Viewpoint

Residency in the USA and Back Home

"The more things change the more they remain the same"

On Leaving India

The moment of departure is indelibly etched in my mind. Tearful faces on either side of the bullet-proof glass at the Indira Gandhi International airport, whispered promises, grim determination and misty eyes. The din of the usual airport business is unable to enter benumbed senses as I turn away from my most precious possession-my family! As I blindly find my way toward the check-in counter, I mentally resolve to come back, or at least go onward with an open and unprejudiced mind to assess for myself what, thus far, I have only heard of the West.Yet, there seems an unspoken finality to the scene.

The trip is tiring and it will take more than the pretty faces of stewardesses to pull my thoughts away from those I leave behind. My mind is in a whirl but it is now too late to analyze the decision again. I am on my way for better or for worse!

The Land of Milk and Honey

Foreign soil at last. Customs clearance seems superfluous since I have but a few books and clothes. The passport is stamped and I am in! It is a different world alright. The first thing that strikes me is not the technology- I have seen better style at Singapore. No, the first thing that hits me is the casual manner of the Americans. "Hi! How're ya doin'?"- but before I can answer, the man is gone. Did he really care that I was acutely aware of every bone in my body after the flight? I later learn the reflex answer to this eternal question-"Doin' good! How 'bout you?". No matter how one feels, one is either doing good or else one is a wimp. The very next thing that strikes me is that every jaw at the airport is moving-behold! the betel leaf has given way to the chewing gum. The billions of calories burnt by the masseters in this exercise notwithstanding, the society by and large is not ruminative.

The next couple of weeks are spent apartment hunting. Unfortunately, I am at a place where public transport is abysmal and a motor car is a necessity. I miss my motorcycle dearly as I muster the courage to buy a used car. Insurance, driver's license and setting up home to suit the needs of my family soon to be joining me, takes up all the time. Here things are easy to buy, rent, exchange or even return-so I experiment a little. By the end of two weeks I am well settled but $ 12,000 in debt! No doubt a frightening thought back home but hey, this is the American way of life! You got plastic money and everything's on credit. Buy now, pay later is the password. It'll take my nervous Indian mind another three years to understand this concept.

Reprint requests: Dr. Jyoti Krishna, 7003 Wayne Avenue, Lubbock, Texas 79424, USA.

First Day at Work

I can quite easily summarize this in one word-bewilderment! I discover quickly that not only is the way of doing things foreign (pun intended) but also the language is different. It is true that I speak English, yet I fail to communicate. How does one impress people with one's knowledge in a nation where N/4 saline becomes "D5 quarter normal *sailin'"',* aminophylline becomes "A-meenaw-fillin", ESR is 'sedrate", polymorphs are "segs" and Ceftriaxone is "Rocephin"? Perplexed though I am, I decide that it will take more than a few tongue twisters to put me down. I make a plan to carry a little notebook in my pocket, jot down things that seem different and commit them to memory overnight. One week later we are all talking the same language but the Texan drawl will forever be my Waterloo.

My first patient encounter is a disaster. I am in and out in 10 minutes with a working diagnosis (which by the way is correct) but I am all at sea when the attending (consultant) asks me for historical details like names of *biological* parents, maternal smoking and environmental allergies! I quickly learn that the lady in the patient's room who responded to 'mom' could be anyone of several types of caretakers, namely, biological mother, step-mother or foster mother, not necessarily in that order of probability. Later, I continue to learn more about social peculiaritis like child abuse and Children's Protective Services- an organization to help victims of abuse and neglect. I soon discover that "allergies" from pollens, dust mites and spores support a billion dollar pharmaceutical industry here.

To my dismay my physical examination is also incomplete because I have failed to peer down the most important bodily orifice in the Pediatrician's lexicon- the external auditory canal! Again, I am reminded that the number one diagnosis in the ambulatory Pediatric setting in the, USA is otitis media and that instead of becoming a doctor had I expended my energies in the pursuit of an effective cure for this malady I could have considered retirement as a billionaire! To my utter frustration I discover that examining the tympanic membrane is a skill acquired after many months of practice. I wish time and again that I had made better use of my otoscope back home where the sole function it served was as a flashlight ('torch' is 'incorrect' and I am reminded over and over again that I do not have to set the patient on fire!).

New Hats and Old

The first couple of months are very interesting. I distinctly recall my first blunder on a chest X-ray. It was pretty straightforward-patchy infiltrates in the right upper zone and an impressive mediastinal lymphadenopathy. Pulmonary Koch's of course I exclaim, but I am soon made to eat my words as it turns out to be a typical case of coccidioidomycosis. Travel history, travel history, travel history! I mentally kick myself in the rear.

One humbling experience leads to another as I learn that diabetic ketoacidosis can be precipitated by pregnancy in a 12 year-old, that urinary tract infections are a significant cause of fever without a clinical focus, and cat-scratch disease may be a more important cause of cervical lymphadenopathy than tuberculosis. I begin to push malaria and typhoid fever down in my list of differential diagnoses and develop a new respect for Kawasaki disease, fungal and rickettsial infections.

Perhaps the setting that I gain the most new knowledge is intensive care. Here the patients on conventional as well as high frequency ventilators are all ours, unlike back home where anesthesiologists valiantly battled with these critically ill infants with a shaky knowledge base of pediatric pathophysiology and scant support from senior colleagues at night. Here attendings, but a phone call away, continue to demand to be updated periodically through the night

and are right by the bedside if you need them. The survival rate is amazing especially in the Neonatal Intensive Care Unit where a 1000 gram baby has a good chance of survival. The eternal question on the issue of quality of life continues to be debated but remains largely unanswered. In the Intensive Care Unit I have extraordinary laboratory support at my command. From culturing viruses routinely to transfusing CMV negative-washed-packed-irradiated blood components, I can order them all without the bat of an eyelid. Mind you, I am writing from a small city in Texas that most people have not even heard about.

ER and Call

The Emergency Room (ER) rotation is a demanding one. Twelve hours a day of constant toil. All pediatric patients have to be seen no matter what their complaint. I find myself sewing lacerations, examining rape victims and reducing a dislocated head of radius all in the same day. Call nights *(i.e.,* 'night duty') are just as busy. The beeper is a nuisance. It is amazing how coordinating air transport of a critically ill child can occupy the entire night. A night with 10-12 admissions is a busy one if one accounts for all the paper-work involved. My mind flits back to my alma mater, Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, where 40-50 admissions were the rule rather than the exception during the 'high season' and my personal tally of 93 makes Ripley's believe-it-or-not material here!

Introspection

Now that I am a graduate of two programs and also certified by the American Board of Pediatrics I can look back and ask myself- has it all really been worth it?

I am aware most of my India based peers are well settled in practice in India. I find it hard to say that they missed out on a lot. Three years is a long time to spend in another residency. Moreover, the clinical skills and knowledge base of a well trained pediatrician compares well with similarly trained physicians here. Whereas monetary gains and material comforts are certainly more readily available here, they are offset to a large extent by the pace of life and the tensions of striving for perfect outcomes in a society that is litigious and poorly tolerant of mistakes. Poor outcomes do occur but the unavoidable truth is easier to explain and better accepted back home where our belief in fatalism provides forbearance and temperance in accepting the inevitable. Of course, when misused, this very nature of our race breeds malpractice and unaccountability. They say in Texas there is a flip side to every coin. Residency in the USA is a wonderful experience but do not lose sleep if you choose to bypass it.

Jyoti Krishna,

Dr. Jyoti Krishna is former Chief resident in Pediatrics, Texas Tech University Health Sciences Center, Lubbock, Texas 79430, USA.