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DukeMedicine

Duke Children's

The Duke Medicine-Pediatrics Newsletter

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A Resident's Training Experience in Nicaragua

Rhett Mays, one of our 4th year Med-Peds residents, just returned from his three month Global Health Elective in Nicaragua. He shares his experience with us.

Having just returned from three months working in Nicaragua through the Hubert-Yeargan Global Health Elective, it is hard to decide what part of the experience was the most interesting and valuable to me. It was simultaneously a lesson in tropical medicine, a lesson in socialized medicine, and a lesson in how culture and politics affect health and health care delivery. A victim of 40 years of dictatorship and civil war funded by our own Cold War, Nicaragua is currently the poorest country in Central America. It faces substantial public health challenges including an aging infrastructure and lack of funding for diagnostic equipment, medications, and preventive services. Yet a vibrant medical community exists there, well-educated and providing care beyond the limitations of the resources available to them.

My first 2 weeks in Nicaragua were perhaps the most satisfying of my short career in medicine - staffing a rural clinic along with Nicaraguan and US medical students in a small village in the Atlantic interior. It was a 30 hour bus ride by unpaved road from Managua, and the three room clinic served several villages, many of which were accessible only by foot or horseback. We treated patients with every type of ailment, from leishmaniasis to stab wounds. We attended deliveries and stabilized several critically ill patients before transporting them to the nearest hospital – another 3 hours away by unpaved road. One adult that arrived gravely ill had been carried to the clinic in the middle of the night in a hammock by members of his village.

The remainder of my time was spent in Leon, a city founded in 1524 by the Spanish. The city of over 400,000 is served by a single public hospital of about 450 beds, and serves as the training site for

both a public and private medical school, as well as residency programs in most medical specialties. The structure of the day is much like it is in the US, with morning report, daily lectures, and bedside rounds with attendings. The difference lies in the way patients were evaluated and treated, using limited diagnostics and what medications were available. Only plain film radiography was available and both the blood gas and chemistry machines had been out of service due to lack of reagents for months. Private diagnostics were available

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Inside this issue:

Greetings from the Section Chief and Program Director

Welcome back to the next edition of the Duke Med-Peds Newsletter. So many things are in progress at Duke! Changes abound on the Medical Center campus and surrounding areas. Also, our program has completed the inaugural site visit by the ACGME (Accreditation Council for Graduate Medical Education) which allows for our continued accreditation. We look forward to greeting a new group of applicants as around the corner is recruitment season….again!! Our current residents and graduates are all key in our success each recruitment season. Best wishes this Fall season and please keep in touch to let us know how you are doing.

Med-Peds Continuity Clinic Updates

The Duke Med-Peds Continuity Clinic continues to expand. Since 2004, our section has grown to a full complement of primary care Med-Peds clinic attendings who precept Med-Peds residents in their continuity clinics. This permits residents to learn primary care medicine and pediatrics from combined trained supervisors and provides them with a Med-Peds "home" within the clinic.

The clinic moved to 4020 N. Roxoboro Street in 1995-1996, but remained as separate medicine and pediatrics clinics until 2006. The clinic now occupies it's own quadrant of the building, where adult and pediatrics patients are seen together, and is staffed by all med-peds attendings. At Roxboro Street, the residents attend continuity clinic generally once per week as interns, and twice per week as upper levels, depending on the clinical rotation. Each clinic session contains 50% adults patients and 50% pediatric patients. Schedules allow for acute, return and annual/well child visits for both adults and children. Just ask the residents, the clinics may be busy, but the patients enjoy being seen by "their" doctor, and often wouldn't have it otherwise!

Jane Trinh and Paden Angelo at work in clinic.

The core clinic preceptors are Suzanne Woods, Ed Evans, Dan Ostrovsky, Dean Miner, and Jane Trinh. Aimee Chung has joined us for the year while she is the Pediatric Chief Resident.

Sue, as most of you know, has been loyal to Duke Med-Peds since her return in 1999, and currently serves as the Med-Peds Program Director, Section Chief and Clinic Director. Ed Evans joined the faculty in 2002, after completing his Med-Peds training at Duke. Ed is one of the two providers that sees his own adult patients in clinic.

Dan came to us in 2004 from the University of Rochester, after serving as Med-Peds Chief Resident. He continues to work to improve the pre-clinic conference curriculum in clinic. Dean was program director of the Med-Peds Residency Program at University of Alabama at Birmingham prior to arriving at Duke in 2005. Dean has done a tremendous amount of work in the last couple of years with Duke IT to develop computer-based notes for the pediatrics clinics, and is planning for a lot more in the upcoming months.

Jane finished Med-Peds residency at Duke in 2006, and served as Medicine Chief Resident in 2007-08, before re-joining the Med-Peds world as the Associate Program Director. Jane also sees her own adult patients in clinic. Aimee is our newest member, finishing residency in 2008, and adds some zest to our group while she is working as one of the Duke Pediatric Chief Residents.

Rhett Mays and Nicaraguan hospital staff

Nicaragua (continued)

only to those who could afford to pay for them, and few could.

With time spent on the Pediatric Infectious Disease, General Medicine and Cardiology Services, I saw many impressive examples of clinical diagnosis and improvised therapy and the frustrations of caring for patients this way. Diabetic ketoacidosis was managed by treating with bolus insulin, monitoring only by respiratory rate and glucometer. Nonketotic hyperglycemia was treated with large amounts of IV fluids until glucosuria resolved. A patient that presented with a clinical syndrome consistent with an exacerbation of lupus was treated without serology with high dose hydrocortisone. No other IV steroids were available. Her pericardial effusion was followed by a member of the medicine faculty that had become the defacto cardiologist, who was learning Echo, advanced ECG interpretation, and cardiac stress testing from visiting US physicians while simultaneously attending on the wards and covering his own private clinic.

The faculty and staff there were always friendly and patient. I traded conversational Spanish and English lessons with two faculty members and sampled the local exotic foods with a third. Both residents and faculty helped clear up my confusion with medical terminology, abbreviations, and idiosyncracies of the system.

After three months my family and I were sad to leave and now miss our friends in Nicaragua. I leave convinced of how much medical care can be done with a few resources and how much more could be done in Nicaragua with just a little bit more.

Thank you to Rhett for his contributions to the newsletter.

Expansions on the Medical Center Campus

If it's been a few years since you have visited Duke Hospital, you will be surprised the next time you step on campus. Duke has experienced tremendous growth on the Medical Center campus, as well as beyond. Duke recently has developed significant capital projects at Duke Hospital and in the community, at Duke Raleigh Hospital, Durham Regional Hospital, and many new clinics in Wake County.

After the opening of the Children's Health Center (for pediatric subspecialty clinics and Rainbow Day Hospital) in 2000, the next major project on the Duke Hospital campus was the renovation and expansion of the Duke Emergency Department, which opened its doors in April 2007. The new ED has 3 adult care areas, a larger pediatric ED (18 beds), dedicated CT scanners, a disaster planning area, more psychiatric beds, and a larger observation unit, with a dedicated stress test room. It remains a Level I Trauma Center.

The Hospital Addition for Surgery was completed in June 2008, and is located between the ED and the back-side of Duke Hospital towards the walkway. It contains perioperative service support, four operation rooms, and family waiting areas.

Duke has also just announced plans to move forward with the construction of a new state-of-the-art Cancer Center and new Duke Medicine Pavilion, a major expansion of surgery and critical care services at Duke Hospital.

With these additions, the two notable Duke historic landmarks that are now gone are the Bell Building, which is where the Cancer Center and Duke Medicine Pavilion will be, and the Duke PRT (personal rapid transit) tram. The PRT was the only underground transit system in the state and closed on October 15, 2008. It started running at Duke in the late 1970's. Now, patients are transported by ambulance, shuttles and electric golf carts. The covered walkway is still open to employees and patients.

The Duke PRT closed on October 15, 2008.

Watch the projected construction of the Cancer Center and Duke Medicine Pavilion online: www.dukemedicine.org/construction.

Global Health at Duke

The Hubert-Yeargan Center for Global Health was created in 2004 with a mission committed to education, research and service. The creation of the Hubert-Yeargan Center represented a true partnership of mutual understanding and reciprocity with our collaborators around the world. Dr. Ralph Corey directs the Center.

The Hubert-Yeargan Center provides global health education for Duke University trainees through the Global Health Residency Program, the Department of Medicine short-term resident rotations, medical student research year, medical student electives , and student internships.

It has developed mutually beneficial, collaborative relationships with global partners to address the health care needs of local communities. There are educational opportunities at Duke for foreign trainees from affiliated institutions, and the Center has developed collaborative research that addresses local community needs.

The Center supports health care service and research efforts in resource-poor locations around the world, by providing funding for infrastructure related to partnerships in educational service, research, and training. More information can be found at: dukeglobalhealth.org.

The Duke Global Health Institute was created in 2006 to address health disparities around the world. The Duke Global Health Institute (DGHI) works to reduce health disparities in our local community and worldwide. Recognizing that many global health problems stem from economic, social, environmental, political and health care inequalities, DGHI brings together interdisciplinary teams to solve complex health problems and to train the next generation of global health scholars.

DGHI is unique in its ability to address global health issues with resources and expertise from the entire university. DGHI is not contained within any specific school or department at Duke, but rather brings together faculty and students from many schools and makes use of multiple perspectives in its education and research programs. DGHI is led by Dr. Michael Merson. More information can be found at: globalhealth.duke.edu.

"To mentor a future generation of students and health care professionals to become globally experienced, socially responsible, service-oriented citizens so that they may work towards reducing the burden of disease and health inequalities." - ***The Hubert-Yeargan Center***

Mount Kilimanjaro

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Featured Duke Med-Peds Alumni: Shannon Hader, MD

Shannon Hader, MD, came to Duke from Columbia Medical School and graduated from the Duke Med-Peds Residency Program in 1999.

From Duke, Shannon entered the Epidemic Intelligence Service (EIS) of the CDC as a Commissioned Corps Officer in the United States Public Health Service, and focused heavily on care and treatment issues and outcomes for persons living with HIV/AIDS.

After EIS, she stayed with CDC-Atlanta and completed an adult ID fellowship at Emory. She moved overseas as Director of the CDC-Zimbabwe Global AIDS Program. On return, Shannon was detailed to the President's Emergency Plan for AIDS Relief State Department office in Washington DC as the Senior Scientific Advisor.

With her 8 years experience at the CDC, Shannon has recently been appointed the Director of the HIV/AIDs, Tuberculosis, Hepatitis, and STD Administration for the DC Department of Health. She feels like it's a job that really brings into play everything she's learned so far as a clinician (both adults & kids), as a public health doctor, as a researcher, as a program implementer, as an administrator, as an "international expert" and a "domestic expert."

Her newest challenge is learning how to interact with politicians—Mayor, City Council, Congress—as well as the local hometown newspaper, the Washington Post. She manages a staff of close to 170 persons, an annual budget of approximately $90 million, and is responsible for the District-wide response to a severe HIV epidemic.

In DC, three percent of adolescents and adults are already diagnosed and living with HIV, and all modes of transmission are in play to drive an ongoing epidemic. Shannon and her team are revising strategies using new data and evidence available, and creating or scaling up programs to match the severity and complexity of their needs.

Shannon Hader, MD, discussing the Washington DC AIDS Epidemic in Africans at a Town Hall Meeting.

In looking back at her decision to come to Duke, Shannon wanted an institution that had high level expectations and provided high level training for both medicine and pediatrics. Duke also gave the options of research training, a research project, and participation in international health rotations. She felt that the balance of training intensity and varied opportunities treated residents-in-training as people who could go after their career visions and goals.

Her advice to housestaff: "Spend as much time as you can with your patients and learn everything about clinical judgment from all of your team's patients—those interactions will build your perspective on 'what really matters' and truly affects your life."

Congratulations!

Posters accepted to NC Pediatric Society Meeting in Asheville, NC, held August 2009:

Priya Gopwani, David Ming, Lisa Nguyen, Sima Pendharkar, Kanecia Zimmerman

*** **Special congratulations to Priya, whose poster won third place!** ***

Deborah Kredich and James Stockman, III, Awards: Aimee Chung, HS'09

Appleseed Teaching Award (from medical students): Apara Dave

Pediatric Medical Student Teaching Award for JARs: Jennifer Pape

David Ming presented a research poster at the National ICAAC Meeting in San Francisco, CA on September 12-15, 2009.

Pediatric Residency Council Members: David Ming (co-leader), Kristin Meade, Olivia Granillo Johnson

Medicine Residency Council Members: David Ming and Lisa Nguyen

Erin VanScoyoc, HS'09, and her husband Rusty welcomed into their family on Annabel Wren Haynes on August 14, 2009.

Jon Bae, HS'09, his wife Michelle and son James welcomed Owen Jacob Bae into the world on September 1, 2009.

Jennifer Walker, HS'07, and her husband Chris welcomed Annelise Clare Walker on October 9, 2009.