Shifting Dullness

October 1991

This Month in Medical History

Chris Tharrington

—The first issue of *Lancet* was dated October 5,1823.

—Francois Magendie, an experimental physiologist and pharmacologist, was born Oct. 6, 1783 in France. His noteworthy contributions include proving the distinct function of the anterior and posterior roots of spinal nerves. The antivivisectionist movement, which included members of Magendie's own family, was active at this time and made repeated attacks on the scientist's work.

—On Oct. 14, 1609, William Harvey was appointed to St. Bartholomew's Hospital in London. Seven to eight years later he had completed enough of his investigations to form his theory of vascular circulation - contrary to Gallen's notion of "ventricular pores." His groundbreaking *Circulation of The Blood* was not published, however, until1628.

—October 18 is Saint Luke's Day. Although he has been considered the patron saint for all of medicine, in the Middle Ages English military physicians regarded St. Luke as their own patron. The city of London granted a charter to the military surgeons in 1369, thus distinguishing their guild from that of the barber surgeons. The guild required aspiring military surgeons to undergo 6 years of apprenticeship with a subsequent examination. Failure of the exam required 6 years of additional training before the test could be retaken. Inadequate performance a second time precluded a candidate from ever becoming a military surgeon.

—On Oct. 25, 1977, a 23-year-old hospital cook in the Southern Somalian town of Merka was diagnosed with the world's last known case of naturally acquired smallpox. He had exposed 161 persons, but after identification, vaccination if needed and surveillance, none developed the disease. During the next several months the World Health Organization searched systematically but found no other cases, and declared smallpox to be eradicated from its natural environment. The virus exists now in only a few laboratories.

—Hippocrates, the Greek Father of Medicine, was born on the island of Cos in 460 B.C. His birthday was celebrated on the 26th day of the month of Agrianus, which does not correspond to a month on the modern calendar, but was probably an Autumn month. One of the first proponents of the bedside method, he also left a legacy of aphorisms, some shrewd for the time, others of everlasting wisdom.

"Disease should be combated at its origin."
"In illness, one should take care of two things, to do good and not to do harm."
"Diseases are not the work of god or demon."
"If a man neglects nature's laws, he suffers."
"Life is short, art long, occaision brief, experience fallacious, judgement difficult; but treament after thought is proper and profitable."

—King Alfred of England died Oct. 28, 900. The earliest surviving medical work in a native European language, Bald's Anglo-Saxon Leech book, was written about that time. Most of its advice consisted of herb teas, salves and various concoctions sweetened with honey. Some, however, were more imaginative; for example, a venomous swelling was treated by churning butter on a Friday from a doe of a solid color, while chanting litanies over it.

—On Oct. 29, 1756, Thomas Bond performed the first lithotomy in America. Bond helped found the first American medical school at Pennsylvania.

Computer Connections to Combat Inefficiency

Michael Weiner

Paperwork accounts for about 25% of the six hundred billion dollars spent annually by health care providers for their services [1]. Medical students on the wards quickly discover that a tremendous amount of time is spent duplicating work, poring through charts and forms, looking for data that is not stored in its proper place, deciphering doctors' scrawls and putting together complex histories. Today, although many hospitals have useful computer systems to handle some of the information, they frequently do not fulfill their potential to automate repetitive procedures and connect to systems at other, often remote locations. An efficient, nationwide computer network of patient records would improve patient care and lower administrative costs, though the system itself would cost billions of dollars.

Computer databases now store a great deal of medical data and have been established as an important component of health care: information systems account for $5 billion of the anual expenditures. Yet inefficiencies abound: a blood gas machine which contains sophisticated computer hardware requires a technician to type the results into another computer containing the patient database. Connecting computers to each other, both within and among hospitals, can help to alleviate this and other inadequacies, and will likely constitute one of the most important developments in medical computing in the next decade.

Systems already erected assume a variety of forms and address numerous distinct or overlapping goals, often within a single hospital. Whereas setups known as hospital information systems have traditionally sought to handle data reflecting admission and discharge, clinical information systeims (CIS) were designed to guide decision-making and help providers manage patients more closely. Efforts are now being made to combine these approaches, along with departmental support systems such as laboratory equipment to provide integrated databases [2].

Across the country, personnel in intensive care units (ICU) have already begun to explore computer technology, due to several observations: (1) nearly a third "of all errors in an ICU involve mistakes in charting or relaying information between shifts" [3]; (2) nurses spend 15% to 40% of their time on "clerical or communication tasks" with handwritten systems; and (3) when making decisions about treatment in the ICU, laboratory, monitors, drug, and fluid data are used four times more often than clinical observations.

Vendors have marketed ICU data management systems for more than fifteen years [4]. At the University of Miami/Jackson Memorial Burn Center, a system has been installed to try to increase efficiency and to improve patient care [5]. A CIS has been used to study the 23-bed facility. Progress and procedure notes are entered into the computer, and data reflecting vital signs is automatically captured every 30 seconds. In the ICU study, the number of computer-based progress notes was greater than the number of flowsheet notes by a factor of 13. For each twelve-hour nursing shift, errors were found at least once in 25% of handwritten records. About 68% of nurses using the system preferred the computer system to the handwritten one. A CIS of this sort can allow nurses to reduce nonnursing tasks, thus allowing more time for direct patient care. As for reliability, the system speaks for itself: in three years, "only twelve hours of data on a single patient has been lost." [3]

The CIS also improves recall of clinical information, a tremendous advantage for anyone searching through records of multiple admissions, in search of specific information. A study in a medical clinic at the University of Nebraska College of Medicine [6] required half of the residents in the study to use computers to manage their patients. Although the system improved availability of information for telephone management, clinic patients waited about five minutes longer for physicians in the computer-based group. Nevertheless, nurses and clerical workers preferred computerized records. The study was complicated by the fact that residents in each group saw different numbers of patients and performed services of varying intensity.

Once again, our own medical center has stepped in at the forefront. Duke's ICU has developed its own CIS. Kevin Fitzpatrick, a physician asistant in the ICU, has been actively involved in its development, and recently demonstrated the system to a small group. It has features of the systems described above, with additional enhancements: entry of notes using keywords to standardize terminology and maximize organization and ability to search for details; a backup system to prevent incapacititation in the event of a hardware or power

(see Computers on pg. 4)

failure; use of color and convenient graphic displays of laboratory data for accurate, rapid interpretation; and a method of viewing instantaneously digitized images of radiologic studies. The radiologic analysis makes use of an AT&T system of high-resolution monitors displaying images with 1000x1000 pixel arrays. Although this system is not complete, it is used heavily by staff, and promises to support an eclectic collection of features.

The federal government has already wet its feet in this field. The Department of Veterans Affairs (VA) has developed a minicomputer-based network of imaging workstations using 80386 technology, for use at the Washington VA medical center [7]. In fiscal year 1992, a federal program known as High Performance Computing and Communications (HPCC) will begin "to develop more powerful scientific computers and to build computer networks" linking centers involved in education, research and development nationwide. Eight federal agencies have allocated $149 million for this task [8]. One goal of the HPCC is establishment of a National Research and Education Network (NREN). Although networks such as Internet—a group of subsidiary [9] government, military, educational and commerical networks—and NSFnet presently support many academic centers, the NREN could increase speed and expand service to a larger number of institutions. Speed of information transmission is an important factor, since a single graphic image can comprise up to six megabytes of data [7]. Sending such an image over modern transmission lines could take close to a full minute. Increased speed will be desired also when searching the rapidly growing national DNA sequence bank. In the meantime, the National Library of Medicine plans to make MEDLINE and other databases available via Internet.

Programs of the HPCC and NREN are meant to stimulate collaboration and to link academic medical centers more closely with the scientific community. On the clinical front, however, it seems that physicians have played a relatively minor role in the use of computerized medical records. This is partly explained by noting that physicians, because of the nature of their work, are already responsible for less than 3% of handwritten data-entry events [3]. In addition, computers have tended to add time to many physicians' otherwise cramped schedules. To achieve adequate benefit, systems must be accessible, fast, reliable, easy to use, and somewhat standardized in general approach, from one location to the next. Physicians must derive direct benefits that exceed those of previous systems, or they will have little incentive ot use them. Security and confidentiality must be ensured. Most important, the quality of patient care must not decline.

Foundations and businesses have already pledged about $800,000 to fund a nationwide computer network of patient records [1]. As more and more of today's information becomes computerized, such a project seems inevitable, and has potential to improve the lives of both patients and their caregivers. If physicians are to benefit from these efforts, they must play an active role in both the development and implementation of the new technology. We have the resources: Duke Medical Center's new five-year plan allocates $23.5 million for computing and communications [10]. Let's hope it is used wisely.

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Third Year Research: Targeting ADA Deficiency

Yoshi Murata

Mike Sicard is a third year medical student who has recently begun working in the laboratory of M. Louise Markert, M.D., Ph.D., Assistant Professor of Pediatrics and Microbiology and Immunology. Mike is working on the sequences of the dg subset of T cell receptors (TCR) that are expressed on T cells of patients with adenosine deaminase (ADA) deficiency.

ADA is an enzyme that catalyzes the deamination of deoxyadenosine and adenosine to form deoxyinosine and inosine, respectively. ADA deficiency, an autosomal recessive disorder, is characterized by elevated levels of deoxyadenosine and deoxyadenosine nucleotides and decreased levels of adenosine nucleotides. In turn, increased levels of deoxyadenosine inhibit ribonucleoside diphosphate reductase and DNA synthesis in precursors of T cells and B cells. As a result, T cell function is often completely abolished and B cell function is variably impaired in patients with ADA deficiency. These patients are severely immunocompromized and experience repeated infections and failure to thrive by two years of age. Current therapy involves bone marrow transplantation, transfusions of irradiated erythrocytes and infusion of polyethylene glycol-linked bovine ADA.

Using lymphocytes from patients with ADA deficiency, Mike is examining the DNA sequences of dg TCRs that are expressed on the cell surface of certain T cells in early stages of development. As the T cells mature, somatic rearrangement of TCR germ-line DNA sequence occurs. One of a number of sequences coding for the V (variable), D (diversity) and J (joining) regions of the TCR are juxtaposed to one another. During the gene rearrangement process, random insertion of nucleotides occur at the joining sites (N regions) between the genes coding for the V, D and J regions. Since ADA deficiency leads to elevated intracellular levels of deoxyadenosine nucleotides, there may be an increase in the amount of deoxyadenosine triphophate (dATP) that is incorporated into the N regions of TCR in patients with ADA deficiency.

In order to test this hypothesis, Mike is sequencing dg TCR DNA in lymphocytes from healthy subjects and patients with ADA deficiency. A potential difficulty encountered during the this study is the tremendous variability of the TCR DNA that is generated as a result of somatic rearrangement and the presence of numerous V, D and J regions. Such variations that are inherent to the TCR DNA sequence makes it extremely difficult to sequence only the N region. A significant amount of sequencing of the V, D and J regions flanking the N regions may need to be performed in conjunction with the sequencing of the N regions. By using a technique called inverse polymerase chain reaction, Mike will hopefully be able to circumvent this problem and rapidly obtain the N region sequences from a large number of T cells.

Once the sequences are obtained, Mike may search for correlations between the dATP content of TCR N regions and the clinical condition and prognosis of patients with ADA deficiency. If such correlations are found, then the sequences of the N regions may be used as a marker for ADA deficiency. Information obtained during this study may also be used to screen individuals who may be carrying defective ADA genes by determining the dATP content of their TCR N regions. In addition, examining the N regions may yield additional information about the alterations in cellular purine metabolism and immune functions that are caused by ADA deficiency.

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Shifting Dullness is a publication of Duke University medical students.

Students Evaluate First Year Courses

Kenny Boockvar

These days, as curriculum committees meet and instructors experiment with their courses, students and faculty alike hope that problem-based learning, standardized patients, computer labs, and clinical arts will make Duke a leader in progressive medical education, as well as produce more humane and inquiring medical graduates. And yet, though these reforms are desperately needed and so far well-received, they will never completely ease the pain of medical students learning the "atomies," "ologies," and genetics. Medical students will let their complaints be known.

In June 1991, the Student Curriculum Committee and Central Teaching Lab surveyed Duke medical students who had just completed their first year. Of 103 students, 60 responded by ranking from one to five (five being most favorable) different aspects of first year courses and by describing how they dealt with time constraints. Results are shown in the graphs below, as well as quotes of some students' comments.

In a presentation to the Student Curriculum Committee, MSII's Ken Altman and Jeff Dugas, who helped conduct the survey, wrote, "The following graphs are by no means a definitive evaluation; rather, they serve to indicate aspects of each course where students had positive learning experiences. Results may similarly reflect the variable demanding nature of different courses. We hope this information provides a constructive opportunity to improve the Duke Medical School curriculum in a time of challenging educational demands."

What Students Said

—"Things were condensed and rushed, but there were no surprises. I feel the courses cover what needs to be covered and eliminate a lot of facts not critical to a practicing physician. There are things wrong with certain courses, but overall I was satisfied with my first year."

—"I think an approach to teaching by organ systems would be better than individual subjects like cell bio, anatomy, and physiology. Teach them together showing how they all interact. Go from normal organ system function to abnormal immediately, not 6 months later."

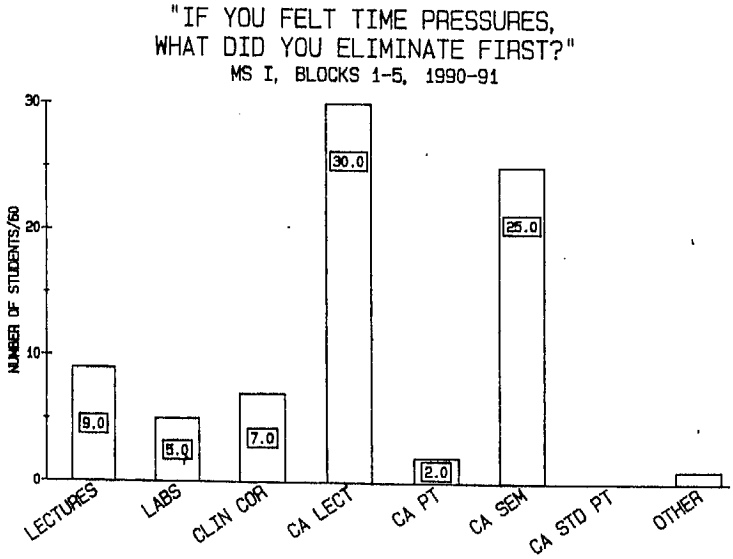
—"All in all I truly feel that the first year was well organized and I actually enjoyed a lot of it. I learned a *lot* and many of the instructors were very good. There are some instructors who were lacking teaching abilities—that needs to be corrected."

—"Overall, I think the first year needs a lot more revision and better integration among various courses."

—"I believe as an adult one must make choices to direct one's effort and time. *Nothing* should be mandatory in the first year class. I believe Clinical Arts would have had better attendance if the subjects were worth discussing—discussions of articles were useless, and the fact that we were graded on attendance was an insult."

Graph Key

BCH—Biochemistry
GEN—Genetics
CBI—Cell and Tissue Biology
PHY—Physiology
BAA—Gross Anatomy
CBI/MA—Microanatomy
NBI—Neurobiology
PTH—Pathology
MIC—Microbiology
IMM—Immunology
PSY—Human Behavior
PHR—Pharmacology
CLIN COR—Clinical Correlation
CA LECT—Clinical Arts Lecture
CA PT—Clinical Arts Patients
CA SEM—Clinical Arts Seminars
CA STD PT—Clinical Arts Standardized Patients



COURSE ORGANIZATION, BLOCKS 1-5
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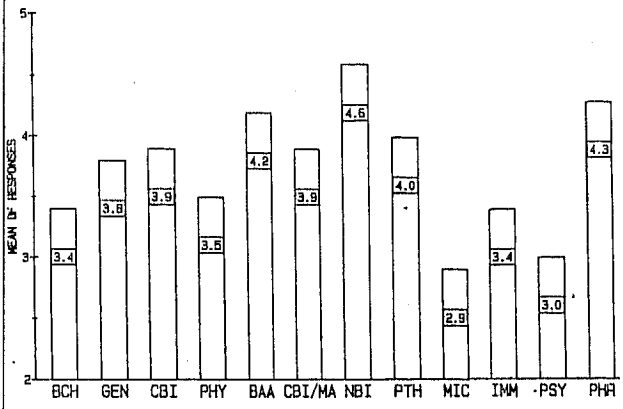
JUNE, 1991



EXAMS, BLOCKS 1-5
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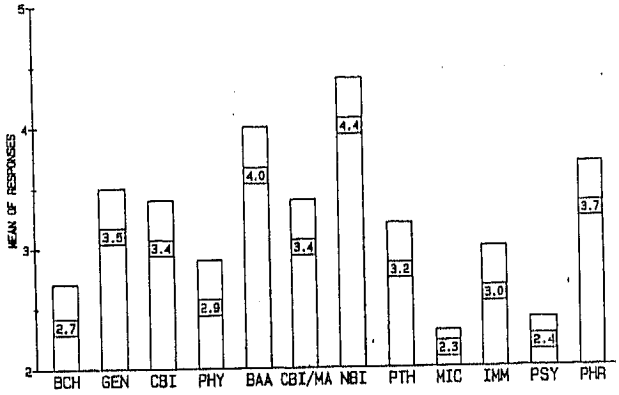
JUNE, 1991



TEACHER EFFECTIVENESS, BLOCKS 1-5
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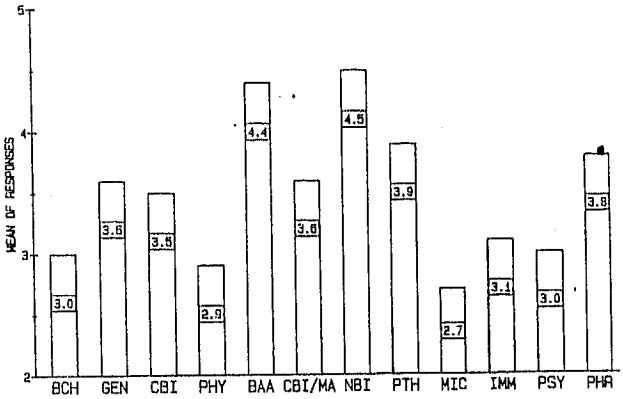

COURSE CONTENT, BLOCKS 1-5
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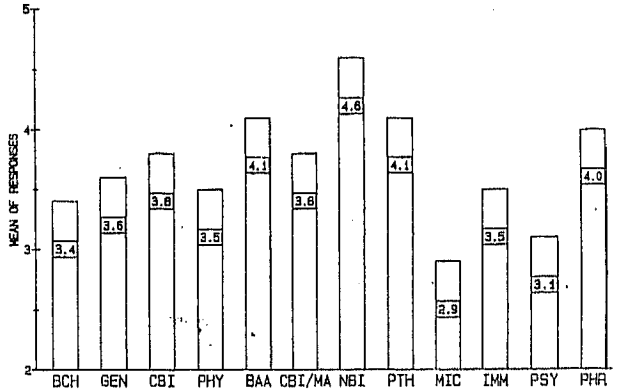

HANDOUTS/TEXTS, BLOCKS 1-5
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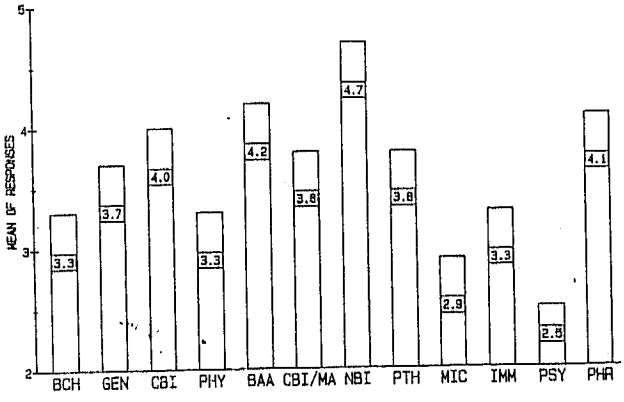
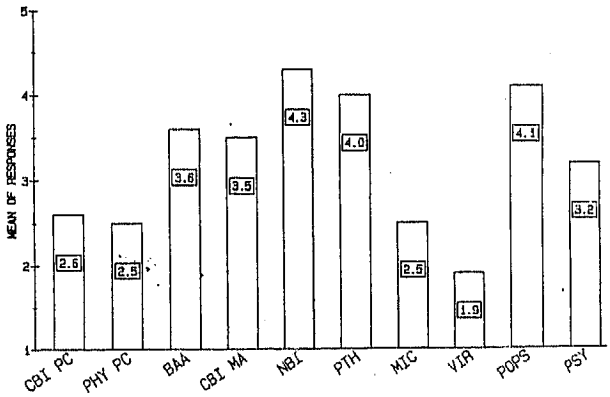
JUNE, 1991



SMALL GROUP ACTIVITIES, BLOCKS 1-5
"EFFECTIVE USE OF TIME"
MS I, 60/103, JUNE 1991



Curriculum View: MSI Problem Sessions Not Accomplishing Goals

Garrett Nichols

Gunners are good for something.

Entering the first finals of my (short) medical career last week, I was feeling pretty smug about my preparation level until the front row's "favorite son" asked the professor a question. You know, about "the basics."

Uh, right, I must have gone over that late last night... doesn't ring a bell....could you repeat that middle part?

So much for preparation.

The impetus to study was provided, however, and an exam tragedy was averted. To one gunner I thus thankfully owe my pride and academic accountability. I now heartily welcome the much maligned gunners to lecture.

Just keep them out of the problem solving program.

You see, it is the science-hungry gunner that is stealing the fire from an otherwise sound program of problem based learning and clinical-style interactions. My group, which is not extremely different from many others, has almost exclusively focused on the arcane biochemical details of Diabetes Mellitus and Sickle Cell Anemia from Day One, leaving little room for the building of clinical skills and sociological awareness.Following week one of each block, in which the standardized patient was interviewed, her existence became a non-issue. In the rush to investigate the relationship of specific HLA genes to the loss of insulin productivity, the newly diagnosed diabetic's psychological status, coping resources and name were neglected. In short, a triumph of the human element.

The blame for this problem, however, cannot fall solely on the gunner's slim shoulders. The problem solving program is lacking one crucial element, on which its success hinges—a sense of direction. Poorly defined goals from the get-go have introduced an uncertainty in the program that is too easily filled by treatises on the impressive heterogeneity of the genetic code that underlies normal hemoglobin formation (an interesting fact, I'm sure, but one that has little relevance to sickled red blood cells). Basic science lectures, in my opinion, should be and are more than adequate in the provision of the biochemical and genetic underpinnings of the diseases we have studied; nothing that Drs. Hill and Nevins have not covered should be explained to me by a first-year med student who himself acquired the information the night before our afternoon meetings.

The goal of problem solving instead should be to encourage contemplation on topics seen from a patient's viewpoint: How would it feel to be 21 years old and suddenly discover that you are diabetic? What changes in your lifestyle would you have to endure—in your diet? in your exercise regimen? in your career goals? What coping programs exist in the community to assist your transition from a "healthy" self-concept to that of a "diabetic"? And from the doctor's vantage point, how does one communicate all of this to a patient that is clearly traumatized by the knowledge of his/her illness?

This approach, of course, is nothing new to many of the problem solving groups. They strike the balance between the clinical and the chemical, and successfully delve into the psychosocial issues that I truly believe were the target of the program in the first place. These groups have defined their own topics of interest, set their own goals, and have worked together to develop a complete understanding of the disease-of-the-month with all of its implications for the individuals involved.

Many, however, have been hampered by the list of essential topics deemed crucial knowledge by the heads of each science department. According to CTL lore, this list is testable, and it is this threat that has pushed many to consider subjects that inspire little group interest (other than examination fear). Group gunners happily hunt for obscure information on science-based topics, while the remainder can sensibly do little but the same, knowing that their issue (on which they will become an "expert") could possibly become an exam question.

This issue is trivial, however, in comparison to the damage to group dynamics that such a list causes. The chemistry of each group is fundamentally different, which creates a wonderful diversity of interests within each group—topics that may generate such enthusiasm within the section as to (gasp!) stimulate conversation outside of CTL walls. A list of required subjects effectively stifles the creative ability of students to identify potential problems and to solve them, which is what problem-based learning is all about. Otherwise, we might as well title the course "Scientific Book Reports with Facilitator Supervision."

Granted, the basic science professors have given up a few lectures to allow the program's existence, and thus they understandably wish to direct the program in some manner. But why not give a lecture or two back? After all, disease-specific lectures that fall a week after the initial standardized patient interview could greatly enhance the program, and spare the agony of student ramblings on the latest in gene therapy treatments for Diabetes Mellitus and Sickle Cell Anemia.

More lecture time—gee, I think even the gunners could be happy with that.

• Announcements •

Financial Aid Opportunities

Nell Andrews

HELP REDUCE YOUR OVERALL STUDENT LOAN OBLIGATION: When a financially needy student obtains a grant or scholarship from a source outside the school, an amount equal to the outside award is taken from the *loan component* of the student's financial aid package. This policy is intended to have a positive influence by reducing the overall amount of student loan debt at graduation.

FINANCIAL AID RESOURCES OUTSIDE DUKE: The Financial Aid Office has a current listing of many "outside" sources of grants, scholarships and low interest loans. Eligibility varies for these resources: some are need-based; some are based on city, county or state residency; some are based on gender or religious affiliation, and so on. The application deadline for some occurs as early as February or March for the upcoming year. This is the best time of year to write prospective sources for more information and application forms.

NAVY SCHOLARHIPS: Two- and three- year navy scholarships are available to upperclassmen beginning 1992-1993. Submission deadline is December 15. Decisions are made by early January and February. Application packets were mailed to each first and secod year student in September. For more information call Chief Norman Rogers 1-800-662-7568.

1991-92 HUGH J. ANDERSEN MEMORIAL SCHOLARSHIPS: up to seven scholarships through National Medical Fellowships, Inc. will be given this year to financially need, underrepresented, minority (African-Americans, mainland Puerto Ricans, Mexican-Americans and American Indians) medical student residents of Minnesota. All first through fourth year candidates must have extraordinary leadership and community service, and no academic deficiency. Awards range from $2,500 to $4,000. More information is available in the Office of Financial Aid, 126 Davison Building.

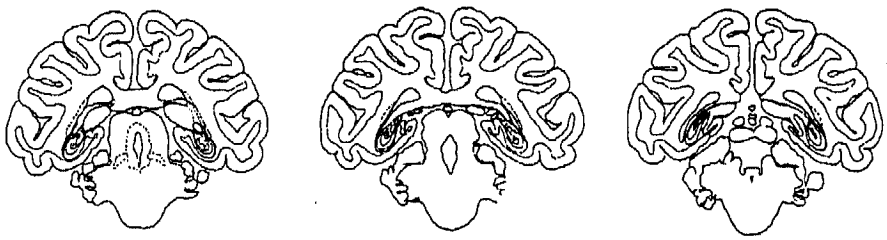
FUNDS FOR ELECTIVE STUDY AWAY FROM DUKE: Students may use financial aid funds for expenses related to approved elective study away from Duke during the third and fourth years. Where the student's expenses are greater then they would have been had the student remained at Duke, need-based financial aid funds from the institution are not available for the additional expense.

NORTH CAROLINIANS: In order to be eligible for the need-based financial aid package for North Carolinians, one must be a North Carolinian at the time of matriculation.

Scholarship Opportunities

HARTFORD FOUNDATION/ AFAR SCHOLARSHIPS: Fifteen scholarships are being awarded enabling students to undertake 3-month research projects relating to any aspect of pharmacology in the elderly. Scholarhips are for $10,000 and are to be shared equally be the student and faculty mentor. Applications are due December 13, 1991 and are available via the Dean's Office or from AFAR, 725 Park Ave., New York, NY 10021.

AMERICAN OSLER SOCIETY-WILLIAM B. BEAN RESEARCH AWARD: An award is available to medical students for support of research in the areas of medical history and medical humanism. The successful applicant may be eligible to present a paper at the annual meeting of the American Osler Society and will receive a $1,000 stipend, with up to $500 additional funds available to support travel expenses. A letter of support from a faculty sponsor along with the application form must be sent by February 1, 1992 to Lawrence D. Longo, The American Osler Society, Division of Perinatal Biology, Loma Linda University School of Medicine, Loma Linda, CA 92350 (from whom applications can be obtained).



• October—November Calendar •

ART EXHIBITS

Duke North Display Cases: Department of Pharmacy Exhibit 10/10-10/14.
American Indian Arts and Crafts from the collection of Terrence Brayboy 10/14-11/15.
Pastoral Care Exhibit 10/20-10/28.
Rankin Ward Exhibit 10/28-11/14.
Rauch Display Case (1st floor Morris Building): Paintings by Steve Allen Whitehead through October.
Eye Center Tactile Art Gallery: Regular Collection of African, Central American, and Egyptian Art weekdays 10a.m.-1p.m. New works by Clyde Jones beginning October 15th.
Institute Gallery (107 Bivins Building, East Campus): "Artifice and Sexuality" paintings by Margaret A. Curtis to 10/11. Recent Works by Catalina Arocena 10/13-11/15.

MUSIC

October 27: Organ recital by Jan Jongepier at 5 p.m. in the Duke Chapel.
October 27: (1991-92 Mary Duke Biddle Distinguished Resident Composer) at 8 p.m. in Baldwin Auditorium.
November 2: Music of the Schumanns and Mendelssohns at 8 p.m. in theNelson Music Room.
November 9: Quartetto Beethoven Di Roma at 8 p.m. in Page Auditorium.
November 10: Music for Chorus, Orchestra, and Winds. Duke Chorale, Duke Symphony, and Guests at 4 p.m. in Baldwin Auditorium.
November 17: "From Salzburg to Vienna,"St. Stephen's Chamber Orchestra with Tibor Szasz at 8 p.m. in Baldwin Auditrium.
November 19: The Dmitri Pokrvsky Ensemble at 8 p.m. in Page Auditorium.

SPECIAL EVENTS

October 28th David Stone of the Museum of Life and Science Brings Talking Dinosaurs to Duke Medical Center.

FILM

Freewater-All films at 7p.m. and 9:30 p.m. (unless otherwise stated) in the Griffith Film Theater in the Bryan Center. Free to Duke students.
October 24: *The Gold Rush*
25: *Landscape in the Mist*
29: Filmmaker Ralph Arlyck presents his film "Current Events" 8 p.m. only.
31: *Adam's Rib*
November 1: *Too Beautiful For You*
5: *Au Revoir, Les Enfants*
7: *The Taming of the Shrew*
8: *Jesus of Montreal*
9: *The Neverending Story*-10:30 a.m.
12: *Lies My Father Told Me*
14: *Dr. Strangelove: Or How I Learned to Stop Worrying and Love the Bomb*
15: *Joureny of Hope*
15: *Pink Floyd the Wall*-midnight
Quadrangle Pictures-All films Saturdays at 7 and 9:30 p.m. and Sundays at 8 p.m. in the Griffith Film Theater in the Bryan Center. Admission $3.
October 27: *Dying Young*
November 2-3: *Naked Gun 2 1/2*
9-10: *Regarding Henry*
16-17: *Boyz n the Hood*

LITERARY LUNCHTIMES

Fridays at noon in the Dean's Conference Room, M32 Green Zone, Duke South
October 18: "First Confessions," by Frank O'Hara.
October 25: Open reading with a focus on the "how-to" poem.
November 1: "The Shadow of the Cross" by Marly Sevick. Suggested by Dr. Frank Neelon.
November 8: Open reading with a focus on dramatic monologue and direct address in poetry.
November 15: Novelist Laurel Goldman will read. Laurel's most recent book is *The Part of Fortune*, published by Tichenor and Fields.

Clubs Med

AMA-NCMS News

Jill Levy

The Duke Student AMA-NCMS has been having a busy fall. The Durham-Orange County Society meeting and dinner on November 9 will have a strong showing from Duke Med. The next meeting will be held on December 11 at the Omni Europa Hotel in Chapel Hill and will include dinner and a speaker. Also coming up is our annual Pharmaceutical Fair on Wednesday, October 23 from 9 a.m. to 4 p.m. in the Searle Center. This will feature company representatives discussing their latest products. All med students as well as hospital staff are welcome. Another event this fall is the North Carolina Medical Society's annual meeting in Asheville which will be held from November 6-8. Free housing will be provided to students who can go to all or part of this meeting. Finally, a symposium on animal research is in the planning stages for the winter. Anyone interested in these events and who missed the organizational meeting in September should contact Jill Levy at 382-2959.

1992 Student Faculty Show

Plans are underway for the 30th Annual Duke Medical Student-Faculty Show. The show will be based on the classic*Willy Wonka and the Chocolate Factory.* If you missed the organizational meetings and are interested in contributing, contact producer Mark Somers (419-0116), directors Brian Bowman (471-8282) and Jason Dimsdale (419-0104), or business manager Matt Areford (684-5354). Everyone's help is needed!

IM Sports

There are two important dates to keep in mind coming up: 1) November 4—Captain's meeting for IM basketball (men's and women's and recreational league); 2) November 18-22—Men's and Women's racquetball singles tournament sign-up (play is November 23-24).

Adopt-A-Highway Clean-Up

MSIII's will meet on October 26 at 10:30 a.m. to clean up a two mile stretch of highway along Pickett Rd

Shifting Dullness

Class News

MSIV

Herb Chen

Congratulations to Todd Levine and Mary Landau on their recent trip down the aisle (or down the beach in this case). Also congrats to Mary Lien on her recent engagement. Thanks for filling out the nomination sheet for class speaker/hooders/etc. Final ballots will be out in late November. Look for information about the CIBA-GEIGY service awsard for 4th years. Phone lists for the class have been sent out. If you did not get one, call Herb (382-0107) or Mac (471-2167).

MSIII

excerpted from *MSIII Progress Notes*

MSIII travelers: Robert Sidbury is working in Sydney, Australia at the Children's Medical Research Foundation on the v-myc oncogene and tumorigenesis; Fred Wenzel is at the Children's Hospital in Boston, working on characterizing the role of HB-EGF, a growth factor, on smooth muscle proliferation; Oded Herbsman is working at UCSF on transforming growth factors and tumorigenesis; and David Ting will be going to Tanzania in January to study anemia in infants in the epidemiology study tract. Wedding bells ring: congrats to Mary Landau and Tod Levine, who tied the knot September 28; to Chris Watke and his fiance Mary (to be married April 25); to Frank and Phyllis, who have reserved Duke Chapel for next June; and to Tim Smith and Miriam, recently engaged.

MSII

Alison Toth

Jill, Judy, Kim and Lisa will be having a party to celebrate the end of the first rotation on Wednesday, October 23 starting at 6:30 p.m. (or earlier if you want to play volleyball, etc.) at 1716 Cole Mill Rd. Call 382-8073 if you have any questions. Reminder: Howard Hughes Scholarship deadline is December 5.

THE DUKE MEDICAL ALUMNI ASSOCIATION

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Annual Fall Pig Picking

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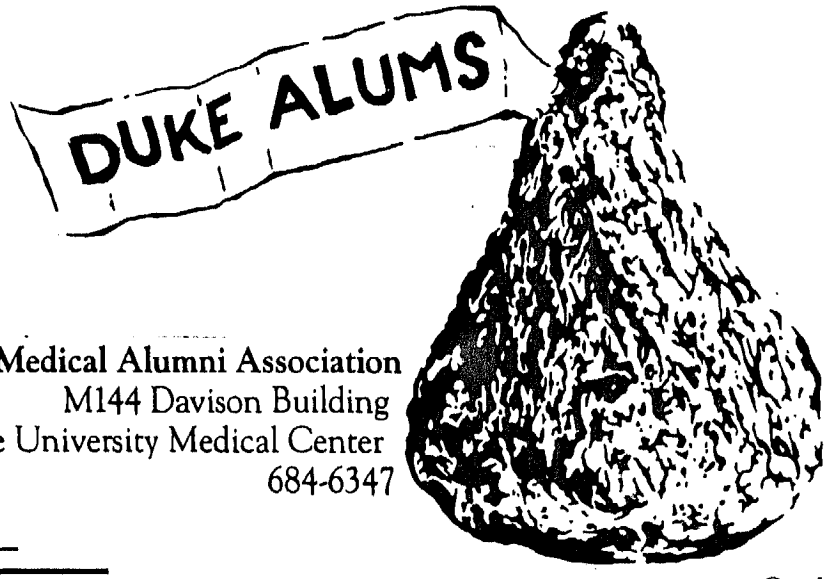
Perspectives

and, of course, the Candy Jar



Medical Alumni Association
M144 Davison Building
Duke University Medical Center
684-6347

Second Opinions

Universal HIV Testing Is Not Practical

Garrett Nichols

Do you remember when you first heard about the AIDS epidemic?

If you are like the majority of the US population, it was 1982, when C. Everett Koop addressed the nation about a deadly disease that was reaching epidemic proportions. In his speech, Koop stressed the gravity of the problem and offered a strategy of education and behavioral change to combat the spread of HIV. Above all, AIDS policy decisions were to be based on rational considerations, not on the fear of the masses.

Guess that wisdom is officially out of the window.

The Kimberly Bergalis case, and her emotional testimony to Congress last month, have freed a conservative backlash that champions universal testing rather than universal precautions among health care workers as a method to slow the spread of the disease. Most recently, fear also appears to be influencing AIDS policy within the Center for Disease Control (CDC). Last week, CDC drafted guidelines that would push hospitals to routinely offer and encourage HIV testing for all patients as well. While the early identification of infected individuals is certainly a worthwhile goal, the location of such a testing program in hospitals is not a practical nor reasonable approach.

In terms of logistics, the country's hospitals simply are not ready for a massive screening initiative. Few institutions have counseling and treatment programs in place that would be able to handle the needs of many newly identified patients. Without such support groups, knowledge of sero status would be useless—and perhaps even harmful—to the seropositive individual.

Counseling's greatest benefits, however, have not been historically reserved for the seropositive. Testing programs in the past have reduced HIV transmission not by preventing high-risk behavior within the infected, but by teaching low-risk behavior to the uninfected; thus, the rationale for HIV testing and counseling coupled with syringe exchange programs or with STD clinics. The testing in these situations is purely voluntary, and has had a dramatic effect on the few communities in which the clinics are located.

Obviously, such extensive counseling for the uninfected is impractical in a hospital setting. While most agree that access to testing has a crucial role in managing the epidemic, a lack of individual intervention designed to produce behavioral change effectively reduces testing's greatest potential in halting the transmission of the virus.

The bottom line on universal patient testing, of course, is the bottom line: funding. The American Hospital Administration (AHA) has voiced the strongest opposition to the CDC guidelines, estimating the annual cost of testing alone at $1.65 billion. In a time of failing hospitals and federal budgets squeezed to the limit, one must wonder from where this money (and the money to pay for treatment and counseling staff) will appear.

Given the fact that education and treatment programs appear to be effective in the few areas in which they are adequately funded, any fiscal windfall could be put to better use than to the indiscriminate testing of all hospitalized patients. "High-risk" groups were specifically identified and selected for a reason—given limited financial and human resources, dollars and personnel were directed to neighborhoods and subpopulations that had the highest incidence of the disease, maximizing results as much as possible.

Face it—when we have so many thousands of people getting AIDS from needle sharing and promiscuous sexual activity (two groups that may be reached through programs already in place), it seems almost criminal to spend so much time and money on a program with limited effectiveness, targeted at a group with comparatively little statistical significance.

Solutions to the AIDS epidemic never have come easy. A focus on the HIV test, however, is not the answer. The test is not magical—it will not cure the individual who discovers that he/she is scropositive, nor will it prevent the spread of the disease.

Universal testing, however, could have other effects. Confidentiality is always an issue with personal medical data, but blanket AIDS testing falls into a hypersensitive category. Fear of inappropriate disclosure of test results could drive individuals away from the hospital sysem altogether, denying patients needed treatment.

And universal testing represents a continuation of the "us against them" societal trend—the need to "root out" those infected with the disease. If adequate treatment programs are not in place before testing begins, this will be the only task accomplished.

Dear Editor,

We are submitting for publication in your newspaper an article that deals with lesbian, gay, and bisexual issues. This is part of a project directed by the Lesbian, Gay and Bisexual People in Medicine (LGBPM) Task Force of the American Medical Student Association.

LGBPM was formed to improve the quality of health care delivered to lesbian, gay and bisexual patients and to improve conditions for lesbian, gay and bisexual medical students and physicians. We believe that much of the intolerance and oppression directed at lesbian, gay and bisexual people by the medical community could be alleviated by increasing understanding and awareness of lesbian, gay and bisexual people and more specifically the issues that affect their access to and involvement in the medical system. It is easier to discriminate against a group about whom your knowledge is limited. By providing exposure to students and faculty on a regular basis, through their school newspaper, we hope to personalize issues that will affect their interaction with lesbian, gay and bisexual patients and peers.

"Coming Out of the Closet" has been submitted to the school newspaper of every medical school in the United States. This project has been funded to provide a series of four articles that deal with issues that affect lesbian, gay and bisexual people and their interaction with and participation in the medical system. Future articles could feature experiences or perspectives of patients, medical students, residents, practicing physicians, faculty and administrators from all over the country. Ideas for topics of future articles will be enthusiastically received.

Sincerely,
Mercedes Menendez
National Co-Coordinator, LGBPM

Coming Out Of The Closet

Mercedes Menendez

My name is Mercedes Menendez. I am a second year medical student at University of Texas Southwestern Medical Center, and I am a lesbian.

I have just "come out" to you. But what does that mean for *us*. *Us*=you and me individually as well as society as a whole.

For me, "coming out" is liberating, self-affirming experience. In contrast to other oppressed groups, most lesbians, gay and bisexual people cannot be identified based on physical characteristics. The result is, for the most part, we are an invisible troup. Our heterosexist society enforces lesbian, gay and bisexual invisibility. The whole issue is treated like an ugly family secret we would rather lock away in a closet and ignore.

"Family secret?" Is that a good analogy? Yes. A conservative estimate is that lesbian, gay, and bisexual people are ten percent of *us*.

History, as well as present day conditions have shown that invisiblity and silence are a deadly combination. Invisibility makes the violence (physical, psychological, institutional) more palatable and easier to swallow. And through their silence many people, institutions and governments have condoned many injustices. It is liberating and self-affirming for me to declare "I am a lesbian" because I will not contribute to my own oppression through my silence.

By "coming out" to you, I have personalized the issue. It is easier to oppress a group about whom your knowledge is limited and perhaps based on stereotypes. This issue is not about dykes and fags. It is about your patients, peers, co-workers, family and friends.

In the past, the contributions of lesbian, gay, and bisexual people have been erased, and in the present, they are ignored. The concepts present in the culture to which we are born to a large degree determine the establishment of our individual horizon. Horizon can very simply be defined: "as far as we can see" or "the possibilities we see for our future." Our society does not support or celebrate the part of itself that is lesbian, gay andbisexual. One result of this is that lesbian, gays and bisexuals are disproportionately represented in the tragedy of teen suicide. We must, generation after generation, overcome the negative images of our selves, taught by our culture, by courageously engaging the adventure of developing new concepts and images that celebrate the fact the we are a valuable part of society.

LGBPM (Lesbian, Gay and Bisexual People in Medicine) was formed to improve the quality of health care delivered to lesbian, gay and bisexual patients and to improve conditions for lesbian, gay and bisexual medical students and physicians. It is a task force of the American Medical Student Association. To open doors and create new possibilities and positive images—join the LGBPM task force. For more information, please contact: AMSA/LGBPM, 1890 Preston White Dr., Reston, VA 22091-4325 or (703) 620-6600

Shifting Dullness accepts letters of opinion from all members of the medical school community. Opinions expressed do not necessarily reflect those of the editorial staff. *Shifting Dullness* reserves the right to edit letters for length and style. Mail to *Shifting Dullness*, PO Box 2865, DUMC.

Franco Recchia Takes The Small Screen

John Savarese

$500. Subject—Duke Medical School. Answer: This first year medical student's last name means "a sheep just before it's wool has been shaven." Question: "WHO IS FRANCO RECCCIA?" "YES!" affirms the smug, self-satisfied Alex Trebek, who incidentally already knew the answer.

And just who is Franco Recchia? This question may never find an answer; however, for two days last month, this man's story kept many of us glued to the television and conversing in question format. Franco (pronounced like "Bronco" or "Ronco"—for God's sake don't say Frank-O as in Drank-O or Spank-O) recently appeared as a contestant on *JEOPARDY!* where he represented the mighty *Tartars* of Wayne State University during the show's college tournament.

Recchia agreed to his first off-camera interview last week and relived his experience with me. It all started with a $42 bus trip from his Detroit home to Cleveland, where he participated in a regional tryout with 500 other contestants-to-be—all vying for two spots. There, he met Alex Trebek for the first time. Recchia's first impression of the game show's guru? "Hate at first sight." The hate was ripened by Trebek's insistence on wearing those earth tone suits by "Mr. Guy, Mr. Guy, Mr. Guy." Months later, Recchia was invited to compete in the tournament, where he advanced to the semifinal round, ultimately falling to the eventual winner but not before pocketing a cool $5000.

But what about the goods, you know, prizes 'n stuff—those "parting gifts" which we hear spoken in fastforward during the final 30 seconds of any game show? Well, as I found out, we've come a long way since *Rice-a-Roni, Turtle Wax,* and *Sue-Bee Honey.* This is where things get iteresting. A first place finish would have landed Recchia $25,000. However, a glance at his runner-up winnings might leave the champion from Georgia Tech wondering who really got the better bag of tricks. Now, you the reader can make the call.

The prized fell into six identifiable subjects, not unlike the arrangement on a typical *Jeopardy!* boar: Food, Electronics, Pharmacology, Personal hygiene, "Fountain of Youth," and Hair.

"Food for three hundred Alex." Five utterly disparate items comprise this category of comestibles. Nourishment first comes in the form of 12 packages of *Velamints* at 12 rolls per package and ten mints per roll. That's 1,440 *Velamints* and fresh breath to carry Franco well into the next block. Also received were 12 boxes of *Luzianne* tea at 100 bags per box. Using applied calculus, I've arrived at a tea total of 1,200 bags. A quick peak at the above figures reveals an interesting pathway. Normalizing a typical cup of tea as requiring one bag and a typical breathfreshening use of *Velamints* as requiring one mint, Franco clearly has enough mints to neutralize all ensuing tea-breath. Accounting for the 1200 *Velamints* used to neutralize the tea breath, there remain 240 excess mints. This "spillover" is known as the *Vela*-phosphate shunt. Finding out what Recchia will do with the spillover is considered the "Holy Grail" of the hot new field of Beverage-Induced-Halitosis Research. *"No-stick!" Spray* (Earth-friendly, no CFC's), *Libby's Juicy Juice* (no longer confused with other non0juicy juices) and a chip-and-dip platter, good for those crazy Recchian *Ruffles* parties.

"Electronics for six hundred, Alex." The *Nintendo Entertainment System.* "What is hours of distraction standing between a career as a doctor or working at the *Sunoco* up the street?" Yes, Franco took home this staple of Americana, complete with the *Jeopardy!* and *Junior Wheel of Fortune* home games. He also received two AM/FM stereo headsets (His and Hers, you ask? No comment from our elusive contestent). Finally, in one of the most baffling of shipments, Recchia received eight, yes, eight *ARMITRON* wristwatches (total value $9.95), in a variety of neon colors includig radioactive pink, uranium yellow, nuclear orange, and Chernobyl green.

"Fast-forward pharmacology for five hundred?" "INCORRECT!!" (replies Alex, visibly foaming at the mouth). "THIS IS NOT THE JOKER'S WILD THIS iiiizzzzzzzzzZZZZZZZZ *JEOPARDY!*" The pharmacology category includes any of the many over-the-counter remedies/narcotics which Franco received. They include *Q-Vel* muscle pain relief pills, *Clear Eyes* eye drops, *Nytol* sleeping pills, and *Centrum* vitamins. Are vitamins appropriate for this category? Trebek justified the association with the following: Vitamins are pills. Drugs are pills. Therefore, vitamins are drugs. Trebek, in a frenzy, continued to exploit his logical deduction skills, noting: Ray Charles is blind. Love is blind. God is love. Therefore, Ray Charles is God. You got the right one BA-BAY, Uh-HUH!

Moving right along, we arrive at the category of personal hygiene consisting largely of soap, and lots of

(continued on page 14)

Recchia (continued from page 13)

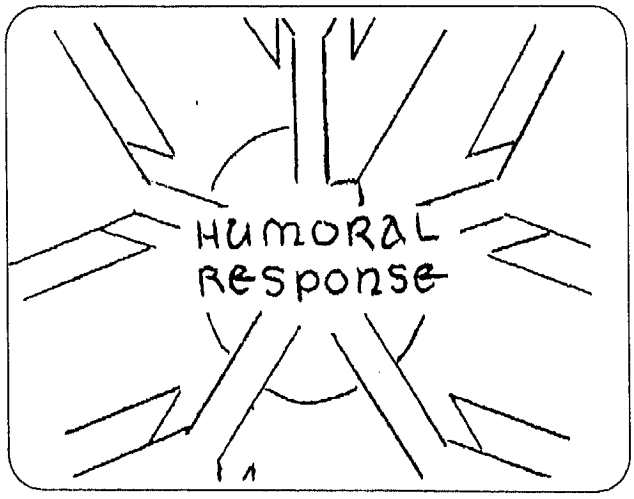
it. Take for istance the 20 bars of *Jergen's* Aloe and Lanolin. However, it's the '90's, and today's liberated soaps need not be confined to a lifetime as a rectangular block. Franco's gift array of *Capri* brand shower soap transcends the bar form, achieving hitherto unheard of prominence as a shampoo and conditioner, a moisturizing "soft" soap, skin conditioner, and (listen up, ladies) BUBBLE BATH.

The "Fountain of Youth" (oh, you mythical word-player, Alex) comprises a curious group of aging remedies. Recchia is not a denture wearer (though he plays one of TV), but that does not stop him from looking forward to his days on Golden Pond when his new supply of *Orafix* denture adhesive may sit firmly on his gums. He'll feel great with plenty of *Centrum* Silver vitamins, but there will be no silver in that head of hair! Oh, no, no-sirreee—not with his *Just For Men* hair coloring kit! Sounds like the retirement we all dream of.

"Hair for one thousand." OOOH! AN AUDIO DAILY DOUBLE!! If you have seen Franco recently, you have seen a man with a hairdo-and-a-half, a collection of confident curls tamed with the right blend of flammability. The number and variety of hair care products which he has received astounds the naked and untrained eye. From *Vavoom* Matrix hair care products: Two bottles each of shampoo and conditioner, glazing gel, volumizing foam, and freezing spray.

More daunting is the deluge from the reigning captain of coiffure, Paul Mitchell. Reccia received two bottles of the following: Shampoo One, "THE" Conditioner, *Awapuhi* shampoo, *Awapuhi* moisture mist, Super-Charged conditioner, hair sculpting lotion, sculpting foam, Super Clean sculpting gel, sculpture spray, soft sculpting spray gel, Seal and Shine, and Freeze and Shine sculpting spray. Fortunately, he also received the Paul Mitchell Hair Repair treatment, which he can use to reverse the inevitable damage caused by the original use of his Paul Mitchell products, whose ingredients make industrial waste look like spring water.

So there it is, the kit, the kaboodle, the kitchen sink, all the marbles, minutiae, and money which accompanied Recchia's *Jeopardy!* jackpot. Fortunately, he has escaped unaffected by the sudden material gain. But, what now? Where does he go from here? "I think I'll lay low in Durham for, oh say, four years. Then it's back to the gameshow scene, this time on the *American Gladiators*. Lace, Diamond, Turbo, Franco... has kind of a nice ring to it, doesn't it?



About the cover: *Untitled,* a neupastel color drawing by MSIV Lisa Oakley screened into a black-and-white halftone by Coby Design, Inc. Lisa recently had a solo exhibit of painting... in Duke North Hospital Display Cases.

Dear E Bach

E Bach,

Be not deceived. I suspect that you have been the victim of an elaborate ruse. I am referring, of course, to the recent letter in your column from an individual purporting to be one Ishmael K. Exalate. You were completely correct in referring to this person as anonymous. An extensive analysis of the Duke University and Durham phone books, calls to the University Student Locator, and finally a computer search of comprehensive junk mail address listings reveals that, in fact, (s)he is using an alias. There is no evidence that any individual with this name ever owned a telephone, held a major credit card, paid taxes, or held a non-agricultural job in the United States of America, the Pacific Rim, or Western Europe. Although "Mr. Exalate" has succeeded for the moment in concealing his/her precise identity, detailed analysis of his/ her communication with you is underway. At first glance exalate appears to be simply a reference to some obscure biochemical intermediate; however, it is actually a word that can take as its meaning either "without wings," or "exalted" (depending on the pronunciation—unfortunately Burger King Hotline audiotaopes of the telephone exchange are somewhat garbeled and difficult to interpret). My guess is that this name reflects a grandiose tendency not inconsistent with the paranoid overtones of his/her letter, although one must keep in mind that it may simply reflect his/her inability to fly or a vague fear of aircraft. Further examination also reveals that the letters ISHMAEL K EXALATE can be rearranged to form the phrases: A SHAME LIKE LATEX, EXILE SHALL MAKE TEA, and MEAL LEASE TAX HIKE. Personality profile experts believe that this may indicate "Ishmael" suffers from profound guilt caused by sexual fetishism, may be an expatriate Englishman (or woman), and is probably a Democrat.

I am working with the BKH and several federal agencies in this regard not only because of our deep concern for "Ishmael"'s safety, but also from a concern for the community at large. Backward masking analysis of several demonic rock and roll albums have yielded a higher than expected, statistically significant rate of occurrence of the word "Ahab," and governmental investigators in recently declassified reports state that films taken during the Kennedy assassination clearly show a large white whale-shaped object wearing sunglasses and lurking near the infamous grassy knoll. Consequently, given "Ishmael"'s pronounced anticorporate hostility, we can only conclude this individual may be involved in a conspiracy of international proportions targeting the very fabric of the American Way of Life. We fear that as a mind-reader (s)he may be implanting hidden messages in his/her letters to your paper in such a way that they are able to enter subliminally into the consciousness of an unsuspecting reader and cause abrupt changes in personality and behavior. A team of volunteer undergraduates who agreed to repetitively read the letter you already published were found to temporarily avoid eating balanced meals, cleaning their rooms and wearing rain boots. The study had to be prematurely ended when two participants began drawing Marxist-Leninist symbols on their textbooks and required emergency treatment with Brady Bunch reruns. If you should feel the need to publish more communications form this individual, please advise your readers not to read the column more than once, unless they are qualified in forensic parapsychology or have access to a reliable deprogrammer.

Advise your readers not to read the column more than once, unless they are qualified in forensic parapsychology or have access to a reliable deprogrammer.

Un ami qui vous veut du bien

(continued on back page)

Dear E Bach (continued from page 15)

Mon ami,

Never invoke psywar (psychological warfare) as a sequel to my reading any letter. I have bolstered myself with countless listening to Partridge Family albums, reviled the sexual frustration of one Gilligan of island fame and pondered deeply the reasons Superman hasn't made clear his super libido. Maybe Lois Lane was suffering from a bit of the proverbial hip disease.

In any case, your letter is ostensibly concerned for our Ishmael, but covertly you seem to identify with the Ishmonster. Let me offer my impressions.

First of all, FBI tactics will never track down our closet Melville. I gather that the surname K. Exalate bears relation to a certain cathartic Ex Lax, and that this individual has not graduated from the anal phase of early development. Chalk one up for sexual fetishism, which grew out of the anal thing. I have agents scouring bathroom walls for messages, perhaps cryptic, that may lead to justice.

I have agents scouring bathroom walls for messages, perhaps cryptic, that may lead to justice.

Mr. Ex Lax also betrays a traumatic upbringing, without the creature comforts of a mom who cooks. I can envision this youngster walking to school with an Ozzie lunchbox filled with cheese curls and cola. He is not likely to be a physical specimen. I'm thinking something in a Kevin McHale prototype. No, anyone who frequents Burger Kings and laments the underqualified help should move north and hire a chef.

With regard to his sexual orientation, I fear that KX may be recovering from a collegiate burn. If I'm correct, KX starting dating an attractive girl in college, only to have his hopes dashed by her becoming enamoured of the fast food industry and developing a severe case of bisquit poisoning. *That freshman fifteen turns into forty in no time, hey Ishmael?*

You remarked that this person's political persuasion is Democrat? I think that his highly intelligent person was sired from distinctly Republican stock, and is only now regretting the error of conservativism. His rejection of domineering parents, and their doubtless anxiety over their impression of his apathy, have lent him an obdurate disposition to anything aristocratic. He is hopelessly homeless, however, because he doesn't belong in the gutter either, as far as he knows.

My tactics for revealing our mystery literary figure are more subtle. I will bring him out of hiding by using subliminal messages to assail the very fiber of his constitution. *Yo, Ishmael.* Years of answering cryptic undertones have expertly trained E Bach. *Your mother.*

I have a strong hunch that Ishmael has left BK lounge for more sophisticated environs. Look for him at late night Kroger check outs harassing the help. *Ishmael, my man.* Watch for old concert T shirts and anyone speaking in a vapid stream of incongruities. *Your girlfriend has end-stage hirsutism.*

In closing, I would like to gratefully thank your efforts in locating Mr. Ishmael. *Ishmaelorama.* Like you said, his anti-American demeanor needs to be challenged by some good flag-waving. *Run up on stage and play air guitar at the Van Halen concert.* That Jefferson Davis Highway must really piss him off. Let me hear from you again, Moby.

Letters to E Bach are actual submissions from members of the Duke Medical community. Send letters to Eric Bachman at PO Box 2704 DUMC or drop them in the Shifting Dullness box in the Alumni Affairs office (candy room) or in the student lounge, Duke North.