April Fools 1990

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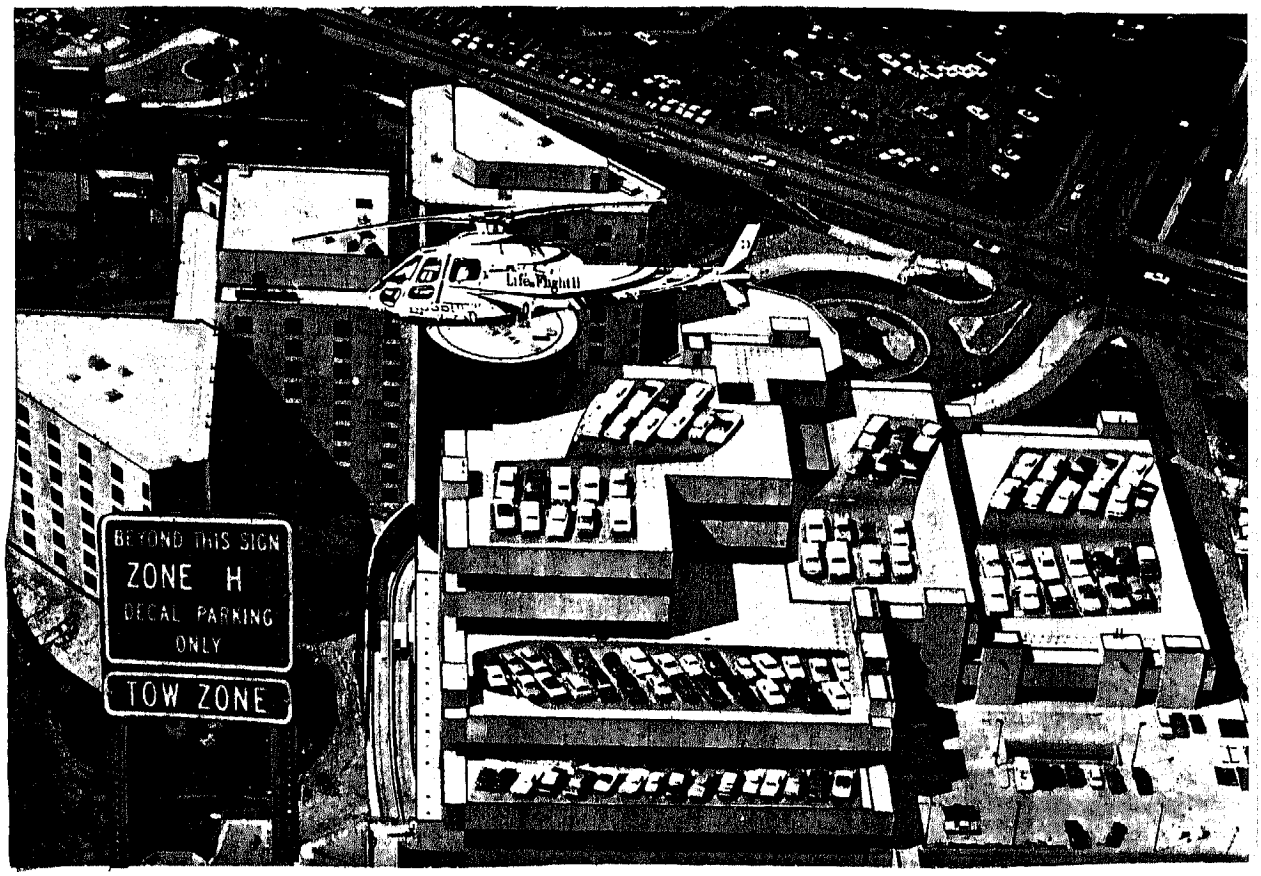

. The new Duke North parking deck.

New Parking Deck Opens

As part of a measure to resolve the scarce parking situation, a new parking deck was recently opened. Due to space constraints and land costs, however, the deck was constructed on top of Duke North Hospital. Asked about the inconvenience of the facility, a top administrator responded that he had faith that bright Duke medical school students would find a way. Pressed further, he conceded that he would look into the possibility of having off-duty Life Flight helicopters transport cars up to and down from the parking area. The roof space was also being condisered for use as an alternative visitors' smoking area.

72% Match in Radiology

A surprisingly high percentage of the 1990 graduating medical school class has recently matched in a Radiology program. Other specialty choices which fared unusually well this year included family practice (24%) and ophthalmology (10%). The Dean's Office was silent about these astounding figures, although an anonymous source which claimed to have knowledge of the deans' reaction noted that they were very disappointed that students were forsaking "real medicine," and instead pursuing more lucrative nine-to-five jobs.

Alex Kemper would like to express displeasure at the absence of his face from the April cover of *Shifting Dullness.*

April in Medical History

Chris Tharrington

• William Harvey was born April 1, 1578. While he is best known for his Circulation of the Blood, which helped lay the foundations of modern physiology, Harvey also made important contributions to the field of embryology through his studies of chick development.

• Thomas Addison (Addison's disease, Addison's or pernicious anemia) was born April 3, 1793.

• Joseph, Lord Lister, was born April 5, 1827. After receiving his medical education in London, Lister studied surgery under Syme in Edinburgh. Using the contemporary findings of Pasteur regarding fermentation, Lister made his mark on medicine by experimenting with carbolic acid as an antiseptic for surgery. This started the trend away from the septic conditions of his time toward antiseptics and aseptic surgery.

• Harvey Cushing was born April 8, 1869. Recognized as the world's leading neurosurgeon in his day, Cushing served as Professor of Surgery at Johns Hopkins, Harvard, and Yale in turn. He also contributed several classic monographs on brain tumors and pituitary disorders, and wrote a well-received biography of Osler. Cushing is remembered chiefly for his eponymous disease, law, and syndrome.

• Sir John Pringle of Scotland, the man who named influenza, was born April 10, 1707.

• James Parkinson was born April 11, 1755. Besides his classic description of *paralysis gitans*, he also wrote the first English description of appendicitis.

• On April 16, 1551, the last outbreak of "sweating sickness" occurred in Shrewsbury, England. Contemporary authors described the disease as more virulent than the plague, killing victims within a few hours of the onset of symptoms; previous epidemics caused the closing of Parliament and the suspension of all business transactions in London. The illness, also known as *Sudor Anglicus*, may have been a type of rheumatic fever, but to date its exact identification remains a mystery.

• The Duke University School of Medicine and the Duke Hospital were dedicated on April 20, 1931.

• Edward the Confessor was crowned King of England on April 22, Easter Day, 1043. His name became associated with the patronage of epilepsy sufferers because of a legend in which the king's ring received healing powers from St. John against epilepsy. The story continued that this ring had shared its powers with a series of other rings, known as "cramp rings;" these were usually made from coffin nails or the silver from Communion vessels. Interestingly, many medieval Europeans considered epilepsy a contagious disease.

• C. A. T. Billroth was born in Vienna on April 26, 1829. Billroth was one of the more important surgeons who accepted the new ideas of Pasteur and Lister, especially in their application to what was then a new surgical field: the abdomen.

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Shifting Dullness accepts letters of opinion from all members of the medical school community which encourage responsible dialogue. Opinions expressed do not necessarily reflect the opinions of the editorial staff. *Shifting Dullness* reserves the right to edit letters for length and style. Submit responses in the *Shifting Dullness* box in the Alumni Affairs Office, the library snack room, or mail to PO Box 2765 DUMC, campus mail.

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Second Opinions

How much can we pay?

Matt Roe

As the U. S. health care system enters the 1990's it faces mounting pressure from the federal government, insurers, and business to control medical spending. The cost of health care has become a major issue both nationally, as seen with the report recently released by the Pepper Commission which proposed a solution to stem health care costs, and locally, as seen with the recent panel discussion on the costs of health care presented by the Duke chapter of the American Medical Students Association. Rising health care costs may soon necessitate drastic changes, therefore it is important to understand why costs have increased so much and what can be done about it.

Modern medicine in the U.S. has become increasingly technological as resources have been poured into powerful new diagnostic tools and complicated procedures which have saved countless lives. Magnetic Resonance Imagers, organ transplants, and CAT scanners are examples of high tech medicine at its best. These devices and procedures have saved many patients who wouldn't have been saved 20 or 30 years ago. But there is a price to pay: liver transplants average over $200,000 for the transplant alone and MRI scans cost hundreds of dollars. While high-tech medicine has dramatically reduced morbidity in many cases, access to such care is limited by ability to pay. Just a few weeks ago, a Durham man made a public appeal for money to pay for a liver transplant he desperately needed, but which wasn't covered by his health insurance. Meanwhile, wealthy patients who can pay for a liver transplant are receiving scarce donor livers. Such disparities in access to high-tech medicine demonstrate that new technologies benefit people with deep pocketbooks or people lucky enough to have good medical insurance, while the poor and uninsured are left out in the cold.

With the advent of high-tech medicine, our society has become increasingly litigious. Patients demand perfection from physicians and physicians demand protection from lawsuits lacking merit. Our current tort system which allows sympathetic juries to award millions to litigants for pain and suffering ends up penalizing patients with higher health care costs. To protect themselves, physicians have been forced to practice defensive medicine which often involves ordering unnecessary tests and services. Physicians raise their fees to cover the outrageously expensive malpractice insurance required to stay in practice.

High-tech medicine and the practice of defensive medicine precipitated by the malpractice crisis have both contributed to rising health care costs, but a more intangible issue is the increasing cost of medical education. Medical school tuitions have increased drastically during the past decade to the point where today's graduating physicians are saddled with an average debt $40,000. When physicians enter practice, they may take the attitude of "It's my turn now," and charge high fees to recoup their school debts or they may enter high paying fields like surgery or radiology which leads to further utilization of high-tech medical interventions these fields use.

Facing mounting costs, health care planners have pointed to the Canadian health care system as one which controls costs yet still provides high quality care to its patients. The U.S. spends more of its Gross National Product on health care than Canada and more per capita on health care. But, all Canadian citizens have equal access to health care, life expectancy in Canada is two years longer than in the U.S., the infant mortality rate in Canada is 24% lower than that in the U.S., and deaths due to heart disease are 20% lower in Canada than in the U.S. (Michael Specter,*Washington Post*, Dec. 18, 1989). While the Canadian health care system does have its problems, valuable lessons can be learned from it. The American Medical Association, however, doesn't think so and it recently distributed a pamphlet to American physicians which charges that Canada constrains costs by limiting medical care. While the U.S. desperately needs coordinated physician input on solutions to control health care costs, the AMA's actions are contemptuous and self-indulgent.

Options for controling health care costs include liability tort reform to reduce malpractice awards, subsidizing the cost of medical education, and changing reimbursement patterns to physicians to discourage the indiscriminate use of high-tech interventions. No national consensus has yet developed. The American public and health planners must keep their minds open to new and even radical ideas about how to stop the rise in health care costs so that the U.S. health care system may become less expensive and more equitable.

The Future of Insurance

Susan Hazzard

People from all walks of life are voicing anger and frustration with the current American health care system (AHCS) system as it struggles to contain costs, improve productivity, and expand access to services.

An example of an alternative system is the Canadian Health care system (CHCS), which has adopted a radically different reimbursement system. Universal coverage eliminates the individual burdens of catastrophic illness, the problems of uncompensated care, and the uninsured populations which now total approximately 35 million in the U.S. Overall health expenditures have been constrained to a stable share of the national income (8.6%) compared to the cost of health care in the U.S. which now comprises about 11.5% of the Gross National Product (GNP) and is projected to reach 15-17% by the year 2000. Canada's successful cost containment can be attributed to the distribution of all forms of medical technology according to region in a fashion that compels physicians to carefully consider which patients would profit from their use. As a result, modern techniques are far less available and there are long waiting lists for some tests and procedures.

Health care is a common good.

There are three national health proposals which have received recognition, the People's National Health Plan (PNHP), the Enthoven-Kronick Proposal (EKP), and the Heritage Foundation Proposal (HFP).

For brevity's sake I will only outline the basic features of each of these proposals. The PNHP's motto is "Health care is a common good." This proposal will assure universal, comprehensive public insurance; eliminate out-of-pocket expenses (e.g. deductibles, co-payment, balance billing); pay hospitals and nursing homes an annual lump sum to cover operating expenses; fund capital costs through separate appropriations; pay for physicians' services and ambulatory services in any of three ways: 1) fee for service with predetermined fee schedule and mandatory acceptance of payment as the total payment, 2) global budgeting for hospitals and clinics that employ salaried physicians, 3) capitation. It will be funded initially by the same sources as at present (Medicare/aid, state and local funds, employer tax, private insurance revenues, general tax revenues) but with all payments disbursed by a single public or quasi-public body (single payer, monopsony). Funding will be provided in the long term through a progressive tax. Other issues addressed include prescription drugs and supplies, long-term care, preventive services, and medical education.

The EKP advocates a consumer choice health plan utilizing free market competition at an aggregate level (Federalism). It will encourage the spread of HMO's and other efficient health care delivery arrangements by giving all "consumers" a choice of plans that require a consideration of costs; encourage nearly universal access and allow for "public providers of last resort" for those unwilling/unable to enroll in a health plan; sponsors (employers and state public sponsors) would provide various insurance options for each member of its group during an annual open enrollment; employers would provide coverage for full-time employees. For others, they would cover them or pay an 8% payroll tax. Employers would pay 80% of average cost for the basic coverage options (employees would have a 20% co-payment and the full cost of any additional coverage); the state "public sponsor" would provide coverage options for those not covered through employment; premiums for the poor would be subsidized (100% for those below the poverty level and a sliding scale for those whose incomes are 100-150% of the poverty level) and small businesses (<25 employees) no more than 8% of the payroll would be required to meet the employers' contribution; everyone not covered through full-time employment would pay an 8% tax on gross income. This tax revenue, and the 8% payroll tax for employers, would go to the public sponsor. The federal government would finance the plan but some combination of state-federal government would administer it; managed competition would be used to keep cost down.

The HFP design will promote free market competition at an individual level so that third party payers will be eliminated, rendering both the public and the physician concious of the cost of care. Components of this proposal are 1) every U.S. resident, by law, must enroll in an adequate health care plan to cover major medical costs, 2) tax credits will be given to offset health care costs in a way that will encourage out-of-pocket payment for all but major expenses: (20% for insurance, 30% for out-of-pocket expense, 50% for expenses > 5% of income, and 75% for expenses > 10% of income), 3) for working Americans, obtaining health care protection must be a family responsibility. Those who can pay should pay, 4) the government's proper role is to: monitor the health market (basic regulations),

subsidize needy individuals so they may obtain sufficient services (administered at the state level), encourage competition, and 5) states should be encouraged to develop innovative methods for caring for the poor.

Another option proposed by the Pepper commission seeks to preserve the private insurance sector, mandate employer insurance, allow small employers and individuals at or below 150% of the poverty level to receive tax benefits and incentives, insure that the elderly have viable Medicare, and design a method of rationing that is based on medical indications and a national ethics committee's recommendations.

The above attempts to outline the insurance plans under consideration for the future. These changes will become relevant to each of us as we break away from the protection of academia.

Rural Health Elective

Are you interested in:

•primary care?

•working in a community controled people's health clinic?

•a more just health system?

•or, learning about societal impacts on worker health and safety, access to care, race issues, and poverty in rural Eastern N.C.

If so, plan to take the Rural Health Elective 214C. Sponsored by the NC Student Rural Health Coalition, this two credit course entails clinical responsibilities, a biweekly seminar, and a community based project. Look for announcements for an upcoming informational meeting.

7th Grade Sex Education in Durham

Jill Levy

We navigated through the crowded hallway past the slamming lockers and the masses of shouting teenagers, many of whom towered above my imposing stature. Upon finding the classroom, we were greeted by the teacher. It was eighth period now and everyone, including the teacher looked like they wanted to go home. As the students filed into the room, I had fleeting thoughts of escaping, but my teaching partner and I plunged in head first and introduced ourselves to the class. We would be teaching sexual education, a program taught to seventh graders and organized for the Durham City Schools by Duke Medical Students.

According to Janice Gault, a third year med student and organizer of this year's course, the student run program began in 1969 to deal with the increasing rates of teenage pregnancy in Durham. The school system has now come to rely on Duke medical students for this program. The advantages of having medical students involved in this is that kids can talk more freely with someone who is not there to grade them and who is closer to their age. The course relies heavily on the participation of first and third year medical students. This year only 42 students signed up, 6 short of the total needed to staff with teaching pairs.

For each class a man and woman are generally assigned to teach together. A syllabus with the information to be covered is provided with suggestions on how to present the material. Topics include male and female reproductive anatomy and physiology, contraception, sexually transmitted diseases, adolescence, and choices about and consequences of being sexual active. Teaching styles vary; discussions, lectures, handouts, role playing, and games are among the methods used.

Although our class was sometimes a rowdy group, they were generally interested in what we had to say and all turned out well. Students were very open to talking about sex, but we left a question box in the classroom for those who wished to be anonymous. Questions ranged from "Can you get pregnant after the first time?" to more outrageous inquiries, but we tried to answer them all without too much blushing. When students became fidgety during class, my favorite technique was to entice them with the promise of candy to remember important information (a method now being looked into by Dean Graham for next year's entering medical school class).

one of the more memorable things I have done

One of the best aspects about this experience for me as a first year medical student was the chance to take a break from the books and to interact with the community. It truly has been one of the more memorable things that I have done. But in order for the program to survive we need the continued involvement of medical students. For those students who would like to participate in the program next year, look around for notices starting in the late fall. Anyone interested in organizing the program for next year should contact Janice Gault MSIII (P.O. Box 2729) now.

Davison Council

Diane DeMallie

Dr. Saul Schanberg attended the February 28 meeting of the Davison Council to talk about changes that may soon occur in the curriculum. Schanberg conveyed some important information, amidst somewhat heated debate.

Schanberg discussed the results of an AAMC questionnaire given to graduating medical students nationwide in the years '87, '88, and '89, regarding satisfaction with med school curriculum. He noted that a higher percentage at Duke (48.1% in 1989) than across the country thought that the basic medical sciences curriculum at Duke was inadequate. Almost 20% of Duke students reported that instruction in patient interviewing skills was inadequate. Schanberg reported that "almost 79 or 80%" of Duke students responded each year, and he thought the findings indicated "students have not been altogether happy here at Duke."

Schanberg indicated that the number one reason for Duke students to choose a residency program is "lifestyle." Many Duke professors believe that to choose a residency based on lifestyle shows considerable lack of character. It was questioned whether Duke admits lazy students or if Duke's curriculum makes us lazy. Schanberg cited the Family Practice Health Survey of Duke students which found that 12 Duke students were using drugs when they came into medical school. "Some percent" drank more than 14 drinks a week, and "some percent" both drank and used drugs. Schanberg seems to think these provlems could be corrected by a new curriculum. He defended the first year block system which includes nutrition, patient interviewing skills, and fewer exams. Many students feel that the same lectures are just being taught in a new order.

Also discussed was the $45 million grant for medical school curriculum revisions. To compete for the grant, each school has 14 months to plan a "total change in administrative authority." The Foundation emphasizes problem-based learning with a clinical focus. Good teachers must be rewarded by salary and position. Dr. Snyderman has appointed the Strategic Planning and Design Committee (SPAD) to consider whether Duke can afford to compete for this grant. Schanberg thought Duke would compete since they could gain much (including a new curriculum) from the money.

SPAD plans to hire a psychosocial dramatist to train actors to act as patients and teach students interviewing skills. They may institute required "exit interviews," to allow attendings to evaluate students's interviewing skills. They have already hired Amil Petrusa, a world authority in problem-based learning. He will arrive in June and will help Duke revise evaluation of faculty, students, and the curriculum itself. Other possible changes include decreasing lectures and increasing participation (by lengthening the first year), changing the length of some rotations (shortening psychiatry and lengthening medicine), adding outpatient clinical experience, making third year more flexible and individualized, and increasing the required credits for third and fourth years to 44 from 36.

These changes elecited heated debate. Davison Council members wanted to know why these changes were being discussed without any student input. At this question, Schanberg adamantly stated that students will be on every one of the specific curriculum committees; they are just not on the executive committee making the big, overall decisions. He expressed great surprise that students are not on specific committees, because they were told that they were not needed. He explained that students are indeed needed; however, the specific committees had not been active since October, because they were all waiting for the "OK" from SPAD before starting work. So no work has been done on any curriculum changes except for some discussions in the top executive committee. Students were not aware of these facts.

Council members asked why no students are on SPAD and whether SPAD read the letter that the student section of the curriculum committee sent them about recommended changes. Schanberg did not recall receiving the letter, but he argued that having one or two students on SPAD would not represent the student body as well as the studies on student opinion cited earlier. He further stated that the administrative decisions made by SPAD simply do not need student opinion.

We thank Dr. Schanberg for attending the meeting. Schanberg refused to take responsibility for informing the student curriculum committee about major meetings and decisions, but he encouraged students to go to specific committee meetings to keep themselves informed. He invited any student who wants to get involved to call him or Sal Pizzo to get more information.

DUKE UNIVERSITY
MEDICAL SCHOOL

1990 STUDENT FACULTY SHOW

SATURDAY APRIL 21, 1990

CAMERON INDOOR STADIUM

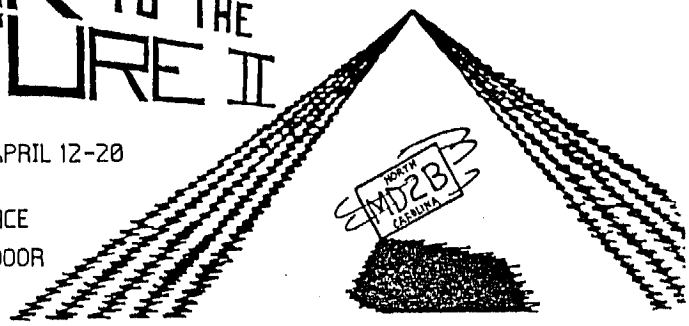
DOORS OPEN AT 6:30 P.M.

SHOW BEGINS AT 8:00 P.M.

BRING YOUR OWN PICNIC
- OR -
PURCHASE A BBQ BUFFET TICKET ($7.00)

FREE BEER AND SODA

BACK TO THE FUTURE II



PURCHASE TICKETS OUTSIDE CAFETERIAS: APRIL 12-20

ADMISSION: $7.00 DONATION IN ADVANCE
$9.00 DONATION AT THE DOOR

DUKE MED DUKE

T-SHIRTS

ON SALE NOW FOR THE 1990
STUDENT-FACULTY SHOW
in CTL and the MED CNTR BOOKSTORE
$8.00 (XXL $9.00)

April Calendar

Films

Freewater Films - 7 & 9:30pm, Bryan Ctr. Free with ID

Apr 3 Woyzeck
5 On the Waterfront
6 The Adventures of Baron Munchausen
10 Das Boot
12 The Last Tango in Paris
13 Breaking In
Escape from New York (12pm)
17 Tin Drum
19 The Godfather
20 21st Tournee of Animation (also at 12pm)
24 Men...

Quad Flix - 7 & 9:30pm, Bryan Center, $3

7,8 The Abyss
14,15 Say Anything
21,22 Look Who's Talking

Duke U. Museum of Art Series, 7:30pm

4 Let the Good Times Roll (98 mins)
25 short films (100 mins total): Give My Poor Heart Ease, Mississippi Delta Bluesman, St. Louis Blues, Dizzy, Boogie Woogie Dream, Rhapsody in Black and Blue, Black and Tan, Josephine at the Foiles Bergeres, Symphony Black.

Art

now till May 20 The Blues Aesthetic: Black Culture and Modernism, Duke U. Museum of Art
now till Apr 11 Margeret Boozer, Perkins Library
now till Apr 15 Mark Eslick, photos, East Campus Library Gallery
now till May 14 Masterworks touring exhibit to benefit Amnesty International, Bryan Center
Apr 12-May 2 Laura Paresky, Perkins Library
Apr 16-June 4 Joyce Blunk, East Campus Library

• Mars Display Case, Duke North

now till Apr 16 paintings by Sarah Kimborough
Apr 16-23 paintings by Jerry Prettyman

• Duke South Lobby Display Case

Apr 2-16 paintings by Jerry Prettyman
Apr 16-30 Duke's own Clinician Research Nurses Exhibition

• Rauch Display Case, Morris Bldg.

now till Apr 9 Ceramic by Mary Wade, Neonatology
Apr 9-Apr 30 photos by students of Duke Artist-in-Residence William Noland

Theater

Apr 13-21 Hoof 'n' Horn: "Damn Yankees," 8pm, Reynolds Theater, Bryan Center, $6

Music

Apr 4 Duke Artists Series: Julian Bream, guitarist and lutenist, 8pm Page Aud., $20/17/14
7 Doran Wind Quintet 8pm Reynolds Theater,$8
8 Duke Chorale, Spring Concert, 4pm Baldwin
11 Blues, Boogie, Swing and Jazz, featuring Robbie Linx, Steve Wing, Brother Yusef Salim, Ray Codrington, John Hanks, 7:30pm Duke Museum of Art
18 Jazz: the Mainstream with a Touch of Blues, featuring Ed Paolantonio, Scott Sawyer, David Via, Charles Dungey, and Carter Minor, 7:30pm Duke U. Museum of Art
20 Duke Symphony Orchestra concert, 8pm Baldwin Aud., free
21 Ciompi Quartet playing Beethoven quartets, 8pm Nelson Music Room, East Duke Bldg., free
22 Duke Wind Symphony Garden Concert, 3:30pm Duke Gardens (rain site: Baldwin Aud.)

IM Sports

Apr 11 Captain Choice Golf Tournament (mens/womens/co-rec); sign up 4/2-4/6

Special Events

Apr 6 SPRINGFEST on West Campus. Crafts Fair: 10-6 Duke Quadrangle, Concert: 7pm Clocktower Quad (rain site: Page Aud.), opening band "Half of Freaks," main band "The Connells"
Apr 29 Davison Club Tennis Tournament, 11am West Campus tennis courts. Call 684-6754

Clubs Med

Debbie Shih

Alpha Omega Alpha (AOA)

The 21st annual AOA Symposium was held on March 29 in the Searle Center. The symposium gives MSIII and MSIV's a chance to present their research in poster or presentation form. Ten abstracts were chosen for platform presentation. The presenters were Mary Amato, Todd Barry, Tedra Anderson-Brown, Adrian Cotterell, Martha Ehrmann, Floyd Fortuin, Amit Gupta, Holly Hedrick, Catherine Walsh, and Eric Weidman. Approximately 50 posters were presented. Awards were given for the top three platform presentations and for the top five posters. The awards went to:

Platform presentation:	Tedra Anderson-Brown
	Floyd Fortuin
	Catherine Walsh
Poster presentation:	Rowena Dolor
	Holly Hedrick
	Chang Lim
	John Stahl
	Stephanie Young

Congratulations to the award winners! Thanks to all for participating. As one non-award winning MSIII put it, "It's like the Special Olympics...we're all winners.

AMSA

"Meet the Resident" program begins in April. This weekly noon program enables students to meet residents in designated specialties in room 1102 Duke North. Bring your lunch! All are encouraged to attend! Specialities for the meetings will be announced. Thanks to everyone who attended the AMSA National Convention in Wash D.C! A good time was had by all!

SNMA

The Student National Medical Association (SNMA) and the Duke University Cultural Services Program are pleased to announce the 1990 Duke SNMA Artist, Jerry Prettyman. Mr. Jerry Prettyman is from Baltimore, MD where he studied Fine Art at Morgan State College. Mr. Prettyman is employed as a visual information specialist for the Department of Health and Human Services and also works as a freelance designer and illustrator. He has made guest appearances on radio programs and cable channels and has been honored as a guest juror for the Maryland State Arts Council in the Gifted and Talented Program of Maryland. Mr. Prettyman's works have been exhibited at various museums and galleries throughout Washington, D.C., Baltimore, and Philadelphia. His works will be on display in the Duke South lobby display case until April 16 and in the Duke North Mars Display Case from April 16 to April 23. Please take advantage of this rare opportunity!

Student Faculty Show

The Student Faculty Show will be April 21 in Cameron Indoor Stadium. The show is a musical comedy, and we think this is the best show ever! We are well into production but still need help in many areas. WE NEED MUSICIANS, ushers, set builders and painters, and help selling tickets and t-shirts. Contact Joe Micca (682-5151) if you are interested in being in the pit orchestra or helping with the set. We will be setting up the stage on 4/16 at 10am and 4/19 at 8am. Anyone who can come at any time during that day will be welcomed! Ushers get in free to the show and are responsible for pouring drinks and showing people to their seats. If you are interested in being an usher please call Debbie Shih (383-2016). Tickets for the show go on sale April 12-20 outside of the cafeterias in North and South. We will be selling t-shirts and tickets to the BBQ Buffet. If you can help please contact Ann Sharpe or Rowena Dolor.

Pplease mark your calendar for the show and support your fellow students by buying a DUKE MED DUKE t-shirt. The design has elicited many questions. In the Northeast, many colleges have adopted this design using the institution name twice to emphasize it and the activity name in the middle. We think this is a very appealing design and the t-shirts are top quality Beefy-T's. You can buy one for $8.00 in CTL, Linda Chamber's office, or the Duke Med Bookstore before April 12. From April 12-20 you can purchase your t-shirts at the ticket sale tables. Tickets to the show are $7.00 in advance and $9.00 at the door. The doors open at 6:30 p.m. Bring your own picnic or buy a barbecue buffet ticket ($7.00) and enjoy our free beer and soda. The show starts at 8:00 p.m. Don't miss it!!!!!!

2nd Annual BP Drive

There will be a Blood Pressure Drive at Northgate Mall on April 14 from noon to 6pm. The drive raises funds for the Student-Faculty Show and service projects (Rural Health Coalition and Children's Miracle Network Telethon). Blood pressures will be taken and information about hypertension will be distributed free-of-charge to the public. Companies around the Triangle are sponsoring the event. If you'd like to donate an hour or two of your time, contact Leslie Rokoske, 684-5672 (day) or 683-8580 (leave a message).

4th Year Elective Survey

Melissa Corcoran

The following is an uncensored summary of the 4th year class survey on elective clinical course selection. Students were asked to list the courses that they would and would not recommend and why. In presenting these comments, a third category was created for courses where the opinion varied. Students were also asked if they had any advice to pass along to rising 4th years. The response was terrific! Thanks to all participants.

Courses recommended:

Anesthesiology (ANE240c): "good review of physiology and pharmacology...learn to manage airways and put in lines... good teaching"

Coagulation (MED275c): "terrific attendings... an outstanding chance to learn/review a misunderstood area of medicine"

Dermatology (MED250c): "useful... great resident teachers... excellent teaching... student involvement in consults, clinics, and conferences... best to take with the basic course in dermatology (Jan or Feb) for ideal teaching/learning experience... fun!"

Family Medicine Outpatient (CFM259c): "at FMC-DCGH... the only genuine exposure to outpatient care in an otherwise tertiary schedule... an excellent motivational rotation"

Gyn Outpatient Clinics (OBG245c/249c): "lots of hands on experience and responsibility for those interested in gynecology"

Infectious Disease (MED280c): "good for people not going into medicine... everyone uses antibiotics... learn when it is appropriate to use big gun antibiotics versus little guns (shot gun approach discouraged)... plate rounds provide a good clinically based approach to the microbiology lab"

Medical Ophthalmology (OPH210c): " well taught... excellent slide presentations... only 2 hrs per week"

Medicine ER (MED220c): "good lectures/teaching...a great variety (high volume) of illnesses seen... learn to recognize sick versus not so sick... hone clinical skills... learn to work quickly... autonomy/independent work-ups... develop algorithms for management of simple problems"

Medicine Sub-Intern (MED211c): "a must... an essential for internship... teaches patient management... take on more responsibility... be your own doctor... lots of fun!"

MICU (Med223/224c): "good unit experience... learn about ventilators... lots of procedures/central lines... patient care at a different level than the wards... DUMC busier/better than VA"

Orthopaedic Surgery (SUR): "see a lot of different operations and gain practical experience in clinic"

Pediatric Health Dept (PED210c): "a chance to see what normal healthy kids look like... lots of well child care"

Pediatric Hemc-Onc (PED217c): "an excellent rotation... see how decisions about patient care and management are really made... one-on-one teaching with the fellow and attending... interpret peripheral blood smears and bone marrows... learn how to care for the whole family, not just the child"

Pediatric ID (PED211c): "good faculty"

Pediatric Radiology (RAD210c): "good teaching"

Pediatric Surgery (SUR276c): "excellent... work up patients in the inpatient and outpatient setting... scheduled surgeries on Tues and Thurs plus all emergency cases... see the super rare and interesting cases in Dr Filston's SPDC on Mondays and the bread and butter (common problem) cases on Wednesdays... experience in the PICU and on the floor... Filston is an excellent teacher... good if going into pediatrics or general surgery"

Pulmonary (MED230c): "good general medicine"

Radiation Oncology (RAD215c): "an excellent opportunity to see a lot of physical findings... initial evaluation, treatment planning and follow-up encouraged... participation in multi-disciplinary tumor board... a super rotation for those interested in medical, pediatric, surgical, or radiation oncology, excellent teaching by all attendings, especially Dr. Halperin"

Surgery Advanced Clerkship (SUR299c): "Dr Ross Ungerleider is a fantastic surgeon and great guy who treats students well... pediatric heart surgery is interesting"

Courses where the opinion varied:

Cardiology (MED240c): "learn to read EKGs, treat acute MI and atrial fib/flutter... become proficient at the cardiac physical exam... become familiar with cardiac meds... No reason to do 2 months of cardiology... MICU is much better than CCU"

Metabolism & Endocrinology (MED290c): "excellent practice in diabetes management... a chance to see diseases you learned about in physiology but forgot... Too much busy work with tedious consults and little variety (almost all diabetes)"

Geriatrics (MED400c): "a wonderful rotation with wonderful faculty and staff... A slow rotation unless you make it otherwise"

Neuropsychiatry Consult (PSC260c): "an excellent learning opportunity, but the 8 wks/4 credits/halftime schedule is a problem"
Clinical Otolaryngology (SUR239c): "good introduction to problems seen commonly in primary care... Poor teaching... very unorganized... residents seem like they'd rather not have us (students) there"
Radiology (RAD229c): "great teaching... everyone needs to interpret a CXR and know the basics... well organized... easy in terms of hours... Absolutely no involvement in patient care or decision making"
Rheumatology (MED320c): "outstanding staff... superb teaching... interesting patient problems... The consult service and clinic are too slow"

Courses not recommended:

Gastroenterology (MED260c): "colossal indifference to student teaching"
Orthopaedics Clinic (SUR): "a blow off, completely"

Advice about residency:

"Think hard about residency... talk to many people... force yourself to consider all options."

Advice about electives:

"Take difficult electives first so you can enjoy your spring. Take a variety of electives, preferably ones other than those related to your future specialty... you'll be doing your specialty for the rest of your life and may not have another chance to do these electives."
"Take rotations for possible specialties early if you're undecided...you may find you can't stand the field... and changing applications at the last minute is horrible."
"Take rotations you might not get to do again, but think you're interested"
"Take some challenging and some easy rotations"
"Try rotations 'away' at the outside hospitals you are considering for residency training"
"Investigate an elective thoroughly before taking it. There is power in numbers. Generally the most crowded with students are the best ones."
"Any elective is good if you work with the right people and any elective can be hell if you aren't working with good people... Good luck!"
"In general, consult services are variable. If you do one, make sure it's something you are interested in because you have to do reading on your own if you really want to learn. Better to pick ones that have some organized lectures on basic topics incorporated in the rotation (i.e., ID- good, Endocrine- ok, Dermatology- ok). Slow and minimally didactic consult services may be low yield learning."
"Depending on the class registering, certain electives are hard to get (i.e., radiology, MICU). Sign up for courses early to get what you want...If you don't get what you want the first time, you might get it the second time. December is a good month to get electives because most people are away interviewing."
"Take a month off... if you have lots of interviews, December or January is good... April is nice too"
"Take courses like Clinical Nutrition, ethical issues in medicine, medical ophthalmology during 3rd year. These classroom courses meet 1 or 2 times a week for 2 months and are very difficult to schedule and attend during tough 4th year rotations."
"Take at least one MICU or Sub I, but have fun too... there's no need to go through a punishing pre-internship first... internship comes soon enough"
"Have fun! Take some time off to travel and relax... This will be your last opportunity for awhile."

1990 Match Results

• Specialties:

TOTAL	92	family medicine	4
internal medicine	22	anesthesiology	3
radiology	14	med/peds	3
surgery	8	OB/GYN	3
int medicine, pre	7	psychiatry	2
pediatrics	7	urology	2
orthopedics	6	ER medicine	1
ophthalmology	5	pathology	1
otolaryngology	4	plastic surgery	1

• Of the 86 matching through NRMP,

60	received 1st choice
14	received 2nd choice
6	received 3rd choice
4	received 4th choice
1	received 5th choice

• Hospitals/Programs (2 or more only):

17	DUMC
8	NC Memorial
5	Barnes Memorial
4	UCSF, U. Michigan, U. Washington, Vanderbilt
3	Baylor, Jefferson, Hopkins, UCSD, U. Maryland
2	Brigham&Womens, U. Penn, Mass. General, Mercy Catholic, Pacific Presbyterian,

What *is* Public Health?

Steve Gallup

When I applied to the dual degree program in public health, I thought it would be nice to "take a year off" to do graduate work at UNC and still to embellish my name with the initials MPH right next to the suffix-MD. After all, isn't the goal to be the person with the most titles when you die?

Well, I found out that there actually are some *good* reasons to seek a public health degree which just might have been lurking under the rather superficial ones that I used. For one thing, public health professionals try to do what is best for everybody and not what is best for a single patient, or worse yet, what is best for the doctor. Now this might sound like an easy thing to do; but it is hard to give up the hooplah of examining the zebreas of medicine and the patient rapport, for the impartial world of biostatistics and epidemiology.

Fortunately, there is great consolation in the feeling that statistics ultimately represent a tool for learning the truth (rather than speculation or ideology) about a disease or a population; and in reality, workers in public health never stray far from a personal involvement with medical care, usually with patients who will benefit the most from their efforts.

Public Health advocates also try to prevent disease and suffering rather than trying to cure or even treat it. Truly a novel idea! What is even stranger — they often try to promote health! Now this is really bizarre. I found it a loathsome task to represent the opinions of the medical community in many instances because the conventional idea is that doctors will step bravely in when something is worng and glamourously intervene. Isn't it scary to think that the greatest strides in decreasing mortality and morbidity have come through imporved sanitation, nutrition, prevention of infectious diseases, and similar public health efforts. Can you imagine the extent of illness that would be curtailed if we did away with cigarette smoking alone?

There are many issues of health to be explored in the programs of Epidemiology and Maternal & Child Health at UNC. Students at Duke may apply to UNC and get an MPH in one year while receiving credit for half a year in third year research.

It is well worth the extra semester, especially if you wonder if there is more to medicine than what you learn in medical school. You will learn a lot about policies and planning of services, and you will have the opportunity to do field work in almost any public health service setting, policy making venue, or research site. For example, I will be going to a preventive intervention services clinic in Tempe, Arizona, to look at creisis intervention projects being developed for children of divorced, alcoholic, and bereaved families.

There are many other good reasons to suffer through a year at Carolina that I will leave to your imagination, but if anyone would like more info, feel free to call.

Word of Mouth

April 5, 6-7:30pm, CTL

The 2nd annual Word of Mouth meeting offers 3rd years and opportunity to ask 4th years questions about the match, interviewing, specific programs, etc. 4th year students wishing to participate should contact Jim Bass.

Dear MS3

Eric Bachman

Dear MSIII,

Do I have reasonable cause for angst if I don't achieve honors during first year?

- Struggling in Mediocrity

Dear Med,

No.

Dear MSIII,

This letter actually emanates from a fourth year student who wants to make sure that I've completed my medical education at Duke, both academically and socially. Can you offer any milestones, events or sites of interest that I should not miss during my tenure here? I'm not likely to return.

- Culture Shock Convalescent

Dear Shock,

Regardless of your place of origin, there are certainly many novelties of a Duke Med experience. This is an excerpt from an article soon to appear in "M" which encapsulates an ideal medical career.

Four years on Duke's campus and three Final Fours demand that you have attended more than one basketball game while here. This sport is for the young and old alike, and missing the artistry of Coach K is an egregious vacancy in one's list of accomplishments. Also, most of you should have at least tried the sport, so as to gain a better appreciation for big-time college ball.

Dining in the Durham area has its limits, but here are the must eat-ats. Bullock's or Porky's Palace, either for sit-down or at a pig pickin', defines the cuisine we have come to expect of the antebellum South. One should have eaten three squares in one day at the hospital vending machines, including the sandwiches with the infinite shelf life. Satisfaction offers more than a large screen TV and dollar long necks. To have sampled the famous "Sats" pizza and cardiac home fries is a must. In addition, at least one of their specialty drinks, like the "screaming orgasm," should be on your resume. For ethnic variety, one in the scores of Chinese restaurant clones should be sampled, or at least delivered. You should have ordered one Domino's to the hospital at some time. If you have not met these gourmet standards, I have but one redeeming dinner site to amend your absence at the rest, lest you wallow in contrition - the Cricket Inn cafe. I needn't expand on that thought.

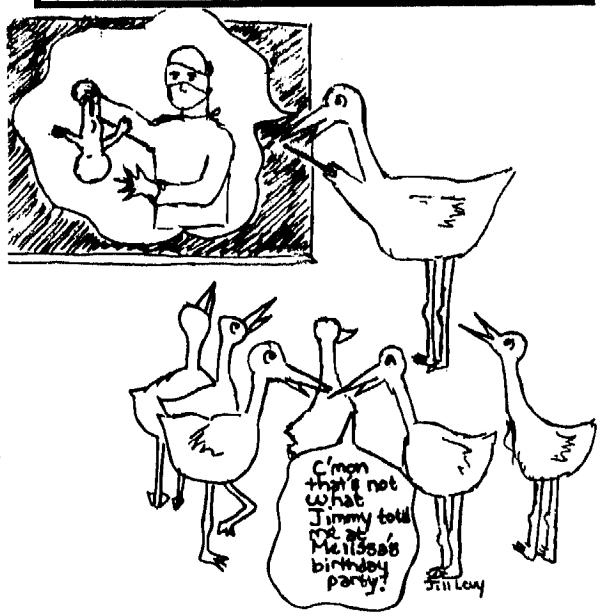
In line with sporting events, you should have attended a Bull's game, watched at least a whole afternoon of ACC basketball, seen a soccer game and wished physical harm to either Chris Corciani or King Rice. My apologies to the Heels among you, but your sentiments probably echo ours. Missing any Duke basketball game is a personal contretemps.

Other milestones include: having read the Campus Heartbeat section of the Duke Dialogue in its entirety, eaten a pimento cheese sandwich at the deli, or any of the VA's cafeteria comestibles, used at least one personal hygiene article from the wards while on call, cursed the Neanderthal street layout for the City of Durham and eaten a full breakfast from the samplings at the candy room.

If you have not fulfilled these standard tasks, then you certainly are not game for the Herculean labors that some students have undertaken to really assimilate into our environment. These include buying a house here, patronizing Your Place or Mine regularly, having a VIP sticker for Bojangles drive-thru and saying "you'all" in distinctly Yankee company. For those who have completed the checklist, my hat goes off to you. For those who have not, see you at the Hofbrau.

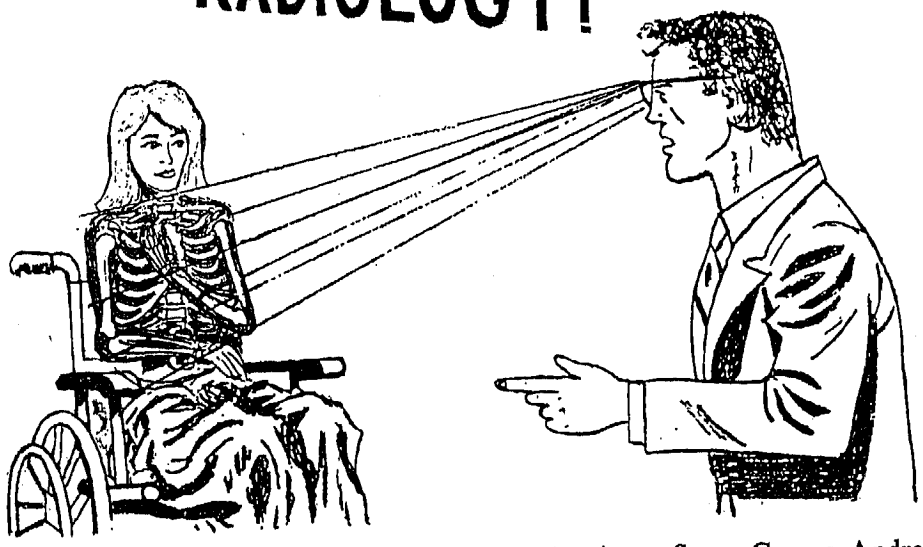
DSMLA dinner

All are invited to have free pizza and get involved in the Duke Society for Medical and Legal Affairs on April 11 at 7pm, apt. 20J Chapel Towers. Please RSVP 383-6955.



CLARK KENT, M.D.... PROFESSOR EMERITUS OF

RADIOLOGY!



by John Armitage, Susan Graves, Andrew Baxter

Dulling Shiftiness

Kenny Boockvar

Shifting Dullness learned in March that it does not lay sole claim to its name. This unfortunate circumstance was discovered when one of the editors received a call from the agent of an Australian rock band which apparently has been going by the name "Shifting Dullness" for over two years now. The agent complained that the band's association with the Duke medical student newspaper was compromising its reputation. The band is known for its thudding bass drum, monosyllabic lyrics, and alternating violent and then near-comatose performances—hence the name "Shifting Dullness."

In a trans-continental interchange, the editors of *Shifting Dullness* got to talk to the lead guitarist of "Shifting Dullness," Dent Billings. Mr. Billings did not known that the band's name is a descriptive term used in medicine, and despite our attempt to prove its medical meaning to him, his tolerance for the idea eroded fast during the conversation. He began to sputter that he might have to hurt us, sue us, or shut down the paper when his agent got back on the phone.

After such an insult, *Shifting Dullness* was in no mood to negotiate—nor did we have to. The editors informed the Australian agent that medicine had used the term "shifting dullness" for over a century, and that Duke's medical student newspaper had used the name for several decades now. This editor added wryly that the medical profession's reputation was suffering no small degree from its association with the band, and that if the band wanted to contnue using a name with medical import perhaps it should call itself "Hemoptysis."

Following this comment, the conversation ended, and *Shifting Dullness* has not heard anything from them since. However, it was recently brought to the editors' attention that there is a hit song rising on the Australian charts called "Obtunded and Out of Control."