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**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 or globalization of the entire medical education and health sectors or to join hands with world health organization, so that a uniform health care facility 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-specialty 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 affirmat-

ive action quota. A national level entrance examination allows 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 remaining seats are offered through a "management" quota. There are a few autonomous institutions that have separate admissions processes.(2)

The medical regulatory organizations in the countries surveyed set as their primary objectives a combination of registering/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 authorities 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 advisory body on medical education, approves medical curricula and syllabi and permits medical school existence and allows for recognition of medical degrees issued by University 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 regarding recognition or de-recognition of a medical college is governed by the Ministry of Health and Family Welfare. Individual universities also have variable sets of regulations for their affiliated medical schools. As a result, there is no uniformity 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 education to world acceptable levels with a vision to eradicate health scourges has been a concern of the Indian planning committees.

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, enrolment of medical students and poorly implemented regulations relating to admissions, faculty strength and infrastructure in medical colleges has adversely impacted quality of training in India's medical institutions. 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 number 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 account for more than half of all medical education institutions in India.

Most medical college permissions were gifts given out as largesse or patronage to political heavyweights from health ministry. 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 examinations. Even clerks in the universities leak question papers 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 hallmark of success for developed countries, India shows an uncanny 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 Bhatia, secretary, Association of Medical Consultants. "Establishing medical colleges have become a money-minting venture for politicians," explains Major General (Retd) S P Jhingan, administrator, Medical Council of India (MCI). "Indians have an insatiable appetite for gold and medical degrees". These medical colleges are run like coaching classes, churning out only paper doctors," condemns Dr Sapatnekar. Ex-president of Association of Consumer Actions on Safety and Health (ACASH), Dr. Arun Bal rues, "What's the use of having innumerable doctors, when the urban sector has one doctor per 300 people as compared to 700 people in the rural sector." So, while the United States is speculating the closure of 50 medical colleges as a measure of quality control, do Indians 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 initiating CBI investigations against the council president on charges of corruption. Recently, the ministry of health has issued 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 required as per educationist calculations to fill the faculty positions in 270 medical colleges purely for the purpose of teaching MBBS. Unfortunately he ignores the existence of 300 odd Diplomate National Board hospitals across India, MCI recognized institutions in China, Nepal, Malaysia, Netherlands 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 require 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 shortage 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 qualified 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 Nursing colleges is also similar.(11)

Perhaps the worst kind of gross unethical practice in academic 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 reputed 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 questionable standards approved or recognized. Illegal money is involved 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 outpour 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 exclude patients thereby ensuring uniform health insurance premium for all Indians irrespective of their health status. Health care reforms is required that would blunt the rapidly escalating cost and provide uniform health care. These things can be achieved by centralization or nationalization or globalization of the entire medical education and health sectors or to join hands with some health organization, so that a uniform health care facility can be given to each and every human being.

Incentivization of the human resource should be taken up as a priority issue, i.e. increments /promotions/ study leaves, and resource allocation should be linked to performance. MCI and DNB Board also need to do more for its medical teacher's- give them more respect, recognition, arrange for their pensions, gratuity, relieving orders or get involved in pay scale recommendations as no entity exists till date to safeguard medical teacher interests. Autonomous hospitals need to be created where transfer is not possible. Recruitment and placement of staff at these institutions should be done at local level on tenure contracts so as to minimize vacancies. The scope of networking with public health institutions that are working in the public sector needs to be expanded within the ambit of the public-private partnership model under the National Rural Health Mission. Handing over public health sector to private hands gradually may not be the right solution.(15)

Indeed, given the sharp increase in the number of medical colleges and the doubling of enrolment capacity after 1980s it is difficult to imagine that enough trained full-time faculties exist to maintain reasonable teacher student ratios. Annual student intake is said to be a critical factor in assessing the requirement for teachers. A punitive MCI, DNB Board and vigilant state medical councils can act synergistically to decrease medical student intake in Medical colleges where teachers are not ready to go or do not exist.(13)

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 / recertification 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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