CONTROVERSY

Why I returned to the UK

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I write this article with overwhelming sadness. The reason I am writing this is because my wife and friends felt that I must at least explain my reasons for going back to the UK, in case it helps someone. I am, however, so cynical about the system that I doubt it will make a difference.

Why I returned to India

I completed my MD in General Medicine in 1987 from Pune and went to the UK in 1988 as I was sure that I did not want to become a superspecialist (despite the objections of my mentor and dear friend). I felt that at 26 years I was too young to settle down in practice.

I had always dreamed of going to England, and with the encouragement of my father (a professor of pharmacology), I did my PLAB and spent four years in the UK on limited registration.

We were 12 batchmates from undergraduate days in the UK and initially we would meet regularly and debate the future with the enthusiasm of the young. Most felt that the government was to be blamed; the situation was bleak; going back would be difficult. Mine would be the lone voice that urged my friends to return and do their bit for their country. Perhaps we would not be able to change the system but we would have a good bash at it! Of the 12, only I returned one week before my permitted four years were up. I remember telling a friend, who is now in the US, that he did not have any love for his land of birth like I had; he returned from England for his parents (he was the only son of his parents). But isn't love for one's country something to be proud of? I remember as a boy reading with great admiration stories of freedom fighters such as Bhagat Singh and Khudiram Bose willingly going to the gallows—of how love for one's country transcends any other love. And that is why I returned to India in 1992—not only for my parents whose only son I am, but for my country that I loved and still love!

I willingly gave up dreams of settling in the UK and achieving a consultant grade in the NHS. After all, career and job satisfaction were not all that mattered. Country, parents, friends, all mattered to an equal degree.

So what happened? I had always known that practice was not going to be easy but I quickly realised that it was more difficult than I had ever imagined. For some time, I debated joining an NGO and working in a rural area. I did not manage that, but married Samata who worked for a rural NGO and continues to do so.

Disappointment

On my return, I joined the newly begun intensive care unit (ICU) in a new private hospital attached to a medical college so that I could have a fixed salary at the end of the month. The experience was an eye opener—although the hospital hardly had any patients, the management still wanted the patients to pay for their treatment. As the hospital was not offering state-of-the-art treatment, the beds in the hospital and ICU remained sorrowfully empty.

Nine months later, I moved to a big private hospital run by a charitable trust to work in the ICU. I had hoped that after four years in the UK and an MRCP, I would at least be appointed as a consultant but I was appointed as a registrar with the princely pay of Rs 4500. (In retrospect, it is humiliating, especially when I compare my 10-plus years of learning with whizz-kids earning an MBA and then landing a job of Rs 2–3 lakh per month.) Part of the reason for not being called a consultant but only a registrar was that intensive care was not well-established in India at that time, and as a consultant intensivist I could question other physicians and surgeons. As a registrar I could only follow orders and be the man on the spot to take care of any emergencies that may arise. I found that drug prescribing was by and large irrational and never based on any protocol. I suspect that in a private hospital, following a protocol is tantamount to saying that someone else is better or has more expertise in a certain specialty—just not the done thing in India. I have since returned to the UK where I am working as a consultant physician and find that the standard protocol to treat community-acquired pneumonia is ampicillin (plus a macrolide). This would be unthinkable in any private Indian hospital.

Other problems

Second opinions were taboo and uncommon, much to the detriment of the patients. Audits were frowned upon,

as no consultant liked to be pulled up for any mistake, genuine or otherwise. This of course meant that patient care did not improve and a good opportunity to learn and continuously educate oneself was lost. I must put on record that I tried to set up protocols and audit systems and had various discussions with my senior colleagues over the years. The response was, not surprisingly, disappointing.

To be honest, I was happy with the clinical part of my job—though private practice was not 'lucrative'—especially as I was not willing to succumb to the usual short cuts to 'successful' practice. I remember interrupting a conversation between two doctors—one saying that if he was referred a patient by another doctor, it was expected that he referred him back another patient. I interrupted to ask what the difference was between such practice and giving overt 'cuts' (paybacks). I also mentioned that I had managed to survive without resorting to such pernicious practices. Both looked at me and nicely pigeon-holed me by saying, 'But you are different.' It was almost an accusation.

I tried to bring in good clinical practices—medical audits, protocols, rational antibiotic prescriptions—but with no great support. We did manage to set up an Infection Control Society but always felt that we skirted major issues and ended up tackling inconsequential minor problems such as where to station water sinks and what soap to order. I ended up spending up to 25% of my time battling with the management on administrative issues, and 25% with colleagues trying to tell them what the best treatment plan should be.

I found that senior doctors in the ICU and CCU earned a 'cut' on every patient in the Unit—it made me wonder whether doctors could remain ethical with such financial temptations. Often, the doctors had insisted on such modes of payment.

I joined the Health Committee of the Lok Vignyan Sanghatana—a group of doctors who want to do rational, ethical practice and provide health education towards that end. Many doctors debated rationally on available evidence about the management of various illnesses. This was heartening. In actual practice, however, not a few of these very same doctors were irrational and even unethical!

I lost faith in superspecialists, many of whom make money on the side for referring patients for surgery. I also had a problem when I wanted a genuine second opinion—experience taught me that I could keep little faith and respect for most fellow practitioners.

I resigned from this hospital and joined another leading hospital. My colleague who headed the ICU invited me to join as a senior member of the team and, after some misgivings, I joined. However, I found it uncomfortable to work there with and under a close friend and on at least some occasions found my decisions overruled without discussion. Although the hospital had state-of-the-art equipment, care was not taken to discuss the cost of treatment and likely outcome with the patients and their relatives. This practice left many almost bankrupt by the time their treatment ended.

This was far from the humane and compassionate medicine that I had believed I could and wished to practise. For all these reasons I decided to return to the UK. I am going with a heavy heart (despite the advice in the *Bhagavad Gita* to do one's duty without expecting reward) and with a sense of defeat.

In the UK, a significantly higher degree of scientific, moral and ethical principles are followed. I hope I can practise in a similar manner at some stage in India. Perhaps this is being overoptimistic.

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