Interview: Professor Keith McAdam

Professor Keith McAdam is past RCP associate global director for Sub-Saharan Africa. Over the course of his 5 decades of working in medicine he has worked internationally with his wife Penny and their three daughters, all of who enjoy sport – including cricket.

He shares his experience of working in global healthcare systems, creating the charity Music for my Mind for people affected by dementia, and helping to establish the East, Central and Southern Africa College of Physicians (ECSACOP) with *Commentary*.

What was your experience of studying medicine after spending your formative years in Uganda?

I went to Uganda, aged less than one. My father trained as a surgeon in Edinburgh and worked at Makerere University teaching hospital for nearly 30 years.My mother was a psychologist at the university's Department of Education.

Undoubtedly, my parents were role models and there were bright students in our home all the time. I recall my father encouraging research and doing surgery at all hours. It was a very exciting and influential time in my formative years, but my dreams were to be a game warden or a district commissioner. I went to school in Kenya, where Latin and maths were my favourite subjects, but I secretly knew that science was the exciting future.

Medicine at Cambridge was full of opportunities. University cricket was full time, so keeping up with medical studies meant working from 4–8am, going to lectures at 9, practicals at 10, before getting to Fenner's cricket ground for an 11 o'clock start.

Somehow, I passed and was thrilled to get a distinction in medicine, or 'physic' as it was called at Cambridge.

How has working internationally shaped your medical career?

My long-suffering Cambridge roommate and I agreed to meet up in 10 years in Papua New Guinea, by closing our eyes and pointing at a world map.

In my third year of clinical training at Middlesex Hospital Medical School, two colleagues and I chose to do a literature review – becoming world experts on a very rare topic; amyloid. It was a pathological curiosity and only had two pages in the medical textbook at the time.

Imagine my delight when I picked up an Australian medical journal and found that the highest prevalence of amyloid in the world was in Papua New Guinea! It led to an exciting 3 years at the Medical Research Institute in Goroka. I saw more amyloid than almost anyone else in the world had ever seen!

I then had 2 wonderful years on a Medical Research Council (MRC) travelling fellowship at the National Institute of Health in the USA, studying serum amyloid A protein. I worked in experimental medicine and geographic medicine at New England Medical Center, Boston and stayed for 8 years, relishing clinical investigation. I was thrilled to be appointed to the Wellcome chair of tropical medicine at the London School of Hygiene and Tropical Medicine; I learnt a lot from teaching and particularly enjoyed meeting students from all over the world.

After 10 years, I became director of the MRC laboratories in West Africa. The MRC unit in The Gambia was involved with all sorts of tropical conditions, renowned worldwide for its study of vaccines. There were about 800 staff by the time I left, and four different research stations. It was a wonderful opportunity to work with both Gambian and international staff.

How did you end up working with patients with HIV?

I was due to go back to the London School of Hygiene and Tropical Medicine but, in fact, ended up on a sabbatical visiting Stanford and the Gates Foundation in the USA. There, I was told that a new Infectious Diseases Institute (IDI) was being developed in Uganda.

This was a massive circle back to my home, 30 years previously.

I spent the best part of 4 years there – building, recruiting and setting up a new institute. It was set up to teach physicians how to treat people living with HIV, with new antiretrovirals. It was a joy to work with people who saw this epidemic as an opportunity to serve about 20 million people in Africa, and it was remarkable to recruit really outstanding staff.

The number of people outside the clinic door each morning rose to 500; we couldn't possibly get through them by the evening.

We asked the people outside what they wanted to be called. They said 'not patients and not clients but *mikwano gyaffe*,' which is 'our friends' in the Luganda language.

We had a sign over the door saying, 'welcome, our friends'. That made a big difference to exhausted staff and to people waiting for up to 8 hours. We started a creativity initiative and electronic queuing – allowing people to do interesting things while waiting, not just hiding so they wouldn't be recognised with this stigmatising condition. There was music, art and board games, social and spiritual support, and entrepreneurial life skills taught.

It certainly helped with stigma and got people involved in trying to be part of the solution. Quite quickly, this spread throughout Kampala as best practice. The clinic changed from being like a morgue to being like a marketplace, with drumming, singing and dancing. Very few people came to visit the clinic without being moved by the experience.

Was this what inspired you to start the charity Music for my Mind?

Upon returning to London, I applied for a role in the RCP's global department as the associate global director for Africa and had to give an inaugural lecture. I spoke about the creativity initiative and afterwards, then-PRCP, Sir Richard Thompson challenged me to do something that would allow the creativity initiative to blossom in a clinical setting.

After about a year of investigation, it became obvious that degenerative brain diseases, including Alzheimer's, were all associated not only with amyloid but with a response to music. With an inspiring group of trustees, we launched a charity called Music for my Mind

People living with dementia may lose cognitive function, but they still remember music from their past. Their faces light up, and they may even sing the words to a song, although they can't otherwise speak.

Over the last 10 years, we've developed an algorithm that creates a personalised playlist. We started with a preliminary study on what music people remember; the teenage years are when we most readily remember songs that we can at least hum.

It made a massive difference in trials in care homes. Even with severe Alzheimer's disease, people were able to respond positively. Quality of life assessments improved for a condition where it would normally decline with progression. The difficult behavioural and psychological symptoms of dementia were also improved by listening to personalised playlists.

We've now been working with AI to read facial expressions for assessments and to create personalised playlists that are genuinely useful for people living with dementia, and the people around them – care workers, families and friends.

We're hoping that we can interest the big tech companies in taking this forward; it's non-invasive, non-pharmaceutical, yet helps people enormously.

It would be lovely if everyone admitted to a care home had a personal playlist created as part of their onboarding process. It would make a difference, and it doesn't take much effort to produce a personal playlist; it's free and takes about 5 minutes on the Music for my Mind website.

In your time with the RCP, you were involved in setting up ECSACOP – how did this come about?

There aren't enough physicians to do the work that's required across East, Central and Southern Africa. Physicians are often isolated – they don't know colleagues in other parts of the region.

More medical schools are being created, but there are no common standards or examinations. You have no idea how the quality of medical education compares between different organisations.

Surgeons set up the College of Surgeons of East, Central and Southern Africa in about 1999, but physicians didn't have anything similar.

We worked with the associations of physicians in the first six countries, to set up a new regional college and a common examination, available to all medical institutions, allowing graduates to be assessed against a relevant curriculum that met the needs of a practising physician in that part of the world.

It's done amazingly well. The original six countries have now become seven, and several other countries have expressed interest. This has become a very wide fellowship, an organisation of physicians who meet every year. There is a shared curriculum and online learning programme that is based on training people in district hospitals rather than in capital cities, which increases the chances that they will stay there and continue to help local communities. There is also the joy of having a young colleague join and help physicians in isolated district hospitals.

ECSACOP is a wonderful organisation, led by very altruistic people. It is a highly effective way of creating more physicians for Africa. The cost is only a fraction of training physicians through a traditional medical school system. Initially there was some opposition from medical schools, but that has largely disappeared as people have seen the advantages of a common examination, common standards, a relevant curriculum and inspiring teachers.

It was born through active and helpful support from the RCP; to think that our 508-year-old college has helped spawn a new college is an exciting reality. I am very proud of the RCP for supporting it and there are so many people in the RCP and ECSACOP who deserve essential appreciation for the work that has been done there.

It's also a wonderful opportunity for people anywhere who want to help; there are opportunities for mutual learning, teaching, mentoring and specialist training. As ECSACOP matures, it will continue to need support. This isn't a short-term partnership. It's a long-term love affair.

What do you think UK-based physicians can learn from a global healthcare system?

Your exposure to medicine in less-resourced places doesn't start when you're qualified. It starts when you do your elective or a gap year. Many people are profoundly influenced in their future careers by those experiences.

When I worked with the RCP on 2-week placements in West Africa, I encouraged physicians to think about three things. First: make a local friend and have a meal with them in their home. Second: take note of all the brilliant people they observe. And third: to laugh with people.

Those may sound like strange goals, but people came back, telling me about the lifelong friendships they had made. People exchanged ideas and opportunities.

There are tremendous opportunities in linking with less-resourced settings; for teaching, research and epidemic preparedness. Epidemics often emerge from less-resourced settings – both infectious and non-communicable diseases.

One thing I strongly emphasise is the importance of strengthening trust in institutions and people. It requires a team spirit in which everyone is committed to maintaining high standards.

Research is another area I'd highlight. The opportunities are enormous and require expertise from different disciplines; joining collaborative research teams is an incredibly rewarding process. Team building is also vital. Many of the challenges we face require integrity, technical competence, impact, resilience, evidence-based decision making and a strong team culture.

Working globally brings tremendous benefits – working together, celebrating partnerships, sharing resources and learning across different cultures and languages. It's an opportunity people shouldn't pass up. Experiences like those can be life changing.

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