

1-2010

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### Recommended Citation

Guthier, Justin (2010) "Lessons from a Career in Medicine and Education - Rani Bright, MBBS," *Voices from the Floor*: Vol. 2: Iss. 1, Article 6.

Available at: <http://digitalcommons.pcom.edu/voices/vol2/iss1/6>

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# *Lessons from a Career in Medicine and Education – Rani Bright, MBBS*

## **An Interview and Narrative written by Justin Guthier, MS-III**

Education has and always will be a major part of my life. I have been at PCOM as a professor for over 22 years, teaching Infectious Disease. But, before I was a professor, I practiced Pediatrics in India. I completed all of my education in India. The path to medical school in India is quite different than here in America. Students in India can start medical school immediately after high school. There are government sponsored schools and there are private schools. I applied at a time when there were only a few private medical schools – most were run by the government. I went to a government school where, at the time I was one of the few girls admitted. There is an age cutoff for admission to government schools as you cannot apply after 25 years of age. Seventy-five percent of the education is subsidized by the government in these schools, which is a great advantage as my parents only had to pay for 25% of my education.

The curriculum in India is based upon the British model. Training was very thorough, and testing was strictly by essay type questions; we had no multiple choice tests at all. We did not even know what a multiple choice question looked like! The essay questions emphasized thinking processes, creativity, writing and drawing diagrams. This model of testing allowed you to display how much you knew about a subject. We had no PowerPoint – and forget about scribe notes. Attendance was mandatory and the class sizes were small so all the professors knew everyone by their names. The big tests were administered by external examiners, and were essentially an oral test. To prepare for one of these you needed to know your stuff because the examiners could ask you about anything, and you had to be prepared to answer them. School was a very rigid and structured experience and testing was grueling. If 50% or more of students made it through the exam, then it was considered to be a good exam. There were no challenges, you just did the best that you could. Our degree was the MBBS or “Medicine Bachelor and Bachelor of Surgery.” It has been debated and suggested to change but the British system is very rigid. We get it upon graduation from a fully accredited allopathic medical college four and a half years of intense

training and completing one year of rotating internship.

In India training was not as technologically advanced as in America. It was very hands-on and emphasized good clinical skills. If I could bring any aspect of my medical training in India to PCOM, I would bring the emphasis on the physical exam. Today, there is a lot of reliance on testing, but performing a good physical and taking a thorough history are the hallmarks of a good physician. A good physician takes his time with the patient and tries to learn as much as possible through the physical and history. When you spend time with your patients it will make them feel appreciated. The time you spend is very important because when you get to know your patient, where they live, what their surroundings and family are like – you will be a better physician for that patient. This mentality directly correlates with the holistic message we teach here at PCOM. In India, there is a great deal of respect for the medical profession; students respect their professors and patients respect their physicians. When you are a physician, your patients, look up to you, you are important to them, do not ever forget that.

One experience I remember vividly during my medical education involved my own father. In my third year of medical school, my father came to me with an eye infection. I treated him with a penicillin eye-drop. Overnight, he developed a corneal ulcer and the next morning he awoke with great pain in his eye. We rushed him to the hospital where I met the head clinician of my school. She did not scold me as I expected, but simply explained that I was treating at a third year level and needed to act within those boundaries. My father recovered but I will not forget that experience. From that moment on, I knew I would always treat students who are trying their best with respect.

Unfortunately, India has poor vaccine coverage for its pediatric population. I have seen diseases that physicians here only read about in textbooks. I have seen diphtheria, meningitis from tuberculosis, children dying from dehydration, from diarrhea and malaria.

Smallpox is a very scary disease, but I have seen it many times. Tetanus, typhoid, rabies, leprosy are all diseases I have come in contact with in India as a physician. Although leprosy is not as intimidating a disease as you would expect to a physician, there is a social stigma against people who have leprosy. Their appearance is very intimidating to the general public. But as physicians, we know the pathophysiology and the route of transmission, so as a result we are not frightened and have no bias; we treat everyone with respect.

I have certified many pediatric deaths during my time, as many children die from infectious diseases. Certifying pediatric deaths was a very painful process. A parent brings you their child hoping that you will be their savior, hoping that you can save them. Then when you cannot and you have to tell them there is nothing left that can be done, it is very painful. I did this so many times, I began to become desensitized. It is the only way you can continue to do your job. I knew we did everything right, did everything we could, yet I wish I had been more receptive to the parents' pain and psychological heartbreak. Despite trying as hard as we could to save the children I still regret our circumstances and retain a bit of pain in my heart today.

When I married, I immigrated to America and spent many happy years as a stay-at-home Mom. As time went on, I began to miss my profession and took a job at MCP and then soon after took a position teaching infectious disease here at PCOM. It was easy to transition from pediatrics in India to infectious disease here because in India, everyone is an infectious disease clinician. Since you see so much infectious disease, it is part of your required training to learn how to treat common diseases like malaria and TB. This applies to all clinical disciplines – surgeons, internal medicine, pediatrics – since everyone sees these pathologies. This is why there is no infectious disease specialty in India; it becomes second nature for every physician to treat them. My favorite subjects to teach are emerging infectious diseases – H1N1, SARS and Bioterrorism. I have seen many students over the years. I appreciate students who come to class even though good students can learn on their own outside of class very well. A student really begins to show their potential when they can go out onto the floors and

apply what they have learned – not just take a test. Whatever I teach I hope they retain, but my proudest moments come during hospital days or when I see a former student out in the hospitals or the clinics and they say, “Dr. Bright – I treated TB” or “Dr. Bright, I saw cryptosporidium!” I feel very proud that they used my teaching to help another person and were able to shoulder the responsibility of that patient's care.

Dedication is a vital character trait as a medical student and a clinician. You can ask anyone who knows me. Every morning, I make it my business to go into the library and read my journals of interest. There is nothing more important than staying current in your field. I have nothing against textbooks, but journals provide you with the most current information. I guess that my training inspires me. In the British system there is a strong emphasis on independent reading and retention. My advice to students would be to choose two or three journals of interest to you as you progress with your training, and stick with them. Read every new issue and you will be at the top of your field everyday ready to treat your patients. Above all, this method of learning takes dedication.

For all of the students reading this, the difference between a good physician and superior physician is simple. Good physicians treat the disease as it appears in front of them. This is the band-aid approach. Superior physicians treat the root of the disease. A superior doctor thinks holistically and takes the whole patient into consideration. I have a fascination with public health. Public health is not sitting in class and taking notes – it is being out there and treating patients and analyzing disease conditions. Preventing disease is the big difference.

