hospital services are not allocated separately to 'planned' and 'unplanned' healthcare.

Finally, partnerships will be monitored on how they perform, based on the nine national health and wellbeing outcomes below.[5]

Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5. Health and social care services contribute to reducing health inequalities.

Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Outcome 7. People using health and social care services are safe from harm.

Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.

Despite the important challenges ahead, we know what we need to do—provide effective, efficient, equitable, person-centred, seamless health and social care to our adult, and in particular, to our older patients and population. We must get it right for the people we serve but also because we may just need to use these very services in the future.

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Letter from Chennai

RESIGNATION *EN MASSE*

Everyone wants more, and so do the doctors of the Government of Karnataka. For 6 years, the doctors kept pressing the government to increase their salaries. Their demand was that they should be paid on a par with the doctors of the Medical Education department, who got higher salaries. What was worse, they had not been paid for 4 months. All my life, the unfailing advantage doctors in government service had was that they received their salaries on time. These days, governments spend so much on election promises and sops to potential voters that they have no money for even essential services, and salaries of their employees are not so important. As for doctors, they rate the lowest priority. The doctors had other demands that to my mind seemed unexceptionable, among them the supply of medicines of good quality to their hospitals, and timely recruitment to prevent posts lying vacant. They also said that Karnataka fell far behind Tamil Nadu which had periodic and timely recruitment drives so that vacancies were filled promptly, and gave preference for postgraduate seats to doctors in service. On 27 October 2014, 3500 medical officers declared they would give a month's notice to the government, and quit service on 27 November 2014 if their demands were not met.

How is mass resignation any different from a strike? It is clear that, irrespective of the outcome of their threat, the entire lot of doctors will not resign. Many may not have the wherewithal to sustain themselves and their families without the salary. It is unlikely that the government will accept their resignations and proceed to hire new recruits, though there are probably quite a few doctors ready to join.

I wondered what the Medical Council of India had to say about doctors going on strike. The code of medical ethics of 2002, amended up to December 2009, is displayed on its website. There is no mention of strikes. The closest it comes to this situation is Article 1.8, which deals with 'Payment of professional services' and says, 'The personal financial interests of a physician should not conflict with the medical interests of patients.' However, I believe Article 2.4 entitled 'The patient must not be neglected' expressly forbids strike action, though not in so many words. It

ends: 'Provisionally or fully registered medical practitioner shall not willfully (sic) commit an act of negligence that may deprive his patient or patients from necessary medical care.' That is, if one doctor resigns after giving appropriate notice, his employer should make provision to look after his patients, but if all doctors should resign this is wilful deprivation of medical care to the patients dependent on every one of them, and contravenes Article 2.4.

No action resulted, and on 28 October 2014 the president of the Government Medical Officers' Association announced that 2800 doctors had submitted their resignation. The health minister announced that he had received 'only' 911, which I thought was an adequate number to prove the point that many were dissatisfied. The minister had made arrangements for Ayush doctors to fill the vacancies, and was posting nurses to help. He said that of the 14 demands made by the doctors he had accepted 10, but the crucial one pertaining to salary could not be conceded.

A public interest litigation was filed in the Karnataka High Court and the Bench declared that both the government and the doctors who 'resigned' were guilty of violation of human rights of the common people. The government for its part said that it was looking into the legal position as to whether this resignation could be construed as a strike, and action could be taken accordingly.

The chief minister met the striking (resigning) doctors and assured them he would look sympathetically into their demands, though pay parity with doctors of the Medical Education department could not be granted for 'technical reasons'. Salary revisions would certainly be considered, said the health minister, but he added an escape clause for himself by saying he would need the approval of the finance department.

With nothing more than this assurance, the doctors withdrew their resignations. I understand from some of the doctors, who had resigned and then retracted their resignations, that till the end of January 2015 nothing concrete had resulted, and they were no better off than they had been before the agitation.

While strikes by organized labour unions almost always yield the strikers some benefits, agitations by medical people usually end this way, 'not with a bang but a whimper'.

BAITING THE BULLS, AND THE SUPREME COURT

I have already reported in these columns that, after many attempts by animal lovers, the Supreme Court finally banned *jallikattu*, or bull baiting, from 2013. January is the season for jallikattu, and demands rose from many bodies to government to permit this traditional sport. Someone must be making a pile out of this, or else why would so many ask for the return of what is in all respects a barbaric custom, cruel to animals and humans alike? Opposition politicians, including leaders of the Dravid Munnetra Kazhagam (DMK), jumped on the bandwagon and said the government was duty bound to permit the 'sport' as the people wanted it. Since the Supreme Court had banned this, does this attempt to pressurize the government to do something illegal not amount to contempt of court? The chief minister, for his part, said the government would do everything possible to restore jallikattu in the state. A review petition had been filed in the Supreme Court to reconsider the ban, and that he would now send a deputation to the Court to request them to do this soon, in time for this year's season. Further, since jallikattu bulls had been declared to be performing animals, and since there was a ban on cruel treatment of performing animals, he would appeal to the Centre to remove bulls from this classification. If it could be declared that they were not performing animals, they could presumably be treated cruelly with impunity.

Notwithstanding the political pressures, the Supreme Court took no action and jallikattu remains banned. But when did a simple matter of a law deter patriotic Indians from doing what they want? Jallikattu was held in a few places, and bulls and people sustained injuries, though not on the scale of earlier years. At one place the police prevented a group of people from holding a jallikattu event, and a police sub-inspector was injured in the fracas.

A variant of this brutal sport was played in some places. Instead of the bull being let loose, it was tied with two long ropes. Each rope was seized by the members of two teams, and they proceeded to conduct a tug of war with the unfortunate bull in the middle. Clearly, this is not jallikattu, and the Court has not yet banned bull tugging. Here too the bull was irritated with chilli powder in its eyes and nostrils, and goaded to run amok. Bulls and men alike were injured.

Maneka Gandhi criticized the patrons of this sport, saying it was just a western tradition. I am not sure she is on strong grounds here. Tamils have been torturing bulls for centuries with no need for western guidance. *The Hindu* of 5 February 2014 carried a photograph of a hero stone from the Government Museum, Salem. This has been dated to 400 years ago. It shows a man holding a bull by the horns, and bears a Tamil inscription that has been translated by epigraphist N. Kumaraswamy as follows: 'Kangan of Kovur village took part in the bull-taming sport held in Karuvandurai and attained martyrdom. Hence in remembrance of Kangan his son Periya Payal erected this hero stone.' Jallikattu was clearly prevalent then, and was just as fatal. I hope the courts will stand firm, and prevent this brutality.

MEANINGFUL ALUMNI ACTIVITY

The alumni of the Stanley Medical College in Chennai have shown greater unity and attachment to their alma mater than their counterparts from many other colleges, particularly my fellow alumni from the Madras Medical College (MMC). For several decades, alumni of Stanley have been meeting in groups, wherever they are, on the last Sunday of January. There are meetings of alumni in the USA, in different towns in India, and always one on the college premises. People attend whichever meeting they can, and have a good time. Occasionally, this is combined with a continuing medical education (CME) session, attendance at which, I understand, provides some tax advantages for alumni from the USA when they come here. A few years ago, alumni from the MMC felt this was a good idea, and we have a meeting on the first Sunday of January every year in the college premises.

Individual batches of students have been more active in meeting their former classmates regularly. I organized two very successful reunions of my classmates, 40 years and 50 years after we joined the MMC, and reported them in my Letters from Chennai.[1,2] With regard to Stanley, I have a peculiar dual relationship. I am a son-in-law of the college, having married a student of the 1957 batch. I have also been a teacher in that college, and some of my wife's classmates were my postgraduate students (I think all had cleared their undergraduate courses before I joined the staff). We recently had a reunion of my wife's batchmates, and I was both welcomed as a spouse and honoured as a teacher. Apart from having a good time and hearing some nice things said about me, I found this reunion stimulating because of some meaningful alumni activity. Last year marked the Platinum Jubilee of the Stanley Alumni Association, and Dr Dinakar Moses and Dr R.S. Muralidharan suggested that the alumni could help some of the poorer students of the college. There are many scholarships and fee concessions for meritorious and financially disadvantaged students. However,

these doctors remembered their student days when a strong deterrent for poor students from towns or villages outside Chennai was the cost of living in the city. Some of their own classmates had been forced to discontinue studies as their parents could not afford hostel fees. They set up the Stanley Alumni Trust, which raises funds particularly to defray hostel expenses of financially disadvantaged students. They have calculated that a sum of ₹7 lakhs (700 000), invested in a deposit at 9%, would be adequate to cover hostel dues for one student; 20% of the interest is reinvested so that the corpus grows and will cover inflation of hostel expenses. No money is given to the successful candidate. The money is given as a cheque directly to the hostel warden, so there is no question of misuse. One student has been given aid since last year, and the trust now has the funds, ₹20 lakhs (2 million), to cover two more, for which there are 45 applicants. They will apply for tax exemption under Section 80G soon. Many alumni are contributing, and efforts overseas are coordinated by Dr M. Nallathambi in the USA and Dr V. Bharathi in the UK. Dr P. Viswanathan is also actively involved. Recipients should not regard this as a donation, and should attempt to repay by donating to the trust when they graduate and start earning well, though of course there is no compulsion to do this. Details of the accounts and the activities will be made available to anyone who wants to know, if he or she writes to *stanleyalumnitrust@gmail.com*. Individuals or groups of classmates can contribute, and my wife's batch already has plans to pay for one such studentship.

I think this is an excellent idea. In the past, alumni have contributed buildings or equipment, but maintenance by the government is so shoddy that many of these are in a sorry state now. This is one form of help that will sustain itself, and will make medical education more affordable for economically disadvantaged students.

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