Impressions of Medicine in India

Medical links with Britain

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Irrespective of whether India needs British management skills as much or more than her medical expertise, arguably Britain has a responsibility to take an interest in health care problems in India. Medical links between the two countries have always been strong, and Indian doctors have played and still play a major part in the National Health Service. Many occupy some of its least attractive niches, and those who are becalmed in medical backwaters—senior house officers in geriatrics or psychiatry in their late 30s with little prospect of passing the postgraduate exams they came for and even less for promotion—are in an extremely difficult position. Returning home is unlikely to be a viable option for, as I have emphasised, the competition is such that they will be very lucky to break back into the system. Furthermore, their roots and especially those of their family may be well entrenched in Britain. It is hard to know how to help them, but that should not prevent us from trying.

Derecognition of degrees

Even those Indian doctors who have obtained British degrees while working over here may have limited options when they return to India. Most head straight for private practice because they know that they are unlikely to get welcomed back into the fold of the government health services, for while British degrees have a certain prestige value in the marketplace, they are not officially recognised in India. Thus an MRCP without an Indian MD will not get you an appropriate medical post in the public sector. This state of affairs dates back to 1975, when the General Medical Council issued a bald statement to the effect that no medical qualifications granted in India after 22 May 1975 were to be recognised for the purpose of full registration, and the TRAB, later PLAB (Professional and Linguistic Assessments Board), examination was introduced.

The reason behind the GMC's decision was concern about the poor standard of education in some of India's medical colleges. And not to be outdone, the Indian Medical Council expressed reciprocal concern (although an influx of British doctors to India was hardly a problem), and responded in kind by derecognising British medical degrees. Many Indian doctors I talked to expressed their regret about this bilateral cold shouldering for they recognise the illogicality of India recognising all manner of foreign medical degrees (including some from Eastern Europe) but not accepting British degrees. (Some believe that it was only a minority of Indian medical colleges that "let the side down" and consider that the British stance was somewhat extreme). Few doctors in Britain seem to have shared this regret for the number of British graduates seeking work in India over the last decade must have been very small. Nevertheless, it is worth reflecting that a British doctor would probably find it very

difficult to get a full time paid job in the public sector in India now, however well qualified he or she was.

Some doctors (from both countries) would argue that India and Britain's medical problems are so dissimilar that clinical experience in the other's country is of no value to the doctor who will spend the rest of his professional life "at home," thus dwindling prospects of exchange is a non-problem. But not all agree, and I must admit to belonging to the old fashioned faction that believes that a short period spent working in India (or another Third World country) may give a perspective and breadth of experience that no amount of careful treading along well delineated career paths at home can provide. But with Britain's understandable concern to exclude foreign graduates and the lack of enthusiasm that seems to lurk behind our outward concern to provide more and better postgraduate training opportunities for overseas doctors (especially those from countries with whom we have no great desire to foster good will in order to forge beneficial economic links) it must be uncertain whether India will continue to welcome the large number of British medical students who go out on their elective periods or the few junior doctors who seek employment.

Why Indian doctors come to Britain

Despite the fact that British degrees are no longer officially recognised in India they still, as I have suggested, carry weight and their acquisition has been one of the main reasons why Indian doctors have come to Britain. The influx of young Indians has tended to be a mixture of those who have failed to get on to a postgraduate course in India (and decided that the best way to get a postgraduate degree is to come to Britain and get a British one) and those who have come a little later, after they have obtained their Indian postgraduate qualification, to gain experience of the British approach to medicine. These doctors often pick up a British degree at the same time, both for their own intellectual satisfaction and because in India quantity of initials rather than quality still has the edge with most patients. (And who knows, with professional advertising lurking round the corner, doctors in Britain may well end up thinking along the same lines.)

Common to most of these young doctors is the desire to broaden their horizons and get a first hand impression of what life is like in the West. But others come with a more pragmatic outlook, many en route to Saudi Arabia or the Gulf States, which are the main outlet for Indian doctors discontented with their lot at home. These countries are said to prefer British postgraduate degrees, hence their acquisition, rather than the experience of working in Britain, is usually the prime aim of this group of doctors. A few, usually the more senior doctors, have come over with definite training objectives such as the acquisition of a new technique that they can take back to their units in India. Arguably these doctors should have priority, but sadly job opportunities for them seem to be particularly limited. The overseas doctors' training scheme proposed by the Council for Postgraduate Medical Education,¹ would provide them with many more jobs but has met with opposition and is still

Infant and maternal care are the major health problems in India, and if we are to continue to provide junior training posts they should, ideally, be appropriate to the Indian doctors' need.

"under consideration" by the DHSS. Places on schemes organised by the World Health Organisation, Commonwealth Society, or British Council are few and the bureaucracy surrounding their acquisition is such that—according to one doctor I spoke to—many never get awarded.

Increasing problems for those seeking to work in Britain

For some time now doctors in India have been well aware that their chances of getting full registration and taking up permanent residence in Britain are slim; and now, any dream of getting full registration should be abandoned for new laws restricting the entry of foreign doctors to Britain came into effect on 1 April this year. The new legislation was ushered in with predictably alarmist headlines. "Britain shuts door on foreign doctors" read the *Daily Express* 27 March and as a result there was a flood of calls to organisations like the British Medical Association and General Medical Council from Indian doctors already in Britain and fearful of being thrown out of the country. This seems particularly regrettable, for provoking needless confusion was surely unnecessary and is likely to have served only to increase the distance between the medical communities in India and Britain. In effect the new legislation—which has been broadly welcomed—will prevent future immigrant doctors (outside the EEC) staying on in Britain and occupying key career posts. And by setting a sum of £150 000 as the minimum needed to invest in setting up in practice this should deter the majority of those who might seek to work independently.

The new legislation does not, however, change the position of young doctors seeking short term employment in Britain. Thus the majority of young Indian doctors (as described above) will be in much the same position as before. Since they are all ostensibly "coming for training" they will not need work permits but they need to appreciate that they now have only four years to meet their training objectives (this refers to time worked, not just length of time spent, in Britain, although it is possible that those who do not get a job within a year will have to leave). Thus it becomes even more important that Indian doctors, and other foreign doctors, seeking to work in Britain know what their chances are of getting suitable jobs.

How hard is it to get a job in Britain?

All young foreign doctors coming to Britain know that it is difficult to get good junior training posts but unfortunately they all

too often have absolutely no idea of just how hard it is (after all it is hard enough for British graduates). And while a senior house officer post in geriatrics may offer suitable training for our graduates—for example, those aiming for general practice—these jobs are usually wholly unsuitable for Indian doctors: there is no appreciable geriatric problem in a country whose average life expectancy is only 56. Yet these jobs or posts in psychiatry, which primarily for cultural reasons are of limited value, are very often the only ones available, certainly until the doctor has obtained part I and preferably part II of the examination for membership of the Royal College of Physicians. But it is Catch 22, for to be eligible to sit for the exam they obviously need experience in appropriate jobs.

All unqualified young Indian graduates coming to Britain need to realise that they are likely to have to weather long periods of unemployment, sporadic locum posts, and jobs that are far from ideal until they find a suitable niche. At the same time they will also have to learn a whole new approach, including the technique of coming over well in the British interview, which seeks to find out if you are a "good, well rounded chap" as well as academically qualified for the job and in this respect is totally different from most job interviews in India. There is also the different doctor-doctor and doctor-patient interaction to get to grips with and, of course, an awareness that English as it is spoken in Britain is not at all like the Indian English they are familiar with. Thus, on balance, and at the risk of trivialising the problems, it is probably advisable to work on the same premise as one does with the builder: it will take twice as long, cost twice as much, and unearth infinitely more problems than you ever dreamt it would to achieve your end. And given that the time limits have now been drawn up very firmly the pressure will be on with a vengeance.

Thus there is more to coming to Britain than passing the PLAB examination (and it must be remembered that not all Indian doctors can sit the exam, for it is open only to those who have qualified from medical schools whose degrees are considered acceptable by the GMC). And according to the GMC up to a third of foreign doctors now get exemption from the exam anyway. Nevertheless, PLAB remains a barrier for some, and it is worth noting that the examination has been getting steadily more difficult in recent years. The pass rate has dropped from 43% in 1980 for all overseas doctors to the low 20s in 1984. The pass rate of Indian doctors, however, remains little changed at about 36% and surprisingly few I talked to seemed to regard this as a major problem.

Unrealistic expectations

Although young Indian doctors may still seek to come to Britain they need to appreciate that it is not quite the same country that their teachers came to some 20 years ago and still remember fondly. (Indeed very often it is their rose tinted view that has influenced the young graduate to come in the first place.) And while doctors in Britain are understandably gathering their own skirts about them in a flurry of self concern they should spare a thought for the junior doctor from India who spends £1800 on an abortive visit to England to sit the PLAB examination (in 1983, 957 took the exam and 348 passed). On a salary of £850 a year he may have put himself in debt for a lifetime, and even those with money have trouble because of foreign currency restrictions. Many travel hopefully, but disillusionment is common, especially for those whose expectations are hopelessly unrealistic—for example, some believe that teaching hospital registrar jobs in major specialties are readily available or that, to quote an example, it is possible to just "pick up a PhD in liver diseases."

The experience may not just be tough, it may be a personal catastrophe, and better counselling of doctors both in India and in Britain is needed to try to reduce the number of such incidents. Appropriate advice should be sought well before the plane ticket is bought, and organisations such as the National Advice Centre, 7 Marylebone Road, London W1, offer a helpful counselling service which appears to be more digestible than the information supplied by the GMC although, and this needs to be underlined, it is not the centre's brief to find people jobs.

Does Britain have a duty?

Some doctors in India obviously feel that they have all the professional skill they need to sort out their own medical problems. Others believe that India's health care problems are political more than medical. My impression was that many still look to the West and Britain in particular, with whom they feel a close affiliation, and several spoke to me of their hopes that communication and cooperation on the medical front between the two countries would increase. This view does not, however, seem to be shared by many doctors in Britain, who may feel that they have little responsibility towards our former colonies and certainly no obligation to offer any further job opportunities to Indian doctors, or any other overseas doctors. Indeed, as the new legislation suggests, there is a feeling that for the sake of our own graduates, we should exclude as many "foreigners" as possible.

But history, reason, and humanity suggest that Britain should do what she can to help her medical colleagues in India. As a recent

editorial in *Nature* pointed out (when talking about the West giving help to the Indian scientific community in the aftermath of Mrs Gandhi's assassination) "colleagues of Indian scientists in India and elsewhere, should exert themselves more energetically to help . . . go give a lecture, send a book, write a letter, is too trite for anything but a personal exhortation. Governments in the West can do more, and should, to help the enterprise along."² Surely the same is true for medicine too, and although many bodies including the royal colleges are active in this respect perhaps more dialogue is needed to define what sort of help is required and how this may best be effected. What is on offer at the moment—primarily limited work opportunities (often in unsuitable junior posts) and a crack at our exams—seems unlikely to be the most constructive form of help.

References

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Philosophical Medical Ethics

Deontological foundations for medical ethics?

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In my last article I outlined the World Medical Association's principles of medical ethics and argued that all such codes, oaths, and declarations required some moral underpinning and that morally speaking they were not self sufficient. This was implicit in the Declaration of Geneva's appeal to "the laws of humanity." What, however, are these moral laws of humanity? Traditionally it has been the business of moral theology and its secular sister moral philosophy to try to answer this grand question, and, although moral philosophers have recently been rather more chary of attempting so ambitious a task, there remain strands even within contemporary moral philosophy that attempt to do so.

Among the diverse answers are two great categories of moral theory. One claims that answers to moral questions about which actions are right and which wrong ultimately depend solely on the nature of the consequences of those actions or proposed actions. Not surprisingly, this group of moral theories is called consequentialist, and its best known and most important members are those moral theories clustering under the name utilitarianism. I shall consider these in the next article. The second category of moral theories are the so called deontological theories (from the Greek word *deon*, duty, not from the Latin *deus*, god). At least some of the explanations of moral obligations offered by this group of theories are not reducible to considerations of consequences.

Certainly most human societies rely in part at least on moral rules that make no reference to consequences, and it is widely accepted by psychologists that our moral reasoning is based at least in part on obedience to non-consequentialist moral rules instilled in childhood. The great religions expect obedience to moral rules (for

example the Ten Commandments) that make no reference to consequences, and, as we have seen, some of the principles of medical ethics embodied in the declarations of the World Medical Association make no reference to consequences. None of this, however, shows either that moral explanation ought to be deontological or that these working moral rules cannot themselves be justified by reference to consequences.

How else then are deontological principles to be justified? Needless to say this is an enormous question with no simple answer. To offer any sort of outline account of one or two theories in a few paragraphs is bound to be inadequate and indeed to many philosophers offensively simplistic. Just as, however, kidney or liver function can be roughly explained in a few paragraphs for the benefit of philosophers who are interested, so too can the bare bones of philosophical theories be roughly outlined to non-philosophers; alas, here and throughout this series I offer no better and I hope that readers will bear this fairly limited objective in mind.

Two justifications

The great religions typically justify their deontological theories on one or both of two grounds. The first is that God has commanded the people he has created to obey his moral laws and it is their moral duty to obey their creator. The second is that the laws of nature include moral laws that bind everyone, including God. Even for believers there are important philosophical objections to the first position, for it commits them to accepting at least the logical possibility that if God were to command cruelty, injustice, or wanton destruction they would be obliged to accept that these were right and morally obligatory.

The second sort of religious justification, that morality stems from natural law, offers to religious and secular theorists alike a possible objective grounding for moral theories in "the laws of nature." In principle, at least, rational beings may be governed by

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