EDITORIAL

Getting doctors to the villages: will compulsion work?

SP KALANTRI

Department of medicine, Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha District, Maharashtra 442 102 INDIA e-mail: sp.kalantri@gmail.com

Despite more than a half century of proclamations on primary healthcare, most rural facilities in India continue to lack enough providers, equipment and infrastructure to offer effective and efficient care. In the latest effort to address this inequitable distribution the union health and family welfare minister announced a plan requiring doctors to practise in rural areas before graduating. On completing their internship, students of the MBBS programme must spend 12 months in rural practice - four months each in a primary health centre, a community health centre and a district hospital. Only after this rural service will they be awarded an MBBS. This initiative, a part of the National Rural Health Mission, will come into force after the Medical Council of India Act is amended and approved by Parliament. The plan, when implemented, will apply to all government and private medical colleges in the country (1, 2).

The minister stirred a hornet's nest and young doctors protested against the proposal. In Tamil Nadu, for example, junior doctors struck work, arguing that a year of rural service was an unreasonable addition to their education. The minister responded that the rural posting was only for one year, whereas countries like Singapore and Malaysia had three years of national medical service. He also promised to appoint a taskforce to cut the duration of the MBBS course by six months. Finally, he pointed out that unlike the ministry's earlier proposal, doctors will not spend an entire year in a primary health centre; the time would be divided in different levels of the rural healthcare system (1, 2).

There is no doubt that the imbalance of doctors in rural and urban areas needs correction. Although 269 medical colleges in the country produce 30,922 doctors each year and there are 683,582 registered allopathic doctors in the country, only one in 10 doctors works in a rural area (3). A fraction of rural health centres have the necessary physicians, surgeons and other personnel.

What promotes ethical practice?

Will compulsory rural service work? Can it work in isolation from the general trends in medical education and practice? Can we force ethical practice by edict, or do we also need changes at the level of health policy to promote ethical behaviour? Can individual policy decisions work without a larger qualitative change?

Many strategies have been tried to remedy the inequitable distribution of doctors in India. In the past policymakers have opened medical colleges in rural areas, designed admission policies reserving a small proportion of seats for medical college applicants coming from rural areas, devised innovative programmes to expose medical students to the realities of rural healthcare, started community placement programmes, made rural placement a prerequisite for post-graduation, and penalised doctors for not fulfilling their rural bonds.

Our experience in a medical college established in a semi-rural environment specifically to encourage community-based practice is that none of these strategies has been successful in encouraging medical students to stay and practise in rural areas. Students from rural backgrounds are as likely to practise in cities as are their urban-raised peers. The undergraduate rural experience is not associated with a greater likelihood of subsequent rural practice. Most students who complete community placement programmes do not find the rural stint personally enriching or professionally rewarding.

Recently the National Board of Examinations introduced the discipline of family medicine. Students get an opportunity to complete their core clinical rotations across a network of teaching hospitals, general practice and community medical centres in rural and urban settings. Only time will tell whether this programme fosters a positive attitude to rural medical practice.

The realities of rural medical service

Of the 30,000 students who graduate from medical colleges each year, most tend to cluster in cities, where they have better living conditions, schools for their children, social recognition, higher incomes, promotion opportunities and greater job satisfaction.

In contrast, doctors fear that rural postings distance them from their friends, families, professional colleagues and teachers, lead to physical and social isolation and lower their professional standing. Rural settings may lack appropriate mentors and students complain that they can neither acquire nor hone technological skills in a village. Unsatisfactory working conditions, lack of

adequate staff and equipment, and primitive living conditions add to their woes. In essence, doctors believe that not only does rural medical service fail to improve access to healthcare in these areas, it also requires personal sacrifice. And they ask: why are medical students expected to make greater sacrifices than other professionals?

Social obligations created by medical education

Policymakers argue that although medical students, at least in government medical colleges, get a highly subsidised education, there are no mechanisms in place to ensure that the beneficiaries of this subsidised education repay their debt in kind. Since medical education is primarily aimed at providing benefits to society, doctors surely have a moral obligation to provide healthcare to the society that paid for their education. In addition, medical professionals have an essential ethical obligation to help distribute equitably the life-enhancing opportunities affordable by healthcare.

Indeed, from every new generation of medical students, some will meet this ethical obligation, joining the small group of young doctors – few in number but significant nonetheless – who follow the long and honourable tradition of service to poor and socially disadvantaged people living in rural areas.

Still, rather than simply expecting students to be ethical practitioners we must look at what prevents them from investing a single year of their lives towards rural healthcare delivery.

Medical education today

For most medical students, the MBBS degree has lost its value because of the way in which medical practice works today, and the pressure to get a postgraduate seat is intense. Entrance examinations for postgraduate programmes are extremely competitive (only one in three students gets into a clinical postgraduate programme). Thus, even during internship, preparation for the MD entrance examination takes precedence over acquiring and honing clinical skills. Students fear that the time taken by rural postings hinders their efforts to achieve their career goals.

Currently students complete five and a half years of medical college before they acquire an MBBS degree, which will be six and a half years with the one-year rural service rule. They must do up to two years of additional rural service before joining an MD programme (it is not clear whether the new MBBS requirement is incorporated within existing requirements for applying for a postgraduate seat). They are awarded a postgraduate degree only after three to three and a half years (depending on the state). An MD graduate will have spent up to 12 years in medical college, a period most medical students consider too long to cope with, especially when compared to education in other professional courses such as engineering, architecture and management.

At the same time, during their training medical students are seldom taught how to identify, diagnose and manage health problems in resource-poor settings. Students quickly imbibe the elite culture of the medical profession through the role models provided by their teachers. Classroom or bedside teaching does not inculcate empathy or compassion among students. Nor does it sensitise them to the real needs of the rural community. Young doctors posted in rural areas often lack insight into the socio-economic determinants of diseases and do not know how to treat these diseases economically and effectively.

Another problem lies in the extreme commercialisation of medical education. Of the 269 registered medical colleges in India, 134 are private (4). Most students admitted to these medical colleges are required to personally finance their expensive education. Can we really expect students who have made what is essentially an investment to forget about money and think of their professional ethics and social obligations? After all, if students pay a fortune for their education they are going to be interested in recouping that investment at the earliest. By encouraging private medical colleges the government is sending the signal that medical practice is for personal profit. Is it realistic to demand social commitment from young doctors when nothing else in the system encourages them to think and act along these lines? Are they wrong if they think solely of their careers and turn a blind eye to the problems of a rural population with no access to healthcare?

The protests by medical students should not be taken lightly. Doctors who feel aggrieved at being forced to serve in rural areas are unlikely to fulfil their obligations to the people there. Making the rural healthcare system work and getting enough doctors to do that is one of the several challenges that the minister faces today. But this will have to be based on an understanding of the forces that have created the present system of medical education and practice, forces that are antithetical to ethical practice. Major changes are needed before we can speak realistically of promoting socially conscious behaviour in the medical profession.

Conflict of interest: *My children are medical students.*

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