The Art of Guile

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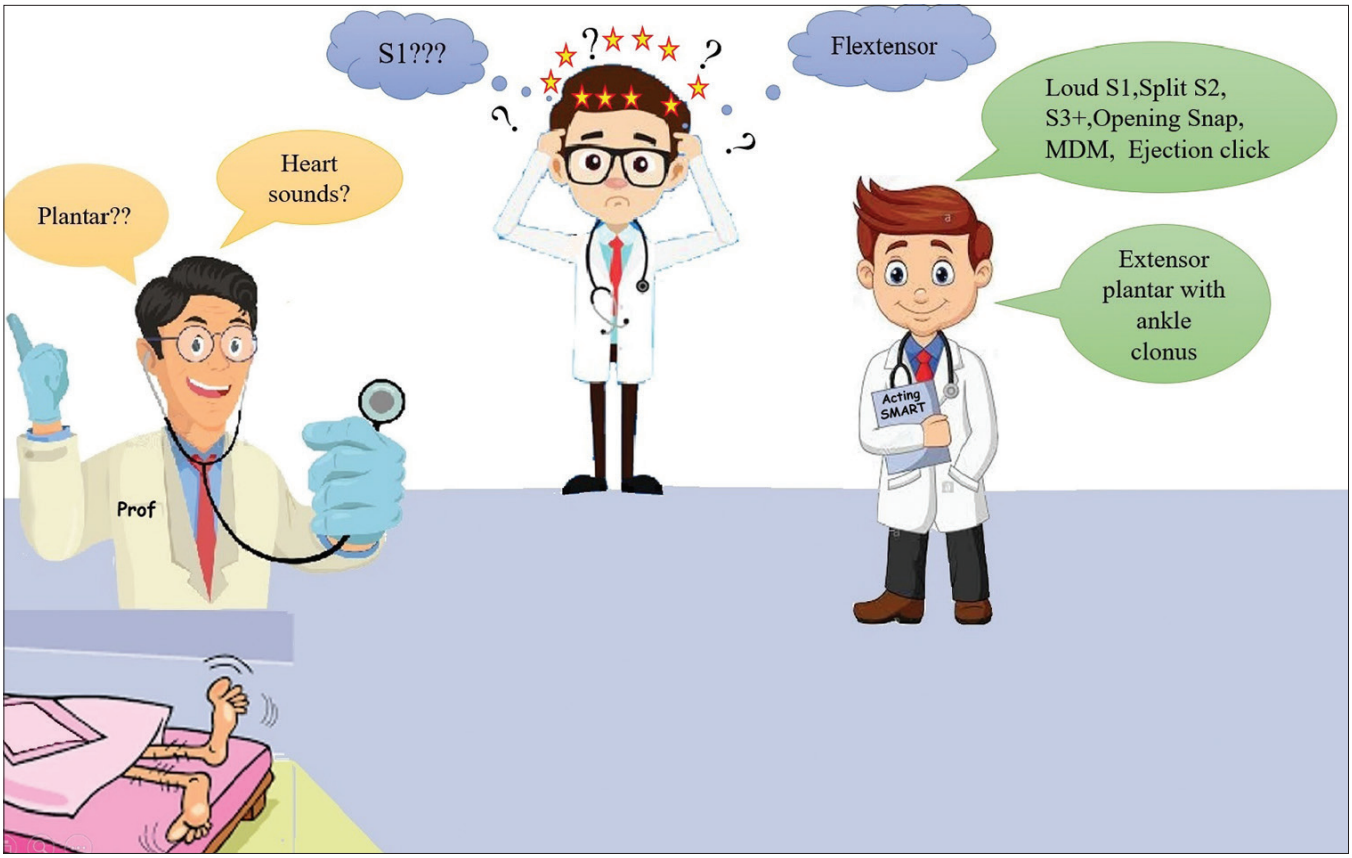

As I soaked in the formalin-filled amphitheater, euphemistically labeled as dissection hall and struggled with a blue book by Cunningham, little did I realize that I was learning a new art in life. An art where you read or rather pretend to read and nod frequently as if assimilating something non-existent. To stretch it more, explain abstract irrelevant data in convoluted, complicated phrases, liberally borrowed from the same blue book, to my befuddled, confused colleagues perplexing them even further. Welcome to the "Art of Guile." Little did I realize that, it is this adroitness which is going to be used more chauvinistically, than all the other prowess combined, henceforth in a medico's life.

Enter 3rd year to the schizophrenic frenzy of interesting cases. As I struggle to figure out S1 from S2, I hear my colleagues ramble about opening snap, S3, S4 and ejection click, which would easily puncture my knowledge ego. Apathetic plantar reflexes were labeled as flexor, extensor or "flextensor" depending on the case scenario. Thence I realized that others too have taken up this art and were flagrantly flouting it, with vengeance, on my face. The disciples of Roentgen were masters of this idiosyncratic art genre. Their detailed reports were as circuitous a confabulation that you can imagine from Captain Haddock after six large pegs, defining new ways of implicitly implying their ignorance about the image. The oft played shenanigan in med school was that, one was forced to believe that the missed lectures were always the best, the unseen cases always the most relevant and the unattended exams, the most crucial. At each turn of a medico's cloister, the "Art of Guile" displayed its jokers face.

After graduation, specialization, pseudo specialization, and pseudo pseudo specialization, this art becomes ingrained into ones genes. As a greenhorn consultant, it starts off with syndromes. Not the easy ones, mind you, but rather abstruse. Many a time these syndromes have no connection to the clinical case presented even if we trace seven generations behind. But since this art is so dominantly penetrant, you can't but express it.

Next on podium is the Q and A session after a lecture in CME, and a lot of crafty contemplation goes behind it. It can be any lecture but often it's the one delivered by an international faculty and the questions may not have any bearing on the talk. The query starts with profuse syrupy endorsement of the international faculty bordering on sycophancy and ends by referring a letter to the editor written by the question raiser in response to an original article authored by the speaker. The entire drama ensures that for a few moments the arc lights are firmly on oneself.

Post-CME dinner showcases specific visual object agnosia expressed by senior faculty. They identify only international speakers and migrate towards them, with adhesive liquid containing crystal tumbler in hand, and appear exclusive. The workforce behind the CME's success become objects of temporary visual neglect and this has been noted to be an ad interim phenomenon lasting only till the end of party hours.

This art has various hues and many exponents. Some become masters with ease while others remain novices. Those skilled, hog the limelight and the rest have to be content being marginalized.

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Conflicts of interest

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