doctor–patient boundaries were and how they might be ‘violated’. Did the authors mean that we should distance ourselves from our patients, with whom we have a fiduciary (trust-cum-financial) relationship, and not be interested in anything else about them other than their disease?

It all smelt of being a non-issue and seemed, like many other medical problems we waste our time working and writing on here, to be derived from the US experience and to be of ‘fringe relevance’ to us (to use the authors’ own words).

The relationship between doctors and patients in India is completely different from that in the USA. Here, patients trust their doctors more (the doctor often being told that he is next to God) and there is much less equality between the two individuals, with the doctor assuming the role of a benevolent father figure. The so-called boundaries will also, therefore, be very different. A sexual association with a patient is obviously wrong both in the USA and India, but is accepting a small box of mithai proferrered in gratitude for what was done, attending a wedding in a patient’s family or giving his (or her) upper arm an affectionate touch a boundary violation?

The authors’ demands include classes on boundary issues for undergraduates, interns and postgraduates. As if they are not already overburdened with more important matters like how to treat diarrhoea or diagnose meningitis in a child!

I think the students’ attitude in this respect is moulded entirely by how their teachers behave. If a student sees his mentor treating a patient with dignity, compassion and competence, that is all that is necessary for her/him to learn about what a proper doctor–patient relationship should be. A Bangalore Declaration with a course on boundary violations will only be a poor substitute.

SAMIRAN NUNDY

Medical Education

Medical education in India: A need to think differently

RAGHUNANDAN KOTHARI

INTRODUCTION

The medical education system initiated by the British in India has not changed much. There has always been a shortage of trained medical personnel and there is a need for many more healthcare centres in several far-flung areas of the country. Though the doctor:population ratio has improved from 1:6300 in 1947 to 1:1700, there is a mismatch in services in rural and urban areas.1 Even the National Rural Health Mission (NRHM) has not been successful in achieving the desired change.2 Medical education should suit the changing perceptions of health in society, the trend to consult specialists, commercialization of health services and the availability of state-of-the-art superspeciality services.

THE PRESENT STATUS

With 330 medical colleges in India, about 35,000 students graduate every year3 after five and a half years of study. As almost all MBBS students plan to do a postgraduation, the first degree is a step towards becoming a specialist. In the present MBBS curriculum, many things are taught that are not of much use in later years when a person specializes in a particular area. The 1-year internship, a phase of training in which a student is expected to acquire skills to function independently,4 is used to prepare for various entrance examinations, often by joining coaching classes. Many a time students get neither the subject of their aptitude, nor the institution of their choice, with 100 multiple choice questions (MCQs) deciding what and where they should study. Aptitude, an important factor, is given no consideration at all. They spend another 3 years on a postgraduate (PG) degree. Thus, at least eight and a half years are required for becoming a specialist. During specialization, much of what was learnt during the undergraduate (UG) course becomes redundant. The PG training at many centres does not meet the minimum standards, with the result that candidates neither gain confidence nor develop the practical skills to start working independently. A large number of PGs then enrol for some fellowship or short course to acquire skills that they could not obtain during their PG training. Another fallout of this long journey of hard work, as well as high investment in terms of money and time, is that many meritorious students now avoid medicine as a career.

A large number of private medical colleges and deemed universities have come up in recent years and they have their own criteria for admission. Often, factors other than merit govern admission to these colleges. It has been estimated that there is a 30%–40% deficiency of medical teachers in India, and due to this, unhealthy practices are followed to meet the required numbers during inspections conducted by the Medical Council of India (MCI).1 One often reads reports in newspapers about fake teachers, deficient infrastructure, colleges admitting more than 50% students under the management quota,4 etc.

MORE CHANGE NEEDED

Efforts are being made to change the present system. These include increasing the number of UG and PG seats, reducing infrastructural requirements for starting new medical colleges, increasing the teacher:student ratio for PG from 1:1 to 1:2,
reducing the experience required for teachers to progress in their careers and increasing the age of retirement for teachers. However, these steps, though welcome, are only replacing the cogs in the wheel. The need is for a radical change. The new course named Bachelor of Rural Health Care, to be run at the district hospital level, will produce only half-baked doctors. I suggest that the following measures be considered to produce a perceptible change.

The MBBS course may be replaced by a specially course of 5 years after class XII, followed by a 1-year internship. The course may be named Doctor of Medicine (MD) in family medicine or general practice. The MBBS curriculum should be completely revised for this course to make the student a competent doctor at first contact. Practical skills should be imparted after the first year and should aim to make the student competent to deal with all emergencies, including trauma, treat common ailments and identify cases for correct and timely referral to higher centres. This course will produce an efficient primary healthcare provider who is younger and who would be available to render service to society for a longer time. Such doctors may not be very averse to serving in peripheral areas, where they will encounter less competition and have greater scope for progress at a younger age. To make this course popular among students, jobs in peripheral areas should be guaranteed and attractive allowances should be given.

SPECIALTY COURSES

Specialty courses should start after class XII and the course should be of 5 years1 duration, followed by a 1-year internship in the specialty. The initial 1.5–2 years should be directed at training in basic sciences such as anatomy, physiology and pathology. After this period, as the students develop an understanding of the field of medicine, they may be given the option to change their subject, depending upon the availability of seats. Having a course of a longer duration will make the student a more accomplished specialist at a younger age. Thus, students will not feel that they have lagged behind their counterparts in other fields. Also, the training should be oriented more towards the field in which the person is specializing.

The parallel system of PG qualification, the Diplomate of National Board (DNB), and various local courses run by some states add to the confusion. A large number of institutes run these courses to get cheap working hands and to be labelled as training and research institutes.9 These centres have neither the infrastructure, nor the academic environment required for teaching. If a hospital running a DNB course fulfills all the criteria specified by the MCI, it should be permitted to run the MS/MD course suggested above to avoid dual streams of PG. The proposed algorithm for PGs with the introduction of newer degrees such as MMEd and dual degrees10 will add to the confusion. Two-thirds of the medical colleges in India are located in six states. One state, Puducherry, which has a population of 900,000, has nine private medical colleges.7 No new medical college should be permitted in a place which already has one as per the population ratio. Priority should be given to starting a medical college in a peripheral rural region and subsidy should be available for this.

The concept of deemed universities needs to be revisited. Newspaper reports suggest that a number of them do not meet the requisite standards and face de-recognition. To ensure uniform and high standards, every state should have only one medical university which should govern admission, curriculum, faculty, examinations and examiners. This will also prevent shifting/hiring of teachers and resources for the purpose of inspections.

An important tool in medical education is continuing medical education (CME) programmes. Unfortunately, organizing CMEs has become an exercise in showmanship, publicity and advertising by many institutes and pharmaceutical companies. Drug companies are also known to indulge in malpractices such as offering expensive gifts, and arranging free trips and accommodation in expensive hotels. The amendment to the Code of Conduct Regulations, 2002 by the MCI is an indirect confession of these malpractices.11 The recent move of making it compulsory for doctors to earn a requisite number of credit hours for attending CMEs has led to yet another type of malpractice—earning credit hours by paying registration for a CME and then not attending it, and also by registering even if the CME is about a subject other than the doctor’s own subject. Only 20% doctors follow the requirement of the MCI of undergoing 30 hours of CME in 5 years, as per a recent WHO report. It is worthwhile to think differently in this regard too. It may be made mandatory for every doctor to be physically present at a premier institute for 60 working days every 5 years in order for her/his registration to be continued/renewed. This will enable her/him to understand the current perspectives better than attending 5–6 lectures at a CME, and also give her/him an opportunity to work with her/his own hands under the guidance of stalwarts in the field.

At present, too much stress is laid on publications by faculty members. This is leading to many malpractices, such as plagiarism, fabrication and falsification. Many institutes do not have requisite facilities for genuine research; nor do all faculty members have a temperament for research. To promote original work worth publication in a national or international journal, facility members who are interested in research and have access to the requisite facilities should be encouraged by evolving a system that gives them benefits in terms of promotions, placements or deputations.

CONCLUSION

Though it is hard to accept a drastic deviation from our traditional, firmly rooted framework of medical education, we will have to think differently to make medical education in India suitable for meeting the challenges of changing attitudes and social requirements. The present efforts will only dilute standards.

REFERENCES