Shifting Dullness

August 1992

Welcome,

Incoming First Years

and Dean Dan Blazer

THE BOTANIC DOCTOR OF YE OLDEN TIME.

Greetings MSI's, From E Bach

Dear Incoming students,

Welcome to Duke med, the best kept secret in higher education.

Greetings from the state of North Carolina, where the sun always shines and obscurantism is the political premium. E Bach would like to offer some recommendations and words of caution to heid your transition to this Duke Med program.

First, welcome to Durham, which is situated equally inconveniently from the mountains to the west and the shore to the east. You won't be lacking for creature comforts, what with our multidimensional everything stores that boast "Beer, bait and breakfast for a buck." When your erstwhile wakeup call was probably the cock, I introduce you to the rebel yell.

That isn't entirely fair. Durham is more accurately described as a comfortable union of excellent education, hospitality and charm nestled in the rolling hills of the Piedmont. That should go on a travel guide.

Either I'm amnesic for the trials and tribulations of first year, or else Duke Med is really one heck of a good time. The first week we were treated to the piece de resistance of Southern cooking, which is called a pig pickin'. Featuring all of the Southern cardiac favorites and the diabetogenic iced tea, I don't ever pose the question, "what is this we're eating?" Hoss, you're eating everything they ground up that day. If'n you go looking for your favorite barbeque hangout, be mindful that an "A" sanitation rating at an authentic joint is an oxymoron.

For any of you skeptics, this Duke basketball thing is for real. E Bach hearkens from one of those stuffy ivies in the North, where our only slam dunk was witnessed toward the end of the season after the rim had been bent ... during a scrimmage. This is probably the most impressive part of my resume: "During my five years at Duke, I helped the team to as many final fours and two national championships ... on a lesser note, I completed an M.D. and a Ph.D. in immunology.

E Bach also has words of caution, so at this time I would like to tabulate my top ten things of which to beware during medical school.

10. Sighted people who sit in the front row consistently.
9. Those pointy-headed intellectuals from the cultural elite who can spell potato(e?).
8. Health clubs that play G105 or any event sponsored thereby.
7. Anyone who says "I'm really bad with names." Come on Holmes, who isn't. When was the last time someone forgot your name and said, "I usually have an excellent memory for names."

6. Radical political correctness. Until someone comes up with a comfortable personal pronoun to replace "he", I am loath to go with any substitute. If this literacy thing means anything to you, allow that "he" should be "... used to represent any person not specified." History is not herstory and has nothing to do with the whimsical treatment of women. Can we please find a real issue?
5. Anger in traffic. If you're from NY or anyplace people have somewhere to g, then you may find some choice expletives issuing from your mouth as you negotiate the 20 minute drive to Bruegger's Bagels. I find that deep breathing and tapes of ocean waves beating against the shore are calming. If belligerence persists, see your doctor for pharmacotherapy.
4. The confederate flag in all of its forms. If 15-501, also known as Jefferson Davis Highway, was a toll road, at least I could vote my conscience.
3. People who quote voluminously from Davison of Duke.
2. Anyone who suggests a road trip to Chapel Hill. It's only 10 minutes away in traffic, and it's a perfect college town to knock back a couple of caffeine-free Jolts.
1. Anyone who remains at Duke Manor for over one year. This is something I inveigh against. Do your time and get out, but I'll let you figure that one out for yourselves.

In closing, embrace Duke with open arms and have your best 4 years to date. I welcome any submissions.

In hopes that the summertime livin' is easy and cotton is high, I remain

Sincerely yours,
E Bach

Send letters to Eric Bachman at PO Box 2704 DUMC or drop them in the Shifting Dullness box in the Dean's office (candy area) or in the student lounge, Duke North.

The Nation

Loan Deferment Lost • • • Chris Cabell

By a vote of 419 to 7, the House of Representatives voted July 8th to agree to the conference report to S. 1150, legislation that would reauthorize for five years the Higher Education Act of 1965. The House vote follows the Senate's June 30 approval of S. 1150 by voice vote.

Although an official copy of the conference report was not yet available, it is understood that the conferees agreed to accept the Senate language creating a "grandfather clause" to allow current Stafford Student Loan borrowers to receive a 2 year loan deferment upon entry into a residency or internship program. It is believed that this provision applies to all loans of all students who started taking loans out before July 1, 1993. In addition conferees adopted House language establishing a 3 year "economic hardship" deferment based on a borrower's income and debt-to-income ratio. It is likely that economic hardship will be determined by the Department of Education. Please watch for the Financial Aid Newsletter this fall for the specific regulations that will be developed by the Department of Education.

S. 1150 increases the annual loan limits for graduate and professional students in the Stafford and Supplemental Loans for Students (SLS) programs to $8500 and $10,000 respectively. The bill also would set the aggregate limit for graduate and professional students at $65,000 for the Stafford program and $73,000 for the SLS; both totals include undergraduate borrowing under the aggregate limits. The interest rate for the Stafford loans will be changed from 8% for the first 4 years and 10% for the next 6 years of repayment to a variable rate based on the T-bill rate plus 3.1%, with a cap of 9%. In addition, the cap on SLS interest rates would be lowered to 11%. The conference committee also agreed that lenders be required to offer forbearance for the duration of a medical residency upon demand of the borrower.

The bottom line is that loan deferment is officially dead. After July 1, 1993, only those with severe economic hardship, in-school (for which residents and interns cannot qualify), or unemployed will be eligible for federal loan deferment. Although deferment is history as we know it, it is encouraging that the most favorable aspects to the plight of medical students from the House and Senate bills were included in the final conference report. Thanks to all who wrote to our congressmen. Your help, time and effort were greatly appreciated. If anyone has any questions , please feel free to call me at 598-1843.

Shifting Dullness

Duke Students Attend OSR Meeting in San Juan • • • • • • • • • • Larry Kelly

The Organization of Student Representatives (OSR) is the segment of the American Academy of Medical Colleges (AAMC) comprised of and concerned with medical student issues. The recent meeting in San Juan was attended by representatives Alison Weidner and Larry Kelly of Duke.

The issues focused on during the meeting of the OSR included social responsibility of medical students, multicultural training, financial aid, counseling, minority affairs, AIDS, the need for primary care physicians, the MCAT and USMLE, and legislative issues. The issues focused upon were broad ranging, covering many topics important to Duke medical students.

Early sessions examined the role of the medical student dependent on alcohol or drugs. Discussion sections included students and administrators from all over the eastern half of the U.S., and ideas for dealing with this very real problem were debated. The predominating policy voiced by administrators is that students who are found to have developed a drug dependency are offered enrollment in a dependency program, after completion which the student will generally be allowed to return to complete his medical education.

The forum for discussing issues surrounding the AIDS epidemic raised the eyebrows of more than a few of the audience. Duke's representative Alison Weidner was a member of the panel discussing the issue, and made some very relevant and thought-provoking points regarding HIV, exposure-prone procedures and the position of medical students. She pointed out that whereas nurses, staff physicians and residents are covered by medical insurance while on the job, medical students are left in limbo, without specific medical coverage should they become infected in the course of hospital duties. The discussions were very frank, and tended not to stress the rarity of HIV transmission from patient to student, but instead focused on the very real fear of exposure that many students experience.

Two medical students from Columbia College of Physicians and Surgeons presented the results of a survey of students at their school. The survey revealed that the attitude of medical students toward patients with AIDS is very pessimistic to say the least, ranging from compassion to resentment and outright hostility. The resentment and

(see OSR Update, p. 4)

OSR Update (from p. 3)

hostility expressed was reported to be an outgrowth of the fear of exposure while working with these patients. A second point made by the survey was that of Columbia's medical students, fourteen had actually been exposed to known HIV positive blood or body fluids by various routes, including scalpel cuts, needle sticks and body fluid contact with mucosal surfaces. None of these students tested positive to HIV by the report date. One shocking statistic presented by David Rogers, M.D. of Cornell University Medical College revealed that a greater proportion of physicians than of the general public (33% vs. 20%) felt that people with AIDS "got what they deserved."

Another issue discussed at length was the state of financial aid for medical education. One conference held for financial aid officers discussed limitations on financial aid, and new advice to students who attempt to enter medical school with a history of bad credit or already enormous debt burden. Several of the panelists reported advising some such applicants against entering medical school because such additional debt burden would likely become insurmountable. Financial aid officers also emphasized the "tidal wave" of loan paybacks that occurs at about the third year of loan paybacks, a wave of debt that most students fail to anticipate. To avoid this unexpected debt, financial aid officers recommend that residency programs offer counseling for residents, because this is the period of payback when financial aid counseling is most needed.

Conferees also discussed the ways in which some schools are attempting to decrease debt burden while students are in medical school and afterwards. Many counsel students to take part-time work, and to apply for specific grant or scholarship programs according to a student's individual circumstances (ie, geographically or ethnically limited scholarship opportunities). Representatives from Stanford described the way their medical students can reduce loan burden by 25% by doing funded research for one year, finishing medical school in a total of five years.

The financial aid officers also stressed alternatives for repayment of the massive loans that can accumulate during medical school, especially the incentives that are widely offered by community, state and federal governments that provide for repayment of up to $20,000 per year for a physician who agrees to practice primary care in their communities. Unlike the well-publicized scholarship programs of this type, community sponsored programs offer the physician tremendous choice in deciding where he or she will serve these primary care needs.

Merit scholarships were also a hot topic of discussion, and just as at Duke, the debate continues over whether money used to fund merit scholarships should instead be used to support financially needy students. Lastly, financial aid officers stressed the need for students to serve as representatives on their school's financial aid committee. The main themes of the discussions focused on obtaining alternative loan sources, attending a school that is affordable and learning how to manage payback of large debts. Another issue related to financial aid is the reauthorization of the Higher Education Act that was approved by the U.S. House and Senate earlier this year. This is discussed in detail in an article by Chris Cabell.

In conclusion, the meeting of the OSR of the AAMC provided a great deal of informatino pertinent to Duke Medical students, and this organization's efforts to improve medical education will continue.

OSR Update

- Reauthorization of the Higher Education Act approved July 8, sent to the President for his expected signature
  - -provision to maintain 2 year deferments in Stafford Loans during residency is eliminated
  - -grandfather clause allows exemptions for anyone borrowing first Stafford Loan by 1993
  - -forbearance continues to be available, more at the student's initiative
  - -"deferment" still available for cases of financial hardship, as judged by the Secretary of Education (probably, deferments will be upheld if debt:income ratio is greater than 10%)
  - -thanks to all who wrote their representatives
- USMLE
  - -will replace FLEX and NBME as of 1994
  - -Step I comparable to NBME Part I, but includes a new "clinical question format"
  - -pilot program by UNC to improve test taking skills for students after their second year led to 98% pass rate of Step I
  - -role of schools in preparing students for USMLE still undefined
- OSR Housing Exchange
  - -purpose is to provide lodging at medical schools for students interviewing for residency positions
  - -Duke needs 10 volunteer homes for Duke students to be eligible to use the exchange program
  - -reduces the tremendous cost of residency interviewing
  - -please contact Larry Kelly 419-0165 if interested
  - -1st - 4th years strongly encouraged to participate

News Capsules

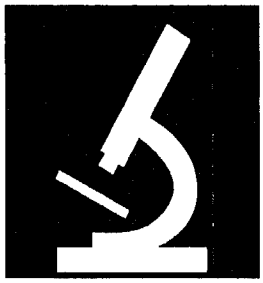
Michael Weiner

• **Duke Med addresses substance abuse.** With $887,479 from the Kate B. Reynolds Charitable Trust, N.C.'s 4 medical schools join the Governor's Institute on Alcohol and Substance Abuse, to improve medical students' education in the science, prevention, diagnosis, and treatment of S.A. The project will be implemented over the next 4 years (News & Observer, 17 Jun 1992, p. 5B; Duke Dialogue, 2 Jul 1992, p. 11).

• **RNA probably catalyzes peptide bond synthesis in the ribosome.** RNA comprises most of a ribosome's mass. Experiments show that a peptidyl transferase reaction persists in RNA-containing Thermus aquaticus ribosomes depleted of nearly all proteins. Authors note that more rigorous experiments must eliminate the possibility that a proteinase- and phenol-resistant protein is responsible for the peptide bond formation. RNA can also catalyze hydrolysis of aminoacyl esters, and may link amino acids to tRNA. The work supports the theory that RNA was the first genetic material (H. F. Noller et al., Science 256, 1416 (1992); J. A. Piccirilli et al., ibid., p. 1420; N. R. Pace, ibid., p. 1402; M. M. Waldrop, ibid., p. 1396).

• **Extra calcium accelerates increases in bone mineral density in prepubertal children.** Forty-five pairs of monozygotic twins completed a 3-year study, in which the daily diet of one twin of each pair was supplemented with 1 g of calcium citrate malate. Only the prepubertal subjects receiving the supplements had significant (up to 5%) increases in bone mineral density of radius and lumbar spine. If the differences endure, the supplements may reduce the risk of later fractures (C. C. Johnston, Jr. et al., NEJM 327, 82 (1992); News & Observer, 9 Jul 1992, p. 4A; NY Times, 14 Jul 1992, p. B6).

• **Interferon approved for hepatitis B.** Recombinant IFN alfa-2b (Intron A) is the first promising drug approved for treatment of chronic HBV. It had previously been approved for treatment of HCV, hairy cell leukemia, AIDS-related Kaposi's sarcoma, and condylomata acuminata. A 4-month course can lead to remission, including loss of HBeAg and HBVDNA, in 30%-40% of patients with chronic HBV. Most mild adverse effects are reversible with discontinuation of therapy. More severe reactions, such as fatigue and fever, were reported in 21%-44% of patients (FDA BBS, 7/13/92, ref. P92-23; J. H. Hoofnagle et al., Gastroenterology 95, 1318 (1988); AMN, 7/22/92, p. 2).



• **Cerebral gliomas regress completely with herpes-based gene therapy.** Murine fibroblasts producing a retroviral vector with the herpes simplex thymidine kinase gene were injected into rats' tumors. Five days later, ganciclovir was administered (IP), causing tumor regression. The retrovirus targets dividing tumor cells while sparing nondividing neural tissue. Long-term survival is unknown. Researchers will now test the technique in 20 human patients (K. W. Culver et al., Science 256, 1550 (1992); Newsweek, 6/22/92, p. 60; News & Observer, 6/12/92, p. 6A).

• **New antihistamines cause cardiac arrhythmias.** Excessive blood levels of terfenadine (Seldane) or astemizole (Hismanal) increase the risk of arrhythmias. Both are contraindicated in patients with significant hepatic dysfunction, and terfenadine is contraindicated in patients taking ketoconazole or erythromycin. Patients should be urged not to adjust their doses independently (FDA BBS, 7/7/92, ref. P92-22; ibid., 7/20/92, ref. P92-25).

• **Dideoxycytidine (ddC, zalcitabine (Hivid; Zalcitibane)) approved as AZT adjunct for AIDS.** ddC prevents HIV replication before infection, and when combined with AZT, can increase CD4 counts. Effect on survival is unknown. The drug is indicated in HIV-infected adults with signs of clinical or immunological deterioration and CD4 cell counts of 300 or fewer per cubic mm. Adverse effects include peripheral neuropathy, pancreatitis, oral ulcers, thrombocytopenia, and abnormal liver function. The annual wholesale price is $1,826. The approval was the first under the FDA's new "conditional approval" regulatory system, designed to speed access to drugs for life-threatening illnesses. If, within 6 months, trials show ineffectiveness, ddC will be recalled (FDA BBS, 6/22/92, ref. P92-19; NY Times, 6/23/92, p. B8; AMN, 6&13 Jul 1992, p. 10; T.-C. Meng et al., Ann. Intern. Med.116, 13 (1992)).

Curriculum Committee Update

Chris Cabell

The Student Curriculum Committee has been meeting throughout the summer, and a number of interesting developments and projects have come to fruition this summer.

Two projects are directly related to the 3rd year research experience and how 2nd year students go about selecting labs. This year the Basic Science Electives Committee with the help of Mike Sicard (MS IV) and the Dean's office have scheduled a series of lunches that are meant to serve as introductions to each of the study tracts. This supersedes the "study tract night" that has historically been held toward the end of physical diagnosis or the early part of the core clinical clerkships. In this way, students learn about the specific requirements and goals of each study tract. So far, these meetings have been very well received by the rising 2nd years.

The second project that ties into the 3rd year involves a group of current 4th year students who have been meeting for the past few months to discuss better ways to pick 3rd year labs. These students felt that there were many misconceptions about the 3rd year that often led to lab experiences that were less than favorable. At the heart of the debate is whether a 3rd year is a "graduate student" who should concentrate wholly on research, or a "medical student" that should take advantage of the year of research without having to forego other classwork and clinical opportunities that are available. This group of students put together an open letter to the second class on the best way to select a 3rd year lab and distributed it to them. They also met with the various Dean's groups to discuss this situation in person. In addition, a 3rd year questionaire was put together to allow students the opportunity to evaluate their lab experience. These questionnaires will be kept on file in the registrar's office, and will be available to 2nd year students.

Both of these projects have been organized in the hope that all students will have the information they need to select the best lab for their individual needs to make the most out of the 3rd year.

In addition, the Student Curriculum Committee has helped to develop a new 2nd year course evaluation to be distributed to students at the end of each clinical clerkship. This will be a standardized document that will be returned to the Dean's office. This will initially by-pass

(see Curriculum, p.8)

Computer Interest Group News

Michael Weiner

Neuroanatomy made easier. CTL has recently acquired an excellent, multimedia, interactive tool for learning neuroanatomy. The Neuroanatomy Project is a carefully planned, professional product, consisting of three videodiscs with accompanying software, for Macintosh computers. Information is presented by a variety of methods, such as quizzes, an atlas with a self-testing mode, and indexed lectures combining audio and video. On-screen instructions are presented clearly, and at almost any time, the user can easily skip to nearly any section of the system. Diagrams and image quality are commendable, and content is appropriate. The utility of the system is not restricted to first-year students, of course; one could use it to review a surgical case, for example. A similar system about the eye is also available, and one covering the heart and mediastinum should be available by the end of the summer. The programs are not yet part of official coursework, but may be used independently. Inquire at CTL.

Library orders videodiscs. The Medical Center Library recently initiated plans to acquire 34 new educational software packages. Topics include anatomy, pharmacology, diagnosis, biostatistics, physiology, and pathology. It is hoped that a new computer cluster will soon house these tools in the library.

Computer prices plummet. A recent price war has affected several PC manufacturers. Compaq is now burdened with orders from consumers, after introducing its Contura notebooks, as well as new Prolinea models, with list prices starting at $899 (25 MHz 386SX, 2MB RAM, 40MB hard drive). Dell has a comparable new line, Dimension, starting at $1,259 (some features vary). Cyrix reduced prices on its math coprocessors by up to 66% (P. H. Lewis, NY Times, 6/16/92, p. B7; P. H. Lewis, Ibid., 7 Jul 1992, p. B8; Newsweek, 20 Jul 1992, p. 63; PC News online, 6/6/92, ref. ZNT:PCW-14; Ibid., 7/20/92, ref. ZNT:PCW-32).

New products. Windows 3.1 users can now use a pen on the computer desktop. Microsoft Windows for Pen Computing 1.a includes support for peripherals such as digitizing tablets. Lexmark now has the IBM Portable Printer, a lightweight thermal-transfer printer, and the IBM 4070 IJ, a desktop ink-jet printer (PC News online, 29 Jun 1992, ref. ZNT:PCW-18; Ibid., 27 Jul 1992, ref. ZNT:PCW-14).

About the interest group. The DUMC Students' Computer Interest Group distributes information to students and assists in developing computer-related resources and policies at the medical center. For more information, call Emile El-Shamma (382-0203).

Analysis

Dr. Marian Wright-Edelman Speaks: "Leave No Child Behind" ▪ Vickie Ingledue

Where is the "American Dream" for millions of children growing up in poverty? Why are these children being left behind in the United States today? What can we do to change the trends? These are the questions raised by Dr. Marian Wright-Edelman, founder and president of the Children's Defense Fund, when she addressed the 1992 American Medical Student Association (AMSA) National Convention in Washington, D.C. last spring.

The statistics are alarming. Over 100,000 children are homeless in this country, 5.5 million children go hungry each day, and 1 in 5 children (that's a total of 13.5 million!) are growing up in poverty. Where our children are concerned, we are falling far short of our role as world leaders. The United States ranks 24th in infant mortality, 16th in overall immunization rates, and a shocking 70th in immunizations of minority infants. In general, our children are more likely to be poor, have improper health care, and be part of a failing educational system. Where is the safer, better world that they are supposed to inherit from us?

In order to reverse these trends, Dr. Edelman outlined a three point plan to give American children what they need and deserve....a healthy start, a head start, and a fair start. First of all, our children deserve a healthy start with basic health care for every child and pregnant woman. A key issue today involves providing proper immunizations for our children. Immunization is both cost effective and successful when compared to the alternatives. In fact, we cannot afford not to give preventive health care to our infants! A head start entails good preschool and child care to help prepare children for school and the future. The comprehensive preschool program Head Start provides health care, pre-educational training, and emotional support for the child in need. Most of all, Head Start instills a sense of self-esteem and achievement in these children who often have little else. But the new federal budget falls $1.4 billion short of enough funds to reach the millions of eligible children who remain. Finally, our children need a fair start in a world without childhood poverty. We can create a fair world for them by enforcing child support payments, providing a tax credit for families with children, and ensuring jobs at decent wages for all workers. To reach these goals, we must vote for government officials who are sensitive to the needs of our children.

Dr. Edelman stressed that we must realize "All children are OUR children," and in the end, "We HAVE to win!" We can save our nation's future by doing what is morally right for our children today. "How?" you ask. Get involved! Currently, our own Duke AMSA chapter is organizing an immunization drive in conjunction with North Carolina's administration of the CDC's national Year 2000 initiative. The funds and training will be available in early fall. All we need are willing hands to help in the fight to provide proper immunizations for all children. Be on the lookout for more details soon and contact Theresa or Matt Flynn (Phone 419-0483, DUMC Box #2084) if interested. We need your help! Please do your part to ensure that NO CHILD IS LEFT BEHIND!

For even more information on how you can help our children, contact the Children's Defense Fund at 25 E Street, NW, Washington, DC 20001, Phone (202) 628-8787, Fax (202) 662-3510. (this could go in a box)

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Shifting Dullness is a publication of Duke University medical students.

What About A National Health Care System? Reflections by AMSA Speaker, Dr. Linda Murray

Theresa Flynn

At the 1992 AMSA national conference in Washington, D.C., several congressional staffpersons vigorously debated proposals for a national health care system. Before the panel discussion began, Dr. Linda Murray, a pediatrician and chief administrator of a Chicago community clinic for over 10 years, briefly outlined the main issues in the debate.

First she provided a historical context for the discussion. National health insurance has been proposed in the United States several times before - by the American Association for Labor Legislation in 1906, by Teddy Roosevelt in 1912, as part of the original Social Security Act in 1935, and by several Senators and President Truman in the 1940's. Medicare and Medicaid were established in 1965. The current proposals for a national healthcare policy therefore have firm precedent.

Second, Dr. Murray presented survey data indicating that 90% of Americans believe major changes in our healthcare system are needed with 29% of these calling for a complete overhaul; the corresponding numbers for Canadiens are 43% and 5%. African-Americans are even more likely to support change, with 48% indicating that the U.S. healthcare system needs to be completely rebuilt. In addition, according to a 1990 NEJM article, over 45% of Americans have supported a totally government supported health program since 1949, and the numbers have risen to over 50% of Americans since 1970.

The health insurance debate, according to Dr. Murray, depends on choices regarding three central models: (1) Is health care to be viewed as a private consumptive good or as a social good? (2) Is access to at least a basic set of health care a basic American right or a moral/charitable obligation for physicians and hospitals? and finally, (3) Should a right to health care be defined and enforced nationally or locally? In the United States right now, health care is considered a private good, a moral obligation rather than a right, and largely regulated locally (e.g., at the state level).

Finally, Dr. Murray presented several questions which figure prominently in the outlining of any national health care plan. If a national healthcare plan is established, who should be covered? How will a health care system be financed? What services will be included? How will public health be prioritized? How will the health care system be organized? Who will control the health care system? Answers to many of these questions have been presented in proposals by Congressmen which are arranged in a summary chart (available from this author). If these issues fire you up (wherever you stand!), think about joining AMSA or attending the upcoming regional conference this fall co-sponsored by Duke and UNC. See you there!

Curriculum (from p. 6)

the courses to assure anonymity. It will also allow the Dean's office to see which courses are strong and weak in specific areas. We hope this will facilitate courses to make changes to continually improve on the second year core clinical education.

The Student Curriculum Committee also plans to repeat a number of surveys this year to look critically at each of the 4 years to see how things have changed over the past few years. We are especially interested in courses that have responded with improvements and those that still seem to languish behind the rest in terms of quality education. We plan to present this data to Dr. Blazer, our new Dean of Medical Education, as well as Dr. Snyderman.

If you have any questions or comments please don't hesitate to call.

professionals exist. There's no question that you can be an effective physician and mother, absolutely no question in my mind whatsoever (personal communication with Dr. Cynthia Kuhn).

I never doubted that I wanted a family or that it would be too difficult. You go through periods where there's lots of stress and you wonder how you can really manage to do everything, you know, juggling the family and the career at the same time. My advice would be to meet stress as a challenge, and to always try to be optimistic and realize that times change. It's not always going to be bad. I never expected things to always be really hard and difficult. I guess that's a certain basic optimism in your personality, but I think it's also a way to teach yourself to cope, and it works, it helps (personal communication with Dr. Andrea Hackel).

There are times just like residency where it's more the fatigue and lack of sleep that get to you. As my mother always said when she went back to work, if it's busy and hectic at work and on an even keel at home, and vice versa, you can handle it. But if both are going crazy at one time, forget it. And you know there are times like that, when schedules are rough both places. Things seem crazy at times, but you know that you get through it. And, having a support system, having women who are going through the same things as you, is helpful (personal communication with Dr. Nancy Allen).

The task of balancing both parenting and medicine perhaps embodies the greatest challenge that women desiring both have to face. Because the medical system was not originally developed to accommodate women in the field, contemporary female physicians confront a novel dilemma: as one woman physician stated, "Your spouse expects 100%, your child needs 100%, and your patients and colleagues demand 100%"[10] The challenge of the medical profession, then, is to adjust to the realistic demands of women's lives, rather than to deny them, which would encourage women in their struggle to be "mother-doctors". And, future prospects contend that with the rising number of women, medicine will continue in the direction of a shifting profession:

> What is happening in the women's movement today has happened in the past and what has happened in the lives of women in the past is still happening today. What is happening and what has happened affects profoundly not just women, however, but both sexes. Finally, in the narrower context, what is happening today and what will happen to women in medicine affects not just men and women in medicine, but medicine itself, now and for the future.[11]

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The preceding article was originally submitted as the final paper for the first year medical student course "Human Behavior."

Write for Shifting Dullness and you too can influence friends and faculty! Positions open for editors, writers, artists, and any other interested parties. Look for us at the activities fair, or contact Kenny Boockvar at 286-3147.

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Blazing Trails with the New Dean of Medical Education: An Interview with Dan Blazer

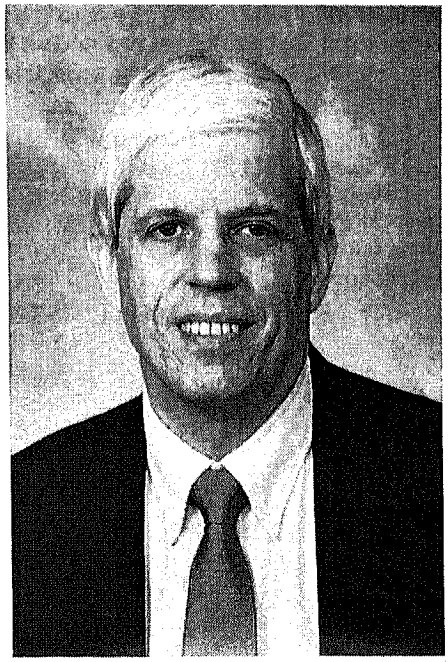
This July, Dr. Dan Blazer, J. P. Gibbons Professor of Psychiatry and Interim Chairperson of the Department of Psychiatry was named the Dean of Medical Education, succeeding Dr. Doyle Graham. *Shifting Dullness* would like to welcome Dean Blazer to his new appointment. The following is conversation that *SD* had with Dr. Blazer three weeks ago, who at the time was trying to obtain a parking place for his new job. *SD* wishes him luck in this endeavor.

Dr. Blazer first came to Duke as a psychiatry resident in 1973, and since then has become a leader in the fields of depression, epidemiology, and liaison psychiatry, especially in the elderly. Dr. Blazer received his medical school training at the University of Tennessee (1969) and a Ph. D. in epidemiology at UNC, Chapel Hill (1980).

SD: What kind of background do you bring to your new appointment as Dean of Medical Education?

DB: I think that if I were a student I would want to know what I have done that has any relevance to medical education. If you look at it in one way, maybe not a whole lot; but if you look at it in another way I think quite a bit. The advantages I bring to the position is that I have done a lot of different things, and a lot of different things at Duke. I come from a family of teachers, so education is something I feel at home with. I think I can really look objectively at the whole educational process of the medical school, the postgraduate training, and some of the other programs as well. Right now the medical school needs to clarify its vision. I just went through a process like that in the Department of Psychiatry where I got the department involved in a planning process which I think we saw as being quite helpful. I'd like to kind of go through a similar type of thing in the medical school. One of the nice things about the medical school is that it really runs well. I think there is wonderful morale. The students like the school and the faculty enjoy teaching. The Dean's office is very well liked by the medical students and has been very supportive of them. To me that really will be a lot of fun to step into.

SD: Have you formulated any ideas about ongoing projects in the medical school? If so, what do you think about the medical school curriculum and its current path of reform?



DB: Three or four months ago I would have said I am so ignorant I can't say anything about those things. I've just begun to identify what I consider to be some issues that have to be addressed, and I have some ideas about how to address them. When I was interviewing for this position some things came to be obvious: one is that for the most part the curriculum works well. Anyone who wants to come in with a chainsaw and just hack it up is probably making a mistake, because in spite of there currently being difficulties and concerns in the curriculum, there is no wide scale belief that we have a major problem with it. One has to go in with the attitude "What things can be done better? What should we be doing to position ourselves for the future?"

Having said that, there are some areas in which it looks like there could be some improvement. It may not be the most important issue, but one of the first things that medical students talk about is the new licensing exams. I don't think that this has ever been a school that has felt it has had to be a slave to the licensing exams. I think that would be a mistake. On the other hand I don't think you can ignore it either. We're going to institute for the third

(see Blazer, p. 16)

year a pathophysiology course and try to use that as an opportunity for "vertical learning," where one goes from the molecular level to the societal level for a given number of topics. That will start this year and will be the big effort to try to prepare the students, especially for Part I of the exam.

I think that the third year itself is something we need to take a look at. Everybody I've talked to seems to think that the third year in principle is an excellent year. I've heard people say that a rule of thirds applies: about a third of the students have a great experience, a third of the students have an OK experience, and a third of the students have a disastrous experience. I think that's not good enough. The vast majority of our students should have an excellent third year experience. It requires us in the dean's office to really tighten down and take a very close look at the preceptors and the preceptors' perception of their responsibilities for students. We will be looking at other things as well, such as course offerings and new models for study tracks. The fourth year has to be looked at, as well, in terms of what students are actually taking for their clinical electives: What can we do to better upgrade some of the electives that maybe we feel should be "elected" more often? The second year has its own set of issues that have to be dealt with. I think that one issue that is lingering is the relative time spent in each of the specialties. The first year is just a bear of a year. It's not clear that everything that is being taught is absolutely necessary. There are tremendous turf issues in terms of how much time is given to pathology, anatomy, etc. I want to take a real close look at this. I would like the course directors to identify much more clearly what they consider to be important to teach, and then to see if in fact the instructor fares well in what they said they were going to accomplish. Maybe we will devote blocks in the first year to concepts that will not be "biochemistry" or "microbiology" but might involve three or four disciplines. Then each discipline would not feel that it would have to cover the concept by itself, again.

All of those are "band-aid" kind of changes, working within our existing curriculum and seeing how we can make it better. I think it's unlikely that we will wander away from the basic structure of the curriculum. I think one of the reasons students come here is for the third year. We need to try to make it work for them. In general, we as a medical school need to be clear about what we are trying to accomplish and clear about how we are trying to accomplish it. And if not, what do we want to do differently?

SD: Do you plan to keep the same structure in the Dean's office, namely the advisory deans system?

DB: I think basically I do. What I'm going to do is review all of the activities of the dean's office and have each component review its activities and develop its own theory about what it wants to do. I will probably have some people from the outside review the advisory deans system. One reason is that there are some people in the medical center who are somewhat (I'm trying to use the right word here) sceptical about whether this is the best use of resources. In my discussions with students, I haven't heard anybody who has not said very positive things about the advisory deans system, although I'm sure there are some out there. And I've talked with a fair number of students. So I cannot imagine us not continuing the advisory deans system. I do want the deans to take a good look at themselves, though. For example, it might be good for the deans to spend more time concentrating on the third year, getting out to some of the laboratories, talking to some of the preceptors and helping to assure that that third year is a better experience.

SD: How do you plan to recruit subsequent medical school classes, especially regarding the recruitment of minorities and the use of merit scholarships?

DB: That is an area I don't know as much about. One of the biggest problems which medical students are facing is financial aid. Already students are leaving school with 20-70 thousand dollar debts, and sometimes higher, as you well know. I think I have to work real hard to try to make the financial burden of our students less severe. And I think a lot of people need to work on that.

The issue of acceptance is a tough one. We do, I think, a very good job, given the minimal amount of time that we have to evaluate students. Not many people would marry with as little contact as we have with prospective students, and yet we probably do better than most marriages do. We do well in recruiting women. We don't do well in recruiting minorities, especially Blacks and Hispanics. I'd like to see us do better. Minority students need to feel not only that they have been accepted to the medical school, but also into the community. And I think we've got a ways to go about it. It's not just a medical school issue. It's a medical center-wide issue.

Children < God (Patois)

"Words are the privilege of an old man.
Spearing with spears is the young men's work;
they have more youth and more strength than I have." -Homer, The Iliad

I wish I could tell you the guy's name - it's not like I'm trying to protect his identity, or distance myself from the embarrassment surrounding his death - I just haven't advanced to the mnemonic level of residents, where names (always first and last run together like they were one) are posed as questions whose answers are diagnoses, with a chorus of "great case" added as a verbal high five. (Remember Mitchell Owen? Bilateral adrenal hemorrhage? Great Case.)

I do remember that he kept hacking up this mucinous oatmeal that he was practically drowning in, which I sopped up as best I could with bedside tissues. I remember some of it got on the sleeve of my white jacket and the back of my hand, and that it felt like sticky bread dough.

Stay with me - I realize I am violating policy regarding avoidance of boring subject matter, with death as the ultimate overwrought topic (forever linked in my mind with bad high school fiction, probably because of the fat girl ahead of me in English whose deus ex machina for rescuing an assignment was suffering through another grandpa). So we can get to my performance, let's get the lesson out of the way.

One, I have entered a lot of dead people's rooms, and what freaks me is not the incredible stillness (of course it's still, the guy's dead), but their eyes: If you die awake, your eyes stay open. Before medical school, I figured that was kind of the final act, your eyes closing as you breathed your last. If there is no nurse in the room after the pronouncement has been made, I always lift up the dead person's lids (nurses are always closing them) and fix my image to the unseen. Retinal cells are still firing after your heart stops, and in the future, this information will be retrieved and reconstructed. Many a dead man has been buried with pictures of his attacker.

"Remember Mitchell Owen? Bilateral adrenal hemorrhage? Great Case"

Two, I am very comfortable with death itself, because everyone knows what to do - withdraw, weep, take over, pretend to go into a kind of shock (so that later they can say, "I was in a kind of shock") - the roles are defined, in other words. The doctor mumbles something inane which he doesn't really believe, the family either doesn't respond or responds according to some Ann Landers dictate appropriate for the situation. It's the period before death, with the family gathered around the bedside, scrutinizing every action, actually listening to every word, when things are most awkward. The physician is keenly aware, from the moment he steps into the room, that he is performing ("Now, I will listen to the heart."), that something is expected of him. The discomfort surrounding death reduces to stage fright.

I say this because there is a misconception, propagated by doctors, that indulging in sick humor is a reward for a) having to confront one's mortality or b) the misery one must deal with every day. First of all, there doesn't have to be justification for submitting an amputated limb to pathology with the label: Left Leg, aka AKA. (I am reminded of a colleague whose response to a question of why he said such awful things about patients was a whimsical "Because they're there.") Physicians are an intelligent lot, with a few psychos sprinkled in, who enjoy a good laugh. Second of all, the justification, if there is one, should not rest on a defective argument. The premises:

P_1 "There is a lot of suffering in the hospital"
and
P_2 "Doctors make jokes in the hospital"

are spatially, not causally related.

This is not self-preservation, at least not in the sense of skirting emotions which may prove counter-productive. This is the bitter humor of the powerless, with the patient, or more commonly (by proxy) the patient's family, as tormentor. They humiliate us with their thought-questions: "Why can't you do anything?" And we can't, so we spit

(see Children < God, p. 18)

Children < God (from p. 17)

on their food.

The code was called by his wife, which is almost never a good sign. I was encouraging some outside hospital night-shift records person to misread a CT report over the phone, my resident had been paged to the ER again, probably by his girlfriend. No one paged me (as usual), I only found out because the guy was in room 1 and I came out to get a drink. I would have gotten away if a nurse hadn't said, "Oh, there he is." It looked like the games were about to begin—they were shuffling his wife out to the waiting area, the code team was paging through his chart, empty except for the nursing admission.

I couldn't say "I don't know anything" (which was the truth) because my name was on the door. I had tried that before and it didn't work. To make things worse, the guy running the code (I know his name, but will refrain for the sake of propriety) was an intern when I was a second year, and he thought I was incompetent—one night he was cross-covering when one of my patients coded (I was in the hospital looking for a billfold). The lady's bone marrow had been shelled by chemo, her most recent neutrophil counts were reported as fractions, and while we're waiting for the party wagon he wants me to run through the different causes of shock. Not only did I not know any besides what she had, I was under the impression, mistaken, that this was a code, not a proving grounds.

"And what kind of shock do you think this is?" he asked after completing a thorough, but entirely superfluous list which included anaphylactic reaction to hymenoptera and third degree burns.

"The shock that needs help," I said. "Can you do anything?"

I had a number of reasons to dislike him — He called me insolent, asked my intern to sign out my patients from then on, spoke poorly of me at the grading session — truth was, I didn't like him mainly because he was smarter than me.

I decided to plunge in, wondering why I had been born to die. "Wildly metastatic renal cell," I started, as he fingered a sub q. met just under his collarbone. "finally diagnosed three days ago when his family noticed he had 'plum give out.' Uro saw him in clinic, washed their hands of him, sent him to the ER with double digit calcium. What little albumin he has is in his lungs, his outside records have been burned in the interest of maintaining the flow of physicians from India, and his wife refuses to sign the DNR. Oh, did I mention cord compression? I haven't had a chance to examine him, but the latest plum he's giving out is clearly a respiratory event."

"She probably didn't realize who was assigned to him. When was that?"

"What?"

"He got to the ER."

"7:30, but we got the call about-"

"Five hours ago? And you haven't even had a look at him? Didn't you write some orders?"

"Dr. Paxton worked him up. I was calling Alamance, trying to get something more valuable than his religious preference. He had orders from the ER. What, do you want to start interferon? I can give you his chest and abdomen CT."

"Which will tell me that he's got a snake in his cava and pericarditis. Good work."

"Pericarditis?" Why no mention on the CT report? Damn, I should learn to keep my mouth shut, I thought, as three hands proffered stethoscopes. Guess I hadn't gotten there soon enough. "Oh, the friction rub," I covered, waving them off. "like the crunch of new-fallen snow. I thought it sounded more pleural."

"Get Bobo up here right away. It's your responsibility to examine these patients first. And it's not pleural."

"He's already been paged." One of the nurses.

"Thank you," I scowled, and then felt like and idiot because she was one of the nice ones.

"This is metastatic to heart. Do you know the number of cases of renal cell metastatic to heart?"

I didn't answer, because they didn't know either. Not including this one? I said, under my breath. Their revelry in their clinical skills directed the attention off me for the moment. I sensed an exchange of "Great Case" was about to occur.

—I.

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Hamlet, MD

To treat, and how to treat — these are the questions.
Whether 'tis nobler in the profession to monitor
The stings and marrows of atrocious diseases
Or to take drugs against a sea of microbes, or by excision, end them.

To treat is to aid, no more,
And by such aid to say we end the heartache of psoriasis
And the thousand natural shocks that flesh is heir to —

To know what came of any interventions —
Which functions were impaired and which restored?
What values, what data, what variations —

Why, 'tis a procedural outcome devoutly to be wished!

To treat, to aid, perchance to spend — ay there's the rub.
For in that course of treatment, what charge may come
When we have shuffled off these hospital gowns?
There's the respect that must give us pause.

For who would bear the whips and scorns of age,
The cancer's wrong, the proud flesh's indignity
The pangs of endogenous depression, gangrene's decay,
The insolence of rabies,
Or the spurs that patient walkers must of the heels expect
When they themselves might their cure effect
With a mere needle?
Who would pruritis bear, to itch and scratch under a weary life,
But that the dread of billing after discharge —
The disallowed operation whose cost no convalescent recovers —
Puzzles the will, and makes us rather bear those ills we have than
Fly to others out-of-pocket.

Thus co-payment doth make cowards of us all
And thus the native hue of remediation is sicklied o'er
With the pale cast of management
And cures of great worth and moment
With this regard, their courses turn awry,
And lose the name of treatment.

— G. Kay Bishop

G. Kay Bishop works in the Division of Social and Community Psychiatry at the medical center.

See other side.