MEDIBEATS
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# Guest Editorial

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## Eclipse of Clinical Medicine?

Some sixty summers back we medical students learnt the nuances of clinical medicine mostly on the bedside of the patient. That the patient generally was from a poor socioeconomic background, and who did not mind a group of enthusiastic students poking his abdomen to feel the hernial orifice or repeatedly placing the stethoscope on the chest to hear a heart murmur. These ward rounds were held in all clinical disciplines. Ward rounds resulted in a particular student or students being assigned to get the required tests done and do the follow up. This meant collecting stool and urine samples, drawing blood and if you are a senior student doing pleural, peritoneal tap and other such minor procedures.

It also fell on us to take these samples to the lab attached to the wards or all the way to the pathology department and to collect the results when due. Often it meant to ferry not only the samples but also the patient. This kind of activity resulted in gaining knowledge not only about the disease but also on the other aspects of the patient, such as his socio-economic status and the why and what of his illness progression.

Thus, by the end of the final year most of us would have imbibed just not about the illness but some of the practical skills described above. During the houseman year these skills were augmented and it was not uncommon for a house surgeon to independently do surgeries such as hernia repair, circumcision, vasectomies, hydroceles and even appendectomy. If I remember right, we were to conduct 25 normal deliveries and assist/observe 5 abnormal ones.These were necessarily done as those days there were no PG students to compete with and the hands of the unit senior houseman and the assistant surgeon were always full!

Over these six decades, there have been far reaching changes in the learning process. First the number of medical colleges have increase exponentially and so is the number of medical students. Post-graduation appears to be the norm for most graduates. What was being done by the medical student of my days is being done by the post grad student/or super speciality aspirant of today. With so many medical colleges, many of them privately managed, there is also paucity of clinical material. Naturally a patient who has paid money to get admitted to a private ward would not like his private parts to be exhibited to a crowd of medical students. In addition, there is a great dilution of standards. I learnt that the present-day medical student is not allowed to conduct deliveries. Imagine an MBBS graduate who has not conducted a normal delivery being posted to a PHC faced with an imminent delivery. I was told it is the job of the nurse!

So, there is major lack of practical training and acquiring skills and the present-day medical student is a mere observer of the patient and the disease process with no direct involvement. Adding insult to injury, after the final year and during houseman ship year, most students waste their time preparing for the PG entrance test, when they should have been spending time acquiring the much-needed skills. There are some 20,000 odd PG seats available for nearly 60,000 aspirants. The remaining are left high and dry. Even those who manage to be one of the 20,000, may not get the specialty of their choice and thus many will end up as square pegs in round holes.

One of the remedies to this dismal situation is to strengthen primary care and see that the basic MBBS doctor acquires basic skills as described above. This will result in a more confident young doctor who when he enters practice will not refer the patient for the procedures which he himself can perform. If Primary care and family medicine is given status and importance, this mad rush for specialization of any sort will come down and there will be all-round improvement in the delivery of health care in this country