Lage Raho Munna Bhai

Indo - UK health collaborations: the story of an Indian doctor in NHS

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September 2021

Summary

This is a partly descriptive and partly reflective story of my work to support health systems in India over the years since I arrived in UK in 1980 after qualifying as a doctor in Delhi, India. I am committed to the National Health Service, even though I do not think it is what should/could be, and believe the model is worth replicating elsewhere and particularly in India which is both, the cause of global health inequalities and the solution with its vast potential. Given the historical links between the two countries and given that migrants can often be the bridges and help both I wanted to share my observations to thank those who helped me and help those who may follow.

This report complements my journey in the NHS – please see https://www.nhs70.org.uk/story/rajan-madhok

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September 2021

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Introduction

The main reason for writing this report is to do with my interest in reflection and I had been meaning to complement my other NHS reflections (https://www.nhs70.org.uk/story/rajan-madhok) for some time when Jim Determeijer asked me to run a session on global learning for his cohort of aspiring leaders on the Healthcare Leadership Academy (HLA) programme and this provided the necessary impetus to finally do it. Although I have wider experience in global health, much of my learning has been in the context of what I wanted to do for India, and so after the session I decided to put pen to paper (so to speak- my handwriting is rubbish).

I was also approached by JS Bamrah and Ramesh Mehta from British Association of Physicians of Indian Origin (BAPIO) who are planning a joint session with all chairmen (sorry, all men) since the organisation was set up in 1996 for the 25th anniversary celebrations in October 2021, and since it is an important part of my story I wanted to fully gather my thoughts and facts. Finally, with my interest in history of medicine I have been working with Stephanie Snow, professor of history in Manchester and director of NHS at 70 project, who had asked me to record the experiences of people on both sides – in the UK and in India - in terms of support to India during the Covid 19 pandemic, especially during the second wave from March 2021 onwards.

As with all my reflective writing this is personal - it is about making sense for myself and finding meaning for the ongoing journey of life. And then there are two different audiences: the first are the peers, friends and colleagues who helped along the way and by recording this account I want to acknowledge my gratitude. The second audience may be the ‘uncommitted and those testing the waters’ and the younger generations, who may find some use for this account and hence continue the work.

Because continue such work we must. My focus is on Indo-UK collaborations, but it could be any bilateral and global relationships. Medical knowledge itself is now universal and we all learn in the global context. The issue is how we use the knowledge, a doctor/nurse in India studies what their counterparts do in the UK but end up working differently, and which is how it should be, but is that good or bad and what can be learnt from it and how to help make things better is what fascinates me.

You can take a man (or woman) out of India (or any other country of their origin) but you can not take India out of the man, and so it was, and as I have grown older, more, with me. I yearn for India, though my India does not exist anymore- the problem of immigrants who get stuck in particular time periods; today’s Delhi is nothing like the Delhi of my youth, and why should it be, time and progress do not wait for anyone. Never before have I felt as helpless as I have done during the pandemic, watching what has been going on everywhere, and particularly in India where the lack of robust health systems and preparedness made it very difficult/impossible to deal with what is/was an unprecedented situation, and I wondered whether whatever I did was any use at all.

A discussion on how to build Indo-UK collaborations for health is timely as the pandemic is not over yet, and indeed has injected an urgency to the need for health systems strengthening. We live in an interconnected One World with One Health (human, animals and plants) – no one is safe unless we are all safe, and that means accelerating global learning and mutual cooperation. India then becomes crucial since although it is the cause of much of the poor health globally – with its low performance on many health indicators, it is also the solution as it proved again by producing the vaccines during the pandemic and over the years as the source of large numbers of Indian health care professionals to the NHS for example.

But it is not just about Indians and India, it is about all immigrants who for various reasons turn up in the NHS and try to contribute to their countries of origin. It is in the nature of being an immigrant to see good and try and share it, they tend to have a more global outlook and a desire to make it a better world due to the struggles they face from dislocations. In my experience it is certainly true of the medical diaspora who are attracted to the values of the NHS, not all are economic migrants.

So, it is for all these reasons I offer this report. As with my other writings my intention is to help, but if I have ended up causing offence in any way then please accept my apology.

Overview

Before I launch into my story some notes: although I have started (very recently) keeping a regular diary - given the long time period the dates/sequence of events inside may be muddled up, but in any case it is not meant to be a historical or chronological recording of events, rather the focus is on some key efforts to help draw out relevant learning/lessons. Of necessity there is a lot of descriptive stuff with many names/places in the following account which will be unfamiliar to the readers and this can be confusing (boring). I apologise but I had to do it to make sense for myself. So without making it too long I will try and explain more where possible and necessary. Just to be clear also that this is not about what was happening as regards Indo- UK health collaborations since there was (is) a lot of activity, and in any case I am only commenting on things that I was involved with, for varying periods of time.

Two over-riding thoughts sustained me throughout. First, that it is important to take a (very) long range view of things- India may be 'down' now but was and will be 'up' again (and UK and the West may go in the other direction, not wishing anything just noting). Second, to keep doing whatever little one can do – its not possible, and futile, to try and predict the future and who knows when one's efforts may be useful and indeed be the final catalyst for change. In any case what one gains from such work is immeasurable and priceless in terms of professional and personal development. Look at what I acquired and honed:

1. Curiosity – one develops a heightened sense by trying to understand why things are the way they are, just because they do not fit own preconceptions does not mean they are wrong.
2. Imagination – although I guess I was imaginative to begin with, being put into new situations forces one to use imagination more.
3. Patience and perseverance – I am impatient by nature and had to learn to wait, things take their own time and you can not force the pace, and you need to stick with it.
4. Hope – what goes down will come up, sadness is followed by joy, and any setbacks should be seen as temporary as things do turn up unexpectedly.
5. Respect – the thing that has struck me in resource poor settings is peoples' ability to use whatever they have to overcome the challenges; there is an Indian word fro this : *Jugaad*, often compared with frugal innovation. But it is more than that and encompasses making do; its the opposite of needs based planning – which focusses on deficits - and more about using existing assets to make the difference. I learnt to respect these people, and sometime feel that having much is a curse, it stops one's growth.

These to me are gains that only come with the experience of doing such work over a prolonged period and after due reflection, no amount of reading self help books or courses can do this although these can be useful adjuncts.

But it is important to be careful on such a journey. One must be clear about one's motivation – is it fame/money or is it doing lasting good – for the former can come through latter but pursuing former is unlikely to achieve the latter (sounds like the famous Rumsfield quote!). And it is important to follow certain rules as one travels and explores international collaborations:

1. Suspend judgement – go with an open mind. There is good and bad everywhere, never judge as learning is agnostic – not good or bad, what you do with it is what matters. What not to do is as important as what to do.
2. Ask questions – to clarify the issue, ask the 5 whys. Getting the right question is more than half the battle with finding the answer.
3. Actively listen – try and get to the root of the issue; active listening is essential especially across cultural divides, paying attention to verbal and non-verbal communication.
4. Corroborate – if necessary check it out with others, do not take things at face value.

Then only you will know what is needed, and if it matches with what you also want to do then it is a success. And remember there are enough people who want to help – and that's what makes the world go around, you are not alone.

So, what did I do?

I was an 'early' deserter and left soon after graduation from Maulana Azad Medical College, Delhi and arrived as a young newly qualified doctor in the UK in Sep 1980. By mid 1990s I had begun to feel guilty and also having finally cracked it in the National Health Service (NHS) had begun exploring how to make amends.

The journey started in early 1992 when after over a decade of struggle including a complete change of career direction I was finally getting somewhere having become a consultant in public health in the NHS. With a family of my own with three small children, I had started wondering about my 'other' family – of my birth with parents and siblings and whom I had deserted in search of the good life in 'Vilayat' (Blighty, as UK was known). I got a call from 'home'; my brother, Raman, rang me to say that our father had been diagnosed with advanced stomach cancer, after months of visits to doctors and investigations for all uncommon conditions, but not Big C. Endocrinal cause for weight loss rather than cancer in a 66 years old man having sent the doctors in a particular direction and it was not till later that the penny dropped. So I flew out to see him. He was already quite ill and soon after my return after two weeks stay during which I tried to help as much as I could, being in Mumbai not Delhi where my contacts were as my parents had gone to stay with my brother, he passed away. I saw Indian health system first, as a 'user' – being on the other side as patients and second, with the benefit of working in the NHS, and began to wonder what could be done to help improve things there. That spurred me and although my activities were slow to begin with, towards the later stages of my career these accelerated as I became more senior in the NHS and had the resources. In addition, in the 1990s I was more attracted to the USA, having worked at Mayo Clinic in 1991 for a short time and spent much of my energies and time travelling there.

I see my work in phases- from 1990s to early/mid 2000s it was opportunistic and to a large extent preparatory, and which then started more earnestly when I came to Manchester in 2005 after which I made good inroads and was able to then build on these with the British Association of Physicians of Indian Origin (BAPIO) when I joined it in 2009, and then with the Global Health Exchange (GHE) through Health Education England (HEE). After formally leaving the NHS in 2012 I was able to spend more time in India also partly as I needed to be there often for personal reasons. Since moving to North Wales in 2017, I have been exploring wider links – beyond health and into art and social development, given the long tradition of exchanges from the time the first missionaries went to North-east India in early 19th century.

Being a public health doctor in a constantly changing NHS, I could not do what most doctors do and which was to provide clinical services linked to a hospital, especially running camps or latterly creating exchange fellowship programmes, Of course many members of the diaspora including doctors contribute in other ways for societal betterment including running schools and raising funds for community development for example. I had to figure out how to add value; from basic knowledge sharing and exchanges and for the last few years to supporting leadership development and particularly thought leadership, 'capacity building' became the focus of my work. My approach has been a mix of horizon scanning and leveraging available resources from my various associations, and opportunistically meeting needs. In every job I did I asked myself: Can this benefit India (and vice versa) and infact approached almost all major NHS bodies (and others) at one time or another. Sometimes things worked and others not with occasional pushback about why do not Indians help themselves with so many rich people there, and 'disinterest' from pressured (or unable to take the long view, perhaps due to my limitations in making a compelling case) NHS organisations. I was also limited by the fact that in the early years, I did not have much time, before the digital and now 'Zoom/Teams' age most of the work required physical presence. Although keen I was very clear that I was not going to move back to India. I felt that I had grown too accustomed to certain ways of living in the West and would not be able to fit back into India, and periodic visits could only do so much, especially as it requires hard slog and persistence to get things done anyway, and especially in India.

In the main, my work was in line with my analysis of what was needed in India – I had written an open letter in the British Medical Journal (BMJ) later on when the Modi Government came into power and which was by then the summary of my assessment based on the work I had done. The letter is in Appendix 1 and essentially I had highlighted four priority areas for the new administration:

1. Better governance not just clinical governance
2. Better education and research
3. Better primary care
4. Better public health

The India seen in popular media is very different to the reality- behind the glitter is immense inequality and deprivation, and the gulf can only be bridged by strong and

sustained governmental action. The single minded pursuit of acute and high-tech medicine with growing investment in both, private and public hospitals, is adding to the problem.

For those wanting to cut to the chase in terms of So What you can jump ahead to the Conclusions – and even there be patient with me, my journey is work in progress. I follow all religions (to hedge my bets) and what has stayed with me is the quote about Buddhism- I forget the source- about Buddhists always talking about practise, when do they perform? And being at heart a Hindu – as Bhagvad Gita says it is all about doing your best, you can only control your efforts and not the results. That about sums up my work. I tried.

My Journey

The initial breakthrough came via Raman when he invited me to address OPPI (Organisation of Pharmaceutical Producers of India) in 1995, he was then working in the industry. As a cocky first time director of public health I knew exactly what India needed and spoke about social responsibility of the industry to the most senior and highly experienced figures. Thankfully my naivety was put down to enthusiasm and opened many doors, and I started meeting people from different sectors – and eventually over the years managed to engage with almost all key stakeholders in private/public/NGO/Research/Teaching sectors in India.

To a large extent this was a necessary period, not least as my travels to India were limited, and helped me prepare for the future. Looking back it is interesting to note how things then evolved. Let me explain these through a few stories here and I will return to these throughout and add more.

One of the participants at the OPPI session was Narges Mahaluxmivala - medical director of one of the companies and her son, Jehangir, was a student on the MSc in Orthopaedic Course that I was teaching on in Middlesbrough then. Yogesh Pai, consultant orthopaedic surgeon, had set up the programme to help overseas, largely Indian, doctors, get something in return for the valuable work they were doing for the NHS. Now see this: In 2019 I had taken my mother to see the ophthalmologist in Mumbai and we got talking, Jehangir was a dear friend of the doctor and when he heard my story, he refused to accept any fee for my mother's consultation because I had taught his friend! Well, it taught me a lesson. And from the same course another time I went to see the Indian delegation led by Raj Murali, consultant orthopaedic surgeon from Wrightington, Wigan and Leigh NHS Trust to recruit doctors from India, they were visiting Mumbai and I joined them for dinner and on Raj's team was another former student, and to my embarrassment (and joy) recounted how that course had influenced his career.

Another fortuitous development following the session was a meeting with Habil Khorakiwala, Chairman of Wockhardt Group, who wanted to know more about the NHS - he then asked Vishal Bali and Anil Kamath, who were his key officers, to follow up with me. They took me out for a nice Chinese dinner and now see this: nearly twenty years later when I was working on the Bhartiya Hospital Project (see later) and needed some 'Indian' expertise I reached out to Anil and he joined the project as a consultant.

I had met Devi Shetty, courtesy of Sanjeev, a childhood friend living and working in Bengalore, in mid 1990s when he had started on his mission to create Narayana Hrudalaya (NH). I remember Devi showing me around and standing on the roof terrace pointing out where the buildings for the key services he envisaged were going to be sited – as time shows he knew what he wanted and went for it. Over the years since then I have been to NH a few times, taken some of my colleagues there, and Devi Shetty came and met the HealthCare UK team informally over dinner when the NHS Confederation conference was on in Manchester few years ago. He never refused any of my requests including joining remotely for our conference in

Manchester, though there was nothing in it for him and most of the top people from UK were available to him.

Hilary Klonin, consultant paediatrician with strong links to Nepal (she gave me an owl as a retirement present- with lifelong suscription!), and I (as the director of public health (DPH) then) held the East-West Conference in Hull in late 1990s. It was about paediatric intensive care with speakers from across the globe. We had invited Subhash Daga, an eminent paediatrician, who had pioneered low cost intensive care for neonates and infants in Mumbai, basically using the throw away styrofoam box as the incubator, an open electric overhead heater and mother as the primary carer to save lives – his modest presentation contrasted vividly with those of the speakers from the west with their fancy, double slide projections (yes, those were the days) and the results in terms of outcomes were similar. Subhash Daga later on featured in the BMJ Innovations in Healthcare Awards in 2011, and I used to go and see him and his wife, Achala, professor of preventive and social medicine everytime I went to Mumbai, until they shifted to Pune, mainly to get a booster dose of inspiration and humility. Kavery Nambisan, surgeon and author, was another delegate at the conference and over the years she helped me understand about surgical services in rural India, as she chaired the group of rural surgeons. They were the real forgotten heroes, and the backbone of essential services – I remember talking to Kavery about the problems of blood transfusions as the government was introducing legislation to ensure safe transfusion with proper equipment and processes but had not accounted for the fact that refrigerators were not an option in villages not just because of cost of the fridges but lack of electricity. She and her colleagues used to do basic tests and get relatives to donate blood for immediate transfusion. Misguided good intentions.

In following up on the conference I came across Duru Shah, consultant gynaecologist and obstetrician in Mumbai, who was then the President of FOGSI (Federation of Obstetric and Gynaeological Societies of India) and apart from then helping with deliveries of my niece, she introduced me to her husband, Sushil who had founded Metropolis, the diagnostic lab, and through him their daugther, Ameera Shah who headed up the organisation. Ameera was keen on exploring business developments in the UK following Tony Blair's opening up of the NHS and I worked with her on her plans. She was very helpful when Martin Fischer from Kings' Fund wanted to take a delegation of senior NHS managers to India as part of knowledge exchange. And more recently I introduced her to Gopal Mahadev, consultant surgeon and entrepreneur, as he was developing his plans to support the NHS during the pandemic.

My introduction to Prathap Reddy, Founder of Apollo Hospitals, happened similarly- and I went to meet him in London with Promod Bhatnagar, an ophthalmologist who was the pioneer in setting up Independent Sector Treatment Centres (ISTC), the initiative to clear long waiting lists in the NHS. Our paths then continued to cross, including when GAPIO was set up with him as the Inaugural Chairman and I was on its Executive Committee, and recently I worked for a while as part of the team led by his grandson, Karthik Reddy, for Apollo's joint venture with University of Buckingham to set up Apollo Buckingham Health Sciences Campus in Crewe.

I could go on as there were so many such interactions – by chance sometimes, and just when nothing was happening something would turn up, and I will return to these in later sections.

Raman being in India and well connected there was key to much of my work – as he pulled me in with his various activities. After the OPPI session he involved me in the work that he did/and still does for other organisations. When he was working at Jindal Iron and Steel Company he took me to meet Sangita Jindal, wife of the owner, an art patron and philanthropist, and who was keen to explore how best to use their charitable hospital in Vijayanagar, based on the NHS model, and later on I interacted with the people from the Jindal Foundation. Having been a Chevening Scholar to Manchester Business School in 2000 he had first hand knowledge and experience of England and subsequently chaired the Association of British Scholars in Mumbai and continues to do that (his daughter, Ruchita also studied at Central Saint Martins, London and is active with ABS). Apart from being a recipient of the Eisenhower Fellowship (EF) in USA in 2004 he was a member of their Global Network Council and championed health and education as the two key pillars of development. I spoke at two of the EF Conferences, in Sri Lanka and Dubai, drawing on my Indian and NHS experiences and raising awareness of health issues: health and wealth being interdependent, the idea of seeing health not as a consumptive but as a productive sector would often resonate with these senior figures from many countries, atleast so they professed. After getting his feet under the table as the Managing Director of CMIFPE and Regional Manager for CMI Group of Belgium in South East Asia, he invited me over to the Europe India Chamber of Commerce for a conference in Brussels which amongst many topics of interest for India and Europe had a session on Health imperatives for India and how Europe could help. I met Prem Sharma there and on his return to Reading we stayed in touch and I met Alok Sharma, his son and MP (and as it happens met Theresa May at their residence) subsequently. Raman, post his retirement from CMI Group now called John Cockerill Group, has been appointed as the Economic Diplomacy Advisor to the Consul General of Belgium in Mumbai. The international connections continued including an invitation to address a conference in Barcelona to the Catalan Government about their plans for collaborations in India – there is a lot more than curries and Bollywood and the country of contrasts always fascinates people. Raman also picked up the work in India, for example he got Doctors For You (DFY), an NGO founded by Ravikant Singh to support his company's CSR (Corporate Social Responsibility) work. He is also a trustee and an independent director on the board of global NGO United Way Mumbai, and is helping Bhandary Foundation in Mangaluru with holistic development for preparing leaders of tomorrow through Sahyadri College of Engineering & Management and as always promoting health and education.

Different people acted as key partners in the UK during my journey- and the following sections expand on these- and here I wanted to highlight what to me was a very useful development, and which was the work by Nigel Crisp. After he left the NHS as the CEO and Permanent Secretary (the only one to ever combine the two roles) Nigel took up the global health mantle – and continues – and started raising awareness of the interconnected world and mutual learning, he was also able to

shape government policy and legitimised and empowered many people who had been feeling rather unsupported before then. I had met him through Andy Bacon, an NHS manager who had worked in Africa before; although I knew of Nigel especially when I was the medical director of the Strategic Health Authority (SHA) in York. I still remember John Reid, the then Secretary of State for Health, trying to score a point at a conference in London – and contrasted himself with Nigel (in his strong Scottish accent), and was following Nigel's work avidly. As a result the NHS was getting galvanised, lot of the NHS staff who were involved as volunteers overseas started sharing their learning and there was a growing realisation of the value of such exchanges. Soon after there were high level discussions about how to leverage the NHS Brand which then led to the creation of HealthCare UK (HCUK) – as a business arm of the NHS, and before that Ara Darzi had talked about the Global Health Forum. So I wrote to Nigel and Ara – Appendix 2. I did try to connect with Ara Darzi on a personal level, both of us having trained in Dublin, at different times!

This environment helped me to then develop further plans with Ramesh Mehta at BAPIO and Ged Byrne at GHE/HEE (see later sections).

My point in setting this out here is to show how my journey unfolded to provide the context for what follows next. In creating the collaborations I was trying to work on both sides simultaneously - the predominant feeling here was that UK was the 'donor' and India the 'recipient', despite the obvious fact that the NHS could not survive without Indian doctors and India was a 'cash cow' with overseas students for example, but such things were taken for granted, and more was required. India had changed too, and had access to all the best as not just UK but rest of the Western world was also trying to get into India – seduced by stories of growing prosperity and demographic dividend - and they did not always take kindly to what the NHS had to offer. So I did the running around to make the 'right' connections to push from UK and to pull from India and create the bridges. In making my overtures I emphasised the win:win strategy. Rather than try to please people I decided to say what I thought, and also be non-partisan – as an immigrant in UK I felt I belonged to both, or neither, and was more focussed on how to address the needs. Over the years the organisations and people kept changing, some having delivered and others 'disinterested' or not able to proceed, as I kept trying to explore collaborations around different aspects of the best from the NHS.

In the next sections I describe some of the specific initiatives (The What) I was involved with, and then about my working methods (The How). The Who, When, Where are covered in these two! Or you can jump to the Conclusions section.

Specific initiatives

Clinical quality and patient safety

Since I had worked at the Mayo Clinic, USA in 1991 and having been sensitised by Liam Donaldson, later the chief medical officer for England, when I was working in the north-east of England, I had become a champion for quality of care, and actively pursued every aspect of it. After the OPPI session which was picked up by the industry news media I guess, I had a call from headhunters asking if I would consider moving to Delhi as Aniljit Singh, a big businessman, was launching Max Healthcare. I was flattered but it was too much for me - and as it happened it was Narottam Puri, a very eminent doctor and my teacher, who joined Max then. I had gone to meet Shubnum Singh, the key doctor at Max Health system, at the time in their first clinic as part of this and liked the model of bringing better primary care. I got asked again later on, by which time Max had turned to establishing hospitals, if I would join as an advisor for the quality work, and I went to meet Aniljit Singh, fully primed by the headhunter, at his palatial house in the most prestigious area in New Delhi, and it was an enjoyable chat, he is a very charming person and host. Pervez Ahmad, a cardiologist from USA and grandson of a former President of India, was the medical director then. Though we were not able to collaborate, Shubnum has kept on appearing at various stages in my journey, and is always helpful.

Such interactions were useful but I was hankering for a ‘proper’ project and was exploring options for how to take this work forward in India. The breakthrough came when Akhil Sangal, a senior doctor who founded ICHA (Indian Confederation for Healthcare Accreditation), invited me to their conference in 2005 where I then met the senior policymakers including Montek Singh Ahluwalia.

Through ICHA I came to the attention of Girdhar Gyani at the Quality Council of India, and they were developing an accreditation system for the hospitals - NABH (National Accreditation Board for Hospitals). Together with Vivek Rae, the then secretary of health in Delhi he drafted me in as the ‘Resource’ person for their pilot project with eight hospitals in Delhi including my alma mater- Maulana Azad Medical College. I also interacted with Srinath Reddy, President of Public Health Foundation of India (PHFI) who was trying to start educational programmes, about a possible course on patient safety. Later on I met the people at National Health Systems Resource Centre (NHSRC) where Sundaraman was the director who were developing similar quality systems to support public hospitals in India.

I had worked closely with Martin Fletcher, NHS manager, when he was in Yorkshire, where I was the SHA Medical Director and with his Aussie approach we hit off; we met up again when he was at the National Patient Safety Agency (NPSA) as the CEO; and between him and Naren Patel, renowned gynaecologist who was the chair of NPSA, I became their India Envoy for a short time (and then sadly NPSA was abolished).

Mala Rao, a public health doctor in UK, had gone to Hyderabad, India to set up the Indian Institute of Public Health as part of the PHFI's plan to build capacity (see later also) around 2008/9 and one of the areas we identified for joint working was patient safety. She engaged the health sector there and I went to see the health secretaries with her – pre-partition of Andhra Pradesh there used to be two of them - and held some workshops to start a systematic programme of work to promote patient safety. I managed to rope in Martin Fletcher and whilst in India for another ICHA conference, he came with me to Hyderabad to support Mala's plans, along with Doris Mugrditchian, who had been the WHO Regional Lead for patient safety in Delhi.

It was apparent that there was very limited capacity to take forward this agenda in India and I made a bid to the Commonwealth Fund for some scholarships – four candidates were chosen: two each via ICHA and IIPH, Hyderabad and they came and spent three months in my department in Manchester (I was then the medical director for the PCT). Judith Strobl, who later on went to IHI as a fellow, coordinated their programme and during their stay we managed to call in many favours (willingly given and gratefully received) from various organisations to enable the fellows to get a comprehensive knowledge of the state of play in the NHS. John Wright, Colin Pollock and Paula Whitty, all eminent public health doctors who have held very senior positions, among others spoke to the fellows; and Andrew Dillon, the Chief Executive of National Institute of Clinical and Health Excellence (NICE) even gave four delegate tickets to enable them to attend the annual conference. I was on a technical group of NICE and went to lobby Andrew, they had already set up NICE International by then and appointed Calypso to lead it and she had been to India, and I was exploring how I could add value to their efforts. I knew the people in India who were engaging with NICE International; apart from Mala Rao there was Sundararaman at the NHSRC, and as always Nobhojit Roy, surgeon and public health doctor in Mumbai, and they kept me briefed about the activities. The fellows also spent time with other organisations including the General Medical Council (GMC). They were exposed to the best of the NHS, and I felt proud and was delighted.

Nikhil Datar, one of the fellows, then did a lot of good work in Mumbai to build on his learning, and created bespoke projects since the NHS knowledge needed contextualising and which he was able to do. As it happens most of my family lives in the city and so I was able to support Nikhil for a few years afterwards. Infact Muir Gray, a voice of reason and very senior public health doctor, came to lend his support during one of the events that Nikhil had organised. Muir Gray also came to see the Health Education Library for People (HELP) that Aniruddha Malpani, consultant gynaecologist and obstetrician, had set up in Mumbai; Aniruddha is very good and I contributed to some of his books including Decoding Medical Gobbledygook!

David Ballard, highly respected physician researcher, has been a great support ever since we met at Mayo Clinic in 1991 and over the years he has been my Go To person for health matters in USA. He also involved me in activities of International Society for Quality Assurance (ISQuA) where he later became the president also and continued supporting the Indian discussions through his role at Baylor Health

system in Dallas where he moved later. Due to an oversight on both our parts he could not come to India for an ICHA conference, as we forgot about visa. Akhil has also continued discussions with the Institute for Health Improvement (IHI), Boston which we started many years ago.

When the Global Association of Physicians of Indian Origin (GAPIO) was set up I became the lead for patient safety and one of the first thing we did was to take stock and outline a possible roadmap for the way forward; many colleagues from overseas and India contributed and for a while there a buzz around it (1). The hope was that those in India may be able to build on what we had done – our ability to do something practical ourselves was very limited. Of course ICHA was the main party I was relying on but it was nice to see have support from others, for example Anupam Sibal, Group Medical Director, Apollo, asked me to support the work his Group had started in Delhi to build capacity locally and Narendra Arora, leading clinical epidemiologist and researcher, at International Clinical Epidemiology Network (INCLEN) who asked Sukhmeet Panesar, public health doctor in UK who had joined me, and myself to support the infection control work and made us honorary associates of INCLEN.

Sonali and I later on worked on the Bhartiya Hospital System (BHS) project (see later) and we really got to the root of patient safety – she brought a wealth of experience from her time in the USA, and we combined our knowledge to 'Indianise' it.

I did not engage with the Care Quality Commission (CQC), the regulator, as I could not see a way of introducing the model into India where I had serious reservations about regulation given the weakness in governance generally. Although I was involved in the NABH scheme in India initially, and was pleased years later when Ramesh Mehta and Shubnum Singh had discussed joint working; there was much concern in India about the government policy of capping payments for certain procedures and which was a two–edged sword. I joined them for the discussions and their plan was to combine the experiences of NICE and CQC, a very good idea and the PWC (the international management consultant company) head who was helping them was Rana Mehta, a doctor, who knew the NHS.

Personally I was able to utilise my role with Peoples-uni (see later) and Joseph Mathew, now professor of paediatric in Chandigarh, developed the first online course on patient safety for general use, and ICHA did a specific programme via Peoples-uni for their members in India. This is now being further developed, this time with support from Johann Malawana, a UK doctor leader, who founded Medics Academy. Akhil, who has been my key partner, continues on the journey and I help wherever I can- we are like minded in terms of addressing the root causes of problems with patient safety, not just technical fixes but how to change the culture, and he has used the pandemic time to both, create a robust succession plan to continue ICHA's work and to start building trust through schemes like ICHA Mitra. I believe that there is a long way to go yet before patient safety becomes a priority in India, and it will require a multi-pronged long term strategy and that is why what ICHA is focussing on now is so important.

Public Health

I had been promoting public health from the beginning- it all started with the session at OPPI and then I interacted with the various government and professional bodies starting in Maharashtra (Mumbai) with Health leaders like PP Doke, Director of Health Services and All India Institute of Hygiene and Public Health (AIIHPH) and Indian Association of Preventive and Social Medicine (IAPSM) – basically whoever could educate me and figure out how to use me! I wrote articles and gave talks. I remember being asked to speak at the IAPSM conference being held in Delhi and had made fine adjustments to my trip to accommodate that, only to touch down and find a message on my blackberry (remember them!) to say that they had moved my session to the following day when I was already committed elsewhere. Overall I was struggling to figure out how to add value.

Although I had been involved in setting up the Hull York Medical School, was an honorary professor of public health at Hull University and was also a trainer for the Faculty of Public Health I had not been very active in academic public health. This all changed when I came to Manchester in 2005 and met Dick Heller, professor of public health at the university, who had set up the first online MPH there. Following his retirement he set up Peoples-uni (https://peoples-uni.org/) to provide affordable quality education to disadvantaged students, mainly in the low and middle income (LMIC) countries, I became the Chair of the Board for the Charity and worked closely with Dick.

Dick has a very strong academic background, having been a leader with INCLEN, the Rockefeller Initiative in the 1980s and knew India well. So we targeted India from the beginning of Peoples- uni. I knew of Srinath Reddy from Dick, as Srinath was another INCLEN alumni, and I had met him on a few occasions in Delhi – he was by then working to collaborate with UK higher education institutes; there was subsequently a project between PHFI and top ten UK public health departments to help build capacity in India, I was not a part it though I knew about it. I was, however, interested in PHFI, and Srinath invited me to the 'launch' of the Indian Institute of Public Health (IIPH) in Hyderabad – it was my first trip to that famous city which cost me dearly as I had to buy the obligatory pearls! This conference gave me further insights into the public health organisations and leaders in India – it appeared to me that PHFI was being set up as a parallel system, rather than working with existing institutes- some of which were good too. However I was keen to support PHFI and infact had actually written to Rajat Gupta, chief of Mckinsey (an international management company) in USA, who was instrumental in getting PHFI off the ground asking him if I could do an attachment with him (before he was jailed!), to further understand it!

So Dick and I went to India to meet various public health organisations in Delhi and then took a taxi (*sic*, it was looong day, and we got caught in the night traffic coming back into Delhi) to Chandigarh where Joseph Mathew took us to meet the dean at PGIMER. Preethi Pradhan, an academic (now in Chandigarh) who was then at Aravind Eye Centre joined as one of the first tutors from India, along with Joseph and

we used to meet them during annual get togethers in UK. Subsequently we had many more tutors and students from India through Peoples-uni. Fiona Reynolds, a public health specialist in England, came along when we signed an MOU with Doctors for You and the Public Health Resource Network (PHRN) in Delhi, supported by Sundararaman to provide education to their volunteers. They also took me to meet the leaders at the Indira Gandhi Open University (IGNOU) to explore collaboration for online learning. Vandana Prasad in Delhi who was another very committed champion of public health and well known, and especially for child health, invited me to speak about Peoples-uni at the get together of the voluntary sector public health leaders at one of the conferences in Ranchi. The conference was an eye-opener since I met some amazing people including Abhay Bang there. Sadly, I could not meet M S Dhoni, the famous cricketer, though they took me to see his house! Andy Bacon had also introduced me to Paul Holley at the Anglican Health Network who offered support, in the states where they operated.

Mala Rao was very keen to go to India and work with PHFI and we had a number of chats as she knew of my ‘connection’ with Srinath. I fully supported her plan when I met Srinath in his temporary office in Delhi, and was pleased that the Department of Health then funded Mala’s secondment to India. After she arrived in Hyderabad to set up the IIPH we had some discussions about aspects of public health where we could collaborate, though to be fair she was more knowledgeable about core public health practice in the UK as I had drifted into medical director roles and hence we concentrated on patient safety (see previous section). Also Sushma Acquilla, who was active within the Faculty of Public Health was helping with capacity building in India, and so was Raman Bedi, a former chief dental officer in England, who leads the Global Child Dental Fund.

In Delhi when I was working with Vivek Rae on patient safety, I also put together a proposal to him about linking all hospitals as part of a Public : Private Concordat to deal with surge in emergency admissions; some of the work was being done as part of the pilot for patient safety project anyway and could be extended.. At that time H1N1 was causing problems in Delhi, with private hospitals refusing admissions – there were many horror stories in the press. I had been responsible for emergency planning for my districts in the NHS and could not see any plans for Delhi. Years later after Satenydra Jain, Delhi Health Minister’s visit to Manchester, I again took this up with his team in Delhi – they were more concerned with access to care especially general practice and better management of government hospitals but emergency planning was not high priority. No shortage of plans - the National Rural Health Mission was later to be complemented by National Urban Health Mission, but huge gap between policy and implementation since there was neither the necessary funding nor any accountability. The recent pandemic has again shown the lack of preparedness and maybe now there will be a change.

In Gopalganj, Bihar, Mahima Pandey, GP in the NHS, was keen to set up a facility to support the community where he was born and had set up Indo-British Medical Association , and had asked my advice from a public health perspective. I followed this up with Vijay Gautam when he went to AIIMS, Patna and with Ravikant Singh as

his base is in Bihar. Overall, on the whole my involvement in any service public health work was very limited.

After Sundararaman moved to Tata Institute of Social Sciences (TISS) in Mumbai I met his faculty members to explore collaboration with Peoples-uni and we worked up a model, it helped me to interact with their students when I held masterclasses. In these, Nobhojit was helpful and also invited me to interact with the group of researchers he was mentoring. We had the tradition of retreating for drinks afterwards in the local equivalent of the pub and especially for the Blue Antiquity whisky (those were the days)!

In the UK I spent a lot of time with various bodies including universities and the Faculty of Public Health (FPH) to find ways of linking – Neil Squires at FPH was the chair of the global health group and tried to help, John Ashton was also supportive.

To complement above efforts, and by this stage I had become interested in history of medicine also (Emma Jones and (Late) John Pickstone had written a book on history of public health in Manchester for me), I decided to build on it by undertaking a project on learning the history of public health research capacity building. I got a grant from the Wellcome Foundation and went around interviewing various people across India and a few in the UK who were part of the PHFI UK collaborative; amongst many I interacted with Lalit Kant from ICMR, Ritu Priya and Rajib Dasgupta from JNU, and Ravi and Thelma Narayan from Sochara in Bengaluru. Mark Harrison, professor of history of medicine in Oxford and who was introduced to me by John Pickstone was especially helpful, he knew India well and connected me to the right people. As with some other things I tried, I found that everything that I could think of had been considered and in much more detail – the issue was not knowledge but implementation.

We ceased operating Peoples-uni in early 2021 and now are working on the next stages to add value through developing the alumni and moving beyond basic education giving. I have also been working with University of Salford for years supporting their MPH programme and where they get many Indian students and we are now developing the idea of providing ongoing support to their alumni, beyond the MPH. I am not happy with the Education system generally and believe that we need new models to support people in the 21st century as they will need life long learning and where reflection and personal development will play a crucial role.

I am particularly keen on the possibility to work in the north-east of India – I came to live in north Wales a few years ago and discovered a long and rich tradition of exchanges between Wales and north-east India, dating back to 1840s when the first missionaries went there. Infact 2022 is the centenary year of the Gordon Roberts Hospital that was established in Shillong. I have had a number of discussions including with Sandra Albert who heads the IIPH there and can not wait to get there to explore how to help. I hope I will do a better job than I did the first time- I was a district epidemiologist for the WHO's Plasmodium Falciparum Containment Programme in 1979-80, before I came to the UK, and was posted in Haflong, North Cachar Hills!

Workforce: Volunteering and recruitment

From the beginning, especially after my early forays and conferences like the East West Conference in Hull I had become convinced that there was much to be learnt from India (and vice versa) and had been encouraging people to Go East. I was aware of the strong and long tradition of clinicians, not just Indians, from the NHS going to India for charity work running camps and knowledge exchanges including through their formal professional bodies such as the Royal Colleges/Associations. I could not figure out a structured way to add value here till mid 2000s when I was the medical director in Manchester. I became aware of the Wythenshawe Hospital's plan to establish their link with Gulu, Uganda and persuaded the Primary Care Trust (PCT) to contribute financially to this venture; this introduced me to people like Stephen Hawes, Darren Walter, Marion Surgenor, Ged Byrne, Tony Redmond and Simon Mardell. The Trust chair(wo)man Felicity Goodie was particularly keen on global health. At the same time Andy Bacon with Peter Mount, Chairman of Central Manchester Trust and Gaye Jackson, NHS manager, was flying the flag for global health and volunteering in the north west. I had been working closely with Andy who also had a soft spot for India, and as it happened Jan, his wife, volunteered (still) in Goa. After early discussions between Ged, Andy and I, we had a session with Nigel Crisp who came over to help us plan; Ged being a proper academic was also keen on evaluating any such projects.

There were some workshops then, and visits from overseas, for example, from Ethiopia (with a small grant from Tropical Health and Education Trust - THET) and China apart from some focussed work on India whilst Ged and Marion continued to develop the Gulu link; Marion was particularly active and a frequent flyer on the route! The workshop we then held to test the waters around India was very interesting and drew out a number of existing UK initiatives; the event itself was difficult for me as my brother in law, David, had died the night before. I had taken Julie Storr, another global health champion, and Hilary Klonin out for dinner when the news came and I had to dash off and did not get back till early morning. None the less, the workshop went off well, we had Devi Shetty via VC, as always good value, and we also had Nobhojit Roy in person who was introduced to me by Tony Redmond, for his global health work. Whilst supportive he was also challenging about the motive and aspirations of volunteers- he was not in favour of good intentioned enthusiasts who sometimes were not equipped; his example being people turning up for disaster relief without knowledge of terrain or language, with fixed ideas of what they wanted to do and needed looking after with bottled water etc; more a burden than help he had rather they saved the money and sent it to those on the ground. Nobhojit has no time for 'Champagne Socialists' and I got the feeling that he did not know what to make of me and kind of 'indulges' me! I am actually agnostic- I work with anyone who shares the same goal, for me it is thrill of doing something useful with people who trust and respect each other. To some extent Simon Mardell also picked up on Nobhojit's theme when he used to talk about neglected processes (measuring respiratory rate in the absence of chest Xrays which was a luxury, for example) and which most western doctors were

unfamiliar with (a fact that came home to Aaron, my son, when he went to Gulu years later after working in New Zealand and Australia, having qualified from Manchester). Tony was another powerful influence with vast experience including in conflict zones and his example of amputations vs limb salvage surgery as a cultural difference between Cuban (known internationally for their humanitarian work, a system I admired though never visited) and western doctors has stayed with me. Mukesh Kapila who had overseen the UN efforts in Sudan along with many other international conflicts, and was then working with Red Cross in Geneva, was particularly inspirational; his book Against a tide of evil really impressed me. I was a pygmy among these giants, and felt very honoured to have their support.

I have gone into these in some detail since the learning, not having any direct recent experience of working in such challenging circumstances, was to inform my thinking and work. Thankfully Ged was similarly inclined and we were also fortunate in securing funds from the Greater Manchester Health Innovation and Education (GMHIEC) Cluster that I chaired and Ged was a member (all done properly!) and we spent time working out the Manchester Centre for Global Health Volunteering – with some endorsement by Nigel Crisp. Basically we wondered about extending Tony's excellent model at HCRI and explore the synergy between volunteers for conflict with peace time activities. Jenni Powis, an experienced NHS professional, agreed to work for peanuts (our budget was tight) and between Tony's work and Gulu link we learnt a lot. At the same time I was trying to figure out a model for placements in India, Nobhojit supports DFY and there were a few others, not just NGOs, and we offered to support the existing charitable links. I met the chief at the Voluntary Health Association of India (VHAI), the umbrella body in India to explore placements for our volunteering plans.

Our aim was to add value to the work of others and we identified a number of areas for this including supporting volunteers acquire basic public health knowledge – what was noticeable was that regardless of their professional background: surgeon or nurse they all began to realise that the greatest need in LMICs was for public health. I was able to leverage my position with Peoples-uni and with Dick's help we created self study courses on various aspects of public health and professionalism and ethics, and tried to work with THET and Health Education England (HEE) where Ged later on became the lead for global health, to adopt these for wider dissemination.

I went around the UK doing sessions with various organisations including the Faculty of Public Health, Academy of Medical Royal Colleges, Royal Society of Medicine and the Department of Health's NHS International Group group, for example.

Along the way the volunteering project morphed into capacity building and workforce recruitment esp as by this time in early 2010s Ged had begun to make inroads through his new position within HEE, and we set up the Global Health Exchange (GHE) which I directed and during this time we undertook work which then led to the Earn, Learn and Return type schemes and GHE became core to the HEE. Before then Ged had brought in Louise Ackers to do the evaluation, and based on her experience and research in Africa wanted to develop the model for India. So Ged, Rose McCarthy and Gill Colgan - from University of Salford- and I went to Bengaluru

and met the range of organisations from providers like NH, Ramaiah Medical College where my classfellow, AC Ashok was the dean, to the Karnataka University of Health Sciences (KUHS). Although Ged had been to India before, having spent time in Chennai during his training, it was interesting to see the cultural differences. One particular time we had arranged to meet with KUHS and having had our breakfast at the hotel arrived at the venue to be greeted by the senior faculty who had all dressed up for the occasion and laid out a formal Indian breakfast, with some of us dressed rather informally in holiday attire, I never saw the pictures that were taken to mark the event but am sure the contrast would have been noticeable. Not that it damaged anything since Ged was able to build on it – he has a romantic spot for India and the side trip to Mysore during the Dusshera festival further convinced him *(sic*) and he has been a frequent flyer since we worked together in the early part.

Gill also travelled to Delhi where we met Mahesh Misra, then Director of AIIMS and Shubnum Singh at Max to discuss the pilot project that Ged had secured funding for- the idea being to send student nurses and evaluating their experience of placements in Indian systems, in the first phase. Lucie Byrne Davies at Manchester University became the lead for evaluations for GHE then also.

As a result of these and based on my previous work I put together the paper for Ged to discuss with HEE Board; Keith Pearson, Chair and Ian Cumming, Chief Executive (Appendix 3) then went off to India with Ged and set the system up to start this project. The international project has grown substantially since then, and not just in India. Meantime I focussed on bringing Ged up to date with India, he is a fast learner and makes connections quickly. I was playing for broke, and wanted to get this absolutely right. I remember taking him and Chas, his brother, to meet Ajay Rajan Gupta for dinner in London; Ged also went to Dubai to follow up with Nobhoji at the global surgery conference; and we met with colleagues from RSM (Royal Society of Medicine) and THET, for example among others. Most importantly I encouraged GHE engagement with BAPIO's plan for Indo: UK collaborations, the roundtable at the BAPIO annual conference in Birmingham that I organised where the key people from India attended was instrumental in getting the collaboration going and has since been followed up through the regular Indo-UK health conferences.

There was a lot more that we did as part of setting up the GHE which went beyond India including the early work to support UK Overseas Territories and it was good to see that it had been built on and came in useful during the pandemic; my old colleague Autilia Newton was the Public Health England (PHE) 's link person for this; or the work in Uganda and Myanmar- the latter was personally dear to me as I had spent part of my childhood in Yangon (Rangoon then), and although I did visit Uganda I did not go to Myanmar (officially, though I did visit there in 2016 as a tourist to show my son where I had grown up). Going to Uganda was particularly important as Ged and I spent a lot of time together on that trip and I remember the discussions we had at the airports between flights - he is also a doodler like me and always building on what he sees/hears and we were fortunate to have time with Nigel in Kampala as he was staying at the same hotel to rehearse our plans for India. The NHS, in its widest sense, can be good once it gets past the early reluctance and teething troubles, and Ged was (is) good at overcoming these.

After leaving the GHE, and which later on became part of HEE, I reconnected with the project, in another development when I joined the Apollo Team for their Apollo Buckingham Health Sciences Campus (ABHSC) in Crewe in 2019 since HEE's original partner in India was Apollo and the Campus was being used to support the nurses coming from overseas for further training till they qualified to start working in the NHS. Now a days, I am grateful that there are global exchanges (albeit still not enough) since health care workforce is such a critical issue for health systems strengthening.

I wish that our efforts to support volunteering were more successful – what has happened in India during the second wave of the pandemic has been tragic. The failure of government systems there meant that it was all left to citizens and NGOs, DFY is now the largest medical humanitarian organisation in India, and have been propping up the fragile health systems. They could have done with some help from overseas healthcare workers also; I do recognise that there were many UK doctors and organisations like BAPIO and BIDA providing clinical support in India, and DFY did get financial assistance for example from British Asian Trust (BAT). I only lament that had we had the volunteering centre combining disaster and elective volunteering, and prepared them as was intended, we would have had a larger 'supply' of critical workforce. As always, the problems of it is too early until it is too late and personalities with resultant lack of preparedness. The more successful initiatives during the recent efforts have built on what was there- designing new systems and gaining trust in chaos is hard/wasteful. The recent cuts in the UK Foreign Aid are terrible, we forget that we are not doing it for them, we support less fortunate because it is in our interest. Perhaps an independent review of the UK's global engagement work in health would help to settle the question, there is certainly a lot of effort but equally room for efficiency to enable more to be done, with learning from last few years including HEE's work which should provide useful data also.

Service provision

I was aware of lot of clinical work being done between India and UK through efforts of various doctors in the NHS, and these covered the range of specialties and I saw some good examples in orthopaedic surgery, cleft lip and palate, ENT, emergency medicine and mental health. The area that interested me most was primary care. I knew about Max Health system's original plans to be primary care based but then there was a gap- the business model for primary care did (does) not exist in India, though there was a great need. Later on some people started trying again: Santanu Chattopadhyay, a gastroenterologist with an MBA from INSEAD went from the UK to found Nationwide Primary Healthcare; Lohith Shivateja, a GP in UK went to start his clinics in Bengaluru; and the well known surgeon Gautam Sen with his son, Kaushik, well qualified management consultant, started Health Spring chain of primary care centres. I visited them, and there were some others too, and was impressed with their plans, Gautam kindly asked me to the opening ceremony of their first clinic in Mumbai too. I tried to find ways to support them and discovered the RCGP plans for India – Kay Mohanna, academic GP was then at Keele and we had already met for my work with Peoples-uni and she was active with RCGP's international work including in India and then there were Liz Goodburn, Sandra Maher and Petra Wahr from the whole RCGP team. In India colleagues were getting organised and formed the Academy of Family Physicians of India. Later on when I was establishing the GHE I became aware of the work by Robin White who had developed a scheme to enable GP trainees to spend time in South Africa as part of their training, and Neil Squires and others were actively trying to explore further options. I used to talk to all sorts of people – whether it was physiotherapists or speech and language therapy, palliative care, rehabilitation services and share and connect whereever I could- it was a scatter gun approach, in the hope that some/one may succeed, in the absence of anything tangible that I could do.

Overall, Indian health system is complex, with a mix of schemes from government to private and employer run schemes like Employee State Insurance (ESI) or Central Government Health Scheme (CGHS) with a lot of small nursing homes – family run ones. There is no way I can even begin to describe it here although Akhil used to educate me! Everything exists in India, some good, many poor, and just not enough. Apart from the government sector with their attempts to provide comprehensive care of questionable variety due to very low investment, the vagaries of the market meant that everyone was trying to find a viable niche. There were good examples in almost every aspect of health services. I visited many of these including the GVK EMRI- the emergency response scheme in Hyderabad where Bujja Rao, another of the Commonwealth fellows took me; Pervez Ahmad also started urgentcare clinics after leaving Max or NIMHANS the top mental health and neurological institute where my class fellow Santosh Chaturvedi was a professor, he had trained at Christie's in Manchester for example. Infact there were so many developments as younger Indians having visited and often trained overseas were coming back to try and help improve the situation.

Overall, although I interacted with a large number of providers in India, including Apollo, Max, Narayana Hrudylaya, Fortis, Medanta, Manipal, Columbia Asia in the corporate sector, and Aravind Eye Care, Fernandes Hospital in Hyderabad and public sector institutions including the AIIMS and my own almamater, I had no involvement in service provision. I, however, did small amounts of work with Sitaram Bhartia Hospital in Delhi and Breach Candy Hospital in Mumbai around patient safety and quality, and Muir Gray also came to speak to the staff at Breach Candy. I was particularly keen on my own alma mater which has the potential to be a world class academic health centre with its range of services and educational establishment; and I lobbied the dean and hospital chiefs.

But then something very interesting happened; my dear friend Arvind Agarwal, a cardiologist in New York was puzzled when I left the NHS in my mid 50s and suggested I help his cousin who was developing a 'mini-city' in Bengaluru, and who wanted a hospital, along with other services for the residents and workers of Bhartiya City (not to be confused with Bhartia Hospital earlier). So off I went to meet Snehdeep Aggarwal at the Hilton hotel in Delhi and over tea and cookies (there must be cookies with tea!) we had a chat. I had had many such conversations over the years and did not think much of it. Except he came back and asked me to lead his project; he had serious reservations about the state of health care in India and wanted to prove that things could be done differently. He gave me free reign to develop the project so long as I adhered to four rules: create something that does not exist, make it truly patient centric, the facility should be for patients from anywhere – not geographically constrained, and be financially viable. It was a dream project. I wont go into all the details and only want to pick up the bits relevant to the story here.

To begin with, a bit about Snehdeep whom I found in equal measures to be inspiring and frustrating; he is successful in his core business of fashion accessories and had moved into real estate and remained true to his eye for detail, meticulous planning and execution and of being a designer at heart. Now, I was not new to design thinking- having first come across this at the Mayo Clinic where I was fascinated with Henry Plummer's work in association with the Mayo brothers and over the years in the NHS had been engaged in it including business process reengineering from the time Peter Homa, a very senior NHS manager, started it at Leicester. But I hit two blocks : Snehdeep did not think much of the NHS and was keen on USA players although he wanted to search globally for best ideas and practices, and I was stuck in my own ways of thinking and working. Most of my early time, therefore, went on unlearning what I knew so far – or rather relearning my own learning to take out the core messages from my experiences in the NHS and abroad given his rule of designing what does not exist (think Steve Jobs and iphone, and our favourite quote was by Henry Ford who quipped about faster horses and not cars if asked, as people could not see cars – another reason why I do not like focus groups). People only believe it when they see it- and Snehdeep, though could not describe what he wanted not being in the health business, knew what he did not want.

Between Snehdeep and I, we scouted the world, many times travelling to see centres of excellence, quite a bit in the USA including Henry Ford System, Cleveland

Clinic, Mayo Clinic and Virginia Mason System in Seattle and also the IHI. Along with Sonali Vaid, who joined me, I undertook extensive literature reviews and gathered information via contacts- she is well connected having travelled and worked internationally professionally. We soon realised we were truly alone, and apart from once in Christchurch, New Zealand where after the 2011 earthquake there was an attempt to start afresh with new health system, most of the thinking and planning of health systems was incremental changes, not radical, despite talks of transformational change. I was totally with Snehdeep on his four rules and to quote Late president Abdul Kalam: Dreams are not what you have when asleep, dreams are what keep you awake; I was all fired up, and the project became my obsession.

I want to describe a bit of this project, albeit briefly, as it has important lessons for my own reflection and generally. I was keen to try and capture everything succinctly – being a doodling guy, thinking in pictures often.

We started with a list of things that we felt patients should have whenever they came into any contact- short or longer term – with the Bhartiya Health System (BHS); we looked at statements about patient centricity of major hospital systems globally and added features unique to the Indian setting. Everyone espouses patient centricity but what did it mean in practice?

This was our list

- We will provide excellent and safe clinical care.
- We will listen to and respect your feelings, needs, values and preferences.
- We will be your custodian till you choose to opt out.
- We will be transparent about your clinical care
- We will be transparent about your billing and financial matters.
- We will ensure your physical comfort and convenience.
- We will ensure ease of access to care.
- We will recognize and encourage family and community involvement in care.
- We will use nature, art, humor, and play to aid the healing process.

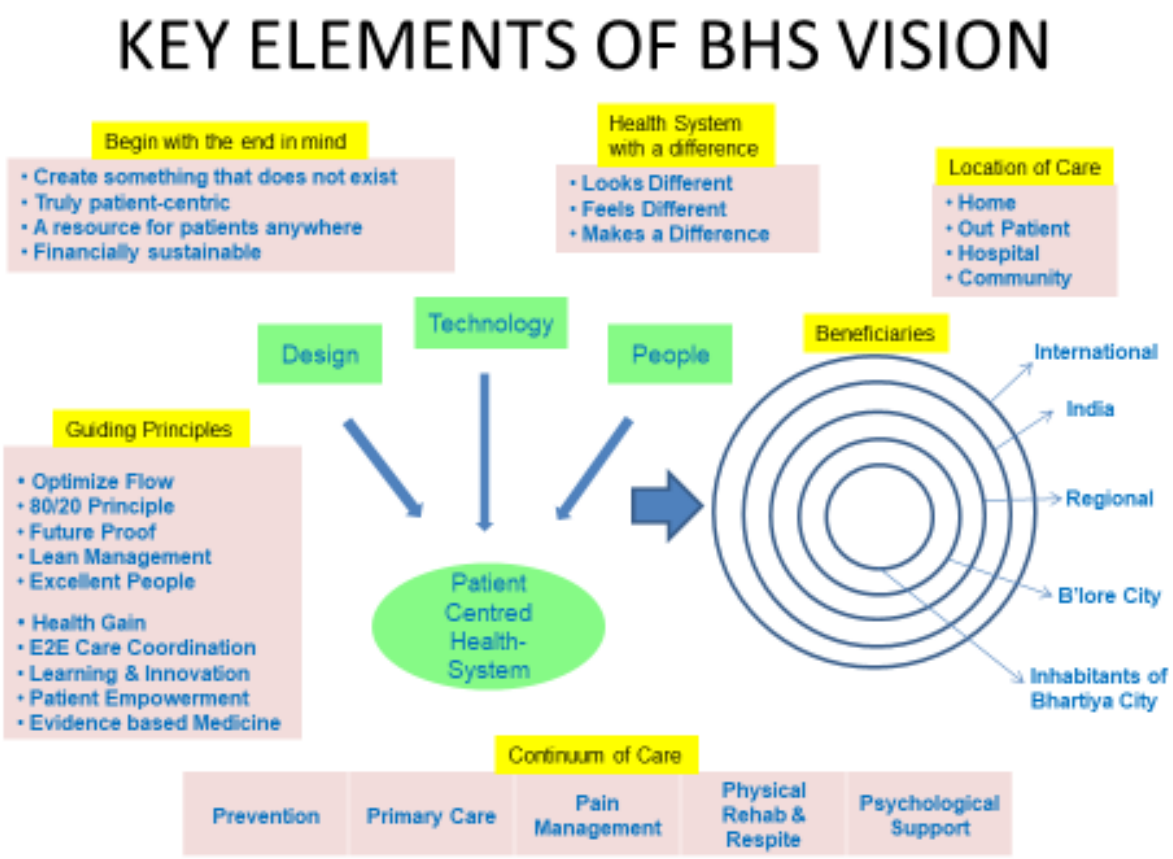
To ensure that these promises could be translated into reality, we defined every key word and broke the promises into SMART objectives and for each of these objectives we used a combination of design of physical spaces, policies and processes supported by technology and then practised by professionals. So we completely broke down the health system into its component parts and built it up again. It was a very stimulating experience intellectually, having to constantly challenge own assumptions and experiences.

Overall, we designed a system that looked different, felt different and made a difference.

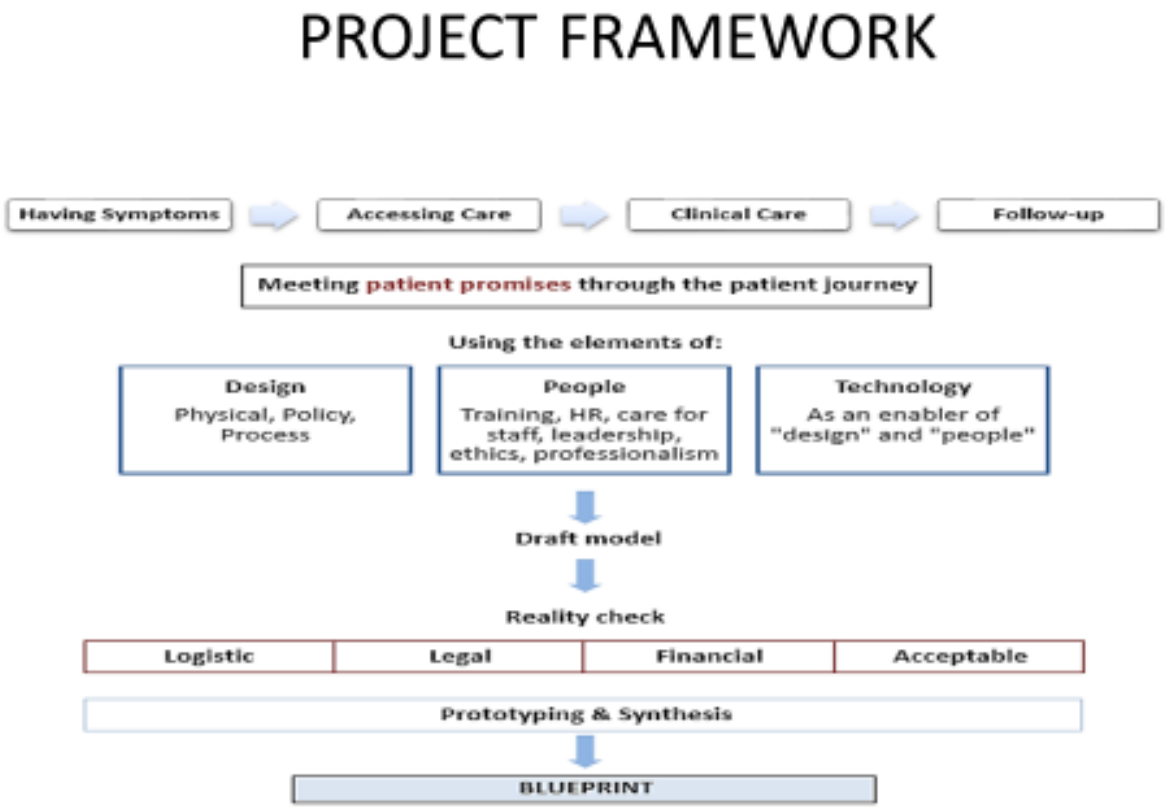
We wanted to move away from the usual model of seeing what the doctors wanted first which was the problem in creating the transformation, we bet on the fact that there are enough like minded people who will join in, if we got the model right. Design was crucial and which could be supported by technology- a lesson still not learnt in the NHS especially with the Connecting for Health (I had worked as the medical director at Computer Science Corporation (CSC) who were the largest provider for what was then known as the National Programme for IT –NPfIT) and

where technology was being used to re-design the processes; did not work, duh. Having been responsible for clinical governance in my NHS jobs, sadly looking at too many complaints and also having been at the GMC I could see how and where things went wrong, but these were very hard to correct in established systems with their entrenched cultures whereas BHS offered a completely fresh start. We were encouraged in this by many examples and by the fact that the Mayo Clinic which was supporting us was a prime example where a combination of doctors, the Mayo Brothers; an engineer, Henry Plummer; and an administrator, Bill Harwick, had managed to start something which has become the best health system in the world. This trio of doctors, engineers and administrators to me is the answer, another one the NHS ignores.

The figure below encapsulates the whole plan.



We were also interested in how Mayo Clinic operated and I combined their ways of project management with my own experiences from the NHS- I felt that the latter were more relevant here. I had been advocating the need to take the NHS to India for sometime – Appendix 4 is the letter published in the BMJ. The constant reorganisations and upheavals in the NHS, as opposed to a steady Mayo Clinic, though were personally painful when I went through them were helpful given that I was in uncertain situations in India. The only way to conceive the project was keeping an eye on all four rules simultaneously, and this dictated the project framework which went from ideal - through imagination to design - to reality check before arriving at the final model.



I was quite radical about how clinical services should be organised- not in specialties but in bundles of care as per patient needs and presentations, and tried to reimagine service organisation by combining the problem based teaching of medicine with reengineering of emergency departments or organisation of cancer care in the NHS for example, with how the Mayo clinical services work. The NHS with its coverage of the whole patient journey from primary to tertiary care via community services as necessary, though more in theory than practice, offered advantages.

Now what has all this to do with the theme of this anthology? The simple answer is that if I had not been in the NHS I would not have had the knowledge and experience – in my early years I had already published ideas like Facilitating Units – which predate the Medical/Acute admissions units in the NHS and the Common Waiting Lists model to pool patients and over the years had built on such thinking (the compendium of my reflective writings has details of these). I was helped by the NHS, not just when I was able to go to Mayo Clinic during my training but over the years through various courses be they about leadership or complexity theories and service redesigns. I interacted with a number of people from the UK in developing the model, amongst others there were Terry Young, Associate Dean for Health Partnerships from Brunel University; Andrew Foster, CEO of Wigan, Wrightington and Leigh NHS Trust; Chelliah Selvasekar, consultant colorectal surgeon at The Christie's Hospital who had also worked at the Mayo Clinic; Promod Bhatnagar with his vast experience of innovative private healthcare provision in England: Niraj Mangalam who had moved to India to set up private hospitals there; and Arpan

Guha, consultant anaesthetist and an academic from Liverpool; and Ged actually visited Bengaluru and met the Bhartiya Team.

The project was part of Snehdeep's longer term vision and has been on hold as the real estate development was a priority- in his typical way of working he was looking decades ahead and clarifying how to do his hospital in line with his thinking. I feel that the change in India will come from someone like him, not the established players who will do things incrementally being reluctant to introduce radical transformation. I do not know if Snehdeep will return to this project, but it is only a matter of time when someone will step up to change the game there. I personally feel it is a win:win but then it is not my investment on line though it is my 'reputation', something more valuable! The one consolation is that the primary care centre in Bhartiya City is being run by Lohith Shivateja – and in the grand scheme of things it is not a bad start, the seeds of NHS are there!

If ever there was a project which would have changed my mind about relocating to India for some time, this would have been it. I had freed myself up from other work to focus on it, and really wanted it to succeed. I have major reservations about the state of medical practice in India and although happy to see many smaller enterprises changing the culture slowly, I wanted to be a part of that movement. Whilst crediting many others and especially the Mayo Clinic I believe that how I worked was most influenced by my time in the NHS. I have a love:hate relationship with it. The NHS often comes up among the best system in major league tables internationally but it is not the best system possible because of fundamental design problems (Appendix 5), and some of these have become clearer to me due to my need to understand and explain the NHS to people.

Leadership development

Along the way I began to reflect on the work I was doing and which was also changing me as I met more people and I have been very fortunate to have learnt from some great thinkers and practitioners. It was becoming apparent to me that whilst technical knowledge transfers and system capacity building were essential, in the end what was needed was leadership, and in particular thought leadership, about transformation and change.

According to many critical observers the Indian health system is completely broken and unfit – services are inaccessible or unaffordable, education is lagging and good quality research is non-existent. I could see much of this myself, but I was also able to see the other side, where so much good was still being done by very committed people. Evita Fernandes ran one of the most advanced maternal health system in Hyderabad, Nikhil Datar had introduced fixed fee model for pregnancy to allay concerns about unnecessary caesarean sections and Abhishek Bhartia was considering this, along with the scale models of Devi Shetty and Aravind for example. I felt that what is in India is no different to many western countries with inequalties or corruption –it is no longer inter- but intra-countries inequalities and divided societies with vulnerable being increasingly left behind, and it was futile to get sucked into such discussions. A better use of my time, at the later stages of my journey, was in helping build the leadership for change by combining the best of both worlds (and infact globally) to create the new change agents.

The non-judgmental, but not blind, approach, to helping had first struck me when I started working with Dick on Peoples-uni and reinforced by people like Nobhojit and Akhil. I had already done a number of leadership courses in the NHS including the holistic one like the Common Purpose Matrix programme in Manchester, and the thinking had influenced the creation the India Manchester Graduate Network (Appendix 6) . I was using all my visits to connect with other thinkers in India and in the UK including British Asian Trust and Common Purpose for example, and raising awareness of the need to invest in health and education as the two biggest issues of the millennium.

I was particularly impressed by the work being done by the Indian Journal of Medical Ethics and interacted with many of their leaders. Sadly due to a domestic issue I had to turn back from the airport on my way to their bioethics conference in Bengaluru once where there was a particular session on corruption in healthcare, something of interest to me. I did contribute my own work to the Journal – from my experience of trying the profession to reflect through my Milroy Lecture in 2003: Doctors in the new millennium: Hippocrates or hypocrites (2) and from my time at the GMC (3). I was keen to engage the GMC for my India efforts and put together the paper in Appendix 7 for discussions.

Through Peoples-uni I teamed up with Roger Worthington, an internationally renowned ethicist, and who struck chords with me with his deep understanding of Indian culture (he has read the Indian classics, and is a sitar player on top) and who challenged the unquestioning promotion of fixed models of teaching ethics. Not only

then he took up the work that Chandrasekhar had done to mobilise a group of people interested in ethics in India to develop a self study course for Peoples-uni, he also travelled with me to Kolkata at the request of Manjari Chakravorty from the UK Deputy High Commissioner's office for a 3 days workshop. We also went to Delhi at the request of Bipin Batra who was then the chief executive of National Board of Examiners.

Having joined the executive committee of GAPIO and been further exposed to the high level Indian ways of working I became more convinced about the need to promote professionalism and ethics in India; I felt that everything else was going to be a sticking plaster and not sustainable unless there was a huge cultural shift. Plans were hatched with Amar Jesani and Nobhojit Roy, who are great role models– they walked the talk. Given my role at GAPIO I wanted to bring in not just the UK diaspora but the global medical diaspora. We held a successful conference on the eve of another GAPIO annual conference in Kolkata and followed it up later in the mid-year conference in New Jersey. I was not naive enough to think that my own effort would create any major change, and in anycase I could see that there were clear tensions, with people like Kunal Saha who had challenged the medical establishment in Kolkata refusing to attend due to his concerns about some of the senior figures involved with the conference. I have attached the report (at the end) we had prepared for the conference as a way of sharing my own thinking at the time and which I feel is still valid. Sonali was very helpful with the workshop and later on. It was very hard/impossible to bridge the corporate/public and NGO's sectors divides, with various personalities tied into different ideologies, and my ability to engineer any lasting collaboration was severely limited.

I was the first member of the Faculty of Medical Leadership and Management (FMLM) in UK when it was set up and had stayed in touch with Peter Lees, Director of FMLM, whom I had known since we were both medical directors of SHAs in the NHS in early 2000s. I spoke to him about a home for taking forward the work I was doing and as advised I sent him the paper (Appendix 8) to enable him to steer it through the system. More recently after I joined the Apollo team in Crewe I updated him especially as Anupam Sibal has done further work as the current Chairman of GAPIO – with their leadership courses throughout India to promote professionalism.

I am pleased to see the Mashaal initiative led by Anurag Mishra from my almamater in Delhi, with support from Nobhojit, to develop future leaders, and also Akhil's work via ICHA. If only we could clone some of these people - where is the science when you need it; the world, and health system, is crying for a new leadership.

Working methods

Working with BAPIO

I was sitting at home at the weekend in early 2009 when the phone rang, this is Ramesh Mehta from BAPIO said the caller, Of course I had known about BAPIO from the time when they fought the visa case for overseas doctors in 2006 and contributed to the fund but I had not followed it up subsequently. He was calling to ask me to speak at the BAPIO annual conference, seemingly the arranged speaker was no longer available; he said Raj Bhopal, professor of public health in Edinburgh, had recommended my name. In a quandary as I had asked Sunil Uphadhay and his family for lunch that day to welcome their new daughter in law – Nidhi who had married Saurabh. Sunil and I went way back to the time when I had gone to Glasgow for my primary FRCS exams in the early 1980s where he was working in radiation oncology – I stayed with him in the mobile home in the grounds of the Stobhill Hospital which was the doctors accommodation (*sic*); infact he and Savita were such good hosts that I went again! And we worked together when I was the DPH in Hull. Anyway he understood and we rescheduled it for the week after.

I duly turned up at the Royal College of Physicians in London on the day, to be welcomed by Raman Bedi, the then chairman and met Ramesh – the Indianness of the event with its pomp (not as grand as it became later on as the organisation grew, but still impressive). I was nervous not knowing what was required and Richard Smith, BMJ Editor, was the other speaker- pressure. But it seems my talk went down well; the summary of my talk is in the article I wrote then (Appendix 9**)**.

Subsequently I had another call from Ramesh asking me to go down to Bedford where the BAPIO Executive was having their annual meeting including deciding on new office bearers. Intrigued I went and after being introduced to the team was told to wait, and then recalled to be anointed as the new Chairman. I was flattered and surprised since I was following Raman Bedi, the previous Chief Dental Officer, and here I was, a jobbing public health doctor, albeit I was on the GMC Council.

Now the surprising bit is due to the fact that I had so far refrained from joining any organisations- I had briefly toyed with the BMA's Public Health Committee and with the Faculty of Public Health's Policy Committee but on the whole I was uncomfortable getting 'boxed' into a particular 'ideology'. I was aware of British International Doctors Association (BIDA, previously Overseas Doctors Association – ODA) and the Indian Medical Association (IMA), and used to read about them and occasionally engaged, apart from my own medical college Association (MAMCOS-UK). GMC was to me a separate matter since I felt that it was there to balance the support for doctors with protecting patients (my views on my time with the GMC have been published and available in the compendium of my reflective writings) and I only applied when there was an open competition- ours was the first time the Council members were selected not elected by doctors. So I had another quandary, and I remember speaking to Mala Rao in Hyderabad, she is smarter than me and encouraged me. In any case I was partly flattered and also could see a way to build

on the work I had been doing on Indo- UK front for many years. I had begun to realise that an organisational base was important to not just build on my work but also create a sustainable mechanism- which did not rely on me alone. I was at the peak of my career (literally as it turned out in the NHS, another story). It seemed like a good fit and so I joined as the Chairman in 2009, the position was (seemingly!) advisory, and (was) largely in Ramesh's gift.

Apart from attending the 'Diwali' functions and giving awards to children (and selected leaders at the annual conferences), I was curious about what was required and how to add value. I joked with Ramesh about BAPIO- as it could have been interpreted as the Bedford Association of Physicians of Indian Origin and British Association of Paediatricians of Indian Origin, as these two were the main constituents then. But Ramesh was not one for standing still and had other plans, including scaling it up both geographically and functionally.

Although I was involved in all BAPIO matters including race inequality which took a lot of time and we fought (and lost) the (infamous) GP examination case in 2014, I had two fundamental reservations about race discrimination: one, that it was tragic and a blot on the society and we should do our best to address it and two, that the usual approaches were not the solutions. Indeed the solutions were perpetuating the discrimination – as the target kept changing, with more and more segmentation and each group trying to suppress the other, and in the end, those who needed the support most were getting further behind. The whole system was broken and these initiatives whilst giving the impression that something was being done created more problems.

I was also very actively involved with the Medical Defense Shield (MDS), the organisation set up by BAPIO to provide professional indemnity, which was going through a challenging period, to the extent that I did not pursue a second term at the GMC (as it happened none of the three BME members from my time had a second term, Johann, like me, had decided not to apply and Iqbal Singh who did was not successful) and ended up running the organisation for some time. I was also interested in the learning from this for potential use in India to promote discussions around professionalism and ethics as Nikhil Datar, one of the Commonwealth Fellows, was also a qualified lawyer and very active in medico-legal work in Mumbai and particularly around women's issues. Paul Lambden who was one of the key MDS advisors had also written a useful book which appealed to the Indian doctors. And I had many discussions with Rashmi Iyer, Raman's friend in banking services in Mumbai, about professional indemnity insurance. Such work influenced me to find ways of supporting doctors in other ways and I undertook some work on suicides by doctors and then lobbied for these incidents (and not just doctors but all healthcare workers affected by an investigation) to be declared a 'Never Event'.

However, rather than talk about all my work with BAPIO I want to focus on Indo:UK collaborations which is relevant to this story. By the time I took over as the Chairman, I had already done a fair amount of work to promote links between the NHS and Indian health system and we started discussing future developments. By this time Ramesh was very actively pursuing the establishment of GAPIO (Global

Association of Physicians of Indian Origin) a joint venture between BAPIO, APPI (American Association of Physicians of Indian Origin) and the Apollo Hospitals Group, and where my predecessor, Raman Bedi, had been actively involved. I also threw myself into it, and remember sitting with Ramesh, Satheesh Matthew and Buddhdev Pandya at the GMC offices in London one evening (we managed to secure a meeting room, though it was not well received) to thresh out the vision and objectives- basically Ramesh was doing most of the running on behalf of the partners at the time.

After a lot of work, and I credit Ramesh, GAPIO was launched and I joined as one of the (Life!) Executive Committee members, I was excited as it got me in touch with other significant health care leaders like Nandkumar Jairam of the Columbia Asia Group and Ramakant Panda of the Asian Heart in Mumbai. I found a particular niche which was my interest in patient safety and I became the GAPIO lead- it was an opportunity to learn more and connect with people from across the globe and after two rounds of meetings in India and USA we put out our analysis of the situation and the way forward (see clinical quality and patient safety section). I did try and engage public and voluntary sectors into GAPIO's plans but in the main, it was seen as the corporate sector initiative.

In doing the above work I also began to realise that whilst technical knowledge transfer was important especially as WHO had launched the Global Patient Safety Challenge goals starting with Handwashing, much of this, given the scale of India, was of limited use. Talks of western systems when even simply water supply was erratic seemed wrong, and what was needed was Indian solutions – the frugal innovations and which was being done by various organisations especially philanthropic ones. So I started thinking about other ways to add value and to accelerate Indian plans to develop future leaders, who were fit for leading in India (see the leadership section also).

Simultaneously Ramesh and I spoke about BAPIO's work to support India and the NHS, over and above the work with GAPIO. There were many initiatives, Ramesh himself was very active with Royal College of Paediatrics and Child Health and had been their lead examiner for India for example and many others were similarly involved. We decided to explore the synergies between these and create a mechanism for bringing such mechanisms together; and I then spent quite a lot of time in pulling together the first Indo:UK Collaboration for health conference through BAPIO in Manchester. I was able to get Ravikant Singh, Akhil Sangal and (Late) KK Aggarwal among others to come and participate also. This was another initiative which made me proud and hopeful for the future- with so much goodwill how could we lose! I tried to build on these when discussions started about forming links around accident and emergency medicine and met vice chancellors of some of the health universities, with the intention to integrate these with GHE's work.

My term came to end in 2015, Ramesh suggested I continue but life had moved on and BAPIO was in a different place to the one when I joined it. May be it was me, but it was definitely not advisory (*sic*), it took a lot of time! I also feel that though continuity is important new blood is needed periodically. I had already left GAPIO a

year earlier; although a prestigious position it did not offer me any clear mechanisms to take forward what I am interested in - and which is making a difference practically. Ramesh takes a pragmatic view of things and finds the balance between activism and establishment, and keeps BAPIO moving forward. I have been particularly impressed with the work being done recently during the pandemic by BAPIO in UK to mobilise support for India.

Working in UK and especially Manchester

In addition to those already mentioned, Parveen Kumar, well known academic and author of the famous Kumar and Clarke Textbook of Medicine and Babulal Sethia, an eminent surgeon who were then connected with RSM were very supportive and keen to explore how RSM could be involved and we had a number of discussions. Ajay Rajan Gupta had run a very successful conference on Indo:UK health collaborations at the RSM at the time. I was partly keen on it as membership of RSM allowed one to use the Cricket Club in Mumbai – one of my favourite places which I could only visit through my friend, VIjay Belani, who lives in Mumbai – as part of reciprocal arrangement! Outside of the NHS I engaged with the British Asian Trust, partly with help from Vikas Shah who was also active with TIE (The Indus Entrepreneur); THET; the Commonwealth Fund; and the Wellcome Trust- I was excited when the latter made a film about traditional Indian medicine (Tabiyat is on https://www.youtube.com/watch?v=fnK0Wv01zb4). Cochrane Murray ran the Department of Health umbrella group on global health and all the main players were members- he invited me to present my work on India. Basically I tried to find out as much as I could about what was going on in the UK about working in India and there is a LOT – I wish there was a proper system to monitor and coordinate things around health, as I could see so much duplication and unsuccessful (unrealistic) attempts. For a while, there was a great interest in India including from top politicians like Patricia Hewitt, a former secretary of state for health who headed the UK India Business Council. Although keeping tabs on all developments, my interest has always been in doing things – talking is only of interest up to a point to me!

Alongside national engagements I was actively pursuing possibilities in Greater Manchester – I was very happy when I finally came to work in Manchester in 2005, although we had started living there in 2001 I had been working away till then. Due to the old historical links- Manchester featured in all our school lessons and the place was tied up with the Indian freedom movement - I felt that there was something that we could build on. I went to the Local Authority- Steve Mycio, then deputy chief executive was sympathetic, and later on Richard Leese, leader of the council also went to India in late 2000s. I had set out an audacious goal of creating half a billion pounds worth of exchanges over next few years! In my enthusiasm and naivety it was doable, with persistence and better use of funds that were being spent anyway on chasing India development- MIDAS, the inward investment agency was in its early stages then and the universities were heavily reliant on Indian students. When I did the Common Purpose Matrix Leadership programme, with participants coming from all sectors, there was some interest in India, particularly from arts, apart from the academic and NHS sectors.

Infact at one stage I was lobbying Vijay Mallya about choosing Manchester as the port for his Kingfisher airlines (may be he would not have ended up where he is, if only he had listened to me!) as he was expanding internationally and was looking for a port in UK, and I wanted to be on the inaugural flight. I went to the Tourist Board – Visit Manchester- about promoting Manchester to Indian visitors as there is so much history. As an example I was fascinated by the Salford Ship Canal cruise (one could

see the Empire and Industrial age unfolding in front of one's eyes during the journey) and wanted to create bespoke tourist packages for Indian visitors to tell them about the rich history, industry and music, and not just the NHS. I had already met John Pickstone, professor at the Wellcome Centre for History of Medicine, Science and Technology and used to have sessions with him about India, and we wondered about creating one of those historical tours on the Salford canal cruise. Manchester Museum was another potential attraction and I had some discussions with the officials there; more recently I was pleased to hear from Esme Ward about the India exhibition/gallery. Overall, I felt the Indian visitors, an increasing number of tourists as UK is a very popular holiday destination, were missing out; their usual itinerary covered London (side trip to Windsor), Stratford upon Avon, Lake district before heading up to Edinburgh (and whisky trails); just 20 miles detour from their M6 journey they could come and see the amazing things Manchester had to offer (and Liverpool was a bonus!). There should have been a sign on M6 – for Indian visitors driving past- LOOK what you are missing.

My part-time role with IT industry as part of the Connecting for Health programme had introduced me to the industry, both information and medical technology ones, and Manchester was encouraging Indian companies to come to Manchester. (Late) Michael Oglesby was another champion of ethical businesses and very interested in health and inequalities, and indeed was the speaker at the first Indo-UK health collaboration in Manchester. Such developments gave the idea for the India Manchester Graduate Network – to create these students as ambassadors for Indo: Manchester (UK) collaborations, with help from Vikas. By that stage I was an honorary/visiting professor at not just Manchester (UoM) but also Manchester Metropolitan (MMU) and Salford (UoS) Universities and kept on exploring possibilities for health collaborations. I tried to find out about Indian connections elsewhere in the universities, not just health related departments, and found people like Kunal Sen, professor or economics at Manchester. I got carried away when I discovered that Ben Kingsley had studied at Salford, and later on found Alok Sharma is also an alumni. Some of these universities links came in handy later on, for example when I got involved in the Apollo project in Crewe as the campus was a previous MMU site and Christine Horrocks, someone I knew from my MMU days was the pro VC who had handled the operations there, and the head of podiatry for the ABHSC is Michael Harrison Blount who was at UoS previously and was aware of their work in Chennai many years ago.

Apart from these wider possibilities, and given that I had engaged many national NHS agencies and needed to find some mechanisms for taking these forward, I approached Mike Farrar who was then the CEO of northwest NHS regional office and he asked me to prepare a paper to take to his Board (Appendix 10)

I also talked to various providers locally: Chris Harrison, medical director, and Vaskar Saha, professor (who later got the prestigious DBT India Alliance Margdarshi Fellowship) at Christie's re cancer links, and Rob Elles, head of labs at CMFT re laboratory links, and then worked with Iain Buchan, professor of informatics who had set up the NIBHI (North West Institute for Bio Health Informatics) and who also roped in University of Washington and the WHO to set up the Global PH Informatics group.

After the launch in Manchester we had meetings in Seattle, USA and then met in Delhi, India where Muir Gray came as well. When we held the inaugural conference in Manchester, we asked Narendra Arora and IAPSM for someone who could be part of the initiative going forward, and they nominated Associate Professor Aggarwal from Chandigarh. He duly arrived sans his luggage and the first thing he saw was the Primark store in Manchester to get some clothes!

Overall I made myself available to anyone interested including giving talks to visiting delegations from India and indeed met the various UK delegations when they visited India as I was spending time there in later years. I could have saved them the trouble of travelling all the way but then they would not have had that prized photo-op at the Taj Mahal!

I began to see UK, the NHS and especially Manchester in new ways- like a kid in a candy shop, full of possibilities. More recently I was pleased to note the work done by Ghanshyam Nabar who also facilitated a health delegation to India led by Andy Burnham, the Mayor of Greater Manchester - the sudden recent demise of Kailash Chand, that champion of the NHS who worked closely with Andy, however will leave a hole. It is also good to see the work being done by Rahul Laud now to promote India Manchester links, with the launch of his Manchester India Influencers List. Nationally, the work that Aman Puri did when he was the Consul General in Birmingham, by bringing together the range of initiatives is noteworthy; from a new generation of senior Indian administrators, being a dentist and a diplomat, Aman's work provides another useful mechanism. I am glad that this is being done by his successor, Shashank Vikram, another medic.

Working in India

Over the years I had engaged with the main governmental, academic, and corporate sectors, and also NGOs.

Mike Nitharvanikis had been the Deputy High Commissioner in Chennai, and then left the Foreign Service for a while to explore his interest in global health and education and was particularly keen on India. He put me in touch with Himangi Bhardwaj at the UK High Commission in Delhi and through her I met all the relevant health leads in various UK deputy high commissions throughout India- we had a full session when they all visited London to work out a comprehensive and systematic plan as much of the work was ad-hoc and opportunistic. I was personally keen on it as I could see so much activity but was not clear about the outcomes – I remember speaking to one of the deputy high commissioners about the 'success' rate of various delegations, almost all of whom had signed Memorandum of Understanding (MOU), and there was no data about outcomes! There are literally hundreds, if not thousands, of MOUs in office drawers and lots of UK professionals with very fond memories of their visit to India, and ofcourse most went to get their photo taken at Taj Mahal – guess an outcome itself! Years later I was pleased to see that Ed Rose, who had worked in the NHS, went to stay in Delhi with his wife, a diplomat there.

On the Indian government side my interactions were with various state governments largely through the state and central health secretaries in Mumbai, Delhi, Hyderabad, Kolkata for example and some ministers – Satyendar Jain the Delhi Government health minister visited Manchester and I followed up with his team in Delhi. Similarly Vijay Gautam had introduced ne to Shri Choubhey, health minister in Bihar and I met him again when he came to address the Bihari doctors in UK. I had also met Nipun Vinayak and visited him at the Rashtrapati Bhavan (President's House – and boy that is really something) in Delhi – he is a doctor and IAS (the elite Indian Administrative Service) officer. I am pleased that there are more doctors in the administrative service and the government including Aman Puri who was recently in Birmingham, and did great work to foster collaborations and Harshvardan as the Union health minister in India.

I interacted with a number of (quasi) governmental agencies including the Indian Council for Medical Research (ICMR), NHSRC, PHFI and AIIMS.

Nobhojit had introduced me to Ravikant Singh, who had set up Doctors for You and the latter introduced me to Mahesh Misra, who was heading the Delhi Trauma Centre in 2000s, and I discovered that Mahesh had trained in Salford, and I shared that with David Dalton, the CEO in Salford, who was interested in India and did later on meet with the Apollo Team (as it happens I was also discussing links between Salford and Mayo Clinic, Eccles being the birthplace of founder of Mayo Clinic: Dr W W Mayo. Having spent time there I was so excited when I came to live in Eccles, and infact the Council held a civic dinner when Chris Chute from Mayo Clinic had come to Manchester as part of the Global Partnerships in Public Health Informatics Conference). What happened then was that Vijay Gautam, consultant in A & E working in London, and whom I met through my college friend Suresh Panjwani, was

keen to get back to India and finally jumped when offered the chance to work to establish the emergency department at the newly established AIIMS in Patna, Bihar (there was an Indian government initiative to roll out the AIIMS model, a bit like the elite Indian Institutes of Technology -IIT). So off he went and asked me to come along for the conference he organised later on and for some brain storming. This was my first visit to Patna and I was really disturbed by the state of the place as it was so backward, even the airport was old and I was stuck there for hours as the flights could not get in or out due to fog and very limited navigational equipment. Mahesh Misra came too and we talked and as it happened Mahesh then became the head of AIIMS Delhi, and between these two I met all the AIIMS directors - some of them had trained in the NHS. I also went to Chandigarh at Himangi's request to participate in an emergency and trauma Conference where Lisa Bayliss Pratt from HEE was a speaker too.

On the provider side, my efforts were largely unfocussed and more in terms of my own learning and seeing if there was any match with UK providers. There were different challenges for the private and public health systems in India, not just financial viability but also need for quick returns, and bureaucracy was very hard to negotiate, for me. Many UK hospitals, partly with the support of their Indian consultants were already making connections directly. Ajay Rajan Gupta then came along and with his Indo: UK Institutes of Health put some structure around it, his model of linking NHS hospitals with his planned institutes across India seemed like a good way forward and he had some strong backers.

I went and spent time with the charitable organisations – I was humbled to meet people like Abhay and Rani Bang, Ravi and Thelma Narayan through Vandana Parsad, Amar Jesani , and ofcourse Nobhojit Roy and Ravikant Singh, for example. I also found my interactions with Aakash Ganju, doctor and entrepreneur in Mumbai, very helpful – he has been able to bridge the private: public gap and create financially viable initiatives to support the worst off. He started a think tank and I enjoyed the few sessions I was able to attend. It was so inspiring to see such committed people, battling the deep inertia and resistance of the system and still making progress. To some extent the achievements of Indian diaspora – and just look at the leading global organisations with Indians in top positions and even in the NHS where race discrimination persists Indians are rising - have been easier. The western world has better organised systems and (some) political accountability unlike the chaos and patronages in India, and the scale of challenges there is enormous and continuous – every step of the way is a struggle. Its a tough world there, I could escape and recover but they had no choice. Doing anything in India is an achievement and there are some phenomenal examples in all sectors of health and education in India- attempting to list them here is impossible for me and also unfair as I am bound to miss some (many).

Being curious as I did not know my country of birth well when I was young I also checked out the places I used to visit for additional draws- apart from the usual touristy things I went to see places like the Toilet Museum in Delhi, or the pearl jewellers and Falaknuma Palace in Hyderabad or the Chand garden in Chandigarh and met people like Pompy Sridhar, country director MSD for mothers and actively

promoting digital technology solutions, Mahendra Bhandari who runs the Sahyadari education establishment in Mangalore. and Rashmi Iyer and her husband Ravi who worked on the different aspects of health insurance,

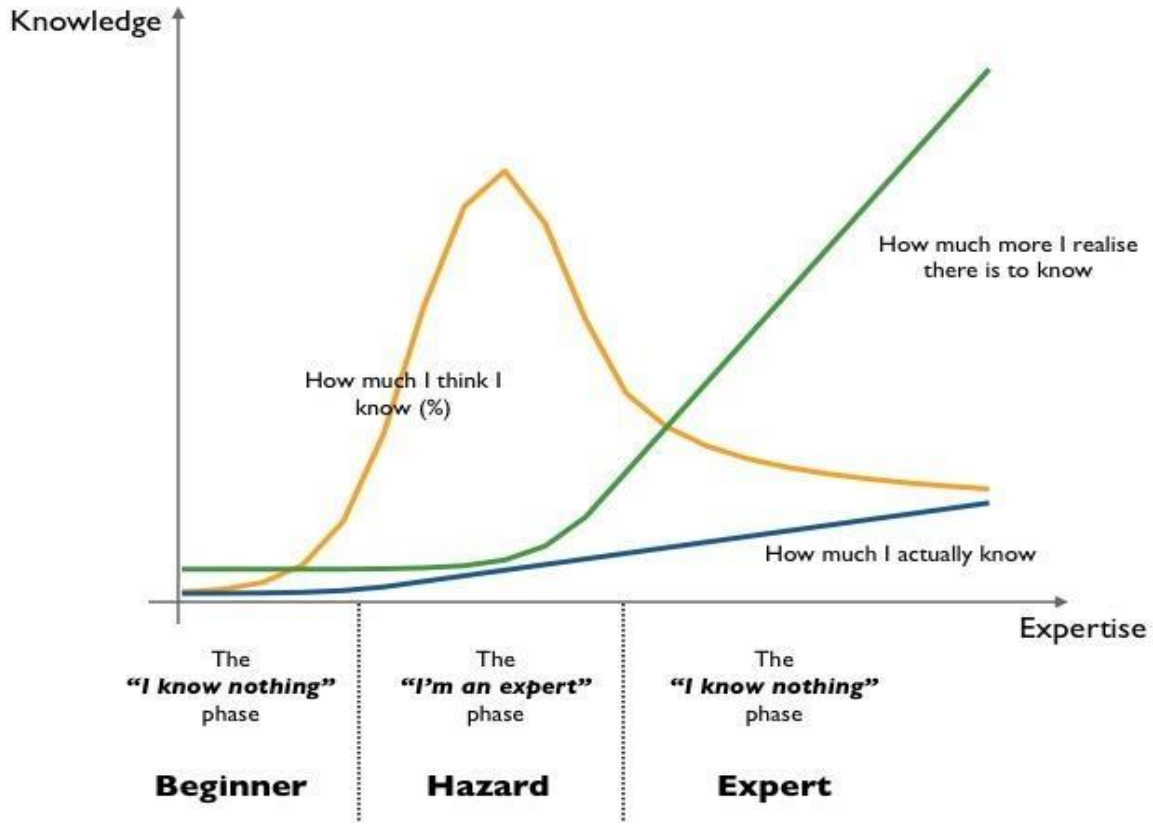
I always enjoyed my conversations even though at times these were perfunctionary with no (immediate) possibility of moving forward. The problem was more acute in India where the frequent change of personnel in public sector was demoralising. I would come back from a trip to India, after being feted (it was a heady experience to be often ‘garlanded’ and waited upon – the courtesy was overwhelming at times) and with promises of taking things forward, only to go back after a few months having the same conversations with different (and sometimes same) people; most senior posts were end of career ones and destined to retire soon.

Conclusions

The ultimate question from this account then is So What – if anyone (ever*, sic*) reads it what will they see: that I met a lot of people, had nice chats, gave talks, attended conferences, had fancy meals, got photos taken and contributed to the environmental damage by flying. What did I achieve is hard to quantify – it is not that I saw patients and saved so many lives, raised funds or built institutions. How did the NHS or the Indian health system benefit from my efforts?

I had not set out to achieve a particular goal though the direction was clear and which was to contribute in whatever way I could to help improve things for both parties. I had identified four key areas which needed strengthening in India and where the NHS could play a part: governance/education and research/primary care and public health and focussed my work in line with this assessment. Often this was by sharing my learning and making connections, some things worked out and others have built on them.

Frankly I started my international work and went to India as a ‘Hazard’ and arrogant and have become the ‘Expert’ and humble (Figure). After over a decade in the UK with some spells in Ireland and USA I thought I knew it all and if only they would listen to me when I first started my work. After one of the first interactions, I was interviewed by a news magazine in India and although well received it was apparent that my comments/suggestions were wholly impractical. Things in India were for a reason and it was not because Indians did not know or did not want to improve. I told a reporter/interviewer why do not ‘You’ do something – scratching basic living, she was doing what she could and did not have the luxury that I enjoyed. To give her credit she did not react but I still remember the look on her face. I had become the Other – Foreigner- in India. Since then I have turned full circle as I met some of the greatest clinical leaders who, unlike me have stayed back, and continue to work in what to me are very challenging circumstances. India is a country of contrasts, when one thing is true then the opposite is also true: the wealthiest and poorest or great women leaders yet sex selection and bride burning for example co-exist, and the trick is to find the balance between the polarities. I went to give and came away loaded with gifts – I was richer for this work, professionally and personally.



Overall finding out about various organisations and talking to people was useful in its own right as part of raising awareness and knowledge exchanges. The most beneficial thing was that I began to understand and appreciate both systems – nothing like trying to explain things to others; I had to really distil the core knowledge. So I had to explain the NHS to Indians and vice versa. I still remember the conversation with (Late) Lt Gen Banga, when he was the CEO of Hinduja Hospital in Mumbai. There was another one of those stories about disgruntled doctors in the NHS and he asked me how much doctors earned and I told him roughly and that after the initial period they were among the top earners in society; how many hours did they work and so I told him again about general societal rule of 40 hours of working week though doctors did work more, and especially junior doctors hours; and then he asked me how much leave did they get – and when I said six weeks, plus bank holidays and study leave, he lost it and just shook his head. (Ratan Tata years later made some remarks about the work culture in UK also). Indians were also concerned about waiting lists and stories of failures in the NHS and again I had to explain about the whole package of care, tax funded, free at delivery etc and openness. Really it was about the essence of the NHS- I do not see it as a 'physical' entity but as part of the British society based on certain values

Over in the UK I had to explain about corruption in healthcare in India, the massive health and social divide with poor government investment in health care; and which co-existed with examples of excellent innovation and service delivery, not least the fact that Indian doctors have been seen as the backbone of the NHS – the savings in

their medical education alone amounts to billions for the NHS despite being racially discriminated. My own concerns about the NHS have been well documented in my other reflections.

Although I got drawn into controversial discussions occasionally, and there were plenty of times when I got frustrated including with accessing healthcare for family and friends in India, overall my approach was to find the balance; criticism without helping to me is wrong. So I agreed with Dr Berger but I also tried to address the professionalism and ethics gap (appendix 11) and did my best to take NHS to India.

Having a foot in both camps was a double edged sword; gaining trust was challenging especially as although Indians get criticised for short-termism and being profit driven, it was not much different here in the UK. Ultimately it is about the WIIIFM (What Is In It For Me) test. But what was interesting was that people wore two hats- individual and organisational; at the personal level they were much more receptive and grateful even though organisationally they were stuck and I saw a lot of goodwill.

My own work was not about showing new techniques/technologies- Subhash Daga's styrofoam box or Devi Shetty factory style paediatric cardiac surgery or Apollo Hospitals organ transplant programmes – the numbers and (much lower) costs there - were non-starter in the NHS, and equally India was/is unprepared with its poor primary care or public health provision, and talking about creating the NHS systems was premature.

I found that things happened organically, opportunistically and unpredictably. It is a bit like the *Celestine Prophecy*, where people come into your life for a reason, which may not be obvious then and only becomes clear later. Let me explain this, as follows.

First, look at this: Mahesh Misra was introduced to me by Ravikant who in turn was introduced by Nobhojit whom I discovered through Tony. Mahesh and Vijay Gautam (via Suresh) then came together, and which then got me together with other AIIMS directors, and the emergency medicine work continued in Chandigarh via Himangi. Few years later when I was helping Abhishek with his hospital, who came to my attention via GAPIO, the lead consultant gynaecologist there was Renu (Misra, wife of Mahesh) and both of them had been to Salford which was very dear to me because of the Mayo connection and given David Dalton's interest in India I brought this to his attention. And so on....

People come into your life, they remember you and you remember them, and at the right time you join up, again and again, and do what is possible then.

Second, you are not the first one, there were others before you as there will be others after you, I often use the quote about Standing on the shoulders of giants. It is important not just to recognise the contributions of those who came before but also ensure continuity by creating a succession plan. Its like a relay race.

So Andy Bacon was leading the international volunteering work in northwest England when I started in Manchester, there were already a large numbers of individuals and

organisations quietly getting on with the job, and Andy was adding value through creating a movement. Then Wythenshawe hospital started the Manchester: Gulu link project which brought Ged into the picture and together we did a lot of work about global exchanges, and which Ged has scaled up. Similarly the work that I did with Ramesh for BAPIO around Indo- UK collaborations and which also linked up with Ged's work.

You help, they help, and then the baton is passed on and it all adds up.

Third, when you think nothing more can be done something comes up. I had given up on ICHA – I was no longer in active practice and was lagging far behind in terms of keeping up with developments in patient safety but then Akhil came back with not just ideas on education for patient safety course but also on addressing the root causes of the deficit in leadership, and given that we had closed down Peoples-uni which would have hosted his course I would have been stuck if Johann with Medics Academy did not step up. They are now working together to take forward the patient safety movement in India.

Just because you do not see it, does not mean that there is no way forward.

I could keep telling such stories – the problem with old men (and maybe women too).

What value did my work add to India and the NHS. Which projects worked and with what effect? I honestly can not answer or quantify this though like to think it did help; if nothing else then by raising awareness and supporting those doing the work. Capacity building and cultural change is not easily measurable. What does it mean to say that ICHA is now well placed especially with support from Medics Academy and that four people from India came as Commonwealth fellows and went back to spread the word about patient safety? Or that over the years we operated Peoples – uni we had 14 students who gained a UK accredited MPH, something they could not have afforded otherwise, and around 600 participated in our programmes from India. Or that HEE has managed to bring over a number of nurses from India to support the hard-pressed NHS. Or BAPIO is actively developing Indo- UK collaborations and raised over half a million pounds, and provided remote clinical services to support India during the second wave of the pandemic recently. Or the work on leadership development carries on. Is all that added value and could all this have happened irrespective of my involvement? May be, and equally things may have even been better if I had been able to take forward other initiatives?

Do I have any advice on what others should/should not do – would I do anything different? This also comes up as part of why some ideas did not work. Again, hard to answer and one needs to decide for oneself, do their best and then take the highs with the lows – as there will be. Things did not always work out as planned and that is life. My strength is also my weakness; I am a dreamer and naive, and can get carried away with ideas but it is very hard to introduce big changes. So, may be I got it wrong – by pitching too early, too little, to wrong people? May be the others got it wrong, became impatient or unable/unwilling to collaborate? Finding the right people to work with is very important – without trust and respect, long term projects are doomed. I was fortunate in many of the projects to find such companions.

Another way to pose the question would be: Would I do it again, if I had the chance? My answer would be unreservedly Yes. Not just because it is needed and is the right thing to do; we are One world, they is us! But also because it helps one to grow, become more effective and live a better life. One is not alone, there are good people who helped me, and others will find them too. With all the projects I supported I threw myself in fully, I used to free myself up to focus on whatever I was involved with whether it was BAPIO or GHE or Bhartiya Hospital. I was 'desperate' to break the mould and knew that half hearted measures were not the way. My own rule has always been to stick with things as long as one is adding value – it does take time and effort to get things done; and one can leave prematurely and equally one can stay too long. I personally did not feel the need to stay on for the sake of it, and if I could see a good succession plan then I was happy to move on.

Whether to limit oneself to specific issues/projects or remain broad based as I did is for individual preference – though I can definitely say that the specific projects get more visibility and recognition and hence support including funding. I may have found it easier to answer the So What question too! Also to not be too deferential or modest; sadly the meek shall inherit the earth does not work in the real world, so donot give in easily, stand up for self especially if you believe in your work and are good. I decided to share my knowledge and contacts as widely, and acted above 'my station', as I could, even though many times without any reciprocation. My view was (is) that unless one tries one would not know; better to try and fail than keep wondering if only. Much as I have disliked publicity – indeed few years ago I dropped out completely from the usual so-called Social Media outlets, I do not exist in the digital world - I feel that one has to use it. And why not if one is good!

Overall, the thing with my reflective practice, and writings, is that as I have grown older I have (tried to) become less judgemental or critical; I actively try and suppress any negative thoughts. This has been another (re) learning from India – as I immersed myself in my work I returned to my Hindu philosophical roots – about being one with the universe, about knowing self and constantly improving, and about being flexible not dogmatic in doing the right thing; the latter is situational and one always has the choice to pursue a particular course of action. And I found that reflection then becomes very important, but it can go one of two ways: it can reinforce the existing mind set (and especially negativity) or can be used for positive reasons, and I increasingly choose the latter. I was patronised, not taken seriously, and I left some projects partway; the short-termism and need for quick gains were real challenges – on both sides. But I feel this is to be expected - it is what it is. I found good people also and that was enough to keep going. I often joke about cream and crap floating to the top, and how important it is to find the 'right' people, not just the visible and those in positions. It is the unseen leaders/heroes and who are the doers I was more interested in. My advice would be to beware and choose well, and not to take sides or indulge in any games.

Is that it then? I hope not as I still have some energy and there is so much to do as health (in its broadest sense) is the defining issue this century. What would I like to see happen next? I have become more convinced about the need for the NHS and hope that the society will safeguard it from the mindless pursuit of market ideology. I

believe the whole world needs something like the NHS, and we must fight for Universal Health Coverage (UHC). But it can not happen with current ways of working, we need something different. There are excellent examples everywhere if one cares to look, but overall it requires a fundamentally new mind set to help scale up such examples and make them universal. I feel even more strongly that more and more global exchanges – and its a lot easier now with technology - will help create the new mindset. I hope that this account will convince others about the need for and value of such work.

One of my favourite (perhaps the wrong word) films is Schindler's List (it should be a must see for everyone so that we never ever go through that again) and the scene at the end when Oskar Schindler (a Nazi Collaborator) is being put in the car to let him get away as Russians were arriving to liberate the prisoners, and he breaks down, crying wishing he had done more. Izthak Stern then consoles him and says what he did was enough. I tell the story to make the point that obviously we can all look back and do the coulda/shoulda but the important thing is to be alert to possibilities to make it a better world, do what you can when you can; and those touched will know, and be grateful. As an aside I have always felt that the real leader was not Schindler, it was Itzhak Stern who changed a profiteering, self-indulgent, womaniser into the caring person we celebrate.

I believe that India, and the world, is in for a very difficult time for the next few years- we are not done with the pandemic yet and the after-effects there will be massive; the economic impact with increasing poverty and malnutrition will need as much support as possible. It will be interesting to see what both governments will do but there is a definite role for citizen led movements and need for collaboration including funds from the west. Indo- UK health collaborations are no longer optional, they are a must. In anycase it is a win:win for not just the two countries but the world. But it will need good leadership and management with a clear plan and sustained efforts over a long period. Sadly, I do not see much sign of that at the scale that is needed; the UK Government cuts to foreign aid seem very shortsighted and will haunt us, and I do not see much sign of change in India and where there are deeper issues holding back the necessary work on health. But I live in hope – generated by the examples I have seen, and because of the work being done by so many people. I thank them for their company on my own journey, and wish them the best.

Learn from my mistakes, nothing would please me more.

The road to wisdom
The road to wisdom? - Well, it's plain
and simple to express:
Err
and err
and err again
but less
and less
and less.

Piet Hein

Epilogue

For some time I had been feeling unmoored as a first generation immigrant to the UK and had written this poem about it:

The immigrant

Leaving on that jet plane
for the distant shores
dream come true
going to Britain
new start, new life
excited and daunted
Will I make it
Will it be worthwhile
Will I miss folk back home
Will they miss me
Fast forward three decades
neither Indian nor British
pulled by both
resentful of both
India of youth gone
Britain has changed too
Or is it me
unable to adapt
rootless and restless
the first generation immigrant

When I was in the UK I wanted to be in India and vice versa; if only I could combine these two somehow! Having retired from a ‘tethered’ job in the NHS I used to spend quite a bit of time, making frequent trips, to India until the pandemic started. I have not been back since Jan 2020, making me very frustrated not being able to see my family there and especially my elderly mother. The forced interruption and then writing this journal has made me review my own views on belonging; home is not a geographical entity, its where one is comfortable (at home), and now I see myself as the lucky one. I have come to accept and celebrate both countries – even though they frustrate me in equal measures, but I feel calmer.

Selected references

I have limited the references to key ones in India, since my UK work is already on https://www.nhs70.org.uk/story/rajan-madhok

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Dedication

This volume is dedicated to my brother, Raman, whose support enabled me to indulge myself – though younger in age he became the elder. Thank you.

Acknowledgement

It is not easy as the debt is great and words limited, and the task is made more difficult by a fading recall given the long period. I am grateful to all the individuals and organisations named in this report, and additionally to Bobby and Monica Malhotra without whose help I could not have come to the UK and latterly to Robert Boyd without whose help I would not have been able to continue on my journey; basically they have book-ended me. I am sorry if I have overlooked any - there literally were hundreds of people who helped me in various ways. I particularly want to thank the organisations and people who have helped India deal with the Covid 19 pandemic.

I am grateful to some friends who reviewed the draft and offered suggestions- I won't name them here since it would be unfair to taint them with the remaining shortcomings!

Key abbreviations

ABS- Association of British Scholars

AIIMS- All India Institute of Medical Sciences

BAT- British Asian Trust

BAPIO- British Association of Physicians of Indian Origin

BHS – Bhartiya Health System

BMA – British Medical Association

BMJ- British Medical Journal

CQC – Care Quality Commission

DFY- Doctors for You

DPH- Director of Public Health

EF- Eisenhower Fellowship

FMLM- Faculty of Medical Leadership and Management

FPH- Faculty of Public Health

GAPIO- Global Association of Physicians of Indian Origin

GHE- Global Health Exchange

GMC- General Medical Council

HLA- Healthcare Leadership Academy

HCUK- Healthcare UK

HEE- Health Education England

ICHA- Indian Confederation for Healthcare Accreditation

ICMR- Indian Council for Medical Research

IIPH- Indian Institute of Public Health

IIT- Indian Institute of Technology

IJME- Indian Journal of Medical Ethics

MOU- Memorandum of Understanding

NGO- Non-governmental Organisations

NHS- National Health Service

NHSRC- National Health Systems Resource Centre

NPSA – National Patient Safety Agency

NICE- National Institute for Clinical and Health Excellence

OPPI- Organisation of Pharmaceutical Producers of India

PHFI – Public Health Foundation of India

PCT- Primary Care Trust

RCGP- Royal College of General Practitioners

RSM- Royal Society of Medicine

SHA – Strategic Health Authority

THET- Tropical Health and Education Trust

UoS – University of Salford

UoM- University of Manchester

UK- United Kingdom

USA- United States of America

WHO- World Health Organisation

About me

You can find out more about me at https://www.nhs70.org.uk/story/rajan-madhok

In summary, I graduated from Maulana Azad Medical College, Delhi, India and soon afetr qualifying came to the UK in 1980. I initially trained as an orthopaedic surgeon in the NHS and then switched to public health. Over the years I held increasingly senior leadership positions as director of public health and medical director in various places in England.

I took a major interest in health care quality and safety and which started when I spent some time at the Mayo Clinic, USA in the early 1990s. I was also interested in evidence based medicine after visiting McMaster University in Canada and then became active with the Cochrane Collaboration and became the Coordinating Editor for the Bone, Joint and Muscle Trauma Group.

Throughout my career I have actively supported and led educational developments. Amongst many other roles I have been the Chairman of British Association of Physicians of Indian Origin, a former Executive Committee member of the Global Association of Physicians of Indian Origin, a Council member of the GMC, UK and the India Envoy of the National Patient Safety Agency.

I am committed to global and public health, capacity building and leadership development with a focus on human rights, ethics and professionalism. My particular interest now a days is on reflective practice and you can see more about what I am doing at www.ramareflections.com

Note

The title is from a popular Bollywood film, and I have used it to emphasise the need for perseverance – Keep Going Little (a term of endearment) Brother – captures the spirit of my story. This is what it felt like and in any case what I was/am after is a (never-ending) journey. One tries.

If inadvertently I have made a mistake then please get in touch via madhokrajan@gmail.com and I will make suitable amends. My apologies.

The pictures are from the internet, and again apologies if I have breached any copyrights- do let me know.

APPENDIX 1 – What does India need?

https://www.bmj.com/content/348/bmj.g2479/rr/699961

Rapid Response:

Re: Expert views: what the next Indian government should do for health and healthcare

India is now at a critical point- Shri Narendra Modi really has the ability and potential to transform the country and restore its rightful place as a beacon in the world. Development, good governance and robust management, the three essential ingredients, are finally coming together under his leadership, and I welcome the dawn of this new era. A focus on economic development, rooting out corruption and accountability is a win: win formula for both: the political party and the public. Of course, it will be a while before we see the results but the next few months will tell whether we are on the right road. To me, being on the right road means addressing the root causes of a failed nation and especially the health of Indian people.
Some of the worst health indices in the world, vast inequalities, unaffordable health care, poor education and training of health care professionals and corruption at almost all levels, with a few exceptions, have become the norm and are a blot on the country. Successive governments have failed to tackle the problem, and the major reasons for this are the conceptual separation between economic development and health and reliance on 'trickle down economics'. The belief that health is a consumptive sector (needing endless resources) is fallacious- health is a productive sector; healthier people work, pay taxes, improve economy and boost development. And the last few decades have confirmed the failure of trickle-down economics- poor have become poorer and access to healthcare is further impoverishing them with millions of Indian falling below poverty line due to illness and lack of affordable and safe care. Health truly is wealth, and it is time to start taking it seriously.

Despite massive growth of the health sector recently, largely in the for-profit private sector and in high tech, acute services although I recognise the investment in public facilities including creating the new AIIMS in various parts of the country, there has been a failure to address the four key challenges facing the Indian health system. To create healthier people and ensure safe and affordable health care requires:

- Better governance including clinical governance to root out corruption, challenge poor clinical practices and raise standards
- More and better academic capacity through using modern educational programmes and promoting research
- Investment in primary care, and out of hospital care in the community and
- Most importantly a robust public health policy and systems for delivering the public health programmes

Although there are pockets of excellence in each of these domains, there has been a serious lack of a comprehensive and joined up health policy and which is then systematically programme managed. The new Government has the unique opportunity, and indeed a responsibility, to pull all this together and create a healthier and wealthier India.

It is also not a one sided affair, there are some very committed people and organisations, who if properly mandated can be mobilised to deliver this transformation and shed the image of India as the ‘Sick Nation of Asia’. I have had the privilege of meeting and working with such individuals and organisations and am sure that they will rise to the challenges, given the chance - this is a once in a life time opportunity to make a real difference for the country.

APPENDIX 2 – Note to Lord Darzi

INDO:UK HEALTH LINKS

A briefing/discussion paper for Lord Ara Darzi

Cc Lord Nigel Crisp

Introduction

This paper outlines a proposal for developing Indo:UK collaborations in health, in the light of the UK's Health is Global Strategy. It is a personal account and not meant to be definitive or exhaustive- clearly there is a lot more work being done by many other colleagues, and the paper is used to illustrate a potential future programme. The case study could serve as a model for other low to middle income countries.

What is the proposal?

Very briefly, the proposal is to create a mechanism for leveraging UK's vast health care intellectual capital in India, and through bilateral exchanges create a win:win. Over the last two decades especially, UK has developed a lot of experience and expertise in various aspects of health care policy, delivery and regulation, through for example: NPSA, NICE, NIII, NPfIT, HCC/CQC and Professsional regulation via GMC

All of these developments are of great relevance to India, and can be leveraged in both ways: philanthropic (linked to our overseas aid programme, volunteer activity for example) and business (both directly by charging for some services and indirectly whereby we can create opportunities for more students/professional to come and train in the UK). We can work with both: government and private sectors for this purpose.

Why do this?

There are several reasons for developing a bespoke programme of work with India

1. Common Heritage – there is a close link/affinity between India and the UK, for historical reasons
2. Substantial Existing Commitment – there is a large Indian Diaspora including nearly 40,000 doctors of Indian origin in the NHS, many of whom have ties back to their roots and are supporting discrete projects.
3. Developments in India – there are a number of developments in India, at both Governmental (central and state) and in the private sector which have brought health to the forefront. Attached pl find a short paper I recently published on the subject
4. Developments in the UK – in addition to long standing reliance on Indian doctors in the NHS, already there are links in terms of R&D, biotech, IT and education, for example:

- various royal colleges holding exams in India
- still ongoing recruitments of doctors from India
- MRC/ICMR (Indian equivalent) links on research

- DH support to Public Health Foundation of India
- NPSA's support for patient safety work in India
- NICE's recent visits to India to explore collaborations
- RSPH has won a contract to deliver training

Alongside these there are a whole range of voluntary organisations and individuals supporting various projects in India. Hardly a week goes by without another UK delegation visiting India for opportunities

Overall, India is one of the fastest growing economies with potential to help us in the west and equally India needs help in terms of health policy/strategy and health care expertise.

How can we do this?

It is important to ensure that any collaborative effort adds value by supporting existing programmes and covering gaps, and not be too diffuse in order to make a real difference. We can start by creating the infrastructure to take forward the currently disparate work of various organisations and individuals – this may include a 'coordinating centre' for Indo-UK Collaboration.

Through this centre we could formalise links at institutional or state levels in various areas such as service delivery or education or research.

This centre can help accelerate existing programmes and in addition meet specific expressed needs by organisations in India.

What has happened so far?

I have been involved in various ways in India for many years and have interacted with many organisations there.

I have interacted with various organisation in the UK. At the national level I act as the NPSA's envoy to India and am the overseas coordinator for the Indian National Convention on patient safety in Delhi – see www.ichapatientsafetycon.com; have discussed the model with Andrew Dillon at NICE, with the GMC and apprised Lord Crisp, for example. At local level I have had discussion within the Northwest with the SHA and various development and academic institutions and with the Manchester City Council.
There has been some interest in launching this initiative in Manchester early next year.

In addition I have spoken to the various Indian doctors associations and indeed I have been asked to become the Chairman of the British Association of Physicians of Indian Origin (BAPIO), with the Prince of Wales Charity- The British Asian Trust, and the Tata Consultancy Services, for example.

Overall I have found a lot of support for the proposal, and I am making some progress in some domains. The education charity I chair – http://peoples-uni.org has

considered setting up further infrastructure in India and we are already delivering an education module on patient safety there. In 2008 I helped host a conference on public health informatics with WHO in Delhi, in my capacity as the steering group member of Global Partners in Public Health Informatics. I am working with the policymakers in Andhra Pradesh through the Indian Institute of Public Health in Hyderabad. I have had preliminary discussions about creating a laboratory for developing innovative low cost health care technologies for use in LMIC.

We could also explore the possibility of leveraging funds from grant giving bodies such as the Commonwealth fund – I have been successful in getting scholarships for 4 people from India who will spend 3 months with me, and am hoping to build on this.

I am keen to develop future 'Brand UK ambassadors' in India, and have explored the possibility of doing developmental work with a hundred or so Indian students who come to the UK for further studies each year. This can pay long term dividends by fostering joint work, when these students go back.

Next steps

I am not sure what is planned for the NHS Global Health Forum but if we can join forces then it might be mutually beneficial. It would certainly help me, as I am basically a 'One Man Band' and find that not being part of an organised effort is a disadvantage, at times. I do visit India regularly, 3-4 times a year, and am intending to spend more time there.

I will be back in Delhi from 25-29 Nov during which time I will have further discussions with a range of professionals and policy makers.

The Indian Union Health Minister – Mr Ghulam Nabi Azad - is most likely to be in London on 7 Feb for the BAPIO annual meeting.

Should the proposal appeal, then perhaps we can have a chat, with a view to developing something, even if preliminary, for discussions with the Union Minister when he visits London?

RAJAN MADHOK
2 NOV 2009

APPENDIX 3- Note to HEE

BRIEFING PAPER

INDO: UK COLLABORATION FOR HEALTH WITH SPECIFIC FOCUS ON EDUCATION AND WORKFORCE TRANSFORMATION

Executive summary

This paper proposes the establishment of a dedicated India Project and describes the rationale and how it would work.

Proposal

It is proposed that a dedicated programme office for Indo:UK Collaboration for Health focussed on education and workforce be established, with support from various government departments esp DFID, UKTI and HealthCare UK, and other relevant stakeholders.

The purpose of the Programme Office will be

1. To provide the single point of contact for work relating to education and workforce involving India and England
2. To support both, India and England based, service and education providers, to develop sustainable and financially viable relationships for mutual benefit
3. To help address the immediate workforce challenges facing the NHS
4. Ultimately to help transform education through global learning for the benefit of not just the NHS but also develop much needed capacity elsewhere.

And the whole programme will be developed around strategic linkages between Indian and English institutions, working under a common framework/mechanism to achieve economies of scale.

Why the proposal?

Over the last few years considerable work has been undertaken to promote Indo: UK Collaboration and which recently (June 2015) culminated in a workshop attended by various Indian providers, the Indian regulator and the Indian Deputy High Commissioner based in London along with the senior HEN staff and other stakeholders from the UK.

Looked at from a global perspective, India offers many advantages:

1. Common heritage and existing links, given the large numbers of doctors from India already working in the NHS for example
2. There is phenomenal amount of clinical learning given the complex case mix and huge numbers of patients material which are essential for training of NHS workforce if they are to become fit for the 21st century healthcare services

3. Equally Indian health system needs help with ‘modernising’ its health education and to scale it up
4. Indeed a future development could include a tripartite relationship with
    a. India being the clinical base
    b. England as the academic hub
    c. Helping to develop new and existing workforce in other countries incl Africa, China and Russia for example

The Healthcare UK has been set up specifically to promote and leverage NHS intellectual capital and preliminary discussions with them have highlighted the need to coordinate efforts and develop more innovative solutions given that so far it has proven challenging to achieve a breakthrough in India and especially financially. The India based Health Advisors have also supported the idea.

Financial viability of the proposal

The assumptions regarding financing of this proposal are as follows:

1. First and most urgent issue is to reduce and stop the excessive agency bills in the NHS. Already many NHS providers are recruiting overseas with variable success. A ‘pipeline’ from India, if developed ethically, can assure regular supply and minimise costs.
2. Second, the new and existing NHS workforce needs more global learning and also the costs of education and training in the NHS are rising. Creating systematic in-programme education/training links will help reduce costs and generate revenue
3. Third, the UK already gives money in the forms of Technical Assistance via DFID (and not Aid) or various Fellowships for example the Commonwealth programme, and which if aligned with the proposed strategic model would ensure better use of such funds. This fits well with the International volunteering responsibility of HEE.
4. Fourth, although the central health budget in proportional terms is very low in India there is recognition of the importance of certain areas of work such as public health and education and skills development (indeed this came up during the Independence Day speeches) , and the states have their own budgets and priorities. In addition, private sector players are gearing up for both, the domestic and overseas ‘markets’.

In summary, stopping waste, reducing costs and resource bending of both UK and Indian funding will ensure financial viability.

Challenges facing the proposal

To some extent there is little new in the proposal, in terms of its basic framework, as UK has tried to do this with other countries in the past (see the WHO report for the MOU with South Africa for example or more recent Zambia UK Health Alliance) and on the other hand this proposal is very different, for a number of reasons:

1. It builds on a strong platform provided by the GHE
2. The above has been developed after extensive thought and learning from previous attempts
3. It incorporates the new world thinking to address workforce and education challenges
4. It recognises the equally important (if not more so) need of the NHS to promote this – it is not just philanthropic
5. It takes on the financial challenge and aims to create a viable model

None the less, it is important to be realistic and accept that there will be challenges, at different levels:

1. Need to get ownership within the HEE
2. Need to secure agreement from to begin with HCUK/DFID/UKTI/indeed Home office
3. Need to engage the India based UK employed staff at various High/Deputy Commissions
4. Need to find early wins, within the current constraints, whilst working on some major system reforms that will be needed such as professional regulations/Visas etc

In crude terms, India is a tough proposition and that is because of two major shortcomings: one is the problem of 'sense-making' and understanding India which is a complex country with very different cultures and values and the other is the absence of sustained and coordinated effort from the UK. And that is why this proposal should be viewed over a 10 year time-frame with clear milestones at regular periods.

To begin with, it should be set-up for a 3 years period starting Jan 2016, although the work can start and indeed is going on as part of the GHE programme.

Some proposed areas of work

The programme should be set up on the twin tracks of delivery and set-up/development, as follows.

1. There are already many identified areas of work, in various stages:
    a. Creating 'pipelines' for the current nursing and doctors shortages in the NHS
    b. Developing specific educational programmes for specialty training of doctors
    c. Delivering public health programme in Odisha state, and possibly others
    d. Delivering programmes on key areas of ethics/professionalism and patient safety
    e. Promoting volunteering generally and specifically on major projects like the recent Commission on Global Surgery report and humanitarian responses

And the arrangements for these could be firmed up.

2. Simultaneously, work will start on assessing the situation and scope for further work in all: Public, Private and NGO sectors, working via the network of the British Deputy High Commissions in India.

   At present, this work is ad-hoc and also lacks expertise both in terms of 'sense-checking' and content expertise. Thus, the Health Advisors at each of these places are regularly approached for help from UK but have limited access as well support to make judgements about potential opportunities- and much of the effort does not translate into tangible benefits either financially or in terms of capacity building.

   In UK, we have seen numerous Indian state delegations coming just as UKTI trade missions go to India regularly with little idea of the success of these, and infact anecdotal evidence of absence of any major returns.

   In the next six months, systems and processes should be set up within India to explore further areas of development, since both, the nature of work required and means will differ from area to area as health is largely a state subject and the presence of private/public and NGO sectors varies. There is a 'dangerous' preoccupation with the corporate sector players – when 90% of health care sector is the very small enterprises and also ignoring very successful and world class public health systems such as the AIIMS, JIPMER, PGIMER etc. Not to mention, the fast moving and agile innovators in technology and IT who are able to support this agenda.

   This work will help produce a road-map and set priorities which should be judged in terms of costs/benefits and overall financial viability, for the next 3 years.

Summary

This paper reflects long learning and experience of health and education in India and the UK, and combines innovation with pragmatism and offers a new way to address a major (indeed the most important) challenge facing the NHS and all health systems.

Creating an Indo: UK Collaboration must be a priority for the NHS and this paper makes a proposal which should be seriously considered for economic and moral reasons, and to build the NHS Brand.

However, this should not be a half-hearted effort; it requires commitment and a longer time frame- if we get it right, the prize is enormous.

PAPER PREPARED BY RAJAN MADHOK, PROGRAMME DIRECTOR FOR PROFESSOR GED BYRNE, THE CHAIRMAN OF GLOBAL HEALTH EXCHANGE

16 AUG 2015

APPENDIX 4 – Taking NHS to India

https://www.bmj.com/content/346/bmj.f606/rr/631166

Rapid response: Taking the NHS to India

A few years ago I was talking to the Chief Executive Officer of the Mayo Clinic (I had worked there for a short time in the early 1990s and used to visit periodically) and he told me of the various UK delegations who were making regular visits to the Clinic to learn the reasons for their success with a view to emulating it in the NHS. He commented that he wished he knew the formula as he could then 'bottle' it and make millions from its sale! The Clinic 'happened' when the original founder William Worrall Mayo happened to be in Rochester at the time of the tornado in 1883 and then due to the long and hard work of his sons, William and Charles, with a small number of close associates, over the next few decades. The usual ingredients of right time, right person, team work, and sustained effort over prolonged period were the reasons behind the success of the Clinic. The CEO described his role as first being about preserving the legacy and secondly when and where possible to add to it.

I was again reminded of this exchange at the recent meeting in London on how to take the NHS to India. There is a clamour for this - many meetings both here and in the UK have taken place and others are planned. However, people forget the long gestation period for the NHS, and that it came after two world wars, and as part of a package of social reforms. It was not easy, and like the Mayo Clinic certain conditions came together to form the NHS. Creating and sustaining great institutions is sheer hard work and requires societal commitment; whilst the fact that the NHS is so political is its downside, it is also its biggest strength. The NHS is in the genes of the British society. Overall, the NHS is not an institution or a set of management and business processes only but at its core it is about certain values, and it is this whole package that goes to make the NHS. And like the Mayo Clinic, it is not possible to 'bottle' this and implant it elsewhere.

Notwithstanding the challenges, and notwithstanding the current problems including the 'Francis' Report on Mid-Staffs Hospital, take the NHS to India we must. There is a lot of intellectual capital in the NHS which has serious value for the developing health sector in India and equally there is much that we in the NHS could learn from India – it was interesting to note that two award winners in last year's BMJ Awards were from India. Most importantly, however, with almost 1 in 6 person in the world being an Indian, and given the health status of its population, its record on innovation (http://crosswordbookstores.wordpress.com/2012/08/06/jugaad-the-indian-wa...) and the economic developments, India is both, the cause of global health inequalities and the potential solution. In this interconnected world with access to health care becoming a security issue, it is in everyone's interest to promote such collaborations. However, we must resist the temptation of quick fixes and fast returns – no doubt there are some early wins in areas of clinical services, research and teaching, but if these are not coupled with investments in leadership development to promote professionalism and ensure good governance and accountability, the whole strategy may backfire. The organ trades and surrogacy and blood farms (http://www.scottcarney.com/category/red-market/) not to mention the distorted child sex ratio due to female foeticides, the poor medical education and growing

corruption in training and the rising costs of health care with almost 40 million Indians getting into poverty every year for example, are the price of unregulated and unethical expansion of the health sector. It would be tragic if our efforts and the rush to secure fast returns reinforces, or indeed exacerbates, these practices.

Being an Indian doctor in the NHS in the 21st century is a privilege and a responsibility – to be able to build on the best of both worlds and make a real difference is a wonderful opportunity. Like many of my colleagues, I look forward to strengthening the many existing links between UK and India and to forging new links.

We hope that the forthcoming trip of the Secretary of State to India to sign a Memorandum of Understanding between the two countries will take note of the considerable enthusiasm of the Indian community in the UK and equally note the need to ensure that we build ethical and sustainable collaborations. Indo-UK collaborations on health is a win-win strategy but only if we neither patronise (we ignore at our peril the tremendous expertise that already exists in India) nor neglect the need to challenge serious governance and professionalism deficit in the Indian health sector.

APPENDIX 5 – What is wrong with the NHS

NOTE: ***This is my analysis, written for some UK health journals, but got turned down by them! Written during April/May 2021***

How do you solve a problem like the NHS – not by doing more of the same

I was talking to a doctor friend in India recently about the pandemic and he said that things were quite difficult there and he wished they had the NHS; he had trained in the UK in 1990s but went back to work as a surgeon in the public sector. On the one hand I could understand his comment and on the other struggled with it. Having been a part of the NHS for over 40 years as an immigrant doctor I feel that the NHS exists more in our imagination as the reality is rather different. It may be the best system there is but it is not the best system possible due to fundamental unresolved problems; let me explain these by using **12345** as follows.

1 NHS –sadly there is no one NHS, it is a set of organisations behaving as separate kingdoms. Frank Dobson managed to get the Blue NHS logo in an attempt to unite it and even that has now lost its currency. I am not talking about the challenges across UK with devolved nations.

2 Design Principles – over the years two have struck me: Darzi and Nicholson reports (1,2) which said Quality (patient safety, patient experience and cost-effectiveness) should be the organising principle and Lansley's: No decision about me, without me (to empower patients) (3), and these two provide a good basis for designing the NHS delivery system.

3 Must Have's – introduce the H (Health- and move away from Illness) in the NHS, inject the 'right' amount of money, and no micromanagement from the Parliament, and without these three there is little hope.

4 Wicked issues – health: social care and primary: secondary care separation and massive fragmentation now; unwillingness to confront the inevitable (and covert) issue of 'rationing'; constant restructurings; and a lack of professional leadership are the four problems we keep shying away from.

5 Years – for two reasons: first is about taking it out of the election cycle (not that the fixed term parliament rule is being followed), basically the Opposition uses and the Ruling party abuses the NHS whilst the underlying ideology has not changed since Thatcher; and more importantly 5 years is what it will take to build any consensus on where we go with the NHS.

Over the years we have failed to address these and keep trying work arounds, most recently in the joint LSE-Lancet Commission report, though others like Reform and IEA reports earlier had tried to promote wider discussions on some of the problems (4-6).

I may (will) be criticised for the above simplistic analysis, but that should not take away the primary point about the need to start by asking what we want the NHS to

do now. Amongst the ‘experts’ there is a major ideological disagreement (7) and the LSE-Lancet report ignores that we already had years of intensive work on quality and safety, workforce planning, and not to mention on prevention and public health for example, and so why would things be any different this time? There is also the general reluctance about structural changes – and whilst I get it, having seen the toll frequent re-organisations take, but would it not be better to do a final system design?

Sadly the NHS is an old institution which has not kept up with the times and there are no clear and agreed rules for what to do with it – everything to everyone, free was never possible in 1948 (as events showed soon after, and anyway the NHS was one part of the overall societal reforms) and certainly not in 2021; it may have to be Less and Better. We need to start from the beginning – accept that the NHS is broken and its original premise needs a review and find a way of uniting the factions by (re) establishing some clear rules.

Ofcourse it will take time and there will be turbulence, but if we are serious and want to be remembered, not as the generation that destroyed the NHS, but as people who loved it and have done their best to preserve it for times to come, then let us start afresh, openly and systematically. Sticking plasters and workarounds over the decades have got us into the present situation, which apart from a tiny minority of profiteers and idealogues serves no one well.

But do we have the new Nye Bevan?

Rajan Madhok

Public Health Doctor

Denbighshire

NOTES:

1. For details of my work including references to the points made and about the Jarrow March to Save the NHS please see https://www.nhs70.org.uk/story/rajan-madhok
2. I applaud the NHS workers for their work during the pandemic and am disappointed by the lack of political recognition of this. .

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APPENDIX 6 – Indo Manchester Graduate Network

The Indo – Manchester Graduate Network

Growing graduate talent & global partnership

1. Summary

There are over 700 Indian students at the University of Manchester and a strong and vibrant community of Indian professionals within the Manchester City Region. There are benefits to be reaped for a diverse range of stakeholders by building closer relationships between the students, regional Indian professionals and the business community in the Region.

The Indo-Manchester Graduate Network will bring together Indian professionals and the business community with Indian students at the University. It will develop talent, support business development and nurture Indo-UK relationships.

Whilst the primary partners are The University of Manchester's MLP, Careers & Employability Division and representatives of the Indian community led by Professor Rajan Madhok, Medical Director – NHS Manchester, the network will also draw in the support of other players including politicians, local authorities, MIDAS, business, cultural and trade organisations.

The Network will be piloted in academic year 2010/11 and will comprise include online provision, skills development, work experience and opportunity sharing events.

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2. Background

2.1 The University of Manchester

The University is committed to playing a full role in the cultural, social and economic development of the Manchester City Region. It plays an important role in the city's international positioning through world class research ratings and through the large numbers of international students that it brings into the region to study.

There are currently over 700 Indian students studying at the University (2009-2010). This is the largest cohort of international students from any country apart from China. Indian students are spread across a range of academic disciplines with high concentrations studying business, law, social sciences and engineering. The University is keen to facilitate the engagement of its international community within the Region; to enable the business community to harness the international talent and motivation of its student population and to foster greater international awareness raising and reputation building for the City Region.

The University is also committed to developing the employability of these students. Research with India-based graduate employers and Indian alumni has demonstrated a real need for Indian students to maximise the benefits of their time in Manchester, not only through their academic achievements but also through cultural awareness, commercial insight, work experience and skills development. This programme aims to

facilitate such opportunity through a series of networking and skills development events and the brokerage of work experience and mentoring opportunities.

2.2 The Indian Community in the City Region

The City Region hosts a vibrant and diverse Indian community. There are currently over 35,000 individuals of Indian origin within Greater Manchester extending to over 72,000 across the wider North West. There are also more than 20 key Indian owned companies operating with the City Region(*). The Indian community, both individually and through various organisations in Manchester, share a passion to raise the profile of Manchester across India and facilitate the integration of the Indian student community within the Region.
(*)The Manchester City Region Strategy for India (Novermber, 2009) – MIDAS.

2.3 The City Region

The region will benefit from an enhanced profile amongst the Indian community both in the UK and overseas and it is hoped that increased understanding will, in the longer term, further enhance cross cultural relationships and economic partnerships between both the City region and India. Key intermediary organisations, such as UKTI, MIDAS and the Chamber of Commerce will be invited to participate in the Network. The Network will support the “Manchester City Region Strategy for India” (November, 2009) drafted by MIDAS to encompass and support Indo – Manchester activity.

3. The Indo-Manchester Graduate Network

3.1 The Ambition

The programme will develop a unique online community of Indian students and professionals in the Manchester City Region alongside organisations with an interest in Indo-Manchester relationship building. Combined with a series of networking events, panels, and skills development workshops the programme aims to facilitate the development of a constructive and vibrant network.

The pilot group of Indian students will have the opportunity to network with and learn from the Indo-UK community and benefit from unique experience & development opportunities throughout the programme.

The programme will include a series of skills development workshops allowing the students to develop key qualities such as cultural awareness, professionalism and networking ability to enhance their experience in the UK and facilitate further experience building. Finally, the brokerage of mentoring and work experience insights within the business community for Indian students will also be put in place to facilitate opportunity exchange throughout the programme for the benefit of both the students and the business community.

3.2 Growing the Network

The Network will launch in Autumn 2010 and the Indo-UK community including all Indian students and alumni at The University of Manchester will be encouraged to join. The Network will be free to join and will be managed by The University of Manchester’s MLP, Careers & Employability Division.

Attendance at events and workshops will be available to all network members, up to capacity, on a first-come first-served basis.

3.3 Programme Content
The programme will focus upon 4 core elements:

- An ongoing online community for students to network with the Manchester Indian community and business community and discuss key topics.

- A series of half day networking events providing an insight into the Manchester City Region, its key sectors and development. These events will also involve development workshops around core competencies such as networking, cultural awareness and effective communication.

- The development of work experience opportunities, commercial insights and mentoring opportunities for Indian students.

- Live video conference seminars for Indian students looking to return to India involving key Indian professionals / alumni based in India.

4. Programme Contact

The University of Manchester, MLP, Careers & Employability Division

Amanda Conway, Head of International Career Development:
Amanda.conway@manchester.ac.uk
Tel: 0161 275 2828

APPENDIX 7 – Note to the GMC

OPPORTUNITIES FOR THE GMC IN INDIA

For circulation to
Peter Rubin
Terence Stephenson
Iqbal Singh
Paul Philip
Neil Roberts

Cc Ramesh Mehta

Introduction

GMC is recognised as a world leader in fostering good medical practice and promoting high standards of medical education. The work on medical regulation to promote patient safety by supporting doctors through clear guidance on standards and ethics and the forthcoming revalidation plans are just two examples of the ground breaking GMC initiatives.

For historical reasons, the Indian medical system is modelled on the British lines and Indian doctors have been attracted to come to the UK since the middle of the last century. There are now estimated 40,000 doctors of Indian origin working in the NHS.

Both countries are changing with times. The Department of Health has several ongoing projects in India; some Royal Colleges are conducting post- graduate examinations already and many more are planning to do so, and there are plans to establish linked medical schools in India. Indian health care system especially in the private sector is developing very fast and the Government there is also putting in huge resources to improve the health of its population. The scale and pace of this change in India offers a unique opportunity for the GMC to assist Indian colleagues.

Not only will this meet the UK's stated intent of helping developing countries as part of the UK Government's Health is Global strategy, it will also promote diversity, further increase GMC's international influence and help with the relationships with the UK based Indian doctors many of whom feel undervalued in the NHS.

This short paper has been prepared to summarise my associations with developments in India and to present my initial thoughts on the way forward.
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Background

For some time I have been supporting colleagues in India about health care developments and public health. A major focus of my work has been clinical quality and patient safety, more recently in my capacity as the India Envoy of the National Patient Safety Agency (NPSA) with support from the WHO. We are hosting a convention on patient safety in Delhi, India from 27-29 Nov 2009 – see

www.ichapatientsafetycon.com for details. As part of this development, we have been in discussions with the Medical Council of India (MCI) about incorporating patient safety within the undergraduate curriculum and colleagues have expressed interest in understanding more about the work on supporting and regulating doctors. There are also plans to review the overall medical education curriculum in India.

It has become apparent to me that the developments in India could benefit from the work that has been done in the UK by various health organisations for the last two decades. Accordingly, my aim presently is to explore potential for collaboration on health and in particular to leverage the UK's health care intellectual capital in India. In addition to the NPSA I have spoken to Andrew Dillon at NICE, Nigel Crisp who leads the Global health work (who told me this week that Ara Darzi is setting up NHS Global Health, and I have just written to him), colleagues at the Northwest SHA and Manchester City Council, amongst others, and there is support for this idea.

Why GMC?

Since joining the GMC it has seemed to me that there is a lot within the GMC which would be valuable for the above developments, in particular I am interested in our expertise and experience in medical regulation and medical education, both of which are at the heart of patient safety.

Iqbal and Paul Philip have already started the BME:GMC Forum and we have had one meeting which provided an opportunity to explore the issues affecting these doctors within UK. There are plans to develop this work further and I won't comment on it anymore here. The main focus of this paper is outward, towards India, although I do recognise that there are overlaps between the interests of Indian doctors in the UK and our potential work in India.

I have had detailed discussions with Ramesh Mehta from the British Association of Physicians of Indian Origin (BAPIO), since BAPIO is also working on this issue. Ramesh is very well engaged in India and has already secured recognition of UK qualifications in India and has also spoken to MCI, for example.

There was a meeting in Sep involving Ramesh, Finlay, Neil and myself. Ramesh was looking for options on how to create a win:win, given that the NHS still needs doctors from India (with shortages in some areas) and potential developments of UK linked medical schools in India and proposed postgrad College exams being held there. On the other hand, the view of the Indian doctors is that they do not get good training in the UK and the UK does not recognise their Indian experience/qualifications, and overall they feel undervalued. At the meeting we realised that there was a need to explore how we could work together and find practical ways forward to ensure fair play, within the existing policy framework.

Such joint working would help:

- to restore confidence amongst Indian doctors
- to support recruitment from India
- to help plans to develop medical schools and College exams in India
- to support developments in patient safety and clinical quality in India and

- to ensure that Indian doctors who come here acquire good training.

How GMC?

We could start all this by exploring how the GMC can work with MCI/BAPIO in terms of 'knowledge exchange' around education/regulation – in Nov when I go for the Convention mentioned above we will have further discussions with MCI. Naren Patel will be at the Convention too and we will invite him for these discussions too. Ramesh is already working with Terence on establishing RCPCH exams in India and will explore how this development can provide a model for others and help bring 'qualified' doctors to come and receive further training in the UK under Medical Training Initiative (MTI). Ramesh and Terence are visiting India in January 2010. In addition, the President of MCI, Dr Ketan Desai, who is also now the Chairman of World Medical Association, may be visiting England in Feb 2010 and we could try and meet him (In principle, Peter has already agreed to this, subject to logistics). BAPIO has been told that the Indian Union Health Minister, Mr Ghulam Nabi Azad will attend the BAPIO annual conference on 7 Feb, and is seeking ways to develop Indo:UK collaborations. You may recall that the GMC had offered to host a special meeting for the Minister in early Sep- but the visit was cancelled. So, there are already many ways for discussions.

To make good use of these opportunities, however, we need to refine our thinking further by creating a small group, amongst the people listed on this paper, and significant others, and to develop practical action points. We will need to be clear about which areas are worth pursuing at present given that we work within a policy framework and are also a charity with its sets of rules.

Conclusion

Whilst recognising that we are very busy at the GMC currently for various reasons, it seems to me that we have a unique opportunity to do further good by supporting developments in India and enhance our international standing and which in turn will help restore better relationships with a very key group (of Indian doctors) in the UK.

We should see this as an evolving and longer term project, and which will be partly opportunistic. The important thing is to take the first steps and create a mechanism for on-going developments. The associated workload can then be managed, as we can pursue this work on the back of some current mechanisms.

RAJAN MADHOK
25 Oct 2009

Personal note

I thought it would be good to share all this with you so that I can get a steer from you as to what areas to pursue and how. I should also declare that I will be more closely associated with BAPIO, as their Chairman from 7th November.

I will be happy to clarify anything I have written and look forward to your comments, and hopefully a decision on how to proceed.

APPENDIX 8 – Note to Faculty of Medical Leadership and Management

PROPOSAL TO CREATE AN INDIA CHAPTER FOR THE FACULTY OF MEDICAL LEADERSHIP AND MANAGEMENT

1. This brief paper has been created following initial discussions between Peter and Rajan to develop an India Chapter for the FMLM. It will be shared with the Governing Council to seek approval with a view to subsequent implementation.
2. Since its start the FMLM has grown rapidly to become an important resource for doctors seeking an understanding of and involvement in leadership and management issues.
3. India is an emerging economy and there are major health developments in all sectors; public, private and NGOs. Leadership and management have been identified as crucial elements to help deliver the planned reforms and ensure good quality, affordable health care to the 1.2 billion Indians.
4. There is a strong and growing tradition of Indo:UK collaborations in health, there is a large number of Indian doctors in the NHS and many of them are supporting various health initiatives in India. They are also very passionate about the NHS and keen to see the model adapted in India. This support is reciprocated by many doctors based in India.
5. We propose to establish an India Chapter of the FMLM with the aim of supporting and developing health leaders in India. A detailed programme of work over the next 3-5 years will be developed in conjunction with all FMLM members of Indian Origin and those with an interest to join the Chapter.
6. It is important to consider a number of questions in terms of this proposal, as follows.
7. First, Is the FMLM, being a new organisation, ready for this development? Whilst new, the FMLM has grown rapidly and enjoys substantial support and it looks likely to become more influential. The India Chapter in some ways will help the FMLM to further grow. But see below also.
8. Second, why India? There is nothing to stop the FMLM from creating other such chapters and we believe that this might indeed happen once we set this up. We will, in any case, explore the potential of India Chapter to cover the South Asian sub-region, in time.
9. Third, are there resources for this development? We plan to work with other organisations and through the Leadership for Health initiative, which has the support of the Global Association of Physicians of Indian Origin (www.leadershipforhealth.com) in taking this forward. Apart from 'indirect costs' and especially some time from the staff in starting this Chapter, no other funds are being requested. India Chapter will become fully self-financing with some revenue coming to FMLM. Funds will be generated in a number of ways:
   a. Through Associate Membership for doctors based in India
   b. Through commissioned leadership development programmes
   c. Through Conferences and workshops

10. Fourth, why should FMLM not seek other partners in India and especially some top management schools? Indeed, and infact that is exactly what may/will happen. India is too large a country and there are some excellent programmes already- we will certainly explore association with them.
11. At this stage it may be worth digressing and sharing how the work may unfold. It is envisaged that we will set up a number of mechanisms as follows:
    a. A National mechanism in India- to basically an India office through the LfH as the coordinating centre
    b. State wide sections – in conjunction with the UK based Indian doctors who come from various parts of India and many of whom support health developments there, we will explore setting up state sections.
    c. Specialty based projects/sections – similarly, there is increasing recognition of the need for medical leadership and management by the specialty societies
    d. Subject specific programmes- GAPIO is promoting a number of programmes some topic based such as diabetes and others cross cutting such as patient safety
12. Fifth, the Faculty would rightly want to be assured that this development does not compromise its reputation; apart from financial risk, the reputational risk must be avoided. Obviously we will need to put proper systems to ensure that the Chapter follows best practice in corporate governance- and we will do so subject to agreement in principle.
13. The immediate next steps would be to
    a. Publicise the Chapter through FMLM website and other mechanisms
    b. Hold a meeting of interested Indian doctors in the UK
    c. Start 1-2 specific projects in India; in this regard the Society for Emergency Medicine in India (SEMI) has already requested support
14. In summary, creating the India Chapter is a risk free and resource neutral (indeed resource generating) project, which will further strengthen the FMLM.

RAJAN MADHOK AND PETER LEES

Jan 2013

APPENDIX 9 – The Indian Conundrum

British Journal of Medical Practitioners, September 2009, Volume 2, Number 3

Editorial

BJMP 2009:2(3) 4-6

Global Health Challenges: The Indian Conundrum

Rajan Madhok

Introduction

The huge disease burden and vast health inequalities and given that one in six person in the world is an Indian on the one hand, and the country's recent economic rise and its intellectual capital in-country and also overseas on the other hand, has created the Indian conundrum for global health challenges. India is now both: the problem – as it contributes to the challenges, and the solution – if it can mobilise its resources. This short paper will expand on the theme and especially explore how the Indian Diaspora in the UK can help to ensure good health and affordable health care to the needy.

The problem: Global health challenges

The World Health Organisation (WHO) has established the ten facts on the global disease burden (Table) [1] and its 2008 report: Primary Care: Now More than Ever [2] has identified the five global challenges in ensuring health care (Box).

As would be expected the situation in India confirms these facts and challenges.

TABLE : FACTS ON THE GLOBAL BURDEN OF DISEASE (Source: www.who.int)
1. Around 10 million children under the age of one year die each year
2. Cardiovascular diseases are the leading cause of death worldwide
3. HIV/AIDS is the leading cause of adult deaths in Africa
4. Population ageing is contributing to rise in cancer and heart disease
5. Lung cancer is most common cause of deaths from cancer in the world
6. Complications of pregnancy account for 15% of deaths in women of reproductive age worldwide
7. Mental disorders such as depression are among the leading causes of disability worldwide
8. Hearing loss, vision problems and mental disorders are the most common causes of disability worldwide
9. Road traffic injuries are projected to rise from the ninth leading cause of death worldwide in 2004 to fifth in 2030
10. Under-nutrition is the underlying cause of death for at least 30% of children under five years of age

BOX: FIVE COMMON SHORTCOMINGS OF HEALTH-CARE DELIVERY (Source: WHO Report 2008)

Inverse care. People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least. Public spending on health services most often benefits the rich more than the poor in high- and low income countries alike.

Impoverishing care. Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care.

Fragmented and fragmenting care. The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced, while development aid often adds to the fragmentation.

Unsafe care. Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health.

Misdirected care. Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health.

As would be expected the situation in India confirms these facts and challenges. There is a lot of health information for India in the public domain [1,3] although the nature and detail could be improved. Like in many other developing countries the life expectancy has increased and although improved health has led to further economic welfare in India, the country is currently experiencing the triple whammy of the disease burden due to communicable (CD) and non-communicable (NCD) diseases and injuries. Communicable diseases account for about 38% of the

education given common heritage and needs and opportunities on both sides. In addition to working on discrete areas like patient safety [7] or public health capacity building [8] an important first step would be to create a mechanism for regular dialogue in order to identify and progress priority projects of mutual interest.

Conclusions

India has come a long way since its independence and given its size and complexity continues to have ongoing challenges [9, 10,11]. It is essential to recognise that health is not a consumptive sector, but by creating healthy people, free from illnesses, can be a productive sector.

The basic message of this paper is that being a physician in India in the 21st century is both, a privilege – given the ancient history and traditions and recent economic successes, and a responsibility- given that despite being the world's largest democracy and an economic superpower there are vast health inequalities and lack of safe, affordable basic health care to a large proportion of the citizens in India.

At the time of writing this paper, there is intense debate about the NHS in the American press triggered by President Obama's attempts to reform US health care. No doubt whilst things could be better in the NHS, there is still a lot that the world, both developed and developing nations, can learn from the NHS [12, 13] . Indeed best practices, regardless of whether they come from US, UK or anywhere else could, and should, be adapted to support ongoing efforts in India.

14. .

ACKNOWLEDGEMENTS
Thanks to Akhil Sangal and Raman Madhok especially amongst many others who have helped me over the years.

COMPETING INTERESTS
None Declared

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APPENDIX 10 – Note to the North West Strategic Health Authority

DRAFT FOR SHA BOARD IN JAN 2010

NHS INDIA @ NORTHWEST: A PROPOSAL

1. This paper describes a proposal for the establishment of a coordinating centre to mobilise and leverage the NHS intellectual capital in India for the mutual benefits of both countries.

2. It builds on the Board paper on the Global Leadership for Healthcare for NHS Northwest in May 2008 which, amongst other things, outlined suggestions for an Indo:UK collaboration in health care.

3. There is a growing recognition within the region, and beyond, that developments in India are of great relevance; Northwest Development Agency has an office in Mumbai, India, and various delegations have been to India to explore/promote collaborative business ventures. An overarching 'India Strategy' is being developed through the Manchester City Council and it recognises the importance of healthcare as a specific element.

4. There are several reasons for developing a bespoke programme of work on health care with India:
   a. Common Heritage – there is a close link/affinity between India and the UK, for historical reasons, and the Northwest has particular links given the Lancashire cotton trade and with Manchester being the first industrial city
   b. Substantial Existing Commitment – there is a large Indian Diaspora including nearly 40,000 doctors of Indian origin in the NHS, many of whom have ties back to their roots and are supporting discrete projects
   c. Developments in India – there are a number of developments in India, at both Governmental (central and state) and in the private sector which have brought health to the forefront – the attached paper gives an overview of this
   d. Developments in the UK – in addition to long standing reliance on Indian doctors in the NHS, already there are links in terms of R&D, biotech, IT and education. The following are just some examples:
      - Various royal colleges holding exams in India
      - Still ongoing recruitments of doctors from India
      - MRC/ICMR (Indian equivalent) links on research
      - DH support to Public Health Foundation of India
      - NPSA's support for patient safety work in India
      - NICE's recent visits to India to explore collaborations
      - RSPH has won a contract to deliver training

Alongside these there are a whole range of voluntary organisations and individuals supporting various projects in India. Hardly a week goes by without another UK delegation visiting India for opportunities.

Overall, India is one of the fastest growing economies with potential to help us in the west and equally India needs help in terms of health policy/strategy and health care expertise.

5. Considerable work has already been undertaken in this regard, and the following are some of the highlights:
   a. Northwest region has emerged a strong leader in promoting innovation and quality and safety within the NHS through the various initiatives including now the Northwest Improvement Alliance and the Leadership Academy
   b. Rajan Madhok, the medical director of NHS Manchester, has been working as the India Envoy of the National Patient Safety Agency since late 2008 and was the overseas coordinator for the national convention on patient safety in New Delhi, India in Nov 2009
   c. He has also developed education programmes on patient safety through the www.peoples-uni.org, and is currently hosting four Commonwealth Fellows from India who are spending three months learning about the NHS approach to quality and safety
   d. He has initiated discussions with NICE and GMC also about collaborative ventures, and more recently in his capacity as the Chairman of British Association of Physicians of Indian Origin (BAPIO) he has explored the possibility of mobilising the support of the large Indian diaspora in the UK.
   e. Rajan has shared his work with Lords Crisp and Darzi, both of whom have expressed an interest in this model.

6. It seems that the above work provides a good platform for the Northwest SHA to build on.

7. The important issues to consider are:

   a. The scope of the work to be undertaken through this Centre: Lord Darzi is leading the work on NHS Global and developing his plans on how best to implement the UK's Health is Global Strategy. We should be guided by it, and also inform its developments. There are already a number of other India related developments nationally: for example, the Medical Research Council is working with its Indian counterparts and the DH is working on issues to do with pharmaceutical industry. Our aim should be to explore how we can complement these developments by leveraging the enthusiasm and support of the Indian diaspora and further add value by addressing areas that have not been picked up. In this regard, it is clear that we have a lot to offer in terms of quality and safety and

capacity/capability building already, and potentially that could be the starting point.

b. The nature of SHA support: given the grass roots development of this proposal and given the organic nature of it whereby the proposal will develop opportunistically and over time, the SHA's role should be supportive and not just directive. The SHA can help by:

   i. Facilitating discussions at the national level: it should be noted that this may not be the only route into India (there are, and will be, other proposals given the enormous interest in India) and we can work with Lord Darzi to create a model, which can work as an exemplar for other countries in time. The NPSA is also keen to support this.

   ii. Providing space for this development: a small office with IT facilities would help establish the presence of this Centre

   iii. Providing a small amount of administrative support- most of the work will be done virtually but will require administration.

c. The name of the Centre: given the currently used 'NHS Global' term being used by the DH, an option would be to name the initiative 'NHS India@Northwest'

d. Funding for the initiative: the Centre should be self sustaining within 3 years. In the meantime, the funding will come from four sources: indirect/in kind funding as in 6b above, redirecting UK's existing health related overseas aid to India– subject to further discussions with Lord Darzi, raising charitable funds via the Indian community and potential private partners either in the UK or in India, grants such as for scholarships/consultancies

e. Governance arrangements: most of the work has been, and for the foreseeable future will be, done by Rajan Madhok, and he can be appointed as the director of the initiative. An advisory/steering group consisting of a range of partners with SHA support would direct the work.

f. Outcomes and return on investment: this should be seen as a longer term investment by the NHS. None the less it is essential that there are clearly agreed outcomes: in the first two years apart from setting the systems and procedures, it is anticipated that there will be increasing professional exchanges including either scholarships or paid attachments to various NW/national institutes and potential consultancies in India, and a wider engagement programme to coordinate and build on the existing voluntary work being done by the UK based Indian community already; the latter would include raising funds.

In conclusion, the SHA Board is asked to consider this proposal and support it, noting that to some extent this is a developmental project and will evolve over time. We can build enough safeguards to ensure that it remains cost-effective, enhances the reputation of the SHA, and benefits the NHS as well as support developments in India.

Mike Farrar

Chief Executive

APPENDIX 11 – Explaining India

https://www.bmj.com/content/348/bmj.g3169/rr/699960

Rapid response: Corruption ruins the doctor-patient relationship in India

I thank Dr Berger for volunteering in India where sadly access to health services and especially affordable and good quality health care remains a big problem.

I also agree with him, and thank him for sharing, graphically, his assessment and highlighting the rampant corruption at all levels.

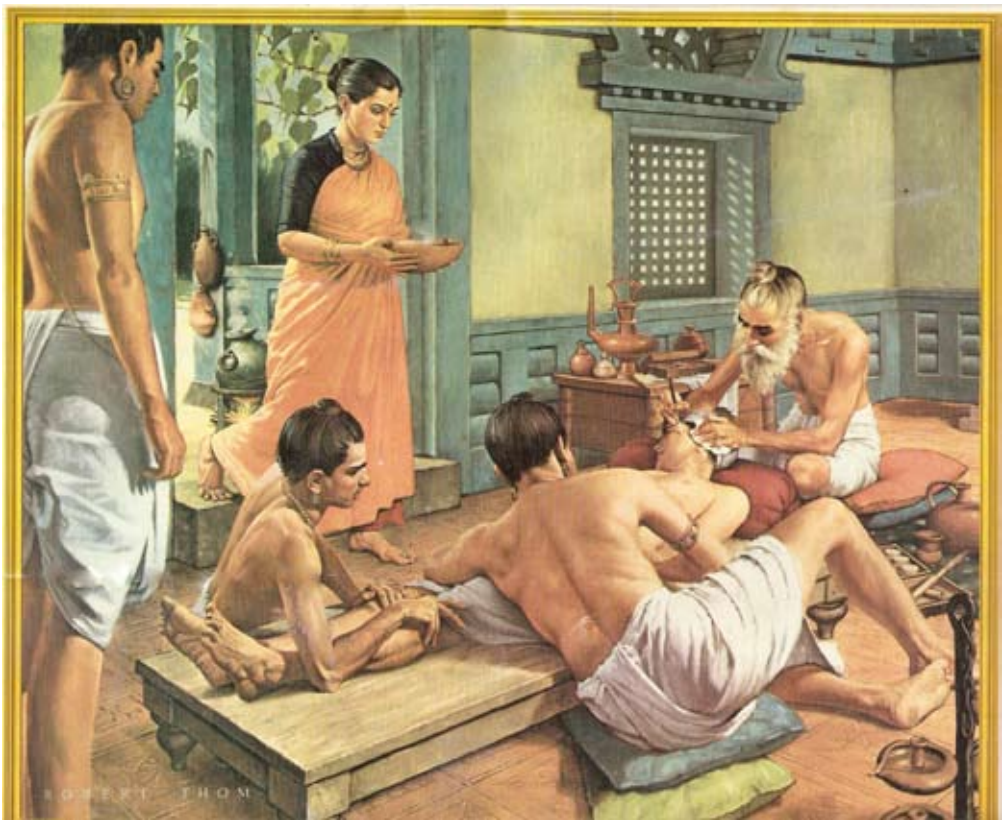
However, I disagree with the proposed solution. Withdrawing recognition of private medical colleges in India amounts to an ill-considered retaliatory action, and is ironic to say the least. As it happens I have just finished the joint Health Education England and College of Emergency Medicine exercise in Delhi, India on recruiting Indian doctors to staff the A & E departments in the NHS! The NHS has always depended on International Medical Graduates (IMG), the largest group being Indian, and for decades they have had to pass the GMC's PLAB test before they can work in the UK, so regardless of their origin –private or public medical colleges- they have been deemed fit for the NHS. Going down this route the NHS will also have to stop doctors from many other countries, since corruption is widespread and not just restricted to India.

There has already been a severe reaction, both, in India and in the UK, to the recent adverse media reports about sub-standard foreign doctors, and there seems to be an unfortunate targeting of Indian doctors. It is almost double standards, whereby on the one hand the NHS relies on Indian doctors and on the other hand pillories them; the recent judicial review case of unfair discrimination in the RCGP exam with the Judge ruling that the British Association of Physicians of Indian Origin (BAPIO) was right to bring the case and could claim moral success though not legal victory shows that we in the NHS are in danger of losing the moral high ground, further polarising IMGs and Black and Minority Ethnic (BME) staff and compromising service delivery and patient safety.

I would request Dr Berger, and others like him, to come and join forces with us; collaboration not blaming is the way forward. What he has reported is important though not new for those of us who have been trying to deal with these issues for a long time. Many of us are equally disturbed and recently held a workshop in Kolkata, India to discuss the lack of leadership and professionalism amongst doctors and explore how we can address these issues by working across the globe (http://leadershipforhealth.com/ - see homepage for the Global Indian Doctor initiative). We are also going to hold a conference on Indo: UK collaboration in health on 28 Nov in Manchester and explore how we can deal with corruption in health, develop leaders and promote professionalism, and create a win: win for both countries.

Note: The leadershipforhealth.com website is no longer in existence.

PROMOTING
PROFESSIONALISM AND ETHICAL PRACTICES
IN MEDICINE:
Indian doctors from across the globe working together



A publication prepared for the Workshop in Kolkata, India on January 10, 2014;
to be held on the eve of the Annual Conference of
the Global Association of Physicians of Indian Origin (www.gapio.in)

Editor: Rajan Madhok (rajan.madhok@btinternet.com)

LEADERSHIP FOR HEALTH

www.leadershipforhealth.com

CONTENTS

FOREWORD

Much has been written about the health problems in India: from being the 'sick man of Asia' with child nutrition levels worse than in Sub-Saharan Africa, to poor quality medical education and training, corruption and rampant absenteeism in public facilities and 'commissions' being paid in the private sector for example. The July-September issue of the *Indian Journal of Medical Ethics* has covered some of these matters in detail (http://ijme.in/issue213.html).

Our purpose is not to repeat these well-known problems; these are the realities of India. Sadly, the negative image is the one that gets more, and increasing, coverage – and doctors are portrayed as uncaring, money grabbing, poorly trained, and unethical professionals. And of course, there is some (much?) truth in these allegations.

It is very tempting to accept this analysis and feel defeated. This would be incorrect and also morally wrong. India remains a land of contrasts in health as in any other field- if one thing is true then the opposite is also true. So whilst the health indicators are going down and some professionals are seen as having abdicated their responsibilities, progress is being made in many areas. Whilst, nationally, there may be more hand wringing and apathy, some states are taking health issues seriously. There are also pockets of excellence in service delivery and in medical leadership (I will refrain from mentioning any names, since by doing so I will be in danger of ignoring others equally deserving!), and all these give cause for optimism.

So our job should not be about continuing analysis or being critics, rather our job should be to build on this foundation, small though it may be, and move forward. Despite the massive economic growth, little attention has been paid to the health sector; and the last two decades since the economic liberalisation in India could be summed up as wasted years, as far as the health of the population is concerned. We could, and should, do better. Crucial to the success of such reforms will be medical leadership- doctors have to take charge and steer the agenda. We need to help take India to the level it is potentially capable of - which is of a nation proud of its heritage, its people and their ingenuity, and their commitment to rising to the challenges and making a differenceat home and globally.

It was with these thoughts that the idea of holding this workshop came about.Fortunately, I discovered many like-minded friends and colleagues in India and overseas; and I was even able to persuade some of them to write for this publication, since I was keen to get views from various stakeholders to set the scene for our deliberations. I have not been entirely successful in achieving this goal in time for the publication – I particularly wanted to hear more from women doctors, from the establishment, and from doctors in the private sector - but as we start our discussions, hopefully they, and others, will join us. I will try and arrange for more writings to be posted online also.

I hope that we will use the time leading up to the workshop to have further informed debates, which will help us spend the time in Kolkata working out what we should do going forward, by learning from and supporting each other globally. The notion of creating the 21st century (since medicine has changed dramatically in the last few decades) code of conduct for the 'Global Indian Doctor' (what do we want the global Indian doctor to be like-what do we stand for), the opportunity to promote and celebrate the true leaders (of whom there are many and who can provide the role models for, and mentor, the coming generations) and the ability to establish leadership development programmes are some of the outcomes that we should be aiming for.

In closing I am reminded of the quote from John F Kennedy:

> *"All this will not be finished in the first hundred days. Nor will it be finished in the first one thousand days, nor in the life time of this administration, nor even perhaps in our lifetime on this Planet. BUT LET US BEGIN."*

We owe it to ourselves and the future generations to address the health challenges in the 21st century and ensure that Indian doctors can hold their heads high wherever in the world they happen to practise. Leadership is not about waiting for the right set of conditions, but it is about creating those conditions and ensuring progress.

Fortunately for us, it is not a totally new beginning, as we will be able to build on the work already done by many

colleagues.As you will see from the articles in this issue there is enough desire for change and more importantly there is considerable experience, expertise and commitment – and we may be at the 'tipping point'. But yes, we will need to speed up and yes, it will need a change in direction. We will also have to find that 'Third Way' – which balances activism with practical action and will help us move forward. Indian doctors can be at the forefront of the much needed revolution in health in India and globally. I hope (and in fact am sure!) we are ready for it – together we can. I am looking forward to our discussions.

Thank you.

Rajan Madhok

ONE OTHER COMMENT

The things that one does for a brother ----! Rajan has kept me busy over the last two decades; he is the elder and in any case it is hard to say no to him! But over the years he has convinced me of the need to do something about health matters in India and not accept the status quo. To my mind, the ultimate salvation is in creating new leaders, leaders who can find pragmatic solutions for India and make progress despite the seemingly insurmountable problems. Having benefitted from participation in various leadership development initiatives, both here in India and overseas over the years, I believe that the time has come to celebrate, support and develop health leaders in India. There is a real need for systematic and structured programmes of leadership development- we cannot leave it to chance and we cannot rely on 'on the job training'. The scale of challenges is vast and we need large numbers of leaders. We can work with other sectors and with the large Indian diaspora (and not just doctors) in this task and achieve the necessary changes which will ultimately benefit us all. After all we want good quality, safe and affordable care for ourselves, our families and our friends. So, this campaign is as much about self-interest as about doing public good.

I am not a doctor but such initiatives do require wider participation and I very much hope that as we take the agenda forward we will include others. I can assure you that there are many people from various sectors who will be delighted to participate and support you on this journey.

I look forward to working with you on this important initiative.

Raman Madhok

NOTE

The one-day workshop is being sponsored by GAPIO, and we wish to acknowledge the personal support of the Secretary-General, Dr Ramesh Mehta.

The Leadershipforhealth initiative, which has provided the platform and some financial assistance will be redeveloped depending on the outcome of the workshop and will have proper constitution, governance and management arrangements.

This publication was produced with help from the Indian Journal of Medical Ethics Office, Mumbai; thanks are due to Meenakshi.

WORKSHOP ANNOUNCEMENT

WORKSHOP TO PROMOTE PROFESSIONALISM AND ETHICAL PRACTICES IN MEDICINE IN INDIA: Indian doctors from across the globe working together KOLKATA, INDIA, 10 January 2014

Introduction

Providing affordable and safe health care is now one of the biggest challenges facing all countries, and with rising costs this is leading to further health inequalities and apart from creating waste this situation has the potential to create civic unrest. The problem is very acute in India – with almost 40 million Indians falling below poverty line due to illness annually- although some recent developments including the Universal Health Care Coverage plans offer some hope.

In addition, with 1 in 6 persons in the world being an Indian and the vast health burden in India and with rising economy and innovation, India is both, the cause of global health challenges and the potential solution.

With nearly 1.2 million Indian doctors worldwide, they can be a powerful resource for change. However, are we up for the challenges facing the health system in India? How can we reinvigorate the sense of vocation and promote professionalism and ethical practices? How do we support and develop health leaders in India? There are serious concerns about all aspects of medical practice: from entry to medical colleges or to post-graduation to the quality of education and training and about self-referrals and commissions paid. The question being asked is have doctors lost their way in India?

The above is not to deny that there are many concerned and committed doctors who wish to see these trends reversed and restore the sense of vocation and pride amongst doctors. The Forum for Medical Ethics with its publication the Indian Journal of Medical Ethics, and Medico Friends Circle; have been raising awareness of professionalism and ethical issues for many years. More recently, the Global Association of Physicians of Indian Origin (www.gapio.in) has been formed to mobilise Indian doctors worldwide to enable them to achieve professional excellence and especially to explore how we can all work together to support health developments in India.

Being an Indian doctor in the 21st century is both, a privilege and a responsibility, and we need to play our part in tackling the health challenges where ever we work. We need to ensure that we not only treat illness but also contribute to human and social development.

Accordingly, it is proposed to hold a one day workshop, at the same time as the GAPIO annual meeting, as follows.

Proposed workshop

The objectives of the workshop are:

a. To learn about the state of professionalism and ethical practices in medicine in India: where are we and what is being done to address any problems
b. To learn about the experiences of Indian doctors overseas and explore their relevance to India
c. To discuss the values and behaviours (the professional framework) required – what should the **Global Indian Doctor** be like
d. To discuss and develop a potential programme of work to recognise, support and develop health leaders who can help promote these values and behaviours

Date: January 10, 2014

Venue: TBA, in Kolkata

Participants: By Invitation; expressions of interest from those wanting to attend are invited

Pre workshop:

Prepare a special publication with invited articles in line with the above objectives/themes, to promote discussion and enable prior preparation.

Post workshop:

The Steering Group will meet the day after the workshop to develop a 'road-map' for the next 5 years.

***Background Resources/Reading*:**

Additional resources will be available here in time, and for now you may wish to refer to

- www.leadershipforhealth/resources/
- http://leadershipforhealth.com/wp-content/uploads/2012/07/milroy_lecture_2003.pdf
- http://indiatoday.intoday.in/story/aamir-khan-satyamev-jayate-medscape-india-medical-institutions/1/198587.html)
- http://www.mfcindia.org/main/Open%20letter%20to%20IMA.pdf

Rajan Madhok (UK)

Nobhojit Roy (India)

Amar Jesani (India)

Shailja Chaturvedi (Australia)

& others

27 June 2013

PERSPECTIVES FROM INDIA: Overviews

Leadership and Professionalism in the Medical profession

Anurag Mishra

(With kind inputs from Dhruv Kaushik and Monali Mohan)

Introduction

Many people ask me why I chose medicine as a career. Whenever I ponder on this I realise that it is because I believed being a doctor would earn me respect and a high social status in the eyes of the general public.

But is this actually true?

I have been forced to think about this over the last 12 years of my professional career as a surgeon. I keep seeing patients and their relatives fight with doctors, at times to the extent of assaulting them. The rising number of litigations against medical professionals is no longer news to anyone. Is this the very profession, which was treated as noble, in which doctors were respected next only to God? It often seems to me that the regard for doctors is due to fear rather than true respect. The answer is disturbing to me as I am in love with my profession and it saddens me to see the fall of what I consider as the purest work for humanity.

The cause

My trained scientific mind analyses this scientifically as it does any problem. In the interest of not being biased in my analysis, I asked different sets of people like doctors, students, patients and non-medicos to give their inputs. I also conducted a survey among doctors. The data I got was a real eye opener. The problem is not simple at all. It has multiple cross linkages with issues which exist in a vicious circle.

The argument (a common man's perspective)

The common thing among several interviews I held with non-doctors, patients and my friends was that they don't trust doctors unless they are family friends or at least have been recommended to them. I could correlate that with the fact that my neighbors would come to me for second opinions regarding cases, even after visiting a specialist of that domain. They lack trust, and believe that the doctors' decisions are driven by the profit motive and not by the welfare of patients. From the patients' perspective, lists of unnecessary investigations and treatments that are long term and costly (but unnecessary) are often deployed as methods by doctors to "fleece" them.

To many for whom cost is immaterial, the attitude of doctors to patients and relatives is a sore point. Doctors don't take well to being questioned and believe that they are at the apex of the process of decision making on their patients' health needs. In India, in most places doctors follow what is called the "father-son" type of communication and decision making which means that the doctor believes that he has the right to take decisions on behalf of the patient because of his/her domain knowledge. Considering the fact that, in modern times, even biological parents have lost the power to dictate terms to their children, it has clearly become a point of dissatisfaction.

Another observation that many interviewees made was that doctors don't have empathy towards patients and their problems. The doctors treat patients as mere cases, which is painful for many patients and more so for their families. It is not an infrequent sight to see groups of junior doctors giggling near the bed of a patient fighting a terminal disease. Such acts indicate that there is a serious lack of professional attitude even though we term ourselves as hard-core professionals. It is rare to see or hear of such behavior in any other profession, especially while dealing with clients, because of the serious personal and professional repercussions of the act.

The counter argument

When asked, almost all the medical professionals argued that while there might be some rogue elements, most of them work to the best of their ability and with sincerity. A medical professional walks a tight rope because even the

slightest mistake can have serious repercussions on patients and their families. Hence, the mistakes of the medical profession are not comparable to mistakes in any other profession.

In a field of such great significance, the system, infrastructure and policies are all too outdated and backward. As a matter of fact, India spends only 1% of its GDP on healthcare, where supposedly there is no room for mediocrity and half measures. With the lack of proper infrastructure and facilities, it is unfair to blame everything on doctors. Also, there are many other factors like the sale of medical college seats for money, the absence of a uniform system for admission into medical education, and the current system of reservation for various classes of society, which lead to many of the meritorious students being deprived of a hard earned seat. It all leads to deterioration in the quality of doctors and suffering of the fraternity as a whole.

The supply of manpower in the health sector is also much below the required level. Thus the existing workforce is overworked and its efficiency understandably takes a hit. There is no time for activities like talking to patients, explaining to them about their illness, discussing the options or at least empathising with them. An average doctor works for about 80-100 hours per week. Scientific literature is full of studies, which clearly show that if any individual works for more than 50 hours per week, his efficiency may fall to unacceptable levels.. To compound that, they work in a high performance and high stress environment.

Another major factor is the medical education and evaluation system. Medical education needs a total overhaul if we want to make healthcare in India a high quality service. The curriculum has to be practical, interactive and inclusive of recent trends/research topics. As doctors in clinical practice, we all talk about ethics but during our training period we are never exposed to this facet of medical education including aspects like patient communication etc.

But why this step-fatherly attitude towards healthcare? Why is everything from the standards to the execution in the field below average? Apparently, the only good thing in this field is that the cream of the educated class aspires to and enters this profession. The likely reason for poor quality healthcare is that the medical profession lacks leaders. Leaders, who can take appropriate initiatives, who are planners, who can reason with policy makers regarding the just demands of the medical fraternity and then plan a proper execution model for the same, are needed. Also, the stream has lost its incentive and strength for innovation and research, leading the Indian medical community to be pushed back year on year at a global level. When I look around almost everything has changed from what it used to be 20-30 years ago. But our hospitals, especially public hospitals, are in the same old era.

The solution

All these factors make me realise that the problem is multifaceted and so the solution also needs to be multipronged. All the stakeholders like doctors, medical students, teachers, policymakers, professional bodies (like the Indian Medical Association, the Medical Council of India) and representatives of the public should identify their roles and come together to formulate an effective solution.

Some of the solutions proposed through discussions with various stakeholders were:

- **Better and stronger policies:** Government should come out of its comfort zones and start taking long overdue steps to enforce regulations. Also it needs to increase the budget allocated to healthcare. Health needs to be made the top priority.
- **Let merit prevail:** There should be no scope for mediocrity in a field as important as medicine, which handles the invaluable human life. So, no sale of seats, abolition of the current system of reservation and also a stricter and fairer system of entrance and exit exams will go a long way in improving the system.
- **Code of conduct for doctors:** There should be a strict code of conduct for doctors along with appropriate audit mechanisms relating to fee structure, investigations, prescriptions, etc. This code should be monitored by an appropriate agency and defaulter doctors should be suitably punished.
- **Upgrading skills and knowledge:** It should be compulsory for all practicing doctors to be up to date with the latest advances in the medical world; making CME compulsory and even a refresher exam for renewal of medical license every 5-10 years can help achieve this goal.
- **Revamping the medical curriculum:** This is long overdue and should be done as soon as possible. In the recent

past some steps were taken but they got caught in the web of the legal system and have been on hold.

- **Promote ethics and leadership:** As part of medical training and later as refreshers, steps should be taken for promoting good ethics and leadership. This can be done by means of workshops, seminars and recognizing and awarding people who exemplify high moral standards and can be an example for the rest.

- **Promoting co-curricular activities:** One major problem is that, at the end of the long medical training, doctors become detached from the real world. They are not educated humans but more like robots who just know their books and nothing else. Putting due emphasis on development of hobbies and co-curricular activities will help them stay in touch with the various aspects and people apart from the medical fraternity.

- **Encouraging new ideas and involvement in research:** A medical resident with a thought that goes beyond what is written in textbooks has to face a lot of hurdles and even criticism, which kills the desire to tread that path. There needs to be a framework established for good research with focus on aspects including funding, infrastructure, recognition, guidance, industry interaction etc.

- **Community outreach:** Doctors should realise that crying themselves hoarse over a deteriorating system is not worthwhile, but one can begin rebuilding in a small way. If a doctor thinks of himself as a professional, then the public are the clients and understanding their needs and giving them a comfortable environment is a part of our job description.

- **Volunteering:** This is out of a personal learning that volunteering makes one a much better doctor and an even better human being.

Keeping the above in mind, I come to the conclusion that the kind of medicine we are practising today in our country is dangerous, both for patients and doctors. But I think there is hope that this will change. I have hope that this profession will regain its sanctity. And for that we will all have to work together as a team. The efforts, therefore, should not come from one sector only. As I mentioned earlier, it is a multifaceted problem and hence the solution has to come from everyone involved, be it doctors, patients, policy makers, administrators or the health ministry. Everyone has to contribute.

I say there is hope because I see some young doctors who differ from the rest, who believe that there is more to this profession than just minting money, who have those leadership qualities that are needed so desperately, who do care about the patients and their needs. What we have to do is to encourage them and I am sure that day is not far when every doctor will proudly follow the same lead.

About the author

Anurag Mishra is a young practising surgeon working at Lok Nayak Hospital(LNH), Delhi, and also Assistant Professor at the Maulana Azad Medical College, New Delhi. He is on the faculty for Advanced Trauma Life Support/Minimum Initial Service Package and various other national programmes. He involves himself in various humanitarian activities like disaster response and preparedness, maternal and child health and mass casualty management. He has a keen interest in improving the state of the healthcare system and medical education in India and has worked actively for the same in the past in his capacity as president of the Resident Doctor's Association at LNH and promises to keep working towards that goal.

Overviews

Activism, ethics and professionalism in healthcare

Amar Jesani

Introduction

I studied medicine in the 1970s in Gujarat. If the context and timing of one's introduction to medicine and then induction in the profession have anything to do with the formation of outlook, I must confess that mine was shaped by the events and processes of that decade. When I moved from a small town to a big city to do the first year of science in order to enter medical college, many parts of India were still reverberating with the peasant uprisings of the late 1960s. Added to that were the war for the liberation of Bangladesh and a series of droughts in several parts of the country. While struggling to learn English to keep up my grades and get into medical college, all of these factors affected me. As volunteers for the National Service Scheme (NSS) we roamed the streets at night to enforce blackouts against the expected enemy attacks (which never took place), we also got drawn as volunteers into visiting and contributing our labour (*shramdan*) to the campaign organised by Gandhian/Sarvodaya groups against another enemy, the drought. Within six months of entering medical college, it was shut down for nearly six months by the anti-price rise and anti-corruption movement of students. The price rise affected many of us who were from a lower middle-class background, and so it was natural for us to get attracted to the movement. However, disillusionment with student politics which was dominated by the politically and economically powerful drew us to work in slums and villages where the real people really affected by the high prices and corruption resided. With this experience, it was difficult to join the rat race of those medical students who were striving to emigrate or aspiring to make good in the health care market as soon as they got their degrees.

In the context of the tertiary public hospital where we trained to be doctors, I discovered that professionalism was identified with clinical excellence, with patients coming from poor backgrounds providing raw material for the acquisition of excellence. While there were a few teachers who supported our social orientation, many of them sympathising in private and not openly; the rest while more appreciative of how we gained technical knowhow, were, at best indifferent to time spent in being compassionate and caring for such patients. We were hardly taught ethics. The best effort at teaching ethics was in forensic medicine, to impart knowledge on how to protect ourselves, from the law as well as from the fury of patients. Added to that were scandals about how a son or daughter of a professor or city's heavyweight prominent practitioner robbed the deserving student of his or her gold medal, or how marks were manipulated to ensure that such persons got the top ranking in the subject in which they wanted to specialise. All of this was completely alienated from the living conditions of patients visiting public hospitals and their urgent need for care.

In 1979 there were only 107 medical colleges for training in modern (allopathic) systems in India. Of these, less than 10% were in the private sector. Many of these private colleges were charitable and non-commercial. In the last three and a half decades, there has been a sea-change in the situation. The Medical Council of India website provides a list of 381 medical colleges, over two thirds of them in the private sector and an overwhelming number are commercial. In the 1970s, I studied in a public medical college at a very low cost. Now when I go to teach in private commercial medical colleges, I find that the fees charged runs into millions of rupees a year. "Good" private colleges among them use high fees from students to subsidise low cost care for poor patients, so that students learn their skills on their bodies. But not all of them are "good" in that sense, and in such situations, there is no dearth of students complaining that they get fewer opportunities to learn. Teachers, many of them very busy in private practice, have less and less time to teach, and the least time to do research. And yet, the students carry on as they have paid money and the primary goal is to get the degree, skills can be acquired later on.

Health care services and the market

The Indian health care system has metamorphosed from a welfare facility of the state and private charity into a burgeoning money-guzzling medical commercial industrial complex, thanks to the default of the state in providing

money for building a public health system and the state's collusion (including provision of massive subsidies) in promoting the business of health care. For decades the state expenditure on health care has hovered around one percent of GDP, the promises to increase it notwithstanding. As a consequence, the medical professionals have emerged as hard working entrepreneurs, oriented to exploit the market (i.e. diseased human beings) for high earnings, profits and wide-ranging investments. At the same time, India has provided the best of its trained medical human power to the world, where the Indian doctors have made their name and acquired a high status. The corporate powers in health care have also created world class facilities in India to cater to those who have purchasing power and attracted medical tourists in large numbers. Indeed, they have also created conditions for some of the doctors to return to India and to work at those facilities. And of course, the pharmaceutical industry is one of the biggest suppliers of drugs to the world.

Less than 10% of all allopathic doctors work in the public sector; the rest are in the open market private sector where neither the quality nor their business practices are regulated by any medical laws. The regulatory laws for registration of private clinical establishments are in place only in a few states. Even where such laws exist they have not made mandatory any minimum standards for running such establishments. A national law has been enacted (Clinical Establishment Act), but it covers only a few states and it is yet to make known the minimum standards, but it has already started registering establishments. The medical profession has opposed such laws and even gone on a nation-wide strike to stop their implementation.

The unregulated nature of the market of medical care is well known. The most pernicious aspect of it is the practice of cut and commissions, wherein the referring health care professional receives a part of the amount charged from the patient by a diagnostic centre, specialist and others who rendered services to the patients. Despite specific prohibition of fee sharing in the Code of Medical Ethics 2002, it still remains an all pervasive phenomenon. Indeed, all doctors involved in such practices are not willing participants, but many feel compelled to do it to survive as successful entrepreneurs and so they resent it; and there are many who have rejected such practices and yet survived. However, only the few with strong ethical convictions and having the support of their patients have tried to publicly challenge such a market. What is disappointing is that the young doctors entering the market have not raised their voices to reform the system.

Two different approaches to professionalism

In the mainstream of the health care profession, it seems professionalism is reduced to technology centric technical excellence in clinical practice, and even this minimalistic professionalism is pursued to the extent it is useful for cornering a slice of the market. Many undergraduate students in their final years and post-graduate students have often told me that ethics does not bring business; it is even bad for pursuing business after investing so much in getting a degree. Despite this general attitude, I find more students attending medical ethics classes today, whenever such classes are organized, than two decades back. Increasing use of technologies throwing up ethical challenges; the implementation of certain specific laws like Organ Transplantation Act and PCPNDT Act (prohibiting sex selection); resistance and even some challenges coming from better informed patients from higher economic strata; increasing medical malpractice cases and above all, the aspiration to migrate are some dominant reasons for this increasing interest. At the same time, there are also those who are increasingly feeling alienated from the rat race whose conscience does not allow them to compromise beyond a point. All such reasons have provided a window for intervention to introduce ethics into the health care profession.

There has been another parallel process, started in the late 1960s and early 1970s, which has gathered momentum, after a few ups and downs. This process is made up of a conglomerate of groups – health, human rights, women's and patients' rights groups, etc – with varied ideologies demanding universal access to health care, accountability and transparency in the health system, striving for better public health and so on. In the early 1970s, many activist group like Medico Friend Circle and community health projects had systematically challenged the technology centric elitist professionalism in health care. The movement for community health and primary health care redefined professionalism in the Indian context. They showed a strong commitment to rational medical care, shunning unnecessary investigations and medication; pursuing innovations to use appropriate low-cost technologies; emphasizing public health intervention to prevent diseases and make population level health care interventions; and brought the issue of access to health care to the centre-stage of debate. Interestingly, its take on access also included an attack on the power of the profession, which keeps the medical profession elitist, with its own mystifying language and mastery over specialized technologies. Thus, it was built on an orientation with a different paradigm

that sought to replace professional elitism by de-professionalized social orientation, monopoly over the occupation by de-mystification of medicine and individualistic excellence by the appropriateness of intervention. Another important contribution that this movement made was to make patients and communities the chief arbiters of the delivery of health care, monitoring and accountability.

While this current did not use explicit ethics language, it provided impetus to ethics by bringing the concerns of common people; particularly those who were left out of the benefits of the expansion of the profession and services. If the practice of ethics is viewed as the most important attribute of professionalism in medicine, then unlike other attributes, it demands that a real professional would have undivided loyalty to the welfare of people and patients. Itwould make a professional place the client above self-interest and the interests of health institutions and industries.

In many ways this parallel process has remained outside the mainstream for long, but in the last one and half decades, under the slogan of right to health care and the campaign for universal access to health care with expanded and community regulated public services at the centre, it has sought to bridge the gap between the high moral commitment of activist professionals and those suffering from and feeling stifled by the unregulated health care market and striving for a better ethical environment. This coming together, if strengthened in the coming times, could provide a platform for activism that could bring about reforms in health care that are positive and people centric. At the same time, it will give a boost to the discipline of medical ethics and bioethics which would help reshape the mindset and practices of a large number of practitioners and would enable medical students to learn about their true role as future doctors.

About the author

Amar Jesani is an independent consultant, researcher and teacher in bioethics and public health. He is also one of the founders of the Forum for Medical Ethics Society and its journal, IJME (Indian Journal of Medical Ethics, (www.ijme.in),. He is presently its Editor. He contributed to the organisation of four National Bioethics Conferences, in 2005, 2007, 2010 and 2012, of IJME. He is also a trustee of Anusandhan Trust, which manages CEHAT (Centre for Enquiry into Health and Allied Themes, www.cehat.org) in Mumbai, and SATHI (www.sathicehat.org) in Pune, India. He is Visiting Professor at the Centre for Ethics, Yenepoya University, Mangalore, India; Associate Faculty at the Centre for Biomedical Ethics and Culture, Karachi, Pakistan; and a member of the International Research Ethics Committee of Medicins sans Frontieres. He has co-authored and co-edited six books.

Overviews

Professionalisation of the medical industry in India: Where are we today?

Nobhojit Roy

Inherent to our profession is the occupational hazard of cynicism which is a function of the medical practitioner's age and years of practice. In India, some suffer from terminal Scepticaemia, but the large majority sit somewhere on the fence. Irrespective of which camp they belong to, they are all believers that India is headed to becoming an economic superpower. In keeping with that economic dream, healthcare in India will need to keep pace by professionalising itself.

Around the world, ObamaCare has deadlocked the US Government, and the NHS is struggling with healthcare costs. India is in epidemiologic transition, with communicable diseases coming down, and non-communicable diseases (cardiovascular diseases, cancer, Injuries) taking centrestage (1). In a rapidly changing world, and a more rapidly changing India, if Indian doctors need to position themselves in the global market, they will need to rethink and adapt rapidly.

Having spent some years practising overseas, I am certain that some of the inputs from other health systems that we need in India require a strategic and long term vision. More specifically, the important areas for professionalising the Indian medical industry will be communication and evidence-based protocols in clinical practice and regulation in health systems.

The traditional doctor-patient relationship in India, which was essentially paternalistic, is evolving too. Clinicians like us who are witnessing this transition have mixed feelings. The system of patient's trust, and the doctor doing his/her best, was ideal, but has been abused and disrespected. A mix of the uneducated patient, who does not 'really' understand and the paternal role of the doctor allowed for implied consent and patient vulnerability. With changing medical practice, we find the questioning patient, the argumentative Indian and the cyberhypochondriac. While this information overload and medico-legal strengthening is inevitable, it would be good to learn early what went terribly wrong in overly-litigious health systems like in the US, and leapfrog over these known traps.

Self-regulation is ideal for the profession, governed by a medical association. However, when narrow self-interest triumphs over the larger profession in India, we find ourselves in a situation, with the Indian Medical Association unable to provide leadership and the regulator, the Medical Council of India (MCI), itself being labelled as corrupt. Multiple attempts are being made to correct this situation; many prominent medical leaders are working towards restructuring the MCI and this is an opportunity. In India, we can learn from the experiences of the British Medical Association (BMA) and the General Medical Council (GMC) in the UK about how to support and regulate with "Good Clinical Practices"(2), rather than have the law step in and pass Acts (like the Consumer Protection Act - CPA) to control the profession.

Meetings such as this workshop in Kolkata propose that the practice of medical ethics within the profession will be the guiding light for future medical practice in India. The recent positive developments have been the implementation of Continuing Medical Education (CME) credit points and the guidelines for accepting gifts from the pharmaceutical sector. And while the sceptics claim that there are enough people bypassing these 'appropriate gift' guidelines, despite the penalties(3); I would say that, at least now Indian practitioners know that a red light means "stop". They may choose to run the light, but not without worrying about the consequences of being caught. Physicians, in general, are wary about being on the wrong side of the law, and while they whine and complain about it, they will generally abide by it. The CPA had such an effect on Indian medical practice, and consent, communication and documentation improved (though for all the wrong reasons), more than with any other previous intervention. On the downside, the practice of defensive medicine did increase. There are some pay-offs and trade-offs with each such legal implementation.

Adherence to protocols is the way forward, and while 'evidence-based medicine' is the current mantra, sceptics correctly caution that this evidence is not generated in India. However, it is a start, and a move from the current anarchy and entropy that exists. India-centric research is gaining momentum, especially for epidemiology of prevalent diseases. Though, India seems to be in a phase, where it is only processing clinical trials, which are being designed in

the developed countries, this process is ushering in an awareness about the global research agenda, systematic data collection and robust methodology. It is up to Indian clinician-scientists to ride this wave and connect with academic universities worldwide to address issues most relevant to India and find Indian innovative solutions, which may not all be clinical – but based in good governance and strengthening health systems.

Regulation and good governance usher in adherence to protocols. A stark example is the use of inappropriate antibiotics in practice, and the alarming incidence of multi-resistant bugs in India. This has been the bane of the much-touted Indian medical tourism industry. While India may produce star surgeons, who are able to perform brilliant surgeries, the outcomes of these surgeries are usually dependent on the weakest link in the chain – like poor sterilisation practices. Team work leading to better outcomes will be another necessary step forward, where all members of the team (and not just the surgeon) will be given credit for excellence. This calls for good leadership.

Unfortunately, there is poverty of leadership and role models in India. In the formative years, medical students do not witness 'good clinical practices' being practised by their teachers and mentors. Currently, 80% of the healthcare is delivered through small private hospitals (nursing homes), and the physician-owners, actually run small businesses, which are trying to stay afloat in pursuit of 'survival'. There is little interest in taking on the complicated cases needing attention, as there is the risk of unfavourable mortality. This will change in the next 10 years, and the new practice will be larger groups of physicians working together in a group practicein larger hospitals. While the bigger hospitals will thrive at the cost of the smaller nursing homes it is hard to say what will be the future of the large public hospitals, catering to the population. Unless there is political will and concerted action, this species is very likely to be consumed completely by the private players, in the name of Public-Private Partnerships, the new mantra in 'shining' India.

At the risk of being labelled over-optimistic, I think India is on the cusp of a new medical practice environment in terms of clinical practice, medical research and health systems, if we decide to adapt and professionalise medical practice.

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About the author

Nobhojit Roy trained as a general surgeon in Mumbai, India and the UK. He also holds an MPH from Johns Hopkins University, with an interest in surgical outcomes. Since 2004, he has served as the Head of the Department of Surgery at the BARC Hospital (Government of India), which provides Universal Health Care to 100,000 people in Mumbai, India. He is a visiting Professor in Public Health at the School of Habitat, Tata Institute of Social Sciences, in Mumbai, India and visiting faculty at the University of Manchester, UK and the Karolinska Institute, Stockholm. He has been associated in various capacities with the Indian Journal of Medical Ethics, since its launch, 20 years ago.

PERSPECTIVES FROM INDIA: Specific Initiatives

Ethics, professionalism and activism: my experience

Nikhil Datar

Introduction

Born into a family of freedom fighters, musicians and doctors, I was never confused about the role and responsibilities of a health care professional. I believe that the medical profession is neither a compulsorily charitable activity nor a business as such. High moral values, ethics and professionalism are the three fundamental pillars on which the medical profession stands tall. However, I realise that practices are extremely variable and values unclear amongst medical professionals. I share two experiences in my life and how I am trying to do my bit through judicial and social activism.

Case study 1

Challenging the law for ethical considerations

In 2008, Mrs X, who was in her seventh month of pregnancy, visited my clinic along with her husband. Her sonography reports had revealed that the foetus in the womb had two major cardiac anomalies. She had taken the opinions of five different pediatric cardiologists and all had warned her that the anomaly was serious and the child would have a poor quality of life. The woman and her husband were very sure that they would want to terminate the pregnancy. Thus they had reached me.

The provisions of the Indian abortion law state that if there is a substantial abnormality in the fetus the termination is possible only till twenty weeks of pregnancy. Termination beyond twenty weeks is not only illegal but also a criminal offence.This is in complete contradiction to the ideology of international professional bodies working on medical ethics. I was at the cross roads of ethics and law! If I acted ethically and morally, I was doing a legal wrong. If I acted legally I was wrong ethically and morally!

Realising the fact that my patient and her husband were just not willing to continue the pregnancy I made them understand the medical and legal tangle. I expressed my inability to terminate the pregnancy and also offered them an option to change the doctor. It was unethical and unprofessional to impose a continuation of the pregnancy upon her against her wish. I considered it my ethical responsibility to fully support them in taking legal recourse to challenge the law of the land and seek permission for abortion. Along with my patient and her husband, I filed a writ petition in the high court at Bombay challenging the Government of India. Although we lost the case in the high court, now the National Commission for Women has strongly recommended to the Government an amendment of the specific sections of the law so that such women can undergo legalised abortion. I hope that this small bit of judicial activism will change the law for the better.

Case study 2

Unsafe care: Major public health challenge in India

Medical errors and their prevention has been a subject of interest to me. As a practicing gynecologist and medical teacher I have seen medical errors throughout my career. I believe that it is not only bad doctors who make errors, but good doctors can make errors too. I have seen that good doctors land up in trouble because of defective health care delivery systems that are just waiting to fail. Victims of these errors are not only patients and relatives but also doctors and health care providers. I was struggling to find answers -- and an opportunity came. I was awarded a Commonwealth Fellowship and got a chance to work in the UK under the guidance of Professor Rajan Madhok. A whole new window of knowledge and ideology on Patient Safety opened before me. The fellowship provided protected self learning time and an opportunity to network with world leaders in patient safety, as well to work with world class organizations such as NICE, NPSA and WHO.

Strongly supported by prominent people in society, I founded an organisation called "Patient Safety Alliance" (www.patientsafetyalliance.in) which aims to empower patients as well as support health care providers in preventing medical errors in a blame-free manner. The organisation has started a unique seminar titled " Be alert, Be safe" for communities, sensitizing them about medical errors .The organization has created simple paper tools that can help patients to communicate better with their doctors, avoid medication errors and maintain their own medical records. The organisation has produced educational films and a booklet containing tips on patient safety. We have started similar workshops for health care providers and doctors that can help them to develop robust systems to prevent errors at their workplaces.

We at Patient Safety Alliance plan to work on the following concepts in the near future:

- Education: Incorporating modules on ethics, quality and patient safety in the medical curriculum**.**
- Patients for patient safety: Creating a demand for quality and safety through patient empowerment.
- Activism in the field of health law and its implementation in a fair and just manner
- Facilitating quality improvement measures in and amongst healthcare providers.

Observations on professionalism and ethics

The abortion law, namely the Medical Termination of Pregnancy Act (MTP Act), was passed in India in 1971. The advances in prenatal diagnostics (such as ultrasound) and abortion techniques have made it possible to carry out safe abortions beyond 20 weeks and the law ought to have kept pace with these medical advances. Although detection of severe anomaly beyond 20 weeks is not an uncommon situation, until now no efforts have been made for a change in the law. Interestingly, most doctors have been terminating such a pregnancy under some pretext or the other, disregarding the law completely. The doctors could have done so purely on humanitarian grounds or for monetary gains or a combination of both! Even more interesting was to see that most of the teaching hospitals and professors were practising and teaching the same to students not even aware of the law of the land!

Medical colleges in India are actually churning out medical technologists not doctors. The medical curricula in most medical universities in India do not have modules on communication, humanities and health law. Studies have shown that most medical students are unaware of provisions in the code of medical ethics. The teaching methodologies have no connection with "on site" application. The whole course is actually deficient in making medical students ethical and compassionate doctors.

My experience in the UK made me realize that Indian doctors might be at par or perhaps better in technical skills; but as healthcare providers they lag behind ideologically. I also realised that medical education as well as Indian medical care is extremely doctor centric and increasingly becoming "specialist centric". The concepts of quality and risk management are almost unheard of. The individual doctors are not strongly supported by practice guidelines or SOPs. There is a complete lack of standardisation. Even more shocking was to know that there are no drivers for change. The lack of leadership has been a serious generic problem in India not limited to the medical profession. When I started lecturing on and promoting the concept of patient safety, I faced challenges all around. While medical organisations were unhappy because I was openly talking about medical errors, many so called NGOs were unhappy because I was promoting the "blame free culture".It has been fascinating to see that society adopts technology quickly but not the ideology, even if it is going to change life for the better! So, we have much work to do.

About the author

Nikhil Datar is a Mumbai-based gynaecologist and noted health rights activist. He is the founder of Patient Safety Alliance. Dr Datar has been a recipient of the Commonwealth Professional fellowship and the Dr B N Purandare gold medal. He has a special interest in patient education, guideline development, error reporting and health law.

Specific Initiatives

From doctor to social doctor

Nipun Vinayak

Introduction

I had always wanted to be a cardiac surgeon. But, in spite of being amongst the toppers in my medical college (Government Medical College, Chandigarh), my interest in surgery proved meaningless before destiny. I appeared for the IAS examination and landed up practising 'development', including public health. The initial years in service allow an IAS officer hands-on experience in rural/urban development, of which health forms a vital part.

There are different views on whether professionals such as doctors should join the IAS and the point can be debated either way. Each stream of education, besides the content part, imparts some 'skills'. Medical education trains the mind to diagnose and then treat. It also conditions one to very hard work. Both these attributes prove useful in administration.

In this paper I describe briefly two case studies from the work I did as the CEO of the ZillaParishad of Jalna district in Maharashtra (2004-7) in the field of health and the Integrated Child Development Service (ICDS), and which became possible with decentralised planning under the Reproductive Child Health Phase II (RCH II) and the National Rural Health Mission (NRHM).

Case studies from Jalna District

Case Study one: public-private partnership in ante-natal care

When Drs. Christopher and Shobha Moses of the Mission Hospital, Jalna, asked me: "Why do some women from rural areas have to approach us just at the delivery time, sometimes with life threatening conditions? We feel so helpless! Had they been given proper antenatal care, or referred in time, the lives of such mothers and newborns would be so much less at risk!"; we realised that, irrespective of our efforts at improvement in service delivery, we fell short. We fell short, not only in terms of the motivation levels of the personnel at the primary level, but also in a real and meaningful effort at training them well to upgrade their skills, instil confidence in them, and provide them with all the necessary logistical support and a good working environment. This led to a joint project which was to significantly improve the image of primary health care delivery, especially ante-natal care delivery, primarily in the village sub-centres..

We took up 44 sub centres (out of 211) and 8 PHCs (out of 38) in the first phase. A team of gynaecologists and nurses from the Mission Hospital visited these selected centres regularly to offer ante-natal checkups, including ultrasound examinations. High-risk pregnant women were identified, and auxiliary nurse-midwives (ANMs) and multipurpose workers (MPWs) were thus trained on-the-job and acquired skills and confidence. Besides this, a 6-day comprehensive residential training module on ante natal care was developed and administered to the health staff of such sub-centres. In addition, during each visit by Mission hospital personnel, one additional health-related activity was taken up. To ensure that no pregnant woman was left without ante-natal care, a vehicle was being deployed by the village to bring all beneficiaries to the sub-centre during such camps.

The project was evaluated by UNICEF Mumbai, in 2008, which noted-

> *"Between October 2006 and July 2008, the infant mortality rate went down from 50 to 21…the still birth rate went down from 27 to 8"*

Case Study Two: Infant and young child feeding (IYCF)

In Chikaldhara, Amravati district, a workshop was organised by the Commissioner, ICDS, in 2005. At this workshop, a presentation on Infant and Young Child Feeding (IYCF) really impressed me. This was to be the beginning of a long term association of BPNI (Breast Feeding Promotion Network of India) with Jalna district. BPNI is an organisation

promoting the cause of breast feeding and young child feeding. It has on its rolls a few paediatric doctors, counselors, and 'mother support group' members. This team is dedicated and committed, and handles the subject extremely professionally. When we realised that early and exclusive breast feeding alone would contribute the maximum to the prevention of child deaths, we sat thinking. Something had to be done urgently.

Although I am an MBBS, I did not know many things about this subject, usually passed off as mundane, or too well known to be discussed. Although breast-feeding was a common practice in rural areas, it was neither early, nor exclusive. Nor were the weaning practices understood. But more importantly, the BPNI's training module made us realise why we had not been able to achieve something significant so far. Most of our training programmes were based on one-way imposition of knowledge. But this training module was *skill based and with emphasis on counseling*. Besides, it hammered the details of this subject into the minds of participants. Thus from simple 'do early and exclusive breast feeding' lectures, our staff began to move to - when to approach, how to approach the beneficiary, who else to approach, how to initiate discussion, how to explain the minute details, etc.

The process was started in 2006, with a three-day training programme for 33 trainees, mainly *anganwadi* supervisors and some health staff. This was followed by a one day sensitisation in batches for all the *anganwadi* workers. The initial trainers were followed up through repeated knowledge and counselling tests and continuously evaluated. To give them exposure to real counselling, they regularly visit maternity homes. Three of our trainers were certified as state-level trainers.

What distinguished the process in Jalna district from other districts was that in Jalna, funds under various schemes such as RCH and Jalswarajya, were utilised to carry such trainings to the community. BPNI termed these efforts the 'Jalna Pattern'.

Lessons from the case studies

The success of the first project was due to a number of reasons. Firstly, the selection of sub centres for this programme was done carefully, primarily on the basis of the working arrangements there. These were places, for instance, where the ANMs were staying in head quarters, and were competent in conducting deliveries, but because the sub centres were not upgraded, or because they were not motivated enough, they were going to the houses of the beneficiaries to conduct deliveries! Another criterion for village selection was that the village had become free from defecation in the open, and in the process, become very positively oriented towards development.

Secondly, the health staff and the *sarpanches* and other village people were motivated, guided and counselled about this project. Because of the earlier work done with people in the field of sanitation, the people readily realised the advantages to the village and extended their whole-hearted support.

Thirdly, the project was closely monitored, and after each round of visits by the Mission hospital team, we all sat together, including the *sarpanches* from such villages, and reviewed the progress made, sorted out any coordination/ other problems, and planned for the next round.

Fourthly, the project was funded out of the training expenditure of the approved programme implementation plan of RCH II. At the time of plan preparation, we had not anticipated that such an opportunity of working in collaboration with a private institution would arise. But because of the flexibility of the plan, we were able to avail of the opportunity.

Lastly, to maximise results, we diverted all resources towards these sub-centres as a priority. We knew that to support such a service, the sub centre needed to be repaired, have some minimum furniture and material, including delivery tables (some deliveries used to happen on the floor earlier!), equipment required to conduct deliveries, electricity and water supply. So we pooled all the resources available with the Zilla Parishad. We are happy to note that to save costs, at some places, our staff repaired and themselves painted out-of-use delivery tables. At another place, the flooring material lying waste after repairs done in a primary health centre was transported to a sub-centre for use.

Overall, success in any such projects depends on a desire to realise where we actually stand, and what the expectations of the people are. As this gap is understood, the ways to bridge it may be found. The existing programmes and policies provide ample space to utilise them to bridge this gap. This desire has to be 'pure' and not 'selfish'. This

desire must come from within, it cannot be forced. Forced work may result in the achievement of targets, but may still fail to bridge the gap.

As this desire peaks, it needs good team building to deliver results. There are many 'jewels' in the Government service whose talents need to be properly developed and they can do wonders. We formed a 'core team' consisting of all good and talented health and ICDS staff to be a think tank for all programmes. The genuine feedback from this think tank was very useful to fine tune implementation strategies. The team had a few basic characteristics- non corrupt, motivated, hard-working and go- getters. That was our team. And this team was built patiently. In the beginning all were welcome to be part of it. Many criticised the long meetings…many said nothing would change. They left in between…or were left out. Those who had faith and conviction in themselves continued...and continue the good work to this day. The newly recruited staff had tears in their eyes, as they had been selected without spending a penny, on pure merit, and they did a very good job.

Our ground army was one we were really proud of. We began all our projects with the best manpower. Generally, if they are supported and motivated, they give results. Then we move on to the next category, slightly less competent and motivated and bring them on par with the best. Thus the cycle continues. The wrong monitoring systems and administrative work may afford very few opportunities to pat the backs of those who deserve it.

Our monitoring system was more a solution finding exercise than a fault finding exercise. The areas where we had to work, we had personally visited. Thus what was to be done, and how, was fairly clear to all so that there could be no deception. Those who performed well were congratulated immediately and decorated at important functions/ review meetings. They became 'heroes' amongst their peers. During the review meetings, we questioned the seniors as much as the juniors. Often, while no guidance is given to junior staff who actually implement reforms, they are made scapegoats at the time of review.. And the seniors will just say- "we had given instructions"! Just instructions do not work. The supervisory staff must also support and motivate the implementing staff for good results.

We used to analyse in detail how our services fared from the point of view of a common man. A common reply to as to why our sub centres and PHCs were not visited enough would be "the 'mentality' of people who wanted more 'injections' as treatment"! On being asked- 'Where do we go if we fall ill-government or private hospital?' They answered:"private"…and as they said it, they realised their folly. We all agreed that once our services improved, people would throng to us because good service is appreciated. Our routine monitoring system, where we just monitored one or two indicators, say family planning targets, needed improvement, as it had resulted in the health staff just completing the targets. We discussed how our roles were much bigger than the mere attainment of FP targets, how the entire rural population especially the children and women need cost effective health services, which can best be provided only by us in the public health service..

With this team in place we were ready to grab any good opportunity for work. Also, we tried to use professional help in all programmes. We, as government, must be open to all help from professionals and NGOs (the genuine ones!), as well as well-meaning organisations. In the market there are experts for most services. But for the support of Sewagram Medical College, the Mission Hospital, BPNI, Media Matters, we would not have achieved much quality in the programmes mentioned above.

About the author

Nipun Vinayak hails from Chandigarh, where he studied medicine, before being selected in 2001 to the IAS. He was allotted the Maharashtra cadre and has served in varying capacities at implementation and policy levels in the state of Maharashtra, including: CEO of the Zilla Parishad, Jalna (rural development), Collector and District Magistrate, Raigad (regulatory administration), Municipal Commissioner, Nanded (urban development) and as Deputy Secretary. in the planning, water supply and sanitation departments in the state secretariat (policy). He is a firm believer in 'participative governance' and believes participation of people/stakeholders is the sine qua non for sustainable development. He has tried to apply this in various rural development programmes- education, health, sanitation; in tribal development schemes for restoration of land rights and during slum upgradation work in the city. He also believes in partnering with skilled/professional organisations outside government to deliver better services. His underlying passion is the empowerment of people, especially the common people and the marginalised. His hobbies include writing. Two of his books have already been published (Beyond Sanitation by YASHADA, Pune and Gramodaya by UNICEF). His third book, documenting his participative initiatives as Collector, Raigad is under publication by Oxford.

Specific Initiatives

Trysts with professionalism and ethics on the journey of ICHA

Akhil K Sangal

Introduction

I have had the opportunity to work in and witness first hand nearly all the systems and stakeholders in healthcare, both in India and abroad. What once looked like a 'rolling stone' career, in retrospect looks like 'fate' endowed me with a fairly comprehensive and holistic view of healthcare. Like a helicopter, on the one hand, was able to observe the larger canvas, while on the other, able to swoop down to study the details and nuances. The following are my learnings and observations. I have tried to distil my thoughts, avoiding the detailed narrative of the experiences which led to them, for the sake of brevity.

The humungous dimensions of the ills of healthcare are too well known to recount – the list is virtually endless. The complex interplay and intricacies of the political, governance, societal, economic factors with their resultant manifestations in complex parochial and vindictive behaviours is quite a cocktail to handle, in India at least.

Journey of ICHA – the leadership challenge

Against the backdrop above, an opportunity arose that led to the conceptualisation and establishment of the Indian Confederation for Healthcare Accreditation (ICHA). ICHA, was envisaged, inter-alia, to restore professionalism and ethics in healthcare to address the prevailing dismal scenario. In taking ICHA forward and based on my learning, experience and extensive research, a rallying point became apparent; *the niche of excellence in healthcare*. Non-management of various factors like complexity, the information explosion, societal changes and expectations of all stakeholders, just to name a few, have led to a situation of gross mistrust amongst stakeholders – a disastrous situation for something almost totally based on trust, which endowed it with the nobility that healthcare and its providers enjoyed. Accreditation, as the name implies, could be the appropriate tool to achieve excellence and restore credibility.

In just 2-3 years an incredible feat was achieved, that took 50 years or more in 'advanced' systems, of being able to bring seemingly diverse stakeholders together on the ICHA platform. The purpose of ICHA is to achieve all round excellence in healthcare delivery. Through striving for safer healthcare for all, and building trustworthy healthcare delivery institutions. ICHA has also grown in size and numbers. ICHA is the national multi-stakeholder confederation of national associations/ institutions for establishing validated excellence in healthcare in line with similar bodies in all developed countries. Today, all the major national associations of medical professionals (clinical, laboratory, administration), nurses, pharmacy, therapists, and consumers' groups, management and architects' bodies comprise ICHA. All the constituent associations are well established and respective apex bodies. (Please visit www.icha.in for details). Alas, the powers-that-be, failed to appreciate or deliberately neglected to capitalise on the achievement and the opportunity.

The short term expediencies and vision or the lack of it, threw up the biggest challenge ie deliberate non-funding on the one hand, and on the other a perception of having the "badge" as more important than achieving excellence.

Excellence having been the prime objective of ICHA, it was decided to strategically shift from accreditation and quality to "Patient Safety" as the right mechanism to pursue. The crowning achievement was the nationwide sensitisation about patient safety in a short span of a few months and bringing together virtually all stakeholders from within India and even neighbouring countries to the Patient Safety Convention held in New Delhi from November 27-29, 2009. A wide array of international partners, including WHO, coupled with Indian experience-sharing resulted in a mass of knowledge to determine a way forward.

While a lot of progress has been made, there are still miles to go and funding remains the biggest challenge followed by the 'buy-in' commitment to invest and seeing it as non-productive expense.

The success in rallying of diverse stakeholders in the above two strategic endeavours, has built up the confident optimism that the desirable and necessary change can happen.

Professionalism and ethics – a closer look

While there are multiple factors e.g. political, social, environmental and economic, affecting the current scenario. I believe healthcare providers can contribute maximally to address the issues of professionalism and ethics, rather, providing the only ray of hope in the prevailing scenario.

In India, there is no dearth of technical expertise, innovativeness, working under unthinkable conditions and yet delivering very good care wherever they can. There is perhaps a lot India can contribute to a model of cost effective care for other countries to emulate. Still, there are issues among healthcare professionals of narrow parochialism, intellectual arrogance and exploitation of the situation they are confronted with. This would be true for a vast majority who will be swayed by and will swim with the current. The onus falls on a small minority of incorruptible ethical professionals to channelise the majority. The biggest challenge and also the casualty is the lack of a proactive spirit, a sense of fiduciary trustee responsibility as well as arrogance manifested as "I know best", "who are you?", "NIH – Not Invented Here" and 'independence' resulting in widely prevalent practices perceived as crass commercialism and a lack of ethics.

Ethics, to me simply put, can mean to "do good" and being "morally right". However, both are subjective, perceptual and thus nebulous. Since they are relative, changing with time and societal evolution, they are a subject of much debate. From the current genre of "EMI (equated monthly instalments for the loans) doctors" who have paid exorbitantly for their education and investment in practice, it would be difficult to expect 'desirable' ethics.

Despite the above some least common denominators are still available and agreed upon. However, they are also under constant threat of changing roles and affecting the provider–receiver relationship, moving from mutual trust to gross mistrust, perpetuated by increasing litigation and violence, escalating into a vicious cycle.

Another dimension and challenge is to answer the question "what is in it for me?" In real life this boils down to 'material' or 'power' gains. Given the current scenario it has been difficult to sell the moral gains or the mental peace and restoration of trust as sufficient reasons to do what is necessary.

Current final observations

Since learning is unending, I refrain from 'conclusions'. I therefore submit my observations at this point of time on the state of healthcare and the necessary steps:

1. I have been fortunate in rallying numerous stakeholders and igniting in them the interest and willingness to address the dismal scenario. It gives me the optimism of "can happen".
2. There is no dearth of technical expertise and desire for professional freedom *per se*. However, as is expected, there is the paucity of a proactive approach and fiduciary trusteeship (for the majority). Managing arrogance is a huge challenge too. The way forward is to channelise the vast majority who will swim along with the current in the right direction.
3. Preventing the degeneration of ethics remains a big challenge in the current scenario of commercialisation seeking exorbitant returns on investment rather than appropriate returns. Increasing mistrust resulting in violence and litigation is propelling us towards disaster. The only solution is, I feel, the right political will and governance to correct this course. The time is now, or it may be too late!
4. Moving to 'interdependence' from 'independence'.Trust – transparency – transaction (communication) as core operative values and from adversarial to collaborative relations.
5. We have to be willing to contribute. It is a "*Mahayagna*" whose "*Prasad*" is wanted and desired by everybody. However, for *prasad* it is necessary to complete the *mahayagna* for which "*aahuti*" has to be put in. This *aahuti* is our contribution – let us do it!

About the author

Akhil Sangal, Chief Executive Officer and Director, ICHA, is a practising medical doctor in addition to being an Accredited Management Teacher in General Management and Quality Management Systems.

He conceptualised and established ICHA and also spearheaded the Patient Safety initiative with global partners. Over the last 40 years, he has acquired in-depth experience in all healthcare systems and sectors, both in India and abroad. He has worked in primary, secondary and tertiary care facilities and received initial training in Medicine and Gastroenterology and has published research papers in these areas. He was Country Head – Healthcare Accreditation and Quality Management Systems with a German multinational health consultancy company, during which tenure ICHA project was initiated in 2002.

A keen practitioner of research based Continuous Quality Improvement, he loves to work in areas of individual and organisational development.

Specific Initiatives

Can we restore public trust in doctors? The case of Dr Ketan Desai

Kunal Saha

My father, a doctor from RG Kar Medical College, Kolkata, practised medicine all his life until he suddenly passed away in 1977, when I had just entered medical school in Kolkata. We were never filthy rich by any definition but he was able to provide adequate food, shelter and above all, good education for his children. I still remember vividly sometimes as we walked down the street near our home in the suburb of Kolkata and bumped into one of his patients with his wife and children, the entire family would immediately stop and bow down almost in Japanese tradition with an intense glow of love, gratitude and respect in their eyes to say "hello" as if my dad was a divine creature who just came down to earth from his heavenly abode. It made me feel proud that I was his child, the son of a doctor.

But there is little doubt that this picture from my youth would appear a fairy tale to most children of doctors in India today. I wonder how many children would even feel like boasting about their doctor-parents now. In fact, recent studies have suggested that most top performers in Indian schools no longer dream of being a doctor. Ask any ordinary man on the street in India today of his general opinion about doctors and you will certainly get an earful. Doctors in India today are compared with goons, cheats and looters of the society whose sole motive is to squeeze out the last dime from the ailing citizens using their vulnerable condition. Public trust in our healers has plummeted in the past few decades in a spectacular fashion. But why is this deep decay in public opinion about our healers today?

The answer to this seemingly complex question may not be that complicated after all. With the rapid growth of India's socioeconomic condition and globalization of the commercial market for public services including the healthcare system, corruption has also flourished almost everywhere in most developing countries. The word "accountability" seems to be non-existent in virtually every aspect of public services in India. Standard of consumer products and services in both government and public sectors has continued to plummet with profit-making being the sole purpose for everybody, as rampant corruption infests the entire system of governance. The situation in India has deteriorated so much that our political leaders no longer feel any shame today to bring in new laws solely to allow convicted criminals to contest elections after the Supreme Court imposed a ban on all criminals participating in the voting process. With rampant corruption sweeping across the entire nation, perhaps it is too naïve to imagine that everybody in the medical fraternity would somehow remain absolutely above the fray.

More importantly, there is no argument that something is seriously wrong when the doctor sitting at the very top of the medical hierarchy, i.e. the president of Medical Council of India (MCI) is caught red-handed by the highest government law-enforcing agency (CBI) for taking a bribe from a private medical college allegedly in exchange for granting MCI recognition for admission of medical students. It is even worse, when the same criminally indicted medical man is able to get himself elected to a state university senate "unopposed" and return to MCI while still free on bail and awaiting the start of the criminal trial.

As everyone knows, the medical man I've referred to above is none other than the disgraced, ex-MCI chief, Dr Ketan Desai. He was arrested by CBI in 2010 and his license to practise medicine was suspended indefinitely by MCI, later in 2010, in response to my complaint/appeal regarding violation of MCI Code of Ethics & Regulations. Ironically, there years later, Dr Desai was able to regain his position as he was nominated as an MCI member in October, 2013 by Gujrat University by virtue of his uncontested win over the senate seat while he is still facing a criminal trial on serious charges of bribery and corruption, with his licence to practice suspended by MCI. This bizarre situation would be unimaginable in the medical community anywhere in the world. But nobody has any illusion that in a big country like India with almost eight hundred thousand registered allopathic doctors, Dr Desai acted alone to achieve this incredible feat of returning to MCI even after the hugely scandalous affair in 2010 which was widely publicized across India and beyond. Without implicit (and in some cases explicit) support from many other members of the medical fraternity, it would have been impossible for Dr Desai to wriggle his way back into the MCI.

The reason for the acute loss of public trust in the entire medical fraternity is glaringly evident from this sordid episode with Dr Desai. In the era of the Internet, the ordinary people of India are well aware that there is not just a single Dr. Desai from Ahmedabad, similar debauched medical leaders are running the show in many places in India while the "good" doctors are watching silently from the sidelines, and the standard of the healthcare delivery system is plummeting to an abysmally low level.

Can we restore public trust in doctors? The onus is on us – the "good" medical men and women of India.

About the author

Kunal Saha graduated from NRS Medical College in Kolkata in 1985 and migrated to the USA soon thereafter. He continued advanced medical education medical training followed by a doctoral programme (PhD) in Infectious and Viral Diseases at the University of Texas-M.D. Anderson Cancer Center. He then joined the College of Physicians and Surgeons at Columbia University in New York City in 1993 to do a prestigious post-graduate fellowship in HIV/AIDS research (Aaron Diamond Fellowship in AIDS Research) followed by a junior faculty position at the Presbyterian Medical Center in New York. Dr Saha joined Ohio State University and Children's Hospital in Columbus, Ohio in 1998 as a tenure-track faculty position to build a new HIV/AIDS research program where they made tremendous progress on AIDS research which resulted in many scientific publications including two research publications in the top international medical journal "Nature Medicine". Since 2005, he has been working as a private consultant and also as Adjunct Professor in Columbus, Ohio.

PERSPECTIVES FROM OVERSEAS: From the UK

Evolution of professionalism and ethical medical practice: A report from the NHS, England

M Hemadri

Indian background: personal view of my experience in India

The issue of ethicality for me, as for many doctors in India, started before joining medical college. In my time and until today, the issue of admission to higher education by merit as judged purely by school final examinations and entrance tests versus the need for social justice to correct the vestigial effects of historical wrongs remains a highly volatile, emotionally-charged ethical dilemma. Once we joined medical college, we saw that the professionalism was often tainted by the general corruption and laissez-fare attitude of which it is often accused. We overcame these issues due to four main factors:

a) We were really passionate about being doctors;
b) the subjects were really tough, so there was not much time to think about anything else;
c) some highly ethical, professional teachers had a disproportionately positive impact on our thoughts; and
d) most of us were only passive players in any unethical and unprofessional behaviour (at that time, that made it okay).

My own brief period of post-graduate training in India was a mixed experience - for me because of where I worked, my training was directly related to my effort, with the occasional heartache when some VIP's son (it was usually the son) forcefully robbed me of my opportunity. Many of my colleagues completed their post-graduate training with limited skills; some of them could afford (the time, money and connections) to gain it in the real world after they finished their training and become better doctors; the normal reality of life engulfed the rest and they entered a self-perpetuating cycle of talent deficit. In the years as a young doctor in India, and then later as an experienced surgeon who practised in India for a brief period, I saw repeated examples of unsupported doctors driven to displaying unprofessional and unethical behaviour which were adversely affecting the patient's clinical care amidst a few individual islands and beacons of high moral behaviour. To avoid being misunderstood or misquoted, let me make it very clear - my view is that the doctors in India want to deliver the highest quality of clinical care and they want to apply ethical methods. The social construct and systems often try to push them away from ethicality; some doctors manage admirably to resist this.

Broad UK contextual principles

The UK is indeed a very ethical and professional atmosphere for doctors. Generally, expressed behaviours are a function of societal standards and expectations. The UK has a high degree of expression of the whole spectrum of the domains of human action - a high level of personal free choice which is tempered with a high level of societal ethics; and a high level of legal control should the personal free action cross ethical boundaries. To phrase it differently, people can do what they want, they do that with consideration for the rest of the society and when they cross boundaries there are laws and rules in abundance which are generally enforced effectively. This was not achieved easily.

Broad context for doctors

There are broader factors that act as the foundation for professionalism and ethicality. As soon as we begin working in the UK, we realise that the bulk of healthcare is delivered by the government through the NHS (though there is increasing privatisation at this time).We learn that the rich and poor can get the same access and treatment, which is more or less of the same standard, across the country. Healthcare has no relationship with the ability to pay - it is free at the point of care. An overwhelming majority of doctors are employed by the NHS on national contracts and there is no difference in pay, and thus earnings, for doctors from various specialties working in any part of the country. Private care exists for people with money or private health insurance; but it is usually to jump any queues and get some frills but the care quality is in substance the same. The system generally removes any financial or professional reasons that might trigger unprofessional or unethical behaviour.

Specific context for doctors

Doctors are held to higher standards of behaviour; these are regularly reviewed and set out in the UK regulator's (General Medical Council's) Good Medical Practice guide. Doctors' annual appraisals are related closely to the domains defined in the GMC's GMP guide. There is a specific area in annual appraisals titled 'probity' which is taken very seriously. Further, a doctor's personal health problems have to be declared and their impact on effective functioning assessed. The GMC's GMP is applicable not just within a doctors' professional and clinical domains it is applicable to behaviour standards in a doctor's personal life as well. If a UK doctor's drunken behaviour during private holidays affected any member of the public the GMC wants to know about it and will investigate it to see if there were any patterns that might impinge on patient care. If a doctor attends a court of law on a completely private matter such as speeding on the road or a financial irregularity the GMC wants to know about it and is likely to sanction in parallel for any major convictions in court. A registered doctor is expected to have a higher standard of behaviour compared to the average member of the public and when it slips the regulator will not hesitate to act against that doctor. The GMC even has guidance on how doctors should interact in the social media even when doctors interact with social media on non-clinical matters. Voluntary compliance is the norm. Breaches are quite a few but these are resolved through either local or social pressure. A word from the senior, a call from the medical director or a well meaning assertive/aggressive warning from people in the social media is usually enough for doctors to pull back and fall in line. Doctors have to reflect on their developmental Continuing Medical Education/Continuing Professional Development (CME/CPD) activity, doctors have to reflect on the complaints they face. Currently, doctors are required to have regular 360 degree feedback administered by an independent party, funded usually by their employers - this feedback is obtained from randomly chosen colleagues including other doctors of various grades, nurses, managers and others. If this feedback shows a need for improvement that has to be undertaken. The UK regulator has recently introduced revalidation for doctors where annual appraisals form the core element of the decision to revalidate a doctor every five years and allow them to practise. All the above descriptions form a part of the appraisal-revalidation process.

The evolution of current practices

This is an interesting exercise in conducting large scale change. It was a slow, incremental multi-channel process that took many years and many stages. CME/CPD requirements were defined by the Royal Colleges in the early 1990s. Clinical audits were introduced in a big way in the early 1990s, 360 degree appraisals were introduced as a part of progression for trainees in the early 2000s; reflective practice was introduced in medical schools in the early 2000s. Cross pollination of these practices between specialties and grades were encouraged. Formal annual appraisals were introduced with it being mandatory for trainees. Soon annual appraisals became an essential part of senior doctors' career job planning and career progress with many elements already having been brought together. Now all these have been pulled together into a comprehensive appraisal-revalidation system which is mandatory.

In the late 1990s, the Bristol enquiry into paediatric cardiac surgery deaths on how a department's poor performance went unrecognised over a period of time; in the early 2000s, the Shipman enquiry on how a doctor could escape any official scrutiny over many years of criminality; and currently the Francis report on how a whole local system focussed on the wrong things causing patient harm without being challenged by clinicians were major national external stressors that have pushed the medical profession to re-focus on the patient and start taking responsibility.

Some counter points

Is the NHS system perfect? Certainly not. Will it catch the bad doctors? Probably not. The scientific evidence for many of these methods is arguable. Many doctors opposed it actively all along and resist it passively even now. Some use it as a purely tick box exercise so that they will have a licence to practise their jobs. No one can be sure if these improve clinical quality for the patient.

What it does seem to have done is to increase the professionalism and ethicality of doctors. When anyone suspects a breach of professionalism and ethicality by doctors anyone is entitled to report the doctor to the GMC. The GMC does a full investigation only for a small number of the cases reported to them. During the investigations the GMC looks for reflection, maintenance of clinical skills, and development of insight. If the GMC is satisfied with these then it decides on minimum sanctions or on no sanctions at all. If it is not satisfied, the sanctions can be very severe, including erasure. The GMC, backed by the law, is a powerful force for doctors to seek a higher degree of professionalism and ethicality.

In practice, a large number of doctors who are international medical graduates (IMG) and who are from black and minority ethnic (BME) origins believe the system may be broadly very fair for the UK local graduates, but for IMGs and BME doctors there is evidence of a higher rate of reporting to the GMC and a perception of a higher chance of sanctions and a higher severity of sanctions. This is seen by many IMG and BME doctors as somewhat defeating the otherwise worthy ideals that in general work well.

It is not as though there are no other sub-radar ethical problems: defensive practice, higher levels of service utilisation with its implications of unnecessary interventions, racial divisions (in jobs, exams, pay grades, bonuses) and others.

Transferable lessons

The principles underpinning UK medical practice are universal and hence transferable. The core principles are:

a) expecting a higher standard of behaviour from doctors in the practice of their profession and in their personal lives;
b) having a strong, progressive regulator backed by law; and
c) encouraging and supporting doctors at every opportunity to be ethical and professional, but with the clear understanding that any breaches will involve facing the full impact of regulatory and legal enforcement without fear or favour.

The practice of these principles is not easily transferable since the context and environment is very different in India.

As very junior surgical trainees in India we used to ask patients to buy a variety of drugs, sutures and allied implements for their care - we would also make a judgement on the economic capacity of the patient, and on that basis ask them to buy a certain amount more than what would actually be needed for their care, sometimes upto double their actual requirement. We then used to store this in our individual cupboards and use the surplus for the care for other patients. Sometimes, we told the patients that this is what we were doing, sometimes we did not - either deliberately or simply due to lack of time. Essentially all of us were running our own individual small scale charity process. We saw this as completely ethical, moral and professional. We were saving lives, we were curing patients.

In the UK, this will be misrepresentation, lying, theft, financial misdemeanour, etc, all of which obviously are offences with the potential to end careers.

In India unnecessary investigations could have a financial motive (essentially fraud), in the UK it is mostly simply a matter of high utilisation (hence an issue of lack of operational standards). In India, talking to the next of kin of ill patients is normal accepted practice; in the UK, speaking to the next of kin without specific consent is sanctionable under the Data Protection Act and is a clear breach of right of privacy.

Creating an Indian system

A two-channelled approach may be needed in India. The first channel is to enable a higher standard of positive behaviours from doctors.

My personal suggestion is for doctors to create and maintain their own personal-professional portfolios. These portfolios could be reviewed by either employers or peers (individuals or professional bodies) every two years; and voluntarily submitted to the state medical councils every four years. In return these doctors could get the status of updated/enhanced registrations. Over a period of time, the medical councils and professional bodies can work together to make the portfolio very robust (perhaps in 20 years' time the whole process can include a 5 yearly voluntary written knowledge test). A higher degree of respect, recognition and remuneration for doctors who have updated/enhanced registration could be an incentive to encourage the uptake.

The second channel would be to reduce the incidence and severity of negative behaviours in doctors. Pro-active, transparent, supportive intervention by the relevant professional society and the state medical council will be crucial. However, when those interventions fail a strict regulatory and legal approach will be needed.

A time defined, long term, incremental protocol, with specific measures that must be achieved, should be mandated with implementation commencing urgently.

I am hoping that this workshop culminates in highly specific workable recommendations to enhance the ethics and professionalism of doctors in India. This will be essential for the future of the doctor-patient relationship and to enhance the reputation of doctors in/from India.

About the author

M Hemadri is an Associate Specialist in General Surgery at Northern Lincolnshire and Goole Hospitals, NHS Foundation Trust, in England and Honorary Clinical Tutor at Hull York Medical School. He has been recognised for his work in innovation and service development. He held the Leaders for Change Award from the Health Foundation and won the local health and social care awards at Hull in 2008. Hemadri was a Fellow of the NHS Institute for Innovation and Improvement in 2009. He has had advanced training in patient safety and healthcare delivery improvement from the world's premier institutions such as IHI in Boston and Intermountain in Salt Lake City. He has trained a large number of healthcare staff in healthcare quality improvement principles and methods. Hemadri is an executive committee member of BAPIO and co-moderator of Indi_go (a discussion forum for more than 5000 NRI doctors); he is at the forefront of a move to improve the cause of equality, justice and opportunities for international doctors in the United Kingdom. His blog is his outlet for modern thoughts on succeeding in healthcare (www.successinhealthcare.blogspot.co.uk)

PERSPECTIVES FROM OVERSEAS: From the UK

Medical leadership: professional road map, personal journey

Dinesh Bhugra

Introduction

Leaders are necessary, especially when the followers need a clear sense of direction to move ahead. Leaders are both born and made. Being born into a certain kind of family or with particular personality traits gives an advantage to a certain kind of leader. However, there are other characteristics or skills which can be learnt. By virtue of our training, doctors are accustomed to making life and death decisions and to working in teams, irrespective of the medical specialty in which we work. Leadership is never given, but must be earned.

In this brief article I propose to highlight some of the issues related to medical leadership skills and my personal journey in various roles.

About leadership

Leadership is not mystical and neither is it entirely to do with charisma. It is to do with passion, vision and courage. According to Kotter (1), leadership is about coping with change, and it needs to be differentiated from management. Leadership is about producing change and moving in the direction of change, while doing the right thing. The vision of the leader is about the interests of the followers. Barr and Dowling (2) note that leadership can be defined in many different ways. Lansdale (3) observes that effective leaders enable people to move in the same direction at the same speed, towards the same destination (largely) because they want to – though occasionally they may be forced to do so. Leaders have a vision and can inspire (4) and influence people (5). Leaders must also have the ability to engage with those who may not believe in the individual.

Characteristics of a good leader

There are many indispensable qualities of a leader, according to Maxwell (6), and these include character, communication, commitment, competence and courage, in addition to focus, passion, the ability to listen, generosity, relationships and vision. There are, of course, different styles of leadership, ranging from consensus to coercion, with affiliative and coaching styles in the middle (7). Obviously, followers will have their own style and the two styles may work in tandem or may not. Good leaders will evaluate if their views are being communicated properly and also whether they are being understood. The leader can thereafter change the communication style or the message, depending upon predictions and outcomes. Self-awareness and emotional intelligence play a major role in developing leadership skills. Certain personality traits are useful and important, eg, the ability to be flexible, but these traits inform the type of leadership. Being technically competent in one's own field is a must, and being a master of knowledge helps to evaluate evidence and change practice and the message accordingly. Mastery is to do with an ongoing awareness of building knowledge and a skills base.

Leadership is a concept and a process (8). It can be transformational, affecting change as well as managing change. Leadership never occurs in a vacuum. The skills needed for leadership are human, conceptual and technical (9). Among the skills required, professionalism must be at the top of the list. Professionalism is at the heart of clinical medicine. It represents certain values which define medicine. These values include knowledge, clinical skills, integrity, mutual respect, compassion and altruism, among others (10). As is clear, these characteristics are not dissimilar to those of the leaders. The judgement (at clinical levels) and moral contract are imperative and have been added to professionalism. Primacy of patient welfare, patient autonomy and social justice through competence, honesty and improving the quality of care as part of professional values apply equally to leadership roles. These are important in medical leadership in particular, as these traits and values are the bedrock of medicine. Although medical professionals are regulated, for leaders or even managers there are no regulatory bodies, and perhaps this may need to be taken into account when defining leadership roles. Medical leadership is essential no matter what

the actual roles are, but it is important that regulatory bodies have teeth so that the reputation and trustworthiness of the medical profession can continue.

Personal journey

Having grown up in North India with parents who migrated at the time of the Partition, I managed to enter the Armed Forces Medical College, Poona. While in medical college I had decided to do postgraduate training in psychiatry. Having failed to secure a training post, I looked at options overseas and moved to the UK for training in psychiatry. I was fortunate enough to secure training posts in Leicester, which, at that time in the early 1980s, had a majority of international medical graduates (IMGs). While training, I developed an interest in research in the field of cultural psychiatry and obtained two Masters in Sociology and Social Anthropology. I completed my MPhil in Leicester and PhD in London. As a trainee, I took an interest in medical politics; I was elected to the Trainees Committee of the Royal College of Psychiatrists and made my way upwards through the ranks as it were. As Dean (the College Officer responsible for education), I led on developing curriculum and on delivering it. I was the first Asian President in the history of the College, and I was elected unopposed. Subsequently, I was appointed Chair of the Mental Health Foundation – the third largest mental health charity in the UK. Having been elected President of the World Psychiatric Association in 2011, I am looking forward to taking up the post in September 2014. It is a great privilege and honour, and I have been fortunate enough to have support and advice from so many colleagues and friends, which has made things easy and worthwhile.

Lessons throughout have been about hard work and using one's strengths to overcome hurdles. There is no question that migrants do have a tougher time and have to work harder, but let your work speak for itself. Even when as a leader and unable to bring about any change, it is important that the leader has the ability and the tendency to listen carefully. Knowing when opportunities are available to make change is important and one should recognise these occasions. Trying to change things that one can, and not worrying about things one cannot change, is a crucial characteristic. In the midst of chaos, keeping calm and taking time out to recharge one's batteries is helpful in continuing to lead.

Conclusions

Leaders have different styles of leadership, which are strongly influenced by one's own personality traits. The important aspects of leadership are related to the ability to communicate and being aware of one's strengths, weaknesses and prejudices. Good leaders will surround themselves with those who can cover their weaknesses. As globalisation progresses, more IMGs will move around. This carries with it elements of responsibility, which is to do with the image of the country they come from, but also acceptance by and contribution to the new country. No question that IMGs have to work harder to overcome prejudice and discrimination at times, but it can be done!

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PERSPECTIVES FROM OVERSEAS: *From the USA*

Professionalism and ethical practices in medicine: A tale of two countries

Abhinav Diwan

As physicians, we are charged with maintaining the highest standards of professionalism and ethics in delivering medical care to our patients. Competing influences based on resource limitations, the fine balance between quantity and quality of care, costs of delivering healthcare, business aspects of the healthcare industry, and societal obligations pose frequent ethical challenges to physicians' practice. Coupled with the explosive growth in medical knowledge and technology, and geographic concentration of healthcare organisations in highly urbanised environments; the prevalent lack of uniform standards and practices in medical ethics has fostered stark inequalities in the quality of care delivered to the patients. A systematic re-examination of these core values is the need of the hour, and both individual and organisational efforts will be required to disseminate information on the principles and practice of medical ethics, and create a cogent and facile framework to implement the highest ethical standards to guide contemporary practice of medicine. In this article, the author examines the framework and practice of medical ethics in two seemingly divergent medical care systems prevalent in the United States (US) and India, to explore the notion that a common set of principles and interventions could guide regional solutions to the global challenges described above.

Professionalism in medical education

Formalised curriculum-based education in medical ethics and in the strict standards of professionalism is an integral part of medical education; and there is an ongoing national effort in the US medical schools to implement this (1). By contrast, in many Indian medical schools, core curricula need to be developed and or revised to expand this beyond a reading of the code of ethics published by the Medical Council of India (2). These could be guided by the principles laid out for graduate medical education in the US, namely professionalism, interpersonal and communication skills, practice based learning and improvement; and systems-based practice (3). Formal training should also be imparted in the behaviour of physicians toward patients and other healthcare professionals. Adherence to core principles should be monitored during training and early intervention encouraged for deviations. Studies in the US have shown that the lack of professional behaviour in medical school correlated strongly with subsequent disciplinary action by medical boards, indicating that opportunities exist for identifying and re-training individuals with suboptimal professional performance prior to potential harm being incurred as a result of their participation in patient care (4).

There is also a growing realisation that efforts to impart and maintain the highest standards of professionalism have to go beyond the traditional "curriculum" and hinge upon its being recognised as a behavioural virtue and the medical profession being viewed as a 'calling' (5). A physician-educator often serves as a role model for a trainee to develop an ingrained sense of values and virtues of medicine as a discipline. The ancient Indian system of the master-disciple tradition (*Guru-shishya parampara* in Hindi) could guide the contemporary mentor-mentee relationship, to complement the core tenets that are explicitly conveyed during medical training. This is likely to encourage authenticity in these behaviours beginning in the formative years of a physician's life.

Training in ethics of waste avoidance is highly relevant to maintaining the highest standards of professionalism (6). This effort is particularly important given the burgeoning costs of healthcare in the US, whereby the many regulatory solutions proposed can be ideally complemented by training in the principles of healthcare economics to young graduates. The US is facing a striking shortage of primary care physicians as its population grows, mainly in rural communities with limited access to healthcare (7) and provision of rural healthcare has also been a persistent challenge for the Indian medical system.

Professionalism in medical practice

Ongoing peer assessment of competency in professionalism, and adherence to the highest ethical standards

by physicians and institutions is necessary; and requires objective, contemporaneous and contextually relevant evaluations. Thereby, it is noteworthy that multiple safeguards are in place in the US to protect the public by ensuring that healthcare providers uphold the highest ethical standards. Professional peer review of physicians, oversight by the state medical boards and a complex system for periodic assessment and granting of staff privileges to physicians that relies on input from organisations and physicians that are familiar with the particular physician's work; are essential components of this process. There is an acute need for development and standardisation of similar approaches in the Indian medical system. The often voluntary recertification examinations administered by various professional medical organisations in the US and requirements for continuing education need to be uniformly mandated and enforced in both countries, to ensure that physicians stay updated with the explosive growth in knowledge relevant to their individual practices.

Various burning issues also need to be simultaneously addressed. Foremost among these are models of physician-hospital contractual relations. It is imperative that decisions regarding hospital privileges must be based upon the training, experience, and demonstrated competence of physicians, factoring in the availability of local facilities and the overall medical needs of the community, the hospital, and patients. A critical aspect of professionalism is to provide medical care to all comers, and not just patients who have the wherewithal to pay and the upper social strata, in a manner free of commercial influence. While laws exist to ensure provision of essential emergency medical care in these settings in both countries, more effort is required to monitor implementation of these regulations, while simultaneously protecting against their abuse. Perhaps one of the most striking contrasts in how healthcare is delivered in the US versus India is the aspect of billing for services. It is estimated that >80% of all healthcare costs in India are out-of-pocket, which often makes even basic healthcare out of reach of the poor; while such costs are a miniscule but steadily rising portion of the per-capita healthcare expenditure in the US which by some estimates are ~300-fold higher than in India (8). Often times, in Indian healthcare institutions, an admission fee is charged at the time of admission and costs are recovered prior to the performance of the procedures which delinks the standards of performance and complications from the costs. Preferred referrals and wilfully excessive or un-necessary investigations and treatment also remain a constant challenge. In contrast, in the US, adherence to the highest standards of professionalism in preventing unnecessary care is challenged by the malpractice system and frivolous lawsuits, necessitating calls for tort reform (9) In both systems, conflict of interest is a major issue, as a staggering 94% of respondents in a US-based physician survey reported relationships with industry with the potential to adversely affect healthcare delivery, sparking calls for voluntary disclosure of conflict as a preventive measure (10). Also, in both systems, the lack of continuity of care results in uncoordinated delivery of healthcare, markedly increasing the costs to the individual and the society. There is a tremendous opportunity to learn from these striking disparities. We must value accountability over autonomy, create an environment to promote data-guided inter-professional development and develop effective models of team-based healthcare delivery to begin to tackle the societal costs of healthcare.

Issues unique to international medical graduates (IMGs)

A unique aspect of the U.S medical system is that more than 25% of physicians practicing or currently in training in the U.S. have obtained their medical education outside the US, with the largest majority having obtained their training in India (11). While the similarities in medical, professional, and ethical aspects of the training facilitate their integration into the US healthcare system, unique professional and ethical challenges confront this segment of medical professionals. Notable among them are the observation that this group is under-represented amongst physician-scientists, both in clinical and basic science research; and in administrative positions. This appears to result from the narrow scope of the available immigration pathways, which are tailored to make up for physician-shortages, and require additional time commitment to pursue research, education or administration-focused career choices. Additionally, these disparities are even more striking for individuals from non-English speaking countries, suggesting that facility with the language could be an impediment in this regard. The Educational Commission for Foreign Medical Graduates (ECFMG) has launched a non-profit organisation termed 'FAIMER' to offer training in leadership and in professional education, conduct research on IMG-related issues in the US workforce; and create and maintain data resources on medical education worldwide (11). Conceivably, such programmes will assist individuals to pursue specific areas of excellence, and foster career choices suited to their training and expertise, to narrow the gap. It is interesting that despite these limitations, IMG physicians outperform US graduates in standardised examinations (11) and go on to play prominent leadership roles in the healthcare sector.

Challenges and the role of leadership

The society in the US and in India is confronted with both unique and common challenges with a goal of providing affordable, accessible and state-of-the-art healthcare to all. Professional organisations such as the American Medical Association and American Heart Association, to name a few, play a central role in guiding national policies towards this end. As physicians of Indian origin, it is imperative upon us to foster the development and nurturing of mature and unified professional organisations in India, with a mission to promote public health, research, training and development of tomorrow's leaders. These organisations should support innovative ideas, such as the one promulgated by Atul Gawande, which is based upon application of checklists to prevent medical errors and markedly improve patient safety across the globe (12). Young physician and physician-scientist leaders must be encouraged and provided resources to bridge the conceptual, technical and economic gaps, and tackle the challenges, head-on.

Future issues

The last two decades have seen an explosion in scientific discoveries and the development of new technologies, which raise new ethical questions. For example, the rapid growth in sequencing technologies holds tremendous promise for 'personalised' medicine tailored to each individual's genetic makeup, whereby individuals at risk for a disease may be prospectively identified and offered preventive care, responders to a particular therapy versus those likely to suffer side effects predicted prior to initiation of treatment; and genetic counseling refined to reduce the burden of disease (13) However, concerns exist whether this knowledge can be used to deny access to healthcare insurance or facilities based on an individual's risk (13). And while a landmark US court ruling struck down patenting of genetic information (14), concerns remain that personal genetic information may be subject to intellectual property rights in the future with drastic effects on healthcare delivery costs and accessibility. The discovery that 'pluripotent stem cells' exist naturally permitting tissues and organs to be regenerated for therapeutic purposes (15). the development of Nobel prize-winning technology to re-program non-dividing cells to 'stem' cells (16), the creation of a synthetic bacterium by genetic cloning (17), and generation of a mutant flu virus capable of triggering a pandemic (18), have sparked widespread concerns on the unethical use of these technologies to cause harm.

Notwithstanding these challenges, it is imperative to recognise that professionalism and ethics are the bedrock of modern medicine, and continued efforts and leadership by physicians guided by the highest ethical standards is required to assimilate progress in science and technology to promote healthcare for all, at a reasonable cost.

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PERSPECTIVES FROM OVERSEAS: *From Canada*

Professionalism and ethics in medicine: role of the Indian diaspora in Canada

Rajat Kumar

Introduction

There is a perception in the popular mainstream as well as among medical professionals abroad that the medical profession in India is not as ethical or professional as that in the developed or high-income countries. Such a perception is based primarily on personal stories, and anecdotal as well as `sensational' media reporting as well as popular television, and is hardly rooted in research based robust evidence. Hence, such a hypothesis may in itself be flawed and debatable. However, for the purpose of this article I begin the conversation on this topic by agreeing with this point of view. I go on to demonstrate that some other factors need to be discussed and taken into account to ensure a more just, balanced, and holistic understanding of the complex issues involved in this debate.

It is understandable, even laudable, that physicians of Indian origin whose working bases are in the so-called `West', comprising mainly of countries like the USA, UK, Canada, Australia, New Zealand and Western Europe, would like to contribute towards improving the medical culture and practices in their country of origin. In order to achieve such a goal, and to make a permanent impact, it is essential to transform attitudes. One of the ways this may be done is to target physicians in their formative years, at the stage when they are medical students and residents. These changes can best be brought about by ensuring that their teachers, that is, faculty members in medical colleges, be involved in this process. It is well accepted that medical education in India is primarily based on the public funded medical schools. The role and ethics of the multiple "private" or capitation medical schools is controversial as students who secure admission after paying capitation fee, have a vested interest in recouping their initial investment. Hence this article will mainly focus on the public sector physicians and institutions in India and Canada, as the author has experience in working in similar institutions in both countries.

Canadian context

Physicians in Canada can either be salaried, "fee-for-service", or have alternative payment plans. The money they earn is through the Government, and patients do not pay upfront. Hence in many respects, it is akin to working in the public sector. Patients are seen according to their disease severity, and factors like their socio-economic status or other forms of influence, do not affect their appointments and priorities. On occasion when that happens, there is usually a public scandal and an enquiry. A similar practice exists in other sectors of public service, such as housing, transportation, licenses, or availability of electricity, water, heating, or security. This reflects a maturity of society based on evolution over the years, manageable numbers and a minimum living standard for the majority of the population. Physicians practice evidence based medicine, keeping financial probity in mind, and using the most cost-effective options. The pharmaceutical industry is not allowed to sponsor scientific meetings, or promote physicians' travel to conferences. University credits are granted to activities with no pharmaceutical support. At the individual level, the privacy of each patient is respected. More specifically, each patient is seen in a private room, their personal information is not divulged, even to close family members, without the express permission of the patient. At all stages, "informed consent" is ensured. For any research procedure, there are multiple levels of oversight, to ensure patient safety and rights. This involves additional dedicated research staff, patients' grievance cells and standards and safety committees. Ambulatory patients are seen with specific appointments, and are provided their investigations and management plans at the clinic or their homes, without the need to run around for information. To enhance clinic and hospital visits, it is common to have voluntary services providing beverages and cookies.

Within an institution, students and residents are treated with respect. They have dedicated academic days, when they cannot be asked to work for patient care. Their hours of service are restricted. Residents are provided with academic responsibilities and not loaded with mundane tasks like drawing blood samples, collecting blood reports, escorting patients for procedures, or running clinics extending beyond clinic times. Weekends and holidays are off, unless on call. Physicians also have fixed responsibilities. Their primary job is academic medicine. They have online

availability of journals and guidelines in their clinics and offices. There are dedicated nurses, clerks, pharmacists, social workers to assist in running clinics and wards, allowing physicians to spend quality time with patients, reviewing results and literature, consulting colleagues and planning management. For administrative and non-clinical work, physicians have secretaries. Clinics are booked according to laid down workload algorithms, and cannot run beyond their dedicated times. Hence physicians have a defined workload, are free on weekends (Friday evening till Monday morning), and are not available to patients on their cell phones. There is emphasis on work-life balance.

Physicians have to fulfill CME credits. This is mainly done during working hours. Most of the clinical meetings are held during weekdays. There are special funds for CME meetings, allowing them to attend 2 or 3 international meetings in a year. According to a Canadian report (26 September 2013), in 2012 the average earning of a physician was $328,000 gross per annum, an increase of 9% from the previous year. This compares with an average salary of $60,000 per year for the average Canadian, making physicians among the highest paid in the country, earning two or three times what the highest paid bureaucrat (public servant) earns. At present, there are an estimated 214 physicians per 100,000 Canadians. This is in addition to nurse practitioners and physician assistants, who perform many of the tasks of physicians. There are long waiting lists in the Canadian healthcare system, but the physicians are not expected to increase their workload, as it is acknowledged that for quality care, an optimal time per patient is essential. The blame goes to the healthcare system and funding and not to the doctors. Canada spent $22 billion in 2012 for doctors' remuneration.

Indian scenario

In contrast to Canada, there are 65 physicians per 100,000 population in India (WHO data). Physicians working In India in the public sector hospitals or medical schools are working in an environment quite different from Canada. The clinical workload is not determined by any standards, but by demand. There is no limit to the number of patients to be seen. All those who register by a certain time, have to be assessed and treated, even if the clinic runs till late evening. The clinics do not have support staff as compared to Canada. In AIIMS, it is not uncommon for Professors to be calling out their patients names in the clinics, with no dedicated nurses, or clerks. The concept of pharmacy help does not exist. Due to constraints of space, a number of doctors share the same room, seeing a number of patients at the same time. There is no dedicated staff to regulate the crowded clinics, making it impossible to ensure privacy or dignity of the patients. There are regular intrusions by those who have letters or recommendations by "VIPs". For indoor care, patient numbers are not limited by the availability of beds or staff. Patients are often seen on the floor or doubled up, because all those who need to be admitted, have to be admitted and seen. It is quite common for faculty to work every day, including Sundays. Due to lack of clerical and secretarial services, physicians often give their cell numbers to patients, to ensure emergency management. Residents work for many hours carrying out routine work, because there is no choice. Academic work is done at night or on holidays. Senior physicians often function under stress, getting calls and messages from "VIPs" all the time. Most of the academic physicians in India have limited funds to attend meetings and conferences.

In terms of patient load and working hours, physicians in public sector hospitals work much harder than their counterparts in Canada, with minimal support, as do the residents. Despite these limitations, a major segment of the population, with very limited means, get extremely good care. These are the patients who would not be able to be seen in the elite "corporate hospitals". On individual levels, physicians trained in India are capable of managing large volumes of patients with minimal resources, providing good quality care. The same physicians find it easy to transit to working in Canada or the "West" where the work environment is far more conducive to professional and ethical standards.

Physicians in India and Canada: a comparison

In Canada, in general, physicians practice "evidence based medicine" which is freely available through the regulatory authorities or professional college through electronic means and can be accessed in the office, home or clinics. These guidelines are country specific to Canada, not necessarily those approved in USA or other countries. Funds and resources to create these guidelines are provided to institutions. Patient privacy and interest are protected through a host of organizations. Continuing professional development (CME credits) is an essential requirement, and can be pursued during working hours. Newly trained physicians and residents are nurtured in this environment, and contribute to further growth of professional and ethical practice. In contrast, in the case of India, due to a number of factors highlighted above, the new generation of physicians are not exposed to issues such as patient

privacy, evidence based cost-effective medicine, research protocols, perils of pharmaceutical support in attending conferences and academic activities, till such time as some of them relocate to the "West" and become part of the Indian diaspora.

Potential role of physicians in the Indian diaspora

The efforts of the Indian diaspora are certainly noteworthy and can help in positively impacting the culture of medical practice in India. Their role should be elicitive, and participatory rather than top-down and prescriptive. For maximum impact, they should target the sector which provides training to the new physicians which in turn provides service to major sections of the population, the public sector hospitals and medical schools. This is a challenging task as it would involve interaction with administrators and politicians who deal with policy making that provides resources to these institutions.

Unfortunately, the Indian diaspora to a great extent ignores the public sector physicians and medical schools. It is perhaps easier to interact with the corporate "for profit" hospitals, which cater to an elite and high-paying segment of the population. It is pertinent to note that in the executive committee of GAPIO, there is no representation of active physicians from any public funded academic medical institutions. As such, recommendations of GAPIO would not affect the vast majority of young budding medical professionals in India. For a genuine transformation in professionalism and ethics, there needs to be representation from this important cohort of health professionals in India.

About the author

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PERSPECTIVES FROM OVERSEAS: *From Australia*

Indian doctors in Australia: an overview

Shailja Chaturvedi

Introduction

This paper is based on personal observations and a review of key sources in Australia, and has been produced to inform the discussions at the workshop.

Background

Australia enjoys one of the best health services in the world. It is one of the nations that have, until recently, relied upon physician migration to meet medical workforce supply shortages. It has the purchasing power for importing well qualified doctors from around the world, including the developing nations. Many from developing countries fill up its least popular medical vacancies. India is the 2nd top source for its highly qualified medical work force.

In 2009-10 Indians rated highly amongst the 7,000 health qualified migrants, Australia accepted from around the world. In the 2006 census, 1,121 Indian doctors arrived from India adding to 3,000 who migrated in the previous 5 years. Although there is no confirmed count of the Indian doctors in Australia, some estimate it may be around 14,000. This excludes our next generation, which is becoming increasingly visible in every field of medicine. The Indian diaspora beyond the Indian sub-continent, is vast as the PIOs have lived, trained and worked in Europe (the UK and Eire mainly), Africa (East, South and some from West), Malaysia, Singapore and Fiji, Australia, the US and Canada in particular.

By 2010, International Medical Graduates (IMGs), made up 53% of all GPs in remote and rural areas, of which 15% came from India. Close to 25% of the medical workforce in Australia is overseas-trained and 45% overseas-born.

Australia maintained its White Policy till 1970 when the floodgates opened for Indian doctors diverting them from the usual destinations of the US, UK and Canada. Until about the mid seventies, the registration was relatively simple in most of the states of Australia without any examination. This gradually changed with the influx of preferred graduates from UK, Canada and South Africa.

In its present form there are 2 categories for medical migration. One is direct recruitment under contract, for a specified vacancy under the identified “Area of Need”; and the other is for those who emigrate for family reasons. It is the latter group which is required to go through a lengthy process of examinations all with a hefty, non-refundable fee structure. The pass rate of these examinations is 56% and time taken on average is about 3 to 4 years. There is increasing concern about the examinations set by the Australian Medical Council for the initial entry to the profession in Australia and to the “specialist colleges” and the over-representation of failure rates. Further, access to bridging courses, mentoring and coaching is very limited and often comes at an additional cost.

Only half of the Indian postgraduate qualifications are considered partly or substantially compatible. Between 2004 and 2010, 2712 applications were received for specialist registration from Indian doctors, 2nd only to the UK. Unfortunately most of these were lost in the bureaucracy of Australian Health Practitioners Registration Authority (AHPRA) and the Australian Medical Council (AMC).

As the employment rate of Indian doctors is about 60%, there are many highly qualified medicos who are unemployed or underemployed as taxi drivers, security guards, wards men and child carers etc. This is ironic and tragic given that there is a shortage of doctors in India. However the loss of highly qualified professionals is not an issue for the Indian government which has signed an MoU with 6 Middle Eastern countries to provide them with a short term public and private medical workforce.

Indian medical schools provide a significant number of high performing graduates to developed nations around the world who have themselves abrogated their responsibility to train sufficient medical graduates at home and prefer to recruit from developing countries, a precious resource they can ill afford to lose. (International Health Work

Force, Migration to Australia,Policy, Trends and Outcome 2004--2010. www.hwa.gov.au/work programs).

Despite the large number of Indian doctors in practice in Australia, only a minority among them has outstanding credentials in research, administration and academia, and a very few make it to the higher positions of leadership. These are the scholars who have an exceptional level of drive and accomplishments to their credit and are globally head hunted anyway for prestigious positions.

We have largely remained service providers away from the privileges of regulating or decision / policy making authorities. Our requests to be part of that segment to alleviate our mistrust and boost our perceptions of transparency and equal opportunity, are generally ignored.

The general perception of Indian doctors is that any complaint against them is dealt with harshly and the avenues for a fair hearing and outcome are few and far between. With the increasing number of locally trained young Indian doctors who are more confident than we were and coming from the ranks of high school achievers, there is fierce competition and envy from the white blended Australians. Even the patients prefer to see an “Australian doctor”. Those who look different or have different sounding names have a task to establish and maintain their credibility.

There are at least 3 highly publicised tip of the iceberg cases of Indian doctors who were wrongly imprisoned, two of which are still in the courts, while one has received a hefty compensation payout.

As Indian immigrants trebled from 96,000 to 340,000 by June 2011 including 21% of total skilled migrants, the Australian government must be alerted to its responsibility as a signatory to the WHO code of practice on the international recruitment of health personnel. Article 46 of this code states that “all health personnel should be offered appropriate induction and orientation program that enables them to operate safely and effectively within the health system of the destination country.”

English language competency exams, bridging courses and access to employment are urgent issues to be addressed. Although Health Workforce Australia is improving its supervision, access to AMC exams, support for education and training, acclimatisation and inter professional teamwork, realistically at ground level it is much less visible.

Medicine is as stressful as it is fulfilling. (http://www.beyondblue.org.au/about-us/programs/workplace-and-workforce-program/programs-resources-and-tools/doctors-mental-health-program). Health systems in any country are complex and expensive. Doctors will have to rejuvenate the public health system and regain the lost faith and glory we once enjoyed.

Next steps in Australia

Our situation in Australia can only improve with unrelenting representations through our joint national medical force and a dialogue between the two governments in Australia and India focussing on the wastage of highly trained medical professionals. We may need to bring up individual cases of unjustified outcome. We must have a better relationship with the regulatory bodies. The migrating doctor must receive clear and honest information and the tests for the approval of registration must be completed with a job offer before the visa is issued, working conditions, expectations and the manner in which the system is set up must be monitored.

How can we help our motherland?

Just like the high remittances Indians are known to send home, Indian doctors are not far behind in their dreams and aspirations to serve their motherland professionally. Unfortunately, the Indian Government has not been able to explore this goldmine to improve health services in India. Corruption is rampant in every field of daily life and does not spare the medical system. A doctor in India today is hardly made up of merits, hard work and academic excellence which represents the global criteria of classification. Just like a dowry, parents have to give their lifetime earnings in training a doctor, which also compromises our global image and possibly downgrades our training. Indian doctors are looked down upon for the inconsistent training scheme and variable standards.

Ethics and professionalism remains vital issues both when we work nationally or internationally.

I am hoping that ethics and professionalism will become part of the medical education curriculum. In the 21st century when a majority of the population is better informed than ever before, demanding better care, our presentation must improve.

Intermixing of suitable NRI doctors to provide health services in the areas of need may help in exchanging ideas to develop best practices in medicine. The role of NRI doctors must be acknowledged; they can be recruited through the same process that other doctors are.

About the author

Shailja Chaturvedi graduated from Lucknow Medical University in 1967. She completed her psychiatric training in Australia, where she has worked for the past 44 yrs in the public and private sectors. A founding member of the Australian Indian Medical Graduate Association, she was instrumental in setting up eye camps in Rishikesh which were later extended to Fiji. She was invited by the Government of Fiji to help expand on their clinical and academic mental health services. A founding member of Vision Beyond Aus, an NGO providing eye care in India, Myanmar, Nepal and Cambodia, she is currently involved in building a charity eye and cancer hospital in Ayodhya, in collaboration with Vasan Eye Care. She is also organising an international conference in Sydney in October 2014, for which she is keen to explore delegate participation on the subject of "Global Indian Doctor -Accomplishments and Aspirations"

TRANSNATIONAL PERSPECTIVES

Going back to India from the UK: early observations

Vijay Gautam

Introduction

I am writing this paper in a newly built flat in at one of the Centres for medical care built recently by the Government of India - these are called “Institutes of National Importance”. There are 16 doors in my flat. Not one of them is attached to the wall with the requisite number of hinges and not one of the hinges has the requisite number of screws.

I will attempt to explore the messages in this observation for medical practice in India and the lessons for a doctor returning after 30 years abroad. My conclusions may surprise you.

In this paper, on anecdotal evidence, I will attempt to postulate that despite a common political boundary, India is made up of several countries and spaces. The visitor’s experience of India depends on the exact level at which he finds himself in this multi-dimensional world. I will suggest that it is not possible for any individual to change the system, which in its aggregate represents evolutionary mechanisms and has as many advantages as disadvantages depending on your moral perspective and practical priorities.It is my belief that for health care planners and providers, including NGO’s, doctors returning to live and work in India, it is necessary to recognise that India is not the country that Indians believe it is. Most certainly India is not the country that outsiders expect it to be!

I will suggest an alternative to the common theories about India’s contradictions.

But first a word about myself.

Personal background

I was a relatively mediocre medical student in Patna Medical College almost 40 years ago, famous more for my guitar playing than my academic achievements. I found myself in England due to limited post-graduate seats in India. My intention was to get higher training and return to India. Over the following 30 years, I set about my objective with a vengeance – gaining two FRCSs in two specialties and then being awarded the FRCP. I was a visiting lecturer to Harvard University for a very brief period and a fellow in Penn State University with an H1 visa – surely for a junior doctor and clinician from India, an achievement more remarkable than all the FRCSs and FRCPs!

I returned to England from the USA to serve in the NHS. With an illustrious and unblemished career, with numerous achievements, with a 42 page CV, at the age of 55 I decided to return to India in the spring of 2013 whilst I could still walk on the knees and hips that I was born with, to put something back into the country whose taxpayers gave me undergraduate medical education for less than 15 US Dollars.

Observations

For a number of reasons, there is a general expectation in India that the private sector is probably the better place for a returning doctor from overseas to work in. I took the decision to apply to the government sector for exactly the same reason. After all, it was not my intention to make money or build a career, rather to put something back into my place of birth.

Every day, I encounter intense debates about the difference between private and government healthcare – there are never any clear winners. Depending on the definitions, each has its strengths and weaknesses.

Discussing these is outside the scope of this paper.

Whose fault is it?

Government, God and Fate — in that order, most Indians vent their frustration on one of these to account for things not being right for them. Usually in conversation around offices, a long exchange of stories about how bad things are, ends without a revolutionary action point; “Such is life for all, nothing can be done except to bear it, things can only get worse (or better).”

Referring to doors, mentioned in the introduction, to have generally poor fittings in my flat (and everyone else’s) within a newly built hospital campus begs a very serious question about the potential quality of construction within the operating theatre etc., that requires an answer for the sake of safety and quality of care.

How can this failure occur and be tolerated – it must be corruption, of course, and incompetence.

I disagree.

Whilst it could be a deliberate act of God or man, the reality is that perhaps the poor worker, who installed the doors, was probably born in a hut, which did not have a door. He probably saw the kind of door he was installing for the first time when he was working on it. If he was very highly trained and actually went to a technical college to ‘earn’ his certificate, then within the ‘lab’ there if the institution had one, he would have learned the proper skills, but there cannot be enough of such people in the Country, partly because there are not enough technical colleges, for lack of teachers, buildings and equipment — not forgetting the migration of labour (such as mine) to better paid jobs abroad.

The worker’s personal standards were probably satisfied by a door that was upright and his supervisor who may have been inspecting several hundred doors each day due to delays in construction, possibly was never given the time and tools to assess each door in detail. He may have been asked to provide a certificate of satisfactory completion each day to earn his own wages in a temporary job after the quickest possible viewing - a huge incentive for positive thinking about the quality of work.

I accept that on scientific grounds the above opinion may appear statistically unfounded and on social grounds patronising. However, if the reader will seriously consider, my counter intuitive explanation, it may be easier to hypothesise the reason why there is genuine concern about standards in India, to use it to predict future behaviour of the medical profession and what can be done to improve things when necessary.

A surgeon who is still routinely performing Roux-en-Y for benign peptic ulcers and has not heard of helicobacter, proton pump inhibitor, was probably trained before the age of Google. He might be a technically brilliant surgeon but he certainly lives in a country quite different from the one where Max, Fortis and Apollo gastroenterologists returning from USA or UK practise. Yes, such colleagues exist in vast numbers and I have personally met many. Having worked to establish skill labs at great expense around London, I am personally aware of the reasons why it is futile to blame God, Government or Fate.

This is the face of evolution and development. It can only be accelerated if everyone within the medical establishment takes personal responsibility to make small but substantial contributions, and sees a personal self-interest in competency based medical care for all by all clinicians.

Donating time and training may be beneficial to every one’s practice. Some corporate hospitals and the government have tried but once the constraints of priority, motivation and resources are considered, the situation reverts to being a challenge beyond the scope of any single agency and becomes quite ineffective in the wider scheme of things.

So what has this got to do with us?

Doctors are a much maligned tribe in India on account of what is perceived to be unsatisfactory levels of the care they provide for irrational fees, in the face of a noble vocation, a matter controversially highlighted in Amir Khan’s famous TV documentary.

To balance the argument it is often said that there are many good doctors whose charges are not exploitative. So the fact that in the human race most people are law abiding but some are criminals is not accepted as an excuse for the villains. Why should then good doctors defend their rogue colleagues in the name of professional solidarity? But this is not just about fee for service.

It is also about self regulation within the profession, setting and ensuring compliance with standards of care. If the doctors cannot agree about this and police themselves, then surely they are inviting suspicion and outside intervention.

Governance and ethics are not compelling priorities for many if not most Indian doctors. There is very little agreement about what these should look like in India, who will define them and who will enforce them. The situation presents a vacuum which is occupied by anything from religious and traditional preaching to modern evidence-based practice. The lack of universally applicable definitions must become a collaborative task between countries and societies that have already walked through this jungle because this will save time which can be better spent in contextualising some of the local issues.

My observations above regarding the poor worker probably holds true for the medical profession — it is likely that bad behaviour and unacceptable practices represent inadequate exposure to systems of governance, mutual policing for self-regulation, ethical concerns, morality and reflective practice. The individuals and institutions burdened with regulating doctors cannot even begin to control the situation due to lack of resources or awareness or agreement about penalties for non-compliance. The Medical Council of India (MCI) is supposed to do this but appears to lack the tools, just like the understaffed supervisor in my anecdote.

It should not surprise anyone that doctors in India, like anyone else, are influenced by who they are and where they were educated. In a country where even the standards of medical education are not uniform from one college to another, what chance is there for colleagues to deliver consistent, symmetrical and transferable care?

How can this be overcome? As mentioned above, one way is for all of us to donate our time to ensure that those around us benefit from a common understanding of professional standards. This must also be part of the undergraduate and postgraduate curriculum and assessed in job interviews. Templates have to be designed, implemented and propagated.

Lessons for others

About returning to India:

One word - Beware! Do not hope to return to the country that you left when you went abroad. No matter for how long you were away, you will find that India has changed - as everywhere else in the world. It will depress you and delight you. You will need to get used to it. India is unlikely to be what you want it to be and you must want to work here, not in the absence of severe challenges but rather in spite of them. Your tool kit will need more than professional competency- and you will need to innovate, adopt and invent.

Press and perception management is a very important aspect of getting things done and a lot of executive decisions get taken in the courts. Right to Information is a good thing, but how you feel about it may depend on whose side you are on. Political affiliations are important considerations in the work place. Society is still class and often caste driven. Hierarchical behaviour is expected and any change you want to make in your dealings with others may need to be calibrated carefully. Politeness is not the same as agreement - even agreement sometimes is not something you can count on.

Shortcuts may be taken and denied - language and negotiations at work place may require many layers of interpretation.

I suggest that you should return because you need the country. Whilst you may think that the country needs you, the reality on the ground may be shockingly different. Your ability to change things will be influenced by now much ‘things’ themselves want to change! Time is often perceived in generations rather than weeks, months and years. The government and the private sector each have their strengths and weaknesses. Politics is multi dimensional and you may not be able to step outside it. Loyalty and dependability may be quite fickle. How much you can trust what you see and hear depends on who is behind the talking and doing. Networks are King. Yet the country is democratic and tolerant - up to a point, in an impatient sort way. Reputation matters a lot. Not much is what it seems to be - linear, symmetrical, predictable and consistent are not the words that come immediately to the minds of returning Indians about their home country - “Show me the man / woman and I will show you the rule” many will say. People and systems are driven very much by ideals and aspirations but anecdotes are grade 1 evidence in a lot of decision making places. What passes for progress is often circular movement. It is possible to get things done but the correct

approach must be learnt. Persistence, fortitude, intellectual and emotional dexterity are all essential.

If the above sounds a lot like life at the top anywhere in the world especially the USA and UK - trust me it is!

I have been back 6 months and never personally encountered financial corruption. No one has asked me for corrupt payment nor have I taken any - but everyone talks about it and appears convinced everyone else is corrupt. The contradiction is obvious.

Remember three dimensional chess — welcome to India, the land of contradictions.

About the author

Vijay Gautam has been Head, Emergency Services, Ashford and St Peter's Hospital, Surrey; Associate Dean, PG Medical Education, London Deanery, University of London; and President, St John's Ambulance (Edmonton), London, UK. He recently relocated to India and is currently Professor .and Head of Surgery,Trauma and Emergency Care, AIIMS, Patna.

This is what he has to say about the AIIMS initiative: The six new AIIMS like institutions have been established with a vision to change the healthcare landscape in the undersupplied sectors in the past 2 years. But these are still based on the template for the old AIIMS which developed over decades. This timeline is clearly impractical. As a general rule, AIIMS should be able to get the funding required and should attract people of excellence. Over the years, some at least will grow into tertiary care centres, medical schools and research hubs of international excellence.

TRANSNATIONAL PERSPECTIVES

From Lahore to London and beyond: some personal observations on medical leadership

Parveen Kumar

Healthcare services across the world are facing enormous challenges in trying to provide safe, affordable and appropriate healthcare. Rising costs of care, of medicines and of new technologies have not been helped by the current financial difficulties in a depressed market. Most countries have some sort of a publicly funded system but the level of engagement, as measured by the percentage of GDP spent on healthcare, varies enormously. There are, therefore, wide inequalities across countries but also inequalities of access within each country.

Over the years, I have been fortunate to travel extensively to lecture, teach, and examine students for their undergraduate and post graduate degrees. This has enabled me to see the different ways in which countries manage their health systems and provide care for patients. There is no doubt that the professionalism amongst doctors is high, although differences exist in the way they practise because of differing cultures. Most hospitals I visited were suffering the same problems of huge workloads, inadequate staff, lack of time for administration and being bogged down by bureaucratic restrictions. Thankfully, the basic tenets for caring for patients were the same. However, often the problem was not just the shortage of staff but a lack of true leadership. No one wanted to stand up and challenge the ways of working as it was always 'someone else's problem'. A change in focus, a different way of doing the same job, cutting across the well-established boundaries of individual departments or sharing tasks to establish team work across departments would have led to more improvements in the services for patients than any added inflow of money.

The NHS in the UK is certainly not exempt from such difficulties. Over the last 2-3 decades the NHS has been through a multitude of changes, one closely following on another. This constant and repetitive change has had the effect of destabilising working structures, destroying the lines of accountability and leaving a struggling, demoralised workforce. Many have questioned the reasons for the changes and the answers are difficult to find, apart from the pressing financial deficit. Central to all our thinking must be the patients and their welfare. However, unlike a new drug which has to go throughrigorous analyses for safety, quality and efficacychecked via randomised control trials, new modes of practice are run out in the health system with little data, but with an almost evangelical belief that they are better for the NHS. This may seem a harsh statement, but large organisations need time to develop and adapt to new modes of working practices.

One such change had interesting long term effects. This was the purchaser-provider split, which had one part of the NHS purchasing the work of another and was introduced in the early 1990s. , This disruptive process did initiate the introduction of some accountability for budgets and spend. Surprisingly, it was, perhaps, the first time that hospitals had to look into their spending habits and identify costs.It provided some detailed data on how the money was spent and where it actually went. However, the downside was that it split the budget between the primary and secondary sectors of the NHS. This left the patient who passed from one sector to another in a hiatus, until the responsibility was passed on. This inevitably increased their length of stay in hospitals by 'blocking beds'which could have been used for the more acutely ill patients, and of course, increased the cost of care.

So where did this leave us? One inevitable consequence was the vast increase in the number of managers. Doctors seemed to have taken a back seat and lost the will to lead in the management of their own work. This is perhaps not surprising as doctors have traditionally felt that their responsibility, and indeed their training, has been for the medical care of patients and not for management.

However, if we really are to take a role in the formation of any new healthcare system which will lead to better patient care - then it has to be the medical profession that takes the initiative. But where are these leaders? Has the profession become so very complacent as to leave it to 'someone else'? Surely we must take the responsibility for what has gone on in the past? And, if our previous lack of adequate engagement has led us to our present state should we not be stepping forward to take a role in formulating the future?

Asian doctors are well respected throughout the world and we should celebrate the hard work and care that they give patients. But they can do much more. If statistics are correct, it is said that 1 in 6 of the world population is of Asian origin. The NHS has always benefited from a large number of Asian professionals. The numbers entering the NHS have increased enormously over the last few decades and this includes both first and second generation Indians. This huge number does mean that we have a large share of the responsibility for the profession.However, in the UK, despite this increase in the numbers of Asians, one sees very few at the top. The time required to reach the top could be a factor; but many have been in the UK for long enough to have ascended the ladder. So where are they?

Clearly this is not the case in some other countries. I attend a large medical meeting in the USA every year and have been impressed by the increased numbers of Asian names at the top of the profession. They are leading both research and clinical teams. It appears that this trend has not been mimicked in the UK. So is it the system in a country that is responsible, or a lack of engagement? Clearly Asian doctors need encouragement and one could argue that there are few role models for them to follow, or indeed, be mentored by in this country.

So how can we help and mentor young Asians? There are many whose lead we can follow. One of the premises in my life has been that one needs to blend into the system one lives in. This does not mean that one forgets one's culture or one's principles, but does mean that one needs to work in, and for, the existing system. In other words, it is all about joining in and working in a team. This provides stability but also harmony, and makes life so much easier. With so many doctors from the Asian subcontinent around the world, they need to take a major role in leadership. We have a lot of managers in health systems who provide much needed support for the system.However,we must not confuse management withleadership as they are not the same; the former is about doing things right whereas the latter is about leadership, is about doing the 'right' things. (Peter Drucker).

Returning to my suggestions at the beginning of this paper, there is a lot to be done by rethinking any health system and working out, de novo, how to do the same things in a better way. This is where doctors can be most effective in reshaping the future of any organisation, and Asian doctors need to be a part of this in which ever setting they happen to be working.

About the author

Parveen J Kumar is Professor of Medicine and Education at the Barts and the London School of Medicine and Dentistry. She co-founded and co-edited Kumar and Clark's Clinical Medicine, a textbook that is used throughout the world. She has held several national offices including: President of the British Medical Association, President of the Royal Society of Medicine, Vice President (academic) and senior Censor, Director of CPD, Associate International director for Education at the Royal College of Physicians, Chairman of the Medicine Commission UK, and was a founding non-executive Director of the National Institute of Clinical Excellence. At a local hospital level, she has been Director of Post graduate Education, Clinical and College Tutor, Associate Medical Director, as well as head of her department. She is on several charity boards as chair or as a member. She was awarded CBE for services to medicine, the BMA Gold medal for medical education, the first Asian Woman of the Year (Professional) award in 1999, and a BAPIO award.

WIDER PERSPECTIVES

Medical leadership and the role of doctors in leading development

Nigel Crisp

Introduction

Doctors are the natural leaders in healthcare due to their education, professional skills and high status. We can all think of examples where doctors have played major leadership roles internationally, regionally and nationally, as well as in their own local hospitals, surgeries and services. However, I expect that everyone reading this piece can also think of examples where individual doctors have been appalling leaders.

There are three major reasons why the need for doctors to become really effective leaders has never been more important than it is now. The first is that the pattern of disease worldwide is changing with the greatest burden now coming from non-communicable diseases. Diabetes, respiratory problems, heart conditions, cancer, asthma and other such long term conditions are increasing fast and bringing with them the need to change service models and treatments. There now needs to be a far greater emphasis on the prevention of disease and the promotion of health. Patients and their behaviours are both part of the problem and part of the solution. They are becoming more important both in avoiding disease and in managing it when it occurs. Doctors frequently have to persuade and *lead* behaviour change and not just prescribe treatment.

At the same time, communications, the internet and improved education are shifting the relationships between patients and their doctors. People and societies are becoming less deferential and more questioning of authority figures such as doctors. They are more aware of their choices and, with increasing affluence, can begin to see healthcare as a commodity and something that they "shop around" for, making choices. Doctors are another supplier amongst many.

Moreover, in fast growing countries like India, there is now a demand for universal health coverage and an expectation that every citizen has a right to health and healthcare. This brings with it new pressures such as how to manage the scale of the problem of reaching everyone in a society, the need to address issues of what is provided as essential care and how to manage the resources to achieve this. Individual doctors work within these systems and the questions that have traditionally been dealt with by public health specialists are becoming the concern of every doctor.

These changes and challenges impact profoundly on the role of doctors and their relationships with patients and society. They also throw up new challenges of leadership. Doctors in this changing world can no longer simply be the clinicians who deal with individual patients and are the fount of all wisdom on health and whose word must be obeyed by passive patients. They are increasingly called upon to think about the whole system, to care about population health as well as about individuals. They find their traditional authority and clinical space being shared by others from different professions. They also have increasingly to explain themselves to their patients, "selling" (in financial and other senses) their services and being accountable for their judgements and treatments.

These changes raise questions about professionalism, ethics and values as well as about the practical day to day aspects of what doctors actually do, how they organise their time and provide services. These are very uncomfortable changes for people who have been educated and trained for a different world. How can and should doctors react?

What does this mean for Indian doctors?

India exemplifies all these changes and challenges and does so at massive scale. The country now contains most of the world's poor people as well as the largest middle class in the world. It has high levels of non-communicable diseases as well as high levels of maternal and child mortality and other problems associated with neglect and poverty. It is also a country of ambition and aspiration, becoming once again a world power with all the expectations

of leadership that status brings.

India is also extremely fortunate in having a very large number of doctors and an excellent tradition of medicine. Worldwide, perhaps a quarter of all doctors are of Indian origin. It is estimated that a third of doctors in the United States are of Indian origin. How Indian doctors react is of importance worldwide.

We can illustrate this by setting out two extreme positions. On the one hand, doctors can choose to remain completely focussed on their clinical work and their individual patients. They can – in this changing and more complex world – become the skilled technicians who provide specific services. Whether in the public or private sector, their services can be bought and sold. They will be competitors in a market and cogs in the larger machine.

On the other hand, they can decide to become the system leaders, taking on new roles and exercising wider influence. They can combine clinical insight and practice with understanding population health and how systems work. They can expand their traditional role as leaders into the wider reaches of the new environment.

There are positions between these two extremes and not everyone need make the same choice. There is room for both sorts of doctors and for those between the extremes. We can already see this happening in practice. There are large numbers of new private medical schools being opened in Asia and Latin America which are geared towards turning out the "technicians" with their expertise who will slot into the system. On the other hand, there are the public schools in Africa and Europe that are training doctors in the context of the system that they will operate in and who will be able to address the wider systems issues of equity, ethics and management. The USA, too, has schools with "a social mission" orientated towards the needs of the population as well those geared towards the demands of its medico-industrial complex. India has examples of both models.

The question that faces the profession in India is: where do you want to be on this spectrum? Is the profession primarily about technical knowledge and expertise, or has it a wider social privilege and responsibility? How can it combine the two? I believe that today's changed environment should force the profession to think these questions through and in doing so re-define itself and update its proud traditions and values for the 21st century.

There will be both sorts of doctors, of course, in reality, not least because different individuals will want different life styles. Where, however, does the heart of the profession lie? What are its values and rationale and what is its uniqueness? Depending on the answers to these questions, two other groups of questions arise:

- What changes are needed in professional education to sustain the chosen role? To what extend will the profession in India embrace the vision outlined in the 2011 Lancet Commission on Professional Education of professions integrated into the system and as the leaders and "agents of change"?
- How will doctors gain the experience and expertise they need as leaders and how will they learn to work alongside the other system leaders?

About the author

Nigel Crisp is an independent crossbench member of the House of Lords where he co-chairs the All Party Parliamentary Group on Global Health.

He was Chief Executive of the NHS in England – the largest healthcare organisation in the world with 1.4 million employees - and Permanent Secretary of the UK Department of Health between 2000 and 2006. Previously he was Chief Executive of the Oxford Radcliffe Hospital NHS Trust.

Lord Crisp chairs Sightsavers, the Kings Partners Global Health Advisory Board, and the Zambian UK Health Alliance, is a Senior Fellow at the Institute for Healthcare Improvement, a Distinguished Visiting Fellow at the Harvard School of Public Health; an Honorary Professor at the London School of Hygiene and Tropical Medicine and a Foreign Associate of the Institute of Medicine. He is also a Global Ambassador for the eHealth Foundation, chaired by Archbishop Tutu. He has written extensively on health. His book Turning the world upside down - the search for global health in the 21st Century describes what high income countries can learn from middle and low income countries and takes further the ideas about partnership and mutual learning that he developed in his report for the Prime Minister, Global Health Partnerships.

WIDER PERSPECTIVES

Developing leadership to promote civic society – the Common Purpose model

Julia Middleton

The 'space'

In every society, there is an invisible, vital 'space'. It lies between the individual and the state, between the immediate responsibilities facing each individual and the institutional responsibilities of the government. It is a place where people come together and act for the greater good. And it is open to everyone, from every sector of society.

In an unhealthy society, this space is empty. People leave the decisions to governments. They are active in their private lives, but passive towards the world around them.

In a healthy society, this space is full. It teems with individuals, businesses, community organisations and political groups. It is alive with energy and entrepreneurial activity. People hold institutions and the powerful to account. They oppose and propose. And, free from the short-term pressures, they can think and act for the longer term and in the wider interest of society.

Common Purpose

I founded Common Purpose in 1989. We are both local and global, running local courses for leaders in 35 cities (and growing) across the world and global programmes for leaders from over 100 countries across six continents. 4,000 leaders each year become Common Purpose alumni (of which there are 40,000 across the world).

At Common Purpose, we have a passionate belief in the importance of the space. In our view, this is at the core of society. Active not passive. Involving the best leadership from all parts of the community.

An international social enterprise dedicated to leadership development, we give people from the private, public and not-for-profit sectors the inspiration, skills and connections to become better leaders at work and in society. We develop their ability to work together, innovate and thrive in different cultures - this helps people, organisations, cities and regions to succeed.

Our aim is to fill the space with as many - and as diverse - people as possible; people who may not see themselves as leaders in a traditional sense. We want to give them the knowledge, inspiration and connections they need to be effective. To encourage all kinds of people into it - and to see all kinds of initiatives come out of it.

We believe that they will then be able to counterbalance the forces of fragmentation in society, getting communities to work better together. They will be better at using and combining scarce resources. And though they may only seldom produce huge shifts, they will deliver the accumulation of many small ones from which most change emerges.

Cultural Intelligence and civic society

People spend time and money building up their organisations but don't always invest in the leaders to lead them. These leaders are often appointed for their IQ, and some may even then be sacked for a lack of EQ (Emotional Intelligence), but leaders who really succeed show plenty of CQ (Cultural Intelligence).

CQ is about being able to thrive when operating across different cultures and contexts. Opportunities and challenges cross boundaries, and leaders need the skills to be able to do this too. Nowhere is this more apparent than in civic society.

This is why Common Purpose courses draw on the widest possible variety of sectors, areas, beliefs and social groups. However diverse a Common Purpose group is, it can't be diverse enough. It's got to have every perspective - an incredible richness and difference of understanding and approach - in every possible way. The word diversity

can sometimes be monotonous – but ours is a multiple slice of every possible type of diversity you can find in a community.

Our approach is based on the belief that leaders need to experience reality rather than theory. You can identify complex and compelling challenges to address –big (enough to be worth the effort) yet small (enough to be relevant), and bring together people from very different backgrounds, sectors, angles and approaches to tackle this challenge. But it's only when you take them out into their city (or another) that they can see both the problems and the possible solutions in practice.

Developing civic society in Libya

Between 2011 and 2013, Common Purpose was commissioned by the EU to carry out an Initial Capacity Building Programme in Libya. The aim was to develop the management and leadership capacities of leaders/managers within emerging interim institutions and civic society.

Our team arrived in June 2011, at the height of the revolution (the Transitional National Council did not declare the country liberated until October of that year).Prior to the revolution there was a single NGO registered in Libya - the Scouts. After the revolution, in Benghazi alone (where we were based initially) there were more than 120 and there are currently 800+ across the country. This is a huge increase in just two years, and gives you a sense of the challenge and context we faced in equipping people to take on the role of leaders in civic society leaders.

Yes, they needed skills like project management, IT and governance; but as important was developing an understanding of what it means to be an active leader in civic society. We worked with nearly 2,000 leaders across a huge spread of ages and backgrounds in Derna, Al Bayda, Benghazi, Misrata and Tripoli. Nearly 50% of them were women, almost unheard of in Libya. It was fascinating to discover that most didn't know how to run a meeting! They had never had to organise anything before, and didn't know how to listen to different views or debate issues. This meant they were never able to reach a conclusion or make a decision. So the breakthroughs they made on our courses might seem less significant in a different context; but here had a huge impact.

We ran a course for the health sector in Libya, and I spoke to a training expert from the National Health Service (NHS) in the UK who we had brought over to help. One thing stood out from what she said - that during the course she *"watched these medical leaders quickly move from a group of individuals to an effective team."* Being a leader in civic society means being able to work with others, however different they may be from you – and in the civic space, you can be sure they'll be different!

Finally, a word for the Scouts (who are members for life, so don't necessarily picture young children as you read on). As the regime fell and battles raged, they were out there doing the tasks nobody else would do – everything from rubbish collection to burying the dead. They did this to draw attention to the fact that nobody else was doing them, eventually finding local or international entities to take their place.

Organisations often say they want their leaders to be responsible, but they don't say what they want them to be responsible for. At Common Purpose we believe that being a leader in civic society means taking responsibility for the world around you. This is exactly what the Scouts were doing.

The NHS and Leading Beyond Authority

Many successful leaders learn to lead in roles or circumstances where they have clear authority, budget and accountability. When they move beyond this - leading peers, partners and stakeholders - the skills that brought them success may not be enough. To operate effectively they need a different approach to leadership –at Common Purpose we call this the ability to Lead Beyond Authority.

Here's a great example. There is a trend globally that whilst acute health care services become more centralised, primary care is increasingly being devolved to the local level. This is certainly true in the UK, where policy changes by the British government are delegating the management of primary care budgets and services directly to local doctors. The roles of these doctors are changing significantly, pushing them firmly into the civic space, yet many have never worked with anyone outside the NHS. So we have been working with the NHS to help these doctors understand how to work across civic society, and to build relationships with the many multi-sector stakeholders they must now engage with.

Leaders in civic society need to be able to lead outside their comfort zone, beyond their circle of authority and make change happen with completely new and different stakeholders. One NHS participant on our courses sums this up quite neatly: *"We are not always clear on what solutions are out there. For example, working with the voluntary sector can be beneficial as so often they can reach people who do not engage or access the system in formal (typical) ways such as the homeless or those in care."*

About the author

Julia Middleton is the founder and Chief Executive of Common Purpose Charitable Trust.
In 1988, Julia formed Common Purpose, an international leadership development organisation, which gives leaders the inspiration, the knowledge and the connections they need to produce real change at work and in society. Common Purpose now offers leadership development opportunities worldwide in 46 cities in 18 countries. Since 1989, more than 40,000 leaders have completed one or more Common Purpose courses.

Julia has been involved in the founding of The Media Standards Trust (fostering high standards in the news media) and Alfanar (developing venture philanthropy in the Arab world) and is now on the board of both. She is also on the International Advisory Council for Fundação Dom Cabral (a non-profit business institution in Brazil). Julia is the author of the bestselling book Beyond Authority: Leadership in a Changing World.