Letter from Mumbai

MULTIPLICATION DOES NOT NECESSARILY LEAD TO ADDITION OF QUALITY

We are witness to a furious multiplication of All India Institutes of Medical Sciences (AIIMS). This is unlikely to help our country or the patients for whom they are intended. The basic premise is faulty.

Such institutes cannot be rolled out on an assembly line. They need careful assessment of needs, research on availability of expert workforce, well-planned means for selections and appointments; and of infrastructure. Apart from the immediate expenditure, there must be a streamlined approach towards continuous and efficient maintenance and upgradation.

The history of the first such institution set up in Delhi is an object lesson on how such an institution should be created. The need for such an institute was identified and confirmed by a variety of experts. Its aims and objectives were clearly defined. Time and effort was spent in ensuring its foundation on a sure footing. The goal was the creation of an institution that was head and shoulders above all others in the country.

We are fortunate in having Dr C.G. Pandit's description of the process and the inception of the first AIIMS in chapter 15 of his book.[1] Dr Pandit was the first Director General of the Indian Council of Medical Research. His life and work are inspiring.[2]

In brief, the objective was to create an institution modelled on the Johns Hopkins Medical School in Baltimore, USA. The achievements of that institution on the creation of an outstanding teaching faculty, designing a comprehensive curriculum, careful selection of students to be admitted and setting a tradition whereby its alumni would go on to staff other medical colleges in the country were to be replicated here.

The Bhore Committee; Professor A.V. Hill, Secretary of the Royal Society in London and Sir Bennet Hance, the Director-General of the Indian Medical Service were involved in the planning. Sir Bennet Hance and Dr Pandit were asked by the pre-independence Government of India to visit the Johns Hopkins Hospital and other major international institutions to gain first-hand experience of requirements. They visited the USA, Canada and the UK. They discussed their proposed institution with many distinguished educationists and scientists and recorded their recommendations. I urge you to read at least this chapter of the book to learn their findings. You will experience the bonus of chuckling at the many anecdotes that are provided in it.

To emphasize the meticulous study by Drs Hance and Pandit, let me just reproduce six heads under which discussions with foreign experts took place:

1. Should such an institute be established in India?
2. Should undergraduate teaching be undertaken in the institute?
3. What should be the composition of the different departments in the institute?
4. What are the methods to be employed in selecting staff and students?
5. What should be the structure and functions of the administrative wing of the institute?
6. What academic qualification should the institute give its alumni?

It was on the basis of these and other discussions that work on the actual plan and structure of the proposed institution began after their return to Delhi. The report of the Bhore Committee on this institute was published in 1946. The foundation stone was laid on 18 February 1956. (It is of incidental interest that Pandit Nehru wished to establish it in Calcutta [present day Kolkata] but on Dr Bidhan Chandra Roy's refusal, it was sited in Delhi.)

The fact that 10 years elapsed between the planning of the AIIMS and its actual creation should give us food for thought. Pandit Jawaharlal Nehru envisaged its creation akin to setting up a temple to science in modern India.

To secure teachers and researchers of eminence, the best available talent in India was tapped. Persistent and sincere attempts were also made to get bright Indians who had gone abroad to study medicine and had proven their merit to return to serve their country.

Even so, progress was slow and departments evolved over time.

Despite ups and downs, by and large, AIIMS has succeeded in meeting the goal defined in 1946. It has escaped the downgrading that public sector medical colleges—especially the three hallowed institutions in Kolkata, Chennai and Mumbai—have been subjected to.

In 2003, the Government of India resolved to correct the imbalances in the availability of tertiary care and allowed the formation of six 'AIIMS-like' institutions. An ordinance to this effect was passed in 2012 and subsequently legislation was amended. By 2021, this number was increased to 22. The ultimate goal appears to be the setting up of an AIIMS in every state.

The sums spent on this proposal range from almost ₹2000 crore in 2016–2017 to ₹7000 crore in 2020–2021.[3]

Of concern is the fact that before these institutions were planned, there was no research on the availability of medical teachers and researchers of international calibre in India who could be appointed to them. Had this been done, the stark fact that we have precious few would have been highlighted.

Promising postgraduate students have either emigrated or gravitated to the private hospitals where fortunes can be made.

Our existing public sector medical colleges had been the mainstay of medical education till the 1960s. These sources, whence these teachers were to be obtained for the 22 AIIMS, have been progressively downgraded and are in a sorry state. The less said about most of our private medical colleges the better.

On a study of available documents, I learn that much time and energy has been spent on worrying about the land on which these 22 AIIMS were to be created, their administrative structure and curriculum but there is precious little of the quality and quantity of teachers that will be needed to staff them and where they are to be found.

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The consequences are evident. Many of the new AIIMS already set up have gaps in their ranks of teachers and researchers. Members of selection committees have confessed in private discussions that they are just not getting suitable individuals for appointment.

An analysis of the academic excellence and research output of those already appointed to professorial and senior posts may uncover unpalatable facts.

Would it not have been better to adhere to the earlier plan of setting up individual AIIMS in the four geographical corners of India and one in the centre? Their workings could have been studied over a decade or so. The identification and correction of deficiencies would have resulted in robust institutions.

Adhering to the plan laid down by the Bhore Committee, and the recommendations of the Hance–Pandit report, each of these AIIMS could have seeded existing medical colleges and their attached hospitals to raise their standards.

Simultaneous strengthening of the three-tiered medical care system of primary, secondary and tertiary care centres would have further improved the care of patients, especially those from deprived and hitherto uncared for villages and townships.

Alas! Grandiosity has triumphed over reason. It remains to be seen what benefits accrue from the expenditure of the huge sums earmarked for each AIIMS.

A similar set of problems is faced by the multitude of Indian Institutes of Technology created. Up to 2008, there were seven of these institutions. The number had reached 23 by 2016. I strongly recommend a study of the report on the performance audit of the new IITs.[4] Targets for infrastructure, appointment of faculty, enrolment of students, quality of research have not been met. The estimated expenditure rose from ₹6080 crore to ₹14 332 crore. The propriety of how sums were spent has been questioned.

Will the many new AIIMS prove similar white elephants?

LESSONS LEARNT FROM PATIENTS AND THEIR FAMILIES

We must approach them chanting to ourselves the counsel offered by Krishna—'You have a right to perform your prescribed duties, but you are not entitled to the fruits of your actions.' (*Bhagavad Gita* chapter 2, verse 47)

During a career in public teaching hospitals spanning 30 years, this is what I have learnt:

1. The poorer the patient and family, the greater the gratitude they show for every little thing one does to help them.
2. The converse often holds true. The well-to-do person may have unrealistic expectations and, in private practice, the attitude that prevails is: 'I have paid you for your services. You have done me no favours.'
3. Never underestimate the intelligence of the patient and the family. Illiteracy and poverty are often accompanied by sharply developed common sense and native wisdom. These are crucial attributes developed in the process of survival.
4. Making it possible for the patient's family to witness efforts being made by every member of the team to help their patient often yields rich dividends. When treatment fails to improve the patient's conditions, you may be surprised by relatives who console the sincerely distraught physician and nurse with such words as: 'You did your best to help. We are grateful.'
5. Keeping patient and family informed at each stage of the illness and treatment is the best way to ensure their trust. Patience when discussing progress; gentle responses to their queries with sincere attempts at ensuring that despite stress, they understand what you are trying to convey; and evidence of your concern for the welfare of the patient are invaluable in ensuring an excellent doctor–patient relationship. Such measures sharply reduce the inclination of family members to sue or direct violence at the treating physician when the outcome is not what they desired.
6. Indian patients are often deeply religious. It is important to put one's own feelings aside when they or their family members bring up such matters. While respecting their faith, it is important to place all discussions in perspectives governed by rational thinking. Gentle but firm responses often help.
7. Modesty and sincerity score much higher in the long run that one-upmanship and the projection of one's own excellence and abilities.

IN PRAISE OF Dr HEMANG DIXIT

This Nepalese educationist, author and paediatrician deserves greater recognition in our country.

His father, Dr Siddhi Mani Acharya Dixit was a pioneering medical practitioner, President of Nepal Medical Association and Nepal Council of World Affairs. Born in Kathmandu, Dr Hemang studied at Bishop Cotton School, Shimla and Sherwood College, Naini Tal before leaving for the UK. Ruskin Bond was his classmate.

He studied at the Charing Cross Hospital Medical School and graduated in medicine before moving to the London School of Tropical Medicine and Hygiene. After obtaining the DTM&H, he obtained the DCH from the Conjoint Board in London.

Returning to Nepal, he taught at the Institute of Medicine in Kathmandu and served as Dean of this institution. Many honours have been bestowed on him.

His original writings appeared in the *Journal of the Nepal Medical Association* but he has since published in a variety of journals. I draw your attention to his 18 and more books—written for children and for adults. He has written about the history and natural beauty of his own country, fiction and of his own life and work.

He has highlighted the problems of addiction to drugs, the consequences of free sex and other problems that plague youth in his country. He has also highlighted public misdeeds by politicians. His outspoken criticism resulted in an attempted assassination on 4 May 2006. Fortunately, he came to no harm.

All is not gloom with him. He is also the author of poems, works of fiction and *Nonsense verses from Nepal*. His autobiographical *My 2 innings* is subtitled *Memories of a non-cricketer*.

CLERK'S GHOST FRIGHTENED GAJRA RAJA MEDICAL COLLEGE, GWALIOR FROM PROVIDING RATIONAL REPLIES TO A REQUEST FOR INFORMATION[5]

Ingenuity is inborn in many of our countrymen. Clerks and bureaucrats appear to have been especially blessed with this quality.

Activists were investigating admissions of candidates who had provided fake domicile certificates to the first MBBS in Gwalior's Gajra Raja Medical College. Stone-walled by the authorities for 3 years, they invoked the Right to Information (RTI) Act.

Mr Pankaj Jain, one of those seeking the information, was asked to provide a letter to the college stating that he had no intention of harming the reputation of the college. Submission of the letter failed to elicit any response. When pressure was brought on the administration, the answers elicited command admiration.

'First they said the documents have been seized by CBI, then they said the clerk who was handling it has been arrested by CBI, and then they said the clerk who was handling it committed suicide inside the room where the documents were kept. The room is now haunted by his ghost and they are scared of opening the locks.'

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4 Pandey P, Murmu GC. Report of the Comptroller and Auditor General of India on Performance Audit of setting up of new Indian Institutes of Technology (IITs). Report No. 20 of the year 2021. New Delhi:Union Government (Civil) Ministry of Education; 2021.
5 Anonymous: Clerk's ghost frightening Gwalior medical college from giving RTI reply. *The Times of India* 22 Jun 2021.

SUNIL K. PANDYA

Letter from London

It is almost two years since we first heard the whisperings of a coronavirus causing concern among public health experts. As the story began to attract media attention and the implications became more visible, people in the UK responded in different ways and at different speeds depending on their circumstances. Among disabled people, many of us began to take precautions early on. A lot of people took the decision to shield from the virus before advised to do so by a government more concerned with keeping pubs open than confronting the reality of Covid-19 and the devastation it was already wreaking in Italy and elsewhere.

We know only too well by now that the pandemic has exacerbated pre-existing social inequalities. This cannot have come as a surprise to anyone other than the most privileged people living in ignorance of the structural oppression that governs the lives of so many of their fellow citizens. For disabled people, it was all too predictable. Demonised by successive governments as either scroungers or frauds, the lesser value placed on our lives has been illuminated to frightening effect during the pandemic. For almost two years the narrative in UK has been that most people who die from Covid are either old (so their time was up anyway, goes the implicit assumption) and/or they have other underlying health conditions which make them more vulnerable (proving that Covid is not a serious threat to 'normal' people and therefore the measures taken to curb the pandemic are unjustified). We have seen this play out through the government's disregard for accessible communication with disabled people, a failure to protect services that disabled people rely on for survival, the imposition of 'do not resuscitate' orders without consent, and the failure to prioritize huge numbers of disabled people for vaccination despite all the evidence showing that we are at greater risk if we catch the virus.

Poor people, black people, women—all have experienced the exacerbation of discrimination during the pandemic, and where these identities intersect, even more so. Yet there is a particular irony to the government's disregard for disabled people during this pandemic, which lies in the fact that Covid-19 has already created so many more of us. There is palpable global relief that the Omicron variant has proved less severe than feared. But any strain of this virus remains a potent threat. Because while you may not be hospitalized, that does not guarantee that you will fully recover. This is something that those of us who have lived with post-viral diseases for years and decades know only too well. We also know the hostility and disbelief that people with post-viral illness are all too often met with from the medical profession, the media and wider society.

The term 'Long Covid' was coined early in the pandemic, as growing numbers of people who got sick during the first wave did not recover. Not recovering does not mean being left with a vague malaise; it means debilitating symptoms that profoundly impair a person's quality of life, in some cases transforming it beyond recognition. That is hard enough to manage, but what can be harder for many people—and I speak from experience here—is seeking help from a doctor only to be dismissed as an over-anxious example of 'the worried well'. Those who persist have historically been offered cognitive behavioural therapy (CBT) and graded exercise therapy (GET). CBT can support people to manage the experience of chronic illness (it is not a treatment), while GET has been repeatedly shown to actively exacerbate symptoms and has left many people far worse than when they began. For those of us with ME/CFS (myalgic encephalomyelitis/chronic fatigue syndrome), seeing people with Long Covid confronting systemic disbelief, invalidation and harmful treatment is troubling to say the least.

Is there any cause for hope here? For those newly ill, that might sound insensitive. But for those of us with longer experience the emergence of Long Covid brings a glimmer of hope for research funding due to its occurrence on a global scale that makes it hard to ignore. There is also evidence from media outlets of increased interest in just how devastating post-viral illness can be, which leads in turn to greater public awareness. And as our numbers swell, research funders are finally showing more interest after the shameful historical neglect of ME/CFS

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