VOICES

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On Race and Medicine

By Lauren Browne, MSIII
Duke University

For a long time, I have not had the courage to write this. Now that I have decided to do so, I will no doubt offend someone. Nevertheless, I must write unapologetically, as I can not pretend to be indifferent to the issue at hand. Today I am writing about race. Over a year ago, I learned that speaking about race, even acknowledging the very existence of race, is no longer acceptable in medical school. I am a white woman, and that fact combined with the surprising notion that medical school and the health care system is "color blind," now precludes me from speaking about racial injustice. Perhaps I should start from the beginning.

As a first year medical student, I was struck by the curriculum's lack of formal education regarding racial disparities and health care in our current social system. The entire class of approximately 100 students had one short afternoon discussion regarding a notion in American racial theory entitled "white privilege." In brief, the theory promotes the idea that society bestows unjustified privileges on white people based solely on the color of their skin. Proponents of "white privilege" argue that for far too long critical racial theory has focused solely on the social and political disadvantages of non-white races and, in doing so, has failed to examine the corollary of this, namely that white people benefit from daily unmerited social privileges. It is a concept that holds white people accountable for knowingly or unknowingly exploiting unearned privileges at the expense of others.

Although it was clear during our single afternoon session that a majority of students had heated opinions regarding racial privilege, those three hours seemed to leave most people angry and unresolved. As future doctors, we obviously needed a reliable forum to speak about the significant intersection of race and medicine. With the collaboration of another medical student, I organized a weekly lunch group entitled "White Privilege," named after the afternoon discussion that had inspired it. Overall, it was a productive group, largely because it chal-

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lenged us to listen to our peers and to acknowledge the fact that racial disparity existed and that everyone identified it differently.

During my second year of medical school, I attempted to introduce the lunch group to the incoming first year class. It was a complete disaster. Several white students accused me of being racist, discriminating against them using a theory that invalidates "all of the hard work" they had achieved in their path to becoming doctors. Some non-white students accused me of being just another white woman trying to "save black people and other minorities" and added that they did not need my help, thank you very much. They angrily stated that they could not believe that I thought they were disadvantaged compared to their white peers and that in reality they had just as much privilege as any other student, regardless of race.

I was not too concerned about the comments from my white peers. Of course I am racist. That is the point. We are all racist because we have all grown up in a racist world. I suppose I had offended several white people because I had highlighted the fact that they would be wise to figure out how hundreds of years of racial segregation and privilege still affects their lives today.

I was, however, disturbed by the second accusation. It was a much more complex argument and grounded in a history of white people taking up the "non-white cause" for some personal gain, whether material or moral. Although I understood the historical roots of the accusation, I was personally very hurt by it. In essence, it told me that I was not allowed an opinion on the issue of race and that I needed to remain silent on issues that I could not possibly know anything about. After all, race does not affect white people; it only affects non-white people, and I should stop trying to be a designated spokeswoman for those that are affected. At that moment, it seemed as if both whites and non-whites had banded together and agreed on one thing, that I should stop talking about race.

So I have tried. Honestly, I have. I never again brought up the idea of restarting the race and medicine lunch group. I have tried to disengage in inflammatory conversations on race. I have pretended that medicine, health care, and society at large do not bestow privileges solely based on skin color. I have tried to hold my tongue when I hear a white classmate say that it is harder for him to get into medical school than it is for a black person because the expectations are less for black people. I have tried even harder when I hear that black people could have just as much social privilege as white people if they just put some effort into it. I have desperately tried to ignore all of the racist comments and racial disparities that permeate my daily life.

I have desperately tried to ignore all of the racial disparities that permeate my daily life. But no matter how much I try to ignore racism, it does not ignore me.

Ultimately, I have failed. The prior accusations are correct. I am a racist being who lives in a racist society and no matter how much I try to ignore racism, it does not ignore me. I do not pretend to be a spokeswoman for non-white people or a savior who advocates for the oppressed and disadvantaged. I am a white woman in a racist society who will soon be a white doctor in a racist society. I am disappointed how many future doctors choose to ignore the issue of race and instead pretend that racial disparity is a historical fact rather than a current reality. Education on racial disparities in medicine should be part of our mandated curriculum and should be seen as an essential element in our professional development. Each one of us holds racist views, and in order to function at a level beyond race, we must first acknowledge the fact that we have all been affected by race. As physicians, we owe that acknowledgement to our patients and as human beings, we owe it to each other. I can no longer remain a silent witness of racial disparity, and for that, I refuse to apologize.

"A Family-Friendly Field"

By Jessica Lloyd, MSIII
Duke University

Recently, an older physician touted his specialty to me and another medical student as "a very family friendly field."

"I mention this because you are both women," he clarified.

I couldn't stop myself: "You wouldn't have said anything if we were two men sitting in front of you?" I asked.

"No, probably not."

Thinking about it more, I realized that this seemingly innocuous comment was a symptom of a dangerous new way of thinking: Socially-sanctioning America's expectation of professional women to do the full work of both breadwinner and homemaker. By targeting family-friendliness only at women, the decision-makers who remain in positions of power are tacitly stating that family-work is a woman's responsibility and that such concerns are inappropriate for and uncharacteristic of men.

Family-friendly careers and policies are a huge boon to American workers, but to generate the greatest social good, they must be targeted at both male and female employees. We must not assume that the spouse who wears the skirt is the only one concerned about how to find time to accomplish the many chores of modern life – time to go to the grocery store, fix dinner, wash clothes, attend PTA meetings, bathe children, check homework problems, and read bedtime stories. Even if this is the case in many (most?) families, the

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Plaza of the Hopeless

Poverty, desperation and nihilism are fueling a suicide epidemic in Nicaragua, killing a blank generation in the land of martyrs

By Beau Munoz, MSIII
Duke University

"Y cuanto toma'te", I asked her in my Caribbean accented Spanish that instinctively drops the letter "s." She just stared at me. My foreign accent and lack of a white coat and necktie made me suspect. I assume it was the stethoscope dangling off my shoulders that restored some credibility because eventually she answered.

"Me tome, como, unas treinta" (*I took about 30*), she said as she shifted her glance downward and tucked herself tighter into a fetal position.

"Thirty!" I thought to myself. Not knowing exactly how to respond I just looked at her with a Mona-Lisa-half-grin-half-frown as if to say, "Thirty! Yep, that'll do the trick alright".

"..Y por que lo hizo?" (*..and why did you do it?*) I asked her directly, completely abandoning any interviewing skills that I had picked up during my second year psych rotation. Without raising her eyes from their avoidant stare she just whispered "Llevo toda la vida combatiendo la depression." (*I have lived all of my life fighting depression*). For the next 15 minutes we just talked.

She tells me about her poverty, her broken family, her failed relationships, a world that doesn't care, a lack of hope, and her desires to kill herself. Throughout the conversation I listen intently, I ask open ended questions, and I try my best to summarize. My practice course leaders would be proud. By the end of our conversation I gather this much; "Ana" is an otherwise healthy 22 year old female with a five-year recorded history of depression. She presented this morning to the ER, accompanied by a friend, with the chief complaint of having swallowed 30 acetaminophen tablets. According to her, this is her first suicide attempt. She has been seen by psychiatrists on several occasions in the past and has been offered treatment but has been non-compliant due to both excessive expense and excessive apathy.

It occurs to me that I probably shouldn't even be talking to Ana. I'm not in Nicaragua on a psychiatry elective. In fact I'm not attached to any service really. I'm here studying febrile illnesses for my 3rd year research project, and Ana isn't a febrile patient. Even if she were, the 30 Tylenol that she took about 42 hours ago would have rid her of just about any fever. So, I get up to excuse myself and remark dismissively "Bueno, me imagino que saldras bien con el

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tratamiento que te dan." (*I'm sure that you'll be fine with the treatment that you receive here*). Her response just about knocks me off my feet and into the mosquito netting of the adjacent bed. "They don't have the antidote here," she whispers. " I have to go buy it before they will administer it to me. And since I can't afford the medication, they say there is nothing they can do for me."

On second thought, maybe she won't be fine.

The irony is so miserably tragic that I have to chuckle in amazement: 1. Patient comes into the hospital, victim of what would, in any developed country, be considered a cry for help; 2. Patient is offered some IV saline and an uncomfortable cot to lie in while she awaits fulminant hepatic failure; 3. Suicidal patient is told that she will die if she does not go to a local pharmacy and buy the six dollar N-acetylcysteine (NAC) to prevent her almost certain death. It's the height of absurdity.

This was the fifth suicide attempt I had seen that week, and it was only Wednesday. And no one else seemed the least bit shocked by this mini-epidemic. "What the hell is going on?" I asked.

I immediately exit the room and find the treating physician. His name is Dr. Hansak, coincidentally a relative of Boston Red Sox pitcher Devern Hansak. Dr. Hansak has become a close friend during my time here and so I feel comfortable questioning the logic of this "treatment" protocol. With a shrug of the shoulder and a wave of his hands he reassures me that she'll be fine. He says "Look, she took the pills 48 hours ago and we have up to 72 hours until hepatic failure starts setting in. And she told me that her sister is on the way from Managua (two hours away) with the money to buy the antidote." While I can't cite the literature off the top of my head, something just doesn't seem right about his time frame. Seventy-two hours seems like way too generous a time gap from ingestion to treatment. He can see the doubt in my eyes and knows that in my head I'm calling "Bullsh–." He just looks at me and gives me the ubiquitous, Nicaraguan reply of hopelessness and wearied surrender, "Asi son las cosas." (*That's just the way it is*). I can almost here the Don Henley song by the same name playing in the background.

The next morning I hurried straight to Ana's room to see if she was getting the NAC. When I entered the large, common room I saw families huddled around the beds of the other patients, and there was Ana, still in the fetal position, still alone, and still only receiving IV saline. I asked her what happened with her sister, the money, and the medicine. She just shrugged her shoulders and said "She never arrived." Maybe it was the lighting or the hue of the sheets but, I could swear that she was already turning jaundiced. She looked weak and dejected which could have been the effects of the N-acetyl-p-benzoquinone-imine (NAPQI) poisoning her liver or it could have been her depression, or more likely, the deadly combination of both. I asked her what she was going to do now. She said that the doctors had told her that if her liver started to fail they would move her to the ICU and treat her there. In my mind her death was certain. She was all alone – no family and no friends around. Still balled up in the fetal position, she looked like an innocent child oblivious to the gravity of her current situation. I stood there, hands in pocket, just staring at her. I felt like National Geographic photographer Kevin Carter, wanting to step in and rescue the dying child from the awaiting vulture but at the same time not wanting to disrupt the flow of nature. I just stood there. The next day Ana's bed was empty and her name was not registered on the ICU census.

As part of my 3rd year research project I spend the majority of my days in the ER taking temperatures and waiting for febrile patients to present for treatment. The ER here at HEODRA Hospital reminds me of a meat locker from the original Rocky movies.

The walls glimmer with ceramic white tiles and white bed sheets turned curtains undulate in rhythm to the frosty air ejected by an extra-large swamp-cooler. The floors are covered with deep-terracotta stained tiles and the fluorescent lights hang precariously on rusty chains. Other than a Casio calculator on the desk and the Treo 650 in my pocket the only objects of modern technology here are a Soviet-Era EKG machine with its bubble-suction leads, and a 20 year old USAID donated defibrillator. The two physicians sit behind wooden elementary school desks and the solitary nurse stands ready at her medication counter which contains the entirety of the ER meds – a formulary of 15 medications, about half of what you would find in a well-stocked US ambulance. In this ER, I have seen a patient come in with his arm completely degloved, a child who accidentally drank a bottle of gasoline, and cholera.

It was just past 3:10 p.m. when the gurney burst through the plywood ER door. The reason I remember the time is because I tend to pass my days staring at the knock-off Citizen clock on the wall which, with its gun-metal sheen and unsullied visage, is the only shiny surface in this place not stained by some form of dried, crusty bodily fluid. The ambulance driver, who looked more like a truck driver – potbelly hanging over his jeans, calloused hands, sweat-stained t-shirt, and a baseball cap, yelled out a series of profanities interspersed with sketchy details about a self-poisoning.

The patient's name was "Letsi". According to family members, approximately three hours prior Letsi had partaken in the most common form of suicide in Nicaragua; she swallowed four pills of rat poison and chased it down with a cherry-red soda called Rojito. Letsi's body was seemingly lifeless; her skin took on a macabre pallor that was only accentuated by tufts of her disheveled, raven black hair and fluorescent red lips still stained from the Rojito red dye #2. Those same neon red lips were gradually being obscured by the emesis flowing freely from her mouth and running down her cheeks like muddy water boiling over a pot. While ER doctors rushed to put on their TB masks (to avoid inhalation of gaseous organophosphate) Letsi's mother stood over her child slapping her hands as if to beat the organophosphate out of her body. She screamed hysterically for Letsi to "stop it right now, and get up!" Using the only tool at her disposal, mom was trying to discipline her daughter back to life – the raw emotion combined with the abject futility of mom's pleas filled the room with somber miasma which was now rapidly mixing with the toxic fumes of rat poison in the air.

This was the fifth suicide attempt that I had seen that week, and it was only Wednesday. Before Letsi there was "Mauricio" a 28-year-old widower, "Ernesto" a 19-year-old college student, "Doña Maria Espinoza" a 36-year-old mother of three, and "Ana". And no one else seemed the least bit shocked by this mini-epidemic. I had to ask. I leaned over to one of the medical residents and subtly enquired, "What the hell is going on? Why are so many people trying to off themselves here?" Dr. Estrada, the lead ER physician, who was trying diligently to get a femoral stick, yelled out from behind her mask, "It's because Nicaraguans are too melodramatic." The medical resident at my side

countered, "It's has to do with the poverty here." Another medical resident looked out from behind his laryngoscope and quizzically added, "Maybe they're just doing it for attention." At the time, I didn't really understand his logic.

The other thing I didn't understand was how they planned to save this girl's life. The only monitoring machine they had was a defibrillator that gave them a heart rate readout; there was no pulse oximeter or end tidal CO_2. They weren't administering any atropine, and at $400 a shot she certainly wasn't going to be receiving any oximes. Instead the doctors went for dopamine to elevate her blood pressure. As I tried to calculate the microgram and drops per minute dosing I noticed a sharp pain shoot through my head starting from behind my right eye and going back to the occiput. At first, I thought it was a result of trying to do the long division in my head but, I quickly realized that it was most likely from the organophosphate fumes that had taken over the room. I made a quick exit. I would find out later that Letsi did as well – her fight against survival was won about two hours after she arrived to the hospital. She died of acute respiratory distress secondary to organophosphate ingestion.

While the affects of the toxic fumes wore off right away, my bewilderment persisted for weeks. Five suicides in one week, with a death rate of about four out of five? Could it be the poverty, or was it an overzealous passion for drama? Getting attention? I started asking colleagues and even looking up literature on the subject.

PubMed and Google Scholar each produced about half a dozen studies on the topic, which indicates to me that I'm not the only one with raised eyebrows.

The first article I came across was a published interview with Dr. Luis Molina, deputy director of the National Psychiatric Hospital, and Dr. Alvaro Lacayo, director of the Institute of Neurology and Human Development. The doctors sited "desperation" as the main cause of suicide in Nicaragua. "Nicaragua is a society of desperation, in which moral, political, and cultural values are disappearing every day while 70% of the population doesn't finish primary school, doesn't have drinking water, and is unemployed," they said. "To these desperate factors must be added endemic problems such as alcoholism and lack of identity." And a look at historical surveillance shows an interesting and counterintuitive association of this "desperation" with the end of the civil war in the late 1980s.

Studies show that suicide rates started to rise around 1990, coinciding with the end of Sandinista political and military dominance, which had started in 1979. Suicide rates in 1990 were about 2.2 per 100,000 and by 2005 they were up to 7.2 per 100,000 -the highest rates being among men ages 15-24. One study conducted in Leon, Nicaragua in 2006 found that the overall one-year prevalence of any suicidal expression was about 45% for both males and females, and that suicide attempts in the past year were reported by about 2% of the respondents. The study failed to show any association between poverty and suicidal attempts and also failed to jive with the frequency of suicides that were showing up in recent days. What *did* jive however, was the study's second conclusion which states that "suicidal behavior amongst significant others and close family members tended to produce a 'contagious' effect on respondents." While at once puzzling, the idea of infectious suicide doesn't seem all too unreasonable after living here for 2 months.

In Leon, you are surrounded by memorials to martyrs. I work at Hospital Oscar Danilo Rosales Arcuello, named after a 26-year-old physician who was assassinated by the National Guard in 1967. An enormous painting of him greets you as you enter the front door of the hospital. And that same front door has one of the most popular images you will find in Nicaragua, that of Che Guevara – dead at the age of 39. General Che's image is only challenged in its ubiquity by two others; that of revolutionary icon Augusto Sandino – dead at age 39 – and Jesus Christ – "dead" at age 35. And a walk around Leon will introduce you to the mural images or stone busts of another dozen or so martyrs including Carlos Fonseca (dead at age 40), Ben Linder (age 27), Sergio Saldana (age 21), Jose Rubi (age 20), Erick Ramirez (age 22), and Mauricio Martinez (age 21). From the post office to the gas station the images of the young and the dead are everywhere. As far as I can tell, the only icon of Nicaragua who wasn't a martyr or, dead by 40, is Nobel Prize-winning poet Ruben Dario. It gives one the idea that in Nicaragua your life is only valued if you write a book worth reading or live a life worth writing a book about. It's no surprise then that Nicaraguan youth find death an inviting option, and maybe the idea of an early checkout *can* be infectious.

Now that the revolution is over, poverty has become systemic (Nicaragua is the second-poorest nation in the Western Hemisphere), corruption is rampant, and inopportunity has become the only infrastructure left in the wake of the Cold War. This lost generation finds itself in a society of desperation, seemingly devoid of a purpose or a meaning to build a future around, and enveloped in a present that reveres martyrdom. As I reflect on the eight suicides that I have seen so far, I hesitate to label them as modern day martyrs in the same vane as the sacrificed heroes who now decorate the city –heroes who have died to further a political, religious, nationalistic, or military cause – but maybe it's not too much of a stretch to say they've martyred themselves to perpetuate the belief of a complete lack of belief. Their politics: disenfranchised; their religion: nihilism; their nationalism: corrupted. They are the martyrs of a blank generation – a generation without a cause, without a purpose, without direction nor the will or resources to find one, and a whole lot of celebrated dead people around them.

This lost generation finds itself in a society of desperation, seemingly devoid of a purpose or a meaning to build a future around. Maybe its not too much of a stretch to say they've martyred themselves to perpetuate the belief of a complete lack of belief.

On my way home from the hospital I pass by the three main plazas of Leon; the first is the Parque Central which commemorates the founding of the city, the second is the Plaza de Las Poetas, celebrating the famous writers from the region, and the third is the Plaza de los Martyrs, a memorial to fallen Sandanistas. As I arrive at my doorstep, I stare at the blank lot in front of my house. I envision a Plaza de los Desesperados, dedicated to Ana, Letsi, Ernesto, Mauricio, and Doña Maria Espinoza, the fallen martyrs of Nicaragua's blank generation.

A ceramic bust and a kitschy mural may be the only attention that their generation will ever receive.

Postscript: I found out much later that Ana did receive the treatment for acetaminophen overdose and left the hospital voluntarily. An anonymous donor purchased the N-actyl-

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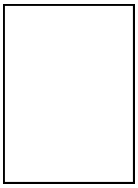
powerful must act as though it is both appropriate *and normal* for working men to worry about—and actively try to solve—these problems as well. If outdated, old-fashioned, *family-unfriendly* views persist at the top, positive change will remain elusive.

Anecdotal evidence leads me to believe that many women who leave the medical workforce or choose to work part-time are not doing so strictly in order to spend more time directly interfacing one-on-one with their children. Rather, women seem to be leaving work because they know that if they aren't at home to make sure that all the many moving parts of family life are attended to and remain in sync, the wheels will fall off. These women know that if they aren't there to run the dishwasher, the washing machine, the carpool, the vacuum cleaner, the Spanish lessons, then the tenuous balance of time and family responsibilities would crumble.

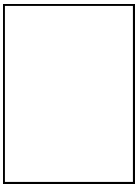
Women who leave for home are not simply playing, hugging, teaching, and nurturing 24/7; they are spending just as much (or more) time washing, shopping, cleaning, planning, cooking, driving, and managing one tedious but essential task after another. Certainly, these basic chores are necessary, but must they *necessarily* be women's work? In a dual-worker household, it is unfair and unacceptable that one partner is expected to shoulder a second job—this one largely invisible and typically thankless—while her partner is invited to relax, sit back, and be taken care of, simply by virtue of his gender.

Targeting family-friendly policies only at female workers perpetuates the perilous idea that home-work is women's work alone. Such ideas are wrong-headed and should not be tolerated.

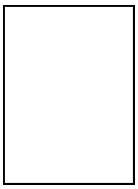
About Voices...



Lauren Browne text



Jessica Lloyd text



Beau Munoz text

Voices Magazine is a publication of the Duke chapter of the AMA. It is dedicated to offering students a place to express the humanity that is of such importance in the practice of medicine. We encourage all medical students to submit content in the form of articles, essays, poetry, drawings, photography, or any other way they find to express themselves.
Alex Fanaroff, Editor

From the President's Desk

This year, the AMA has gotten off to a good start and we're looking forward to making it a great year. Below is a list of events that are coming up after Christmas.

All are fantastic ways to support the AMA as well as get involved with the organization that is representing you now and will be doing so in the future.

- January 16-18th, 2009: Region 4 Annual Meeting, Raleigh, NC
- January/February, date TBD: AMA Annual Date Auction
- March 31st, 2009: Student and Resident Lobby Day, Washington, DC
- April, date TBD: White Coat Wednesday – State Lobby Day, Raleigh, NC

Service events are being held on a monthly basis. In the New Year, these will include continued work with Urban Ministries, The Durham Rescue Mission and The Durham Ronald McDonald House.

Social events will continue in the New Year. Events currently being planned include a mixer with the UNC AMA chapter and a reception with the Medical Alumni Association.

We hope you have a great Christmas break, and a Happy New Year. We look forward to seeing you when you get back!

Cheers,

Matt Uhlman, President
Kaitlin Rawluk, VP