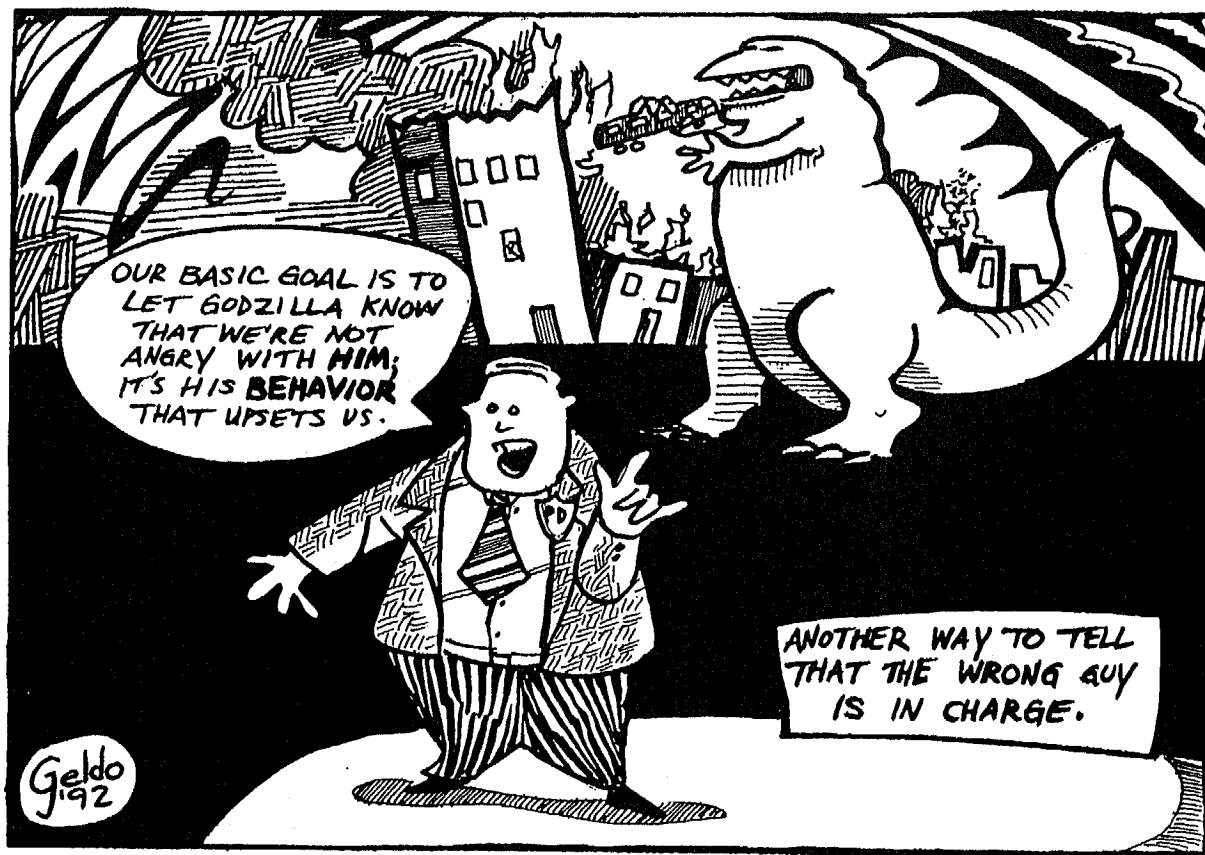


Shifting Dullness

July, 1994



Inside this issue:

- Interview with Dr. Sabiston
- A look at the Board Exams
- Humor by Roadside Assistance
- Inaugural Wine Column by Greg Della Rocca

Crystal Ball

Crystal Bernstein

As Duke medical students, we have some unusual privileges (or disadvantages, depending on how you look at it). We get to finish our basic science classes in one year. We get to start working on the wards a year sooner than our cohorts at other medical schools. We get to spend a year (or more) in a lab of our choosing pushing back the frontiers of science, or in public policy school tackling the country's health care issues, or even in business school learning how to wheel and deal with the best of them. We get to eat free candy.

After investing enough money to buy a mid-sized yacht, the least we deserve is a seaworthy lifeboat.

With these privileges, however, come some interesting problems. The problem that looms large in many of our minds is the USMLE, or the national boards. We know there was once a mysterious thing called the FLEX exam that students were allowed to take instead of the boards that, in keeping with our unique curriculum, seemed to allow them more freedom than the national boards in terms of when they had to take it and how they had to prepare for it. We also know that this is no longer an option for us and that we must suffer through parts one and two of the national boards, just like our friends at more traditional medical schools who receive two years of basic science education and are usually granted a fixed amount of time off from school to study for the exams.

While we know that passing the national boards is something we must do at some point, many of us are not certain exactly when and how to go about it. Do we take part one, which tests our understanding of basic sciences, after our first year, when the small amount of basic

science knowledge we have is still fresh in our minds, or do we wait until our third year, when we will at least (so we are told) have enough time to study and learn a few more things to make up for the gaps in our training? And for part two —

Do we take this after our second year, when we have just completed clerkships in every field covered by the exam, or do we wait until our fourth year, when we have had more clinical experience but have not dealt with problems in certain areas of medicine since our second-year clerkships? The dilemma is enough to give any frustrated medical student a headache. And the contradicting advice we are given does nothing but confuse us further. Some sage upperclassmen advise us it is best to take part two of the boards early to prevent the shock of failing it during our fourth year and being forced to retake the test during our intern year. Others tell us to wait until we know more and we'll perform better on the test. And no one really seems to know when is the best time to face the nightmare of boards part one.

As Duke students, we are expected to be intelligent enough to catch up on the basic science facts we missed or were taught too quickly to digest sometime before we take the boards part one. However, most of us could probably use some help in this endeavor. Which is why we are asking faculty to give us general basic science lectures to gear us up for the USMLE during our research year. The lectures will not only help us to prepare for the boards: they will also add some structure to our approach to the exam and reassure us that the faculty is not giving us a bon voyage party to set sail on the turbulent, shark-infested waters of the medical licensing exam armed with the intellectual equivalent of a styrofoam kickboard. After investing enough money to buy a mid-sized yacht, the least we deserve is a seaworthy lifeboat. ■



Quest for a Basic Science Review Course Matt Hepburn

The unique curriculum of our medical school allows us to engage in an in-depth research project in our third year. Any additional basic science education we acquire is by self-motivated studying. The USMLE board exams usually provide adequate incentive. However, an idea has recently surfaced among the current MS II's to organize a basic science review course in order to supplement our understanding of the courses of first year as well as provide some lecture and teaching time towards studying for the board exam. In prior years, upperclassmen have attended a Pathophysiology class during one weekday evening throughout their third year. However, due to lack of student participation, the course was canceled. Our current idea is to schedule approximately 20-25 sessions beginning in October or November of third year. These sessions would normally be 90 minutes in duration and would involve a discussion of a relevant basic science topic by a faculty member.

As this course lingers in its developmental

stages, student input is needed to decide which topics should be discussed and what professors should teach them. The administration is willing to coordinate and schedule these lectures if the students indicate their preferences. Therefore, we are asking current MS II's to generate some suggestions for subjects and faculty members and contact Steve Crowley (383-1047), Matt Hepburn (490-5706) or Russell Rothman. If you are interested in participating in organizing the course throughout the year, let us know. With solid student participation, this course could strengthen our basic science foundation and facilitate our successful mastery of Part I of the boards.

The Editors of Shifting Dullness would like to apologize to The Davison Council and Michael DiCuccio for our misrepresentation of their names..

Shifting STAFF Dullness

EDITORS

Matt Hepburn
Ed Norris
Jamy Ard

WRITERS

Crystal Bernstein
Vickie Ingledue
Steve Crowley
Julie Lapp
Corinne Linardic
Steve Kent

Michael DiCuccio
Edward Norris
Greg Della Rocca
Matt Hepburn
Umeshe Marathe
The medical politician

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Any and all submissions are welcome and need only be placed in the "Shifting Dullness Box" located underneath the candy shelf in the Deans' Office. Please submit your material on a 3.5 disk utilizing Microsoft word for Macintosh. Word Perfect programs on IBM software are also acceptable.

Cover by Dave McCarty

Crushed Grapes

It appears to have become less avant-garde of late for the "younger population" of this country to try obscure beers and wines from around the globe. For many of us, this would seem to result in bank accounts that are much less extensive than we would like. Then, there are those of us who are perfectly content to enjoy a 12-pack of Olympia beer ("It's the water" - you know who you are). Of course, there is no reason to spend \$130.00 for a bottle of 1989 Chateau Margaux or \$6.50 for a six-pack of Pete's Wicked Ale if you aren't going to like it, right? The bottom line is that one should drink what one chooses and enjoys. With that said, let's get to the wine for this installment.

Port is an interesting class of wines in that many non-wine drinkers will thoroughly enjoy a good hearty glass of port after most dinners. Also, many wine drinkers simply despise port. When one thinks of most ports, two subsets likely come to mind. First, there is the exorbitantly expensive vintage port (stay away from the years 1963, 1977, and 1985 if you are looking to save a couple or few hundred bucks), which is well beyond the means of most. Second, there is the absurdly cheap, poor quality port that most of us would only drink if paid to do so. Fortunately, there are quite a number of less well-known ports that are relatively inexpensive and yet are of repeatedly good quality. These are the "vintage character" ports, and a port called "Warrior" by Warre's and Co. is a prime example.

Ports are wines fortified with brandy to bring the alcohol content up to 20% (40-proof) on average. They are generally aged for two to three years in oak casks before bottling. Of course, there are other subtleties that distinguish one port from another. While a Taylor's 1977 vintage ("vintages" are only declared in exceptional years) is the product of considerable care during the manufacturing process, most of us are unable to afford this wine. Many port vintners

realize that the vast majority of the world's port-drinking population cannot afford a true vintage port. They also realize that many consumers do not want to wait for the twenty years that some vintage ports require for aging before they can drink what they have purchased (i.e. don't plan any romantic dinners that you would like to finish by swilling some 1985 port unless said dinner will not take place until well beyond the year 2000...). So, they have taken various batches of their port varieties and blended them together to produce a good, young port with polished edges. These are the vintage character ports, and they require no aging. In addition, they only cost between ten and twenty-five dollars a bottle.

Along with Warre's Warrior, Fonseca's Bin No. 27 is another vintage character port. Bin 27 is quite enjoyable, but it can be a little rough and hot on the way down. This is the characteristic of a "young" port, although aging will not help with any vintage character port. Warre's Warrior is smoother and lighter-bodied. It has recently received an 80 on a scale of one to 100 (decent for a wine not striving for perfection, as does Chateau Petrus, for example), compliments of the Wine Spectator. The Warrior is easily available in this country (it can be found at Fowler's and Southern Season) and is relatively inexpensive. It does not need to be decanted (after pre-bottling filtration and spending 4-5 years in casks, as opposed to two years and zero filtration for vintage port, which always requires decanting), and can be held after opening should you not be able to finish an entire bottle at one sitting (the cork can be easily replaced - it is manufactured for just that purpose). The Warrior has a sweet and fruity taste, and approximates very nicely the character of a well-aged vintage port, although it has a lighter body. There are few tannins, which are those natural chemicals that cause your mouth to dry out after drinking an excellent red wine or a good



Crushed Grapes continued

cup of tea. If one concentrates on the flavors and aromas, one shouldn't be surprised to find hints of chocolate and raspberry (which, by the way, are not added during the manufacturing process).

Port is traditionally served after dinner, and compliments cheese (roquefort or cheshire in particular) very well. If you would like to serve the Warrior with dessert, you should probably refrain from serving it with an extremely rich and/or sweet dish, as the dish will likely overpower the wine. The Warrior can stand on its own as well, and is drinkable at any time (during Davison Council parties, for example). The Warrior is a prime example of careful and skillful port manufacturing, and is enjoyed by many

throughout this country each day. Port drinkers will find it refreshing and elegant, as will those unaccustomed to drinking port. However, purchase of a pipe (700 bottles) of Warre's Warrior for your children when they are born is not a good idea as it will not age the traditional 21 years (it is a tradition among the English nobility to buy a pipe of vintage port for each child when he/she is born and hold it until the child is 21). If you are rich enough, forget this column and consider 700 bottles of 1985 Dow's... Otherwise, Warre's warrior may prove to be a pleasant surprise.

I have received only a handful of lucrative endorsements for writing this column... ■

Summer Activities, and most are FREE

Matt Hepburn

Carillon Demonstration - J. Samuel Hammond, carillonneur, Summer Festival of the Arts, Wednesday, July 20 at 7 pm, Duke Chapel. **FREE!**

African American Dance Ensemble - An informal participatory lecture demonstration. Summer Festival of the Arts, Sunday, July 10 at 6 pm at the Sarah P. Duke Gardens, parking lot on Anderson Street. Inclement weather site: East Campus gym. **FREE!**

The Tarwater Band - Flying Fish Records recording artists perform American folk and original tunes. Summer Festival of the Arts, Sunday, July 17 at 6 pm, Sarah P. Duke Gardens, Inclement weather site: Griffith Film Theater, Bryan Center, West Campus. **FREE!**

Triangle Brass Band - Strike up the band! Back by popular demand for two summer concerts. Summer Festival of the Arts, Sunday, July 24 at 6 pm and Sunday, August 7 at 6 pm, Sarah P. Duke Gardens, Inclement weather site: Griffith

Film Theater, Bryan Center, West Campus. **FREE!**

Fourth Annual OLD TYME SING-ALONG - Malarne Chamber Players with Ellen Williams, mezzo-soprano and pianist Susan Hoskins. Summer Festival of the Arts, Sunday, July 31 at 6 pm, Sarah P. Duke Gardens. Inclement weather site: Griffith Film Theater, Bryan Center, West Campus. **FREE!**

FIREWORKS - Holiday Fireworks at Wallace Wade Stadium, 6-11 pm.

Freewater Films: every Thursday at 8 pm Griffith film Theater, Bryan Center, **FREE!**

July 7: Coming Home

July 14: Labyrinth

July 21: The Paper Chase

July 28: American Graffiti

JOURNAL WATCH

Steve Kent & Umeshe Marathe

The return of Phineas Gage: Clues about the brain from the skull of a famous patient.

Damasio et al. Science 1994;264:1102-1105.

The story of Phineas Gage goes back to 13 September 1848, when this 25-year construction foreman had a 3-cm thick, 109-cm long tamping iron blast through his face, skull, brain and then into the sky. He was only stunned and immediately regained full consciousness, walking away from the accident. But this was not what makes the story so fascinating; it is Gage's profound change in behavior that piques our interest. Prior to the accident he had been responsible, intelligent, and well-liked by his peers and elders, but after he became irresponsible, disrespectful of social conventions, and took to a life of wandering. Other than his personality changes he had no reported cognitive, motor, or speech deficits. He died in 1861 without an autopsy. His skull was exhumed 5 years after his death and now along with the tamping iron is part of the Warren Anatomical Medical Museum at Harvard University.

The case was presumed to have involved the left frontal region, but some questions were raised as to the exact placement of the lesion. Measurements from Gage's skull and modern neuroimaging techniques were used to recreate the accident and determine the probable location of the lesion. The damage involved the left and right prefrontal cortices in a pattern that causes a defect in rational decision making and the processing of emotion.

Effects of tamoxifen on uterus and ovaries of postmenopausal women in a randomized breast cancer prevention trial.

Kedar et al. The Lancet 1994;343:1318-1321.

Tamoxifen is a beneficial treatment for metastatic breast cancer; in addition, it may be effective in preventing breast cancer in high-risk women. Unfortunately, several studies suggest that tamoxifen may increase the inci-

dence of uterine cancer. Transvaginal ultrasound and endometrial biopsy were performed on healthy postmenopausal women taking tamoxifen in a breast cancer prevention study. These women had been using 20 mg/d of tamoxifen for a median of two years (range zero months-six years). Women taking tamoxifen (n=61) in comparison to placebo (n=50) had a much higher incidence of endometrial abnormalities by biopsy (39% vs. 10%). The majority of these abnormalities were atypical hyperplasia with no cases of overt malignancy. Tamoxifen also increased mean uterine size. These findings support a potential link between tamoxifen and uterine cancer.

Antibodies to glutamic acid decarboxylase as predictors of insulin-dependent diabetes mellitus before clinical onset of disease

Tuomilehto et al. The Lancet 1994;343:1383-1385.

Autoantibodies can be found in patients with insulin dependent diabetes mellitus (IDDM). In particular, anti-glutamic acid dehydrogenase (anti-GAD) antibodies are found in approximately 75% of patients with IDDM. This study was designed to determine if anti-GAD can be used to predict which patients will develop IDDM. All pregnant women in Finland have serum samples that are saved by the Public Health Institute; these samples were tested for anti-GAD in 151 women who developed diabetes as many as ten years later. Of these diabetic women, only 28 had IDDM (the remainder had gestational diabetes or NIDDM). 23 of the 28 IDDM patients were positive for anti-GAD. Thus, the sensitivity of the anti-GAD assay in predicting the development of IDDM was 82% and the specificity (nondiabetic controls, n=100) was 100%.

Linkage of the angiotensinogen gene to essential hypertension.

Caulfield et al. NEJM 1994;330:1629-1633.

Researchers at St. Bartholomew's Hospital (London) looked for linkage between the angio-

tensinogen gene and essential hypertension in the affected members of 63 white families. They determined the genotype of each person for a particular marker (the 3' GT repeat) that flanks the angiotensinogen gene. Using linkage analysis, they discovered that affected relatives shared alleles of this marker more often than would be expected by chance ($p < 0.001$). After comparing allele frequency with a control population, the angiotensinogen marker was found to be significantly associated with essential hypertension. They conclude that mutations in the angiotensinogen gene may contribute to the development of essential hypertension.

Recombinant human Interleukin 1 receptor antagonist in the treatment of patients with sepsis syndrome: Results from a randomized, double-blind, placebo-controlled trial

Fischer et. al. JAMA 1994; 271(23):1836-1843.

Septic shock is the 13th most common cause of death in the United States and is a frequent cause of death in the intensive care unit. The presence of bacteremia and endotoxemia elicit the production of endogenous mediators that cause an inflammatory response. TNF alpha and IL-1 beta either alone or in combination have been shown to reproduce many of the physiologic and laboratory changes seen in patients with sepsis syndrome and septic shock. IL-1 receptor antagonist (IL-1ra) is a naturally occurring human protein produced by macrophages that prevents IL-1 mediated cellular responses by competitively and reversibly occupying receptors. In a recent randomized, open label, placebo controlled study, IL-1ra was shown to reduce mortality in a dose dependent manner in patients with sepsis syndrome and septic shock.

The total patient population was 893 with sepsis syndrome who received either a IV loading dose of IL-1ra, 100mg or placebo followed by a continuous 72-hour IV infusion of IL-1ra (1.0-2.0mg/kg/hr) or placebo. Among all patients there was not a statistically significant increase in survival time for IL-1ra treatment vs. placebo.

But in a retrospective analysis, treatment with IL-1ra showed a dose dependent increase in survival time among patients with documented infection, ARDS, DIC, renal dysfunction or predicted mortality risk of 24% or greater at study entry.

Incidental cholecystectomy during colorectal surgery

Annals of Surgery 1994; 219(5):467-474.

Asymptomatic cholelithiasis is found commonly in patients having laparotomy for other indications. The risks and benefits of performing a cholecystectomy has been a controversial issue, with many different study approaches reaching contradictory conclusions. The purpose of this study was to assess whether incidental cholecystectomy increased morbidity/mortality and to determine the long-term risk for biliary complications in those individuals who had asymptomatic gallstones but did not have cholecystectomy.

The study group was 305 patients, 185 had incidental cholecystectomy and 110 did not; the groups were similar with regard to age, gender, primary disease and associated medical conditions. The overall operative morbidity rates were the same. After a median follow-up of six years, 16 patients developed biliary pain or cholecystitis, 12 eventually requiring cholecystectomy. The cumulative probability of needing cholecystectomy at two and five years after the initial colorectal operation was 12.1% and 21.6%, respectively. The authors conclude that incidental cholecystectomy did not increase postoperative morbidity and that there was a substantial risk that previously asymptomatic gallstones would become symptomatic.

Interaction of prenylcystine methyl esters with the multidrug resistance transporter.

Zhang et. al. J. Biol. Chem. 1994; 269(23):15973-15976.

P-glycoprotein (P-gp), also known as the multidrug resistance transporter, is commonly overexpressed in tumor cells that have devel-

oped drug resistance to antineoplastic agents. Its role in normal cells is not completely understood.

This paper reports that prenylcysteine methyl esters, representing the C-terminal structures of prenylated proteins (see addendum below), stimulate the activity of these transporters and compete for drug binding. These findings indicate that these molecules are potential physiologic ligands of the transporter. The relatively simple structure of these molecules should facilitate design of compounds that inhibit the P-gp-mediated transport of anti-neoplastic agents.

Addendum- Prenylated proteins are proteins with a cysteine residue at or near their C-terminus that are modified by attachment of either 15-carbon farnesyl or a 20-carbon geranylgeranyl isoprenoids to the cysteine residues.

tery disease. Initial results from the era of coronary angioplasty.

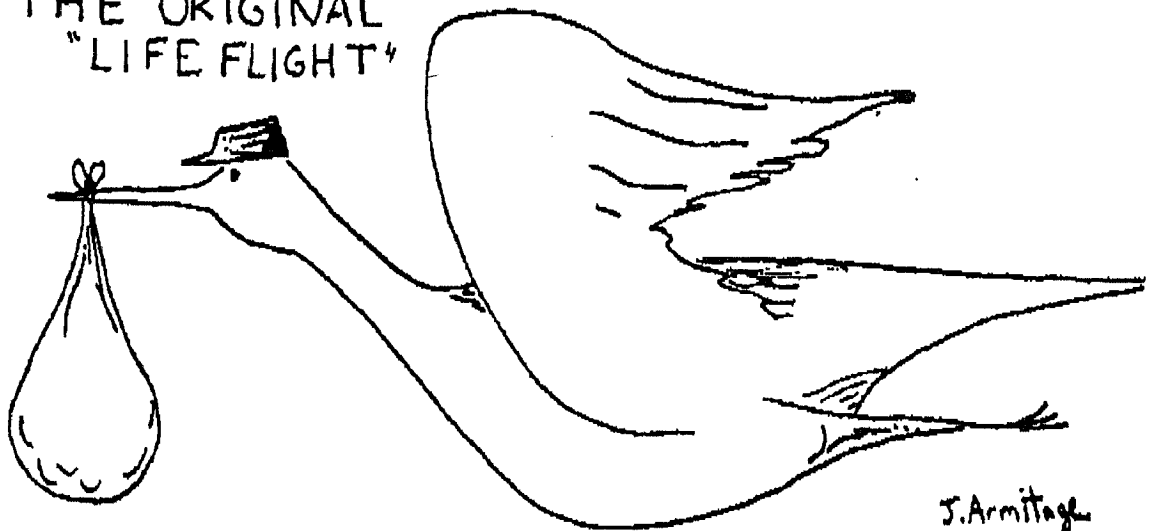
Mark et. al Circulation 1994;89:2015-2025

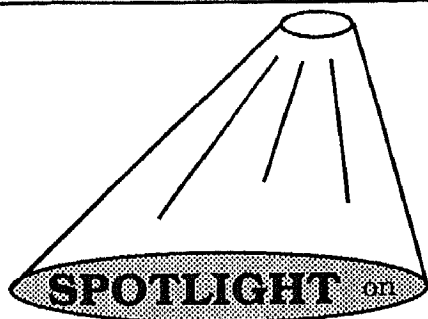
Survival after CABG and medical therapy for CAD has been studied in both randomized trials and observational treatment comparisons. Over the past decade the use of PTCA has increased dramatically, without guidance from either randomized trials or prospective observational comparisons. This is the first large-scale prospective observational treatment comparison of CABG, PTCA, and medical therapy.

Subjects in the study were 9263 patients with symptomatic CAD referred to DUMC for cardiac catheterization. It was confirmed that CABG had a consistent survival advantage over medical therapy for three-vessel disease and severe two-vessel disease. For less severe CAD, there was trend favoring PTCA over medical therapy but this was not statistically significant. ■

Continuing evolution of therapy for coronary ar-

THE ORIGINAL
"LIFE FLIGHT"





Dr. David Sabiston

This is the first interview in a series with Duke Faculty. Shifting Dullness is grateful to Dr. Sabiston for sharing his time with us for this article. While in the interview format, some of the replies have been edited.

Edward Norris

Dr. Sabiston, how was it growing up in Onslow County?

I was born on a farm in Onslow County and quite early learned something of that life, and it has been useful in many ways. It meant much in the early years in teaching me a firm work ethic which I have since reflected upon very favorably.

From Onslow County you went to the University of North Carolina at Chapel Hill; what led you there?

Other members of my family had attended UNC. It was the first of the State Universities having been founded in 1793. It had a good reputation then as it does now.

From there you went to Johns Hopkins?

At that time, Hopkins and Harvard were the two leading medical schools in the country. Wishing to remain in the South, I applied to Hopkins and was surprised to be accepted there.

When did you decide that you wanted to become a surgeon?

While I was a second year medical student,

Dr. Alfred Blalock did his initial "blue-baby operation" on a cyanotic infant with Tetralogy of Fallot. The procedure provided these children a much improved pulmonary blood flow and their cyanosis and exercise intolerance was relieved. Prior to operation most were so seriously compromised by cardiac and pulmonary problems they could scarcely perform any exercise at all, and after the procedure they were essentially normal. It was the first major cardiac surgical procedure to be performed. I spoke with Dr. Blalock about a surgical career, and he advised that I begin working in the experimental laboratory while a student. From that time forward we had a very good relationship, and I admired him greatly as a teacher and as an example. After finishing the Residency Training Program, he appointed me to the faculty.

You did a lot of research as a medical student at Johns Hopkins. How do you think that helped you as a medical student and with the decisions in the rest of your life?

As I reflect on it now, the work in the laboratory was extremely important as it taught me the difficulties of research as well as the challenges and inspirations one receives from doing original work. Of course, at the beginning there were few successes and many failures. It became apparent that perseverance and trying again ultimately leads to success. That was a fundamental point. My first published paper appeared in *Surgery, Gynecology and Obstetrics*, during

Continued on page 10

the week of graduation and from that time forward I spent much time in the laboratory.

Wasn't that paper with Dr. Ravitch concerning the ileo-anal pull-through?

Yes, the study involved a lot of experimental work before performing an ileo-anal anastomosis on the first patient.

Duke is unique with its third year devoted to research. How do you think that it helps the Duke student?

I believe it helps enormously. Medical students at Duke obtain their reputations nationally and internationally to a great extent on their achievements in Year III. The challenges the students face and the opportunities created are extremely important in their subsequent careers. When our students apply for residency training programs, about 70 per cent obtain their first choice. That must be the highest, or very near the highest, of any school in the

Medical students at Duke obtain their reputations nationally and internationally to a great extent on their achievements in Year III.

nation. This aspect is inevitably discussed during the internship interviews, and our students fare extremely well. Moreover, many students have published their work, and this is firm evidence of their productivity. Many will remain in academic medicine, and for those who do not, the experience of working in research makes one an even better clinician.

In properly controlled experimental studies, the student recognizes the difference between the *cause* of a certain response rather than it being an *incidental* one. Repeatedly, I have heard students reflect on their residency inter-

views, and they recognize that work done in the laboratory has meant much in their careers.

I know that you did research with Dr. Gregg at Walter Reed Hospital and with Lord Florey at Oxford, England. Would you care to comment on those experiences?

I was very fortunate to have an opportunity to work with Dr. Donald E. Gregg, since at that time he was known as the world leader in *coronary physiology*. He had the greatest knowledge of anyone about the coronary circulation and its metabolism. He had published the definitive monograph on the subject, and it contained practically all that was known in the field at that time. He was a perfectionist and a very exacting investigator in the laboratory with much attention to detail. Moreover, he insisted upon multiple repetition of experiments to be certain of the facts.

It was a very special occasion when, with Dr. Blalock's assistance, I was awarded a Fulbright Research Scholarship to work at Oxford University. It was a delightful experience for my wife and me and our children to live in England. The facilities at Oxford, and especially the mentors there, were extraordinary. I had the opportunity to work with Lord Florey, the Sir William Dunn Professor of Pathology, who was primarily interested in experimental atherosclerosis. As you know, he had earlier won a Nobel Prize for his work on the discovery and use of penicillin. When I knew him he had given up research on antibiotics and felt that the most important unsolved issue was the pathogenesis of atherosclerosis. He was a great thinker and taught me much about the experimental method and the production of atherosclerosis and healing of blood vessels and prosthetic grafts. I also worked with Professor Philip Allison, the Nuffield Professor of Surgery at Oxford, on experimental and clinical pulmonary embolism and learned much from his vast experience in the field.



Would you like to comment on your work leading up to and your feelings after your first saphenous vein graft bypass operation?

It was a very interesting subject and especially because of its clinical significance. When Dr. Blalock asked me to remain as a member of the faculty it was delightful news as you can imagine. I was extremely happy, but when he said my major assignment was to develop a successful surgical procedure for myocardial revascularization it seemed at the time less attractive since nothing significant had been done in the field and many thought such an operation to be impossible. He knew that I would have preferred another primary assignment but emphasized that in attacking a new problem one begins in the experimental laboratory. It was then that he arranged that I should work with Dr. Gregg. After studies in experimental atherosclerosis and the use of vascular grafts, it became apparent that such grafts to the coronary arteries were successful in experimental animals. Therefore, on April 5, 1962, I did the first patient. A saphenous graft was intentionally taken from the leg and anastomosed from the aorta to the patient's right coronary artery. The cardiologists and cardiac surgeons alike were quite pleased with the procedure. The patient did very well immediately postoperatively, and we were enthusiastic about the operation. However, a fatal cerebral vascular attack occurred which was unfortunate. I did not do another similar procedure until both Favaloro and Johnson had done the procedure successfully.

Then you came to Duke, what led you here to become Chairman of Surgery?

Duke enjoyed a rapidly escalating reputation throughout the nation, and after the initial visit I was completely convinced that becoming Chairman of the Department of Surgery here was a special challenge. The environment here

was an excellent one, and although having similar opportunities previously, this one was unparalleled. When offered the post, I accepted immediately.

Your enthusiasm for teaching medical students as well as instructing residents is well recognized. Why that special interest?

As far back as I can remember, I have had an interest in teaching. I enjoyed the experience both as a medical student and a surgical resident and this continued as a member of the faculty at Hopkins. From the outset it has been my belief that a teacher should stimulate the students to think and to make the subjects interesting and fascinating. The students' sug-

Sir William Osler said, 'Work is the master word in medicine.....with the magic word in your heart all things are possible, and without it all is vanity and vexation!'

gestions should be heeded and made a part of the course. Their advice concerning improvements in teaching and topics through the years have been of much significance.

Looking towards the future and the uncertainty of the new health care program, where do you think medicine is going? And what do you think the role of the surgeon will be in the new plan?

It is interesting to reflect upon this very important question since it is of much significance to everyone. While a student at UNC, there was great concern about socialized medicine in this country. Congress was considering the Murray-Wagner-Dingell Bill. President Roosev-

Continued on page 12

elt had endorsed this legislation, and it came very close to passing. In 1965, the Medicare Bill was enacted by Congress and there were many who viewed it as catastrophic legislation. In truth, the past thirty years represent the finest era in medicine of all time. I believe in being optimistic about the future and working diligently to make a success of whatever confronts us. We are fortunate in having the best medical care and finest medical research in the world. It is our challenge to maintain this position.

What has been your most memorable experience to date?

There have been many memorable experiences, but I believe the confidence and trust placed in me by the leadership and faculty at Duke in offering me the post of Professor and Chairman of the Department of Surgery at the age of thirty-nine was clearly the most outstanding.

What are some of your hobbies and interests outside of medicine?

My wife says that fortunate is the person whose work is his hobby. I fully share this view. I have always had an interest in history and have pursued it through the years. It has been a privilege to edit several texts and journals and this has been very rewarding. Our children and grandchildren have added much to the joy of life, and I am continuously astonished at how rapidly they learn at such early ages and how quickly they become computer literate. It is really quite extraordinary.

I have heard that you are interested in architecture; you helped design a hospital at Johns Hopkins?

While I was at Hopkins, the Children's Medical and Surgical Center was being designed

and built. Dr. Blalock assigned me the responsibility of planning all the surgical facilities in

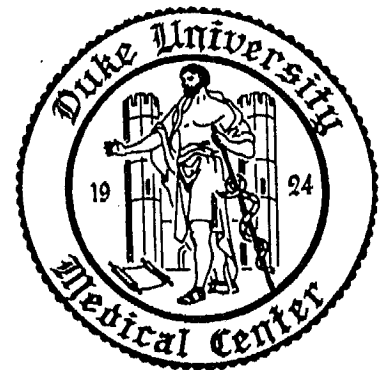
Fortunate is the person whose work is his hobby.

this Center which occupied half of the entire space. It was an unique experience to plan the clinical facilities, the research laboratories, the conference rooms and offices. It was a rewarding opportunity and taught me much about planning and construction.

What advice do you have for a Duke Medical Student who wants to have a successful career, especially if they are looking to become a surgeon?

I am convinced that one's success is directly related to one's commitment to it. Thomas Jefferson said many years ago, "I have always been a great believer in luck, but it is an interesting thing, the harder I work the more I have of it!" Similarly, Sir William Osler said, "Work is the master word in medicine.....with the magic word in your heart all things are possible, and without it all is vanity and vexation!"

Again, Shifting Dullness and the author would like to thank Dr. Sabiston for setting aside time for this special interview.



ATHLETE(S) OF THE MONTH

Welcome to the first edition of athlete of the month! This is a column dedicated to honoring those devoted medical students who somehow find the time to get out and be physical in the face of the hard work we all must endure.

This month, we have two recipients of this great honor. They are Laura Havrilesky and Diane Allen, who, incidentally, happen to be roommates. Perhaps it is this common bond that was the beginning of their now-distinguished running careers. Laura and Diane have been training together for some months now, and up until last fall, they ran an average of 3-4 miles per day. Then, for some reason they got crazy, and decided to start training for a marathon. Diane, who hails from Lexington, Kentucky, was a cross-country runner at Vanderbilt, but she had never done a marathon. For Laura, a genuine Durhamite, it was her third competitive race ever. So at the end of May, Laura and Diane set out to do the Vermont City Marathon in Burlington, VT. They ran the entire course together, and finished in 3 hours, 36 minutes and 1 second. This time resulted in qualification for next year's Boston Marathon,

In fact, they would like to start a secret society, called the *Benji Durden Society*, in honor of the man whose article in a running journal helped them train.

which they do intend to run.

Both Laura and Diane are excited about their new-found fortune. In fact, they would like to start a secret society, called the *Benji Durden Society*, in honor of the man whose article in a running journal helped them train. This society will consist of a small, select group of medical

students, chosen by their peers and nominated by their deans, who fulfill the following three criteria: 1) **academic excellence**, 2) **intellectual curiosity**, and 3) **having run a marathon**. If you would like more information on this society, I suggest you contact Laura or Diane.

In any case, our sincerest congratulations go out to these women for such a great job in the marathon. They are an inspiration to all of us. Happy running!!

SUMMER HOURS

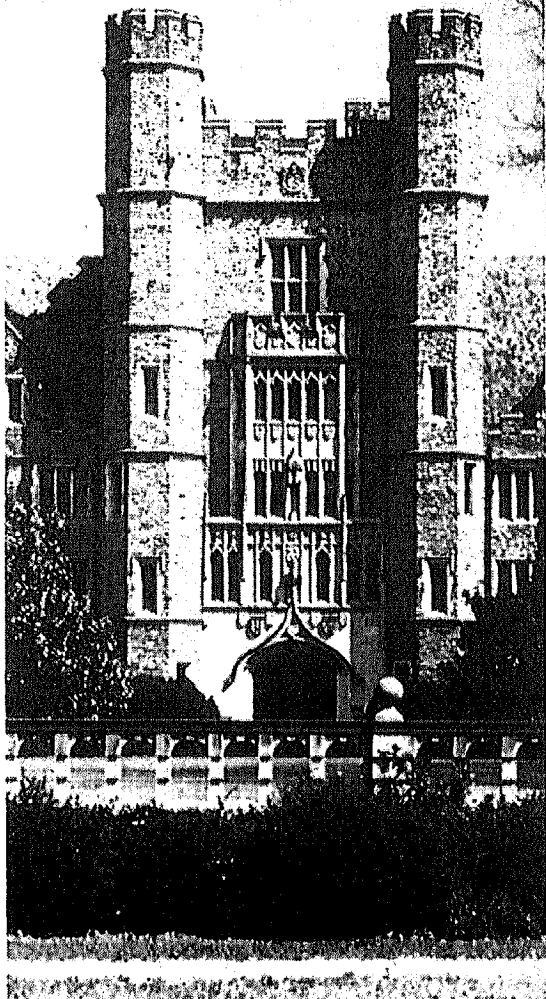
For all of you athletes out there, here are the hours for the gym and pool at West Campus for the summer:

Card Gym	Mon-Fri 9am-7pm
IM Building	Mon-Fri 9am-7pm
Weight room	Mon-Fri 12noon-7pm
Aquatic center	
(West)	Mon-Fri 11:45am-1:45pm
	5:30pm-8:00pm (2lanes only)
	8pm-10:30pm
	Sat-Sun 2pm-5pm

*** The East Campus facilities, as well as the West gyms and weight rooms, are closed for the summer.

IM SOFTBALL UPDATE

The MS I team, nicknamed the "**Creamasters**," enjoyed a successful season under the tutelage of Shawn Miles. Unfortunately, the playoffs coincided with their three week vacation. The still undefeated "**Fatty Streaks**," composed of an optimal combination of MS II's and III's, are seeded second in the playoffs. With the power hitting of Todd Jacobs and Franco Recchia, the fielding acumen of Paul Baird and Ed Norris, and the welcome addition of free agents Umesh Marathe and Jeff Cusmariu, the team anticipates another championship. Thanks to all of you that participated. ■



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Medicine Abroad Corinne Linardic

This is the first in a series of brief reports about opportunities for working in medicine abroad.

Armed with their stethoscopes around their necks, their EKG wheels in their pockets, and their diplomas under their arms, medical school graduates around the United States are marching to their internships, be it three year adventures in medicine or pediatrics, or decades at Duke (or what have you.) Further training in their residencies of choice will make these new doctors finer physicians. They will populate major medical centers around the country, practicing with novel therapies and in the ever-changing but all-too-familiar light of health care reform. Off the beaten path, however, are many opportunities to practice medicine in unusual locations and situations. Some time ago I received in the mail some information concerning an organization that I had heard much about, but never contacted. Doctors Without Borders, Inc. is the American branch of the French parent organization Medecins Sans Frontieres. This non-profit, international organization of approximately 2,000 volunteers disperses medical emergency workers and supplies to nations around the world caught in the midst of civil strife, civil war or natural disaster.

Doctors Without Borders has existed as a humanitarian relief organization for almost 22 years. They are currently the largest private emergency relief organization in the world, and claim no governmental, political, or religious affiliations. In response to need, Doctors Without Borders sends out teams of relief personnel, each including at minimum a nurse, an anesthesiologist, a surgeon, and an expert in logistics. In April of 1991, Doctors Without Borders took part in relief efforts in Kurdistan, in response to the plight of the Kurds being bombed by Saddam Hussein. For this population they provided temporary shelter, blankets and protein biscuits. In October of 1993 in Russia, during demonstrations and rioting in Moscow,

they provided medicine and medical and surgical supplies to aid local Moscow hospitals. In September of 1993, Doctors Without Borders sent a team to a region of India then recently devastated by an earthquake, and provided medical supplies, portable operating rooms,

Almost 70% of the medicine available in Sarajevo was provided by Doctors Without Borders.

drinking water, and temporary shelter. Currently Doctors Without Borders is involved in 220 missions in 65 countries. Most recently, Doctors Without Borders has focused their energies on Sarajevo, Bosnia, and has sent 30 volunteers to provide medical care for approximately 380,000 people. At the time of printing of the information, almost 70% of the medicine available in Sarajevo was provided by Doctors Without Borders. They have also brought medical help to the cities of Goradze, Tuzla, and Srebrenica.

There is no doubt that medical work of this sort requires an adventuresome spirit and persistent optimism. Of course, the stethoscopes and EKG wheels may come in handy. For more information, contact the American branch of this organization:

Doctors Without Borders USA, Inc.
PO Box 110
New York, NY 10277-1218

Think About What If

Jamy Ard

What if every time your friend decided to set you up on a blind date, you asked, "What's his genotype?" rather than inquiring about his physique. **What if** you brought your newest girlfriend home to meet your parents and they pull you aside to quiz you about whether or not you've considered obtaining a map of her chromosomes. Or **what if** a total stranger proposed to you because you had the dominant gene that her family lacked. I guess what I'm trying to say is **what if** mate selection were based primarily on genotype rather than phenotype.

As I see it now, there is often little thought about the compatibility of a couple's chromosome maps until after the knot has been tied and there have been many futile attempts at procreation. What generally occurs is the selection of a mate based on phenotype (i.e. looks, build, money, status, or lack thereof). This is a very natural process, being in line with that of many species of wild animals. In the wild during breeding season, animals meet in groups called leks and do exaggerated mating displays. Females then choose males with the most extreme plumage, vocalization, and displays, giving very little thought to the possible viability of the pair's offspring. This process of nature closely parallels with the artificial leks of humans (i.e. singles bars/night clubs). Single males and females of the species gather and seek out the person with the most extreme appearance, occupation, or earning potential. There are no cortical functions involved, strictly reflexive breathing.

This method of mate selection often leads to offspring that have no greater chance of surviving than do the parents. It is a known fact that people are attracted to people like themselves, so many of the recessive genes linger in the gene pool. Maybe one day we will be able to predict with a high degree of accuracy what the prob-

able genotype of an offspring will be using Punnet square calculators, guiding our choices of mates. The advantages of mate selection by genotype are unlimited. National IQ scores would rise, people would be faster, stronger, and more disease resistant, and by using this method we could possibly eliminate all genetic abnormalities and concentrate research efforts on acquired diseases.

On the other hand, spending the rest of one's life with a person simply because he or she has good genes could really be a drag. What about love, friendship, or a good sex life? These things play a huge role in choosing a lifelong companion as well and must not be sacrificed for the production of a genotypically perfect offspring.

What if one day, the government decided that because people were choosing poorly in selecting mates, they would outlaw sex and procreation as we know it and began to produce genetically superior humans in the laboratory and called them GEOs—genetically engineered offspring. **Think about it.** ■

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S	SD	Sd
s	sD	sd

Politically Correct?

Comments from the medical politician

Us versus Them

Now that the heat and humidity of summer are upon us, you might look around campus and notice the distinct lack of students. In particular, all the law school students have taken flight from the City of Medicine to their comfortable summer jobs at wealthy law firms with money to spare. Now the best and brightest of these students, if applicable, are getting paid up to \$2000 per week for their indispensable services. Two thousand bucks a week for knowing arguably nothing more than the day they graduated from college. If my math is correct, that could yield an eager-beaver J.D. over \$20,000 for the summer.

Don't get me wrong...some of my best friends are law students. But what has motivated these firms to waste their annual profits on these aspiring BMW owners? Well, it seems that the most successful folks at manipulating the law, end up doing pretty well for themselves and their firms: the American Dream, suing the private sector and the government, the self-made lawyer building a fortune through hard litigation, etc.

Lucky for us, Hillary's talent has now been applied to our field

All one has to do is look at the American Dream incarnate: Billy-Bob, Hillary Rodham, Chelsea, and Socks. The Clinton-Rodham duo worked their way up from quite modest backgrounds through the law. I get all misty-eyed when I think of young Bill working his way through Georgetown as a Foreign Policy major,

getting a Rhodes scholarship with the help of his former boss Senator Fulbright (D-AR), going to Yale Law, returning to Arkansas to captain the paddleboat of state from Little Rock, and preparing with MTV for his election to the presidency. And his partner, H.R., her story is all the more noble tale of American know-how. From Yale she followed Bubba down South and understandably needed to put her talents to work. The social conscience of America went to work for the corporate firm of Rose & Associates. Her friends provided her with first-rate bond trading advice, and in 1992, the year Clinton won the presidency with his message of the rich getting richer, Hillary reaped over \$200,000 only in salary. I don't know what you can buy in Little Rock, but with that sort of money you could sure buy a lot of it.

Lucky for us, Hillary's talent has now been applied to our field. It's because she cares, honestly. As we've heard, she did a "tremendous" job in reforming Arkansas' state education system and she can do the same for health care in America. I don't want to underestimate her ability, but I have the sneaky suspicion that a lot folks out at Butner could have met with some success in improving education in Arkansas.

So what's the take home message? The White House is full of itself with a pair of self-centered, deceptive con-artists? No. Law students get paid too much for summer jobs? No. Anything is possible in Arkansas? Maybe. Based on geographical diversity alone, Bubba was destined for success: Georgetown, Oxford, Yale, and the White House.

The kicker in this convoluted tale is that there are fewer acceptance spots in medical school for which one must be brighter and more diverse. I believe that if the entire Duke Medical School applied to Harvard Law School next year, we'd account for 400 of their entering class of 500. And just imagine how we could spend the summer of '95. ■

DAVISON COUNCIL NEWS

SOCIAL EVENTS

—Vickie Ingledue

Great Escapes! Rock Climbing at Moore's Wall—Saturday, July 9. No experience required. Come out and have an adventure! Call Andrea Coviello (286-2574) for details.

ANNOUNCEMENTS

Extended Library Hours! Due to the efforts of Russell Huffman, our student representative to the library advisory committee, the medical center library has extended Sunday hours to 12 noon-12 a.m. throughout the summer. So all who make use of the library on Sunday nights this summer, thank Russell!

1994 AOA International Distinguished Teacher Award! Five Duke physicians were nominated to serve as the official Duke nominee: Dr. Charles Putman (Radiology/Medicine), Dr. Barth Reller (Pathology/Medicine), Dr. Daniel Sexton (ID), Dr. Robert Drucker (Pediatrics), and Dr. Marvin Hage (Ob/Gyn). Upon reviewing the CVs of the nominees, the Davison Council Elections Committee selected Dr. Robert Drucker due to his dedicated involvement in medical student education.

MS IV Class Representative Elections are final. The MS IV reps are as follows:

Robb Romp, President
Annemarie Thompson
Bobby Dabal
Jeff Johns
Andrea Monroe

Applications for MS III Admissions Committee Representatives will be requested soon. All MS IIIs are eligible.

Community Service S. Crowley

Children's Miracle Network Fair—We would like to thank the many students who participated in the Kiss-a-Pig contest (which raised \$2287) and the Miracle Network Fair (which raised \$544). Members of the first year class under the direction of Lisa Criscione took valuable pre-exam time out to table for the KAP contest. The large number of students who gave of themselves on the day of the fair and in preparing goods for the bake sale was a welcome reminder of the altruistic attitudes that prevail in our medical student community.

Habitat for Humanity—Habitat is attempting to complete the construction of 7 houses in the neighborhood of the Lincoln Health Clinic. Med students have been involved in landscaping the past 2 Saturdays. Rima Nasser has graciously volunteered to act as MSIII coordinator. Work will be continuing through the end of June or until these houses are finished. Anyone interested in contributing to this effort on any Saturday during the next month should contact Claire Horton (490-6316) or Rima (490-6685).

Shelter for Good Hope—We will be continuing to serve food to the homeless on alternate Tuesday nights during the summer (beginning 6/22/94). Anyone who would like to come along should contact Steve Crowley (383-1047) on the Sunday before.

Coming this fall....**The Red Cross Blood Drive Pizza Fund.** Any med school class who can get a total of 40% participation (approx. 40 different people attempting to give blood) during the period extending from 9/1/94 - 11/31/94 will win pizza for those blood donors, provided by the Davidson Council. The council recognizes that people give blood to help those in need and not to win pizza and that this offer is a shameless gimmick to raise awareness with respect to the need for your blood. More news to follow on this heated contest.



Roadside AssistanceContinued

check, only to discover the recent formation of an enterocutaneous fistula (if you haven't seen one, hope you never do). After a routine KUB revealed, shall we say, an "overloading", the poor person received a grand total of 17 enemas in one day, with some but not total improvement. This, my friends, is the true definition of "bowel cleansing." To this person's credit, this indignity was borne with a great degree of nobility. Not once did anyone get slapped for suggesting another enema.

Klingons do not prescribe "energy pills" of any sort. A dear patient of mine presented to the Duke High Risk Obstetrics Clinic for evaluation of her new pregnancy. It was late in the afternoon - this would be my last patient of the day. I was cruising. Well, I'd better look at her old chart first. *Whoa*. She had tested positive for almost every virus I could name. Many bacteria as well. Throw in a few recreational pharmaceuticals. And several children, living with Grandmama. And a baker's dozen of prior commitments to the John H. Umstead Memorial Hospital in metropolitan Butner, North Carolina. This was going to be fun.

I walk in. Hi, how are you doing? "Doc, I don't know what it is. I'm just feeling run ragged, I'm so tired and run down all the time. I was wondering if you could give me some kind of energy pill." Well, I thought, I think I'll just check the box that says, "drug seeking behavior." Needless to say, she did not get the desired pharmaceuticals; I trust none of you will ever prescribe such medicines.

Klingons do not advance someone's television to "Sesame Street." Ah yes, poor Mr. X, who never left his bed even though he could. A fine example of North Carolina mountain folk, this gentleman had never been to school a day in his life. After presenting his case one afternoon, the chief of the service doled out his recommendations: "Give him some potassium, he's a little low. Advance him to regular diet. Advance his television to 'Sesame Street'." Apparently this mild-mannered man in his fifties had been

caught watching *Barney* one fine morn. In exploring this patient's tastes in television, he said he never watched any of that "trash" on prime time (a wise choice for us all, especially the 90210 and *Melrose Place* crowd), obviously preferring large purple fake dinosaurs. "Yes, I heard you're very particular about your television," the chief replied, barely concealing his smile. We students had to dive out of the room to prevent rising gales of laughter. Please, never be so rude as to insult your patient's viewing habits - and never laugh about this rudeness.

Klingons do not wear other people's secretions on their jackets. Ah, yes, Dr. Camera, we know how you take care of - or *fail* to care for - your beloved jackets. In one week's time, this notorious student collected the visible signs of several people's bodily secretions on his jacket. His Jacket became a paint-by-numbers, using nasogastric tube drainage and blood and sputum and lots of fun stuff for paint. Much to our bald-faced relief, the Jacket was eventually washed, but not soon enough.

A six month follow-up visit of the Jacket revealed it had gained quite a bit of character. There were undeniable indelible stains dotting the once vast landscape of white. Across the lining was scrawled such memorable phrases as "You can't win. You can't even get ahead," and the classic "Kick me. Everyone else does." For those out there who may have fallen into the bad habit of toting dirty jackets around, remember to wash regularly - dirty jackets are disgusting.

Klingons do not ignore their patients. There are very few things you need to know to treat your patients and succeed on rounds. Keep in mind that most of what you need to know you can learn from your patients. Listen carefully - it will save you time. Care - even if you don't. Know your patient - it will spare you embarrassment and heartache. And above all never ignore your patient or their needs. After all, they are the ones asking for help. ■



Klingons do not . . .

Micheal DiCuccio

Klingons do not play with toys. Klingons do not laugh. Klingons do not lie. Klingons do not have fun. Not an episode of *Star Trek* passes without Worf dictating another chapter in the Klingon Manual for Social Behavior. I am sure that, if this work were ever published, we would find a chapter entitled "Klingons do not . . ." nestled neatly between "Routine Decapitations and Disembowelments" and "Prune Juice: A Warrior's Drink."

Worf's continual list of *Thou shalt not's* strikes a deep chord with me. Perhaps growing up Catholic (Church motto: You can't) has instilled a keen sense of what cannot be done in me. Perhaps considerations of the ridiculous occupy my mind. I, personally, would have loved the script writers to work in times for Worf to say such things as *Klingons do not wipe their rear-ends or Klingons do not become incontinent with age.* Alas, the final episode has come and gone, we will never hear Worf openly discuss bowel and bladder function in such an open

Klingons do not wipe their rear-ends or Klingons do not become incontinent with age.

vein. (N.B. - This is probably for the better.)

The only other alien race in the history of science fiction with as much character is, of course, Douglas Adams's Vogons. For those who haven't heard about Vogons, these beasts were belched from the great seas of their home world only to have evolution give up on them. They enjoy beating the snot out of any form of life that comes near them. They shout a lot. They write poetry. Their poetry is so vile that it has been known to kill at 100 yards. Unfortunately, they do not continually create unique aphorisms beginning "Vogons do not . . ." like Klingons do.

We here at Club Med all share common traits with Klingons. We all have notions of being honorable students. We all have inborn senses of duty to our classes and our patients. We must all have the courage to perform our first

interventions on real patients. And so, in the grand tradition of *Star Trek*, we at Roadside Assistance will present the list of the most important medical student proscriptions, with a decidedly Klingon bent.

Klingons do not perform six rectal examinations on one healthy patient in one day. No one looks forward to doing a rectal examination, but they are exceedingly important diagnostically for many patients. I performed my first rectal while doing Physical Diagnosis at the ECRC in the VA (a souped up nursing home). Our patient (great word for him - he was really *patient*) agreed to let me, my four classmates, and my attending each perform a rectal exam on him. Brave soul. What was worse than being near the end of the line (no puns intended) was having this dear patient precede my exam with, ah, a fine example of bodily function. He let loose with a truly impressive bout of flatus so profound in range and character as to tear the paint from the walls. The funniest part of this was his somewhat surreptitious opening announcement: "Uh-oh. Stand back!!"

Klingons do not order 17 enemas for one patient in one day. In case your patient ever has problems with serious constipation, enemas will be their godsend. Thankfully, we do not administer these. There was a certain poor patient for whom this got somewhat out of hand, though. It seems that the order, "Fleets enema x 1. *May repeat.*" was taken too literally. On morning rounds, we performed a routine wound

Continued on Page 19

