A glass ashtray sits on a windowsill in the foreground. The background shows a window with a view of a city at night, with lights and a dark sky. The text 'Duke AMA VOICES' is overlaid on the right side of the image.

Duke AMA VOICES

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VOICES

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Background photography by Neechi Mosha, an MS4 who hopes to pioneer innovative technologies that will improve the health care experiences of patients and their providers. When not thinking about medicine, he loves driving cars, taking awesome photos and greatly appreciates beautiful design.

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“Thank you for seeing me,” the patient said, softly. It was early October 2011, and I was sitting with my division director, Dr. D. He had last seen the patient a few months prior, in August, when her tremors and abnormal gait were diagnosed as Parkinson’s disease, a devastating neurodegenerative disease that slowly robs patients of their independence.

“You look like a new woman!” Dr. D beamed, with a rapid crescendo of his voice. She had fewer tremors today and could walk much farther without stumbling. The Sinemet was working and the side effects manageable. Her initial depression was less evident.

At the end of the meeting, Dr. D would have shaken her hand except that she was not in our office. He was in his office in Baltimore, where he directed the Johns Hopkins Movement Disorders Center. She was sitting in her living room in Panama, thousands of miles away. She was the first of many patients I was fortunate to develop relationships with as I coordinated their care with a movement disorder specialist via telemedicine.

When I first started working, I did not initially see how videoconferencing could replace the clinic. However, I soon realized that for many, the clinic simply didn’t exist. Despite the growing burden of neurodegenerative conditions, access to care was limited by the distribution of physicians. Though Parkinson’s disease has no cure, it does have inexpensive treatments that can greatly improve quality of life. These treatments typically require guidance from a neurologist

or movement disorders specialist. However, forty-percent of Medicare beneficiaries with Parkinson’s disease have never seen a neurologist. This is unacceptable given that patients who see a specialist are less likely to fracture their hip (14%), be placed in a skilled nursing facility (21%), and die (22%).

As with any conversation about health policy and access to care, I can cite statistics until my voice runs dry. But those aggregate summaries don’t do justice to the individual faces of patients who have fallen through the cracks, who lack access because of where they choose to live. The patients I met were hard-working Americans living in rural Delaware, the rugged Eastern Shore of Maryland, California, and even other countries. Some were quite wealthy, others were rather modest in means. All were handling with great poise and perseverance the debilitation that dopamine death brought. Their stories touched me in unexpected ways and remain with me as I pursue the profession of medicine. I want to share one such story.

Mr. M and his wife remain two of the nicest people I’ve ever met. But things weren’t easy for them. He was an early onset patient, diagnosed a few years before his fifty-fifth birthday. A successful career in sales was replaced by a continual life on disability. Though the medications were decently effective, Parkinson’s disease had had a few more years to assert itself due to his early diagnosis. It had taken away the height of his career, the prime of his life, and his rugged independence in a largely unceremonious way. It was not a

disease he could survive and overcome, but one he would manage as it got worse with time.

A two-income family suddenly became one. He was no longer the primary breadwinner. His wife had no choice but to assume that role, at an awkward time when she was retraining to become a nurse practitioner. Some patients will hide the pain of their disease, perhaps focusing on the positives: their success on medication or more generally, their perseverance. Mr. M was not that type. The emotional, physical, and financial strain on both himself and his wife was front-and-center every time he talked with me about his Parkinson’s. Money was tight, feelings were tense, but he had no choice but to make the most of it.

He had to come up to Hopkins every three months to see Dr. D. The Chesapeake Bay made any attempt to shorten the journey impossible. The drive each way was three hours of time, 150 miles of distance, and most importantly, as Mr. M liked to put it, “a whole nursing shift” his wife had to take off.

He enrolled in one of our telemedicine studies and was randomized to receive a year’s worth of visits via telemedicine in his home. He described that bit of luck as “a godsend.” I looked forward to connecting and talking with him every three months before the visit. He’d always have something to talk about.

“I think I’m going to call you V from now on,” Mr. M said, resolutely, during one visit.

“Um... sure?” I replied, hesitantly. My name had given rise to several nicknames in the past, such as

Vinny or V-squared, out of convenience. My mom had always hated this since my name is religious, but I never cared that much. V seemed acceptable to me.

“Oh, I probably should explain,” Mr. M continued, reacting to my initial puzzlement, “since you aren’t from Baltimore.”

I nodded. He told me he was born in Maryland and spent his entire adult life hopscotching around the state. He grew up rooting for the Baltimore Colts until their bitter split with the quirky city it called home. Once the Ravens came to town, he became a die-hard fan. His eyes glistened behind his thin-framed glasses as he discussed their recent wins.

“Vonte Leach, man, he’s one beast of a full-back. He’s my favorite player,” Mr. M said, gently stroking his off-white goatee, as if whimsically replaying Leach’s best blocks for Ray Rice.

“People here call him V,” he continued. “I’m going to start calling you that.”

After that point, we’d talk Ravens football first thing; he respected that I held onto my allegiances to my beloved Buffalo Bills. I promised him that despite that, I had room in my heart to root for the Ravens too, especially Vonte Leach. Just by coincidence (or perhaps subconscious planning), he had a telemedicine visit scheduled the day after his beloved Ravens won the Super Bowl. He couldn’t stop smiling. Though I knew it might be short-lived, I was happy he had reason to smile.

Each time we connected with him, his beard seemed to have a few more white speckles, his face slightly more wrinkled, but he was no less appreciative of the experience. He saw the same specialist directly



in his home, with software no more complicated than Skype. And while his depression still lingered, his motor symptoms dramatically improved due to carefully monitored medications and a budding interest in yoga and tai chi. He continues to receive his care via telemedicine, and his wife will soon start work as a nurse practitioner and educator.

Telemedicine is merely a tool, not a magic wand that solves all challenges. There are geographic and socioeconomic barriers to care that even the most advanced technology cannot overcome. The digital divide is deep and telemedicine favors those with Internet access. And I admit the interactions did not always feel as organic as an office visit might. I did wish I could shake Mr. M’s hand to greet him, or give him a high-five to celebrate a Raven’s win, or pat his shoulder to console

him. Telemedicine removed the sensation of touch and physical presence, and for some patients or medical specialties, that’s the ultimate deal breaker.

But for Mr. M and countless others we saw, it was a sacrifice they were willing to make to see the physician they needed to see. And they were offering something personal to us in exchange — an invitation to join them in their home, to hear their story in its most natural setting. Though I may never meet them again, I am grateful for the invitation they bestowed upon me and for the opportunity to serve them and become a part of their lives. And for that, I can’t thank them enough.

Vinayak is an MS1 who enjoys learning about the implications of health and policy, through the stories of patients and doctors he meets.

For Margaux

kristian becker, MS1

La Vita—

Here waiting for you, still by the door: A hat, your pair of lavender shoes

— Nuova

The vase of marigolds
And its pitcher of water.

In Memorium: The life regained through poetry.

How your hair shone red,
as if coaled in the sun.

The pale afternoon in December

Their tender words on your behalf.

The silverware shined. The bowl of almonds.

Kristian Becker is a first year medical student at the Duke University School of Medicine. He has previously studied biochemistry and poetry at Boston University and Columbia University School of the Arts.



Neechi Mosha, MS4

The Calling

eddie blay, jr, MS4

This noonday, he reclines on the sofa
Recalls, clear as crystal, the journey just begun
His faith unwavering; his passion unshaken
A bright-eyed student drawn to surgery's practice
To learn and to serve; to seek and to discover
Papa told him, "Son, you were born to sew. I see it in your eyes."

This noonday, he ponders other options
Resolute, despite the pain and weight of his sinews
His joy is boundless; it's a journey not a race
A son of the scalpel with a healer's touch
To probe and to handle; to change and to restore
Nana told him, "Trudge along. These are life's vicissitudes."

This noonday, he witnesses a success
Unwanted mass removed, years granted to that boy
His mind revels; things that fella will learn and see
A newbie set to improve humanity
To be stoic and brave; to surmount and overcome
Dr. L told him, "Don't be afraid. There's no limit to your imagination."

This fine day his zeal cannot be mistaken
Knowing full well the unforgiving nature of his craft
His hand is steady; His mind at peace
A boy from distant shores devouring the teachings of Sabiston
To hold the torch and to blaze the trail
His inner voice tells him, "Brother, this is your calling."

Eddie Blay, Jr is an MS4 who loves to dream aloud with both feet on the ground.

Grappling with its Failure

Towards the end of second year, the situation seemed hopeless. In an email to friends seeking advice for their last rotation, I tried to warn them. I told them that the worst was coming out of everyone and that you would see and do things that you would be ashamed of. The code of professional conduct was failing and standards of professionalism were dissolving.

As I was struggling with my own failures, I found comfort in learning more about the

problem both at Duke and nationally. Around that time, Dr. Danielle Ofri wrote an article called "The Darkest Year

of Medical School," in which she described the decline in empathy and professionalism during medical students' first year on the wards. The trend was well documented around the nation. Also around that time, Dr. Chudgar gave a lecture on professionalism, during which it became clear that the spectrum of what students considered acceptable behavior had grown tremendously. The black-and-white of right-and-wrong held by most students at the beginning of the year transformed into a world of gray where ideas about professionalism depended on a range of questions: who was on your team, how many hours did you sleep, was your supervisor evaluating you, when was your SHELF exam, etc. This was further

evidenced at a student retreat at the conclusion of our second year. The advisory deans revealed that nearly everyone witnessed honor code violations, but very few reported them. Many students, including myself, who failed to report violations, cited "it could have been me." The honor code became a system of implicit collusion and dishearteningly, our class' survey results were "typical."

Feeling disheartened at the end of my second year, I struggled to un-

"...at the conclusion of our second year, the advisory deans revealed that nearly everyone witnessed honor code violations, but very few reported them."

derstand the cause of these changes. Students emerging from the experience still have good values, but in hindsight we seem to agree that we "bent the rules." In a public policy course covering game theory, it became clear to me that behavior on the wards was not perplexing, but completely rational. The forces at play can be modeled as individuals choosing between communal responsibilities to clinical duties and individual responsibilities to study for exams and achieve high marks.

For example, consider a group of 10 medical students rotating together. Each student has 10 units of energy, which they invest either in patient care or in personal activities (e.g., studying, sleeping, etc.). The units of energy dedicated towards

patient care go into a common pool that upholds the code of professional conduct and fosters trust in the work place. Every unit invested in the common pool is doubled and then divided equally among the 10 students to signify the incentive to invest in the community.

On one hand, the higher the investment in the common pool, the higher the payout to all students.

If every student chooses to invest 8 units of energy into upholding the

code of professional conduct, the 80 units are doubled and each student is returned 16 units of energy. Adding the 2 units held onto for personal

activities, every student ends up with 18 units, nearly double what they started out with. Thus, collective investment can make life better for everyone.

However, individual students are also incentivized to not invest in the common pool. Regardless of how well students perform on clinical duties, obtaining Honors on most rotations requires countless hours of studying. A unit of energy invested in the common pool is a unit of energy not spent studying. If student A contributes a unit of energy into the common pool, this increases the common pool by 2 units after the doubling. But 1.8 of the increment is distributed to the other 9 students; student A only gets back 0.2 units. From this perspective, contributing

nothing into the common pool is strategic. For example, if student A keeps his 10 units of energy to study while the other 9 students each invest 8 units into the common pool, student A leaves with 24.4 units (10 plus dividends from the common pool) and every other student leaves with 16.4 units (2 plus dividends from the common pool). The same reasoning can be applied to any student who wants to spend time studying, but hopes to be a “free rider” on the efforts of others to fulfill clinical duties.

Countless situations during second year reveal this tension between collective and individual interests. A classic example is a clinical re-

quirement, say a lecture, the day before a SHELFL exam. Collectively, students want each other to attend the lecture to uphold the code of professional con-

duct and maintain trust in the work environment. However, students, like myself, individually feel pressure to miss the lecture and invest that time and energy into studying. The dominant strategy would be to miss the lecture and be a “free rider” on the effort of others.

Game theorists describe this set up as a multiperson prisoners’ dilemma. Players are assumed to act out of individual interest and abide by their dominant strategy, which in this case would be to defect and violate the code of professional conduct. However, if all students play their dominant strategy, the common pool is left empty. Despite how well students perform on SHELFL exams, trust is eliminated from the work place. Medical students lose

their sense of professionalism and supervisors lose their respect for students. One supervisor, surprised that another medical student and I were showing up to work, told us he became accustomed to students escaping to the library.

Strategies to improve the Duke University School of Medicine code of professional conduct can be found in *The Art of Strategy*, by Avinash Dixit and Barry Nalebuff. The authors propose ways to achieve successful cooperation in multiperson prisoners’ dilemmas. New methods of detecting cheating must be introduced, because the current system of peer-reporting is failing. If the detection is fast and accurate,

“Instead of blaming individual students for shirking clinical responsibilities or individual supervisors and clerkship directors for a lack of oversight, understanding the incentive structure helps explain the frequency of violations.”

repercussions can be immediate. This reduces the gain from cheating while increasing its cost, and thus increases prospects for successful cooperation. Second, repercussions must be appropriate. If students fear that honor code violations will permanently damage an individual’s record, violations will persist unreported. Third, boundaries of acceptable behavior must be revised. Expectations must not remain an unattainable ideal, but must be grounded in the reality of the medical student experience. If certain violations are truly ubiquitous, we must question the appropriateness of regulating those behaviors. If the majority of students feel that a clinical experience wastes their time, must they be required to participate

when they could instead be learning information necessary to practice medicine? Fourth, student groupings must be made more stable and enduring. New teams of students who do not have a stake or a history of participation in a collective arrangement are less likely to cooperate. Similarly, if an established group expects to be disrupted, incentives increase to cheat and take extra benefit right now. Thus, the transience of team composition during second year rotations encourages honor code violations. Finally, students must have confidence that there will be repercussions for defection and that cooperation will be rewarded.

The multiperson prisoners’ dilemma provides great insight into the failure of the medical student code of professional conduct. Instead of blaming individual students for shirking clinical responsibilities or individual supervisors and clerkship directors for a lack of oversight, understanding the incentive structure helps explain the frequency of violations. But despite what feels like complacency with a failing system, the situation is not hopeless – the system can be revised to enhance cooperation and standards of professionalism. The medical school has a responsibility to refine the code of professional conduct in order to graduate students who can more skillfully balance personal and collective interests.

Mark Dakkak is an MS3 completing a Masters in Public Policy who hopes to pursue internal medicine and work in health systems research.

Short Story

sf, MS2

Philip slapped snooze.

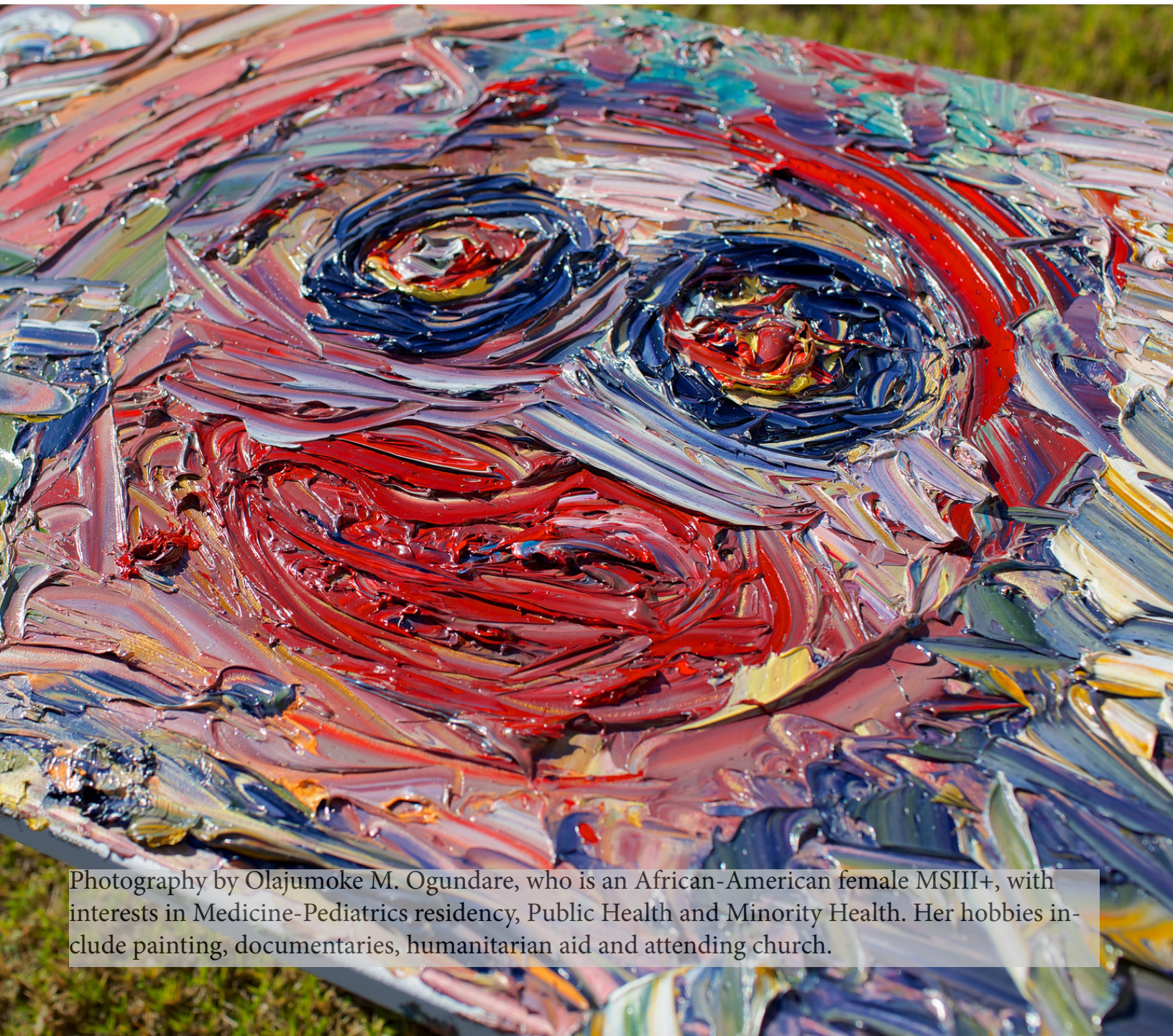
Again. He never went to his stats class but always set his alarm as if he had every intention of attending. Talk about internal conflict. He rolled onto his back knowing he had just under seven minutes before he'd berate his clock again. He closed his eyes and perceived Sabrina facing away from him, fiddling with something at their lab bench, her tush flawless as ever. As her hazy

silhouette began to rotate slowly towards him he noticed that what he had originally conceived to be Sabrina was actually a bare-breasted Mrs. Mentor, his 5th grade art teacher of questionable morals and unquestionable unattractiveness.

Philip fled bed.

He still had no intention of going to class but the repulsive mental image of Mrs. Mentor made returning to sleep impossible. He

spotted his left-footed slipper next to the foot of his bed and after some investigation found the other one under last night's outfit. Draped in his terry-cloth robe, he exited his room, entered the kitchen and began his morning routine. He filled his electric water-boiler under the sink faucet and got some coffee from the pantry. He mixed the coffee and near-boiling water together in his Bodum French-press and gave the



Photography by Olajumoke M. Ogundare, who is an African-American female MSIII+, with interests in Medicine-Pediatrics residency, Public Health and Minority Health. Her hobbies include painting, documentaries, humanitarian aid and attending church.

mixture a swirl, his nostrils reeling in the aroma.

Philip sat down.

At the kitchen table in front of him stood the typical breakfast soldiers: a carton of 2% milk, a mug of black coffee, and a box of Trix. He reached for the cereal box and aggressively opened the cardboard flaps. Staring into the box he was disappointed to find a meager amount of sweetened corn-puff fruits within the box. He reached his right hand into the box to grab the remaining cereal.

Philip was confused.

As he tried to remove his hand from the box the cereal became increasingly heavy, forcing him to stand up in order to gain leverage. As Philip grabbed the rim of the box with his left hand the weight of the cereal trumped his strength and he fell, head first, into his box of Trix. Although he felt weightless, the indiscernible items whizzing by his body at an alarming rate suggested he was falling. Fast.

Philip fell fast.

And although he perceived it to take hours, within about a minute he splashed down into a swamp of strawberry yogurt. He struggled frantically and as his gasps became increasingly filled with active cultures and thickened dairy he felt himself being tugged by his hair. A wild force had removed him from the yogurt swamp and flung him to the ground. Philip placed both hands on either side of his nose and wiped the yogurt from his eyelids only to see the myth, the legend, the Trix Rabbit.

Philip screamed Trix.

And the bunny told him that they had no time for shenanigans. We've gotta save Sabrina, he told him emphatically. Philip tried to respond but every time he opened his mouth Trix cereal spewed out like projectile

vomit. The rabbit casually picked at the bananas as they flew through the air before tossing Philip gingerly on his back.

Philip was helpless.

As Trix hopped with haste through what seemed to be a two-dimensional forest of pastel shrubbery, Philip decided to completely shed all reservations. He had found the Trix bunny stories lackluster as a child, but the scenes before his eyes had him perceptually pleased. Embracing the absurdity of his environment – oversaturated fruits, two-toned plants and lollipop trees – he tried to wrap his head around what the rabbit had said. We've gotta save Sabrina. It echoed between his ears, reverberation driving contemplation.

Philip thought hard.

And reasoned that he must still be asleep. How else could he be inside a cereal box on the back of the Trix rabbit that knew the identity of his girlfriend? He slapped himself firmly in the face to test his dream-state theory but this only caused him to spew more Trix. In fact, the puffed-grain fruit shot out with such force that they startled the rabbit to a halt.

I'm trying to help you find Sabrina, can you please stop these shenanigans? Trix sounded about as frustrated as a silly rabbit could get without risking his mascot contracts with General Mills. Philip tried to apologize, again forgetting that his oral cavity had been magically converted to a cereal geyser. As the silly rabbit restarted his hopping and quickened his pace Philip decided to get creative.

Philip got creative.

He jumped off the back of the rabbit and as he was falling screamed Sabrina's name towards the ground. The force from his Trix cannon was enough to combat gravitational

forces and keep Philip suspended in the air. With enough gusto he could actually form a propulsion pillar with the Trix.

Philip flew up.

He continued to yell and continued to rise, piercing through the rain-forest canopy of the cardboard Trix world towards a sky of indiscernible color. He passionately screamed her name repeatedly and accelerated upwards when suddenly he felt himself rapidly slowing down. He couldn't see the ground below him but it didn't matter – he knew the problem. Fucking rabbit! He thought to himself. With every jerk back towards the ground he knew that Trix was taking another bit of the questionably nutritious cereal escape pillar that Philip had built for himself.

Philip fell down.

He landed with a thud directly in front of the silly rabbit's hind paws. The rabbit burped. Philip sighed, and as he sighed more Trix shot out, only this time they flew directly into the silly rabbit's mouth, causing the rabbit's eyes to fractal and spin like pinwheels. Philip repeated this procedure again and this time the silly rabbit keeled over and died. Philip wasn't sure what to think. He hadn't tried to kill the rabbit, and the rabbit had actually been trying to help him. Regardless, he repeated his Trix tower building procedure, screaming at the ground with great enthusiasm. After what seemed like hours but was probably seconds, Philip found himself again sitting at his kitchen table.

His phone rang. It was Sabrina.

Philip got dumped.

SF is an MS2 who enjoys creating short fiction and hopes to continue to write new pieces no matter what field of medicine he enters.

It is a Privilege

josh rivenbark, MS2

“It is a privilege to be a physician.”

I first heard that phrase in an “Unsolicited Advice” lecture during Clinical Skills Course, just before starting rotations. I’m sure there was some eye-rolling going on in the class, but I kind of liked it. At least, I liked the idea of it. If nothing else, an optimistic view of life...

So I wrote it down and promised myself I would look at it every once in a while over the coming year. Everything from the internet to senior students to Practice Course had told me that rotations would burn me out, and I thought I might need something to refresh my optimism in the near future.

Imagine my surprise, then, when I heard that exact phrase less than two weeks later, during my very first day of internal medicine. As my team sat in the workroom going over our patient list, someone commented that our list contained a fairly high prevalence of IV drug users and alcoholics (there is, from time to time, a negative stereotype associated with these patients). Without pause, the attending physician smiled, raised his eyebrows, and said, “Ya know, it is a privilege.” It would have been the perfect sarcastic response to propagate the comment’s implications... but it was totally sincere.

I thought it was a striking coincidence to hear that phrase repeated so genuinely in a clinical setting. If I didn’t have it on my mind that night, I certainly did by the end of the week; the attending continued dropping that line, every day we were on service together.

“It is a privilege to do what we do.”

“People are pretty amazing, and we are privileged to see it.”

“It is a privilege...”

It’s hard to write that phrase without feeling... cheesy. And maybe even a little self-righteous. At the very least, it can sound painfully positive.

Yet... as with many things, repetition makes it real.

A couple days into the rotation, the attending and I left the room of a patient who was truly down on his luck, in the hospital for a place to sleep as much as he was for any medicines. As the attending walked away, he made a joke about the patient’s request for a cigarette, smiled, and said, “It is a privilege to take care of people.” The rest of the morning, as I power-walked the hallways of Duke North in search of something to do, I found my brain playing the phrase on loop. And for some reason, while it rolled around inside my head that morning, it cemented for me.

Later that month, I was helping admit a patient having a sickle cell pain crisis, another negatively stereotyped patient. It really resonated when he said, “Man, I wouldn’t come anywhere else for this. I trust y’all to take care of me and give me respect.” We couldn’t promise to completely take away his pain, and he knew it. But we could promise that we’d keep a close eye on him and listen to what he had to say. That was the next best thing, and what he was hoping for. That level of trust is pretty cool, and the opportunity to hold someone’s trust like that is something I previously would have only anticipated to come from the very closest of relationships.

So it is a privilege to take care of patients, just as it is a privilege to take care of friends and loved ones. When a best friend calls me to tell

me they’re going through a break-up, it’s my duty to provide beer (or ice cream, as the situation merits) and consolation. Likewise, when my sister calls me in the middle of the night from a different time zone freaking out about something that can probably wait until morning, it’s my responsibility to calm her down and make sure she’s all right.

In both of these cases, however, there’s more to it than just the responsibility. I feel privileged to be the person they turn to, just as I feel privileged to be able to help them out in some small way. That’s what makes the relationship what it is. And while I can hope that beer will magically cure my friend of his break-up blues (clinical trials have been equivocal thus far), it’ll more likely just be my presence and availability that really helps.

In the same vein, there is real privilege in being in the profession that people look to for medical needs – the profession that people think will take care of them. We hope that what we do in the hospital will provide for that medical need, and it is certainly rewarding when it does. The great privilege, though, comes simply from being the ones that people turn to; the great reward comes from simply taking care of people, whatever that means... including refusing requests for cigarettes.

“It is a privilege...”

So it may be cheesy, but I’ve also come to think it’s true. And it’s no longer just the idea of it that I like.

Josh Rivenbark is a second year MD/PhD student who loves medicine and plans to pursue a PhD in Public Policy with a focus on global health.



Psalm

kristian becker, MS1

When you died of heart failure and a small cough
I was eating a sandwich, which is not unheard of

Because I like sandwiches.

It was late, and cold, and blankets were brought
And piled, and your wife, half-ghostly with dementia,
Put in the crook of your arm the plush dachshund

To hug, as if you could stir and reach
Out through the darkness.

Near the butcher block there is a letter for you,
Which I could not send.

On my phone there is a note to call after 6:00
And ask about the meteors and snow.

Dear window left closed, dear beach stone and sand,

Dear desk chair and vacant pen
I'm sorry



Neechi Mosha, MS4



***On the Discovery** of 1054 New Planets in the Milky Way Galaxy by the
Satellite Kepler, February 6th 2011*

Like a young Alvie Singer
Speaking to his therapist,

I too am worried
About the universe,

How it is expanding,
And that I am caught here

Waiting in the bedroom
To brush my teeth

Because you are taking
Too long in the shower again.

*Kristian Becker is a first year medical student at the Duke University School of Medicine. He has previously studied
biochemistry and poetry at Boston University and Columbia University School of the Arts.*

Photography by Neechi Mosh, MS4



DukeMedicine

