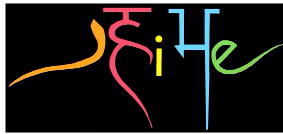

My internship ‘sans’ residents

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Abstract:
During internship, newly graduated doctors practice under supervision to apply knowledge and skills along with a proper, ethical attitude in the treatment of patients. The Government Medical College, Thrissur, located in Kerala, India, was started in the year 1981. The institution did not have postgraduate students / residents for several years during the initial phase. In this article the author describes his internship experience at the institution in the nineties. There were advantages to not having residents in terms of greater opportunities for patient care and for ‘doing’ different procedures. Closer relationships were forged with faculty members. The drawback was the lack of a group of doctors closer to oneself in age and training who could provide practical tips and advice from a near-peer perspective.

Key words: Internship; Medical education, postgraduate; Medical education, undergraduate; Peer teachers; Residents.

The coffee was aromatic and strong, and the ‘dosa’ stuffed with a tasty combination of potatoes and crisp beetroot. We were at the Indian Coffee House, a venerable institution in the temple town of Thrissur, in the Southern Indian state of Kerala. We were posted as interns in the department of Obstetrics and Gynecology. Having just finished rounds and essential ward work at around one in the afternoon, we had earned ourselves a hearty lunch.

We did not have any postgraduates or residents during the nineties. The Government Medical College was still in its infancy in those days, and the absence of residents provided greater opportunities to interns. We performed minor surgical procedures under supervision and then, later, on our own. In the labor room, we assisted during deliveries, first watching and then performing episiotomies. As we progressed in the training, we were allowed to decide when women should be shifted to the delivery table, and, still later, were able to deliver babies ourselves.

As there were no residents, faculty members took turns of duty in the Emergency Department. The Emergency (or Casualty, as it is known in Kerala) had a general surgeon, an orthopedic surgeon, and an ENT surgeon available on the premises, and an ophthalmologist and a psychiatrist were on call. There was a pediatrician

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on duty in the pediatrics ward and a gynecologist in the labor room. The medicine department was in the college campus fourteen kilometers (eight miles) away. We formed close bonds with these faculty members through numerous shared hours on duty. Most faculty were friendly and approachable. They had taught us during our undergraduate years and were now our guides.

The district hospital, which was temporarily serving as the medical college teaching hospital, was old and had seen better days. I still remember the first procedure I did there on my own. The attending surgeon was in the adjoining theater, probably ready to take over should I need help. I was to remove a subcutaneous lipoma in a patient who was in her thirties. The procedure had looked so easy when the surgeon had been the one to do it. When I was to be doing it, everything - from making the incision, to cauterizing the bleeding blood vessels, to closing the incision with sutures - looked different and difficult. Luckily, the assisting nurse was experienced and well-versed in the procedure. I took more time and had to expend more effort but eventually I removed the growth and sutured the incision.

During the nineties there were no simulation centers in medical colleges in Kerala and patients were more accepting and less demanding compared to today. The internet and smartphones were still in the future. Sometimes, I feel guilty that we 'practiced' and 'learned' on these individuals who were from the lower strata of society. However, we were working in a busy teaching hospital and the patient load was tremendous, making our contribution a necessary and a welcome one, with our teachers constantly monitoring and supporting us.

I still remember a patient in the Chest and TB ward whose lungs had been ravaged by tuberculosis. On examining his chest, we noticed cavitation, collapse, consolidation, and bronchial breath sounds. The poor man was unable to work, and his family was no longer close to him. He was admitted again a while later with severe difficulty in breathing. On investigation, we found he had developed a pleural effusion. Our attending physician guided me in performing a pleural tap and we removed over a liter of fluid. Needless to say, his breathing improved.

During the intervening three decades many things have changed. Kerala has always been at the forefront of education and consumer rights in India. Today patients are no longer comfortable with 'learners' doing procedures on them and there has been a big impetus toward developing simulation centers to teach medical students and residents. Students first practice in a simulated, controlled environment and only after they are assessed to have the required level of skill can they do procedures on patients.

For us, not having postgraduates or residents had both advantages and disadvantages. Our contemporaries at other medical colleges in the state were envious of the important role we played in patient care and of the procedures we carried out. They were mainly restricted to writing the patient record, noting down medicine orders, and preparing discharge summaries. In their institutions, there were many residents, and it was they who were given priority in performing procedures and assisting with surgeries. We got more direct patient care opportunities and developed closer bonds with the faculty members. We learned procedures from experts in the field. Internship for us was truly a period when we took the knowledge, skills and attitudes that we had acquired and applied them in patient care.

There were also drawbacks. Space was at a premium, the working environment cramped, and errors did happen. Sometimes I felt having a resident to work with may have been better. Our faculty members were helpful and supportive; however, I was reticent in discussing my fears and misgivings with them. Talking to someone closer to me in age might have been easier. As experts, our faculty may have had greater difficulties in putting themselves in the position of novice learners. Residents could have monitored us more closely and provided us with career guidance and support especially regarding doing well in the postgraduate entrance examinations. Being closer in age to medical students allows residents to be more easily

accepted as preceptors, teaching important clinical skills to interns and medical students. Peer and near-peer teaching are considered increasingly important in medical education. However, residents may need to be adequately trained to fulfill their role as teachers and facilitators.

When I meet my batch-mates these days as middle-aged men and women, our consensus is that not having residents worked, overall, in our favor. Today internship is mainly used as a period to prepare for postgraduate entrance examinations and the involvement of interns in patient care has steadily decreased.