

Medical Education in India

Sethuraman K. Raman

Faculty of Medicine, Sri Balaji Vidyapeeth, India

I. INTRODUCTION

A. Why this is an issue of global relevance

India is the world's largest exporter of doctors and healthcare workforce to other nations. More than 70,000 medical graduates from India (nearly 10% of the qualified doctors in India) are in the USA, UK, Europe, and the other nations. Therefore, the quality of medical education and the competence level of medical professionals from India acquire global relevance. Over the years, several critiques have been published on Indian Medical Education (Solanki & Kashyap, 2014).

II. PERSONAL VIEW

A. Strength of Indian Medical Education: Quantity

"The best medical schools in India are absolutely world class," said David Gordon, president of the World Federation for Medical Education.

In terms of numbers, there has been a great upward surge in the recent years. In 2016, there were around 57,000 medical seats in India, of which 28,000 seats were in the public sector and 29,000 in the private sector. An addition of 10,000 MBBS seats have been announced for the current year (2017-18) to be shared among 58 medical colleges run by the Government, which would make it as 67,000 MBBS seats per annum. As on 12th April 2017, there were 460 medical colleges with a total of nearly 64,000 seats for MBBS. The postgraduate seats have been increased by 4,000 for 2017-18 giving a total of over 35,000 PG seats for this academic year.

B. Weakness: Variable Quality

While the top 25% to 30% of the 460 colleges offer high quality medical education (adopt the current best practices in designing, maintaining, and enhancing medical education programmes), the others are mediocre

or below par. In mediocre institutions, it is left to the motivation level of the individual student to strive and acquire the basic competencies expected in a primary care physician. That many medical doctors are not more competent than untrained 'quacks' was revealed by a study (Das et al., 2012) funded by the Bill & Melinda Gates Foundation: this study compared the doctors holding medical degrees with the untrained practitioners and found no differences in the likelihood of either group of providers diagnosing correctly or providing the correct treatment. The study concluded that in India, formal training in Medicine did not guarantee quality practice.

Institutions below par try to cover their deficiencies by the use of ingenious street-smart methods. The Medical Council of India (MCI) is well aware of such behaviour and the Council recently barred 32 colleges across the country. A recent news report reconstructs how one of those marshalled doctors on hire, fake patients and life-saving equipment on rent for inspection day to cover up their deficiencies (Krishnan, 2017). Even some of the "Institutions of National Importance" are not immune from such deficiencies: the first cohort of medical students of one of the newly set up AIIMS would reportedly graduate without practical skills due to several deficiencies including the absence of functioning operation theatres. As these are Government run public institutions, their violation of the norms is either condoned or goes unchecked.

The sad state of affairs persists because the "pliable Universities and Councils" are made to bend rules and violate standards of quality in order to accelerate the business of medical education; this is pushed through by politicians for political advantage or by private players for profit. In a four-month investigation reported in 2015,

Reuters has documented the full extent of the fraud in India's porous system of medical-education (MacAskill, Stecklow, & Miglani, 2015).

A Parliamentary committee report has recently said this: Indian Medical Council (IMC) Act 1956 provided India the initial impetus for the growth of medical education; sadly, the Council has not kept pace with time. Various cracks have appeared in its structure and functions that have had deleterious effects on medical education and by logical extension, the delivery of quality healthcare. Moreover, India is perhaps the only country with two parallel systems of Post-Graduate Certification by MCI and National Board of Examinations (NBE) respectively, which needs to be rectified (NITI Aayog, 2016).

C. Weakness – Scientific Research:

A recent review of the research output during 2005-2014 reported that only 25 academic medical institutions produced >100 papers a year, contributing around 40% of India's research output in medical sciences. Around 330 academic medical institutions – belonging to MCI and Diplomat in National Board streams – did not publish a single paper during this 10-year period. Two states with the most number of private academic medical institutions, viz., Karnataka and Kerala, fared the worst with zero publication.

D. Challenges – Globalization:

Globalization of medical education has created a huge demand for English speaking medical educators, especially in China, East Europe, Arab nations and erstwhile Soviet Republic. Several hundreds of qualified and experienced medical teachers have left India on teaching assignments resulting in severe shortages in many departments of medical sciences.

Similarly, to escape from the prohibitive cost of higher education in its private sector, India has become a net consumer of overseas education, spending nearly \$3 billion a year to study abroad. In 2008, industry estimates had announced that annually, 150,000 students went for studies overseas. A significant proportion of them went to study Medicine. There is a downward trend in spending for overseas education and it has dropped by 20% to \$2 billion in 2015-16 from \$2.5 billion in the previous year.

E. Opportunities

Global funding patterns clearly show that medical education still remains a state dominated sector run with public funds. In countries belonging to the Organization for Economic Cooperation and Development (OECD) such as Denmark and Holland, public funding provides

98% of health resources in this sector. The figure is nearly 90% for Canada and as high as 78% even in the US.

Globalization demands a paradigm shift in the regulation of medical education in India. To meet the current demands of globalization, the Indian government must spend more on medical education, increase student access, and permit greater autonomy with accountability to its universities. More funding combined with greater flexibility and autonomy, would strengthen the research capacity. India's rigid regulation of all aspects of medical education blocks the intellectual growth of its academia, and diminishes its ability to attract global talent to enhance the quality of medical education to world standards.

Starting from the academic year 2016, the Supreme Court of India has ordered that all the medical and dental colleges admit students based of the individual rank obtained by each student in the 'National Entrance cum Eligibility Test' (the NEET exam). NEET is a single entrance examination in the country for providing admissions to medical (MBBS) and Dental (BDS) seats across all medical colleges/universities in the country. A total of 731,223 appeared in the NEET-UG-2016; 409,477 candidates qualified, out of which the top ranked 28,000 were eligible to enter the Government colleges, while the remainder could try to enter any of the private colleges.

The Parliamentary Standing Committee's Report-92 of 2016 has recommended the formation of a National Medical Commission (NMC) through a new Act to replace the IMC Act. The NMC will have four verticals, viz., (i) UG Board of Medical Education and Training, (ii) PG Board of Medical Education and Training (iii) National Assessment and Accreditation Board and (iv) National Board for Medical Registration (NITI Aayog, 2016).

The committee has also recommended common entrance and exit examinations for both undergraduate and post-graduate medical education. It has recommended restructuring of the postgraduate medical education under a single control by merging the best elements of both the systems, viz., the Medical Council of India and the National Board of Examinations (NITI Aayog, 2016).

Meanwhile, MCI has released its vision for value added MBBS course. Ten new teaching-learning components proposed in its Vision-2015 document are:

1) A preparatory Foundation course;

- 2) Curricular integration, both Horizontal and Vertical;
- 3) Early Clinical Exposure;
- 4) Student-Doctor mode of hands-on Clinical Training;
- 5) Electives and self-directed learning;
- 6) Competency-based Training with certified skills acquisition;
- 7) Secondary Hospital Exposure;
- 8) Adoption of Contemporary Education Technologies;
- 9) Integration of principles of Family Medicine;
- 10) Integration of ethics and professional values in all phases of the course.

F. Summing up: Bright Future Beckons

The current initiatives undertaken by the government and the regulatory agencies augur well for the betterment of medical education in the foreseeable future in India. Concerned professionals and informed citizens would endorse the Parliamentary Standing Committee's strong plea to the Government of India to quickly usher in a radical reform of medical education with focus on national relevance so as to cleanse the present ills and defects and to elevate Indian medical education to align with the current global pedagogic practices (NITI Aayog, 2016).

Note on Contributors

Professor K.R. Sethuraman is currently the Vice-Chancellor of Sri Balaji Vidyapeeth, a deemed-to-be-University at Puducherry, India, and formerly the Dean of Medicine and Deputy VC (Academic & International Affairs) of AIMST University in Malaysia.

Acknowledgements

The permission granted by Shri M.K. Rajagopalan, Honorable Chancellor of Sri Balaji Vidyapeeth to publish this article is gratefully acknowledged.

Declaration of Interest

The author has no conflict of interest to declare.

References

Das, J., Holla, A., Das, V., Mohanan, M., Tabak, D., & Chan, B. (2012). In urban and rural India, a standardized patient study showed low levels of provider training and huge quality gaps. *Health Affairs*, *31*(12), 2774–2784. doi: <https://doi.org/10.1377/hlthaff.2011.1356>.

MacAskill, A., Stecklow, S., & Miglani, S. (2015, June 17). *Why India's medical schools are plagued with fraud*. Retrieved from <http://www.reuters.com/article/us-india-medicine-education-specialrepor-idUSKBN0OW1NM20150617>.

Medical Council of India. (2011, March). *Vision 2015*. Retrieved from https://old.mciindia.org/tools/announcement/MCI_booklet.pdf.

NITI Aayog, Government of India. (2016, August 7). *A Preliminary Report of the Committee on the Reform of the Indian Medical Council Act, 1956*. Retrieved from http://niti.gov.in/writereaddata/files/document_publication/MCI%20Report%20.pdf.

Solanki, A. & Kashyap, S. (2014). Medical education in India: Current challenges and the way forward. *Medical teacher*, *36*(12), 1027-1031.

Krishnan, V. (2017, February 25). *Betraying the oath*. Retrieved from <http://www.thehindu.com/sci-tech/health/betraying-the-oath/article17362851.ece>.

*Prof Sethuraman K. R.

MD, PGDHE, Vice-Chancellor and Senior-Professor of Medicine, Sri Balaji Vidyapeeth Pondicherry-607403, India

Tel: (+91) 4132611802

Email: krs@sbvu.ac.in