WE CARE

The Story of GMCANA



Third Annual GMCANA Awards Function
December 23, 2002

GUNTUR MEDICAL COLLEGE ALUMNI OF NORTH AMERICA

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"To help develop Guntur Medical College and Government General Hospital - Guntur, as premier modern Medical Education facilities for undergraduate and postgraduate medical students, staff, and medical community at large".

THIRD ANNUAL GMCANA AWARDS FUNCTION

DECEMBER 23, 2002

List Of Invitees

Dr.Kodela Siva Prasada Rao, MS
Hon'ble Minister, Medical, Health & Family Welfare,
Govt. of Andhra Pradesh. Hyderabad

Dr.K. Anji Reddy, MS, MS
Director General of Medical & health Services & Commissioner APVVP
Hyderabad.

K. Rama Krishna Rao, IAS
District Collector & Magistrate, Guntur Dt.
Chairman, Hospital Development Society, GGH, Guntur

Sri Yemparala Venkateswara Rao, MP
Loksabha, Guntur

Sri S.M. Lal Jan Basha, MP
Rajya Sabha, Guntur

Sri. Yadlapati Venkata Rao, MP
Rajya Sabha, Tenali

Sri. SM Ziyauddin, MLA
Guntur – 1

Smt. Sanakkayala Aruna, MLA
Guntur – II

Sri. Makineni Peda Rattaiah, MLA
Prattipadu

Sri. Chukka Yesuratnam,
Mayor, Municipal Corporation, Guntur

Dr. Kolli Sarada, MD, DGO
Chair Person, V.G.T. UDA

Dr. O. Madhava Kalyani,
Principal, Additional Director of Medical Education.
Guntur Medical College, Guntur

Dr. Md. Fayaz Ahmed, MS
Superintendent , Additional Director of Medical Education
Government General Hospital, Guntur

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LIST OF AWARDEES

Dr.Tummala Ramabrahmam,M.D. memorial GMCANA Research Endowment Fund :

This Endowment Fund is established by Mrs & Dr.Venkata Subba Rao Uppuluri, M.D. Dr.Gazula Srihari, Dr. L .Nageswararao and Dr. Ramprasad Chilakapati in memory of their friend Dr.Tummala Ramabrahmam, M.D.

The Third award is being presented to **Dr. Y. Nayudamma,** MS, MCh Prof of Pediatric Surgery

Dr. Y. Nayudamma, MS MCh, has performed the historical separation of Ischiophagus twins case on October 23, 2002. This is the successful third set of conjoined twins that he and his team operated and separated... 1) Ram and Lakshman 2) Anjali and Gitanjali 3) Rekha and Surekha... since he joined GGH. It is with pride that GMCANA has recognized him with the third "TUMMALA RAMABRAHMAM RESEARCH AWARD" which was announced at the GMCANA Biennial reunion at Chicago on September 1st. GMCANA congratulates him for this historical operation and his possibility of inclusion in the Guinness book of world of Records.

Sri Vasireddy Seethapathi and Smt.Gowri Devi Memorial Scholarship Endowment Fund:

This endowment fund was established by an anonymous donor . The awards are given as scholarships in equal amounts to two Guntur Medical College students each of whom scored the highest marks in the most recent MCET and I M.B.B.S. examinations respectively.

The third year awardees are :

1. **Usha Kiran Anne,** Highest score in EAMCET-2001-2002 Rank No. 5.
   Conducted by NTRUHS in Guntur.

2. **A. Anjani** : Highest score in 1st MBBS Exams Conducted by NTRUHS
Marks: Biochemistry 156/200; Anatomy:164/200; Physiology:142/200

Tummala Ramakrishna Sastrullu Memorial fund:

This endowment was established by Dr.Tummala Satyaprasad in memory his late grandfather Tummala Ramakrishnasastrullu. Dr.Satyaprasad is an alumnus of GMC (1976). The award will be given annually to the candidate who is economically backward but academically bright. The committee to identify the candidate will be formed by the coordinators of GMCANA along with the help of Principal and other staff.

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BOARD OF TRUSTEES:

Chairman: Veeraiah Chowdary Perni (64)

Chalapathi Rao Gudipati (71)
Aruna Prasad Kancherla (60)
Venkateswara Rao Kata (60)
Ramarao Kaza (65)
Bhaskaramurthy Ponnuru (63)
Prasadarao Ravella (66)
Harikrishna Reddy Syamala (65)
Venkata Subbarao Uppuluri (63)

COORIDNATORS AT GMC & GGH

Chief Coordinator:
Venkateswararao Nuthakki

Krishna Murthy Gade (71)
Renuka V Inuganti (74)
Asha Thota, (71)
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PREFACE

'WE CARE' — This is the Story of GMCANA. It gives an insight into the evolution of the thinking of GMCANA alumni regarding their dreams of *making GMC and GGH premier institutions of Medical Education, and Medical Care to all people, rich and poor.* It tries to do that by reproduction of the basic documents developed by GMCANA leaders over the past few years. It does not imply that the ideas presented here are the only means to accomplish this dream, but that they can serve as a basis for discussion by all stakeholders who then can contribute to the realization of the dream. We hope this will be a catalyst in promoting interest among all of the alumni, present and future.

Welcome to the Story of GMCANA. 'We Care' – So do you.

Ravikumar Tripuraneni

President, GMCANA

A ROAD MAP FOR GMCANA AND OTHER NON-PROFIT ORGANIZATIONS

Excerpts from "Managing the Non-Profit Organization" by Peter F. Drucker*

The product of non-profit organization is a **"changed human being".**

Non-profit organizations in this country collect 2-3 percent of Gross National Product. I consider it a national disgrace, indeed a real failure that the affluent, well-educated young people give proportionately less than their so much poorer blue collar parents used to give.

For a non-profit organization, the **mission** comes first. A mission statement has to be operational, otherwise it is just good intentions. It has to be simple and clear.

Only good intentions pave the way to Hell. We need to remind ourselves again and again that the results of a non-profit institution are always outside the organization, not inside. The moment we lose sight of the mission, we begin to stray, we waste resources. From the mission, one goes to very concrete goals.

The three 'musts' of a successful mission are: **Opportunities (needs), Competence and Commitment.** I have never seen anything being done well unless people were committed.

The **mission** is always long-range. But **action** is always short-term. So one always has to ask: Is this action step leading us toward our basic long-range goal, or is it going to sidetrack us?

We will have to look at the mission again and again to think through whether it needs to be refocused, because needs change, because we should abandon something that produces no results and eats up resources, because we have accomplished our objective.

Strategy begins with the mission. It leads to a work plan. It ends with the right tools. Strategy commits the non-profit organization to action. Its essence is **action** – putting together the mission, objectives, the market – and the right moment. Mission and plan are the good intentions. Strategies are the bulldozers. They convert what you want to do into accomplishment. Strategies are not something you **hope** for. Strategies are something you **work** for. With strategy, one always makes compromises on implementation. But one does not compromise on goals.

Converting good intentions into results – you need four things: **plan, marketing, people and money. It is much easier to sell the Brooklyn Bridge than to give it away. Nobody trusts you if you offer something for free.** You need to market even the most beneficial service.

When a strategy or an action doesn't seem to be working, the rule is "if at first you don't succeed, try once more. Then do something else. There are also true believers who are dedicated to a cause where success, failure and results are irrelevant, and we need such people. They are our conscience. But very few of them achieve.

We need to be result-driven. Yes, 'need' is always a reason but by itself, it is not enough. There also have to be **results.** Non-profit manager has to define results and report back to the donors, to show them that they are achieving results. There are always so many more moral causes to be served than we have resources for that the non-profit institution has a duty – toward its donors, toward its customers and toward its own volunteers – to allocate its scarce resources for results rather than to squander them on being righteous.

What could **marketing** be if it isn't selling? The shortest definition I've heard is that it is finding needs and filling them. I would add that it produces positive value for both parties. The contrast between marketing and selling is whether you start with customers, or consumers, or groups you want to serve well – that's marketing. If you start with a set of products you have, and want to push them out into any market you can find, that's selling. :know your customers". We know what is good for them. But what are their values? How do you reach them? It needs a marketing plan with specific objectives and goals.

If you have consensus on an important matter, don't make the decision. Adjourn it so that everybody has a little time to think. Important decisions are risky. They should be controversial. Acclamation means that nobody has done the homework. Look upon dissent as a means of creating understanding and mutual respect. A second reason to encourage dissent is that any organization needs a non-conformist.

Organizations are based on **trust.** Trust means that you know what to expect of people. Trust is mutual understanding. Not mutual love, not even mutual respect. Predictability. This is far more important in the non-profit organization, because typically it has to depend on the work of so many volunteers and on so many people whom it does not control.

Volunteer professionals get their satisfaction out of their work, not the paycheck. It is important someone says: "Thank you very much, you've made a major contribution". The leaders who work most effectively never say "I". They don't even **think** "I". They think "we". They think **"team".** This is what creates trust, what enables you to get the task done. Leaders take their roles seriously – not themselves seriously.

Fundraising is going around with a begging bowl, asking for money because the **need** is so great. Fund development is creating a constituency which supports the organization because it **deserves** it. It means developing what I call a membership that **participates** through giving. In fund development you appeal to the heart, but you also have to appeal to the head, and try to build a continuing effort. They see the support of the institution as self-fulfillment. That is the ultimate goal of fund development.

You need a board that takes an active lead in raising money, whose members give both of themselves and by being fund-raisers, fund **developers.** When a board member calls a potential donor and says, "I am on the board of the hospital", the first response he gets from his friend is, "How much are you giving yourself, John?" If the answer is five hundred bucks, well, that's all you're likely to get.

*Published in 1990 by Harper Collins.

A Brief History

Of Guntur Medical College Alumni of North of America (GMCANA)

The Early Years

On May 24, 1981, right in the midst of the 3rd North American Telugu Conference conducted by the Telugu Association of North America (TANA), several alumni of Guntur Medical College (GMC) gathered in a large room at the Oak Park and River Forest High School in Oak Park, Illinois. They decided that it was time for the Guntur Medical College Alumni living in North America to have an association of their own in order to meet the goals of raising money and material to promote teaching and patient care needs at Guntur Medical College and its affiliated institutions, and serving the needs of the alumni in North America.

Dr. Ramaiah Samala ('54) was elected as the First President, and a committee chaired by Dr. Rama Rao Kaza ('65) drafted the constitution. Other office bearers at that time included Dr. Seetharama Rao Bobba ('60) and Dr. Babu Rajendra Prasad Dandamudi ('64). Guntur Medical College Alumni of North America (GMCANA) was formally incorporated as a General Not For Profit Corporation in the State of Missouri on December 31st, 1981.

The First Reunion

During the early days, GMCANA would meet during the TANA Conferences. Dr. Srikrishna Murthy Nuthi ('59) succeeded Dr. Ramaiah as President. During his term, a GMCANA Grand Reunion and Convention was organized at the Rosemont Westin Hotel in Chicago on September 2-4, 1989. A membership directory was also published at that time marking the occasion. Dr. Ramaraja Bhushanudu Yalavarthi ('67) was the Convenor for this very successful reunion. This reunion is a milestone in the organization's history as the alumni met for the first time by themselves and could dedicate enough time to discuss, without distraction, issues relevant to GMC and GMC alumni. This meeting established the organization as a real viable entity, imparted enthusiasm, and spurred the growth of the organization.

Since then, the reunions now occuring biannually, held in the even numbered years, have become a major social event for the alumni and their families. (Since 1992, alumni of Rangaraya Medical College have been conducting their reunions together with GMCANA; Kurnool Medical College and Andhra Medical College have joined the group at different times). In odd-numbered years, GMCANA conducts a general body meeting at the time of the North American Telugu Conferences conducted by TANA.

The Second reunion was held the next year in Nashville, on November 9-11,1990. At this reunion, Dr. Ramaraja Bhushanudu Yalavarthi was elected as the third President of GMCANA. A new constitution was adopted. Decisions were taken regarding new projects that included CG Ramamurthy Memorial Fund, the first endowment fund setup by GMCANA. A check for $14,000 was sent to GMC to setup an annual continuing education seminar in Obstetrics and Gynecology. Dr. Ramakrishna Rao Pinnamaneni ('58) and Dr. Sriharidas Kanuru ('60) began coordinating the Alumni Building Project raising $100,000 within a year. GMCANA began publishing a newsletter, *Alumni News*, in April 1991with Dr. V. Chowdary Jampala ('72) was the first Editor. The newsletter ensured that the alumni are kept informed of all developments effecting GMC and GMCANA.

The Third reunion of GMCANA took place at Falls Church, VA (a suburb of Washington, DC), on August 21-23, 1992. Dr. Sriharidas Kanuru was elected as President. Dr. Peraiah Sudanagunta ('58) was elected as the Chairman of the Board of Trustees. A copy machine was purchased for use at GMC. Several new endowments were set up at GMC to provide continuing medical education in Cardiology, Internal Medicine, Maternal and Fetal Medicine, Surgery, Pediatrics, Orthopedics, and Health Education.

Dr. Mangaraju Vanapalli ('58) became President at the Fourth reunion in St. Louis on August 12-14, 1994. Dr. Seetaramarao Bobba was elected the Chairman of Board of Trustees. Efforts were undertaken to supply books and journals to the GMC Library. However, the Alumni Building Project got stalled due to bureaucratic hurdles and some of the alumni began questioning the commitment of the leaders of the parent institution.

Development of The Strategic Plan

Dr. V. Chowdary Jampala became President at the Fifth reunion in Atlanta on August 9-11, 1996. Dr. Mani Akkineni ('64) was elected the Chairman of Board of Trustees. During their term, GMCANA entered the electronic age with its own site on the World Wide Web at *www.gmcana.org*. Dr. Ravikumar Tripuraneni ('71), Chairman of Communications Committee, took the leadership in developing this web site which has become a major communication tool for the organization. GMCANA donated funds to install a bust of Dr. DJ Reddy at GMC and once again supplied books and journals to the library.

The Superintendent of the Government General Hospital (GGH) contacted GMCANA in 1996 asking for help to rejuvenate the hospital and help with the training resources. Drs. Venkata Subbarao Uppuluri ('63) and Aruna Prasad Kancherla ('60) visited GMC and GGH in 1997 on fact-finding missions and consulted with the leaders of the two institutions as well as local alumni. They made a preliminary assessment of the situation and determined that the training resources of the institutions were at an all time low, but the attitudes of the leaders of the institution were really positive. They felt that the time is ripe for GMCANA to help GMC once again become a great training institution if GMCANA and the leadership at GMC approached it the right way. Dr. Jampala and the executive committee developed a strategic plan for the rejuvenation of the institutions and the efforts kicked into high gear. At the urging of the then Member of Parliament from Guntur, Sri Rayapati Sambasiva Rao, the Andhra Pradesh State Government approved Dr. Jampala's request to appoint a Special Officer for development of GMC and GGH.

Redefining the Mission

At the Sixth Reunion in Pittsburgh (August 14-16, 1998), Dr. Aruna Prasad Kancherla took over as the President and Dr. Venkata Subbarao Uppuluri became President- Elect. Dr. Ravikumar Tripuraneni and Dr. Gowtham Mulpur ('75) were

elected as Secretary and treasurer. Dr. Ammani Dasari ('57) became the Chairman of the Board of Trustees.

This team immediately set out to refine the strategic plan with a focus group meeting in Chicago on November 11, 1998. The organization defined its mission: *"To help develop Guntur Medical College and Government General Hospital-Guntur, as premier modern Medical Education facilities for undergraduate and postgraduate medical students, staff, and medical community at large"*.

With the mission clear, GMCANA acted quickly. A fundraising campaign was developed. A set of "Frequently Asked Questions" (FAQ) and answers were developed to communicate easily with all members. Several fundraising dinners were held around USA. The web site and the newsletter provided all the alumni with the information regarding the various developments at GMC and GGH.

In a period of twelve months, GMCANA, with large donations from the alumni, provided GGH an X-ray unit, a fetal ultrasound monitor, a chemistry analyzer, a modern three-room operating theatre, and a large number of text books to the library. A Research Endowment Fund and a Scholarship Fund were established at GMC. A Continuing Medical Education Center with 3 computers, multimedia software and Internet access was established along with an additional reading room wit a capacity for 60 students was also established. In addition, an electronic teaching microscope with TV attachment for the department of pathology, a bronchoscope and PFT machine for the Govt.Fever hospital and an image intensifier for the X-ray department were also donated.

Suddenly, the postgraduates and medical students have a chance to learn and practice modern medicine, and their enthusiasm is revolutionizing the learning culture at Guntur Medical College. In the process, the quality of medical care delivered to the indigent people in the area has improved tremendously.

Auditorium and New Buildings

Dr. Venkata Subbarao Uppuluri was installed as President at the Seventh Reunion in New York (August 4-6, 2000). Dr. Ravikumar Tripuraneni became President- Elect. Drs. Gowtham Mulpur and Nagarjuna Ponugoti ('72) were elected as Secretary and Treasurer with Dr. Kaza Ramarao ('64) taking over as the Chairman of the Board of Trustees.

This team continued on the gains made by the previous leadership. They maintained constant communication with leadership of GMC and GGH; actively participated in the deliberations of the Hospital Development Society (HDS) chaired by the District Collector Hiralal Samaria; kept in touch with the local legislators, the Health Minister and the Chief Minister; and monitored all developments relevant to the institutions. The GMCANA leadership visited the parent facilities often and personally kept track of all projects and development activities. Communication between GMCANA leadership and the members has improved a great deal and funds were raised at a record pace.

The tenure of this committee is distinguished by several remarkable events: The GMCANA auditorium project, on the anvil for more than a decade, finally got off the ground with a combination of funds from GMCANA and the state government and construction has finally begun in April of 2002. This state of the art facility would remain a lasting symbol of the commitment of the North American Alumni of GMC to their parent institution. The generosity of GMCANA members has led to the renovation of the Infectious Diseases Hospital, and a new Obstetrics and Gynecology wing. Donations for various other equipment and teaching activities continued at an accelerated pace.

Comprehensive Proposal

Dr. Uppuluri and the GMCANA leadership developed a Comprehensive Proposal for Improvement of Medical Education and teaching hospitals in Andhra Pradesh and presented the proposal to the Chief Minister in December 2002. The Chief Minister agreed to implement some of the changes recommended in the proposal including opening the hospital for paying patients.

Elsewhere in this book, one can find a comprehensive list of the many projects that GMCANA is involved in at GMC and GGH. Clearly, GMC and GGH have turned the corner and thanks to the support and guidance of GMCANA are once again becoming the leaders in medical education in Andhra Pradesh.

Towards an Even More Glorious Future

GMC alumni met once again in 2002 in the place it all began, Chicago, the City of Big Shoulders. In the grand setting of the Chicago Hilton Towers, the eighth Grand Reunion was larger than ever! In a well organized general body meeting, the Executive Committee presented the progress over the past two years including the groundbreaking of the GMCANA Auditorium, and then the Chief Guest, Dr. Anji Reddy made an emotional presentation about the efforts to improve GGH and GMC. The properly impressed alumni responded generously. A large sum of money has been pledged within 30 minutes so that the auditorium project could be completed quickly. The alumni now are confident that the leadership in GMCANA and GGH/ GMC know how to get the best results effectively and are committed to working together for a glorious future. The alumni now are 'participating members'.

Dr. Ravikumar Tripuraneni was installed as President at the Eighth Reunion in New York (August 4-6, 2000). Dr. Gowtham Mulpur became President- Elect. Drs. Nagarjuna Ponugoti and Umadevi Gavini ('65) were elected as Secretary and Treasurer with Dr. Veeraiah Choudary Perni ('64) installed as the Chairman of the Board of Trustees.

We Care!

Several people from Guntur have been helpful to GMCANA in achieving the above. Besides the administrations of GGH and GMC, many local alumni and faculty from Guntur have been instrumental in these projects. Drs. Nutakki Venkateswara Rao and Venigalla Balabhaskara Rao. G. Krishnamurthy, I V Renuka, Asha Thota have been acting as liaisons between GMCANA and GMC/GGH. Dr. Anji Reddy, first as the superintendent of GGH and later as the Director General of Medical and Health Services, provided the necessary administrative leadership to create the necessary atmosphere to bring back GGH's eminence as a premier medical center. GMCANA heartily thanks each and every one of them.

All of this could not have happened without the generosity of the caring members of GMCANA. Several volunteers spend countless hours in planning and executing the various projects. The alumni generously donate significant amounts of money to develop GMC and GGH, two institutions that they care a lot about.

With new vigor, focus, and dedication, GMCANA, thanks to its large hearted donors and a strong volunteer force, has been forging ahead towards attaining its goals. We Care!

A Strategic Plan *for* Improvement of GMC & GGH December 1997

V.S.R. Chowdary Jampala, M.D. President, Guntur Medical College of North America

What GMCANA can and should do for GMC?

1. Utilization of GMCANA's Contributions to GMC so far:

The DJ Reddy Statue sponsored by GMCANA is installed on November 25, 1997 in the main hall of the college building, next to the principal's office.

The many endowments sponsored by GMCANA for continuing medical education resulted in several conferences. Since 1991, there have been 7 conferences in Obstetrics and Gynecology per the Prof. CG Ramamurthy memorial endowment fund, the oldest of our endowments. Of the more recent endowments, there was one CME Conference in Internal Medicine per the Vakamudi Tripurasundari Memorial Fund. The KRR Mohana Rao educational fund in Surgery has sponsored 2 conferences, one each year in 96 and 97. There are active plans for CME conferences being sponsored by Chalasani Nagaratnamma memorial endowment fund in Cardiology, Kodali Sugunamma memorial fund in maternal and fetal medicine and Kanuru health and educational endowment in Pediatrics.

The Professor Ethirajulu memorial Gold Medal in Orthopedics, sponsored by GMCANA, began to be awarded in September 1996.

The Xerox machine that we purchased for the library is still functioning, being maintained by funds generated locally. The library books that we made available over the years are being utilized by the students and postgraduates. I met with the librarian as well as several undergraduate and postgraduate students, who thanked GMCANA profusely for its contributions to the library and assured him that the donations are being well utilized.

In summary, all our previous contributions to GMC have a) helped enhance the educational activities at the college and are 2) being properly utilized.

2. A tour of the hospital and college revealed the following.

a) There has been very little done in the way of upgrading equipment and facilities at both the college and the hospital. One of the very clear results of this lack of updating is that the students, interns and post-graduates are not able to learn or practice modern medicine. For example, the lack of facilities in laboratory and radiological services mean that the trainees are not capable of properly ordering and interpreting the laboratory tests and integrating them into the care of the patient.

b) The hospital and college authorities have supplied a list of needed resources ranging from the most basic (microscopes in pathology and microbiology laboratories) to the advanced (CT scanner for the hospital). Also, almost all departments were unanimous in requesting basic audio-visual educational equipment.

c) It is also clear that there is a need for equipment and that the available equipment is being utilized maximum capacity. However, such maximum use also necessitates funds for maintenance which also unfortunately remain scarce.

d) Some of the faculty members have shown initiative and resolve in upgrading the facilities and clinical and educational resources even among these adverse circumstances.

3. What should our aims be in helping these institutions?

GMCANA cannot, of course, take on the role of enhancing the healthcare of the public through Government General Hospital, Guntur. That role properly belongs to the Government of Andhra Pradesh, which has the authority and responsibility to do so.

Even the responsibility of ensuring the quality of the educational experiences at Guntur Medical College and Government General Hospital properly belongs to the Government of Andhra Pradesh. However, as alumni, we have both philanthropic and vested interests in ensuring that educational standards at GMC are on par with or exceed accepted standards. We feel an obligation to our alma mater to ensure it remains a prestigious institution and that its graduates are treated with respect worldwide. We can achieve this only if we ensure that the educational facilities available to the trainees are adequate and are of the state of the art.

So, our aim should be that we enhance the educational experiences in both basic and clinical disciplines. This means that we should first assess these educational needs and then plan to fill those needs through our own efforts, through collaboration with the local community, and through collaboration with the local government.

4. Areas of concentration:

In this process, we need to establish some priorities and focus on the areas that need help most and that we can help most. To ensure a quality education, the minimum resources should include:

1) Good teachers
2) Good clinical material (patients)
3) Modern clinical facilities
4) Modern laboratory support
5) Good library
6) Continuing Medical Education

The provision of teachers has been a responsibility of the Government. There continues to be plenty of good clinical material as this still is the hospital for the masses in the area. It is the other three areas that we can help with both immediately and in the long term.

Clinical facilities: Each of the clinical departments presented a list of needs. However, even among these lists, some things stand out such as the operating rooms, which have not been updated in several years.

Laboratory support: At one time, medical college laboratories used to be the referral laboratories for private practitioners. Now, the situation is in reverse with most necessary lab and x-ray

tests for GGH patients needing to be performed outside. This is one of the areas that need immediate help.

Library: While we have consistently helped the library over the years, we need to continue to do so in an ongoing manner CME: Another area we can continually help.

5. **Problems and pitfalls.**

Historically, our previous efforts have been hampered by the following:

a) Lack of consistent leadership at GMC and GGH
b) Lack of coordination between GMCANA and GMC/ GGH
c) Communication problems
d) Questions about maintenance of equipment
e) Skepticism about utilization of resources.

The CM of AP has agreed to appoint a special officer whose responsibility it would be to enhance educational facilities at GGH/GMC. That should help with the first problem. The rest can be dealt with by setting up a structure that would help with coordination and communication.

6. **Coordination and Communication.**

We suggest the following:

a) GMCANA will appoint a local physician in Guntur as our 'local coordinator'. This person should enjoy GMCANA's confidence as having a demonstrated interest in the well-being of GMC/GGH and should have an abiding interest in medical education. This person will have the responsibility of

1) setting up a local board of advisors for evaluation and prioritization of all requests from GMC/GGH, convening their meetings on a periodic basis, setting up the agenda and drafting the minutes.
2) communicating a prioritized list of these needs to GMCANA
3) supervising all GMCANA projects in Guntur and providing annual progress reports to GMCANA.

The local coordinator may need some part time help which should be paid for by GMCANA.

b) GMCANA will form a GMC development committee with President serving as chairman and members serving four year terms on a rotating basis to provide continuity in the committee. This committee will review all requests and reports coming from the local coordinator and will act as needed.
c) All necessary equipment will be purchased by GMCANA (or the local coordinator on behalf of GMCANA) and delivered to GMC/GGH only after ensuring that a feasible plan for the utilization and maintenance of the equipment is in place.

The following is a schematic of how things should work for each project.

GMC/GGH prepares a prioritized request for needs, and includes plans for utilization and maintenance of that equipment

V

Local coordinator convenes a board of advisors meeting to evaluate and prioritize these requests

V

Local coordinator conveys his recommendations to GMCANA

V

GMCANA Development committee evaluates the recommendations and funds those projects deemed appropriate

V

Funds released to local coordinator /paid directly to the vendor to purchase equipment

V

Local coordinator sends progress report to GMCANA

7) **Current Needs**

A list of furnished by the various departments at GGH and GMC comes to almost 1 million dollars. To address the immediate needs of GMC/GGH and also to overcome the current skepticism of the members, we need to do the following:

a) It is not clear to us that the auditorium that we proposed to build is an immediate need. We suggest utilizing those funds (with the approval of the donors) as the beginning fund to address some immediate needs.
b) Develop a stepwise plan of funding these needs.
c) Work with the government to supplement the funds we provide so that there is an enhancement of facilities.
d) Based on the success of these initial projects, we can continue to raise funds locally to help with the other needs of these two institutions.

8) **Prioritized List**

A prioritized list can be developed based on the following characteristics:

a) The immediate need for the equipment and its impact on learning
b) The track record of the receiving department
c) cost and affordability

The following are identified as high priority needs (in lakhs of rupees):

Ultrasound unit with transvaginal probe:	7.0
OR and anesthetic equipment (2 suites)	7.8
Orthopedic c-arm x-ray plant	10.0
Pediatric surgery	
incubators and ventilators (2 sets)	12.4
Radiology	
500 MA Plant	8.5
700 MA plant	9.5
Computerized biochemistry lab	5.0
Biochemistry lab workbenches, gas burners	0.35
Anatomy cold storage units (3)	1.0
Microbiology microscopes	1.0
Pathology microscopes	1.0
Radiology (x-ray cassettes, processing	
equipment etc.)	1.35

These items can probably be supplied with the money currently on hand from the auditorium funds.

We can also give a grant of 5 to 10,000 dollars to the library for immediate enhancements, and a similar amount annually.

I believe that we now have an opportunity to get some concrete results with the right plan and implementation. We can demonstrate to the leadership at GMC/GGH and out own membership that things can indeed be changed and the future indeed can be very bright!

CHICAGO **FOCUS GROUP MEETING**

(November 11, 1998) Our President Aruna Prasad Kancherla met with several members in Chicago and discussed various issues. The following is a summary:

The Focus Group agreed with the President that the Directory Project is the number one priority. The idea is to include all alumni of GMC – whether members or not. Data is to be collected via our Website or the postcard enclosed with the newsletter as soon as possible. This GMC Directory is intended to be more comprehensive than the previous one and is due out in early 1999.

The Focus Group also developed a Mission Statement for our GMCANA Janmabhoomi Project:

> *"To help develop Guntur Medical College and Government General Hospital, Guntur as premier, modern Medical Education facilities for undergraduate and postgraduate medical students, staff and medical community at large".*

In other words, our focus should be primarily Educational activities and secondarily Patient Care Projects. Accordingly our major goals are GMCANA CME Center staffed by visiting Faculty and the GMCANA Multi- Media Center. However, all activities that increase Occupancy Rates and enhance Patient Care and thereby promote Educational activities should also be supported.

All Departments at GMC and GGH submitted lists of their needs. With the help of corresponding Specialty members, GMC Coordinator in Guntur and other interested members, the Executive Committee will categorize all the requests into four categories:

1. High impact and high feasibility
2. High impact and low feasibility
3. Low impact and high feasibility and
4. Low impact and low feasibility.

This final product will form the primary basis of our activities for the next year or two.

GMCANA Executive Committee makes all policy decisions for GMCANA and the President will implement the decisions by delegating responsibility to different people for selected projects. Define goals and implementation guidelines clearly before fundraising for specific projects.

Special emphasis should be placed in enhancing our credibility both here and at GMC.

As such, only high impact and high feasibility projects should be undertaken, at least in the beginning. We need to continually inform our members of all our donations - past, present and planned, and their impact – real and potential, through our newsletters and our website. At GMC, we should only promise what we can deliver and deliver what we promise in a timely manner.

Appoint GMCANA Janma Bhoomi Project Representative or Coordinator and an Advisory Board in Guntur with possibly a part-time office to facilitate our GMC activities as soon as possible.

It is noted that the Auditorium Project is being thoroughly reassessed by the Building Committee in consultation with all the Donors for the project. The Executive Committee is to act on the recommendations as soon as they are submitted.

Explore Janma Bhoomi Scheme and Naandi Foundation to find out if we can enhance our donations with matching grants from the government of A.P.

Fundraising activities discussed in detail. Multiple approaches are advocated. Donations by

(1) individuals,

(2) groups – eg.:

(a) different classes (class of 67 or 72 etc.) or

(b)different specialties (Ob.Gyn. or Anesthesia) adopting and overseeing specific projects ;

(c)donations in memory of friends, classmates, parents etc.;

(3) donations through pension plans (post-humous) as part of Estate Plans to maximize tax efficiency;

(4) VDTPP (Voluntary Deferred Tuition Payment Plan);

(5) Fundraising events.

(6) Marriage and grandparent gifts etc.

were discussed. We need to refine and implement these and other ideas.

It would also be helpful if all alumni channel their donations through GMCANA so that all efforts could be coordinated.

Finally, all these and other ideas are to be discussed, ratified and acted upon by the President and Executive Committee.

— submitted by
Venkata Subba Rao Uppuluri

Medical Education in Andhra Pradesh:

An Urgent Need for Administrative Reforms A COMPREHENSIVE PROPOSAL 2000 - 2001

Venkata Subba Rao Uppuluri, M.D.
President, Guntur Medical College Alumni of North America (GMCANA) for the Executive Committee, GMCANA

There are about 1500 of medical graduates from Guntur Medical College, many of them joining the college before the 1980s, in North America. Guntur Medical College Alumni of North America (GMCANA) is a very active organization with the mission of helping "develop Guntur Medical College and Government General Hospital, Guntur, as premier, modern medical education facilities for undergraduate and postgraduate medical students, staff, and medical community at large."

Over many years, particularly the last three, we have spent more than Rs.3 crores towards realizing that mission. This includes building operating rooms, a new wing at the fever hospital, furnishing urgently needed equipment, supplying books and journals to the library, providing scholarships, rewarding deserving students and faculty etc. This month, we are making a donation of 2.25 lakhs of dollars towards the construction of a new auditorium/ seminar hall. And yet, we consider our sweat equity and assessment that went into each project before implementation to be the more significant achievement than the actual monetary contributions.

Our members have had the good fortune of studying at Guntur Medical College and Government General Hospital when they were considered premier institutions, and having further post graduate education in some of the elite institutions in North America. Several of our members are active in medical education and research. We are all extremely concerned at the state of medical education at our alma mater and in the state. In particular, we feel that our students, house surgeons, and post-graduates, for no fault of their own, are not able to master the necessary modern clinical skills in the current environment. We are failing to properly prepare these extremely bright young people who have overcome several difficult hurdles and stiff competition in their quest to become physicians. A good mind is a terrible thing to waste.

Several problems, many of them systemic, impede our efforts at improving this situation. The projects that cannot be successfully implemented without reforms include Intensive Care Unit with state of the art ventilators, Dialysis Unit, Cardiac Surgery Unit, hospital ambulance, significant expansion of Biochemistry laboratory services, central Sterilizer etc., to name just a few. In addition, the benefits from existing programs and services to patients and medical students cannot be fully realized without reforms.

Having closely worked with the college, hospital and local authorities and legislators over a number of years, we understand that the problems seen at Guntur are not confined to Guntur Medical College alone; the same problems are prevalent through out the state. The current situation in medical education calls out for urgent and radical reforms. Otherwise, the graduates from our medical education system will continue to be poorly prepared to properly practice modern medicine.

Pursuit of excellence in medical education is not an elitist luxury. It provides the society with immediate rewards through excellence in specialized medical care at the teaching institutions and long-term benefits through providing the public with well trained physicians and advancing medical knowledge through research.

The predominant model of medical education all over the world is based on a good grounding of the normal anatomy and physiology in the earlier years followed by clinical training where the students learn to examine, diagnose and treat sick people. The clinical training requires a good, well equipped, teaching hospital and a diverse patient population. Both the college and the hospital need good laboratories, museums, and, above all, competent faculty dedicated to teaching and research.

A seniority system depriving the institutions of effective leadership:

One of the foremost problems we see is the lack of effective leadership at the helm of the medical colleges and teaching hospitals. Medical education has been changing rapidly in the last few decades and needs effective leadership to implement the advances. However, in our medical colleges, the senior-most professor is offered and selected to be the Principal without any regard to his/her aptitude or capability to direct and update undergraduate and postgraduate medical education. This is like the senior-most legislator becoming chief minister! Even in arts colleges or engineering colleges, the senior-most lecturer does not become the principal automatically. Why does medical education deserve such a system?

Compounding this problem is that the senior-most person who gets promoted to this job is very close to retirement. One of the principals was on the job for a single day. Even when the senior most person selected has the right capabilities, they rarely get to stay on the job for more than a few months.

In teaching hospitals, while all of the above still apply, the situation is even worse. Most superintendents do not have any administrative experience handling thousands of recalcitrant employees, let alone supervising medical care. Even those who do cannot devote all their energies to the job since it is a part time job and they have to tend to their own patient-care responsibilities. Even if some are extremely capable or tend to 'learn on the job' (who would want to do that in the last few months before retirement anyway?), by the time they learn the ropes, they retire!

Even worse, all the superiors, administrative and political, and the press are constantly after the Superintendent to "perform" and "know" everything that goes on in the hospital and blame him or her for everything that goes wrong!! Upgrading the 'Superintendent' position to 'Additional Director' status made it even worse as no senior person wants to give up the

opportunity to spend a few weeks or months in the job and retire with a higher pension and prestige. Only doctors who are actually capable of doing the job but have lucrative private practices forego the opportunity to avoid all the hassles of the job. The result is that there is no effective leadership and, more importantly, there cannot be a lasting and effective leadership, given the system.

In the early days, the medical college principals and teaching hospital superintendents were in their positions for several years at a time. That gave them the opportunity to understand what needs to be done, have a vision, and implement a plan to achieve that vision. The current system does not afford such an opportunity.

Not enough time spent on teaching:
The issue of "private practice" by government doctors has been a vexing one for more than 50 years. Some times, it was banned and at other times it was allowed in one form or the other. No matter what the policy was, the private practice always happened and no effective policing ever happened or could ever happen. The reasons are many. Access to specialists cannot be restricted. The elite of society, political, social and bureaucratic, has always obtained care they needed from the Specialist outside the government hospital.

Also, the salaries paid to physician specialists are meager when their training, responsibility and working hours are considered; especially so in comparison to the income of their peers in private practice. There is not enough of an incentive for highly talented and competent individuals to work in the government institutions. The result is that many competent physicians are opting to stay out of the government employment, and some of those in government service are tempted by private practice and are not spending enough time teaching in the colleges and hospitals. This directly leads to falling standards in medical education.

The knee jerk solution would be to ban private practice altogether. By now, over the last 50 years, we have enough experience to realize that this could never be implemented effectively in the past and is not likely in future. Even if it works, we are likely to end up with predominantly second or third rate doctors as teachers. The alternative would be to allow or condone private practice to augment doctors' incomes. This has led to the current situation resulting in not only deterioration in medical education but also degradation of hospital care to all patients, especially non-paying patients. Our goal should be to recruit and retain the most competent medical educators.

Lack of focus on equipment and infrastructure:
The declining budgets of the teaching facilities over the years led to a drastic negligence of maintenance and purchasing of necessary equipment. Currently, most of the teaching hospitals do not have the necessary equipment to do even basic laboratory and radiological tests. Advanced diagnostic and therapeutic equipment is mostly absent. Even when equipment is present, they become unusable in a short order due to inability to maintain them in good condition. It appears that even small private hospitals have better diagnostic and therapeutic equipment than many teaching hospitals.

The magnificent buildings of yesteryears have become dilapidated with age, or have become unsuitable for modern medicine. They need urgent repairs and renovation.

An absence of diverse patients:
It is not surprising that any person who can obtain their care at a private facility does not want to come to the government hospitals anymore. This, in turn, changes the patient mix of the hospital. The trainees get cheated in the process as they do not have enough patients to learn from.

Also, when patients go to mandal and district level government hospitals and need more advanced care at the teaching hospitals, there is not a good referral system in place. The patients are left to fend for themselves. This puts a hardship on the patients and families and leaves the students without adequate access to interesting and challenging cases.

Lack of a well structured Teaching Environment, especially for the Post-graduate students:
For a trainee interested in medical education, particularly the post graduates training to be specialists in a filed, the teaching environment is found wanting in several respects. Often, there is a shortage of good teachers, modern diagnostic facilities, adequate libraries and advanced search facilities. More importantly a culture of learning is missing. The lack of educational leadership is clearly evident.

Failure to use available teaching resources in the community:
Medical education facilities in USA and across the modern world realize the important contributions that can be made by volunteer faculty and go to great lengths to attract private practitioners to teach the trainees; clinical rotations in private practice settings are developed so that the trainees are exposed to diverse clinical populations and are better prepared to practice in the real world. We find that our current system completely ignores these resources even when they offer better training opportunities for the trainees. For example, a radiology post graduate in a teaching hospital without a MRI or a CT scanner does not get to rotate in a private facility with such scanners.

Poor functioning of the support staff:
Physicians alone do not make a great hospital or a teaching institution. It needs to have dedicated nursing, laboratory, administrative staff. It is our experience that the current system has created a culture where patient care has taken a second seat to employee convenience and/or corruption.

Lack of stakeholder involvement:
In the current system, there is not much opportunity for the stakeholders, the consumers of healthcare and the local administrative bodies to get involved in matters effecting the hospital and medical colleges. The recent constitution of hospital development societies is a step in the right direction.

Lack of resources and failure to develop additional revenues:
Of course, our medical colleges and teaching hospitals are entirely dependent on government grants. Decades of budgetary woes of the government have left these institutions in the current situation. The institutions themselves, for a variety of reasons, could not develop additional revenues to offset the declining government budgets.

What should we do about these problems?

While the current system served its purpose well for many years, it has not kept pace with changes in medical education and medical practice. We have felt, for quite some time now, the acute need to institute some reforms without which no further progress can be made. We have culled these ideas from our own members, from the staff members of Guntur Medical College and Government General Hospital, Guntur and local administrative, political and social leaders some of whose opinions were expressed in a recent Town Hall meeting conducted by Eenadu newspaper. We developed a set of proposals after extensive thought and discussion within our membership and synthesized it into a 'Comprehensive Proposal for reforms. While all these ideas are developed for GMC and GGH, they are equally applicable to all allopathic medical colleges and teaching hospitals in the State.

As physicians trained both in India and North America, we have a unique perspective regarding medical education. Yet, in spite of the fact we are in North America, the proposed reforms are not based solely on a foreign system. It is rooted in incremental changes to our existing system, changes based on local imperatives.

Pursuing a clear mission:
Modern management principles suggest that for an organization to succeed, it should have a clear mission that dictates the course of the organization. An unambiguous mission statement should be developed and efforts directed to implement it to the full extent. An example of a mission statement for a teaching hospital could be:

To provide excellent, affordable medical care to all patients, irrespective of ability to pay.

To provide excellent, caring medical education to undergraduate and postgraduate medical students and nursing and ancillary personnel.

To provide state of the art medical facilities so we can truly serve as a referral hospital for complicated cases in four districts.

It is extremely important to for the administrators and employees of these institutions to keep their focus on these goals and not be distracted by less important issues or extraneous factors.

Developing an independent Healthcare Administrator cadre by legislation:
We suggest that the Superintendent and Principal positions be delinked from the current seniority based system where the civil surgeon with the most seniority gets appointed to these posts without regard to their educational and administrative capabilities. A candidate with a degree and/or experience in hospital administration needs to be sought for the post of the Superintendent; such a candidate does not even need to be a physician. Someone with a demonstrated aptitude for medical education should be sought for the post of the Principal. In other words, these two positions should be 'selection grade' appointments. They should be given a 'contract' for a period of 5 years and made accountable primarily to the Hospital Development Society (HDS) under the leadership of the District Collector and secondarily to the Director General of Medical and Health Services.

These should be **full time** positions since the current part time positions are incompatible with effective management of a 1000 bed hospital or several hundred undergraduate and postgraduate medical students.

Only legislation can effectively implement these changes and avoid litigation. An "Allopathic Medical Colleges and Teaching Hospitals Leadership Selection Act" needs to be passed. Credentials of all candidates may be approved by Director General of Medical and Health Services and the local Hospital Development Societies could be allowed to compete for the right candidates from the list. The Superintendent and the Principal should have the authority to reorganize, hire and take appropriate disciplinary actions against all hospital and college employees. Responsibility without such authority does not lead to improved efficiency of the institutions. In turn, the Superintendent and the Principal themselves should be accountable to HDS and Director General of Medical and Health Services for achieving the mission of their institutions.

Changing the incentive structure for medical staff:
An incentive structure that would encourage the Medical Staff spend **all** their time in the Hospital or College should be developed. We propose that **"Unlimited paying patient practice allowed for all Medical Staff in the Teaching Hospital."** Up to 50% beds in the teaching hospital can be allocated to paying patients (non - white cardholders) by expanding the B class and C class beds.

The Proposal is implemented by creating facilities and working conditions conducive to care of paying patients rather than prohibiting private practice outside. The current regulations regarding private practice are not altered.

In addition, *the financial interaction between the clinical Medical Staff and their paying patients should be entirely private.* While the hospital can charge and collect fees from the paying patients for 'hospital services' – room, x-ray, lab. etc. – the Hospital should not have anything to do with charges for professional services rendered by the clinical Medical Staff. The Hospital will pay incentive money to the physicians in hospital based specialties – Pathology, Anesthesiology, Radiology and Casualty – from out of its collections for hospital services. These payments are to be based on the amount of work done. **At least 50% of the total beds in the hospital would be reserved for white cardholders.**

This single measure will change the entire paradigm with a new incentive structure and will provide the following benefits:

1. Additional revenues to the hospital which will ensure a good hospital with excellent physical plant and equipment. In addition, citizen donations and NRI contributions can be tapped with the assurance of optimal utilization of the funds.

2. The Medical Staff will be much more efficient and productive, and not having to travel all over the city, will find time to teach and research. They will be more fairly compensated for their knowledge, skills and amount of hard work.

3. The paying patients will have excellent care in all specialties, all under one roof at a discount price, compared to the market prices.

4. The patients who are paying for their services will demand and ensure that the services in the facility are good, and the medical staff also have a stake in ensuring a well functioning hospital that will help generate them income from private patients.

5. Undergraduate and postgraduate students will have access to patients belonging to all strata of society with all different problems. They can work with paying and nonpaying patients under supervision of their teachers round the clock and learn to be superior physicians. Medical Education will be the single most important beneficiary of this change in the system.

This would be a **'win, win, win, win'** situation for all stakeholders.

Improving the teaching environment:
It is extremely important that the Principal of the Medical College should be a full time administrator and academician, closely involved in **every day** teaching schedules at the College and Hospital and constantly updating curriculum, teaching methods and research opportunities. For starters, all conference schedules as being practiced at Nijam's Institute of Medical Sciences (NIMS) should be adopted 'as is' by all teaching hospitals.

Utilizing teaching resources in the community:
There are excellent physicians, some with great aptitude for teaching, in the community outside the teaching hospitals. We should provide an avenue for them to teach in or out of the teaching hospital. The students may even 'rotate' through some of these private hospitals for additional and alternate learning experiences. The physicians may be compensated by conferring on them honorary teaching designations (for example, Honourary Associate or Assistant Professor). They may not have any 'units' or 'beds' in the hospital and not monetarily compensated, but the opportunity to teach will make the appropriate candidates very happy while at the same time the students will benefit from learning from a different perspective. Also, the trainees should have an opportunity to rotate in community facilities that have advanced equipment not available in the teaching hospital.

Developing and maintaining equipment and other infra-struture:
All the money collected under the "Nominal Payment Program" should be used only for medical equipment. In addition, up to 50% of the annual development grant from the government should be used for the equipment as opposed to pure physical plant maintenance. NRI funds could also be used for equipment. To tackle another big problem which is in maintenance of the equipment, the Superintendent should have the power to authorize the basic maintenance of the equipment costing minimal amounts instead of having to go through the current bureaucratic procedures.

Medical care and education have changed enormously over the past 50 years. The policy of handing over all the money for hospital development to R&B department, enacted in the days when medical equipment was minimal, is archaic now. Within the supervision of HDS, the hospital Superintendent should have the **primary** responsibility of **prioritizing** the needs of the hospital, in consultation with all the departments.

Involving citizenry in institution development and operations:
Establish Citizen Committees to take greater responsibility and develop 'stakeholdership' on the lines of 'Rogi Kalyan Samithis' in Indore, Madhya Pradesh, for which its founder, Mr. Mohanty received a Global Development Award. Interestingly, the very first problem they handled was "rat menace" – the main current problem at Government General Hospital, Guntur.

Hospital Development Societies involving representations from all groups of stakeholders (community members, legislators, district, hospital and college administrators, faculty and students etc) should be encouraged to regularly evaluate the functioning of the institutions. develop strategic plans, and raise funds to implement these plans.

Take action against inefficient and corrupt employees
An able, stable and full time Superintendent (or principal) with appropriate authority should help alleviate this problem to a great degree. The permanent solution is to privatize the administration of the Hospital. This may seem far fetched but recently, the state government handed over the management of University General Hospital in Vijayawada to Kanaka Durga Temple Trust. And the Communist West Bengal Government has announced privatization of the government hospitals.

Establish a Referral System for patients from peripheral hospitals
A system should be developed so that patients from PHCs and Taluk hospitals are 'referred' directly to the needed specialists at Teaching Hospitals. APVVP could closely work with DMS to establish such a system.

DISCUSSION OF THE "COMPREHENSIVE PRO-POSAL"

What will prevent the medical staff from spending all their time in private practice and not in teaching or providing free care to the 'white card holders'?
Answer: This is where the comprehensiveness of our Proposal comes into play. The tenured Principal will enforce and ensure adherence to the teaching schedule, based on bench-mark NIMS schedule. The house surgeons and postgraduate students will gain responsibility by primarily taking care of patients with the with graduated increase in responsibility for the trainees under the guidance and supervision of faculty.. Currently, even the senior postgraduates (who will be branded 'specialists' within a few weeks or months) may not have the opportunity to take on this direct responsibility. This is a major gap in the current system. In any postgraduate training program in the USA, senior postgraduates are independently in charge of indigent patients while still under the guidance of teaching staff. In addition, house surgeons and postgraduates will help teaching staff manage their private patients, thus gaining invaluable experience in management of all classes of patients.

Are we giving away government assets to private practice?
Answer: On the contrary, we are gaining additional resources from paying patients, both financial and political which will help improve facilities that result in better care not only for private patients but also non-paying white card holders and also, in the process, improve medical education, providing better specialists for the society.

An essential component of this proposal is equal access to all facilities for all patients and equal access to all patients for all students. The obligations of the Government are not confined to care of poor patients. Especially in Teaching Hospitals, they include Medical Education and Research in addition to care of poor patients. As the government already recognized (and is charging 'user fees' for lab and x-ray for resource mobilization), the government role and monopoly in Medical Education does not preclude private-public partnership. Involvement of private citizens in developing financial resources and exercising oversight function through active participation in HDS will only enhance both medical care and medical education.

"We are helping doctors make more money". Are they not "double dipping"(getting paid twice for the same work) by engaging in care of paying patients?

Answer: There is nothing wrong in working hard, providing needed service and making money, as long as the responsibilities of teaching and research are fulfilled. Doctors' incomes cannot be restricted without the society suffering lack of advanced, and advances in, medical care. With current incentives, many physicians good at their work and teaching do not find it attractive to enter or stay in the teaching system and are 'lost' forever to medical education. The salaries are to be viewed as payment for Teaching and care of non-paying patients. The issue for the government is not what the doctors earn but what is the best way to realize its twin goals of superior medical education and excellent medical care to all patients, regardless of the ability to pay.

"Driving out good doctor teachers is only theoretical since no one resigned after recent strict enforcement of non-private practice regulations."

Answer: It has not happened so far only because, from past experience, everybody knows and expects the enforcement to get lax with time, with political pressure or with change of leadership. This behavior is not sustainable. There are some very good doctors who juggle good teaching and successful private practice and pushed to make a choice, they will resign. Thus successful enforcement of the ban on private practice will impoverish medical education and unsuccessful implementation will restore 'status quo' with all its problems.

Recently a G.O. was issued not to post anyone to additional Director positions (Principal or Superintendent) if they do not have at least one year of service left before retirement. Is this not enough?

Answer: This is a good beginning, and addresses part of the problem. We would like to see at least 3 to 5 years of tenure. In addition, this does not address the issue of competence by basing it solely on seniority. It may even be counter-productive if an unsuitable candidate holds the office for an extended period of time.

"There are excellent doctors in government service who do not practice outside and devote all their energies to Teaching. Why can everyone not follow their lead and example?"

Answer: As everyone knows they are few and far between and are exceptions rather than the rule. Any 'system' should address the majority and not the exceptions. We should remember that the 'best' physicians with advanced qualifications increasingly choose not to enter the government service or leave the government service quickly as they realize the inadequacies of the incentive system.

"The real solution is privatizing entire Medical Education and Teaching Hospitals."

Answer: This sounds appealing and is an option. The Government of India Committee of Health Care recommended corporatization of Government Hospitals. However, when the focus is on the bottom line as it would be with private hospitals, the non-paying patients will suffer and the government's social obligation to non-paying patients will be unrealized. In addition, the best teaching programs anywhere in the world are those that incorporate care of both paying and non-paying patients. Hands-on education will suffer if teaching hospitals have only paying patients.

"Why can the students not be 'rotated' in private hospitals?"

Answer: They can and should be, but not exclusively. It needs a visionary Principal to integrate private hospitals into teaching rotations. It is not possible to make it work unless the Principal is selected for his qualifications and given a tenure of 3 to 5 years rather than someone who is there by virtue only of 'seniority'.

"There will be abuse in the 'white card holder system"

Answer: This is entirely the responsibility of the government administration and is outside the purview of doctors and hospitals.

DISCUSSION OF ADDITIONAL IDEAS:

We applaud the efforts of 'EENADU' newspaper that extensively chronicled the problems of Government General Hospital, Guntur over the last couple of years. We are pleasantly surprised to note that 'Eenadu' conducted a 'Town Hall Meeting' on the issue of development of GGH, Guntur in "Dinosaur Auditorium" of Gandhi Park, Guntur. Political, social and administrative leaders expressed their opinions and suggestions freely.

'HOUSECALLS' magazine recently published a panel discussion on "Declining Standards in Medical Education". Several prominent physicians were interviewed by our own GMC alumnus, Dr.Jyotsna Codaty. Several ideas were advanced.

In our efforts to improve GGH and GMC over last three years, we came across several problems and some solutions. In addition, during our market survey over last year and a half, several other ideas came to light.

We incorporated many of these ideas in our "Comprehensive Proposal".

Some of the other ideas are discussed below.

1. The patients, doctors and students should all have "feeling of Ownership" in Government General Hospital".
   Mr. Hiralal Samaria, District Collector.

■We could not agree more.

2. "Consumer Awareness" is very important
   Dr. Chigurupati Nageswara Rao

■Eenadu, Vaartha and others are doing a great service in this regard. The HDS and Hospital could do a lot more by establishing and publicizing a "MISSION STATEMENT" and by being

'transparent' in all activities.

3. "A full time Superintendent is a must" "The physician salaries are inadequate"

Dr.K.Sadasiva Rao

■We incorporated solutions to these problems in our Plan.

4. "No new Specialists are joining and existing Specialists are leaving"

Eenadu

■This is an acute problem, especially with establishment of new Medical Colleges. Our Comprehensive Plan will solve this issue.

Capable physicians interested in teaching **and** medical practice will find a welcome place in the Teaching Hospital System. Those in private practice with an aptitude for teaching will find an outlet in the 'Honourary Professor System'. If these proposals are not implemented, the Teaching Hospitals will be left by and large with "Teachers" who have 'nowhere else to go' and **not** the 'best, brightest or interested'.

5. "The finances allotted to Medical Institutions are downgraded annually."

Dr.Sunil Pandya, Professor of Neurosurgery in "Housecalls"

■Additional allotment from the government is no doubt essential. The 'Nominal Payment Programme' and private donations willaugment these funds. And our proposed 'system' with its incentive structure will make sure these funds are utilized wisely.

6. "The government has come up with ideas that the institution should generate funds for itself. Even this is O.K., but they interfere in how or where or which department should be allocated the funds generated by the department. This is neither privatization nor autonomy. It is like 'you do the work and generate funds, but we will be the boss who tells you where to use them'." — 'Housecalls'

■It is important to make grassroots departments have a say in how the funds collected from the patients will be spent. The Superintendent can evaluate all claims and decide equitably for the good of the institution. He/she of course should be accountable to HDS.

7. "The medical colleges and the private sector have different strengths. While the medical colleges are strong in basic sciences like Anatomy and Physiology, the private sector is well equipped with ultra modern gadgets. A marriage between the two would be an ideal teaching and learning experience, along with a rotation with experienced GPs in training young doctors."

Dr. Sunil Pandya in "Housecalls"

■These ideas are incorporated in our Proposal.

8. "Transparency in hospital spending and performance is essential to promote consumer awareness and participation."

Several speakers at 'Eenadu' Forum

■ We recommend newspapers to publish details of all funding and spending as well as performance reports, both positive and negative at least once a month, following every meeting of HDS.

9. "Nothing can be changed in the system. There are enough private hospitals coming up."

Anonymous

■ Though this may seem true for the rich and powerful, it is not really so, even for them. If an MLA or Minister is on tour and gets sick or injured, it is the nearest local hospital that gets to take care of him or her in the critical moments. Besides, in the best of times, only a fraction of one percent of population can be served by the private hospitals. Of course, such a statement totally ignores the health care needs of all but few people and the medical education needs of the entire state. It also challenges the capacity of the government, the society and the system to reform themselves and we feel such **extreme** cynicism is not warranted.

Other comments expressed at the 'Eenadu Forum':

"Ideas of 'Dean' and 'Evening clinics' to be explored"

Dr. S.Aruna, Honourable Health Minister

"We should enhance the credibility of Government Hospitals and Doctor"

Alapati Rajendra Prasad, Honourable Minister for Technical Education

"We should properly and productively spend the donations from philanthropists so that they can donate more.

Y.V.Rao, Honourable Member of Parliament

"Consumers should feel awareness and responsibility for their own care and work constructively to improve care, instead of just criticizing.

J.Purnachandra Rao, District Police Superintendent

"It is important that in addition to doctors and patients, administrators, political leaders and hospital staff should be stakeholders in the development of the hospital

Dr. Fiaz Ahmed, Superintendent, GGH.

Conclusions

None of our proposals is 'new' or 'radical'. However, what we have proposed is a **Comprehensive System** which maximizes effectiveness of the changes already made and proposed new changes leading to the realization of our dreams of improved medical care and education. While every proposal is good in and of itself, it cannot be successful without implementation of other proposals. For example, evening private clinics within the Hospital did not and will not work without at the same time creating needed facilities and working infrastructure in the hospital and without at the same time totally prohibiting outside private practice. Similarly, private practice within the hospital itself will not pay any dividends to medical education unless coupled with a strong, full time educational leader as Principal, ensuring daily educational conferences and activities as already developed by NIMS.

We would like everybody interested in good healthcare in the state to support quick implementation of these reforms.

"Presented by the GMCANA Executive Committee to the Chief Minister of Andhra Pradesh on 10 December 2001"

I CARE - WE CARE

June 2002



'I CARE' – This sums it all up. The reason for the existence of GMCANA. The sentiment that will transform the landscape. The feeling that could be infectious. The idea whose time is long overdue. The concept, nurtured properly, that will help us realize our mission statement. The central piece that can help complete the puzzle. The essence of our lessons from intense involvement in GMC and GGH over the last 4 years. 'I CARE' – NOT 'WE CARE' since the latter often ends up meaning 'everyone else except ME'. Hence the dedication of this Reunion issue to 'I CARE'.

No, contrary to popular opinion there is no dearth of money; no, there is no deficit of talent; no, there is no short supply of patients; no, there is no laziness when the work is rewarded appropriately. Yet the health care product in the Government teaching hospitals is worse now than it was 30 years ago. Why? As India's future President, A.P.J. Abdul Kalam aptly points out, "Our excuse: it's the whole system ….. so who's going to change the system? What does a system consist of? Very conveniently for us it consists of our neighbors, other households, other cities, other communities and the government. But definitely not me and you."

So all members of GMCANA 'Cared'; cared for the past several years; cared when they adopted its mission statement; cared when they translated it into action by spending and planning to spend more than $750,000; cared when the money is spent with a definite plan so lot of equipment that actually works in GGH today has been donated by GMCANA and cared enough to present a Comprehensive Proposal of reforms to the State Government when they realized further progress depends on systemic change. As Nicolo Machiavelli so long ago stated "There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its outcome, than to take the lead in introducing a new order of things." But lead we must take since no one else is better qualified or equipped than us with our perspective and insights into two entirely different systems.

As the venerable Dhirubhai Ambani declared "you have to sell your ideas to the government. Selling the idea is the most important thing, and for that I'll meet anybody in the government. I am willing to salaam anyone." As much as this is true for business it is even more true in the social sector. We are glad to report that Sri Chandra Babu Naidu reacted favorably to our Proposal and ordered implementation of part of the proposal at GGH on a trial basis (25% of beds to be private paying beds). It is our responsibility to make it succeed and be adopted statewide. It is our responsibility to sell the rest of the items/agenda in our COMPREHENSIVE Proposal. And GMCANA will strive for it, because it cares and all its members care and all of them feel 'I Care'. All our efforts are beginning to pay off: recent announcement that GGH is awarded 'A' grade among all the teaching hospitals in the State. A good beginning it is but no more. While Osmania figures in the top ten teaching hospitals in India, we do not find GGH/GMC in that list. There is a lot more to plan, a lot more to strategize and a lot more to execute. But the goal remains the same: "To help develop Guntur Medical College and Government General Hospital, Guntur, as premier, modern Medical Education facilities for undergraduate and postgraduate medical students, staff and medical community at large." And the ultimate goal, in the words of Peter Drukker, the goal of any non-profit organization, is a "Changed Human Being."

Let us get to work. Let us all say 'I CARE'! Let us translate that sentiment into action!!

I CARE ! YOU CARE !! WE CARE !!!

Venkata Subbarao Uppuluri, class of 1963

(From the 2002 GMCANA Directory)

CHICAGO FOCUS GROUP MEETING II

November 2002

Success of the recent 8th Biannual GMCANA Reunion is celebrated. The operating profit of the Reunion is resolved to be used for a worthy cause at GMC like an Ambulance for the newly conceptualized Trauma Centre.

It was noted with satisfaction that the GMCANA AUDITORIUM construction is progressing well. Different ways of increasing its utilization are explored. Public Health Education and use of the facilities for upscale non-medical meetings in Guntur are considered. In this regard, separate access through the Deyyala Meda site is considered essential to avoid disturbance to the Medical College activities.

It is proposed to establish Specialty Coordinators between GMCANA and GMC to enhance the level of cooperation at all levels. CME could be extended from lectures to actual surgery, clinical rounds etc.

The status of 'Comprehensive Proposal' is reviewed. All the proposals are to be pursued vigorously.

Several measures could be taken up by HDS for improvement of GGH and GMC. Some of them are:

1. Deliberate and adopt the goal of GGH and GMC.

   Examples: GGH: To be the Best Hospital in Coastal Andhra Pradesh GMC: To be the best Medical College in the State of Andhra Pradesh Develop a motto to be displayed prominently next to the name of the Hospsital. Example: "Rich or Poor – Excellent Service for All"

2. Consider change in the Telugu name of the Hospital. The word 'Saadhaarana'needs to be dropped. Examples of potential names: 'Prabhuthva Samagra Aasupathri' (true translation of Government General Hospital) or 'Prabhuthva Bodhana Aasupathri' (to reflect the true mission of the hospital)

3. Adopt a Mission Statement for the Hospital to express the goals mentioned above.

   Example: "To provide excellent, affordable medical care to all patients regardless of ability to pay. To provide excellent medical education to undergraduate and postgraduate medical students and nursing and ancillary personnel. To provide state of the art medical facilities so it can truly serve as a referral hospital for complicated cases in coastal districts."

4. A 'LONG RANGE PLAN' needs to be developed taking into account the goals mentioned above. Strategies could then be developed to translate the Plan into reality.

5. Leadership issue as outlined in GMCANA COMPREHENSIVE PROPOSAL could be pursued so that the strategies of Long Range Plan could successfully be implemented.

6. "Infrastructure" is a priority and it includes physical plant, equipment and maintenance, personnel and the organizational dynamics. All government funds are to be channeled through HDS. The assessment of needs and Capital Budget Process should be a 'bottom up' process conforming to the Long Range Plan and starting with requests from each department submitted to the Superintendent, deliberated by the entire Medical Staff, prioritized and submitted to HDS for implementation.

7. "THINK ONE HOSPITAL" – Duplication of facilities and equipment is to be avoided where possible. Efficiency and productivity should be enhanced.

8. All Operation Theatres could be centralized in one building to improve patient care and efficiency. For example, this could take the form of adding one or two floors to the newly proposed OB Delivery Room Block.

9. 'User Fees' collection could be streamlined. It should apply to all services and all non-white card holder patients. The user fees on tests and services are to be used solely to maintain the equipment and acquire new equipment and such use could be adequately publicized to enhance patient satisfaction, cooperation and compliance.

10. HDS could also include prominent philanthropic citizens who could help develop funds for the hospital and college. A "PUBLIC-PRIVATE PARTNERSHIP" is to be actively pursued with local citizens, GMCANA and other NRIs taking an active role in the improvement of the hospital.

11. Computerization could be pursued to bring in transparency, accountability and efficiency.

12. Employee governance could be reformed. The Government is already using the 'contract' appointments. In addition, the existing nursing and 4th class employees could be made accountable to the Unit Chief where they work. Exceptionally performing employees as recommended by the Unit Chief could receive a bonus or recognized in some way.

13. "Public-Private Partnership" could also be tapped for the construction of a new 'paying patient block' of about 100 to 200 beds to implement the '25% paying beds at GGH' as approved by the Chief Minister on Dec. 10, 2001.

In summary, HDS should be the ultimate governing body of GMC and GGH and needs to take a more active and day to day role in setting policies, planning and executing long range plans and oversee all aspects of GMC and GGH.

Submitted by
Ramaraja B. Yalavarthi

Projects and Endowments

List of Completed Projects:

1) Copier , Text books, journals, in early 1990's
2) CME center, Several computers, printers, internet connections. Over 75 educational Cd Roms
   New state of the art XEROX multi purpose copier/ laser printer, Scanner and Color printer, Digital camera with accessories and Notebook computer.
3) 500 MA x-ray plant, 300 MA Wipro - GE X-ray image intensifier.
4) Several multi purpose monitors to the OR with EKG, SPO2, NIBP, ETCO2,Temp.
5) Physical therapy equipment for Orthopedics dept,
6) Pediatrics: Ventilator, Incubators, nebulizers, emergency cart.
7) Ultrasound machine, Fetal monitor and infusion pumps for OB & Gyn Dept. ,
8) Emergency OR 3 rooms fully air-conditioned and with all equipment.
9) ABG machine, Biochemistry lab with immediate results,
10) Central monitoring, Infusion pumps, Defibrillators, EKG machine in Cardiology.
11) Fiber optic Bronchoscope, PFT machine for Govt Fever hospital
12) LCD projector, Slide projector for CME purposes.
13) Text Books and journals to the Library in 1999
14) EEG and EMG machines to Neurology Dept.
15) Urology equipment in ORs. Elerctrocautery equipment to Surgery dept.
16) Computer with printer and various anesthesia equipment to Dept. of Anesthesia.
17) A modern Leica teaching microscope, remote display 30" Flat panel monitor,
18) Computer room with computer, printer, scanner, digital camera for Pathology dept
19) Colonoscope and other endoscopes for GE dept.
20) Seventy chairs to the nurses quarters GGH for nursing school education needs. 60
    Chairs to the Library at GMC.
21) Text Books worth Rs 2 Lakhs in November 2002.

Projects under construction :

1) GMCANA Auditorium
2) In patient building at Govt. Fever Hospital
3) New building for Maternity Unit at GGH
4) Intensive care unit.

Endowment funds:

1. Mrs. Chalsani Nagaratnamma Memorial Endowment in Cardiology donated by Dr. Narasimha Rao and Aruna Patibandala.

2. Mrs. Vakamudi Tripura Sundari Memorial endowment in Internal Medicine donated by Drs. Lalitha and Narayana Rao Kosuri, Drs. Hemakumar and Rama Vakamudi, and Drs. Ashok and Sudha Vakamudi.

3. Mrs. Kodali Sugunamma Memorial Endowment in Material and Fetal Medicine donated by Drs. Vijayalakshmi and Lakshmana Rao Nimmagadda.

4. Dr. K.R.R. Mohan Rao Educational Endowment in Surgery donated by Drs. Ramakrishna Rao and Nirmala Pinnamaneni.

5. Kanuru Health and Education endowment in Pediatrics donated by Kanuru Health and Education Trust donated by Mrs & Dr.Sriharidas Kanuru.

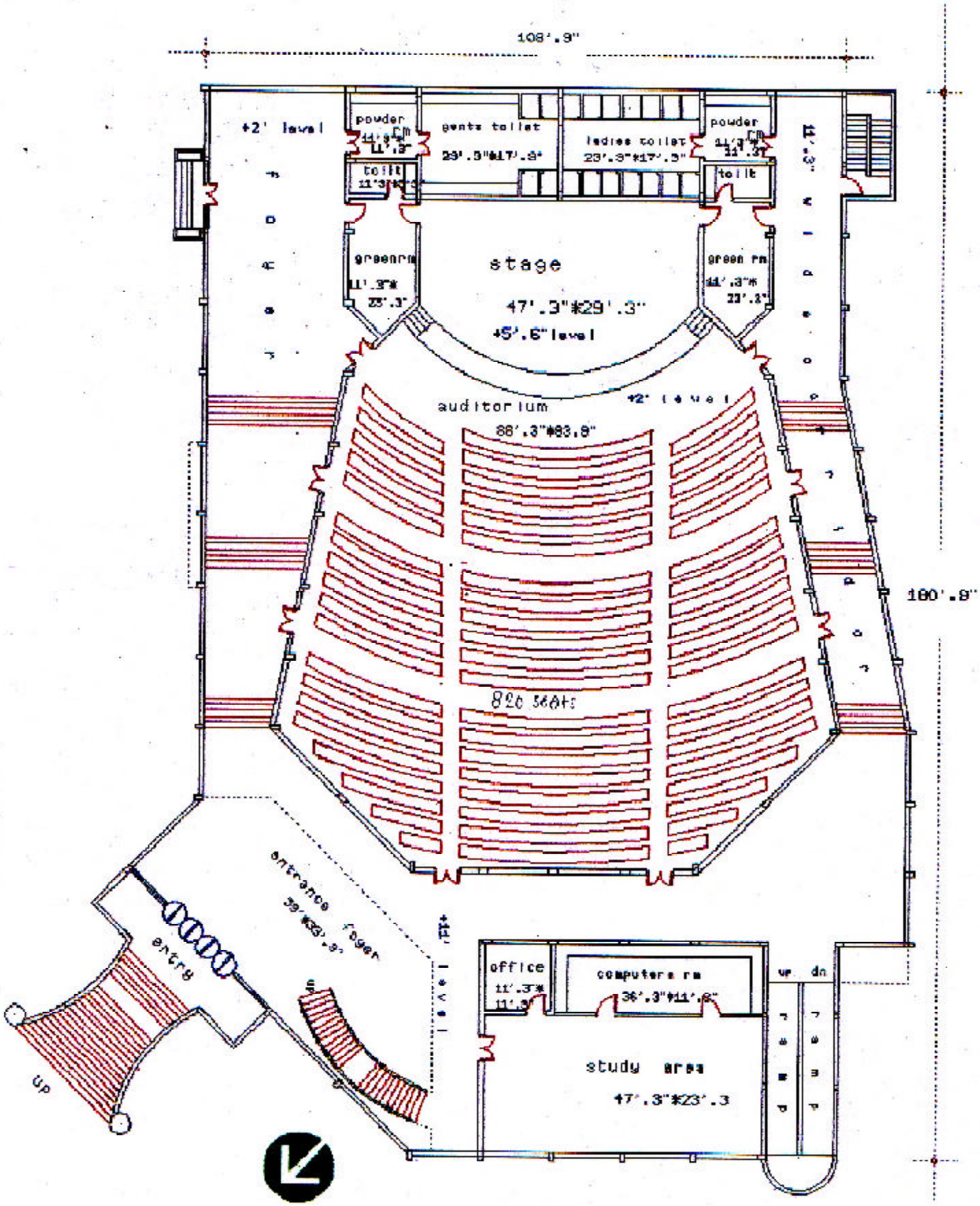
6. Dr. C. Ramamurthy Memorial Endowment in Obstetrics and Gynecology: various donors.

7. Dr. Tummala Ramabrahmam,M.D. memorial GMCANA Research Endowment Fund : various donors

8. Sri Vasireddy Seethapathi and Smt.Gowri Devi Memorial Scholarship Endowment Fund

9. Dr. Mandava Srimannarayana Murthy Memorial Endowment Fund for General Surgery donated by Dr.Leela Dhanekula

10. Tummala Ramakrishna Sastrullu memorial Scholarship Fund donated by Dr.Satyaprasad Tummala



ground floor plan

ground floor area =19941 sft

Ground Floor Plan GMCANA Auditorium