Preamble
You wake up at 4:00 p.m. and change from pajamas into scrubs. You down a cup of coffee and your best guess at food that you won’t regret later. Food regret overnight boils down to two main types: not enough and Chinese. Given the abundance of graham crackers on most floors, the latter is the greater misfortune. Alone, or when accompanied by incorrect preparation for unanticipated temperatures, it can be a calamity.

The Ritual of Sign-Out
You arrive at 6:32 p.m. You worry that people hate you for being two minutes late to your fourteen-hour shift, as you should. They do. With a mix of that specific hate and the diametrically opposite and equal euphoria that accompanies the end of any shift at the VA, the four teams hand over their pagers, which are usually warm with their body heat. This is the initiation of the ritual of sign-out.

The variability in style, helpfulness, and enjoyability of the ritual of sign-out is profound. It is not unusual to hear variations of the following: you will definitely be called on this guy; try to avoid going to his room. His family may call; they want to discuss goals of care and code status. Check his EKG at 3:00 a.m. and call the EP fellow to discuss. This vet is having an MRI for back pain that he has had for 24 years, please follow it up. This vet has not had a bowel movement for eight days. You are given the attendings’ phone numbers and told that they are really great and would like to be notified for any deaths.

The Pagers
At the end of sign-out, everyone vanishes. Literally, vanishes. The moment this happens, the pagers start to go off. The nurses have questions or statements that are posed as though they are questions: The fingerstick is 350, he is written for 12 units. The patient has been waiting for you to come talk to him all day. The patient had five beats of V-tach two hours ago.

Each pager reads a different date and time. None has the correct date or time. Each message received on the pager is a call-back number that consists of four numbers. One pager’s screen is damaged such that only the left-most aspect of the fourth digit is visible. An unexpected challenge of internship is discerning between 1, 3, and 7 (which show up as nothing), 6 and 8 (full line) and 4, 9, and 5 (half line). The only gimme is 2. As with so much in medicine, you must resort to using your best guess. Your best guest usually yields a nurse who did not page you but who does have a patient requesting pain meds before they’re due.
This is Nightfloat at the VA (continued)...

The tempo at which the four pagers on your hip go off is unpredictable. Superstitions develop. By the second week you realize that there are certain spots in the hospital where the pagers do not work, as if annulled by some benevolent cosmic force field whose main point is: enough already.

One of those magic spots is the Emergency Room. Once discovered, you might plan to spend as much time as possible there—quiet page-free time. However, the trip is devastating. The Emergency Room is about a quarter mile from the building where the inpatients are kept. Each clog you are wearing weighs about two and a half pounds. If you count the four pagers, stethoscope, and highly variable array of pens, paper, and quick-reference guides whose font size and abbreviation scheme make them incredibly less useful than a quick search on the internet, you tow upward of ten pounds of paraphernalia with you on each trip to the ER. Toward the beginning of the year, the sheer multitude of paper sticking out of the pockets can be enough to cause significant delays due to air resistance, or, more classically, the dropping of the papers, everywhere.

Incorrect Preparation for Unanticipated Temperatures

At a certain point in the night, you start to get slow. You develop a chill and bad breath. Your bowels are, in a word, upset. Your mind will naturally wander toward philosophical and existential thoughts (they start with “why...”), but it is critical to avoid them. The hospital is freezing. Patients refuse to let you touch them with your ice block hands. You vow to bring sweatpants and sweatshirts and a hat the following night. You do, and the following night the hospital is a sauna.

Four East

There is a wing of the West Haven VA that is unlike the others. It is difficult to explain precisely why and how it is different than the rest of it, but it is undeniably so. Suffice it to say that every resident has a Four East story. Mention the unit while socializing and you may ruin an evening’s potential for conversa-

sion about something other than patient care disasters. But you do not know this yet. You are the nightfloat intern.

What you know immediately is that the unit itself is physically different. To start, the walls are a wan shade of green, which casts an aquarium-like murk over the entire place. There are photographs and long captions on the walls that when inspected closely do not describe the mating and eating patterns of beluga whales. They are mostly passages about American warfare in the twentieth century. The topic of warfare is relevant to Four East in many ways.

Another marked difference is that there is no capacity for telemetry, and therefore the patients must have an acuity of illness that does not put them at high risk for cardiac arrhythmias. You have to think for a moment about what sort of hospitalized vet does not have high risk of arrhythmias. A resident you trust says that admitting to Four East is like admitting to your living room—someone on the way to the fridge for a midnight snack might notice a patient, but the surveillance efforts end there.

All Bleeding Stops

You are called by a nurse who says, the patient is bleeding please come to bedside. She is impatient with your questions, which include what patient how much and from where. She agrees to do a set of vitals. You see the man. You recall, from the ritual of sign-out, nothing about this man. Your piece of paper says he is GI bleeding, maybe from his stomach maybe from lower. He would have gone for endoscopy/colonoscopy today but refused to take the prep. It also indicates that he has schizophrenia and is conserv-

ed by an attorney.

You go to him. He is the only person in a four-person room toward the end of the dank Four East corridor. The other three beds in his room are made up with cold clean linens, somber and expectant. The man is uncomfortable and uninterested in you. There is a pink basin at his side holding the material he has
been retching up, and you see that it is flecked with red. He keeps his eyes closed but does talk to you. He denies pain. He says he has been throwing up that stuff all day. His heart is contracting just over one hundred times each minute. His pressure and oxygen levels are normal. You are uncertain what to do. You confer with seniority. Seniority kindly suggests a check of his blood levels, some intravenous saline, and something for nausea. It’s already 2:00am, and the GI team is coming to scope him at 8:00am—unless he tries to die in the next few hours, there’s no way they’re coming in earlier than that.

That all seems so obvious. You do it. His heart slows down to normal and he stops throwing up. His blood level comes back low but stable. A few hours later, he falls asleep. You are not paged about him again. You start to think about sleep, too. The merciless CPRS font and white glare of the computers assault your eyes and create a confusion that does not resolve when you look away. There is a call room on the sixth floor that is a freezing and dark.

***

It involves: An intern en route to the call room. A detour to his room, a last check before turning in. Confusion, it’s all wrong, sprawled belly up over the short axis of the bed. Denial, a dark wet lake on the floor. Paralysis, to run for help or run to him and scream for it. Dread, his skin is cold. Horror, the first compression, the thick geiser of blood from his mouth and nose. Ambivalence, do no harm. Solitude, are they on their way? Words, when they arrive. Theater, a nurse slips and falls. Absurdity, CPR on a corpse. Relief and regret, stopping.

Disconnect, calling the attending. Best guess, to leave a voicemail or not. Sadness, finally, calling the conservator, expecting a machine, reaching the voice and then the gasp and then the tears of the man who has taken care of the dead man for forty years.

***

In the morning, there is the retelling. There is the composition of a utilitarian code note. There is a favor—the sparing of the graphic details. You are uncertain of their gratitude, or rather awareness, of this favor. On rounds, there is a quiz—what is the only thing proven to improve mortality after cardiac arrest? There is a compliment—that’s correct, compressions. You did the right thing. You did a good job. There is perception of an emotional state, and there is normalization: was it your first code?

There is release. There is sleep. There is return.

Hannah Rosenblum
Value and Cost of Cancer Drugs

JOHN and ARMAND RUSSO

The cost of cancer therapeutics is a daunting economic and policy problem in the American cancer care system.

Why has the average price for a cancer regimen risen from $5,000 per month before the millennium to $10,000 per month [1]? Why is the best price [what pharmaceutical companies can charge and insurance will pay] so discordant with the fair price? How can Sanofi-Aventis reduce the price of its version of bevacizumab by 50% the week after a New York Times Op-Ed while other companies would not do the same? Unfortunately, oncologists do not necessarily think about issues of cost as it relates to their practice and patients [2].

Centers for Medicare and Medicaid Services have an enormous stake in cancer therapy, yet they cannot negotiate prices with manufacturers [3]. Medicare and Medicaid pay for 70% of the care of new cancer patients. This will increase since the Affordable Care Act has added millions of people to Medicaid in addition to subsidizing private health insurance for workers whose employers are under mandate.

The Medicare payment structure for cancer drugs has changed drastically in the last decade. The “average wholesale price” changed to the “average sales price” plus six percent formula to limit the amount physician groups could bill Medicare relative to the discount price the groups paid manufacturers for drugs. Generic drug prices decreased and so were produced less, but patented drug prices were negotiated between physicians and manufacturers to preserve the profit margin from Medicare. Further, lobbyists for manufacturers have secured legislation in many states requiring private health insurance to pay for all on- and off-label cancer drugs, so price negotiation will essentially allow continued Medicare reimbursement before the rule change. Insurance companies transfer these costs to premiums and out-of-pocket costs for patients [3].

Only recently has the knowledge bounty of the Human Genome Project (HGP) been applied to pharmaceuticals. These products are in high demand among a small group of patients. The investors who invest in these products are often unsure about the FDA approval process and the high cost of treating these complex patients. Therefore high prices are a necessary measure to attract those investors. Economic theory would thus demand high prices, since the market for a particular targeted drug is being subdivided as much as cancer itself is splintered into disease entities based on genomics. Generic versions of patented monopolistic medications, called ‘follow-on biologics’, may help reduce the cost of drug prices over time but so far this has not happened to a meaningful degree [4].

The solutions for lowering specialty drug prices is not at all clear, but the HGP will continue to spur higher demand for target specificity. Clinical benefit of a drug should be reflected in its price. This is both an economic and moral imperative in cancer care at all levels of care and policy, whether public or private. Perhaps oncologists can play a leading role in this worthwhile challenge.

References:


Book Review:

*What Doctors Feel: How Emotions Affect the Practice of Medicine*

By Dr. Danielle Ofri

AMANDA FREED

Dr. Ofri recently wrote an intriguing article in the New York Times about the dilemma physicians face regarding opioid prescriptions. I identified with the struggle she addressed in that article so I picked up her most recent book. In *What Doctors Feel: How Emotions Affect the Practice of Medicine*, she has gathered several stories from her own training and practice as well as numerous stories from other trainees and physicians. Many stories reflect on, and revolve around, the importance of empathy.

Particularly, I identified with stories like those with the exhausted intern or the nervous resident at her first code. Other stories less so. In two stories, Dr. Ofri chastises herself and her trainees for using humor to deal with their emotions. I try my best to provide empathic care every day. However, I think I would be unhappy if I always stood in my patients’ shoes and never stopped for a laugh. I believe that the laughter that we share is necessary for our survival as trainees. I don’t think I could come back day after day if I couldn’t find some humor in my job. Although Dr. Ofri admits to also having used laughter as an escape, I think she would chastise me for doing the same.

A second important point that Dr. Ofri makes in the book is that the patients of empathic doctors have better outcomes. I felt that the book conveyed the message that this is a one-direction, causal relationship: if doctors are empathic, their patients will have better glycemic indices and blood pressure control. However, I think that control of chronic diseases is more complex. I find that for my patients with uncontrolled diabetes or hypertension there is a whole host of complex psychosocial barriers to good control. It is unfortunate that in our clinics and wards we just do not have the resources to address those issues. I think that is how most trainees lose their ability to be empathic—because we don’t have the resources to help our patients and often feel helpless. Just as I was feeling this way Dr. Ofri introduced the story of Julia, a patient with idiopathic cardiomyopathy in desperate need of a heart transplant. I won’t spoil the ending of Julia’s story for anyone considering reading the book but I will say that Dr. Ofri demonstrates empathy in the face of a very difficult and seemingly hopeless situation.

Overall reading the book reminded of the value of empathy. More important, it reminded me that for decades doctors have been facing the same struggles that I face every day. I am not alone.
Choosing Poorly

MERILYN VARGHESE and KARL LANGBERG

The Choosing Wisely Campaign is an initiative by the American Board of Internal Medicine Foundation to spark conversations among health care providers and patients to help promote tests and treatments that are supported by evidence, not duplicative of other tests or treatments, and are free from harm. Numerous national medical organizations have now published lists of five common high value care recommendations.

Here at the Beeson Beat, we want to help share these lists through our new game: Choosing Poorly. We have included two real recommendations and one fake recommendation. In this issue we will use the list from the American College of Medical Toxicology and the American Academy of Clinical Toxicology.

1. Phenytoin and fosphenytoin should be used to treat seizures caused by drug toxicity or drug withdrawal.

2. Don’t recommend “detoxification” through colon cleansing or promoting sweating for disease treatment or prevention.

3. Don’t administer a chelating agent prior to testing urine for metals, a practice referred to as “provoked” urine testing.

Go to page 9 for the answer, and choosingwisely.org to see all the recommendations.

For the Neonate with Candida Endocarditis

EMILY PINTO TAYLOR

It’s cliché to mention the size of a neonate’s hands, but you weighed 600 grams and your fingers were larger than I expected.

When I felt your rash, your ribs bent under my fingertips gently grazing over the bumps.

I felt your liver, no bigger than a thimble, your thread-like intestines, your lima-bean kidneys the soft pulse, tap-tap-tap, of your aorta under the pad of my thumb.

They joked about trying to do an echo with a mouse probe and I realized you weighed less than some mice.

Later, your rash spread, “declaring itself” as the experts said that it would, and your tiny heart had a fungus ball flailing along your tiny valve.

Endocarditis, they said casually, “It’s a shame, he won’t live.”

I drove home from the NICU and sat in my car in the driveway the fireflies blinked on and off, floating like bubbles above the grass and somewhere, miles away, your hummingbird heart flutters the fungus ball flails and your mother is crying.
Chief Concern: Savory Skappo

KRISHNA UPADHYAYA

Subjective: Our patient is an 11-year-old Italian wine bar named Skappo. Hidden away on Crown and Orange Street, this family-run restaurant offers a unique style of food that hails from a small town in Italy, known as Assisi. This town may sound familiar because it is the birthplace of the famous St. Francis of Assisi, who interestingly wrote the first Italian poem. And it is from that very poem where St. Francis conveys his love for nature that the word Skappo, which originates from “skappare,” meaning “to escape,” comes from.

Objective: On physical exam, the exterior appears thin and narrow, with a likely BMI of less than 18. However, the glass facade offers a view into the more robust interior and people quickly find themselves staring in, like a child window-shopping at a chocolate store. Upon walking in, we were quickly greeted by members of the family, who kindly escorted us to a table.

We started off with the Crostini con Pomodori, which is ricotta cheese and semi-dried tomatoes on ciabatta bread, and the Fichi Riempi con Gorgonzola, which is fig stuffed with gorgonzola cheese. The sweet caramelized fig provided a stunning contrast to the sharp and tangy gorgonzola, which was then smoothed over with a bite of creamy ricotta and hearty tomato on fresh toasted ciabatta. This was all washed down with a sip of Pinot Grigio, which calmed down the explosion of flavor in my mouth leaving me with a light citrus after-taste and a cleansed palate wanting more. For the main course, I tried the homemade gnocchi. It took a while for the dish to come out (almost one hour), but the family was preparing the meal from scratch and so I did not mind. These gnocchi were unique in that the dumplings were made out of ricotta cheese and butternut squash rather than potato. The texture was perfectly chewy, which allowed me to soak in the flavor longer and really tease out the quiet, but slightly sweet flavor of butternut squash. The dumplings were adorned in a warm sauce of goat cheese and dried cherry that tasted so fresh I swear the chef had just gathered the ingredients from the Assisi countryside.

Assessment/Plan: Food: A+, Appearance/Atmosphere: A+, Service: A. In summary, I give Skappo an A+, not only for its ability to really capture Italian taste in unique and non-traditional ways, but also because I admire that every aspect of the restaurant is entirely run by a family whose heart and soul is so clearly invested in sharing their kitchen and culture with everyone. As St. Francis expressed his love for Mother Nature, I encourage you all to express your love for food and “escape” into the cuisine of Skappo!
Intern Spotlight

YIHAN YANG

Roger Kim — Traditional
Hometown: Fort Myers, Florida
Undergrad: Yale College
Med school: Yale School of Medicine
Interesting Facts:
1. Roger loves music. He plays piano, guitar, bass guitar, and drums. In medical school, he was the drummer for a band called “The Laws,” and they recently released their album entitled, “Somewhere They’ll Never Find Me.” Check them out on iTunes!
2. Roger plays on a men’s league ice hockey team with co-intern and hockey superstar Samir (“Sami”) Gautam.
3. When not on the ice or in the hospital, Roger can be found hanging out with Andrew Marple (“Marps”). They met on January 13, 2015 on the interview trail, and “the bromance has blossomed without inhibition ever since!”

Jana Zielonka — Traditional
Hometown: New York City, New York
Undergrad: Yale College
Med school: Weill Cornell Medical College
Interesting Facts:
1. After graduating from undergrad Jana worked as a pianist and conductor in NYC, playing in the pit for Broadway and Off-Broadway shows, as well as some operas, rock bands and for several recordings.
2. Jana has two 75-pound rescue dogs, Stella and Joey, who are very happy to have made the move from NYC to New Haven!
3. Until she was 14 years old, Jana’s dream was to play shortstop for the New York Mets.

Chris Alonzo — Primary Care
Hometown: El Paso, Texas
Undergrad: Texas Christian University (Go Frogs!)
Med School: University of Texas Health Science Center of San Antonio
Interesting facts:
1. Chris used to teach beginners Salsa dancing!
2. He makes epic red wine brownies.
3. Chris and his best friend Shane like to reenact moments from “Scrubs” when they meet in person.
Records

Extreme values witnessed by our residents and attendings, in patients who have since benefited from our dedicated care.

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<thead>
<tr>
<th>HIGHEST</th>
<th>LOWEST</th>
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<tr>
<td>A1c</td>
<td>18—Albert Do</td>
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<td>Ammonia</td>
<td>541—Pranay Sinha</td>
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<tr>
<td>Anion Gap</td>
<td>45—Matt Griffin</td>
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<tr>
<td>Bili, total</td>
<td>39.27—Mohsin Chowdhury</td>
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<tr>
<td>Bili, direct</td>
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<td>16.6 Andrew Marple</td>
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<td>1710—Amish Desai</td>
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<td>&gt;29.99—Elana Shpall</td>
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<td>225 units NPH BID—Adam Phillips</td>
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<td>26—Steph McCarty</td>
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<td>HCV Viral Load</td>
<td>&gt; 100,000,000 (log &gt; 8.00)—Albert Do</td>
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<td>Troponin</td>
<td>228—Ali Romegialli and Mary Grace Baker</td>
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<td>308—Cecilia Davis</td>
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<td>WBC count</td>
<td>239,000—Steph McCarty</td>
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Choosing Poorly (continued)

ANSWER

The fake is #1. Phenytoin is largely ineffective for seizures due to medication or drug toxicities. It can be harmful for seizures due to theophylline or cyclic antidepressants. Benzodiazepines are first line treatment for toxin induced or withdrawal seizures.

http://www.choosingwisely.org/clinician-lists/acmt-and-aact-phenytoin-or-fosphenytoin-to-treat-seizures/
Internship

GEORGE GOSHUA

There is much to be said and much to dissect
When is a physician born and whence is this ritual from?
The world of student and doctor intersect
In internship this transition is an illusive storm

It’s misty, it’s hazy, and the boundaries morph
As one becomes agile at one thing, three-dozen more mourn
In the messy hospital world you seem to dwarf
Then another tide of progress and learning wherever you turn

You see there have been many before us and so many to go
All have had doubt, but also changed lives and helped people cope
Halfway through internship you trudge through the snow
For when the light is most dim you know you are still their hope

Hannah Rosenblum
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