

CASE STUDY 1



*The thinking of a person gains in breadth,
the concepts become clear, and the boundaries of
narrow thinking and criticism of others,
can be overcome.*

- Dr. Suresh Tandon

DR. SURESH TANDON is a very senior Physiology professor in a private medical college in Uttar Pradesh (UP). His words reflect his wisdom and knowledge of his subject beyond the theoretical perspectives. He quotes freely from Sanskrit literature and truly personifies a teacher in all forms. He has retired from teaching in a government college, but is still working as a professor.

Dr. Tandon hails from an illustrious family from one of the large cities of Uttar Pradesh. His grandfather was a civil surgeon¹, his father a proprietor, and his mother a teacher. Dr. Tandon was a teacher before he chose to enter the medical field. He completed his medical graduation from UP in 1968. He got married after his parents died quite early. He completed his post graduate studies in Physiology in 1972 and joined as a lecturer in a college in Meerut the next year. Currently, he lives in Meerut, UP with his wife.

PRE-MIGRATION

Dr. Tandon was satisfied with his job as a lecturer; his lectures were practical and well received by the students. However, as the years went by, he began to feel that the management was not appreciative. He had worked for 7 to 8 years without any promotion. Apart from teaching, Dr. Tandon had a keen interest in research, specially in the area of chrono-biology. The college had meagre facilities for this area of study, thus adding to his frustration. At that time, Germany was leading the research in this field and Dr. Tandon was invited to present a paper at a college there. Dr. Tandon found the process of going to Germany fraught with hurdles and disappointments. He was denied government assistance. The clerks who were processing his papers asked for favours. Dr. Tandon said it was unfortunate that, instead of acknowledging that an Indian doctor was receiving such recognition from Germany, the government seemed to want to penalize him for this honour. During his visit to Germany he met an internationally respected professor and a stalwart in this field who invited him to join his work in the US; however, he had no intentions of working in the US at that moment, so Dr. Tandon declined the prestigious offer.

Later Dr. Tandon received another offer to join a research project in a University in Germany. As recognition for this work, he was awarded the Humboldt Fellowship in 1981. The university in Germany requested him to get the Indian government's

permission and move to Germany. However, he experienced the same hurdles with the government departments. The corrupt clerks again asked for favours and the government department raised questions about his earlier trip to Germany, which was a self funded trip. Bugged down by such depressing events, Dr. Tandon refused the offer, even though he knew this scope of research was not available in India, at the time.

Dr. Tandon felt very frustrated and unhappy with the circumstances, but his passion for teaching kept him going. It was at that time that a friend offered him a teaching post in Libya. Initially he was hesitant as his children were very young and in school. However, he felt that 'survival was difficult' for him in India. He finally concluded that with no house, little savings, and increased responsibilities towards his family, this was a timely opportunity and he chose to accept the offer. He applied to the Indian government for permission but did not receive any communication even after 3 months. Thereafter, Dr. Tandon informed the department of his decision and intimated them of his working address in Libya. Preparation and documentation for going to Libya was then done by himself. He left the country in March 1981, accompanied by his wife.

MIGRATION

Dr. Tandon became a lecturer in the medical graduate course in Libya and additionally handled some courses for the Membership/ Fellows of the Royal College of Physicians (UK), Membership of the Royal College of Obstetricians and Gynaecologists and pharmacy studies. His lectures were interactive and he was popular among the students. His lectures were even attended by some college officials.

He was satisfied with his stay and work in Libya. He felt that the country provided good state support to its population and a good living standard. The country also offered support to foreign staff working there; providing them residence and other amenities. Dr Tandon could avail free medical support for himself and his wife and could lead a comfortable life. He did not face major language issues as Arabic is somewhat similar to the Urdu spoken in UP.

RETURNING BACK

In 1984, while working in Libya, Dr. Tandon woke up to a rude shock when he received the news that the UP government had terminated him from his job at the medical college. He was stunned by this sudden development. He had never intended to live outside India forever since he was quite attached to his own country. In order to address this issue, he decided to return back to India. His colleagues and other officials tried to make him change his mind, but he needed to come back. Without much preparation, Dr. Tandon returned to India after four years of work abroad.

When he returned, Dr. Tandon paid several visits to the government department in an attempt to get back his job. Amidst his struggles, he decided to start his private clinical practice. Through his determination and efforts, his clinic started running well. He was earning Rs. 4,000 every month, so with this, and the money saved from working abroad, he was able to build his house in Meerut. In 1986, after the chief minister's interventions, Dr. Tandon was able to get his job back in the medical college. Before his old job could be granted back to him, he had to clear an interview where most of the interviewers had been his students. He took this challenge with stride and did not flinch.

He then joined as a junior lecturer in Kanpur with a monthly salary of Rs. 2,000 as his experience was not considered and he had to join at the starting level. After much effort, he was able to convince the current Health Secretary in Lucknow to reinstate him to his seniority. His post was then revised to that of Reader and he was paid a salary respectable to that post and also the arrears. He was able to establish both his sons in their respective careers and get his daughter married.

After working with the government system for many years, Dr. Tandon decided to retire in 2002 as he felt disillusioned with the system. Dr. Tandon felt that the government health and education systems did not appreciate the performance of its employees, and demonstrated more preference towards people who are better at "going around saying sir, sir..." to please their seniors.

WORKING IN OTHER COUNTRIES

Post retirement, Dr. Tandon continued to work in the capacity of a teacher and took up many assignments in countries outside India. In 2002, he obtained a job in Ethiopia through some friends. The recruitment interview was conducted in Delhi at the Ashoka Hotel. Though he had not applied formally, he could enter the recruitment process because he was senior and recognized in his profession. With his qualifications and experience, he could also demand a good salary. All the paperwork was processed by the Ethiopian authorities along with all other arrangements. The professor received the visa for himself and his wife through the post.

In Ethiopia, he worked as the Head of the Department of Physiology in the medical college. He was provided with residence, amenities like refrigerator, gas, water heater and even cooking utensils. The job entailed long hours and the living conditions were not so good; the surroundings were unclean, and the rainy weather was not easy to live in. In Ethiopia, the social culture was very different and Dr Tandon felt uncomfortable at times. He recounts one such incident when a female staff had come to him to seek some medical help. He asked her to point out which part of her body was ailing and she did not hesitate to strip completely. This behaviour embarrassed Dr Tandon immensely.

Moreover, the country was poor and even the medical college was not well equipped. There was no Electro Cardiogramme machine, but since he had his personal machine he would often provide help, whenever required. Dr. Tandon did not receive any medical support in Ethiopia, and at times, even gave medicine to staff in need. In Ethiopia, he perceived an element of mistrust among people that might have been due to the country's political and domestic instability. After having worked in Ethiopia for 6 to 7 months, Dr. Tandon received another job offer in India, and he and his wife returned to their home country.

In 2002, Dr. Tandon also did a short assignment of 6 weeks in Mauritius. As an advisor there, his responsibilities included helping to establish a new medical college. All arrangements including tickets and visa were processed by the Mauritius authorities and handed over to him. The standard of living in this country was very comfortable due to its flourishing economy.

After coming back to India in 2003, he joined as the Principal and Director of a private medical college in UP. For 1 year and 9 months, he was part of a panel of specialists responsible for establishing the new medical college.

While working at the medical college Dr. Tandon received a job assignment in China through professional contacts and based on his vast experience. For him, the job seemed to be more challenging than his current one and promised a better pay. So, in 2005 he quit his post in India and went to Nan Chong, in Sichuan district of China where he became a Professor in a public medical college. The college authorities had taken care of all his personal requirements of housing, food and other support. He found the Chinese people to be very supportive. The weather was good and "nurtured good health", which he very much appreciated. The one major challenge faced in China was the language, but he and his wife were able to manage their routine chores by signs and gestures. After working for less than two years, Dr. Tandon felt homesick and decided to return to India in 2006.

Back in India, Dr. Tandon joined as Professor in Physiology at a newly opened Medical College in Muzaffarnagar, where he is working currently.

WHAT HE LEARNED

Dr. Tandon has an in-depth understanding of the migration process having worked in numerous locations. He found that work culture in most foreign countries was generally good. Their systems were governed by professionalism and discipline, with the exception of Ethiopia where there was uncertainty and instability in the country. He summarises the work culture in other countries saying that 'everyone works'. He feels this is in contrast to India, where most workers, from the desk staff at the airport to the staff in offices are lethargic and hardly work.

He says he has been lucky to have co-workers who have been cooperative. He believes that if one is "focused on his work, does not try to disturb the system, deals well with his co-workers, does not try to force his opinion onto others nor tries to

create any nuisance, she/he would be easily accepted in any new and foreign place of work. She/he would earn respect and enjoy the comfort and life provided.” According to him, different countries provide different kinds of support to the migrant workers working in their country. This primarily depends on the economic situation of the country and the resources allocated to invite and retain foreign workers.

In India, he states that corruption affects the system at all levels- from clerks to administrators and policymakers. Consequently, ethics are compromised as there is no established decent work culture in any department including health. Dr. Tandon feels there is a breakdown of social structure of the Indian society and this is reflected in the lack of respect for people, lack of decorum in interactions, and absence of honesty. He adds that even the field of research is rife with dishonesty.

LESSONS LEARNED

In Dr. Tandon opinion, people must avail a chance to go abroad as it contributes to the overall development of an individual. The thinking of a person gains in breadth, the concepts become clear, and the boundaries of narrow thinking and criticism, of others, can be overcome. Working abroad also provides the opportunity to make good money and build up one's savings. Individuals can learn and inculcate good ethics and culture into their work through these experiences. Having said that, he feels that the best place to live and work is still one's own country. There are choices and freedom one can enjoy here that are not available elsewhere, even in the best of places.

Policymakers in India should be far-sighted and honest, says Dr. Tandon. This would promote a better atmosphere of work and culture in India and will then attract professionals to return.

CONCLUDING

Dr. Tandon explained the ancient system of division of castes in India which was based on the work a person did, and how it was propagated to promote a culture of work and discipline. The caste system at the time of its origin was very different from the narrow, demeaning entity as it is currently. According to that system, he says he has been a “Brahmin” all his life – by virtue to giving away knowledge. This choice of professions has left him poor since a lack of assets is a quality attributed to teachers or providers of knowledge. In spite of being senior in years of experience, he says he does not possess enough savings even to hold a fixed deposit in the bank and to fulfil his material responsibilities towards his family. In fact, the disbursement of his pension was delayed by 5 years and clerks asked for bribes to release it. Therefore, according to him, the Government of India should provide aid for the under-privileged to improve their quality of life, and not merely reservation of seats in education.

However, Dr. Tandon has not allowed the system to make him a victim and he has faced all difficulties with an inner strength. Most of his savings come from job stints abroad. Today he lives with those savings and spends time with his other passion – reading. He believes that only in one's own country, ‘can we receive a robust family support system’.

Spirituality and love for his country keeps him grounded and it sustains his wish to continue to contribute to India in his own way. Dr. Tandon dreams of a system which is honest and is supportive towards quality of work and good performance. He believes that in India we can enjoy our freedom to live and work. India's rich culture ‘nurtures the mind’ and provides individuals the mental strength to go on in the face of adversity.

¹ Civil surgeon is a doctor in an administrative position at the district level, responsible for directly administering all Govt. Medical and Health Institutions for implementation of various health programmes in the District



CASE STUDY 2



*Resources are needed
to support your ideas otherwise
ideas will remain ideas,
dreams will remain dreams.”*

- Dr. Anil Pandey

DR. ANIL PANDEY is a dynamic, extremely busy paediatrician and probably the only neonatologist in Meerut, Uttar Pradesh. He is currently working as an Associate Professor in the Department of Paediatrics in a College in Meerut. Dr. Pandey was born and raised in Meerut and lives there with his family. Through his work, he continues to contribute to this place which has nurtured him.

PRE-MIGRATION

Born into a family of doctors, Dr Anil Pandey became a doctor as if it were a natural process. He completed his graduation from Meerut in 1995 and post-graduation in 2002, from a prestigious medical institute in Delhi. Though his higher degree was from the premier institute in India, he felt that his training lacked practical exposure to some of the issues taught there, for example, specialized ventilation, extracorporeal membrane oxygenation (ECMO), specialized nursing etc. He wanted to “take the extra step and learn whatever more there is to learn in Paediatrics.”

In 2003, Dr Anil Pandey attended a conference in Kochi and Delhi, where he presented a research paper. There he met a senior doctor from a prestigious institution in Australia. Impressed with his paper and after interacting with him, the senior doctor suggested that he come work with him in Australia. Dr Pandey went home and discussed the opportunity with his family. His parents were apprehensive at first because it was so far away, and they had no close friends or family in Australia who could help him. He evaluated the positives and negatives aspects of going to Australia and was able to reassure his parents. He considered the fact that no qualifying exam for his area of specialization were required to work in Australia and the degree from India was valid for working there. This was unlike the U.S. and some other countries. The U.S. was his second preference but working there would require clearing examinations to practice. Ultimately, the decision was made to go to Australia.

The senior doctor from Australia who recruited Dr Pandey was a Professor and the Unit in Charge at a famous Medical Centre in Melbourne, for the past 25 years. He personally guided Dr Pandey in the migration process. Paperwork was duly completed and submitted to the embassy by the institution and no extra running around was needed. Dr Pandey had to submit only his resume to the institution and the rest of the process was taken care of for him. He had to undergo some medical tests but no English test was required. A Medical Association qualification examination was required of migrant doctors before working in Australia, but Dr Pandey was exempted from it as paediatrics from India were in the exempt category. Dr Pandey left for Australia in 2003, with his wife and child.

MIGRATION

Dr Pandey joined as a Senior Registrar in the Melbourne Hospital Neonatology unit. He received support from some acquaintances in settling down; and the arrangement of housing and other logistics. The Australian people were very helpful, as was the local Indian community. He had to arrange for health insurance for himself and his family, and enrol his child into a local school.

Working in Australia was an extremely good experience. "If I look back, it was probably the best time of my life," says Dr Pandey. The staff were from many other countries like Germany, Philippines, Japan, and China, in addition to Australians. Professional ethics were maintained and the social environment was good. Neither he, nor his family, faced any racial discrimination at any time. His co-workers were cooperative and the faculty was very helpful.

He learned that the place was a "zero harassment zone" and that any kind of harassment if reported would be acted upon. There was an incident where a nurse had complained of sexual harassment against a senior faculty member. After investigation, the doctor was found guilty and debarred from practicing for a year. This, Dr Pandey feels, rarely happens in India.

Performance at the workplace was assessed through a written feedback system based on knowledge of the clinician, patient care provided by her/him, and direct feedback received from the nurses and parents of the newborns. The process of assessment was multi-disciplinary and comprehensive as it took into consideration the work, interaction with patients, research completed, and papers presented. Appreciation of work was shared easily with the employees and at times was informal. He recollected an incidence when a set of very small (pre-mature) triplets were born at the hospital. The senior faculty who was the consultant in-charge for treating them placed full confidence in Dr Pandey and let him handle the case. Such acts of appreciation of his abilities urged him to be cautious and excel in his work, and to justify the flexibility and responsibility entrusted on him.

Dr Pandey feels he gained a lot from his experience working abroad. He says he was able to re-learn that honesty and integrity are the basis of all interactions, and it pays. "If you call in sick, people would believe you and offer help." In India, people would think one is faking if she/he calls in sick and does not report to work. Appraisals in the hospital in Melbourne were based on recommendations on the staff's work performance, in contrast to India, where everything is based on examinations. According to Dr Pandey, "If you are a good clinician, a good doctor and a good human being, you can keep on rising in Australia."

The salary was better in Australia than in India and was based on one's location in the country. Different states of the country had different salary structures- the states that are deprived and not well performing, pay better salaries to retain their doctors. For example, Brisbane offers better salaries as compared to Melbourne, which is better in terms of health performance.

Asked if there were any downsides, Dr Pandey stated that "there was no scope for mistakes." If anyone committed a serious mistake and the consultant in-charge felt it could have affected the life of the patient, the errant doctor could be shunted out of the ICU for a considerable time (1 year or more). This rule was also valid for staff from other countries, like UK. He recalled an incident involving a doctor from England who was debarred from practice for 3 years due to some error in judgement committed by him, twice in 6 months. This system, he feels, was challenging and tough.

Every Resident Doctor had the chance to discuss the management of his patients with senior nurses and other doctors. The treatment of patients was based on pre-defined protocols. Deviating from protocols could give rise to problems and follow with disciplinary action. Dr Pandey feels it is reasonable to follow standard protocols of medical care; otherwise any doctor could use his own methodology while treating patients and justify his actions saying "as per my experience, I would do it this way". This practice is commonly observed in India. The clinical protocols were created after thorough discussions with many specialists of different experiences, and once the protocols were prepared, they were mandatory for everyone to follow.

The overall experience of going to Australia was excellent. His family was very comfortable and that was an added advantage. Given a chance, he would like to go there again for work. Dr Pandey worked in Australia from 2003-2006.

PRE-RETURN

While working in Australia, his father died suddenly and his mother was alone, in India. Being the eldest son of his family, he was prompted to consider returning back to India. At that point, he was the senior most Registrar in the department. His contribution to the department were significant. There had been no presentations at international forums in the 2 years prior to his joining the department in Australia. He had taken the initiative and was active in research and presented papers. The mentor professor was satisfied with his work and asked him to stay back and continue working there. But once he shared his decision to return home, the faculty supported him, saying that it was the need of the hour for a specialist to return to work in India. If Dr Pandey had stayed back, he would have been promoted as a consultant¹ within the next 6-8 months. Before coming back, he had received a job offer in a reputed Medical College, in Delhi. He did not face any issues with documentation or paperwork before returning to India.

RETURNING BACK

Dr Pandey joined a college in Delhi but was not satisfied with it and did not continue there for long. He left the college to join a corporate hospital in Delhi. It was a large hospital equipped with all modern facilities. He had been working there for 3 months when he was offered a post as lecturer in a Medical College in Meerut -his home town. With a wish to go back to his roots, Dr Pandey returned to Meerut.

After being exposed to Australia, working in India was different. There is a huge difference in the work atmosphere. While Australia was a tertiary or quaternary health facility, the hospital in Meerut was much lower in standard. Merging back into the system was difficult for him, as the government system is fraught with deficiencies and gaps. Many drugs are not available, essential equipment are not there, and even the way of dealing with patients was different. To compound these issues, there were vacancies in nursing positions. There were not as many nurses trained in neonatology as the nurses in AIIMS and abroad, and there was also a disparity in their proficiencies. Research activities in India and Australia were not comparable. In India, research was limited to the basics, while in Australia different research modalities were available, such as animal research. Also, the funding available for research was greater in Australia.

There were major differences in the work culture, too. In Australia, the staff were punctual, honest, and had a collective responsibility towards things. Dr Pandey felt that the staff were better educated and trained there. The most important positive factor was the excellent salary offered in Australia. In contrast, India has a paucity of funds, including that allocated for research and for infrastructural support or equipment. In India, promotions do not happen at the right time and there is corruption at all levels. Dr. Pandey feels that low salaries, lack of good research, and lack of essential investigations and infrastructure, lead to unsatisfactory performance. He feels that there is no role model to emulate and this is an important lacuna in the Indian system. There is no system of feedback except the Annual Confidential Report for performance review (ACR), which are filled out by the staff themselves and is more subjective than objective. The system does not offer a scope for sharing feedback with higher authorities because it is deemed disrespectful.

Since Meerut is his home town, he and his family did not face any issues in settling down. It was not the same for other doctors who had returned to India from Australia, along with him. They were not able to adjust to the systemic and socio-cultural environment even though they were located in large cities as Mumbai, Nagpur, and Chennai and eventually returned to Australia.

In Australia, the quality of life had been good. "There is no one pushing and everyone was ready to help if you wanted to do something extra," he says. In India, dishonesty and corruption are rampant. "Flexibility is looked down upon, and your motives tend to be questioned if you want to do something different or more." There are few avenues to stimulate professionals intellectually; though there might be some opportunities available in reputed institutions.

"Challenges lie in sailing through the rough waters," the doctor says. It was a struggle to fit into the old system though a familiar one than it was to fit into an already well functioning but new system in Australia. For all these reasons, sometimes Dr Pandey regrets coming back. But since the medical college at Meerut, was his alma mater, Dr Pandey wanted to give something back to it. He is now happy to teach courses there, but would like to do more research work.

LOOKING BACK...

Every health professional should attain the learning experience that comes with working abroad. It would facilitate bringing back to India the knowledge that can be added into its system. Dr Pandey feels that there is a lot to be learned from systems in foreign countries regarding clinical knowledge, handling of patients, speaking to their relatives, and dealing with circumstances collectively as a team.

His decision to come back to India was personal. Anyone considering the return to India should understand their own personal motives for the move. Dr Pandey would ask “why you want to come back and what your priorities are. If it is for a good job and the intention is to replicate what you were doing abroad, it may not be entirely possible in India. But if you want to translate that knowledge and tailor your work as per the situation, be ready for the grind.”

“Give it time and then the results will come in,” he advises patiently.

CONCLUDING

Dr Pandey suggests professionals to look for jobs before they return or else they may face some delays and difficulties, though for specialists seeking employment it is generally not a problem. Everyone needs to plan well before coming back to India. He feels more professionals would return to India if there is a better work environment. Government doctors, he feels, are an unappreciated group of staff, with no proper salaries or work environment. Public hospital doctors feel themselves to be 50 years behind with dated equipment and gaps in availabilities of drugs and systems. He believes that the situation is the same even in big cities like Delhi. “Facilities in the health system have to be beefed up, otherwise professionals will feel out of place if infrastructure does not support their work and they are bogged down by staff vacancies and lack of diagnostics.” Dr Pandey feels that a bigger portion of funds should be marked for the health sector.

But in spite of these challenges, several professionals return to India and are working in big cities as Mumbai and Delhi. This may be explained by what the doctor said to analyse the situation, “After all you are a second citizen in any country except your own country.” So, one should be happy working with the challenges in one’s own country.

Dr Pandey shared his philosophy about life. “When things are observed in isolation, everything seems good; but individuals should be taught in schools how to deal with situations when everything is not doing well.” Learning to work as a team is essential, and is a practice prevalent in other countries and promoted from school days. This learning gets reflected in your personality, social interactions, and workplace dealings when you grow up.

Dr Pandey’s message to thinkers and decision makers in the country is that “Resources are needed to support your ideas otherwise ideas will remain ideas, dreams will remain dreams.”

¹ ‘Consultant’ is the title of a senior hospital-based doctor who has completed all specialist training and been placed on the specialist register. Consultants accept ultimate responsibility for the care of all the patients referred to them so the job carries significant personal responsibility.



CASE STUDY 3



“Given a chance, I would rather be a third class citizen in India where everyone is also a third class citizen rather than be a second class citizen in a foreign country where someone else is the first class.”

- Dr Sudhir Chatterjee

DR SUDHIR CHATTERJEE is a clinician at a reputed hospital in Kolkata. He attended the Calcutta International School, affiliated to the University of London. His grandfather was a doctor and his father encouraged him, as the eldest son, to take up a career in medicine. Dr Chatterjee has 2 siblings, both of whom are currently pursuing PhDs.

Dr Chatterjee completed medical school at a college in Moscow in 2004, and has been working in India since 2005. He has been at a reputed hospital in Kolkata for 5 years and holds the post of Registrar in the Department of Nephrology.

PRE-MIGRATION

After completing high school, Dr Chatterjee took the medical entrance examination in India but could not pass it at that time. He had two choices: to spend the year preparing for the entrance and take the examination again next year, or to go abroad to study. His school in Calcutta was under a foreign curriculum and board making it conducive to study abroad. Also, most of his friends from school were non-resident Indians (NRIs) and were already studying abroad. However, education expenses in foreign schools were an issue. His initial choice was studying in the US, but the fees were too high and no scholarships were available for under-graduate courses. Education in Europe was also expensive.

Dr Chatterjee came to know about medical studies in Russia through newspaper advertisements and recruitment agencies and sent in an application. Applying and processing the necessary documents required individual effort. He visited the Russian embassy's education department that provided guidance to students on the pre-requisite information for the course of study, fee structure, and information about Russia. He learned that, the Moscow college was ranked 2nd in the WHO global ranking list of medical schools, and the expenses to be incurred were not huge. In addition to all these favourable factors, his mother had been interested in Russian studies and encouraged him to go. To ensure his future prospects, confirmed with the Medical Council of India (MCI) that a medical education degree from the college was valid in India. The Russian embassy helped him correspond with the college. There were some delays due to bureaucracy and he had to make many visits to the embassy to complete all the paper work.

MIGRATION

Dr Chatterjee went to Russia in 1998. The college had sent a foreign student (Sri Lankan) to pick him up from the airport, show him around, and take him to the hostel. This introduction was helpful and alleviated all his hesitation of being in a new place. After that, he could manage on his own. The school was not like the enclosed college campuses in India but was spread out over the city. Initially he was worried about reaching his classes, but soon he befriended some Indian students in the hostel and travelled with them by buses, metros, and trams.

Dr Chatterjee first enrolled into the course in English. In the first 3 years, there were pre-medical courses in English and Russian, after that the medical courses were in Russian.

It took him one week to get oriented. Mixing with foreign students belonging to North Africa, Mediterranean countries, South East Asia and China did not pose a problem to him, though it seemed to be challenging for other Indian students. Some others faced problems adjusting to the bland diet in Russia and the “openness of culture”.

Students could seek help from the school’s Indian association. They were advised to bring dollars for to pay their fees, because due to the economy, the *rouble* was not the best option. Every student was issued a student card to open a bank account and for local travel, etc. Students were asked not to keep money in banks as the economy was not stable. There were some issues related to personal safety, but feels it was not much different from any other part of the world. Some parts of city were not safe and students were asked to avoid them. A sect of Neo-Nazis created some problems related to racial discrimination and there was an incidence of an Indian student who had ventured alone and was killed. In general, the police were very strict as was the college. In fact, the college instituted rules, like declaring two days as holidays on Hitler’s birthday, so that the students stayed in.

Dr Chatterjee had heard a lot about the tough living situation in Russia, with its very cold climate and the endless queues for bread and other amenities. In reality, he did not find many queues. People seemed quiet and reserved due to the current political situation, which at that time was uncertain. People did not mix with foreigners and stayed in their own groups. While he was there, his main problems were the language barriers and communicating with his family in India.

The medical internship in Russia was different from India, where students have to complete compulsory posting in all departments. In Russia, students were required to work in one department of their interest. In the final year, students basically reiterated the learnings from the courses content completed in the previous year: medicine, surgery, obstetrics, and gynaecology.

The college atmosphere was amiable. There was no formal teacher-student relationship, teachers were friendly and helpful and, unlike India, there was no system of seniors and juniors. It was more of friendly situation with a ‘first name basis’. Students were encouraged to work on their own with no ‘spoon feeding’. Dr Chatterjee recalled, “Course studies depend on how interested you are – no one tells you go there and do that. If you are interested in some subjects or projects, discuss with your teachers and go ahead”. Dr Chatterjee did some informal project work, like assisting his professor in the translation of course lectures into English.

Dr Chatterjee fulfilled his objective to become a doctor in the same number of years as it would have taken in India. Overall, it was a good experience. The only loss which he could cite was the feeling of home sickness for the first few months, as he was staying away from his family for the first time in his life.

Grade performance of students after course completion determined if they could move on to the next level of studies. Dr Chatterjee had received good grades (5/5) and had the option to stay in Russia, complete two-years of work and training and then enrol into a 3-year post-graduate course. However, the salary amount he would receive for work was not much. Moreover, the post-graduate courses were expensive and it would have put a strain on his family, who were also supporting the education of his siblings then about to join college. Dr Chatterjee considered and rejected the option of taking up higher courses in Germany, since there he would again face the challenge of learning a new language and high fees. Dr Chatterjee decided to come back home and enrol into post graduate studies in India. His teachers supported him in this decision.

Dr Chatterjee had anticipated some of the difficulties he may have to face in India. He knew that the rules for foreign medical graduates had changed in India and that the medical degree may not be automatically valid to practice in India. Foreign degree holders now had to clear a licensing examination from the Diplomate of National Board (DNB) and a mandatory internship in a designated medical college in India. The examination was non-competitive and was similar to the postgraduate entrance test in India. He was ready for these challenges.

After six years, Dr Chatterjee left Russia in 2004. He recollects that in his years of stay, he was able to see visible changes in the culture and atmosphere of the host country during the political transition. He felt that people had become very open and more 'western'. By the time he left, "Russia seemed to be more like any European country".

RETURNING BACK

Dr Chatterjee came back to India in July 2004 but the DNB examination for licensing, which is held twice in a year in March and September, had been put on hold that year due to some internal problems at the DNB. Some fellow students had joined the post-graduate entrance courses and some had started working. "You could work in private hospitals 'informally' but would be paid less as you still did not have the licence". Dr Chatterjee decided to prepare for the post-graduation entrance examination and not work.

In January of the next year, he went to Delhi to take the March DNB examination. There he faced some problems with his eligibility for taking the examination. Since his school examination had been held under a foreign board, the officials did not consider him to be a part of the Indian system and therefore cancelled his eligibility for the licensure examination. His test result was put on hold and the matter took 3 months to resolve. He faced similar problems when he applied for internship through the University in Kolkata. He procured a letter from his school principal and referred to the article that had been passed by then to ratify graduation from foreign schools.

So while his peers had joined internship in 2005, he lost one year running around and getting clearances from institutions. Due to lack of clarity in directives and lack of standardization in the system, he could join internship only in April 2006 and only procure a provisional registration into the Medical Council of India. He recalled that two friends from the same school had joined medical studies right after completing school and had never faced this problem. In spite of this long struggle to fit back into the Indian system, is not bitter and would rather look back at it as a 'one of a kind' incident.

Adjusting to the work atmosphere also took time. During internship, he had some initial problems due to staffs' unprofessional behaviour towards patients. During Obstetrics and Gynaecology rotation posting in the wards, he observed that some nurses and doctors shouted at, and even slapped patients who were screaming with labour pains. This shocked Dr Chatterjee, who had been trained to be polite with patients. Moreover, he felt that staff did not believe that patient care was their priority and were absent from duties for extended lunch and tea breaks. For him, lunch time was a brief break and holidays were not important. The patients observed his sincerity and many would come to him specifically.

According to Dr Chatterjee, the teaching standards in India are better as there is more patient exposure and, therefore, better learning. However, there is a lack of ethics and the work attitude is not supportive. He remembered an incidence when he had protested against a professor who was smoking in the ward but instead, the professor threatened him, citing his seniority and post. Thereafter, he decided to keep quiet and concentrate only on his work. These times were challenging as a young person educated outside India and working hard to be accepted back. Thankfully he had a close friend to rely on for support. He says "after a while everyone gets used to this atmosphere. If you do not support it, you do not have to practice it". He had also heard from friends that sometimes Indians with foreign degrees feel less welcome after returning to India and that others look down on them.

After completing his internship, he cleared an interview to join senior residency in a public hospital from 2007 to 2008. He worked in the Intensive Thoracic Unit (ITU) and nephrology, where he developed a keen liking of the latter. One of the consultants recognized his performance and suggested he join the nephrology department in a private hospital in Kolkata. Dr Chatterjee started working there in 2008, initially as a Resident Medical Officer (RMO) for two and half years and thereafter as a Registrar in Nephrology.

His experiences in India and abroad have given him some insights into the system. He feels though the capacities of health professions in India and abroad are the same, there are differences in the work culture. He finds that Indians are lazy, which makes their performances suffer. "People just want to finish their work even if the work is for 6 hours. It does not matter to them how well they have done the task". A recent personal experience highlighted the same findings. His mother was recently admitted to a hospital in England and again in India for some treatment. Comparing the experience she had in both places, she said she never wanted to be admitted in India again. Analysing the situation, states that nurses and doctors abroad are friendly with patients, explain the medical situation to them, and allow them to ask questions. On the other hand, in India, if a patient or her/his relatives ask more questions, it is considered wasting the time of the health staff. He feels that the staff are not interactive and senior doctors seem to have a condescending attitude towards patients.

The appraisal system in India is informal. Feedback of one's work is received through some good words being said by the patients, nurses, and other staff. Salary in the private sector in India is better than Russia, but much less than in Europe. Salary increments are not regular and often staff have to argue and convince the management. Still, Dr Chatterjee believes that hard work pays off. He has worked here for many years now and feels his work is appreciated and reflected in his improved salary package.

In Dr Chatterjee's opinion, systems abroad are more organized and patient care and investigations are done step-by-step. In India, he feels that sometimes patients get sent directly for MRIs and higher investigations just after the initial check-up, without following a logical sequence based on evidence. This creates a scope for corruption, unnecessary use of high end antibiotics, and more investigations. Conversely, practitioners rue that often they are not able to do all relevant procedures for poor patients or prescribe all required medicines for them, as treatment is expensive. Many patients do not have money or insurance and are unable to complete treatment.

Dr Chatterjee's motivation comes from senior medical professionals who are working in India, after returning from overseas, and retain their work ethics and an attitude of service towards patients.

Looking back...Looking at his own experience, Dr Chatterjee's advice to students and professionals is to plan well for the future before going abroad for studies. They should plan to study, work, and complete a post-graduate course before returning to India. This would ensure they wouldn't waste time like he did. He feels that you can learn more while living outside India than living under the shelter of your parents.

He thinks there is a need for more people to come back and work in India to foster a "mix of Indian and foreign systems". He opines that Indian medical professionals have good knowledge and believe in instincts, while foreign professionals are more protocol based and are more updated on newer developments.

Health systems in India should create more lucrative jobs which offer more money, ensure that the staff are looked after through logistical support and give them the freedom to work. "Try to remove 'red tapism' and unnecessary delays and make Indians with foreign degrees feel welcome," he urges. It is important to ensure that skills acquired abroad be recognised in India. Health professionals would want to come back and work if their requirements are fulfilled. In turn, they would need to re-adjust to the system.

CONCLUDING

Recounting his experiences now, Dr Chatterjee feels he had a smooth transit from school in India to Moscow. Thereafter, residency in India provided a lot of experience and hands on training. That, along with the support he received from his family and professors, made him grow as a health professional.

"Given a chance, I would rather be a third class citizen in India where everyone is also a third class citizen rather than be a second class citizen in a foreign country where someone else is the first class." This disparity affects promotions and a person then has to work doubly hard and for longer to achieve success.

With a depth of understanding of the system that comes from experiences abroad, he concluded that he has learnt to "walk with the system but not be a part of it."

¹ 'Consultant' is the title of a senior hospital-based doctor who has completed all specialist training and been placed on the specialist register. Consultants accept ultimate responsibility for the care of all the patients referred to them so the job carries significant personal responsibility.



CASE STUDY 4



*...rewards come from God,
and the social appreciation
for a job well done and
service to the community...*
- Mrs Jaya Joseph

MRS JAYA JOSEPH comes from a family of 5 children in Kerala. In 1979, she completed her nursing training at a hospital in Mumbai. She has been working since then and specializes in cardiac care. At present, she is working as in-charge staff nurse in the cardiac catheterization laboratory (cath-lab) at the high clientele hospital in Kolkata, West Bengal. She lives with her husband and two children.

PRE-MIGRATION

Sister Joseph, as she is called here, started her career in a hospital in Mumbai, immediately after completing her training. She worked for four years (from 1979 to 1983) as a staff nurse in the Cardiac Care Unit (CCU), earning Rs.300/month, with an additional monthly allowance of Rs. 75 for her speciality. She lived in the hospital hostel, sharing a room with five others. Sister Joseph supported her family and other siblings by regularly sending home money. After sending home money, she did not have enough left for personal expenses. Though she followed a non-vegetarian diet, she could not afford to eat anywhere but the vegetarian cafeteria in her hostel. The low salary motivated her to look for better opportunities. Many of Sister Joseph's friends and colleagues had applied for jobs abroad, also due to monetary reasons, and she decided to try this option as well.

Advertisements for recruitment agencies and job openings in Gulf countries were frequently placed in Mumbai newspapers. Sister Joseph applied to one such advertisement for a job in Saudi Arabia and got through the walk-in interview. She paid the agency fees of approximately Rs. 10,000 to handle all the formalities. The agency helped in completion of documents and the visa to Saudi Arabia, which took a reasonable amount of time. She states that now the process and preparation period are longer and the fees are much higher. At that time, the interview was held in December and she started working in the new country by June. She regrets allowing the recruiting agency to hold her passport as it prevented her from applying for jobs in other countries, where the salary was better.

MIGRATION

All logistic arrangements had been taken care of when Sister Joseph arrived in Saudi Arabia. A contract had been signed with the hospital and they had arranged for her pick-up from the airport. The hospital arranged for an orientation one week during which

time no work assignment was given. All the newly recruited nurses were taken around the hospital and their duties explained to them. The doctors interacted with the new staff and tried to evaluate their work capacities prior to assigning their duties.

The work environment in Saudi Arabia was excellent and Sister Joseph faced no major problems. The staff seemed dedicated to their work and were cooperative. The hospital employed a meticulous record keeping and used a card method for filing detailed patient information. The supervisor allocated tasks to the nurses, including the senior nurses, and everyone followed this system without questioning. The entire process was systematic and disciplined. Sister Joseph found this process very impressive.

Sister Joseph found her co-workers pleasant to be around and work with at the hospital. They came from Bangladesh, Sri Lanka, Korea, Thailand, Jordan, Egypt and Saudi Arabia. The staff nurses worked in 3 shifts with good team coordination. There were no staff vacancies and no one took leave unless genuinely sick. The management provided duty rooms and nurses' stations. Performance assessments were carried out round the clock, which further added to the quality of nurses' performances. Feedback from the assessments was shared with the staff along with support to improve performances through counselling and training. Staff salaries were paid on time and they were provided with excellent food from different regional varieties. There was a salary raise yearly, though she could not recollect if promotions were linked to salary raise. The staff members were satisfied with the work conditions and amenities provided.

Sister Joseph got married in 1985 to a man who was working in the same city in a watch repairing firm. She worked in three different hospitals in the city between 1983 until the end of 1989. Working in Saudi Arabia helped her meet her objectives to earn well, improve her own living standard, and to support her father and siblings.

She feels that working abroad was a good experience and "there was nothing to worry about". She feels there were only gains in this experience. She did not feel homesick living outside of India. It helped that she was able to take yearly leave to her native home in Kerala. The flight took less time from Saudi Arabia than it took to travel from some cities in India that did not have direct flights to her home city.

Sister Joseph fondly remembers the time of her first pregnancy and delivery in Saudi Arabia. She immensely appreciated the support and care that was provided in the hospital. The doctors gave her personal support and counselling, the management took care that she could get adequate time to rest. She received care during the delivery and was provided drugs, sanitary materials, personal items. She received maternity leave and her friends and other staff living there helped her take care of herself and the baby.

When she was expecting her second baby, her husband fell ill and was unable to work. Her first child was young and the situation became difficult to manage alone. Facing these personal challenges, she was prompted to return to India even though she wanted to stay and continue working in Saudi Arabia. Her father had even suggested she stay back and continue working at the hospital. On hindsight now, she feels she should have arranged for help and stayed in Saudi Arabia.

RETURNING BACK

Sister Joseph returned to India with her family in the end of 1989. Since she was due with her second child within a few weeks of returning, she had not planned for working in India or begun the job search process. In January 1990, she delivered her second baby in India. While taking care of her family at home, she noticed a vacancy advertised in the local newspaper for a job in a cardiac care hospital in Kolkata. She applied for it and attended the interview in February 1990. She was selected and joined the hospital in May 1990. She had been looking for hospitals with "English staff" with whom she felt more comfortable working with and was happy with the staff in the new hospital. She was posted as Sister in-charge with a salary of Rs. 2,600. This was a huge change from her previous salary in Saudi Arabia.

Sister Joseph reminisces that "life had been tough". Trying to manage her family needs with this salary was a challenge. The salary was spent on rent, bringing up their two children, and household expenditures. Moreover, her husband was still undergoing treatment and had not fully recovered. Almost all the money she had saved while working in Saudi Arabia was spent in taking care of her family.

The work atmosphere was drastically different in India. While recounting her initial re-entry into the Indian system, Sister Joseph became overwhelmed with unhappy memories and bottled-up emotions. She felt that the hospitals here were not as well equipped as those in Saudi Arabia and lacked crucial equipment. She felt that she had gone back "20 years behind". Although she joined as intensive cardiac care unit (ICCU) staff, she was given charge of the cath-lab, a specialised ward for cardiac procedures. There was no formal handover of responsibilities or orientation given by the out-going staff, who unprofessionally commented, "You are so senior, surely you know everything." Without any prior experience in running a cath-lab, this situation was a challenge for Sister Joseph. The training she had received in well organized and well performing cardiac units overseas, provided her with the confidence to do a good job with her new responsibilities. The patient turnover increased remarkably from 70-80 cases a month to 425 a month and her work was appreciated by the management.

In addition to this situation, she could recount many differences in working styles and systems between India and Saudi Arabia. As a senior staff in Saudi Arabia, she was able to share feedback and have discussions with her seniors. In India, on the other hand, she says, "you would be out of your job if you say something two times." Her experience with the higher quality of work in Saudi Arabia caused her to pay careful attention to the conditions of her workplace. She brought any shortcomings to the notice of the doctors and instituted necessary corrective measures. She felt there was a bias against those staff members with foreign experience. Although she had joined at a senior post, she recalled being asked to clean the wards. Being a professional, she complied, but felt that not all staff were asked to do the same.

Sister Joseph has also noticed behavioural differences. She has observed jealousy among staff and a general attitude of self interest rather than service to patients. She also cites a lack of professional discipline. Staff could take leave at short notice, even for not so serious reasons as rains, etc. This behaviour added pressure on the nursing staff, working on shift duties, in small teams. Moreover, there is no accountability and in-fighting was evident in the team. "Whoever does the job also gets the blame if it does not turn out well and people, who don't work, are ultimately spared of it," she summarized.

She feels that if average workers in India continue to get better salaries than the good ones just by being close to the people in power, those working hard and sincerely will start to emulate the average workers by performing indifferently. In her opinion, senior level and managerial staff should regularly evaluate work performance and be aware of the activities and behaviours in wards and departments. They should verify before they take action if they receive any complaints against a staff member.

Sister Joseph said that the hospital offered good trainings and orientation for staff because many of the staff members were trained abroad. However, she feels that recently the standard of nursing training in India has deteriorated. Most training is theoretical and student nurses do not receive the requisite practical training. She has also observed some lacunae in the sequence of care for cardiac patients. She feels that there is no system of patient follow-up after cardiac interventions, which is very essential. Through her own personal motivation, Sister Joseph follows up the patients discharged after such procedures and are still sick by offering them counselling and support. In this way, she has tried to bring her past learning into her present work. She personally orients and provides help to all new staff.

Sister Joseph voiced sadly that even though she has been working since 1979, she still does not carry home a salary more than Rs. 50,000 per month. She finds it difficult to maintain even a middle class living standard with this salary. She is thankful that she was has been able to face the numerous challenges through hard work and with the support from friends and colleagues.

Sister Joseph is dedicated to her work and service towards her patients. She feels bad when she observes other medical professionals not showing enough dedication in their work towards patients. She believes that if she takes care of someone here, someone will take care of her parents elsewhere. After all, 'What goes in comes back'.

LOOKING BACK...

Sister Joseph would like to advise staff to work abroad provided there are no additional expenses, insurance is paid, and one is able to save money while working. She feels people can learn to be dedicated to patients and work professionally from working abroad. Medical professionals should work sincerely to avoid mistakes with patients and should not have an attitude based only on making money.

Sister Joseph shared some socially relevant feedback regarding the personal status of young migrant nurses. She said that young nurses often send all their money back home and then do not have enough money to spend on themselves and are sometimes deprived of basic amenities.

Considering India's rising costs of living, revising the salary system for nursing staff would enable the country to bring back and retain professionals. There should be a new training system, updated with modern knowledge and training methods. Regular training updates are required for staff. Proper and urgent action is required to be taken by the government regarding these aspects. The system should improve by providing nurses good hostel facilities, amenities for their stay, entertainment, and train them well. "Dedication will follow".

CONCLUDING

Sister Joseph thinks that the nursing profession is no longer lucrative and fewer trainees join the profession these days. Furthermore, with new hospitals constantly coming up, the lack of staff nurses will be a significant problem. Unless the government offers an attractive package for nursing jobs, there would be less candidates coming into the nursing profession, more out migration and many job vacancies, so much so that "the system will collapse."

She feels health personnel can derive professional satisfaction in India but would have to rely on their own dedication and self-motivation for the work, since appreciation of work is not uniform in India.

She says that rewards come from God, and the social appreciation for a job well done and service to the community.



CASE STUDY 5



*...there should be improvements
in nurses' work conditions, workload, salaries, and
more opportunities for their career growth, only these
improvements would bring the nurses working abroad
back to India*

- Susan Samuel John

SUSAN SAMUEL JOHN has been working as an Associate Professor at a private nursing college in a district in, Kerala, India, since 2006. She lives with her family in a small township near Kottayam, Central Kerala. Her husband works as a Bio-Medical Engineer at Kottayam Medical College and she has two school-aged children.

Sister Susan graduated from a reputed nursing college in Delhi in 1995. After completing her BSc Nursing, she joined an established hospital in Delhi, where she worked until 1997.

PRE-MIGRATION

Working at the Delhi hospital was a good professional experience for Sister Susan. The hospital provided good quality healthcare to patients, staff adhered to protocols of care, and the facilities available were of high standards, almost on par with international standards. However, even though the hospital was in India's capital city and had the best amenities, she felt her workload was excessive and the pay was not satisfactory. Sister Susan feels that even now most hospitals in India do not have mechanisms to evaluate and regulate their staff's workload causing nurses to carry a burdensome workload and work for long hours. Hospitals also lack mechanisms to motivate staff, such as good pay packages.

The poor condition of the nursing cadre had started to de-motivate her. She would have loved to keep working in India if the salary and work conditions were better. In the present situation, she could hardly send back money to her family in Kerala. Sister Susan decided to look for work outside India and earn a salary that would help support her parents and siblings.

Sister Susan looked at all the countries that offered well-paid nursing jobs like Kuwait and Saudi Arabia. She had learned from friends that one could work with more professional freedom in the Gulf countries. In addition, many people from her home state of Kerala (Keralites) lived and worked in Gulf countries and they had built a good social support system. There was the possibility of working in a Western country, but the laws were stringent. Sister Susan had heard that the people who worked in the West found it difficult to save or send money back to their families, due to the high taxes. This information tilted her decision towards the Gulf countries, as financially supporting her family was a top priority.

Recruitment was handled by a private agency in Mumbai, which had placed the job advertisement in Times of India (a leading English newspaper). Sister Susan applied for a job in Bahrain in a government hospital and was selected. She did not have to pay any service charges for recruitment and the entire process was smooth and transparent. She underwent a free medical check-up and the recruitment process was completed in three months.

MIGRATION

Sister Susan joined a Bahraini government hospital in 1997. The salary offered was almost eight times the salary that she earned in India. She received an excellent, furnished, three bedroom accommodation, which she was to share with two other ladies. The hostel was within walking distance of the hospital and had adequate security for the female staff.

Newly recruited nurses were given a proper induction and were oriented to the hospital and its systems. Initially, worked under a preceptor or nursing mentor, who mentored her for a month until she became familiar with the new system and was able to manage independently. The work condition was very good, compared to Indian hospitals. The hospital was equipped with advanced technology and infrastructure and provided quality health care facilities. Besides salary, had access to free medical treatment. The hospital environment was excellent and she found her colleagues cooperative. The hospital even arranged transportation for the nursing staff if they wished to go to the market. Sister Susan stated, with satisfaction, that she enjoyed the respect given to her as an individual and as a professional in her new position. She never experienced rude behaviour from colleagues or patients. She felt taken care of and safe.

Although this was the first time Sister Susan had worked outside India, she did not experience any cultural shock. She was able to follow her routine life as she did in India. She could follow her religious practices and go to a local church in Bahrain. She did not have to wear a veil 'parda'. The local "Keralite" community provided her with a strong support group and she attended cultural functions and gatherings within that social circle. The quality of life was good and she found it easy to settle down. She learnt the local language quickly, enabling her to improve her work performance and provide better nursing care.

Sister Susan worked in Bahrain for one and half year. Thereafter, she moved to the neighbouring country Qatar where she worked for three and a half more years. Her work situation in Qatar was much better than Bahrain, where migrant staff had job security, received a very good salary, and the workload was better distributed and managed. In Bahrain, however, the government had started encouraging more local staff and hired just graduated nurses, out of the local nursing college, thus affecting the job situation for the migrant workforce. The local nurses got better salaries and were favoured for promotions. Sister Susan recalled that there were incidences where the migrant nurses were assigned "lower level nursing tasks", but the local nurses were exempted from these tasks. In Qatar, she felt the work condition was more supportive to her. But, in general, the atmosphere in both countries was cordial and supportive.

Sister Susan is happy with her overall experience of working abroad and considers it to be a very positive chapter in her life. She was very satisfied with the remuneration that she received. She was entitled to an annual leave for 45 days and, every alternate year, the hospital provided a two-way fare to India for vacation. She gained good experience working in the quality hospitals in the Gulf. All staff received regular in-service education and monthly training. The hospitals provided opportunities for continued education in the form of short courses to improve knowledge and skills in nursing care. She completed an advanced cardiac nursing course while working there. The hospital appointed nursing educators who ensured that quality training and mentoring was provided to the staff. Sister Susan says she gained professionally and personally by working in the Gulf.

Sister Susan got married while she was working in Qatar. Her husband stayed with her in Qatar for about a year, but had to return to India since he could not get a job or a work visa. Sister Susan continued to work in Qatar for another year and then decided to come back to India to be with her husband and family.

Rejoining her family was the major reason for Sister Susan's return to India. Another reason prompting her return was her eagerness to complete a master's degree in nursing. In the Gulf, there was limited opportunity for higher education. After she decided to leave Qatar, she submitted a one month notice to the hospital. The relieving system in the hospital was smooth and hassle free. The authorities settled all the dues, including gratuity, before she left.

She was able to achieve her objective of gaining financial security, the primary reason that she had migrated out of India. This position enabled her to buy some land for her family in Kerala. Sister Susan returned to India in 2002.

RETURNING BACK

When she left her job in the Gulf, Sister Susan was aware she was returning to a place where job opportunities were poor. It was a professional risk for her. One solace was the fact that, by then, her husband had a regular government job in India. She says that there are several nurses who have had to continue working in countries away from their families, because there are few opportunities in India and the salary is meagre.

Prior to her return, she did not make any plans or search for any jobs in Kerala. She thought it would be best if she did her research after she came back. Shortly after her return, she became painfully aware of the reality, that the situation for nurses had not changed much in the years she had lived abroad. Jobs similar to hers in the Gulf countries were impossible to come by in India. She opted out of jobs in private hospitals which paid less and did not offer a satisfactory working condition. She decided that if she failed to find a suitable career option in India, she would look for work abroad in a Western country.

Sister Susan spent a year taking care of her child and the rest of her family while simultaneously preparing for the entrance examination for the Master's degree. These times were not easy and the family had to face considerable financial problems since she had stopped earning a salary. She held on to her positivity and managed to tide over this rough patch. She was hopeful about getting a better job after completing her master's degree. Above all, she was happy to be with her family.

Sister Susan joined a public Nursing College in Kerala and graduated with a Master's in 2006. She had the option of joining one of the Employee State Insurance (ESI) hospitals as a staff nurse, which was a government job. However, she opted for the academic profession since she did not wish to return to unrewarding work system in clinical care. She joined a private college of nursing as a lecturer where she is currently employed. Since this is a teaching position, the nature of the work is very different from her clinical experiences in the Gulf so they cannot be justly compared. She finds her current work environment is good and she enjoys teaching.

LOOKING BACK...

Coming back to India was a major challenge for her professionally. She realized that in the Gulf countries she had been working in some of the best hospitals, with the best equipment, and in well functioning environments and systems. She realized that after this experience it would not be easy for her to work in hospitals in India, where the working conditions were not satisfactory and the systems were not modernized or well functioning. These factors (plus the unsatisfactory remuneration) discourage most health workers, especially nurses, from coming back to India.

Health systems in India, both private and public, should be able to effectively utilize human resources, Sister Susan says. The nursing education system needs to be regulated so as to ensure good quality training. Policymakers should address the issue of limited career opportunities for professionals. The cadre of 'nurse practitioner' should be institutionalized. In Sister Susan's opinion, this will open a window of opportunities for India's nurses and will encourage them to come back if they have gone abroad.

Nurses are often not able to practice what they learn and are often burdened with unskilled tasks like shuttling patients to tests and investigations, and collecting laboratory reports. This belittles their skills and leads to wastage of crucial health resources. Sister Susan says that the Indian health system should learn from countries abroad and optimally use nurses for

providing nursing services only. Sister Susan also noted that in India there is a huge disparity in the salaries between doctors and nurses. In private hospitals, 75% of the profits are shared with the doctors. On the other hand, nurses are forced to work for longer hours and are compensated poorly.

Sister Susan feels the salary system of private hospitals should be improved and that the government should provide support through partial contributions. She reminds us that the health care of the population is addressed by public as well as private hospitals; hence it is the government's responsibility to facilitate improvements in the private system as well. She also suggested to address of the salary disparity between the doctors and nurses. Adequate importance should also be given to strengthen on-the-job trainings for nurses and promote continued education for them. Although there is a Continued Medical Education (CME) system for nurses, which requires them to attend 150 hours of classes; most nurses are not able to do so as they are often not relieved from duty for that much time. Such trainings and education improve the work performance of nurses and improve patient outcomes; therefore, hospitals should encourage them. Salaries should also reflect a significant raise for those completing higher studies.

CONCLUDING

Sister Susan says she would advise health workers working abroad to continue working there if they are with their families. She finds it difficult to promote migrants to return to work in India given the existing work environment and pay, especially in the private sector.

She concludes saying that there should be improvements in nurses' work conditions, workload, salaries, and more opportunities for their career growth in India. Only these improvements would bring the nurses working abroad back to India and help improve the grossly inadequate nurse/patient ratio in our country.



CASE STUDY 6



...implementation of the ILO policy on decent work in health care institutions, better regulations and their enforcement to ensure that standards are maintained in the colleges of nursing, improvements are needed in the work environment to promote better nursing care...

- Mary Anthony

MARY ANTHONY is the Principal of a nursing college in Kerala, India and has been working in this position since 2007. She hails from a small town in central Kerala and is the eldest of the three daughters. Her father was a superintendent in the education department of the Government of Kerala and her mother was a teacher. Mary completed her Bachelor's degree in nursing in Kerala in 1988 and her Masters in Nursing from a premier institute in Bangalore in 1993.

Sherin specializes in Psychiatric Nursing. With an interest in the academia, she completed an M. Phil in Rehabilitation and Behaviour Science in 1996. She worked in Oman for six years. Currently, she is pursuing PhD studies from a university in Kerala. Mary's husband is a Professional Nurse and she has a daughter.

PRE-MIGRATION

After completing her preliminary nursing training, Mary worked for three years as a nursing instructor in a college of nursing in Coimbatore, Tamil Nadu. After completing her Masters, she taught briefly in the same college before joining a noted institute in Karnataka. Though she continued to acquire higher degrees, her salary was in no way commensurate with her qualifications and experience.

Mary's husband was working in Saudi Arabia, but, at that time, jobs there did not allow spouses to accompany their partners. Newly married, she wanted to stay with her husband and also plan for her own family. "So, we decided it would be better that we go to a place where both of us can work together," she says. At the same time, Mary was undergoing treatment in India for certain medical complications, but the treatment was very costly. A large chunk of her husband's salary had to be spent on the treatment.

She was informed by friends that some hospitals in Oman provided quality treatment for conditions similar to hers and if she worked there, the treatment would be free. This information motivated Mary and her husband to seek work in Oman. "I was

not keen to leave India. I believed in serving the country,” she says. The low salary and high medical costs here urged her to work abroad to meet her personal expenses. She learned about opportunities in Oman from her friends who were working there. She was selected directly by Government officials from Oman, through a written test and interview.

MIGRATION

Mary and her husband migrated to Oman in 1998 where she joined a reputed institute as a Senior Clinical Instructor. Upon arrival, she was provided a fully furnished villa. Being a new employee, she underwent a short orientation programme, of one week, organized by the institute.

Her primary job responsibility included training the nursing students and nurse educators. She was responsible for organizing theoretical training as well as assisting students in the clinics. She also supervised them while they provided nursing care to the patients. Mary was well qualified and was given the charge of ‘continued education and quality improvement of nurses and nursing educators’ in the hospital. She held the additional charge of internship coordination and training of preceptors.

Working in Oman was an excellent professional experience for Mary. She established good working relationships with all her colleagues. She received respect and acknowledgement for her work from the students and her colleagues. The work environment in the institute was exceptionally good. “Nurses are treated as health professionals,” she recounted. They are recognized, appreciated and valued for their work. In India, this was less common. She feels that in India, the work pressure, lack of good facilities and equipment for procedures negatively affects the quality of care.

Being an astute academician, she compared the teaching system in India and Oman. She concluded that, in India, the learning mechanisms for the methods and procedures was through textbooks, which is different than when learning through practical experiences. The training is also different between the countries. In Oman, students were trained in a standard way that ensured uniformity in knowledge of medical procedures throughout the country. Protocols are followed for conducting procedures correctly. In contrast, India lacks protocols and clear standards, often leading people to resort to improvisation while performing the procedures using whatever facilities/equipment are available at the moment.

Mary received some opportunities for professional growth while in Oman. The country was in the process of developing its own Nursing Council at that time and the Dean of her institute was a member in the council. Since Mary held an MPhil degree, she was qualified to contribute substantially to the institute. She was given the opportunity to participate in designing the Nursing Council, for which she reviewed and helped prepare the policy documents and guidelines. She can proudly look back and speak of her contribution in establishing the council which is functioning successfully now. Mary was also the member of the Psychiatric Nursing Task Force under the Director General of Education and Training of Muscat. She prepared the course book for the teachers and students while she was in Oman.

Culturally, Oman was in some ways similar to India and there were no restrictions. Mary and her family could enjoy their life freely. They could attend churches and participate in the Sunday services. She was able to avail the best treatment for her medical complications in Oman and was ultimately cured of the problems.

The people in Oman were very friendly. There were people from all parts of the world. The Government officials in Oman were always ‘protective’ towards foreigners. Administrative officers deputed by the government were responsible for their welfare. After some time, her husband left for India to pursue higher studies. During that period, she lived alone with her child and a caretaker, but did not feel insecure in any way. Good remuneration, structured work conditions, and additional benefits motivated her to continue working there for six years.

The salary in Oman was less than other Middle East countries. There is no scope for higher education in the Middle East and this, Mary feels, is a major lacuna that affects professionals there. Analysing her work, she concluded that her professional growth was being affected by the fact that she was working in an undergraduate training program; when by the time she had left India she was a part of the Post Graduate and MPhil programs. Moreover, there was no opportunity to take up PhD studies in Oman and Mary was keen to continue her studies.

Alone with her two-year-old daughter, she missed the support and company of her family. She felt that her daughter needed to grow up with her cousins and know her grandparents. She wanted to go back to her roots. She also felt she was not growing professionally and was stagnating in her career.

Since her main objective had not been only to earn a higher salary, she was satisfied with her experience in Oman and did not look for jobs in other countries, when she finished her tenure there. She started looking for jobs only in India and planned for her return home.

Asked if she would like to go back again, Mary says she could go for short assignments if she got the opportunity, but her personal commitments now would not allow her to stay away from home for long.

RETURNING BACK

Mary returned to India in 2005. At that time, many colleges in India were starting post graduate courses and there was a scarcity of post graduate teachers. She and her husband joined the same institute as teachers. However, this was an undergraduate training program and a PhD degree was required to teach in post graduate programs. Mary joined the PhD course in 2006 but could not continue for personal reasons. After resolving those responsibilities, she joined a PhD program again in 2008.

Mary is actively contributing to the training of nurses in India. She works to improve the quality of education in the institutes where she teaches. She organizes continued education for nurses by purchasing books and journals for them and also organizing staff development programs to add to their clinical knowledge and thereby improve health outcomes. She says she is lucky to have a good team with a shared vision of improving quality of care. The hospital management has been supportive, too. Mary feels happy she returned to be with her family and that she has been able to attain success in her endeavours.

She is a part of the Trainers Association of India which motivates nurses for continuing education and updating their knowledge. The association has been organizing Nursing Continuing Education Programs on a zonal level and contributing to building the nursing cadre of India. Until now, 4 education programmes have been organized in Kerala. She believes that such trainings should continue in order to reach all the staff and the curriculum needs to incorporate clinically relevant topics.

The Kerala Nursing Council has introduced training programs and provides registration for five years to nurses who complete 30 hours of credit in Nursing Continuing Education. It is now mandatory for nurses to undergo these programs in order to get registered with the council.

LOOKING BACK...

According to Mary, working in India is often not motivating for nurses -the salary is poor and there is no job security. Staff are often exploited in the private sector and burdened with heavy workloads. Private hospitals often focus on profit-making and do not invest in improving the quality. They do not allocate resources for training their staff or employ any motivational strategies like better pay and work conditions.

Learning from her work in Oman, Mary strongly feels nursing education should have better regulations to improve its quality. According to her, corruption at different levels affects quality, especially the accreditation process. Facilities in nursing schools are not often adequately scrutinized before providing license. Often norms are not adhered to while giving permission to start a nursing college. Norms related to infrastructure and qualifications for faculty positions and their number, are commonly violated. She feels that colleges are permitted to run Graduate and Post Graduate courses without the requisite facilities. Political involvement in nursing education is another disturbing factor. Similarly, the guidelines for teachers' salaries are not adhered to, more so in private nursing colleges.

Mary had several suggestions to improve the quality of work condition of health workers in general and nurses in particular. She would like the implementation of the ILO policy on decent work in health care institutions. She wants better regulations and their enforcement to ensure that standards are maintained in the colleges of nursing. Improvements are needed in the work environment to promote better nursing care. Some of these necessary improvements include higher salaries and provision of supportive infrastructure and facilities. Proper work division between staff members with clear job descriptions and incentives to motivate staff are needed to improve performance. The staff should be encouraged to pursue higher education. Nursing education should be regulated and protocols of care should be established to maintain standards in nursing practice. Career pathways for nurses should be better defined, as well.

CONCLUDING

Mary feels that major changes are required to woo back the migrant nursing workforce. The country should augment its investment in research related to the nursing profession. This would strengthen the nursing cadre and help it receive its due recognition.



CASE STUDY 7



...if a mistake had been committed, own it and try to rectify it by carrying out the necessary steps to manage as it was the patient's life at stake.

- Mrs. Theresa Francis

MRS.THERESA FRANCIS has worked as a nursing lecturer since 2005. She lives with her husband and daughter in Pala, Kerala. She is from a simple Keralite family and was born 8th among 7 boys and 3 girls. Her father was a farmer, who educated each of his ten children. She completed her basic education in Kerala and joined a bachelor degree in arts (B.A.) program but was not sure which profession to pursue. Her elder sister was a laboratory technician and took her along to the hospital where she worked in Orissa. The hospital work and environment impressed young Theresa and she decided to make nursing her profession. She studied nursing (Bachelor of Science, BSc) at a college of nursing in Uttar Pradesh and graduated in 1978. Thereafter, she started her career as a tutor in a well-established nursing college of New Delhi, where she worked from 1984 to 1988. Her younger sister was also inspired to take up the medical profession and is trained as a laboratory technician.

PRE-MIGRATION

While working in Delhi, Mrs Theresa developed a keen interest to work in foreign countries and be exposed to their style of work and culture. She knew working abroad would come with the added advantage of earning a good salary. She had a chance to work in the U.S. where her husband's brother and father were working, but her husband did not think this was the best option because of the differences in the culture and systems. An opportunity in Iraq was also ruled out due to the war situation there.

She applied for a job in Saudi Arabia. Recruitment was through an agency, which received a fee of Rs 20,000- for the process. The interviews were conducted by officers from the Ministry of Health (MoH) of Saudi Arabia. The process was difficult. There were many applicants for the posts and people had to wait in queues for a long time, but her eagerness paid off. Though the interview was for staff nurse posts, the management decided to sign her up for administrative work as her prerequisite work experience of 3 years was in the non-clinical domain. She willingly accepted the post offered. Her documents were processed within 2 months. Although her friends got theirs much later, she decided to go ahead alone. She had heard that she may need a parda (veil) and bought one. Other than that, no other preparations were required.

MIGRATION

In 1988, Mrs. Theresa left India to work in Saudi Arabia.

Some staff from the MoH received her at the airport. She was worried as she was alone and being received by an all male team, but soon realised there was no problem. She was taken to the hospital hostel where everything had been arranged. Newly migrated staff had to go to the ministry within the next 2 to 3 days where the officials would interview the appointees again and then assign work at different hospitals. There were 23 hospitals under the MoH at that time. She was provided with a furnished apartment with a living room, kitchen, etc and fitted with gas and air conditioner. Food was available at the café and she could also cook independently in her house. Domestic help was available for cleaning the apartment and washing. Incidentally, these cleaners were also migrant workers. A one day orientation at the hospital was given to the new staff.

Initially, when she joined as supervisor, people did not expect much from a small-built person like her. Gradually, the people observed her work, dedication, and her astuteness in catching mistakes and they understood how capable she was in her work. Someone even called her an 'atom bomb' – small but powerful.

Working in Saudi Arabia was a good experience. Good facilities and the latest equipment were available. Mrs. Theresa feels that if a person is skilled, she/he would not be hesitant of doing any work. She was proud of her training which equipped her with technical skills. She was equally comfortable with pushing the trolley as well as doing specialized procedures which other nurses would hesitate to do as it is generally done by doctors. As a supervisor, she was strict about the quality of work, but she did not harass anyone. She recalled one incident when a Filipino nurse had administered an injection without doing a preliminary skin test. Mrs. Theresa saw the patient having allergic symptoms like wheezing, while doing the ward rounds and checked for the skin test mark which was not there. She quickly talked to the doctor and gave the patient anti-allergy drugs. The nurse on duty had denied it was her fault. Mrs. Theresa's prompt action saved the patient and patient's daughter thanked her for saving her mother's life.

She heard of unprofessional practices in the hospital. For example, some nursing staff asking junior or unqualified staff to give injections, like chicken pox vaccines, since the nurse on duty was pregnant. She was sure no one tried these on her shift as she was vigilant. She recounts that even when doctors made some mistakes and urged her not to report it, she would reiterate that she was not there to police but to help and serve. She urged everyone that if a mistake had been committed, own it and try to rectify it by carrying out the necessary steps to manage as it was the patient's life at stake. After such initial incidents, the staff became more confident about her expertise and knowledge and shared more with her. She sincerely states that she worked, helped, and cooperated with everyone.

Recognition of her work was in the form of promotions in designation. She had joined as a Nursing supervisor, subsequently assumed the post of Assistant nursing director, then the In-service education coordinator, and finally the officiating Nursing director. In 1991, she received the Best Nurse Award from the King. While working as the Assistant nursing director, she used to organize and participate in symposiums and was awarded the second prize and certificate for these. Her seniors were confident she would do well. In her tenure, the hospital had been winning the best In-service award among the MoH's 23 hospitals. She had also been considered for a gold medal for good service but for some reason, it did not materialize. Since there were no students, she supervised the staff and often provided guidance for symposiums, which was appreciated.

Awards were not linked to promotions. Promotions were on the basis of work. Salary was according to work performance. The staffs were supported with other amenities such as free housing and food. Medical treatment, if required, was free. Mrs. Theresa could save her salary and also received a gratuity at the time of leaving the work. She also received social support through her friends there and colleagues who were from diverse regions- Filipinos, Sudanese, Egyptians and Nigerians.

Mrs. Theresa had been married and had 1 child before joining her job, but she had gone alone for this job assignment. Her family was able to join her after 5 years. They stayed there for 12 years and during that time, her daughter studied in the embassy school until the 4th standard. She had not planned to come back to India at all, but her husband and daughter returned after some years as

her husband had set up his small business in India. She missed her family and wanted to join them, especially her daughter who was a teenager by then, and required her support. So, she quit her job and returned to India in 2000 to join her family.

Mrs. Theresa feels that for her, working abroad was a good professional experience and she believes that people earn more respect "there than here." She adds that she could learn more there since she was the coordinator and had the opportunity to visit different hospitals and later share those experiences. Other than that, there were monetary gains. She was able to build a house for the family while working there. Loss was felt mostly in the terms of being away from her family. She did not feel insecure or restricted and she clarified that use of parda was not compulsory. The management provided a vehicle for the staff to visit the market. She felt safe there and had no other tension. Another important gain from her work abroad was the quality time she could spend with her family and friends as she could avail some leave every 9 months to visit India. Leave could be applied for as vacations (45 days) or for emergencies.

Her "always happy to do something" attitude and sincerity towards her duties impressed her employers in Saudi Arabia and they were not willing to release her. Her resignation application was rejected three times, before being sanctioned. The process of paper work for returning back was handled by the MoH.

RETURNING BACK

Mrs. Theresa had not planned to work when she returned to India. Her family had enough money and her husband was earning. However, she got a job within 1 month when her college senior was setting up a school of nursing in another city in Kerala, and asked her to help. She and her sister started a School of Nursing, and for 1 year, both of them taught all the study courses. They stayed there from Monday through Friday, and apart from the salary, food and accommodation was provided. Eventually, the distance from her family urged her to leave the job and take up a position in her hometown. She worked in a nearby private hospital which had a convenient daily commute. She worked there for 5 years before her current position as a lecturer at the University.

Mrs. Theresa and her family had to adjust a lot to reintegrate into the Indian system. Her daughter did not know Malayalam, which was required even in English medium schools. In addition, the living expenses in India are significant as commodities are expensive. She had to face several unnecessary hassles from the municipality and electricity departments and there are "24 hrs tensions" here. She also said that after working abroad for many years, there is a loss of awareness about the changes in the system. After returning to India, she felt she was not aware of the situation in Kerala and "culturally it felt different."

She feels there is no recognition for hard work in India and professionals receive inadequate money and no benefits working here. Working conditions in Kerala are not good, professionals have to work hard to earn and the hours are not conducive. She recounts several people who had difficulty in finding jobs after returning to India.

Patient behaviour remains unchanged in any country and people's demand for services is universal. On comparison, there was no gender discrimination in Saudi Arabia but it exists here. Professional growth is better in India and our country is good for higher education. While working in other countries, "once the staff members there understand your style of work, no one interferes; while in India, you have to face a lot of interference in work". She feels there is no appreciation of work here at all.

In spite of the present conditions, she feels satisfied having worked abroad and was able to learn and earn while she was there. Money here is lower than she expected, but she feels happy being with her family and friends. She has had several opportunities to go abroad but does not want to leave her family again.

The work atmosphere here has not been great but she continues with her profession as an instructor since it benefits the students. Being the coordinator for the first year of students' training, she feels that she is contributing significantly by moulding the students who are fresh out of college.

LOOKING BACK...

Living is difficult in India due to rising prices. So many qualified people go abroad just for monetary benefits. Moreover, 3 years work experience is currently a prerequisite for foreign jobs and many nurses and technicians work for three years in India and then leave the country to work abroad. If the government could improve the salaries of health professionals based on qualifications and experience, people would stay back. Skilled professionals should be given the recognition and respect due to them.

Nursing training here is not adequate. Mrs. Theresa opines that schools should have cross learning, which should be a continuous process of in-service education. Skilled workers should have an organization in each district to serve as a common platform. They should meet annually to share ideas and also maintain a list of resource persons in each district.

She wishes to advise young health professionals to go abroad for some time, to be exposed to the working environment and earn money. She suggests that they should go before they are married as they have lesser responsibilities at that time. Afterwards, they should return to India to stay with their family and work in this country.

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CASE STUDY 8



*...one's quality of life is better when with his or her family.
Living away from family and community, in another
country, deprives a person of these strong bonds.*

- Ms. Elizabeth George

MS. ELIZABETH GEORGE works as a laboratory technician in Parathode, a small township in Kottayam district, Kerala, India. Born in Kerala, her parents were farmers and she was the youngest of 10 children. After completing her class 10th school education, she went on to receive training (from 1974-75) as a laboratory technician from a paramedical institute in a nearby city, through a one-year certificate course.

She started her career in a missionary hospital in Kerala immediately after her training. She worked there for two years. This position allowed the opportunity to sharpen her skills and expertise under the guidance and mentorship of her elder sister, who worked in the same hospital. In 1978, Ms. Elizabeth moved to Delhi to work at a private laboratory where she stayed for the next eight years. She then left India for work in Libya but returned in 1990 and has been here ever since.

PRE-MIGRATION

Working in Delhi was a pivotal experience for her. Ms. Elizabeth expressed that, "the fact that I went to Delhi, changed my personality". It helped her gain confidence and interact better socially. It helped her improve her English conversational skills and ultimately move ahead in her career and work abroad. She added that if she had worked only in Kerala, speaking in English would have been a problem and she would not have cleared the interviews for jobs in other countries.

In Delhi, Ms. Elizabeth was doing well and her family could lead a fairly comfortable life with her salary. However, she was not able to save anything after taking care of the monthly bills and any family emergency would strain the situation even more. This fact compelled her to seriously think of options to earn a better income. Many of her colleagues had migrated abroad with better paying jobs. Ms. Elizabeth decided to follow the same course.

Interviews for foreign recruitments are held frequently in Delhi, as it is the capital of India. Where Ms. Elizabeth worked in Delhi, she had some interactions with Libyan patients and this basic familiarity with the country prompted her interest in

migrating there. She attended a recruitment interview for Laboratory Technicians conducted by officials from Libya's Ministry of Health. She was selected based on her merit and experience. The entire process of the interview, selection, and processing of documents was simple and it took only three months for her to get the visa for Libya.

MIGRATION

Ms. Elizabeth migrated to Libya in 1985. On reaching the new country, she stayed in a hotel that the hospital authorities had provided for. From there, she had to find her own, more permanent accommodation. With the help of some "Keralites" from her home state who lived in Libya, she was able to find a house for herself and after three months, her husband and child were able to join her. She was appointed to work in a clinic and manage it independently. She did not receive a proper induction when she joined the job, but nonetheless, was able to manage well with her experience.

Ms. Elizabeth found the work environment to be comfortable. She felt that the workload at the clinic was appropriate and the salary was very good. When she joined, the clinic was in the process of being established and she had to take the lead in setting it up. She received a significant raise in her salary from what she had received in Delhi, which was her major motivation to continue working in Libya for nearly five years. During that time, she did not consider shifting to any other country in the Gulf. The cost of living in Libya was low and she spent only half her salary in taking care of her family and could save the rest. There were other Keralites living nearby, with whom she could spend time with and enjoy a social life. On Fridays, which was the weekly holiday, she and her family would visit their friends.

Overall, Ms. Elizabeth considers the experience of working in Libya a success due to the significant monetary gain. However, she did point out some negative elements in her professional experience. First of all, the clinic where she worked was very small and conducted only minor investigations. She missed doing a wider range of investigations and felt she was not growing professionally because of this limitation. Moreover, she did not receive any additional training while she was there. In retrospect, she feels that if she had worked in a bigger hospital, or in another Gulf country, she may have had more opportunities to learn and grow in her career.

Personally, she also faced challenges during this time. Since she was the only technician in the clinic and it was difficult to find short-term replacements, it was hard to get time off for vacations in India. Ultimately, she had only one vacation in the three years that she was there. The most unfortunate incident was that when her father died, she could not get leave to reach in time for his funeral. It remains in her heart as one of the greatest regrets of her life.

Another challenge in Libya was the access to a good education for her children. The closest Indian school was more than 500 km away from where her family lived. She felt it would be better if her children received their education in India.

When her contract ended in 1990, the authorities did not renew it, nor did they convey the information to her officially. Fortunately, she became aware of this through other sources so she was able to make arrangements for the future. She received a gratuity when her contract ended. Ms. Elizabeth returned to India in 1990.

RETURNING BACK

Initially, after coming back to India, Ms. Elizabeth did not return to working as a laboratory technician. She did not feel inclined to work in the laboratories in her town which offered a low salary and unsatisfactory working conditions. Her sister suggested that she should start her own pathology laboratory, but Ms. Elizabeth did not venture into it because of the risks involved in establishing a financially viable new business. Moreover, she wanted to take care of her children and elderly parents-in-law. She resumed her work several years later when her children had grown up.

The work environment in India is different, Ms. Elizabeth says. In general, there is gender disparity and women are not adequately respected for their abilities. In Libya, she had never experienced any such disparities and felt that women were more respected there. Patients' attitudes are also different between the two countries. In Libya, patients were very respectful to her but, in Kerala, she felt that patients tend to be more seemed to be sceptical. They often get tests repeated in 2 or 3 different laboratories, are reticent and often difficult to handle.

Ms. Elizabeth's current position is in a private laboratory, which conducts more tests and has more facilities than her clinic did in Libya. She has a busy schedule and receives the best salary package that this private laboratory could offer for her position and experience. At present, she receives respect from the authorities and clients and she feels happy and satisfied.

She has been working in her current position for the last five years and regrets the fact that she delayed rejoining the workforce in India. Had she joined earlier, there would not have been a loss in continuity and she could have gathered more experience and received a better salary because of more opportunities that would have been available to her.

LOOKING BACK

In India, Ms. Elizabeth was unable to get a government job because she had done a certificate course which was not recognised for jobs in this sector. She was not aware of this when she joined the course as a student. Ms. Elizabeth feels it is important for students to be careful when they choose a course or program. Students should pursue graduate or post-graduate courses only if the degrees are recognized, to ensure eligibility for government jobs. She suggests that the government should regulate such institutions which offer certificate courses, in order to maintain the requisite quality or else not allow them to run.

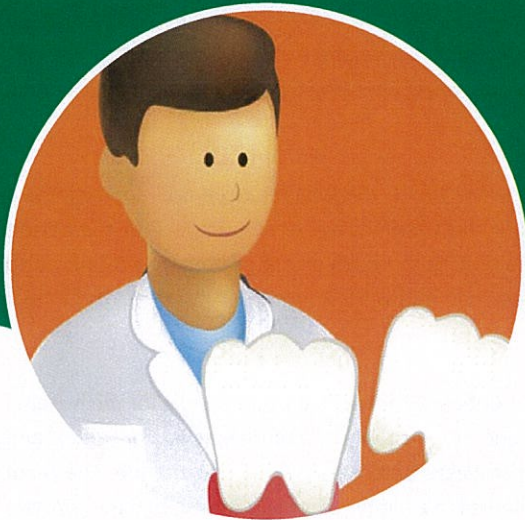
Ms. Elizabeth believes that health professionals can be encouraged to return to India if they are offered better job opportunities and good salaries. She says, "It is impossible to get a good salary in India and one cannot expect that in India". This, she feels, is the primary reason why professionals do not want to migrate back to India.

CONCLUDING

In Ms. Elizabeth's opinion, one's quality of life is better when with his or her family. Living away from family and community, in another country, deprives a person of these strong bonds. She urges the government to improve the work conditions at home so that "our professionals can return back to their families".



CASE STUDY 9



*... there can be no greater freedom
than living in your own country.*

- Dr Mani Shankar

DR MANI SHANKAR has been practicing dentistry in Pala, in the province of Kerala for almost 37 years. Dr Mani's father is a reputed dental surgeon and he took up dentistry to share his father's vision. He has 3 siblings, but none of them are in the medical profession. He graduated in 1998 from a college in the adjoining state of Tamil Nadu and in 2003, he completed his post-graduate work in Maxillo-facial surgery at a private college in Mangalore K. He lives with this wife, also a dentist, and their two small children in Pala, Kerala.

PRE-MIGRATION

After his post-graduation work in 2003, he started practicing dentistry in his father's clinic. In addition, he taught dental science at a private dental college. The college was 140 km from his home, but since it was newly established he was allowed to follow a flexible schedule of 3-4 visits monthly as an additional faculty. He continued teaching there for 3 years until 2006. While he was successful in his profession in India, he felt some of his dreams were taking a long time to be fulfilled. As the eldest of his siblings, he wanted to build a house for his family, but needed substantial amount money to see that dream through. The opportunity to pursue this dream came to him in the form of a well paying job in Saudi Arabia with the Ministry of Health (MoH).

The procedure for applying for work in Saudi Arabia was fairly simple. Health professionals did not need to clear any qualification examination. Specialists were not required to take a written test, though non-specialist doctors did have to clear one. He found the post advertised on the internet and he applied directly for it. He received a call from a recruitment agent in Kochi a few days later asking for an interview. The agent functioned as a mediator for Saudi Arabia recruitments and the interview was conducted by Saudi Arabian MoH officers. After being selected for the post from his interview, it took less than 6 months for the processing of documents and other arrangements, including having his family go with him. No preparation was required for the migration process except for buying a 'parda' for his wife, which his friends had advised him to buy since it was essential for women to wear one. Dr Mani and his family left for Saudi Arabia in 2006.

MIGRATION

Dr Mani worked as a specialist in a, 600 bedded public hospital in Saudi Arabia. His 3 years work experience as a post-graduate provided him with the pre-requisites of the position.

Although he had asked for accommodation to be arranged for his family, this had not been done when they arrived. The MoH offered initial stay for him and his family in a hotel, but he wished to live in a rented apartment and he had to arrange for these accommodations himself. Being new in the country and accompanied by a wife and a small child, this process was "tough and tense". Eventually, he received the help of a Malayalam (native language) speaking person and was able to find a house to rent.

There was no formal induction process at the hospital. The first 10 days were spent doing paper work and applying for a resident permit 'iqama'. This permit is mandatory for any foreigner to work and travel in the country. Papers for the permit were provided by the MoH, who also took him to the passport office. Along with the form, some photos were required to procure the iqama. The hospital supported new staff by not giving them on-call duties for 2 months, until they got familiar with the system and the local Arabic language.

The working schedule for specialists were 5 working days – 2 for out-patient duties, 1 for surgery duties, and 2 for the hospital wards. Dr Mani was on a team of 3 specialists - a Jordanian, a Pakistani, and him. At that time there was no consultant and the post remained vacant until the end of 2009, when someone joined just weeks before he was leaving the job. The team operated together. Since there were no consultants, difficult cases were referred to a higher centre. They also had to do 7 days of emergency call duty, where they worked 24/7. If any duty coincided with a holiday, they were compensated by an extra day of leave.

Dr Mani found his working experience in Saudi Arabia excellent. He worked in the maxillo-facial surgery unit, doing mainly trauma care and pathology. The department had excellent technological equipment and well functioning infrastructure. Signing of the attendance register was proof of one's work. There was no interference from the management. For all patients admitted under a particular doctor, this doctor's decision determined the treatment. While performing surgeries on his/her patients, this doctor would be the main surgeon and the other specialists would assist him. Such trust and responsibilities were a great motivating force.

The salary and benefits he received with the post were very good. "The day you land at the airport, your salary starts", he said. He received housing allowance which was equivalent to three month's salary. All MoH employees and their families were eligible for free medical treatment. Although there was no Provident Fund provision for employees, anyone working for 3 years was entitled to get extra salary of one month. Staff worked for 7 hours in a day, 5 days a week, with 2 days of official leave every week. All employees received 60 days of paid leave in a year. In Ramadan and Haj, there were 5 days holiday for each. Staff working those days got an additional 10 days of leave, which was added to the annual vacation period. Compensatory offs for working on holidays could also be added to the vacation days. He was provided a food allowance of 10% of his salary, transport allowance of 5%, and travel with family for vacations was also reimbursed.

Dr Mani bought a car within a month and got a driving license from transport office. The system for doing so was simple: 5 officers test the applicant's driving and give the license if satisfactory. The system was made even easier for him since "the transport office staff 'mudir' and the hospital 'mudir' were friends, the process was easier for doctors applying for the license".

Work contracts, though for a minimum period of 3 years were subject to annual renewal, based on performance. Specialists like him reported to the head of general surgery who noted their capacities and gave them points as per their performance. Certain minimum points were required for renewal of the contract. Based on the points scored for performance, all employees received a yearly salary hike ranging from 15-25%. Employees scoring fewer points, received a lesser hike.. If a person worked there for 10 years, she/he could be rewarded with 10 months extra salary.

Strict rules and regulations were followed in Saudi Arabia and Dr Mani deemed them as the “worst or best”. For example, if while driving someone has an accident and his wife and kids die, he would be punished. This is very different from Indian laws and was difficult for him to understand. Severe crimes are punished by decapitating the criminal, especially for murder. The punishment is carried out in the public after the Friday prayers. “Criminals get the death sentence for crimes like rape, and no one is exempted of punishment even if he belonged to a higher status”. All rules are adhered to strictly and the overall crime rate is lower than India. The rules are restrictive for women; even foreigner women have to be covered in public.

Another challenge he faced while working in Saudi Arabia was the Arabic language. Dr Mani had to learn the language to some extent to communicate with his patients. Dr Mani also felt he was discriminated against due to his religion, as he and his family were Christians.

Some losses Dr Mani felt were a lack of a social network of family and friends, the feeling that he was “always a foreigner”, and being a non-Muslim, in a Muslim country. For women, the place did not seem to be secure. There was not much of a social life for migrant health workers and even children did not have the freedom to play outside. He missed his private practice, but he did have the benefit of working for less number of hours and earning more money.

Dr Mani was able to find support from friends in other professions and some colleagues while he worked there. An important element of their experience was that his wife, who was also a dentist, was not working. Although she was offered job in a private hospital, she did not join because the couple would have two types of sponsors: the government for him and private sponsor for her. This may have created some problems due to differences in work hours and their vacations may not have coincided. At that time, Dr Mani was entitled to a 45 vacation days after completing 10.5 months of work, but the situation may not have been the same in the private sector.

Another issue Dr Mani and his wife faced was regarding the decision of the education of their children. He felt that the standard of education there was not satisfactory, even in the Indian schools. He felt that there were no good teachers in Saudi Arabia and that the quality of education for his son was best in India. This situation spurred the family’s decision to return to India. After completing three years of work in accordance with the contract and related benefits, Dr Mani decided to end his tenure of work in Saudi Arabia and submitted his letter to finish the contract. “If papers are in order, you need not take help of embassy and only if your papers not in order, you need their help”. Since he was employed by the MoH, he did not have any problems while finishing his work and coming back to India.

Dr Mani’s biggest gain from his experience in Saudi Arabia was monetary. He was able to save a good deal of his salary since his leave was paid and he had few expenses with food and other amenities being so cheap. He felt that his objective of working in Saudi Arabia was fulfilled.

Dr Mani felt his work in Saudi Arabia was appreciated not through a formal system of recognition but when patients came to the department and wished to be seen by “the Indian doctor only”. Additionally, months after he returned to India, Dr Mani received a call from the hospital director in Saudi asking him to work again in the country with the assurance that he would take care of the visa formalities. Though Dr Mani politely refused the offer, it felt good to be appreciated in this way.

COMING BACK

Dr Mani came back to India permanently at the end of 2009. His father was practicing in Pala and Dr Mani joined him and started working again in their clinic. He also re-joined the same private hospital where he had worked earlier, after a vacancy was available 7 months later. He decided not to join the teaching college again as it now required mandatory visits 4 days a week, which did not suit him.

He did not face any problems adjusting back to work in India, as it was his own clinic and the work atmosphere was familiar. Being born and raised in the same town, he and his family could easily fit back into the social environment. The only issues he felt were worth noting was the fact that he now had to work for 10-12 hours in a day, the earnings were a quarter of what he

earned in Saudi Arabia, and personal expenditures were incurred here as compared to none there. He stated that running his own clinic has allowed him to only take 7 days of leave since coming back in 2009.

In India, he faces more competition and cannot refer out any cases since that may harm his professional reputation. He does not perform major surgeries as his clinic is small and he practically runs a “one-man show”. Moreover, since this is his native place, he wishes to avoid any kind of complications. Therefore, he performs only minor surgeries and the cases he can manage at his clinic. To conduct the major surgeries he was doing in Saudi Arabia, he admits patients to the private hospital where he is affiliated.

Infrastructure is vastly different in India compared to where he was working in Saudi Arabia. Even in private hospitals here, the arrangements and equipment are not of the same standard, though it might be much better in India’s metropolitan city hospitals. As the doctor reminisces, he says that patient behaviour has changed in India over the years. He feels that, earlier, people used to be more respectful of doctors and now it is best to have no expectations from your patients, as is the case in foreign countries.

Even with these issues, Dr Mani feels that India is his own country and he can enjoy more freedom here. There are no rules which bother him here. His wife is now working and his child studies in a good school. His family owns the clinic which has been there for 37 years and is running well. He feels very satisfied with the process of migrating to Saudi and coming back and settling down in his home town of Pala. He was able to fulfil his dream and build his house, which otherwise would have taken another 8-9 years of working in India to save that amount of money.

LOOKING BACK

“If you want to be happy and satisfied, come back to India and settle down”.

The doctor feels that India should offer more motivation to health professionals who are thinking of coming back. The government should provide better salaries, create good working atmospheres, and make facilities better by improving the infrastructure. He compared the health system in India and Saudi Arabia and summarized that in Saudi Arabia all patients, rich and poor, go to the government hospital that had the best and most modern care in a clean and proper atmosphere. In India, the rich do not go to government hospitals as there are no facilities and the poor do not have money to go to any private hospital. There is a dire need to improve health care and delivery at the public hospitals, which cater to the general population.

Changes in policy should see to it that professional salaries are improved according to qualifications and experience. This would attract more people to come back to India. Additionally, there are no taxes levied in the Gulf countries on salary, whereas there are many taxes in India. This may be a reason for professionals not coming back, so the government should consider addressing this issue in some way.

CONCLUDING

“If you have something to live for in India, come back”. Dr Mani opines that “your own country is the best always. You are safe here and you can go anywhere you wish”. He said that there can be no greater freedom than living in your own country.



CASE STUDY 10



If their interests lie in serving their communities and they are motivated to live in India, they should be courageous to face the differences in life situations and working systems here and be patient in achieving their goals.

- Dr Agnes Mitra

DR AGNES MITRA is a Public Health professional in Bangalore, India. A dentist by training, she graduated from dental school in 1999 in Bangalore and went on to complete her Master of Public Health degree in 2002 in Boston, USA. For the past 10 years, has been working in a Bangalore-based health resource centre and continues to travel abroad for professional assignments. On her return to India in 2004, she started work as a public health professional. Dr Mitra was then a British passport holder but currently has dual citizenship of the UK and India.

A true global citizen, Dr Mitra grew up in the United Kingdom and other European countries as her father's position as a noted Gynaecologist and Obstetrician had sent the family to various posts outside India. After her father passed away, Dr Mitra's support system included her mother, brother, and friends. She currently lives in Bangalore with her husband.

PRE-MIGRATION

When Dr Mitra completed dental school in India, her aim was to work and gain more experience in the field. Despite the magnitude of dental problems prevalent in India, she observed that the work available was limited. There were few jobs in India at that time, and fellow graduates generally assisted other dentists in their clinics or started practicing independently. However, setting up a private clinic required large capital costs.

Another option for her was to apply to a post graduate program. But the scenario for higher studies, in India, during that time, did not instil optimism. Acceptance into these programs was extremely competitive in India. There were approximately 5000 students vying for a single post graduate seat. Additional hurdles such as reservation and quota for seats, or considerable finances required for the paid seats in some programs, put applicants like her in a disadvantage. In order to make it professionally as a dentist, Dr Mitra felt she must "fight for survival" in the system. Weighing her options, she decided the best choice would be to take a position outside India where she could gain more experience while earning a good salary.

In India, she found little information available about the documentation process required to work abroad. However, Dr Mitra saw that jobs for dentists in the UK were advertised online so she applied directly to hospitals for the advertised posts. Since the UK is

closer to India than the US, and she had many family friends living in England, her family did not object to her moving there. After completing all the formalities in 2000, Dr Mitra left for the UK to practice dental science in 2001.

MIGRATION

Since Dr Mitra had been born in the UK and had lived there throughout her childhood, she was familiar with the country and its culture, and it was not daunting to return there for work. While jobs in dentistry were competitive in the UK, life for a dentist there was quite easy. There was a registration process to be completed for a practicing dentist and the process was fairly straightforward. Her position was located in a “state of the art” hospital under the UK’s National Health System (NHS), in Bath, England. The hospital had a beautifully structured, formal orientation where she was introduced to the dental wing as well as the rest of the hospital, and she felt welcomed.

Dr Mitra found the work environment a positive one that accepted innovative ideas and contributions. She found her education in India had taught her well and she was able to hold her own with colleagues who had 30-40 years of experience. Her colleagues were supportive and not at all condescending due to her lack of experience. With her patients, Dr Mitra was an exponent of allowing the body to heal itself and avoiding aggressive treatments if possible. Her colleagues paid attention to her points on habit forming diseases which lead to mal-alignment of teeth and using behavioural therapy to break the habit forming conditions. She felt professionally satisfied, enjoyed participating in debates, and learning from others. Academically, she was able to pursue her interest in research, publish papers, and enjoy opportunities for further study. She felt she was treated as a professional like any other, not differentiated based on her nationality.

The city of Bath is centrally located in England and she found it pleasant to live there. Her position provided her with a comfortable living. She had little expenses and the hospital covered her housing, phone, a car (if needed), and food was available in the cafeteria. She received support from family friends and did not face any security issues living in the UK as a single woman.

Dr Mitra could list the positives of this experience without hesitation. She received an extremely good income, gained rich professional experience, and enjoyed a good social status. She was proud to say that she achieved these accomplishments through her own personal effort and work performance and not based on being “someone’s daughter”. Dr Mitra felt that in India, professional status could be easily acquired by simply belonging to a particular community, or bearing links with established professionals and having high family connections. In the UK, she was also able to enjoy a lot of free time, where she could take part in cultural activities, pursue her hobbies, and write. In India, she would have been obligated to work long hours in a clinic.

The few negatives she recounted included the loss of time with her family and not being able to fulfil her interest in serving her community. She also faced some social challenges while in the UK. Since most of her colleagues were very senior, there was not much social life to be had at work. She also found it easier to interact with her English friends rather than her friends of Indian origin who she felt were ‘confused about India’. She felt a lack of good intellectual company. Another challenge was that as an unmarried, successful young woman, many local Indian families tried to arrange a marriage with their sons. This component, she felt, was “frivolous and not very pleasant,” but she was able to manage the situation.

Dr Mitra had a rewarding one and a half years working in the UK. Her acumen was observed by her supervisor over some time, and she had begun to receive clinical cases with higher level of difficulty. Towards the end of her tenure at the Bath hospital, she began considering her major career move as she was interested in pursuing a Master of Public Health degree. Moreover, she had been dealing with difficult cases where supervision of her seniors was needed but not always available, including serious trauma cases. Even though the hospital was a very good one, she realizes now that it was probably understaffed. This extremely tough work with trauma cases had left her “burnt out.” With no colleagues in her age group to mingle with in the hospital, she had started missing her social life. Though she was comfortable living there and was financially secure, she knew she did not want to settle down abroad.

Dr Mitra followed her desire to study Public Health in the United States of America and went to a University in Boston for her Master’s in Public Health (MPH). She was farsighted enough to take up this subject when it was not so common in India, but she was hopeful it would lead to a good job when she returned. She liked the American teaching style she experienced in Boston as well as

the semester arrangement of studies. After completing her studies, she worked in the United States of America for another one and half years and earned enough salary to pay off much of her student loans.

While she was in the United States of America, she started planning for her return to India and her family. Her mother and brother were living in Bangalore, but her brother had completed school and had decided to join medical studies abroad. Dr Mitra felt it was now her time to be in Bangalore with her mother.

Having lived in seven countries while growing up, she was aware that a lot of paperwork was required when returning to India. She spent two years preparing for her return. She hoped to find a job before coming back but positions in Public Health were not commonly in the public domain yet, and “you would not know where to look unless you knew what you were looking for”. She reached out to different people in the field, including her college alumni, signed into online forums for jobs, and searched the ‘Devnet’ website for jobs. She was not aware of any services to help professionals returning to the country, so had to go through the process on her own. In spite of these obstacles, she was able to complete preliminary rounds of interviews with some prospective employers in India while still in the United States of America. She had scheduled the next round of interviews before she returned to India at the end of 2004.

Prior to leaving for United States of America, Dr Mitra set up a Non Government Organization (NGO), which delivered oral health care services for the poor. She closed it after four years of successful operations as it was difficult to manage the organization long distance.

RETURNING BACK

Back in India, she observed that the working system was vastly different and “strange”. Documentation was required of foreign migrants and she was required to register at the Foreigner’s Registration Office (FRO). Dr Mitra could obtain the requisite form online but the process was tedious and many attempts to register were unsuccessful. She had to visit the office several times before making any progress. Finally, she requested a local person to accompany her to the FRO and that helped her complete the registration process. The initial period after returning to India was a difficult one and she felt discouraged. She does not think that the complex processes for migrating back to India have changed since then.

Dr Mitra came prepared for the interview process in India with salary requirements according to the current trends and was happy with the amount she was offered in her public health position. She found the work atmosphere in Bangalore was quite serious, which was different from the UK and the United States of America where the workplace was “very sunny and chatty”. Her colleagues here were formal at all times; however, she feels this situation has changed considerably now. She was very satisfied by the work in her new position and she enjoyed the non-hierarchical atmosphere of the organization. The major challenge she faced working in India was when she would go to health facilities and government offices and was faced with the prevalent culture that was biased to her gender and age. She felt she was not respected as a young woman and she often had to request male colleagues to accompany her for meetings in order to be taken seriously. It took her some time to “figure out how to tackle the system and get things done without being hassled”. She feels she has now learned the best ways to deal with such situations.

Back in India, Dr Mitra missed the efficient public transport of the UK and the discipline and amenities she enjoyed there. Some systems took some time to manoeuvre but she learned to deal with them. She found it difficult to drive in Bangalore’s unruly traffic and she had to go through the process of procuring a gas connection and other domestic necessities, but such things were manageable with the help and support of family and friends. She soon settled down in Bangalore, as the city had “caught up” and modernized since she had last lived there. There were other benefits to living and working in India; for example, she was able to hire domestic help, which had not been possible in the UK. Her social circle was surprised she had left the United Kingdom and the United States of America to come back to India, and she received many questions about why she had shifted to a non-clinical profession.

She feels satisfied that she was able to return to India and fulfil her desire to work for the community she lived in and achieve professional success. Most importantly, she is happy to be close to loved ones.

LOOKING BACK...

Dr Mitra believes that the process of migration requires research and preparation. Any person contemplating return should be clear on her/his objectives for returning –“what will you gain and how you would move to gain that”. She advises that professionals could follow her method and network with people before returning to India to find satisfying jobs. Once back in India, they should be prepared for some complications and seek the help of locals to help to deal with the systems and the re-integration process.

In Dr Mitra's opinion, if Indian authorities were to improve the systems for re-integration for return migrant workers and provide more information about registration, housing, job opportunities, etc, then, many more professionals would be attracted to return back. Authorities should make the portals for information on migration more user-friendly and appoint agencies or agents to help in arranging for houses and other amenities. Support groups and forums should be promoted to connect people in similar professions in India and abroad, so that assistance can be found in planning to go abroad and returning to India. The Indian embassy could establish links with professional groups and Non Resident Indians (NRI) groups. The government should also lay down clear guidelines for professional registration and the process that is required, including the time period for re- registration etc. Such guidance should be clearly documented and readily available at the embassy as brochures and hand outs.

Information about public and private sector jobs should be publicly advertised as well. Dr Mitra feels that improved facilities in the health sector, promotion of medical tourism, bolstering of the research system, and motivating professionals by offering better salaries would bring back many of India's professionals.

If given a chance, she is not averse to working abroad again. She knows several other professionals who had to go through the complicated reintegration system like she did, and had decided to return abroad.

CONCLUDING

Dr Mitra would like to advise professionals working abroad to return to India if they have a family here and if they have some prospect for pursuing a successful career. However, they should be wary if their objective is only to make money as India is a place where “you can get rich but not very rich”. If their interests lie in serving their communities and they are motivated to live in India, they should be courageous to face the differences in life situations and working systems here and be patient in achieving their goals.

