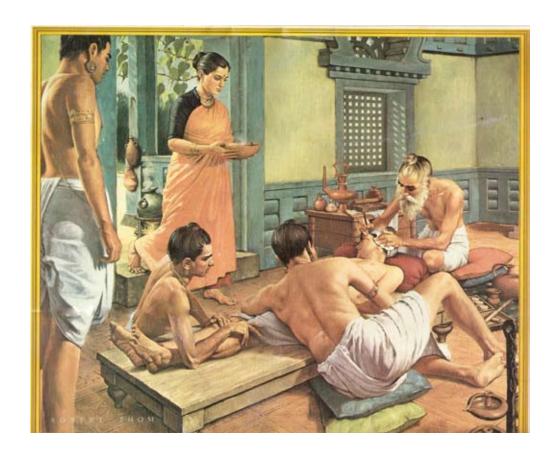# PROMOTING
# PROFESSIONALISM AND ETHICAL PRACTICES
# IN MEDICINE:
# Indian doctors from across the globe working together



**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)**


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# 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 21$^{st}$ 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 21$^{st}$ 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

# 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)*

## 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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### *About the author*

*Dinesh Bhugra is Professor of Mental Health and Cultural Diversity at the Institute of Psychiatry, King's College London. He is also an Honorary Consultant at the Maudsley Hospital, where he runs the sexual and couple therapy clinic. His research interests are in cultural psychiatry, sexual dysfunction and service development. He has authored/ co-authored over 350 scientific papers, chapters and 30 books. His recent volumes include Principles of Social Psychiatry, Mental Health of Refugees and Asylum Seekers (Highly Commended in the 2011 BMA Awards), Migration and Mental Health, Textbook of Cultural Psychiatry (Commended in the BMA Book Awards in 2008 and recipient of the 2012 Creative Scholarship Award from the Society for the Study of Psychiatry and Culture), Culture and Mental Health and Management for Psychiatrists. He published Mad Tales from Bollywood: Portrayal of Madness in Conventional Hindi Cinema in 2006.*

*Professor Bhugra is the Editor of the International Journal of Social Psychiatry, International Review of Psychiatry and International Journal of Culture and Mental Health.*

*From 2008 to 2011 he was President of the Royal College of Psychiatrists. In July 2011 he became Chair of the Mental Health Foundation. In 2011 Professor Bhugra was elected President-Elect of the World Psychiatric Association and in early 2012 he was awarded a CBE.*

# 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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## About the author

*Abhinav Diwan is a physician-scientist at Washington University School of Medicine in St. Louis, USA. Abhinav obtained his MBBS from the All India Institute of Medical Sciences, New Delhi, in 1997, and subsequently trained in Internal Medicine and Cardiology from the Baylor College of Medicine in Houston, Texas (USA). He has held academic appointments as Assistant Professor of Clinical Medicine and University of Cincinnati. He is currently Assistant Professor of Internal Medicine, Cell Biology and Physiology at Washington University.*

*Abhinav's research work focuses upon defining the role of lysosomes in cardiac muscle cell death under stress, as a mechanism for development of heart failure.  His work has been published in leading peer-reviewed journals in cardiovascular diseases and biology, including Circulation, Journal of Clinical Investigation, Proceedings of National Academy of Sciences and Autophagy. Abhinav also has an interest in healthcare policy and is actively pursuing leadership programmes to foster development of physician-scientists, and engaging in collaborative projects in India towards this end.*

# 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*

*Rajat Kumar is Professor, Department of Medical Oncology/Haematology, University of Manitoba, Canada, and Medical Director, Clinical Investigations Office, Cancer Care Manitoba. He is also the President, Manitoba Association of Asian Physicians (2013-14); and a recipient of the 2013 Prix de Excellence/Specialist of the Year award of the Royal College of Physicians and Surgeons of Canada for Region 2.*

# 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.*