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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H.S. KOHLI

Division of Community Based Sciences
Public Health and Health Policy
University of Glasgow

Director of Public Health and Health Policy
NHS Lanarkshire Headquarters
Kirklands
Fallside Road
Bothwell
Scotland

harpreet.kohli@lanarkshire.scot.nhs.uk

**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 get 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
I have already reported in these columns that, after many attempts, I have baiting the bulls, and the Supreme Court end this way, 'not with a bang but a whimper'.

The strikers some benefits, agitations by medical people usually January 2015 nothing concrete had resulted, and they were no their resignations. I understand from some of the doctors, who had approval of the finance department.

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. Kumaran 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. 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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M.K. MANI