AN INTERN'S REFLECTIONS

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The regulations governing internships prescribe that the intern should have time for reflection. Since little opportunity for this luxury was afforded me during my internship I have taken the liberty of spending a few hours in constructive reminiscence now that the year is done.

My internship was unusual in that it was divided into two terms of extreme contrast—in a teaching hospital and in an isolated mission hospital in 'virgin soil'. Witnessing these two diverse forms of medical practice has left me with an impression of the virtues of each and an understanding of the place of each in the profession and in the community. It has given me what I sought most—a sense of balance and perspective to guide me as I enter into practice myself.

TWO CONTRASTING PRACTICES

In my humble yet privileged post in the teaching hospital I was associated with about 40 other interns and perhaps 5 times as many doctors of much higher qualification. Specialists and authorities abounded, and were readily available for consultation. As far as I was concerned, real problems did not exist, for when they arose they could be delegated to someone more qualified than I to solve them.

Besides this assistance in the clinical sphere there were the medical personnel and technicians attached to the diagnostic departments—pathology, radiology, and more circumscribed fields such as electrocardiography, angiography, plethysmography... All of these services were available to add confidence, and a degree of absolute certainty, to the clinical diagnosis.

The diagnosis having been established, treatment was instituted on the sole basis of efficacy and convenience. An efficient pharmacy apparently (if not actually) unencumbered by financial considerations and wholly devoted to dispensing, operated under the same roof, and catered for the most enthusiastic, exacting, or generous physician. One could prescribe the best for the poorest patient with the abandon with which one enjoys any item that is 'on the house'.

One may wonder why an intern working under such luxurious circumstances should choose to transfer to a humble mission hospital where financial considerations dominated the management of every patient.

This hospital, serving a community of Native villages up to 75 miles distant, boasts two doctors, a hundred beds, and eight thousand out-patients a year. There are medical, surgical, obstetrical, and pediatric departments, but the divisions are artificial except for accommodation, for the same staff operates all departments; and the medical and surgical departments include all the specialties.

The range of conditions encountered was as great and varied as in a large city institution, but there were no avenues of delegation or reference. Diagnosis was mainly clinical, aided by simple 'side-room' investigations. Treatment was a compromise between economy and efficacy, and ways and means of satisfying both *desiderata* were fully explored. It is remarkable what can often be accomplished by adding a little trouble to simple measures, in exchange for an easier way at higher cost.

CONTRASTING VIRTUES

In the large teaching institution I witnessed the most advanced, the most scientific, the most thorough and the most generous medical practice. Herein for me lay one great virtue and one great drawback. The virtue was that a high standard was set before me—an ideal, something which I could not practice in its fullness myself, but could strive towards. The importance of a critical outlook, and of accuracy, was impressed upon me. I was taught to develop an objective approach to medicine, and to rely on facts rather than on feelings and impressions. Professional honesty was regarded as supreme. It was good discipline, and good discipline is invaluable to the practice of good medicine. Of all the lessons I have learned since I began medicine as a student, perhaps this is the most important.

If the virtue lay in what I learned from observation, the drawback lay in what I lost through lack of personal experience. Simple technical procedures only were left to me. Decisions of moment were made by others. Administrative problems were dealt with by a separate staff entirely. Finally, even my own movements were not spontaneous, but were closely directed by others. Thus the indispensable virtues of dexterity, discretion, economy and individuality had little chance to develop.

In the smaller institution I entered the practice as an apprentice-partner. I was trained to share the work and responsibilities and, if necessary, carry them entirely for short periods. This forced me to apply myself to the practical issues of medical practice, including surgery. This latter, so exclusively guarded in training institutions and specialty practice, I found to be amenable in part to inclusion in a general type of practice.

My chief was a general practitioner of innate and cultivated dexterity; his local renown was a testimony to his work. Under his guidance I learned to do what he did—the common operations in general surgery, and some usually included in specialist departments.

Modern trends in medicine lean towards ever-increasing departmentalization and specialization, and the sphere of the general practitioner is gradually becoming more circumscribed. While this is to a certain extent inevitable, I cannot but feel that the rightful status of the specialist—as a consultant rather than the exclusive practitioner of his sphere of medicine—should not be lost sight of; and that the dexterous and experienced general practitioner is still the ideal agency for the practice of medicine in the community today.

Perspective and Practicability

I chose to transfer to a mission hospital for part of my training for two main reasons: (1) Because medicine as practised in a large departmentalized institution is not wholly practicable at the domestic level, and (2) spiritual and social ideals of medical practice tend to be lost sight of in the environment of a large specialist hospital.

Just as difficulties, fallacies and exceptions tend to be overlooked in general practice for the sake of convenience and economy, so they tend to be exaggerated in specialist practice for the sake of precision. The general practitioner's method is based on probability, and it is fortunate that the vast majority of pathological conditions can be diagnosed clinically with an acceptable degree of accuracy. I say fortunate because the clinical method is adaptable, economical and simple. To make medicine a more exact science, clinical methods are supplemented by physical and chemical methods which, though frequently precise and objective, are often elaborate, unadaptable and expensive. In specialist practice the indispensability of these methods is impressed upon the intern. I recollect being told once that 'no cardiac condition can be adequately diagnosed and treated without an ECG'. Statements and teachings such as this tend to distort the perspective of the beginner in medicine and lead to distrust of the

clinical method which is unfortunate, for the clinical method is, and probably always will be, the sheet anchor of medical practice.

It is easy in circumstances where special investigations are readily available, to apply them more generally than might be necessary. They become items of adornment rather than of utility. This tendency to 'window-dressing', as one teacher expressed it, is becoming too common in medical practice today. It is a danger to universal good practice because (1) it is expensive; (2) it is attractive to the layman, and may be exploited by the mercenary; (3) it tends to become a substitute for, rather than a supplement to, critical clinical observation.

Social and Spiritual Ideals in Practice

Enlightened men in every walk of life today visualize something greater in their occupations than the mechanical accomplishment of their task. Higher ideals than material or mere academic attainments and gains should motivate one's life and work.

Social medicine is an organized attempt to apply this philosophy to medical practice. Social medicine seeks to serve the needs, problems and interests of the community. Though it can be taught in universities and demonstrated in large institutions, the general practitioner is the medium through which it must be applied to the nation. Health education, maternal and child welfare, and a healthy attitude towards disease by laymen, can all be most effectively taught and promoted by the practitioner at the domestic level.

As a student one is often enjoined to 'treat the patient as a whole', yet the fullest expression of this injunction is seldom appreciated even by those who teach it. True, if a patient has diabetes, one should examine the eyes for retinopathy, the limbs for neuropathy or vascular disease, the chest for tuberculosis, the abdomen for evidence of liver or pancreatic disease, and the urine perhaps for a nephrotic lesion. Yet when every physical system has been thoroughly examined only part of 'the patient as a whole', has been studied. There are social and psychological aspects to the case. Has the impact of the disease on the patient, his family, and his livelihood been considered? Has the patient's reaction to his illness been observed and guided along healthy channels? Has his illness affected his emotional stability or his spiritual integrity?

Every illness influences the patient's psyche to a greater or lesser extent, and often the practising doctor witnesses experiences which must profoundly, and often dramatically, influence the outlook of his patient. In this field there is an urgent, supremely important work to be done. The reward is the satisfaction of seeing a patient well adapted to his illness. This is almost as great as the satisfaction of seeing a patient respond to well-advised treatment.

Illness, especially when associated with distressing circumstances, is an occasion of great spiritual need for the patient. A tactful instilling of confidence at a time like this is a powerful adjunct to successful therapy. In a large departmentalized institution little opportunity is afforded one to learn this aspect of the healing art. There is so much delegation of responsibility that the same degree of confidence and liaison can scarcely be established as when one doctor is the patient's sole confidant. During the second half of my internship I was impressed with the potential of a spiritual liaison with the patient. It aids the doctor by increased patient-confidence and thus a greater revelation of the patient and his disease. It aids the patient by dispelling fears and imparting a sense of trust and security, and adding hope to what might otherwise be a dismal outlook.

Success in medical treatment cannot be gauged by temperature charts, ECGs and ESRs alone; the patient's attitude towards his illness must also be taken into account. A discouraged or disgruntled patient is a failure by any standard, while a patient with a cheerful, understanding outlook, especially against great odds, is a refreshing person to meet and a reflection of good treatment of the patient as a true whole.

The part played by religion in doctor-patient relationships should not be overlooked. Those who practise it are conscious of the great power of religion to direct the attitudes and sentiments of people. It has tremendous potential when allied with the healing art. Even a time of crisis can be made sublime by those of religious persuasion. The Psalmist appreciated the sustaining power of religious faith when he wrote, 'Yea, though I walk through the valley of the shadow of death, I will fear no evil, for thou art with me' (Ps. 23 : 4).