News from The American Association of Cardiologists of Indian Origin

Message from the President:

It gives me great pleasure to invite you to attend the fall semi-annual meeting of the AACIO on Sunday, November 10, 1996, at the Hyatt Regency Hotel, New Orleans, Louisiana. The registration form is enclosed with this newsletter and I would appreciate if you send your RSVP as soon as possible.

In the 11 years of its existence, the AACIO has met semi-annually at the American Heart and American College of Cardiology meetings. These gatherings have served a useful social function of renewing friendships and establishing new contacts. Over the years a number of members have participated and helped to organize conferences and seminars in India. In the past two years we have instituted awards to be given to young investigators for research work performed during training. Unfortunately the response has not been satisfactory. We have received only two abstracts and the authors have been invited to present their work at the New Orleans meeting. The first one is Mr. Farhan Mustafa, "The Role of G-Proteins in Receptor-mediated Response in Coronary Artery", and the second one by Dr. Ashish Parikh, "Ribozymes to CDC-2 kinase and PCNA prevent intimal hyperplasia in rat carotid artery". I would like to urge the members, especially those involved in cardiovascular fellowship programs, to encourage young trainees of Indian origin to send the abstracts of their research work for consideration of presentation at the next meeting of the AACIO in March, 1997. You will find the details of these awards elsewhere in this newsletter.

Every year there are many Indians finishing their cardiovascular fellowship program and are looking for job opportunities across the country. There are others who wish to relocate and are looking for positions in private practice. We have decided to offer the services of the organization to advertise "positions wanted" and "positions available" through our newsletter. Initially at least, this service will be offered free of charge to members. Advertisements of nonmembers will be accepted provided they join the organization.

There has been an increasing anti-immigrant feeling circulating in the country, especially in the past couple of years. Every country has a duty to curb illegal immigration, but concerns have been expressed that even legal immigrants may be affected. Inevitably, when one migrates to another country, difficulties and obstacles need to be overcome. All of us have faced them and most of us have overcome them and achieved success. It should be pointed out that the United States offers greater opportunities for hardworking people who possess talent and skills than any other nation in the world. But as legal immigrants and naturalized U.S. citizens, we expect to be treated fairly and not face discrimination. To be effective we have to work within the system and make our voices heard. A good example was a successful challenge to the discriminatory practices of the Louisiana State Board of Medical Examiners against international medical graduates. The state board had a law with a catch-22 rule which stated that a foreign medical graduate could not do residency training in Louisiana unless he or she had a Louisiana state medical license. However, this rule further stated that a license to practice medicine could not be obtained unless the physician had completed residency in Louisiana. The foreign physicians already licensed in Louisiana petitioned the parish and the state medical societies which in turn unanimously urged the state board of medical examiners to end their discriminatory practices. The rules have now been changed and it is now possible for international medical graduates to undergo residency training in Louisiana.

Many of our members have achieved a high degree of recognition both in academics and as community leaders and have certainly enhanced the image of cardiologists of Indian origin. I urge all members to maintain and increase their involvement in the affairs of the communities they live in. We should become more active in county and state medical societies and work with international graduates from other countries to ensure that our rights as legal immigrants and naturalized U.S. citizens are preserved. If everything else is equal we demand no more but ask for no less than what is available to the graduates of U.S. medical schools.

Raja W. Dhurandhar, M.D.

ANNOUNCEMENT OF RESEARCH INVESTIGATOR AWARD

The American Association of Cardiologists of Indian Origin announces a Research Investigator Award for trainees in cardiovascular disease.

Eligibility: Current trainees or Assistant Professor level individuals who accomplished the work during their training. The applicant must be of Indian subcontinent origin. The work may have been conducted inside or outside India, and may relate to any domain of the cardiovascular system including physiology, pharmacology, pathology, medicine or surgery.

Award: The first and second prizes will include a cash award of $500.00 and a plaque of recognition. The applicants will be invited to present their work at the annual meeting of the AACIO in conjunction with the American College of Cardiology meetings in Anaheim, California in March, 1997.

Submission of Abstract: All abstracts should be submitted in AHA abstract format in triplicate to:

J.L. Mehta, M.D., PhD
Professor of Medicine and Physiology
University of Florida
College of Medicine
Box 100277 JHMHC
Gainesville, FL 32610

All submissions must be made prior to February 1, 1997. The cover letter should include the applicant's current address, phone and fax numbers. For further information, please contact Dr. J.L. Mehta, (Fax 352-374-6113).

CONFERENCES

The Asian-Pacific Society of Interventional Cardiology invites you to attend the APIC '96 Interventional meeting at Madras, December 5-8, 1996. The purpose of the APIC Conference is to bring into focus the mercurial changes in the domain of Interventional Cardiology in the Asia-Pacific region in the enlightening presence of International leaders of the field. It will be a gold mine of information regarding recent advances and innovations made in relation to newer devices in invasive cardiology. For more information call 91-44-8269493 or fax 91-44-8230747.

The Traditional Bedside Clinic: Gone But Not Forgotten

By Ivan A. D'Cruz, M.D., F.R.C.P. (Lond. & Edin)
Professor of Medicine, University of Tennessee
Director, Echocardiography Lab, U.T.
and V.A. Med. Ctr. Memphis

Those of us who are medical students in Bombay will recall the ritual of the bedside clinic. Such teaching clinics were conducted by the elite of the profession, Honorary Physician, gradually replaced over the decades by full-time staff. In those days the head of Unit was a Professor or Senior Honorary Physician, usually a well-known personage whose large private practice included treating the wealthy and famous. The aura of distinction, of which his British M.R.C.P. degree and his teaching hospital appointment were a constant reminder, preceded him as he alighted every morning from his impressive car and strode into the hospital. All whom he passed in the hallways, from peons and orderlies to house-staff and head-clerks, greeted him obsequiously or at least respectfully, because everyone knew that here was where the real power and prestige lay.

In his ward, his senior and junior house officers (residents and interns), ward-sister (head nurse) and staff-nurses awaited his arrival, not to mention research assistants and other hangers-on such as postgraduate students, out-of-town visitors, etc. One or more patients, chosen by the resident as appropriate "clinic material," would be lying ready in a hospital bed, enjoying the luxury of clean new-ironed bed sheets and pillow case, either in a side-room of the ward or in a corner of the ward partitioned off by moveable screens. By the bedside was placed the most comfortable available chair, upon which the eminent clinical teacher seated himself. All others attending the clinic stood all through the clinic or sat on small hospital stools. An attendant hovered nearby, bearing a bowl of antiseptic lotion in his hands, and a towel on his arm, a custom that originated perhaps in the nineteenth century when running water was in short supply.

The student who presented the case did so with trepidation and barely concealed misgiving. His nervous account of the patient's symptoms would be auditioned by the eminent consulting physician with courteous attention, if he was of the gentlemanly kindhearted kind, or with savage sarcasm, if he was of the opposite type; more often a mixture of toleration and criticism in equal parts. Sometimes the same physician would vary from cheerfully benign (if the recent past had been agreeably remunerative) to irascible and fault-finding (if his nerves had been frayed by do-

mestic tribunation). As potential sources of referral, the students merited some measure of amiable courtesy, either genuine or simulated.

Then came the most crucial part of the bedside clinic, the description and verification of physical signs. A rigid discipline had to be followed: inspection, palpation, percussion, auscultation. Looking at the chest wall tangentially from the foot of the bed for precordial bulging or for asymmetry of respiratory movement, palpating the precordium for the presence and nature of right ventricular, left ventricular or pulmonary artery impulse, the brachial pulse for character of arterial pulse percussing the anterior chest for shape of cardiac dullness and flatness of note elicited; how many times does one see this taught (or even done) here today? Yet many of us had the benefit of having master-clinicians making our eyes witness, and our fingers feel these valuable lessons of the clinician's art. The student who mistook a pericardial rub for a murmur, a diastolic for a systolic murmur, an opening snap for a third sound, an abnormal for a normal heart sound, squirmed in shame before his teacher and colleagues; the latter would make similar blunders when their turns came, but subsequently would be better clinicians for it.

Proficiency in auscultation was then the yardstick of a budding cardiologist's expertise. At the postgraduate (M.D. or M.R.C.P.) level, it was not sufficient merely to state whether a murmur was systolic or diastolic; to do a good job of it one had to mention all the eight or ten attributes of a murmur.

After the case presentation, the illustrious teacher would then summarize the case, marshaling its salient features cogently and concisely. The student would consider himself fortunate if he managed to conceal most of his ignorance and errors with vague or equivocal answers, a strategy which came easier to female students who blunted the sharp edge of criticism with propitiating smiles or an affable femininity.

Concerning the further investigation and management of the patient, the master would bestow a few weighty words of wisdom, distilled from his vast experience, on his eager audience, not excluding the patient himself. He would perhaps add a few general remarks about the disease itself and the differential diagnosis.

The clinic over, the Honorary Professor would then spend a few minutes passing by the beds of the patients who merited his valuable attention, however brief, usually because of their referral or political connections. Escorted by his retinue of house-staff and hangers-on, he would soon proceed on his way to his large (often chauffeured) car, perhaps pausing here and there to greet a colleague and exchange the latest gossip in medical politics.

Bedside clinics given by Assistant Honorary Professors followed the same general pattern, but the level of ceremony and deference by all concerned was much lower. If the Junior Honorary happened to be a bright young man who had recently spent a year or two at a good American or British academic center, he might actually have much more knowledge and expertise to impart than his more exalted chief. However, such brilliance and dedication was rare. Most bright young specialists pursued the almighty rupee of private practice with greater zeal than the lesser attractions of clinical science or research.

The bedside teaching of clinical medicine and of physical signs in particular, is important in itself, intrinsic and vital to every clinic's expertise. It was also important in those places (India and Britain) because passing or failing in medicine depended largely on success or defeat in the medicine practicals, the long case and short cases, followed by the oral inquisition. This was true then and remains true now, not only of the Membership Examination of the British Royal Colleges but also of the corresponding examining bodies of the Commonwealth, the erstwhile British empire.

In those practical exams, to miss an important physical sign, or to get a sign wrong, to reveal one's uncertainty about the significance of a sign, or to demonstrate an ignorance as to how a sign should be properly elicited, was to put one's passing in peril at the Final M.B.B.S. exam. To perpetrate similar errors at the higher (M.D. or M.R.C.P.) test was to sink beyond rescue, until the next examination six months later.

Beside clinical teaching, often of a high order, does of course take place in American teaching hospitals. Brief conversations between specialist, house staff and students do take place in the patient's vicinity; information relevant to the patient is conveyed to the specialist physician, and instruction regarding diagnosis and treatment of the patient's disease is transmitted from the specialist to his audience. However, little if any of the time spent by the bedside is devoted to elicitation or elucidation of physical signs. More time is spent on reciting levels of enzymes and electrolytes, blood gases and electrocardiograms, the interesting paper that appeared last month in the New England Journal of Medicine or the controversial opinions expressed in an editorial in the last issue of Circulation, than on the jugular venous pulse or the intricacies of auscultation and palpation.

Clinical medicine always has been, and should be, centered on the patient. What questions to ask the patient, how to evaluate his answers, how to perform a proper bedside physical exam, what to conclude from the physical signs obtained, all of these are the essence of the diagnostic process, of doctor-patient interaction, and should come first and foremost. What investigations to do next, what algorithm to follow, are the logical next phase, but these components have displaced the bedside examination in the board exam protocol. Fictitious hypothetical test cases, and the sequence of multiple choice questions arising from them, however cleverly devised, are a second-best substitute for the real thing: a patient with a real manifest disease a physician-candidate, and an experienced master-clinician standing by watching the latter's every move. I am referring to the short cases in the M.R.C.P. exam routine, a prototype that is followed with

little variation in all Commonwealth countries.

The acquisition of up-to-date numerical patient data, and the most recent literature pickings, is of course very useful and even laudable. But, on the other hand, should our rich heritage of skillful bedside diagnosis be forgot and never brought to mind? And the bedside clinics from which we first learned the elements of our profession, be relegated to the distant days of auld lang syne?

American Association of Cardiologists of Indian Origin • AACIO
Semiannual Meeting: Hyatt Regency Hotel,
New Orleans, LA • Sunday, November 10, 1996

Program: 6:30 PM Cocktails, 7:30 PM Dinner Meeting
Admission: Free for members / Life members • $40 for non-members
Please fill in the following information and fax to Ms. Linda Quellmalz,
Dr. Dhurandhar's Administrative Assistant, at 504-897-8336 ASAP.

Atul Ladduu, MD, PhD
1216 N. Clandge Way
Carmel, Indiana 46032