Doctors are used to seeing, touching, and probing the bodies of patients. We tell them not to be shy. Dr. Taddei once told me that the key to good patient care is to “love them and make them naked.” (She then stressed the importance of appropriate draping.)

Modesty in medicine has its redeeming traits, however. In fact, Dr. René Laennec developed one of the most important diagnostic tools in modern medicine due to his modesty. As a young physician in France in the early 19th century, Dr. Laennec’s area of expertise was using percussion and direct auscultation (that is, planting his ear firmly on the patient’s precordium) to diagnose conditions of the chest. As the story goes, he was called to the bedside of a suffering woman and was faced with the un-percussable pillow-like composition of her generous bosom. He was in a dilemma: to place his ear upon her chest would not be fitting for such a gentleman, but not to listen would not be fitting of such a physician. In a moment of insight, he rolled a piece of paper into a tube and listened, from a respectful distance, to the sounds of her heart. He made a diagnosis and, behold, the stethoscope was born.

But before we think too highly of modesty, we should acknowledge the many benefits, both personal and professional, of embracing the naked body. Dr. Papanicolaou, a Greek physician, took what some might call an immodest approach to science. He spent his early career studying cytological changes in the vaginal smears of guinea pigs at different points in their estrous cycles. He was curious if these cellular changes also occurred in humans. As he did not yet have a medical license to practice on humans, he studied the only subject he did have access to—his wife. Mary Papanicolaou allowed her husband to perform daily cervical swabs. There are some accounts that she also invited friends over to give samples; other accounts say that he obtained additional samples from the employees at the hospital where he worked. Either way, Dr. Papanicolaou had to have had numerous immodest conversations to get those samples. It was thus that he noticed the distinct cytological changes in one woman with cervical cancer. While the origins of the “pap” smear may have been immodest (and, let’s face it, creepy), the procedure has decreased mortality from cervical cancer in this country by seventy percent—a modest improvement, to say the very least.
I walked in late; they had already started. Fortunately, no one seemed to mind. Amir Mohareb, one of the clinic’s resident leaders, was discussing the Ebola epidemic. Everyone else was eating pizza. I was assigned to see one patient, an 18-year-old girl who recently immigrated from Iraq via Lebanon with her family. The entire family was there in clinic, each member in a separate room. Ruth Mansi, the coordinator for Integrated Refugee & Immigrant Services (IRIS), went between rooms helping everyone get settled.

The Refugee Clinic is held every Wednesday evening in the pediatric wing of the Primary Care Center. Clinic always starts with a short lecture on a relevant topic. Then there is a brief orientation that includes time to review the labs (which are completed prior to the appointment) and a cheat sheet on health topics particularly important among refugees. As it was my first time there, Amir pulled me aside and made sure I had an Arabic interpreter and felt ready to see my patient.

I walked into the exam room and took the history as I would from any patient. Then, I moved on to the refugee-specific questions as listed on the cheat sheet. My patient was surprisingly open and nonchalant about the tragedies her family had faced and the difficulties of being uprooted from their home. Although she did endorse some symptoms of PTSD, she declined therapy or other help. The only thing she wanted help with was her finger. She had accidentally cut herself with a kitchen knife six weeks ago, and she had no access to care at that time. Now she still had pain and decreased range of motion in her finger. This reminded me that I was the first physician interacting with her in the American health care system. She was coming into this interaction not with mistrust or a general dislike for physicians but with hope of getting the help she needed. So many of the patients that I interact with on a daily basis are unsatisfied with physicians and the healthcare system, which, as a resident, can be very disheartening. Her optimism about the visit renewed my own optimism that high quality healthcare can make a difference for an individual and a community.

Other residents have had similar experiences of renewal. In the words of Dhruva Kothari, a former resident leader, "Refugee Clinic re-introduces us to that romantic notion of what a physician can be. We try to help a marginalized population that has limited support. We wrestle with broader differentials, such as schistosomiasis and Loa Loa, and we get to see in real life the importance of psychosocial determinants of health.” As Amir puts it, "These patients are ‘survivors’... they take advantage of every little opportunity they are given, from the refugee camps in their home country to the clinic and community resources here in New Haven.”
The Flimsy Morality of Birdman, Oscar Winner: Movie Review

ARMAND RUSSO

The surreal ironic comedy Birdman (Or, the Unexpected Virtue of Ignorance) has an obvious moral conflict: the troubled relationship of entertainment on the one hand, and dramatic artistic endeavor on the other. One side must win. The film is an aesthetic success but a moral failure in resolving this dilemma.

The main character is Riggan Thompson, played by Michael Keaton. Riggan is a washed-up actor from the 1990s who played the superhero "Birdman." Now he has risked his reputation and all of his savings to write, direct and act in a Broadway version of Raymond Carver's short story "What We Talk about When We Talk about Love." Quite brilliantly, Birdman is a separate entity from Riggan Thomson the man. In a nagging, gravelly voice, the voice of Birdman whispers in Riggan's psychotic ear, urging him to be a superhero again and abandon his artistic dreams. This voice is the crucial structural component that instills the main moral dilemma.

Here it is more specifically: Is Carver on Broadway more meaningful than the exorbitant movies in which Riggan starred? The failure of this movie is that the answer is not an undeniable yes of course. Throughout the movie, Keaton is fighting out this truth with his psychotic voice; with death (as in he tries to fly); with the theater critic who resents him; with suicidality; with Ed Norton as the serious stage actor who otherwise is morally bankrupt; hipster Emma Stone, the worst character in the movie and the abandoned daughter; and the girlfriend who is also in the play and denies Riggan progenerative ability. While it is all quite humorous and the pace of the dialogue and the Broadway-behind-the-scenes are thrilling, we never really come to the correct conclusion about the value of the theatrical art that Riggan risks everything for against his cinematic history.

Raymond Carver is why Riggan wanted to be an actor in the first place. At a play in college, Carver happened to be in the audience. On a cocktail napkin, the writer penned that Riggan gave a truthful performance. Here is where the idea of truth-in-performance comes into the narrative. This idea is batted around the movie like the swiftly changing camera angles. But as you watch this movie, pay attention to how 'truth-in-performance' is circumvented at every turn. The most clever part is when Norton's character is quick to point out over a whiskey that Carver's message was written on a cocktail napkin, so Carver was probably drunk when he wrote it. Riggan forgets the napkin relic in the bar anyway after having it out with the theater critic later in the movie.

Except for Riggan, these characters have flimsy backbones, and in the end they don't care about the Carver play at all. The movie's ending confirms this. Keep in mind Stone's concluding laugh and you may end up agreeing that Birdman entertainment wins out over Carver artistic meaning any day, and one can only be sad.
What’s in YOUR White Coat?

PGY2 Alex Norcott turns her pockets out for The Beeson Beat

DEBBIE DOROSHOW

1. Cheetah-print kleenex: “I promise I don’t give these to people I don’t know…”
2. Littman III stethoscope with attached light
3. Portable pulse oximeter: “The best $32 I have spent in a while.”
4. Business cards from various attendings
5. Hair rubber band and bobby pins
6. Lidocaine 1%
7. Variety of pens and sharpies: “I promise I have never used one on a white board!”
8. $4 in Wow bucks - one of which reads “Great catch - escalation of care”: “Proof that something happens to your RL solutions!”
9. Chapstick
10. Earphones
11. Specimen bag
12. ABG kit
13. Sabatine’s Pocket Medicine
14. Hospitalist handbook
15. Super sticky tape: “I had to go up to the colorectal surgery floor to get this tape to secure a NG tube while on Klatskin. Paper tape just doesn’t cut it.”
16. 2 pagers: “I may have lost one of these in between the spokes of my wooden dining room chair while on night float and had to get a new one.”
17. YNHH ID
18. NEJM article on “Cardiovascular Events During World Cup Soccer”
19. Coconut scented hand sanitizer: “Because a side of MRSA with my noon-conference food sounds like a bad idea.”
20. Fruit snacks and granola bar
21. Random key ring: “For keeping my patient cards organized.”
22. ACLS cards: “In case the 3rd year ‘code whisperer’ is missing.”
23. University of Virginia Pin: “GO HOOS!!”
Cool Tools: Pocket Ultrasounds Come to Yale

AUSTIN ROBINSON

Boards, travel, Step 3: there aren’t too many types of educational reimbursement requests. Dhruva Kothari turned heads when he submitted a request for a hand-held ultrasound. Long interested in the practice of medicine in low-resource settings, Dhruva’s purchase was inspired by an attending he met during his international health elective. The attending lugged an ultrasound in a briefcase around the wards of his Uganda hospital and used it to aid diagnosis and procedures. Anticipating similar work in his future with Possible Health in Nepal and wanting to get started while still at Yale, Dhruva took the plunge and bought his own personal ultrasound.

After comparing models, Dhruva opted for a second-generation GE V-Scan pocket ultrasound. With a phone-sized screen and dual transducers on a single probe, it provides high-resolution images and better-than-briefcase portability. The device is expensive - at $9000, it costs more than Heather Russell-Millici is willing to dole out in a year, leaving Dhruva to foot much of the bill himself. While that may seem like a lot, Dhruva is quick to point out that musicians regularly spend comparable sums on personal instruments. Much like a violin, Dhruva feels that a personal ultrasound is essential in developing and practicing his own craft. He’ll tell you that from arterial lines to paracenteses, he has put his ultrasound to good use.

Dhruva isn’t the only physician-sonographer at Yale. The medical school has a program that gives pocket ultrasounds to first year medical students who then receive weekly training from radiologists. Emergency medicine has long been at the forefront of point-of-care ultrasound. Their residents have the opportunity to learn skills like FAST scans and bedside echo under trained fellows and attendings.

Have we been missing out? Many internal medicine residents have an interest in learning ultrasound, yet we lack a well-established ultrasound curriculum. All around us, momentum is building: intensivists in the MICU are increasingly proactive about teaching critical care ultrasound at the bedside, and VA cardiologists are closing in on a sophisticated ultrasound simulator for residents and fellows. Add to that the gumption of individual residents to invest in their own devices, and the future for IM ultrasound at Yale seems bright.
Favorite Artwork

BETH HEUZELY

In the hallway that connects Smilow to the Park Street building, one photograph always drew my eye. Entitled “Laughing Water” (Artist: Linda Cummings, collection now removed), it depicts a piece of graph paper floating in a river. What may otherwise be ugly—pollution to ignore—is serene and interesting in its abstraction. It calmed me after a rough day.

We spend so much time rushing through the hospital focused on our check boxes, seeing only sickness and death and sadness. It sometimes feels impossible to notice beauty here. This image reminds me that we all deserve a moment of tranquility, and if we slow down we will see beautiful things: husbands and wives holding hands, families laughing together despite illness in their midst, people working tirelessly to care for others.

Image Challenge

JOSHUA BILSBORROW

This patient presented with five days of right lower extremity swelling and erythema with associated fevers and chills. A diagnosis of cellulitis was made and intravenous antibiotic therapy was initiated. After two days, coalescing bullous lesions started to form within the more defined erythematous region of the cellulitis. What is the diagnosis?

Answer on Page 8
Chief Concern: Delicious Da Legna Pizza

KRISHNA UPADHYAYA

Subjective: Our patient is a four-year-old Italian establishment named Da Legna. Rooted on the corner of Clark and State Street, Da Legna is a bold youngster making a name for itself despite the veteran establishment, Modern Apizza, right next door. True to its name, Da Legna, meaning “of wood,” primarily serves wood oven pizza (including gluten-free!), but offers a selection of other small plates and salads as well.

Objective: On physical exam, the exterior was in no acute distress, and painted a bright sky blue that lit up my day. As I walked in, I was greeted by super friendly servers who appeared to be freshly imported hipsters straight from San Francisco, a feeling that was corroborated by the Mason Jars they used to serve drinks. I sampled three pizzas: Clark Street, Margherita, and Funghi. Made of eggplant pieces, sliced tomatoes and little globs of ricotta, the Clark Street pizza offered a different taste with each bite. The dough was soft and chewy, and a basil-garlic seasoning perfectly complemented the eggplant. The Margherita was your run-of-the-mill margherita pizza, and if compared in a head to head trial with other pizza joints, would at least show non-inferiority if not a trend towards superiority. The pizza that took me by surprise was the Funghi, not just because of the unbelievably fresh mushrooms, but because of the dollops of burrata (mozzarella mixed with cream) that gave the pizza a unique polka dot appearance. The creamy texture and concentrated flavor of the burrata gave just the right kick I wasn’t expecting. However, what really made Da Legna pizza incredible was the quality of the crust. It was crunchy enough to give contrast to the chewy dough, but soft enough to not scratch your buccal mucosa. Furthermore, it is imbued with the smoky flavor of the wood oven giving the perfect finish to the perfect slice.

Assessment/Plan: Food: A, Appearance/Atmosphere: A-, Service: B+. In summary, I give Da Legna a solid A—and definitely recommend that everyone try it. Forget Pepe’s or Sally’s, I’m joining the Da Legna camp, and I hope you’ll join me in grabbing a slice!
Image Challenge, cont...

Answer: Bullous Erysipelas

The patient was a 68-year-old gentleman with a past medical history significant for type 2 diabetes mellitus who had presented with systemic symptoms of fevers, chills, and myalgias and erythematous swelling of his right leg from mid-thigh to distal calf. He was diagnosed with cellulitis and started on IV ceftriaxone to cover for presumed Streptococcus organisms. With the appearance of bullous lesions, his antibiotic regimen was changed to IV vancomycin to cover for MRSA. Culture of the serous fluid from one of the unroofed bullae was negative. His systemic symptoms resolved and the bullae collapsed by the fourth day of therapy. He was eventually changed to an oral regimen of amoxicillin-clavulanate and trimethoprim-sulfamethoxazole to cover for Streptococcus and community-acquired MRSA and discharged in good condition with close outpatient follow-up.

Erysipelas is an acute bacterial skin and soft tissue infection involving the dermis and cutaneous lymphatic vessels, which is distinguished from cellulitis by the more superficial distribution, raised borders, and clearer demarcation between erythematous and normal skin. The infection is predominantly caused by Streptococcus pyogenes. Risk factors mirror those for cellulitis and include immunocompromised conditions (such as diabetes mellitus, renal disease, advanced age, and/or alcoholism), obesity, chronic skin disorders, and/or impaired lymphatic drainage.

Bullous erysipelas is a clinical diagnosis and represents a severe form characterized by the development of coalescing blisters filled with serous fluid upon an erythematous base. The bullae can be observed up to several days following the initiation of antibiotics and represent a phenotypic evolution of the erysipelas rather than a bacterial superinfection and/or propagation of resistant organisms. While erysipelas is caused by Streptococcus species predominantly, this bullous variant is believed to be highly associated with community-acquired MRSA as either a concurrent or sole pathogen. The serous fluid within the bullae can be sterile, and cultures can be negative or grow normal skin flora, even in the presence of MRSA. The mechanism of bullae formation remains controversial, with postulation of a role for Staphylococcal exotoxins including exfoliatin.

Further Reading:
Intern Spotlight

Yihan Yang

Justin Rucci – Med Peds
**Hometown:** Livonia, NY
**Undergrad:** College of the Holy Cross
**Med School:** Loyola University Chicago Stritch School of Medicine

**Interesting Facts:**
1. Josh played the drums as a music major in undergrad and has recorded three albums with various bands.
2. He was the captain of his college club soccer program for two years and continues to play indoor soccer here in CT.
3. Josh and his wife Elizabeth just became proud parents to their first daughter, Catherine Elena Rucci.

Suzie Luft – Traditional
**Hometown:** Madison, CT
**Undergrad:** Amherst College
**Med School:** Dartmouth

**Interesting facts:**
1. Suzie loves backpacking. Her favorite place to go is the White Mountains in New Hampshire.
2. In med school, Suzie got really involved in Dartmouth’s jewelry studio. She still makes jewelry and has started getting into larger scale functional work. “I love using hammers and torches to figure out the mechanics of creating sculptures with a purpose.”
3. Suzie grew up with an enormous Newfoundland dog. In high school the dog outweighed Suzie by 60 lbs. They had to share the backseat of her mom’s Honda Civic.

Kristen Hysell – Primary Care
**Hometown:** Oakland, NJ
**Undergrad:** Boston College
**Med School:** Boston University School of Medicine

**Interesting facts:**
1. During her fourth year of med school, Kristen spent several months working in Lesotho, Africa.
2. During college Kristen worked as a “Mad Scientist” entertainer extraordinaire for children’s birthday parties. “My name was Kilowatt Kristen and I made science fun.”
3. Kristen flew her preceptor’s airplane one day while on her family medicine clerkship in med school.
Throughout the course of our collective experience, we have seen some remarkable physiology. Here are some extreme values that our residents and attendings have witnessed, in patients who have since benefited from our dedicated care.

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<tr>
<th><strong>HIGHEST</strong></th>
<th><strong>LOWEST</strong></th>
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<tr>
<td><strong>A1c</strong> 18—Albert Do</td>
<td><strong>BUN</strong> 2—Dan Cleary</td>
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<td>Ammonia 336—Alex Norcott</td>
<td>Hemoglobin 2.2—Aaron Soufer &amp; Elana Shpall (Fe deficiency anemia from GI bleed)</td>
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<td>Anion Gap 45—Matt Griffin (DKA)</td>
<td>Platelet Count &lt;1,000—Beth Heuzey (ITP)</td>
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<td>Bili, total 39.27—Mohsin Chowdhury</td>
<td>Potassium &lt;1.5—Dan Savage (Hypokalemic Periodic Paralysis)</td>
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<td>Bili, direct 25.53—Mohsin Chowdhury</td>
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<td>BNP 41,000—Alex Perelman</td>
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<td>BP 234/106—Jenna May Kim (ESRD)</td>
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<td>CRP 373—Necrotizing MRSA PNA</td>
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<td>Glucose 1710—Amish Desai</td>
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<td>INR &gt;29.99—Elana Shpall (warfarin, abx, poor PO intake)</td>
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<td>Insulin Dose 225 units NPH BID—Adam Phillips</td>
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<td>Lactic Acid 26—Steph McCarty</td>
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<tr>
<td>HCV Viral Load &gt; 100,000,000 (log &gt; 8.00)—Albert Do</td>
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<td>Tele Pause 10 seconds—Krishna Sury</td>
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<td>Temperature 106.2F—Jenna May Kim</td>
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<td>Troponin 51.99—Austin Robinson</td>
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<td>TSH 308—Cecilia Davis (hypothyroidism with medication noncompliance)</td>
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<td>WBC count 239,000—Steph McCarty</td>
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