Opinion:
How to Strengthen and Reform Indian Medical Education System: Is Nationalization the Only Answer?
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Abstract:
As India marches towards an exciting new future of growth and progress, medical education will play pivotal role in crafting a sustained development agenda. Efforts have to be undertaken to create a medical educational system that nourishes innovation, entrepreneurship and addresses the skill requirement of the growing economy. Last decade has been witness to phenomenal growth in numbers of the medical colleges, nursing colleges and other similar training institutions. This unregulated rapid growth in number of medical colleges has adversely impacted quality of training in India’s medical institutions. The policy of privatization of medical care has seriously undermined health services and further limited the access of the underprivileged. Therefore the only solution is centralization or nationalization of globalization of the entire medical education and health sectors or to join hands with world health organization, So that a uniform health cares facilities can be given to each and every human being.

Key Words: India, medical education, medical colleges, Faculty shortage, Reformation, Nationalization

Introduction:
As India marches towards an exciting new future of growth and progress, medical education will play pivotal role in crafting a sustained development agenda. The idea of creating a healthy society is no longer a debatable luxury; its significance has been grasped by policy shapers worldwide. This idea has become even more crucial in view of the three critical challenges of demography, disparity and development. The incredible pool of human resources needs to be harnessed with a focused education and skill development agenda to meet the challenges of the coming century. In view of this, we need a substantial expansion in the educational opportunities, with a special emphasis on inclusion so that nobody is left out of the system. So efforts have to be undertaken to create an educational system that nourishes innovation, entrepreneurship and addresses the skill requirement of the growing economy.

The importance of working on Indian medical education system reforms and the important elements of sector reforms are paramount in Indian context. It is important to pause and ponder about the ultimate and intermediate outcomes of education systems. As far as the composition of the Indian medical education system in the country is concerned, we know that the education system is highly heterogeneous and, complex with a wide range of providers. If we wish to provide 100% coverage for education, improve the medical education status, then we need to answer many issues in terms of efficiency, quality, and access related issues. Again quality is most abused term in education and health systems. The management systems, the providers, third party administrators, education management organizations, clients, community are the different stakeholders. Quality influences both education statuses and satisfaction.(1)

The Indian medical education sector can be broadly classified into two– the modern (western) system of medicine i.e. Allopathic, or Non Indian System of Medicine (NISM) and Indian Systems of Medicine and Homeopathy (ISMH) that includes Ayurveda, Unani, Siddha and Homeopathy.

Modern (NISM) medical training for doctors in India is provided at the undergraduate, post-graduate and super-specialization levels. The undergraduate degree, referred to as MBBS (Bachelor of Medicine and Bachelor of Surgery), comprises of 5 years of coursework followed by one year of internship, and provides basic training in clinical medicine and is also the prerequisite for further training/residency in various specialties. The three main types of “post-graduate” training opportunities include three year residency programs i.e. MD (Doctor of Medicine) or MS (Master of Surgery), one or two year long diploma training programs and DNB (“Diplomate of the National Board”) programs offered by the National Board of Examinations, an autonomous organization established by the Government of India. Further there are super-speciality residency programs in medical and surgical specialties for those who have completed the MD/MS or the DNB. Medical education in ISMH institutions is a 5½-year training process, similar to that in NISM, leading to the award of Bachelor’s degrees. There are also areas of post-graduate specialization, leading to the award of an MD (or equivalent) degree. Admissions to government medical colleges in each Indian state are conducted on the basis of a merit list, or entrance examinations, sometimes with an affirma-
ive action quota. A national level entrance examination al-
low students from one state to seek admission to institutions in
another. Private medical colleges offer subsidized “merit seats”, based on a common entrance exam, while the remain-
ing seats are offered through a “management” quota. There
are a few autonomous institutions that have separate admis-
sions processes.(2)

The medical regulatory organizations in the countries sur-
vveyed set as their primary objectives a combination of regis-
tering/licensing medical practitioners, setting standards for
the profession, promoting best practice and patient safety,
promoting fair access to health care and regulating medical
education. In most of the countries, medical regulatory au-
thorities do not formally distinguish between registration and
licensing processes, and registration alone may be sufficient
to entitle doctors to practice.

The Medical Council of India (MCI), the regulatory and ad-
visory body on medical education, approves medical cur-
ricula and syllabi and permits medical school existence and
allows for recognition of medical degrees issued by Universi-
ty Grants Commission controlled Indian universities. The
MCI accreditation process for medical schools focuses largely on the infrastructure and human resources required
and on the process and quality of education or outcomes.(3)
The implementation of the recommendations of MCI regard-
ing recognition or de-recognition of a medical college is gov-
erned by the Ministry of Health and Family Welfare. Indi-
vidual universities also have variable sets of regulations for
their affiliated medical schools. As a result, there is no uni-
formity in the standard of medical education across India.

Medical Colleges in India:

Establishing a medical college requires a huge number of
qualified, competent, medical council compliant manpower
to produce quality doctors. Maintaining the high standards of
degree of education to world acceptable levels with vision to erad-
icate health scourges has been a concern of the Indian planning
committees.

Last decade has been witness to phenomenal growth in num-
bers of the medical colleges, nursing colleges and other simil-
ar training institutions. This unregulated rapid growth in
number of medical colleges, enrolment of medical students
and poorly implemented regulations relating to admissions,
faculty strength and infrastructure in medical colleges has ad-
versely impacted quality of training in India’s medical insti-
tutions. British India had just 19 medical schools. By 1958,
this number has risen to 86.(4) The college total increased to
112 by 1980 (at a rate of 30%), to 143 in next decade (rate of
growth of 28%) and since 1990 over past 17 years the num-
ber has increased to 260, an increase of 82% compared with
the figure in 1990.(5) Today, there are 271 medical colleges
out of which about 31,000 medical graduates pass out every
year. And private sector medical colleges have grown to ac-
count for more than half of all medical education institutions
in India.

Most medical college permissions were gifts given out as lar-
gesse or patronage to political heavyweights from health min-
istry. Most of these colleges do not have adequate space,
laboratories or hospitals as per MCI norms. Corruption and
bribery have made permanent inroads into medical education
since past few decades in health universities or entrance ex-
aminations. Even clerks in the universities leak question pa-
ers and manipulate marks.(6) Nearly 30 officials have been
found prima facie guilty of leaking question papers in some
reputed universities.(7-9)

While the quality of medical care and education is the hall-
mark of success for developed countries, India shows an un-
canny obsession of churning more medical colleges every
year. In India it is the privilege of every minister to start a
medical college in his/her constituency, opines Dr G M Bha-
tia, secretary, Association of Medical Consultants. “Estab-
lishing medical colleges have become a money-minting ven-
ture for politicians,” explains Major General (Retd) S P Jhin-
gon, administrator, Medical Council of India (MCI). “Indians
have an insatiable appetite for gold and medical degrees”.
These medical colleges are run like coaching classes, churn-
ing out only paper doctors,” condemns Dr Sapatnekar. Ex-
President of Association of Consumer Actions on Safety and
Health (ACASH), Dr. Arun Bal rue, “What’s the use of hav-
ing innumerable doctors, when the urban sector has one doc-
tor per 300 people as compared to 700 people in the rural sec-
tor.” So, while the United States is speculating the closure of
50 medical colleges as a measure of quality control, do Indi-
ans have to be a mute spectator to more medical colleges in
the future? The first attempt to crack on this nexus was made
by the Supreme Court judgement on November, 2001 initiat-
ing CBI investigations against the council president on
charges of corruption. Recently, the ministry of health has is-
ued a notice reducing the number of seats of 76 medical and
9 dental colleges for violating the MCI norms.(10)

Another major problem of this excessive increase in medical
college is faculty shortage. Nearly 27000 teachers are re-
quired as per educationist calculations to fill the faculty posi-
tions in 270 medical colleges purely for the purpose of teach-
MBBS. Unfortunately he ignores the existence of 300 odd Diplomate National Board hospitals across India. MCI
recognized institutions in China, Nepal, Malaysia, Nether-
lands training MBBS doctors of Indian certifications. All
these institutions draw Indian medical teachers to satisfy MCI
or DNB stipulations for accreditation. Also his manpower
calculations are only for colleges purely teaching MBBS and
ignore multiple course Colleges like Mangalore, Manipal
which harbor 90 MSc students per year per department and
ignores existence of PhD students which evidently will re-
quire more teachers. He also ignores the net strain on the
same faculty who are simultaneously teaching Physiotherapy,
Nursing students in allied institutions. A great academic
strain on medical college teachers exists, which has never
been accounted by council or by educationists. So, on the
whole, it means that a great qualified medical teacher short-
age exists in India.(11)

Privately, much management agree that it is very difficult to
get faculty and that it is even more difficult to retain them in
the wake of continuous offers or lure from newly established
medical colleges. Certain medical college locations in smaller
cities or semi-urban areas do not have facilities, ambience,
or charm of big cities hence attracting teachers or other quali-
fied staff to such medical colleges has been difficult. Such
colleges have been surviving council inspections by window
dressing or luring faculty or inspectors with money. In certain
new colleges which are literally brick fresh, bereft of hostel
or quarters or other amenities the teachers delay even more to
move or settle down themselves. Situation in Dental or Nurs-
ing colleges is also similar.(11)

Perhaps the worst kind of gross unethical practice in academ-
ic medicine happens around the time of inspection post 1998-
2000, in new private medical colleges. In emergency-like
frenzied two day shows, busloads of patients are mobilized to
fill up empty wards, carloads of doctors are paraded before
the inspectors, and even instruments are hired or shifted
between colleges, during the period of inspections. Many re-
puted physicians and surgeons, professors, directors and
deans working in new private medical colleges fabricate and
falsify records like even birth records and lie to the MCI and
the courts in order to get their medical college of question-
able standards approved or recognized. Illegal money is in-
volved in the business of getting new private medical col-
leges approved or recognized by the MCI and the health ministry.(12) In absence of health education quality standards, it can be presumed that the student output from these health science institutions is definitely substandard.

Remedies and Reforms:
The menace posed by the unfettered merchandisation of medical education has to be controlled and efforts should be made by the Government to ensure maintenance of standards and check the unplanned growth of substandard medical colleges and substandard education norms in universities or their constituent medical colleges.(13)

Some of the suggestion given by most authors can be welcomed. When young doctors recently went on strike to protest against the proposal to introduce reservations in medical colleges, some well-known doctors pronounced in a televised programme that selection through quotas introduces a "risk" to patients and a scalpel in the hands of such doctors is not desirable. Underlying this statement was the assumption that all "quota" students lack skills and knowledge.(14) The solution for this problem will be to make the merit, a high percentage of marks as the main criteria for admission to the medical college and to give financial support for the financially backward classes. India needs also a MCI controlled and Supreme Court monitored screening system of students admitted to medical colleges under the "discretionary management quota" so that merit remains the paramount criterion. There should be publicly accessible information on admission standards practiced by colleges, including transparent nondiscriminatory ranking by performance, and enforcement of sanctions on colleges violating norms.

The patrons of the protestors also invariably support privatization. Almost half the medical colleges in the country admit students on the basis of their ability to pay high fees, rather than their marks. Policy makers confess that these doctors after their graduation will not go where they are needed the most because of inadequate working conditions. Instead of investing to improve the conditions, policy makers, under the political compulsions of health sector reforms, have decided that rural services must depend on Accredited Social Health Activists (ASHA), Ayurveda, Unani, Siddha and Homeopathy (AYUSH) and registered medical practitioners (RMP). Instead of fighting for the revival of secondary and basic level services for the nation and a socially responsible and accountable tertiary care support system, the striking doctors were supporting a system in which super-specialty-based tertiary services are reserved for the rich and ASHA, AYUSH and RMP are meant for the poor.(14)

The policy of privatization of medical care has seriously undermined health services and further limited the access of the underprivileged. From the perspective of medical regulation, the more interesting aspect is the centralization versus decentralization of the regulatory process. Privatization in general has been known to increase the gap between rich and poor, amounting to encouraging survival of the richest which cannot be an acceptable goal of any civil society. Some of the best solutions for these problems will be like introducing a government run health insurance options which provides low cost, universal coverage, affordable health insurance. Barring insurance companies from providing policies that would override MCI, DCI and supreme courts decisions and this is undesirable.(15)

Indian Institutes of Technology (IITs) can be allowed to start medical departments and encourage genuine research. Increasing the retirement age of MD teacher’s up to 70 years will harness hard earned medical experience of senior professors to guide preparation of efficient faculty, discipline enforcement, more projects, PhDs and papers of relevance. MCI can think of sharing of medical faculty among medical colleges, or dental colleges, and ensure less burdened teaching schedules. (13) Recently MCI has reduced the faculty requirement for 100 students admission.(16) Whether it is a right approach to compensate for faculty deficiency is doubtful. Further, Indian Health ministry has been known to interfere in the functioning of MCI, DCI and DNB Boards, override MCI, DCI and supreme courts decisions and this is undesirable.(17)

Number of seats available in various post-graduate medical courses is approximately 11,005 annually which is one third of MBBS graduates coming out every year. Nearly a third of these seats are diplomas and a diplomate cannot be considered for even a junior lecturer post like an MSc graduate, but will be considered for post of Tutor, the lowest cadre of medical teachership. Increasing the number of MD seats in Para clinical and preclinical sciences and replacing existing Diploma seats with corresponding MD seats is a just approach and should be the right approach to follow. MCI also has to think of giving junior lecturership posts to MBBS graduates who have been serving as tutors for more than 3 years in any department.(13) The BDS graduates (Bachelor of Dental Sciences) who are also equally exposed to the medical subjects during their course like MBBS can also be considered to junior lecturership posts. They too have good clinical exposure like MBBS graduates. MCI can also think of recognizing foreign degrees.

For existing medical teachers, high standards of teaching are to be maintained and improved upon with constant seminars, workshops and research works. Teaching aids, computers, medical compact discs, medical e-books, Internet facilities and availability of the latest journals and literature on the subject should be provided in every medical college. As a long-term policy, no new medical colleges must be permitted in prosperous states, unless they demonstrate an MCI compliant infrastructure and facilities. A revitalized Medical Coun-
cil of India must be the only agency permitted to recognize such colleges and ministry need not have any role.\(13\)

It is also observed that none of the countries examined have a formal system for revalidation / competence assurance / re-certification similar to the one being developed in the United Kingdom although some have a form of re-registration. These include Egypt, Germany, Greece, Italy, Pakistan and Spain. Only in Poland is some form of revalidation (recertification) required, although there are no direct sanctions if a doctor does not get recertified. The American style of giving credits for demonstrable good performance throughout the years can be introduced. This will help in updating of the knowledge and recent trends to private practitioners who don’t get the opportunities of getting exposed to academics.

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