



Thank You for Pimping



By Tasha Marenbach, MS IV, UC Davis School of Medicine

SHOULD I ONE DAY HAVE A PATIENT who, after an ill chosen maneuver in a bar brawl, resigns himself to lying in our hospital bed, I am comforted knowing that this man will not suffer the complications of atelectasis. This is because he will get out of bed every day. Even if he needs help, and even if the only person who has time to help him is me.

Why? Because the most commonly asked pimp question on my Trauma Surgery rotation was, "What should we do about that shortness of breath?" And the answer was always, "Get the patient out of bed."

My attending asked about it all the time. At least twice a week he'd pick from his hodgepodge of atelectasis-related pimp questions: "What's one of the most common and most serious post-operative complications?" Atelectasis. "Cardiopulmonary disease, smoking, obesity and advanced age are all predisposing factors for what pulmonary problem?" Atelectasis.

The culprit of pneumonia on post-op day four? It never hurt to mention atelectasis. If a patient had prolonged sedation and neuromuscular blockade...at risk for atelectasis, so get him out of bed. If a patient had crackles and no incentive spirometer: atelectasis, out of bed. When the two new interns came on they struggled at first: "Put him on oxygen? Get a chest film? Nebs?" My attending would then turn to the rest of the team with an orchestrated gesticulation that meant, *Tell 'em*. Feigning ennui, we would all chorus, "It's atelectasis. Get the patient out of bed."

Despite learning the answer to that question, there were a thousand others that stymied me. I found myself walking home faster each day - I scuttled along fervently, bee-lining for the books and PubMed. Indeed, this particular attending didn't send me home at the end of the day to feel warm and fuzzy. (Except on one occasion, please see "The Kindness of Surgeons," *Sierra Sacramento Valley Medicine*, Sept/Oct 2005.) When I went home after a day on his trauma service, I went home to work. I was motivated to take care of my patients (my joy), and I was motivated by my attending's proclivity to quiz (his job).

Pimping.

Pimping is essentially a form of Socratic teaching; the student is asked a series of questions, generally while rounding with the team. Dr. Frederick Brancati writes, "Clearly, pimping - good pimping - is an art." Brancati attributes the earliest reference of pimping to Harvey in 1628. He then cites Koch, who in 1889, prepared "Pumpfrage" - questions he used during rounds in Heidelberg. Brancati laments - and I tend to agree - "Despite a long and glorious history, pimping is in danger of becoming a lost art."¹

For me, it all started with that pesky broken leg on Davis 14. I don't remember much about the patient's face, only a voice muffled by the darkness of 4 a.m. Clear lungs, soft belly, a little tachycardic. One, cool extremity in traction that was profoundly painful to touch.

On rounds, my attending never looked up from his patient list, but started in right away.

"Heart rate of 110?" He interrupted my canned report, sounding only mildly interested.

"Yes sir, 110. And he is sixteen years old."

"Oh. Sixteen. So you're saying heart rate depends on age? Even in a teenaged linebacker?"

I frowned. Furrowed my brow until the wrinkles took the shape of, what I am told, is almost a perfect square. "Well, because children, er, athletes... athletic children, that is, in general ha-"

He interrupted. "Tasha, what are you doing?"

"I'm doing that thing I do, sir."

"What thing."

"The thing where I don't know the exact answer right away, so I just start talking about stuff that is probably right but not relevant?" I looked at him hopefully.

"And how did I know?"

"Because you can recognize bamboozling, sir. But I wasn't bamboozling this time, absolutely not. It was more of a thinking-out-loud kind of thing."

"Tasha. Don't think out loud. Think, *then* speak."

"Yes sir."

"Ok, so your patient with the broken leg is tachycardic. And a little hypertensive too, I'll bet."

"Yes sir. But he doesn't have any chest pain or shortness of breath and-"

"Why do I care about *that*?" My attending looked up from his list, suddenly interested.

"Tell me about this young gentleman's *pain*." He drew that last word out. The P was enunciated perfectly, the A-I was at least two breaths longer than needed, and the N was a humming, ringing thing that kind of scared me.

"Oh, that. Yes, I believe it's getting worse-"

"I'd agree."

"And the scheduled morphine isn't helping-"

"Not surprisingly."

"So I was thinking perhaps we could consider a PCA?" (See, a real, original idea of my very own!)

(Enter Beethoven's four most fearful chords. Duhn duhn duhn duuuunnn.)

My attending allowed his face to transform fleetingly to a mild rage, then a funny little look of befuddlement, then an almost mocking mien of surprise. He cut right to the chase. He knew I was so far off the mark, I no longer deserved that funny little dance called pimping.

"Or, how about a fasciotomy?"

I looked at him blankly.

"Tell me about what a fasciotomy is, Ms. Marenbach."

"It's a placement of a hole in the fascia, um-" I then spared him the linguistics approach. "I don't know sir."

"Read about compartment syndrome tonight," he said firmly, almost dismissively. He turned on his heel and marched off to the next patient. Then, over his shoulder, "Talk to the Orthopedics team. They are going to do the surgery today."

Oh. *Compartment syndrome*, I thought. *Did I not learn this last year? I must have read about it. Why doesn't it sound even a little familiar?*

When I arrived home I went straight to the computer. By midnight I had mastered the pathophysiology, presentation, management (fasciotomy), and complications of compartment syndrome.

The next morning, it was as if my blunder never existed. I prayed for the pimping, but it never happened. I suppose in the end there was no need to test me, the goal had been simply to teach me.

So compartment syndrome was tucked away, knowledge that lay dusty and unused for almost a year, until, quite recently, my generally laid-back motor vehicle accident victim told me his pain was a 20 out of 10. When I suggested "fasciotomy," my new attending told me somewhat reproachfully, "He had a femoral rod placed 12 hours ago, that kind of pain is expected. Stop saying compartment syndrome unless it's compartment syndrome."

Sigh.

Pimping has its ups and downs. I'd say that 80 percent of the time, I don't know the answer, but I am beginning to believe that's the point. Daniel D. Pratt, in his chapter, "Alternatic Frames of Understanding," writes of five different perspectives on teaching. In reading this chapter, I realized that pimping has the potential to teach in many different ways. It is a type of teaching that is "fundamentally committed to locating teaching and learning within contexts that are as authentic as possible." I realize that when my first attending hounded me about compartment syndrome, he was helping me "to move beyond previous ways of thinking." That is, "learning is a change in the quality of one's thinking rather than a change in the quantity of one's knowledge."

Ergo, these are the things I will never miss in a patient, thanks to pimping: PE. (I have only actually seen one real, new-onset pulmonary embolus on the wards, but I've been quizzed on it so many times, I feel like I've seen many.) Ovarian torsion. Koplik spots, Paget's disease of the breast, coccidioidomycosis, sarcoidosis, Kawasaki disease, and Huntington's. There's Legg-Calve-Perthes disease, Lyme disease and Legionella too. I'll know duodenal atresia when I see it. I'll feel the pulsatile abdominal mass when it's there. I'll send for *leptospirosis* labs every once in a blue moon, and when appropriate, I'll ask about those infamous pigeons.

It's strange, when you think about it, that in less than a year I will be a doctor, yet there is so much I have never actually seen. Even things like carpal-tunnel and glaucoma! In the end, we have no control over the diseases we will actually see in our time on the wards, and reading about them in books is not enough. The best substitute is a small moment where we are standing in the hallway outside a patient's room, suddenly asked in front of our peers and teachers, *What would you do next?* And in that moment, the pithy catch phrases of review books go out the window. Our file cards seem far away, our highlighters are useless. In that moment we must open our mind to the realm of possibility, gather everything we know about lab values and physical findings, outcomes and complications, *and make a decision.*

Pimping is about teaching. It is about learning to commit to an answer. The goal is to build knowledge and confidence, so that one day (and without double checking with someone else) we can say calmly, "Don't worry, your child is developing normally," or, "I think we should open your abdomen immediately." Pimping is about becoming someone who can take care of patients. It's not always fun. It takes time, and energy for everyone involved and my suspicion is that being the Pimper is harder than being the Pimpee. Still, it is a tradition in medicine which supplants that which we learn in books and for exams, and it is one of the best ways to learn.

So help us! Ask us! Challenge us every day! Know that one day, each of us medical students will be an exhausted, overwhelmed resident on our third week of internship, in the middle of the night, all alone, with a patient whose leg pain is out of proportion, and is actually tachypnic, too.

Will we think of fasciotomy? Will we wonder about an embolus?

Yes. So thank you for pimping.

elven@ucdavis.edu

1. "The Art of Pimping" by Frederick Brancati, JAMA. 1989 Nov 10; 262(18):2541-2

Sierra Sacramento Valley Medical Society
5380 Elvas Avenue #100 • Sacramento, CA 95819
916.452.2671 PH • 916.452.2690 FX • Email: info@ssvms.org

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