1993 case in which a pipe bomb was sent to a colleague of Dr. Bishop’s at Children’s Hospital Boston.

The bomb did not go off, no one was ever charged in the case, and no proof ever emerged connecting the couple to the bomb plot.

On Sunday, Mr. Anderson firmly defended his wife in an interview at their home in Huntsville, saying that she had been completely cleared in the pipe bomb case and that her brother’s death had been accidental.

“That’s incorrect,” he said about reports linking him and his wife to the bomb plot. “We were not suspects. They questioned everybody that ever knew this guy.”

The target of the mail bomb was Dr. Paul Rosenberg, according to The Boston Globe, which first reported that the couple had been questioned in the case. After returning home from a vacation, Dr. Rosenberg opened a package that contained two 6-inch pipe bombs connected to two nine-volt batteries, The Globe reported. The doctor and his wife fled and called the police.

Officials said that Dr. Bishop was concerned that Dr. Rosenberg would give her a negative evaluation on her doctorate work, the newspaper wrote, and that they were concerned about the incident involving her brother. The authorities in Boston searched Dr. Bishop’s computer at the time and found a novel she was working on about a scientist who killed her brother and atoned by excelling at her work, The Globe reported.

Though he firmly protested his wife’s innocence in the earlier cases, Mr. Anderson said he remained
mystified over Friday’s shootings, which left three professors dead and three other people wounded after a faculty meeting at the University of Alabama, Huntsville.

Dr. Bishop was charged with capital murder; three charges of attempted murder were added on Sunday. Mr. Anderson said he did not know of any specific incident that could have led to the shooting, and did not know that his wife allegedly had a gun when she went to the meeting.

“I had no idea,” he said. “We don’t own one.”

Those killed were Gopi Podila, 52, the chairman of the biology department; Maria Ragland Davis, 50, a professor who studied plant pathogens; and Adriel Johnson, 52, a cell biologist who also taught Boy Scouts about science.

Two of the wounded were Joseph Leahy, 50, a microbiologist, and Stephanie Monticciolo, 62, a staff assistant, both of whom were in critical condition. The third was Luis Cruz-Vera, 40, a molecular biologist, who was released from the hospital on Saturday.

Mr. Anderson said that months ago, the university administration overruled a successful appeal of the decision to deny Dr. Bishop tenure in spring 2009.

“She won her appeal,” he said, “and the provost canned it.”

The university has declined to elaborate on the details of Dr. Bishop’s tenure application, saying only that she was denied last spring and that she could stay at the university only until the end of this academic year. Even if a faculty member successfully appeals a tenure denial, the final decision rests with the administration.

But Dr. Bishop had continued to fight, appealing to two members of the University of Alabama System’s Board of Trustees for help and hiring a lawyer, who was “finding one problem after another with the process,” Mr. Anderson said. One issue was a dispute over whether two of her papers had been published in time to count toward tenure, he said.

“She exceeded the qualifications for tenure,” Mr. Anderson said. “The review board said, ‘Grant it or go through the process again.’ ”

Mr. Anderson said that his wife’s research was generating millions of dollars for the university, that she had published numerous papers and that she was a good teacher.

But that estimate of her financial benefit to the university seems likely to be premature. One of her innovations, an automated system for producing cell cultures that the couple developed together, has attracted $1.25 million in financing but has not yet reached the market. Another, a potential treatment for degenerative diseases like Alzheimer’s, is in the process of being licensed from the university. Typically, universities share the proceeds from such licenses with the scientists responsible.

The police said Saturday that Dr. Bishop was 45, but her birth date on a university Web site indicated that she was 44.
Mr. Anderson said he could not gain access to his wife’s e-mail account and did not know if she had received any news that might have set off the shooting. The police, he said, had taken a thick binder documenting her tenure battle, her computer and the family van. At least one of the trustees had recently told her that he could not help reverse the tenure decision, a family friend said.

Mr. Anderson said he had already told the Huntsville police that they might come across the Boston pipe bomb incident during their investigation.

Sylvia Fluckiger, who worked as a laboratory technician at Children’s Hospital when Dr. Bishop and Dr. Rosenberg were working there, said Dr. Bishop had acknowledged that she was questioned by the police about the pipe bomb incident.

“She was visited by the police,” Ms. Fluckiger said. “What she said is they asked her if she had ever used a stamp, taken it off an envelope and put it somewhere else.”

Ms. Fluckiger said Dr. Bishop “had a smirk on her face” when asked about the incident. “I don’t know why she was smirking,” she said. “It was a funny expression on her face.”

“We did know that there was a dispute between Paul Rosenberg and her,” Ms. Fluckiger said, adding that she could not recall the details.

On Saturday, the police in Braintree said they were considering reopening the case of the shooting death of her brother, Seth Bishop, 18. Although a state police report said investigators determined that the shooting was an accident, Police Chief Paul Frazier said other officers remember that it came after an argument and questioned why local police documents could not be found.

On Sunday, Mayor Joseph C. Sullivan of Braintree, a Boston suburb, issued a statement saying the town would conduct a “full and thorough review” of its records for any material relating to Seth Bishop’s death. But he noted that records from 1986 were created and maintained manually, which would complicate their retrieval.

Standing at his door after church on Sunday, Mr. Anderson confirmed the existence of the novel reported in The Globe, as well as two others his wife worked on in her spare time. The couple has four children, ranging from grade-school to college age. Mr. Anderson said that somewhere in his files he had a letter sent by the Bureau of Alcohol, Tobacco and Firearms after the bomb investigation, saying: “You are hereby cleared in this incident. You are no longer a subject of the investigation.”

“This is one thing from the past I hoped would not be dredged up,” he said.

Shaila Dewan reported from Huntsville, and Katie Zezima from Boston.
February 15, 2010

Expecting a Surge in U.S. Medical Schools

By ANEMONA HARTOCOLLIS

Peter Allen applied to 30 medical schools after graduating from the University of Pittsburgh last year. Twenty-eight said no.

Of the two that said yes, one had something in common with Mr. Allen: It, too, was starting out in medicine. He enrolled in the inaugural class of The Commonwealth Medical College in Scranton, Pa.

“Twas ecstatic that I had been accepted to a medical school,” Mr. Allen said, adding that he would have gone for a master’s in bioengineering if he had not been accepted. “It’s a giant sigh of relief; it secures your plans for the rest of your life really.”

The Commonwealth is one of nearly two dozen medical schools that have recently opened or might open across the country, the most at any time since the 1960s and ’70s.

These new schools are seeking to address an imbalance in American medicine that has been growing for a quarter century. Many bright students were fleeing to offshore medical schools, or giving up hope entirely, when they could not get into domestic schools. Meanwhile, American hospitals were using foreign-trained and foreign-born physicians to fill medical residencies. During the 1980s and ’90s only one new medical school was established.

“Huge numbers of qualified American kids were not getting into American medical schools or going abroad to study,” Dr. Lawrence G. Smith, dean of the proposed Hofstra University School of Medicine, in Hempstead, N.Y., which is not yet recruiting students, said last week. “I think it was a kind of wake-up call.”

The proliferation of new schools is also a market response to a rare convergence of forces: a growing population; the aging of the health-conscious baby-boom generation; the impending retirement of, by some counts, as many as a third of current doctors; and the expectation that, the present political climate notwithstanding, changes in health care policy will eventually bring a tide of newly insured patients into the American health care system.

If all the schools being proposed actually opened, they would amount to an 18 percent increase in the 131 medical schools across the country. (By comparison, there are 200 law schools approved by the American Bar Association.) And beyond the new schools, many existing schools are expanding enrollment, sometimes through branch campuses. While The Commonwealth is an independent school, many of the other new or proposed schools are affiliated with established universities, like Hofstra, which is teaming up with North Shore Long Island Jewish Medical Center; Quinnipiac University in Hamden, Conn.; the University of California, Riverside; Central Michigan University; and Rowan University in Camden, N.J.
Supporters of the expansion say that having more doctors will improve care, by getting doctors to urban and rural areas where they are needed, by shifting care to primary and family practice physicians rather than expensive specialists, and by reducing long waits for people to see a doctor and get the care they need.

But skeptics say that although many parts of the country do need more primary care, American doctors tend to congregate in affluent, urban and suburban areas that already have a generous supply.

They say that doctors create demand for their own services, and that nurse practitioners and physician assistants could fill gaps in medical care at a lower cost.

“When you add more physicians to an area, they just add more services, and their salaries don’t go down anywhere near in proportion to the increased supply,” said Dr. David Goodman, professor of pediatrics at the Dartmouth Institute for Health Policy and Clinical Practice and a practicing physician who has studied work force issues for 20 years. “More care may not be better, but it certainly is paid for,” Dr. Goodman said.

Many of the developing medical schools are well aware of such arguments, and are billing themselves as different from traditional medical schools, more focused on serving primary care needs in immigrant and disadvantaged communities. Administrators say that they expect that approach to be buttressed by a shift in state and federal reimbursements from specialists to primary care doctors.

Riverside County, an inland area with a diverse population including immigrants and Native Americans that has expanded rapidly, has a deficit of about 3,000 physicians, according to Dr. G. Richard Olds, founding dean of the University of California, Riverside School of Medicine.

Riverside has applied for licensing, the first step toward becoming a medical school, and hopes to admit its first four-year class in 2012, and to have 400 students by 2016, a typical size for the new crop of schools. Dr. Olds said his educational focus, building on his background as a tropical disease specialist, would be on prevention and “wellness.”

“I think we have to crank out different kinds of doctors,” said Dr. Olds, who started his new job Feb. 1.

Whether the demand for new medical schools exists among patients, it clearly exists among prospective doctors.

Dr. Olds said that at his former job as chairman of medicine at the Medical College of Wisconsin, 25 percent of the students came from California. “So obviously there’s a ton of California kids trying to get into medical school traveling a long way.”

The Association of American Medical Colleges, a trade group, has called for a 30 percent increase in enrollment, or about 5,000 more doctors a year. The association’s Center for Workforce Studies estimates that 3,500 more M.D.s will enter graduate training over the next 10 years, roughly half of the 7,000 international medical school graduates now entering medical residencies in the United States every year, according to Edward Salsberg, director of the center.

At Quinnipiac, the trustees last month approved plans for a new medical school, to open in 2013 or 2014, if it passes accreditation. John L. Lahey, the university president, said that the proposed school would build
on the university’s existing health sciences programs, and the hope was to recruit at least some students who had worked in health care and wanted to become doctors.

“We certainly think they will be what we tend to call nontraditional students, older, some minority,” Dr. Lahey said.

Six developing medical schools, including The Commonwealth, have received preliminary accreditation, enabling them to begin recruiting students, and six more, including Riverside, have begun the application process, according to the Liaison Committee on Medical Education, which accredits American medical schools. An additional 11, including Quinnipiac, have announced their intention to apply for licensing, according to Mr. Salsberg.

Whatever the expansion may mean for the cost of health care, it is a relief to aspiring doctors like Mr. Allen, who took tough undergraduate courses and had a busy extracurricular life of mock trials, robotics and work as an emergency medical technician. His pre-med adviser told him that with his 3.3 grade-point average, he should apply only to osteopathic schools, but he persisted, and was admitted to The Commonwealth and New York Medical College in Valhalla, N.Y.

He was one of 1,300 applicants for 60 positions (eventually class size will double) in the inaugural class at The Commonwealth, according to Dr. Robert M. D’Alessandri, the president and dean. Mr. Allen has a United States Navy scholarship, but for his classmates, the school took $20,000 a year off the tuition, a reduction of about half, as an incentive to take the risk of a new school.

Given the pent-up demand, Dr. D’Alessandri said, he was not worried that he might produce too many doctors for the good of society. “We should worry about too many lawyers,” he said dryly.
February 14, 2010

Results Unproven, Robotic Surgery Wins Converts

By GINA KOLATA

At age 42, Dr. Jeffrey A. Cadeddu felt like a dinosaur in urologic surgery. He was trained to take out cancerous prostates the traditional laparoscopic way: making small incisions in the abdomen and inserting tools with his own hands to slice out the organ.

But now, patient after patient was walking away. They did not want that kind of surgery. They wanted surgery by a robot, controlled by a physician not necessarily even in the operating room, face buried in a console, working the robot’s arms with remote controls.

“Patients interview you,” said Dr. Cadeddu, a urologist at the University of Texas Southwestern Medical Center at Dallas. “They say: ‘Do you use the robot? O.K., well, thank you.’ ” And they leave.

On one level, robot-assisted surgery makes sense. A robot’s slender arms can reach places human hands cannot, and robot-assisted surgery is spreading to other areas of medicine.

But robot-assisted prostate surgery costs more — about $1,500 to $2,000 more per patient. And it is not clear whether its outcomes are better, worse or the same.

One large national study, which compared outcomes among Medicare patients, indicated that surgery with a robot might lead to fewer in-hospital complications, but that it might also lead to more impotence and incontinence. But the study included conventional laparoscopy patients among the ones who had robot-assisted surgery, making it difficult to assess its conclusions.

It is also not known whether robot-assisted prostate surgery gives better, worse or equivalent long-term cancer control than the traditional methods, either with a four-inch incision or with smaller incisions and a laparoscope. And researchers know of no large studies planned or under way.

Meanwhile, marketing has moved into the breach, with hospitals and surgeons advertising their services with claims that make critics raise their eyebrows. For example, surgeons in private practice at the New Jersey Center for Prostate Cancer and Urology advertise on their Web site that robot-assisted surgery provides “cancer cure equally as well as traditional prostate surgery” and “significantly improved urinary control.”

Robot-assisted prostate surgery has grown at a nearly unprecedented rate.

Last year, 73,000 American men — 86 percent of the 85,000 who had prostate cancer surgery — had robot-assisted operations, according to the robot’s maker, Intuitive Surgical, the only official source of such data. Eight years ago there were fewer than 5,000, Intuitive says.

Dr. Sean R. Tunis, director of the Center for Medical Technology Policy, a nonprofit organization that evaluates medical technology, said few other procedures had made such rapid inroads in medicine.

Medical researchers say the robot situation is emblematic of a more general issue. New technology has sometimes
led to big advances, which can justify extra costs. But often, technology spreads long before investigators know whether it is worthwhile.

With drugs, the Food and Drug Administration requires extensive tests to determine safety and efficacy. But surgeons are free to innovate, and few would argue that surgery can or should be held to the same standards as drugs. Still, a situation like robot-assisted surgery illustrates how patients may end up making what can be life-changing decisions based on little more than assertive marketing or the personal prejudices of their surgeon.

“There is no question there is a lot of marketing hype,” said Dr. Gerald L. Andriole Jr., chief of urologic surgery at Washington University. Dr. Andriole does laparoscopic prostate surgery, and although he tried the robot, he went back to the old ways.

“I just think that in this particular instance, with this particular robot,” he said, “there hasn’t been a quantum leap in anything.”

Evaluating technology is complicated. As often happens in surgery, doctors can become enthusiasts without rigorous studies ever being done.

And with prostate cancer, more is at stake than just an academic dispute, said Dr. Jason D. Engel, director of urologic robotic surgery at George Washington University Medical Center in Washington. One in six American men develop prostate cancer in their lifetime. Treatment options include radiation and watchful waiting, but the most popular is surgery.

“With the stream of prostate cancer patients that come through,” Dr. Engel said, “this is a big, big business.”

Dr. Michael J. Barry, a professor of medicine at Massachusetts General Hospital in Boston, said that once a hospital invests in a robot — $1.39 million for the machine and $140,000 a year for the service contract, according to Intuitive — it has an incentive to use it. Doctors and patients become passionate advocates, assuming that newer means better.

“Doctors and medical centers advertise it, and patients demand it,” Dr. Barry said, creating a “folie a deux.”

The robot’s ability to reach into small spaces comes with tradeoffs. Ordinarily, doctors can feel how forcefully they are grabbing tissue, how well they are cutting, how their stitches are holding. With the robot, that is lost. And the robot is slow; it typically takes three and a half hours for a prostate operation, according to Intuitive, twice as long as traditional surgery.

A few highly experienced doctors are much faster. Dr. Vipul Patel, for example, at Florida Hospital in Celebration, Fla., has done more than 3,500 robot-assisted prostate surgeries. He often does six a day, taking about one and a half hours for each.

“From Day 1, when I sat down at that robotic console, I knew we would give patients a better outcome,” Dr. Patel said. “I have not seen anyone who has done a good amount of robotic surgery go back.”

Dr. Patel also started The Journal of Robotic Surgery to provide a forum, he said. Dr. Engel said he and others who use robots welcome it. They had had difficulty getting published in traditional journals, Dr. Engel said.

But papers in the new journal tend to report on one surgeon’s experience. Studies like that, which were also published in the past to promote traditional surgery, have methodological problems — biases in patient selection and evaluation are likely and, because the surgeons tend to be much better than average, it is hard to generalize.

In contrast, the national study of Medicare patients from 2003 to 2007, by Dr. Jim C. Hu of Brigham and Women’s
Hospital in Boston, included 6,899 men who had surgery with four-inch incisions and 1,938 who had laparoscopic surgery, many with a robot.

The study was not ideal — patients were not randomly assigned to have one type of surgery or another, and laparoscopic operations done without a robot were included with the robot-assisted ones because Medicare did not distinguish between the two. But it is the only large national study that compares what is thought to be a largely robot-assisted surgery group with a group that did not have a robot.

The paper, published last October in The Journal of the American Medical Association, found that laparoscopic surgery patients had shorter hospital stays, lower transfusion rates and fewer respiratory and surgical complications. But they also had more incontinence and impotence.

It is not known whether the extra costs of robot-assisted surgery are balanced by lower costs for shorter hospital stays and fewer surgical complications.

Experts in robotic surgery say studies like Dr. Hu’s can be misleading. Medicare data, they say, include results from surgeons who may have little experience with robots.

Dr. Barry, an author of Dr. Hu's paper, said Medicare data reflect the real world. “Everyone tends to cite data from centers of excellence as though they were their own,” he said.

Highly skilled surgeons, like Dr. Ashutosh K. Tewari at Weill Cornell Medical College in New York, say it takes about 200 to 300 robot-assisted operations to become highly proficient. Dr. Tewari has done 3,200.

Surgeons who do nonrobotic prostate surgery agree.

“What happens is that if you take leading experts, whether they do open or robotic, they are going to get good results,” said Dr. Herbert Lepor of New York University, who has done more than 4,000 traditional open prostatectomies.

“I say robotic surgery has to be better to justify its learning curve,” Dr. Lepor said, “to justify its unknown cancer control, to justify its increased cost.”

Both traditional surgeons and those who do robot-assisted surgery point to patients who did extremely well.

Among them is James Lamb, a 40-year-old New York City police officer who had robot-assisted surgery with Dr. Tewari on Jan. 5. Two days later, while he was in the hospital and still had a catheter in his penis, Officer Lamb had an erection.

Two days after that, Officer Lamb said, he was home and had sexual intercourse. (In one study by Dr. Barry, which surveyed patients a year after surgery, only half the men, regardless of surgical method, were back to their presurgery potency a year later, with or without the use of a drug like Viagra.)

But, Dr. Barry and Dr. Tewari note, an extraordinary patient or two can be misleading. “The message for patients is not to assume that newer is better,” Dr. Barry said. Measures like the number of operations a surgeon has done “still matter a lot,” he said.

Dr. Cadeddu, though, said that sort of message is falling on deaf ears. Patients want the robot. So Dr. Cadeddu has now begun offering robot-assisted surgery to those who want it.

“The battle is lost,” Dr. Cadeddu added. “Marketing is driving the case here.”