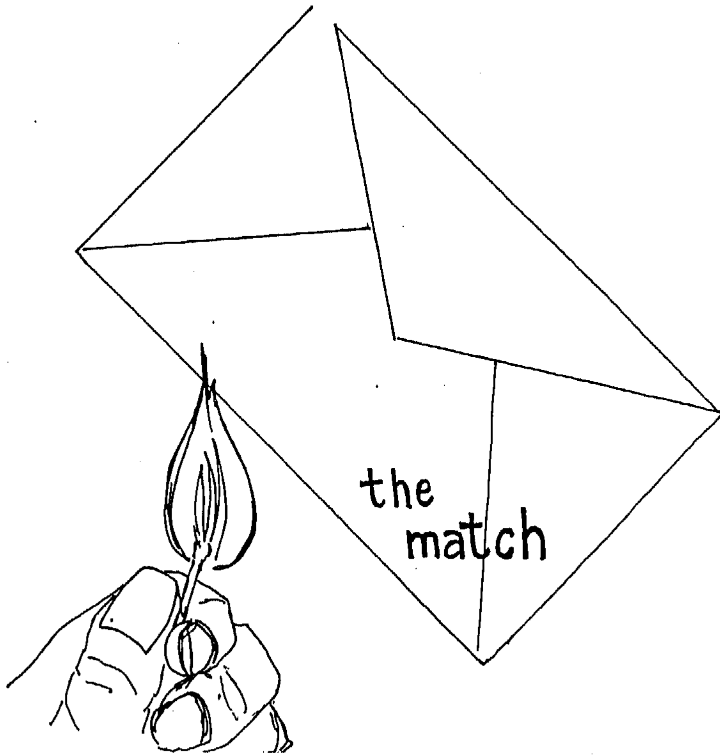
Shifting Dullness

March, 1997

The "We Sure Hope Jamy Matches Somewhere" Issue



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Plural Effusions

Jeff Drayer

So, forgetting for a moment that my cache (as we say in the biophysics study track) of artistic talent pretty much amounts to being able to put those little yellow biohazard stickers on patients' bags of normal saline when no one is looking, I decided to go out and sign up for a pottery class.

Now, I'm sure you're wondering just how I could have time in my data-analysis-packed day to squeeze out a few spare moments to pursue something even more non-medical than my psych rotation. It may seem like a good question to those who've never softened their clay to spinning texture with their own sweat and tears. But you're wrong— it's not. Because pottery, as it turns out, is a lot like medical school.

But how? How can taking an unformed lump a clay, throwing it onto a cold, hard wheel where it lies helpless and exposed until forces beyond its control cruelly begin to bend and shape it, until it finally reaches a new, unrecognizable form— how could this be similar to med school?

The most obvious answer, of course, is that pottery is deceivingly, maddeningly difficult. Now, if you're me, when you sign up for a pottery class, you imagine it's going to be a lot like what you see in the movies. You know, how in Ghost when all that great stuff happens where they see each other again and end up making love and singing Unchained Melody and all that? You think that that's pretty much what goes on in the East Campus Craft Center. And similarly, you watch these movies about gutty kids making their way through med school, overcoming obstacles using only their intelligence, wits and rugged good looks, and you think, heck, I could do that; that doesn't look so bad. As it turns out, though, only now am I finding out that sometimes movies don't actually tell the whole truth. Yes, pottery, like med school, can be very, very hard.

"Well Jeff," you would think to yourself, if you had been one of the several thousand OR staffers to have had the opportunity to eject me from a surgery due to contamination, "in the OR, before I caught you picking wax out of your ear barehanded, I saw you do some fine retracting and boveying, and you never once cut the ureter. I bet you'd be great at the pottery wheel." But once again, you're wrong. Horribly, horribly wrong.

First of all, much like in med school, the most difficult thing about the pottery wheel is just *getting* centered. You go in with an idea of where you want to be, but even as you apply all of your energy toward getting there, you find yourself slowly drifting sideways, away from your goal. And as you ease away from the center, you find yourself becoming less and less well-rounded, until you're left with nothing more than a mushy, motionless lump, far away from where you wanted it.

And then, of course, nobody tells you about the time commitment. Pottery class, like med school, cannot exist as something that occurs only during certain hours of the day. In order to be successful, it must become a way of life. Whether you're wearing blood- or clay-stained shoes, you cannot escape the thought that you could always be studying more, or that you could spend just another hour at the wheel. And when you take some time for yourself, there's always that sense of one more bowl gone uncreated, one more biochemical pathway gone unlearned.

Furthermore, when you get to class, you expect to

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It's time for the...

17th Annual Shifting Dullness Pasta, Beer and Dessert Party!

That's right-- bring your homemade pasta sauce, your home-brewed beer, and your home-baked desserts, over to Drayer's Place (site of party subject to change) to be eaten, drunk, and judged. That's right, on **Saturday, April 5th, at 5:00,** we'll make the spaghetti, you bring all the other stuff, and we'll judge it, with the winner in each category getting **big prizes!** So mark your calendars, and get your grandma's recipes. It's the culinary event of the season!!!

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get good, directed instruction. But as I've discovered time after painful time, class is simply not worth attending, since my pottery teacher believes in "letting us discover pottery for ourselves," much as the genetics professors believe in "teaching us genetics in such a confusing and disorganized manner that we could never understand a word they were saying, even when we asked specific, focused questions about a subject they had devoted their entire lives to studying." Eventually, I realized it would just be best to learn from my own mistakes, both on the pottery wheel as well as with all those mice whose genomes I've recently been trying to alter back in my "special closet" at my apartment.

But finally, no matter how distorted and unsatisfactory your end product may be, it is still not complete until it's been hardened by fire. Whether in a kiln or between two peds residents who missed their afternooon naps, only after exposure to incredible amounts of heat can a clay pot or a med student be prepared for the life ahead of them. And only then can the finished products be relied upon to perform the same exact action, whether it be pouring water or doing gallbladder surgery, over and over and over again for the rest of their useful existences. Though of course, in my particular case, I'll publish a ground-breaking journal article on hard-to-detect pulmonary nodules before the clay pot even finishes its data analysis. Maybe. ■

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will be assigned to the little sibs of their little sibs. MSI's who are "orphaned" by the fact that their MSIII grandsib is unwilling or unavailable will be assigned to MSIII's who are willing to have more than one little sib to counsel. The social VP of the Davison Council and the rising MSIII class officers will be in charge of the logistical details. The new policy will take effect for the incoming MSI's. ■

Congratulations!!!

The following talented and accomplished medical students were recently elected to the distinguished order of AOA:

Junior AOA

Jayme Allen
Matt Hanley
Aamer Farooki
Patrick Lager
Ashvin Pande
Lisa Soltani
John Williamson

Senior AOA

Iain Asplin
Sylvia Becker
George Huffman
William Lane
Regina LaRoque
Sean Montgomery
David Tong
Christine Wong
Joy Huang Wu

Cold Jelly and a Little Pressure...

By Rodney Alan MSI

It was a cold Saturday morning. I sat in the waiting room of the Gynecology clinic in Duke South with three other classmates. As I waited, I wondered what I was doing at the hospital at 8 a.m. on a Saturday morning. A month ago it seemed like a great idea. I would get the pelvic exam out of the way and be done with it. What was I thinking? Friday night had ended only a couple of hours before, and I had no business being awake. How was I supposed to know Quin would throw his Party like it's 1999 Party in 1997 on the night before my exam? Somehow, I got there on time.

Two ladies from the Women's Health Education Consultants arrived and took us into a room in the corner to begin our pelvic exam session with a disucssion. I thought it was a great idea to learn how to perform a pelvic exam from a group of women. They had experience from both perspectives. During th discussion, we went over all the parts of the exam. We began with communication. "First establish a rapport with the patient. It will make the patient feel more at ease." Having already discussed this topic ad nauseam, I figured I should be pretty good at it. No problem. From there we moved on to language.

"What's wrong with these words: put it, pull out, withdraw, scrape?"

I didn't know. They didn't seem vulgar. To my surprise, one of the instructors explained that these words can make a woman feel vulnerable. Considering the circumstances, I realized that she was right. Instead, we were instructed to use words like "insert, remove, and collect." Fine.

"Always explain what you are doing, and warn the patient when you are about to touch her..." The list grew on an on, but everything made perfect sense. After a while, I began to think that this exam wouldn't be difficult after all.

But then it was time to perform the actual exam. The four of us crammed into a tiny room and first watched the instructor perform the exam on the standardized patient. She made the exam seem so simple. I was sure I was ready, but I thought I should watch once more before volunteering to go. So I watched againt as one of my classmates performed the exam. As I watched, I went over each step in my mind. When my colleague finished, I felt like volunteering, but I thought maybe I should watch one more time just to be sure I got everything.

> After a while, I began to think that the pelvic exam wouldn't be difficult after all.

About thirty minutes later, there was no one left go except me. The moment of truth had arrived. I knocked on the door, and entered the room. After a short introduction, I explained the procedure to the patient and began the exam. That's when my eyes were opened. As incredible as it may seem, I never quite considered how close you need to be to a person in order to perform a pelvic exam. There's something about being that close to a person that makes you feel a little uneasy. It makes you think twice before you start examining things. Immediately, all that rapport stuff went right out th window. I had been betrayed! There was nothing I could have said or done to the patient in that first five minutes of the exam to make me or her feel more comfortable. From that point on, nothing seemed to go right.

I could remember the steps of the procedure... I had read my Bates book...I had even watched other people perform the exam, but all that didn't matter. I soon realized that there are several small steps involved in a physical exam that you just don't realize until you've had the opportunity to mess up. For example, during the external part of the exam, I

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A Shifting Dullness Editorial

by Jeff Drayer, Editor

Recently I found myself leafing through the Chronicle, and I came upon an article discussing upcoming cuts in the number of residents at Duke Hospital. As with every time I read about the thinning out of housestaffs, I began experiencing the usual fever and chills. But, I figured, at least the hospital administrators were doing all they could to stem the tide, and so read on to find out what was being done.

Imagine my surprise, then, when the chair of the anesthesiology department was quoted as saying that he thought the quality of care would go up after the cuts, since each individual resident would have to spend even more time taking care of patients and, therefore, become a more experienced and, in fact, a better doctor. I could not have been more disappointed in him.

Why was he saying this? It's like telling your attacker that it's good he's cutting off your right arm, so you can become more adept at using your left. When you're in a position such as chair of a department, it is your duty to tell the people what's what. The truth is, for every doctor forced to work even longer hours or replaced by a nurse practicioner, the likelihood of complications or death to the patient increases. By lying to the lay public and their elected lawmakers in this way, you only encourage the sort of uninformed actions that are resulting in these residency spots being cut.

By making this statement, this doctor is letting down not only his residents, but the Duke University Medical Center and, in fact, the entire profession of medicine.

People look at the buying and selling of doctors in today's managed care environment, and wonder how physicians ever allowed this to happen to them. The answer is: through the misguided leadership of people such as the chairman of our very own anesthesiology department. That's how. ■

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Davison Council Stuff

The Davison Council meets every other Thursday at 6 p.m. in M133, Green Zone. Requests for funding for organizations were due February 17 for discussion and approval at a February 24 meeting of the Budget Committee.

THANKS AND CONGRATULATIONS:

Thanks are in order to Tola Roberts and Jamy Ard, who went to Southern High School's Surgical Anatomy class and spoke to high school juniors and seniors about medical school. Thanks also to Dave Zidar, Mike Morowitz and Mike Bolognesi, who organized the Medical School Super Bowl Party at Cosmic Cantina.

Congratulations to Ning Wu for his newsworthy Career Development section of the Davison Council Web page. The Duke Chronicle ran an article on February 5 about the information Ning and his committee have worked to put on-line. Because of the lack of a single source of concise, relevant information about residencies and training programs, Ning's Career Development committee has been polling Duke Med alums using a questionnaire designed to assess the training programs they have chosen. Responses to the questionnaires can be found on the Duke Med home page, under "Career Development." The Davison Council web page address is http://www.duke.edu/web/medstudent/. Check it out!!!

BIG FOUR SPORTS DAY (March 15):

Medical students from the four medical schools in North Carolina will come together in Greenville for a fun-filled day of sporting competition. Nate Mick MSII and Matt Kalady MSIII, Intramural Co-chairs, are hoping to have a good turnout from Duke Med. Matt is looking forward to having possibly a bus full of people. He is investigating the possibility of staying over and having fun after the Sport Day is over. Check the web page, or contact one of your Davison Council representatives if you are interested.

DAVISON BALL (March 21): The Durham Omni is the chosen location for the Davison Ball, which will take place on March 21. At this black-tie affair, the Davison Council Excellence in Teaching awards will be given to the six faculty and housestaff who have earned the accolades of medical students who nominated them.

MEDICAL PARENTS WEEKEND AND STUDENT-FACULTY SHOW (April 18-20): Tour guides for the weekend are being solicited by class presidents to be available on Saturday, April 19. Casting calls and organizational details are underway for the medical school Student-Faculty Show, which will be held the evening of April 19. Proceeds from the show will be split between two organizations: the North Carolina Family Center, a physician- and student- founded organization which intervenes through counseling and support for at-risk families; and the North Carolina Student Rural Health Coalition, a community-based organization which the Duke Med chapter assists in providing free health clinics to underserved rural populations in eastern North Carolina.

BIG SIBS AND GRAND-SIBS: A proposal was recently brought to the council by Tim Lahey, Joanne Lager and Quin Mallette in order to address the lack of moral support MSI's traditionally get from their MSII big sibs once the passing of the test file has taken place and the MSII's disappear onto the wards. The proposal, which was approved by the Council at the February 6 meeting, still entails rising MSII's passing the test file on to their selected MSI little sibs; however, once rising MSIII's are finished with their rotations, they will step in to the Big Sib role and assume mentoring responsibilities of the MSI's. MSIII's who are in town and willing to be Big Sibs

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Rodney Alan from p.5

pointed out all of the oxternal structures and began to move on when the instructor said, "You have to actually touch each of the external structures." For some reason, I never realized that everyone else had been touching the patient. Palpating a person's genitalia can be pretty embarrassing, especially when everything appears normal. Nevertheless, I made the corrections and proceeded to the internal exam.

The patient was obviously moving her cervix around because, once again, I couldn't find it.

I carefully inserted the speculum. "Hot, Hot, Hot, Hot." It seemed like minutes passed as I sat there wondering what to do as the patient kept saying hot. I could hear everyone in the room saying, "take it out," but for some reason I stood motionless aftraid to do anything. The speculum was obviously too hot, but was it really THAT hot? Go figure. The speculum was warmed the same way each time, but when it's my turn, of course it's too hot. I quickly removed it. After a brief pause, I inserted it again, this time remembering to touch the speculum on the inner thigh of the woman before inserting.

I asked one of the students to turn on the light behind me, and I looked into the speculum. I looked and looked, but couldn't find the cervix. Having recently completed gross anatomy, I was sure that the cervix should be there somewhere.

"You haven't inserted it far enough."

How could this be? If I pushed it in any further, my hand would disappear. I moved it around and kept looking. Then suddenly, as if the patient aligned her cervix with the speculum, there it was. "I am now going to scrape...I mean collect some cells."

With that over, I began the bimanual part of the exam. Almost done, I thought. I added the lubricant and inserted my fingers. I felt around for a while. After several moments, I felt everyone's gaze on me. Okay, obviously, this patient was moving her cervix around because once again, I couldn't find it. There was no evading the issue. Feeling like a complete idiot, I confessed that I could not feel the cervix.

After further instruction, I was convinced that I had found it, and made the sweeps across the ovaries and uterus. Because we didn't have to perform the last portion of the normal exam, I was done. I helped the student up and breathed a sigh of relief.

When it was finally over, I had a strange feeling. The whole experience was way more personal than I had realized when I watched from a distance. I wanted to apologize to the patient, first for violating her privacy, and second for all of the mistakes I had made: for forgetting to tell her she could watch with the hand held mirror, for not making sure the speculum was the right temperature before inserting it, for taking so long to find the cervix, for saying "scrape some cells" instead of "collect some cells," for saying her ovaries were "unremarkable"... She realized something was wrong and told me I did "fine."

I wish I could have believed that, but I couldn't. If you've ever had a bad haircut, you know how it feels when someone tells you everything is okay when it's really not.

She knew that her comment didn't make me feel any better so she offered a second word of encouragemen, "Look at it this way, you'll never have to perform your first pelvic exam again."

This time, she was right.■

On the Ward

By Jamy Ard MS IV

A little more than one month ago, the medical center was sued for negligence in the death of a young boy. A few articles appeared in local media describing the events surrounding this child's death. This death occurred back in 1992, when the patient was being seen in the Private Diagnostic Clinic. Based on the autopsy report, the child died of blood clots in the lungs. The plaintiffs' attorneys argued that this death could have been prevented if the Duke physicians had only paid attention to the signs and symptoms of the patient. The defense's argument stated that the standard of care was followed for what was presumed to be a pneumonia and that the occurrence of blood clots was a sudden and unpredictable event.

The thing that struck me was that the plaintiffs' attorney produced a medical student note that stated there was something more serious than a pneumonia going on with the patient. I cannot be certain of the classification of the medical student, but I am sure that his or her note was very thorough, much more so than any of the resident or attending notes. This is generally the case in most ward or clinic settings. Our training is geared to help us get the maximum amount of minutia out of a patient in the longest possible time. Therefore, I can be certain that the medical student asked this pediatric patient every question under the sun, including sexual, tobacco and ethanol history.

Usually as students, we ask these questions because we have no idea what is pertinent to the patient's care. When we do occasionally stumble upon some useful information, as perhaps this keen medical student did, we must get someone to take heed. I can imagine that this student probably launched into a lengthy but meticulous presentation on how this young child presented to clinic with multiple complaints, numerous social problems, and a myriad of positive physical findings. Annoyed by the length of the presentation, the primary care givers probably cut the student off midway through and suggested that the student go practice giving more concise presentations. Obviously, the student had something to say that was either ignored or was not heard. Although long gone, this student got to say "I told you so" through the verdict of the jury. This is a statement that I have longed to utter on countless occasions as a Duke med student; here's my chance.

Often as the student on a given service, you will find yourself at the bottom of the totem pole. It gives you little primary responsibility, which is good if things go bad. However, people are less likely to listen to what you have to say. So when you spend all night formulating a plan based on your history and physical exam and no one wants to hear what you have to say, do not worry. Eventually you will get to say, "I told you so." (Note: You may want to just say it silently to yourself. A statement like that could possibly affect your final grade in the rotation.) For example, while doing a rotation on a service that shall remain nameless, a surgery resident offered to teach me how to insert a foley catheter. Because I am always excited about learning, I jumped at the oppor-

(Cont'd on p.10)

Annoyed by the length of the presentation, the primary care givers probably cut the student off midway through and suggested that the student go practice giving more concise presentations.

(Ard from p. 9)

tunity. As he proceeded, I noticed that the catheter was going into the wrong orifice, and politely mentioned this fact to him. He quickly told me I was wrong and jokingly asked if I passed my brief Duke anatomy class. Now, I know that anatomy at Duke is short, but it's not that short. Several minutes later, he asked the patient's nurse what the urine output was. She replied that there was none in the foley bag, but the bed was soaking wet. At that point I could have run up in his face and done a wild victory dance while shouting "I told you, I told you, I told you," but I restrained myself.

Occasionally you will find the patient that will not listen or cooperate with your instructions, because you are only the student. Or you may run into the patient that does not want "any students or residents practicing on me!" Once a patient informed me that only the attending could draw blood from them. I informed the patient that our attending spent most of his time in a laboratory swirling cells around and had not even seen blood in 10 to 15 years. Although the attending was knowledgeable, he had not done any scut work because that is not in the job description. However, the patient insisted that only real doctors work on her. As I watched the attending stick her for the sixth time on the back of her hand, I wanted to jump up on her bed and spike my imaginary football on her head while chanting "I told you so, I told you so!" Despite this almost overwhelming emotion, I restrained myself yet again, and I took solace in the fact that she had to pay me to draw her blood the next time.

Saying "I told you so" may be unprofessional and childish, but there is something about being childish that makes me feel good. ■

Don't Miss It!

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malYoderous

by Dan Yoder

They're back. No, not the fake actors from clinical arts that could instantly go from one emotion to the next and then back again as smoothly as any rectal exam performed with a liberal helping of Surgi-Lube. No, I'm talking about those nightmares. "Oh, the ones where you totally forget who the patient is that you are trying to present at Sabiston conference that every other Shifting Dullness columnist writes about?" you might ask. No, not even those. Those simply go away either by not reading Shifting Dullness or by realizing that you can picture everyone in their underwear (not including Dr. Sabiston), whereupon the details of your standard 176-yo-Lumbee-Indian-with-a-45,700-pack-year-history-of-smoking-who-has-an-89cm-"unidentified"-lung-nodule come rushing back to you. No, I"m talking about the other series of nightmares, The Pediatricians Strike Back series, which, although re-released every 20-some-odd years, never fails to have essentially the same evil cast of physician-emperors and resident-troopers.

Now, please don't misunderstand me. I, too, had the naive misunderstanding when I started medical school that all future pediatricians were the ones who not only said "I want to help people" in their medical school interviews, but who actually meant it. In fact, all during first year I labored through countless hours of information that was "absolutely critical to know before you will be allowed to even step onto a patient care floor in this hospital" all the while fully intending to become a loving, caring pediatric neurocardioorthopedic nephrologist with an emphasis on treating children between the ages of 18 and 20 months who were suffering from kwashiorkor. Of course much of my outlook was changed when I found out that a) they let PA students on the wards, and b) Medicare did not consider neurocardioorthopedic nephrology a primary care area and, hence, I would never be reimbursed for my time on the golf course. Needless to say, my first year class attendance took a sharp dive and I quickly took the reasonable step of transferring my Tertiary Care Group membership into the much more loving and caring Primary Care Interest Group, this despite the fact that the next Tertiary Care Group meeting was enticingly entitled "Liver Transplants: Don't Be Caught Dead Without One."

With these initial delusions behind me, I set out on my second year thinking that Pediatrics was certainly still a good possibility. My first experience with children was, not surprisingly, on my obstetrics rotation. Now, you might not think that your first advice to a pediatric patient would be "Push, keep pushing, OK, now take a deep breath and we'll try it again in a minute," but then again, you've been wrong before. On outrider, I quickly learned that adolescents were not going to be my strong suit if I indeed did end up deciding on pediatrics as my chosen field of medicine. I was performing a pelvic exam on one pediatric mother who, it turned out, also happened to be a health professional. How did I figure that out, you ask? Well who else would know the order of procedures? She kindly pointed out to me that I needed to perform a bimanual exam before the rectal, saying (and I am paraphrasing her exact words here), "That is the wrong [orifice] you [medical student]!" I tried to explain to the resident in the room at the time that the patient was "morbidly obese" and "my field of vision was obscured by superfluous tissue," but I guess it's hard to hear when you are on the floor with the nurse pounding your fists on the ground and laughing hysterically.

"But brighter days are ahead on pediatrics" I mistakenly surmised. In fact, though, my very first day on pediatrics was great. After all, orientation has a decidedly slim chance of ruining anyone's view of any field. But by the end of the second day, I knew that maybe peds wasn't for me. Again, don't get me wrong. The kids were great, except of course for the

Continued on page 12

vomiting, diarrhea, getting coughed on, "spit-up" (I never did quite figure out what that was, although when the residents said it, I kind of got the impression that it was like one of the original classifications of matter that Aristotle came up with, you know, "Wind, Water, Spit-Up, Fire") etc. As a matter of fact, I loved the kids, even the cute little 5 year old girl who said, "You don't know what you're doing, do you?" when everyone in the room, including her parents, could clearly see that the speculum was defective and would not properly attach to the otoscope, no matter how many times I politely asked it to (a trick that all Clinical Arts veterans use as their ace of spades when things are looking increasingly desperate). No, it was Darth Vader, who cunningly appeared to be a nice pediatrician to anyone who was not using the force, who contributed to the ruining of my future career in peds. I'm still not sure whether it was the fact that, by using his admittedly keen sense of the force, he felt threatened by my superior clinical acumen or whether he knew he could easily prey on a young, completely ignorant medical jedi that he decided to give me a tongue-lashing between his harsh, positive-pressure respirations. After all, not being able to recite the 17 reasons why children with sickle-cell anemia need transfusions on your second day of peds is like not being able to identify a I/VI crescendo-decrescendo murmur radiating to the carotids on your psychiatry rotation. But Vader takes no prisoners. I was fortunate to get out of his death-grip in the nick of time; another medical jedi-student distracted his attention long enough for me, Yoda, to get out of the "Death Star Clinic." After that, I met some decent peds resident-troopers, even though they had succumbed to the dark side. Of course there were others who seemed to enjoy the sinister side of the force, almost relishing the chance to closely examine each and every variety of intergalactic spit-up. But mostly from that point on, my peds rotation was just a blur of destroying Jeff "Obi-Wan" Drayer in game after game of Ms. Pac-Man down in the Subspecialty clinics before being kicked off by the equally devilish Imperial Guard-nurses so that the ewok-children could play (I'm all for diversity here, because without the 4'6" and under quota Duke Med has to fulfill, I wouldn't be here, but I believe playing Ms. Pac-Man should be strictly based on merit, and quite frankly, "Obi-Wan" and I were taking the ewok-children to the cleaners when it came to average score or high score, whichever way you want to slice it).

Fortunately, I finally awoke from this awful Pediatricians Strike Back nightmare when, although I thought it was the "Death Star Clinic" blowing up, my alarm went off. It was 10 AM. Too early to go do "research," but not late enough to get out of bed. As I drifted back to sleep, I thought of Vader, but smiled as I realized that there would be no Return of This Medical Student playing at any local peds wards come next year. His words, "Yoda, I'm your Attending," will never haunt this jedi student again.

ATTENTION!!!

During the month of March, Shifting Dullness will be running a special **fund-raising promotion!** Now, for a limited time, you can help support Jeff Drayer's Spring Break trip to **Panama City Beach!** For a donation of $1, you will be listed in the April issue of Shifting Dullness as one of Jeff Drayer's sponsors. For $5, you'll be listed as a Friend of Jeff Drayer. For $20 you get a personally addressed postcard sent by Jeff from PCB, and for $50 you can get a free t-shirt commemorating Jeff's vacation on the sandy beaches of Florida. So don't hesitate-- join in the **fund-raising action** today!!!!

GAG REFLECTS

by Jane Gagliardi MS III

Here is another good reason to walk to the bursar's office and pick up refund checks yourself:

To Whom it May Concern:

Enclosed please find check number 54321 written to me erroneously as a refund credit on my account. Following a conversation today with Larry in the Bursar's office, during which I discovered that I have a large outstanding balance as a result of this mistakenly printed check, I have voided the check and am enclosing it in order for the outstanding balance to be removed from my account.

I have had a particularly difficult experience getting my refund checks this year. In October, the Bursar's office apparently sent my refund check to the Medical School financial aid office to be sent to my campus box, which I share with three other students. I never received the first check, so it had to be canceled. I had to wait for three additional weeks until I could pick up my refund check, which caused me considerable concern.

This time, I specifically requested in writing that my check be sent to my Durham address, where the bills also come. Not receiving the expected check at the beginning of the semester, I called the Bursar's office on January 13 and was told that a check had been sent to my Durham address on January 6. On January 23 I called again because I had not received a check. The January 6 check was canceled and I was assured that a check would be sent to my Durham address "by the end of the week." On January 24 the January 6 (canceled) check arrived in my medical center box (which is NOT my Durham address, and where I had specifically requested that the check NOT be sent). It took another week for the correct check to arrive at my Durham address. The check,

I was assured that a check would be sent to my Durham address "by the end of the week."

dated January 30, clearly was not sent "by the end of the week" of January 24. Additionally, I received a second refund check dated January 31, which is the check I enclose with this letter.

The delay I have experienced in receiving the correct credit refund has once again caused me financial worry. It has also not escaped my attention that the money credited to my account from the Duke loan I signed for in December has been accruing interest since it was credited to my account, yet I have not had access to the money until today, when I have finally straightened out the confusion surrounding the checks and am confident that I may cash the one appropriate check.

I might be able to understand the delay in getting my check to my Durham address if the statements from your office had also experienced similar delay. However, the bills from your office always find me on time, at my Durham address. Therefore, I repectfully request once again that the next time there is a credit on my account that the refund check be sent once to my Durham address so I can use the money that is accruing interest that I will someday be expected to pay in a timely fashion.

Sincerely,
a medical student ■

Ligament of Trite

Lisa Criscione

This fall, I had the opportunity to work in the medicine branch of the National Cancer Institute. All of the patients we saw were enrolled in phase I clinical trials of new cancer chemotherapy agents. One of the issues that surfaced repeatedly was informed consent.

This issue is especially important at the NCI because of the nature of phase I clinical trials. Phase I trials test medications in humans for the first time. Although the drugs have been extensively tested on animals, not all of their effects on humans can be predicted. Thus, the purposes of a phase I clinical trial are to determine the toxicities of the drug in humans, and to determine the maximum tolerated dose (MTD) of the new drug. People do occasionally die while enrolled in phase I trails. Overall, only about 4% of people enrolled in phase I trials (of all kinds) will benefit during the study. However, a phase I clinical trial is successful if the toxicitiies and MTD are determined, even if the drug has no beneficial effects. Because cancer chemotherapy medications have so many toxicities, it is unethical to do phase I chemotherapy trials on normal volunteers. The patients must have cancer, and in most cases must have failed standard treatment or run out of treatment options.

Imagine enrolling a cancer patient on a phase I clinical trial. The patient has no other treatment options. Theoretically, you don't know what will happen if the patient takes the drug. In reality, you do know some things. You know the drug mechanism. You can explain the mechanism to the patient, can't you? To give the patient your understanding, the patient would need your education. But even any two doctors could potentially disagree as to the precise mechanism of action of a new drug. What do you know about the drug, really? You know how many patients have received the drug, and how they reacted to it. Phase I clinical trials are small, often enrolling around 5 patients at each dose level. You know which dose level the patient will receive, and you know how many people have taken this drug before, with what consequences. You know about the patient's disease and can guess their prognosis in the absence of the drug.

What do you not know? You don't know the patient's prognosis in the presence of the drug. The drug's developers have evidence to suggest the drug will be useful, or a clinical trial would not be conducted. You don't know how this drug may physically or emotionally benefit the patient. You don't truly know the patient's motivations for entering a phase I clinical trial.

What do you know about the drug, really?

You can present all the information you have in myriad ways. We all know from experience that the presentation of the information can determine the patient's reaction. If you believe that the clinical trial will benefit the patient, you can present the information in such a way that the patient will be receptive to entering a trial. If you believe that the medication will not benefit the patient, or that the patient is not well-suited to be in a phase I trial, you can couch the information in such a way that the patient will decide not to enter the trial. How informed does a patient have to be to give informed consent? You can try to explain the drug in a way that you think is appropriate for the patient to understand, or you can try to give the patient all the information you have, whether the patient has the knowledge base to understand it or not. In short, obtaining informed consent is a huge responsibility. I believe the reality of informed consent is that although he patient ultimately gives consent, often times we will be the real decision makers. ▪

Physicians Unite!

Mike Morowitz MSIII

What is an aspiring physician to do about the health care problems in this country? Is it sufficient to concentrate on our studies for the time being, and wait until later to address the realities of managed care and cost-driven medicine? It's very hard to say. There are so many conflicting opinions and so many dubious forecasts about medicine in the next century that it's nearly impossible for medical students of our generation to make good decisions for the future. In many ways, we're being forced to jump onto a moving train-- we know it's moving, we know we should get on, but we have no idea where it's going. Similarly, we know that medicine is changing and we have the hunch that we ought to account for these changes in our future plans, but somehow we don't really know what to do about that hunch.

Unfortunately, the same sense of uncertainty has come to afflict established physicians practicing in the 1990s. For whatever reason--whether it was laziness, greed, or naivete-- doctors failed to seize the opportunity during the 1980s to gain control of the health care industry internally, from within. As a result, control over the care of patients has shifted away from the people who actually take care of the patients to external influences: namely government and insurance companies. Many physicians today are caught in limbo. Should they sell their practices and join large groups? How about quitting clinical medicine altogether for a $3 million-a-year job as medical director for a large HMO?

There are many new questions and many possible answers to those questions. All we can really say is that the cost of losing our autonomy is too large for us to sit on the sidelines and allow the debate to be resolved by others. Recently, a Duke house staff officer gave me a copy of an editorial which he had heard on the radio. He knew that the words he had heard that morning needed to be read by the Duke community. He also knew that *Shifting Dullness* is a progressive forum for informed people that make informed decisions, much like Thomas Paine's *Common Sense.* As such, we provide you with an excerpt from the editorial by Laura Archer Pulfer, a columnist for the *Cincinnati Enquirer*, on NPR's *Morning Edition*, 2 August 1996:

> Isn't it about time you [doctors] rescue medicine from the questionable mercies of business and politics? You were the smartest kids in the class, so why are you letting everybody else tell you how to do your job? You people who became doctors were the brains, the bookworms, the merit scholars, the Eagle Scouts, the hall monitors. You were the ones whose homework the rest of us copied because you had the answers. You are the people with the magnificent arrogance to put your hands around a pulsing, human heart. You are the voices that are bright enough to give us the bad news.
>
> So, what's the problem? Are you scared of a bunch of bean counters? You whipped their butts on the SATs, and now they're making medical decisions in consultation with you. Consultation? Why aren't you running this show? Are you really prepared to become just another employee? Why have you allowed insurance companies and managed care to demand that young couples leave the car running when they enter the maternity ward? Where have you been- on some extended golf holiday? Is it the money? Is it us? Are you tired of taking care of us and our untidy illnesses?
>
> Does it honk you off that Shaquille O'Neal is going to get $120 million to dunk round balls and you still owe money on your med school loans? I beg of you-- get back in the game. When I get sick, I'd still like to know there's a doctor in charge, not some MBA. I sure don't want Hillary Clinton or Newt Gingrich or Ted Kennedy to be taking my temperature.

Pulfer's message is clear, and it should resonate within each of us. What we do to solve the so-called health care "crisis" is not as important as the mere fact that we remain active and just do something. Soon. ▪

Simply Smashing!

It's the annual Student-Faculty Tennis Tournament

Doubles play fun for all skill levels
served up by the Davison Club and the Medical Alumni Association

Saturday, April 12, 1997

- West Campus Tennis Courts
- Celebration supper afterwards

Watch your mailbox for registration materials. For more information, call Brenda Painter at 419-3200.

The 28th Annual Shifting Dullness

March Madness!!

Yes, it's time to pick up your bracket, guess who's going to win based on which team has prettier uniforms, and still do better than Jamy!

That's right, if you've got a writing utensil, then you have a chance. To win!

Just grab a bracket from the candy room, and then return it to the box marked "Madness" before tip-off. We'll take care of the rest.

Hanley in the Kitchen

First off, thanks for all the compliments on last month's feature, "Pizza Love". It's good to know that people are actually reading the column. For a while, I thought I was writing to myself.

No doubt, some of you are curious as to how my big valentines dinner went. After elaborating on the romance of cooking a dinner for two in last month's column, I am sure that some of you expected me to follow my own advice, and attempt some magnificent gastronomic feat. Sorry, not this year - I ordered out Chinese.

This month's recipe is an adaptation of a dish I found in one of my favorite cooking magazines, Bon Appetite. It is a hearty stew inspired by the flavors of the Mediterranean, particularly Spain and Portugal. Served with a loaf of crusty bread, it is a meal in itself. It can also be refrigerated and reheated the next day without detriment. A personal favorite..........enjoy.

Chicken, Shrimp, and Sausage Stew

3 c chopped onions
2 c chopped green bell peppers
1 tbs. paprika
1 28 oz can diced tomatoes
3/4 c green olive (stuffed w/pimientos)
3 tbs. fresh oregano (or 1 tbs. dried)
2 tbs. fresh thyme (or 1/2 tbs. dried)
1 lb fresh, deveined, large shrimp
6 large chicken thighs/drumsticks
or a mixture of both
1 lb smoked sausage cut into thick slices(pref. and ouille) - may substitute w/kielbasa
1 1/2 c chopped red bell peppers
6 large garlic cloves, chopped
1 c dry white wine
2 1/2 cups chicken broth

In heavy pot, sauté sausage over med. heat until brown. Set aside. Repeat for chicken. Pour off all but 1 tbs. of drippings from pan. Sauté onions and bell peppers in drippings until just brown. Add garlic, oregano, thyme, and paprika and sauté for further 2 mins. Return sausage and chicken to pot. Add tomatoes (with juice), chicken broth, and wine. Cover and simmer until chicken is cooked through (25 mins). Add olives. Simmer uncovered until consistency is that of a thick stew. Add salt and pepper if desired. 5 minutes before done, add shrimp. Simmer until cooked through. Serve with a loaf of chewy sourdough bread. ■

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business. The following evidence proves this point.

My parents didn't know anything about my pager until midway through my second year. It had never come up in conversation, and I suppose there had never been any particular reason to tell them that I was carrying a beeper. But I inadvertently mentioned it to my mother one day, and !Shazam! my parents' image of me was drastically transformed. They began to think that I was so important in the Duke hospital that I needed to be reachable at all times. In fact, my parents still brag about the fact that their son is at Duke medical school and that he carries a beeper. Recently, they were in Florida visiting my grandparents, and shortly thereafter I was speaking to my grandmother on the telephone when she said to me, "Michael, I understand you're carrying a beeper now." For a few short moments, I basked in the pride of a person who has fooled his entire family tree into thinking that he has made something of himself. The joy of the moment came to a crashing halt, however, when my grandmother varied one of her usual questions and asked me "Have you met any nice Jewish girls carrying beepers?"

But the social implications of being on-page reaches far beyond parental acceptance. Specifically, studies have shown that a single person can increase his or her "attractiveness" to the other sex by ten- or twenty-fold simply by wearing a pager. A recent report in JAMA concluded that ownership of a pager by a medical student dramatically increases the probability that a person of the opposite sex will accept an offer to go out on a first date. The authors, well-known Harvard epidemiologists, noted that this effect was most dramatic in certain regions of the Jersey shore ($p= -4.0$). Most remarkable was their observation that the pager doesn't have to actually be turned on to exert this effect! They were surprised to find that ownership of a pager has no effect whatsoever on the probability that a person will accept a marriage proposal, particularly if it is the third or fourth marriage proposal to the same person. I have found this data to be correct, as supported by my own experience at local bars. Subtly flashing your pager by raising the bottom edge of your coat can turn an otherwise risky date offer into a sure thing!

Although these anecdotes illustrate the vital sociologic importance of continuing to pay my bills from A+ communications, I would be remiss not to point out the important professional ramifications of the pager. The obstetrics ward demonstrates this most clearly. Without a pager, the eager med student who wishes to deliver his first baby is forced to loom around the OB suite, periodically checking each patient for signs of impending parturition. He desperately wants to go catch an hour's nap, but how could he possibly leave knowing that he could miss a rare opportunity? But contrast that tragic scenario with the astute med student with the positive pager sign. She too is weary-eyed, but she mentions to the matronly OB nurse that she is going to rack for an hour and that she would appreciate a page in the event that Ms. Multigravida in Rm. 5 should progress. Taken aback and impressed that med student owns a pager (even if it has a strange number beginning with the prefix 405), the nurse smiles and agrees to call if anything happens. Sure enough, the student sleeps for 40 minutes, and then is paged to scrub in on an emergent C-section for the delivery of septuplets. How beautiful.

A caveat to my defense of the importance of pagers relates the animosity of the house staff towards the small, black electronic "wundermachin" on their waists. Have you ever noticed the utter dismay, nay disgust, on the countenance of an intern or resident when he or she hears the precious, beeping noise emanating from the pager? I truly never could understand their animosity towards pagers. In fact, the contrast between their stark white uniforms and the audacious black color of their waist-borne communication systems should only potentiate the wondrous effects of wearing a pager. Nevertheless, there seems to be some incorporation of the pager into an intern's parasympathetic nervous system

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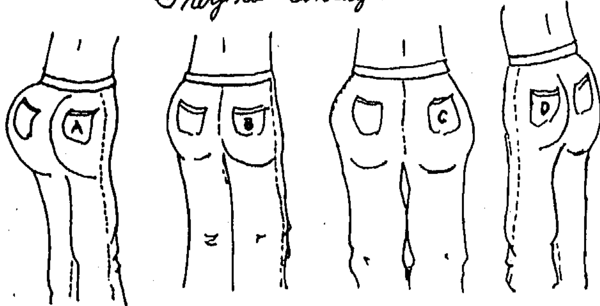
such that when the beeper goes off, the intern instantly becomes nauseous. This is unfathomable to me, but I can offer two possible explanations. First is the possibility that the house staff use the pager for more business-related issues and that therefore they have more responsibility and stress related to the use of the pager. Second, and much more likely, is the fact that the house staff do not use A+ Communications (most of them probably haven't even met Tim Rutt!), and so they probably are not completely satisfied with the telecommunications network with which they are currently involved. This is a shame, for I believe that the intern armed with the proper beeper can be a happier intern.

Life can be a curious thing. I never would have surmised that a pager would come to shape me as a person and as a physician. But it has. The pager makes me whole, it completes me. In fact, I believe that, from an evolutionary standpoint, wearing a pager offers me specific selective advantages over other species. When was the last time you saw a horse or a monkey paging one another? I don't think you'll ever find an A+ Communications representative renting a pager to an amoeba or even to a guinea pig. It is the human being who has developed the capability to page or beep one another, and it is this capability which will protect our species for centuries to come. I would not be the least surprised to hear Matt Cartmill, while teaching an anatomy class 3000 years from now, describing how pagers worked their way into the human genome and ultimately became a normal part of the human anatomy. Who knows? Maybe the appendix, which some have labelled as vermiform, will ultimately prove to be simply a precursor to a natural abdominal beeper found at the ileocecal junction, occasionally in a retrocecal fashion. If you should find out that this indeed is the case and that my suspicion was correct, would you do me a favor and page me? ■

AS SEEN ON TV!

HEPATIGHT-ASS JEANS

They're contagious!



PEOPLE WHO WEAR THEM SAY:

..."They made me yellow in the face!"

.."I never felt the same way again."

"..."They're killin' me!"

Shifting Dullness

Duke University
P. O. Box 2865
Durham, N.C. 27705

Dr. Jim Gifford (2)
Medical Center Archivist
Box 3702 , DUMC

MORO REFLECTS

Mike Morowitz

It has been 18 months now since Keith Berry MSIII spearheaded efforts to obtain pagers for Duke medical students. When I signed an agreement to rent a pager, my first year had just ended, and I told Tim Rutt, the gritty salesman from A+ communications, that I would only needed the pager for 12 months. And now here I am, 6 months into my third year of laboratory research, and my trusty pager is still clipped to my belt, vibrating and beeping as only a pager could. I have been reluctant to return the pager because, strange though it may sound, the pager has become an integral part of my medical education. I dare say that the pager has, in large part, defined the person that I am today.

That the pager has exerted such a large but unprecedented effect on my life should not surprise those with a firm grasp of some basic sociologic tenets. One of the defining characteristics of modern America is, of course, the status symbol. Sure, America offers democracy, equality, and freedom of expression; but, in many respects, the fluidity of the social structure and the egality of the political environment are only valuable insofar as one person can prove to the next that he is making the most of his opportunities. Consider the American obsession with cars, gadgets, decals from Ivy League institutions. These are simply material objects collected by individuals in an attempt to impress one another.

To make a list, then, of bona fide status symbols in our country, one thinks of a limousine or perhaps a private jet. Soon thereafter comes the electronic pager! If you wear a pager, you have made it to the big time! Purists will deny this, arguing that everybody and their step-mother wears a pager today. They may try to make the point that, whereas fifteen years ago the only people bearing pagers were physicians, today you can't distinguish whether a man bearing a pager is a drug-dealer or an expectant father. These people are wrong. The truth is that pagers are synonymous with power, and that beepers mean

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