To make the entire process paper-free, each candidate must make his submission in .docx .xlsx or .pdf files. In turn, the institution must provide laptop computers to each selector. These should be connected to high-speed internet. All the submissions by each candidate must already be loaded on it. This enables the selector not only to scroll through the candidate's submissions but, when in doubt, search online for the veracity and adequacy of statements made during the interview and study papers and reviews by others on the subject being discussed. It also makes it possible for the selectors to check which of the journals in which the candidate has published papers belong to the category of predatory publications.

This modified procedure will enable the selectors to make a more comprehensive assessment of the work done by each candidate and the quality of replies to questions.

MEDICAL EDUCATION IN REGIONAL LANGUAGES: A PRESCRIPTION FRAUGHT WITH PROBLEMS

Once again, we learn of satraps promulgating legislation to ensure that medical colleges in the states teach subjects in the local language. Northern states favour Hindi while southern states push for Tamil, Telegu and Malayalam.

It is a pity that we do not learn from history.

In the 1830s and 1840s, as the East India Company set up medical schools in their three Presidencies (Bengal, Madras and Bombay), it decreed that instruction in each of them was to be in the regional language. Teachers in these schools were asked to translate English texts into the regional languages and use them in their classes. As can be expected, this resulted in markedly substandard education. When Sir Robert Grant, Governor of Bombay, decided to set up what was later entitled the Grant Medical College, he analysed the demise of the medical school set up earlier by Governor Mounstuart Elphinstone. Based on his findings, his medical advisor, Dr Charles Morehead, and he insisted that the language of instruction in the proposed medical college would be English. The college, posthumously named after him, flourished from its foundation in 1845 onwards. Education in regional languages once again raised its head in the 1870s. Dr Morehead, then retired and settled in Britain wrote to the college authorities in Bombay arguing against such a change. After a short period of experiment, instruction in the regional languages was stopped while that in English continued successfully.

It is beyond comprehension why proponents of regional languages ignore obvious facts.

1. We are fortunate in having inherited competence in English that is envied in several countries, most notably in China and Japan.
2. The literature of medicine is immense in scope. Even the use of the most powerful computers will not permit translation into regional languages of more than an infinitesimal fraction of books, journals, seminar proceedings and other repositories of medical knowledge. Add to that the fact that explosive growth of scientific knowledge augments collected data at a furious pace. Regional texts must, inevitably, be dwarfed substitutes of what is available to those studying in English.
3. English is the language in which exchanges of ideas, projects, techniques and recent advances occur. How will a student graduating in Bihar in his regional language converse with a scientist in Tamil Nadu or Maharashtra, leave alone an expert in London or Bonn or Stockholm or Tokyo? How will this young and impressionable individual learn from journals such as this or that published by the Association of Physicians of India and other national medical societies, leave alone the likes of *The Lancet*, *New England Journal of Medicine* or *Journal of Neurosurgery*?

It is high time powerful voices in academia, the medical profession in India and the various scientific societies and associations are raised to scuttle this retrograde legislation and chauvinistic way of thinking.

SUNIL PANDYA

Letter from Glasgow

SOCIAL CARE: A NEW BEGINNING OR ANOTHER FALSE DAWN?

During lockdown in the first wave of the pandemic in 2020, I did my bit to help. I returned to work that summer providing public health support to the (rapidly expanded) contact tracing team in Glasgow, and I volunteered to deliver lunches to vulnerable people who were shielding at home. I volunteered with the Mel Milaap Centre which, pre-pandemic, had provided day care social services for elderly South Asians in northwest Glasgow.[1] With the lockdown came the realization that these vulnerable people would still need lunches and so the food delivery service, open to all who needed it, was developed. At a time when the population was confined to their home unless they were essential workers, shopping for food, or exercising it was eerie driving through largely deserted roads in Glasgow making my lunch deliveries. With the poverty and social inequalities that Scotland and the UK still experience, it was humbling to see how people were coping with the pandemic. This was despite the huge disadvantages they faced and, in my opinion, they were steadfast in supporting each other in their communities.

Social care provides support to vulnerable people, for example the elderly, the infirm, or people with learning disabilities with a spectrum of services including information, advocacy, financial support, day centres, support at home, and residential social care homes. More broadly during the lockdown, if there was one thing I wanted to see, given the large numbers of preventable deaths in social care homes, was improved care homes so that it was fixed once and for all.[2]

At that time the Scottish government had overseen the transfer of patients from hospitals to care homes during the first wave to provide sufficient acute hospital beds for patients with Covid-19. But the consequence of this was to rapidly spread the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) to multiple locations with vulnerable people and a large loss of life.

So, the outcome from the lockdown I wanted—apart from getting through the pandemic as best as possible—was that social care, and care homes in particular, be reformed, improved and adequately funded. You may think I should be cheerleading for more resources for health and championing effective healthcare and preventive services. However, unless we have effective social care, which complements healthcare, the work of health professionals is much harder and less effective and our patients/citizens get poorer care all round. More than that, social care should be something older people and others who require care could consider positively and look forward to without fear. This is not to say that social care is universally bad in Scotland or the UK, rather that it is uneven in quality, quantity and cost and so getting or choosing a care home or care services in your own home can be variable and unsatisfactory.

It seems that social care is the problem that politicians recognize is important but do not have the vision nor commitment to tackle. Partly this is about their fear of the cost of such an endeavour but as economists say it is not the cost alone of something which should determine a decision, but its value. Indeed it is important to look at costs of not acting, the costs saved elsewhere in the system and overall benefits accrued. This lack of action may be about to change but I won't hold my breath given the complex, almost Byzantine, recent history of developing a National Care Service (NCS) in the UK.[3]

The pandemic provided a push for politicians to act due to the problems that care homes endured. The ruling Scottish National Party (SNP) Scottish government commissioned Derek Feeley, a former chief executive of the NHS Scotland, to chair the Independent Review into Adult Social Care (IRASC).[4] The Feely Report as it is known concluded that three things had to change to ensure better adult social care in Scotland. There needed to be a:

1. shift in the paradigm, e.g. new, positive ways of thinking and working in social care;
2. strengthening of the foundations of social care, e.g. valuing the social care workforce and paying them appropriately, and recognizing the crucial role of unpaid carers and supporting them; and
3. redesign of the system, e.g. through the development of the NCS.

Interestingly 10 years ago Nicola Sturgeon, the present First Minister of Scotland, when she was Health Secretary in Scotland rejected the proposals for a NCS. Nonetheless, the pandemic revealed the fault lines in social care and in the 2021 Scottish Parliament elections, the Scottish National Party (SNP) had a manifesto commitment to create a NCS in Scotland. Since their re-election, the Scottish government has been developing those plans starting with a consultation.[5]

That consultation sought views from individuals and organizations about the NCS including improving the planning and delivering of social care, the precise role and remit of the NCS, improving regulation and scrutiny of social care to ensure delivery of quality services, and valuing and supporting social care staff. This issue of social care staff is critical. I have seen the difference in attitudes and pay between health staff and social care staff. If we want the vulnerable in our society to be cared for in a loving and effective way, then we have to recognize the physical, emotional and psychological burden staff endure and pay them accordingly.

The UK government, which has responsibility for health and social care in England, has also been looking at the issue of social care again following the problems during the pandemic.[6] 'Build Back Better: Our Plan for Health and Social Care' policy paper is not comprehensive but one thing it does do is consider increasing funding for health and social care. There is a proposal for a new 'Health and Social Care Levy' of 1.25% on National Insurance contributions, which are paid by employers and employees. This levy will be UK-wide and ring-fenced to provide increased resources to healthcare in the initial years to tackle the backlog of postponed healthcare due to the pandemic. Subsequently, this increased funding will go to improve social care in England. The levy will provide a proportionate increase in funding for the devolved governments in Scotland, Wales and Northern Ireland.

From a personal perspective having good social care complementing good healthcare is not an abstract idea. As I get older, I think about whether I may require social care and would I be happy with some of the current provision of social care. So I am not afraid to admit to a selfish aspect to this issue—I want the best for myself just as I do for others. Perhaps our battle cry should be 'Quality health and social care for all'!

The Scottish and UK governments adopt different approaches to improving and sustaining good social care. For my money the Scottish government has a better strategy but the key will be in funding and implementing the proposals and providing quality social care. Consequently, the jury is still out in Scotland and England whether this is a new beginning or another false dawn for social care.

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