COMMENT

MBBS doctors working as quacks: private practice by interns in Kerala medical colleges

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The idea of calling MBBS doctors "quacks" may seem strange to many, especially to those who are used to hearing about unqualified people practising medicine. For many in the medical fraternity, the practices described here may not be viewed with disapproval. So what exactly is this practice and what are its ramifications? Before I get into the details, it will be worth taking a look into the life of an intern in a medical college hospital.

In the early 1990s I was working in a medical college hospital in Kerala as an intern or house surgeon. The house surgeon's post, or internship, was a year-long, compulsory programme for all medical students after passing the gruelling MBBS degree course. It was a time in the professional life of a young trainee doctor where s/he would be directly involved in the care of patients with a degree of autonomy in clinical decision making. A prototypal internship programme saw an intern spending three months each in the core departments of medicine, surgery and obstetrics and gynaecology and in allied specialties such as paediatrics, ophthalmology and ear, nose and throat. Another important spell in the internship programme took these trainee doctors to a primary health centre for three months for a posting in "social and preventive medicine" or "SPM".

Young doctors considered the internship physically taxing but immensely satisfying. Internship in Kerala (I imagine this is true in other states as well) was a training ground for more than one reason. Interns were taken under the wings of senior doctors who supervised them and also imparted clinical skills. Interns sometimes saw the senior doctors as mentors and the choice of speciality for their postgraduate degree or diploma was often affected by the charisma and influence of these senior doctors.

Interns performed many clinical procedures independently, ranging from simple ones like urinary catheterisation and cannula insertion to more complicated ones like conducting deliveries and performing minor surgeries. Some young doctors saw internship as an opportunity to put into practice what they had learnt as undergraduate students. For many, especially those who stopped their academic pursuits at the MBBS stage without aspiring to become postgraduate specialists, internship was a natural step towards building successful careers as practising clinicians. Although supervised by seniors most of the time, there were occasions when interns found themselves forced to take decisions on their own, which was nerve racking to say the least. But independent decision-making was mostly reserved for simple and uncomplicated clinical situations.

For a significant number of these interns (incidentally, almost all of them men), internship was also memorable for "quack" practice. It was jokingly referred to as "quack practice" in the local parlance because interns did not have the legal sanction to practise without supervision and work in private hospitals, clinics and nursing homes. It is not difficult to understand why: Interns were half-baked physicians who could, potentially, jeopardise the health of patients if left to treat them without supervision. But these arguments did not deter interns.

This form of clinical practice thrived for many reasons. Foremost among them was the monetary gain it offered. There was also the belief that it would prepare interns well for when they went out to work in the private sector. Interns saw this practice as some kind of programme for mental toughening which would keep them in good stead for the rough times ahead. Peer pressure and a sense of accomplishment were two other reasons.

What did this quack practice entail? And how did the system work?

During my days in Kerala, interns stayed in quarters centrally located in the hospital. The quarters were, in some ways, a hub where young doctors with impressionable minds got some of the most important lessons of their career. This tutoring had a non-classroom, rugged, macho feel to it.

People learned their lessons the hard way, they would say. The quarters had a reception room located in such a way that the interns had to go past it to enter or leave the building. The reception room also housed the housekeeper's workstation and the housekeeper knew every intern in the quarters. It was in this room that the deals were struck. The reception boy and the housekeeper brokered these deals. It was common for messengers of private nursing homes or hospitals to bring offers to the receptionist who would in turn pass it on to the intern–who was only too willing to make some extra money. Another way was through word-of-mouth publicity about the hospitals.

A majority of these offers involved up to two to three days of work. These opportunities arose because doctors (often doctors who were single owners of private clinics) needed someone to run their clinics while they went out of town for a few days. The

presence of an intern ensured that there was no break in the regular routine of the clinic resulting from the owner's absence. This was done with an eye to maintaining the goodwill of people in the community. It was also considered "safe and judicious" to seek help from interns because the money they needed to pay interns was far less than the revenue they generated for the clinic or hospital–not to forget the other non-monetary gains involved in maintaining the continuity. Some other advantages of hiring interns included their easy availability, the ease of "handling" them, and the fact that they were not perceived as a threat to the doctors' own practice.

There were unwritten rules of such practice, all meant to avoid mishaps that could destroy the reputation of the clinic and of the regular in-house doctors. These privately-owned clinics had one clear brief for interns: to manage patients in a manner that maintained continuity and ensured that the reputation of the clinic was not tarnished by negligence or misconduct. For an intern keen to make some money on the side, this was not a tough proposition to follow.

What was considered "safe practice"? Examples include clinically managing a young patient with typical symptoms of acid peptic disease. Examples of unsafe practice could be an obstetric case that required the conduct of delivery, or an old patient with a history of heart disease. Interns were advised to refer "unsafe cases" to a medical college instead of a nearby private practitioner capable of managing them. This was to avoid loss of goodwill and also to safeguard the business interests of the clinic which feared losing its clientele.

This form of "quack" practice was considered a win-win situation by the interns: the money they earned was a fortune considering what they received as stipends, there were no legal obligations to the clinic they served, and the job was perceived to be safe. Many interns who accepted such offers did not feel that they were doing something wrong. After all, "quack practice" was a long and deeply entrenched tradition and had the tacit approval of the postgraduate resident doctors and the teaching staff in medical college hospitals. Those with ethical misgivings stifled them with the argument that interns would never do anything "stupid" during "quack" practice that would cause harm to or jeopardise the life of the patient. This was because there was nothing to gain, monetarily or otherwise, from indulging in daredevilry. Second, interns would mostly ensure that these offers did not clash with their official responsibilities as interns. They would accept these offers only on the weekends when they did not have weekend on-call commitments–or when they had an SPM posting at a primary health centre, which they viewed as not so important for their careers. They would rarely trade their clinical postings for these offers because they valued the skills acquired during internship more.

But the biggest push factor in favour of "quack practice" was that this form of practice served as a springboard for interns in their future careers. Interns also sought refuge in the "baptism by fire" argument: people who did not experience quack practice would be inept in handling the more difficult real-life situations in their private clinical practice. This confidence-building argument gained a lot of credibility and was often used by interns to assuage their guilt about having done something wrong.

Quack practice was also viewed as an achievement and an indication of the market value of interns. They would brag about the number of such offers they received. Some earned enough money to buy a motorcycle, or to splurge on expensive clothes. Others were more judicious and spent the money on books for postgraduate exam coaching classes. A select few were known to be hard bargainers and would manage to negotiate for higher payments when the nursing home owner was desperate for their services.

It was a simple business. The reception boy would get his kickbacks from the intern. If the kickbacks were good he would ensure that the same person got the opportunity again. Of course, feedback from nursing home owners also mattered when re-employing the same intern.

Incidentally, it was almost unheard of for women interns to indulge in this form of practice.