

EDITORIAL

Medical education In India – the way forward

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In 1956, the four-year-old republic of India replaced the colonial Indian Medical Council with the Medical Council of India (MCI) (1). This institution was meant to guide the young republic in establishing a modern system of medical education and developing the human resources to provide the most appropriate medical care to all citizens.

The Bhore committee report had already been completed in 1946 (2). It had advised the establishment of a universal medical delivery system, with the primary health centre as the basic unit, *taluk* and district hospitals at the secondary level, and medical colleges at the tertiary level.

Thus the medical colleges had two tasks: to develop the human resources required for expansion of the medical facilities available, and to provide the highest level of treatment that the country could afford. In keeping with the spirit of the times, everything was supposed to be available to everyone.

Up to the 1980s, medical education remained largely a government responsibility. There were a few private colleges, but these were generally not-for-profit, like the Mahatma Gandhi Medical College at Wardha and the Christian Medical College in Vellore. In the medical care sector, however, private providers were plentiful, but this was mainly in primary and secondary care. Tertiary care remained largely the province of government hospitals.

All this changed in the late 1980s. There were huge advances in medical technology in the Western world. Interventions like open heart surgery, transplantation of human organs, and joint replacements became commonplace. This medical technology is expensive. It became an area of interest to corporate groups in India and, quite rapidly, the tertiary medical care sector in India shifted to the private sector. The goal of universal equitable medical care was quietly abandoned. Many medical interventions became available primarily to those who could pay, with patchy provision in the public sector.

Almost simultaneously, medical education underwent increasing privatisation. Successive governments continued to pay lip service to the idea of universal comprehensive medical care and equity in medical education but allowed private entities to establish medical colleges, ostensibly as a public service. In theory, the colleges are supposed to be not-for profit, fees are supposed to be regulated by the government, and the hospitals attached to the colleges are expected to provide subsidised treatment for the poor. In actual practice, nearly all these colleges collect very large sums of money from students and keep this money off the books.

The sudden expansion of medical colleges led to an acute shortage of teaching faculty, especially in certain specialties which were not popular choices of medical students because of lack of social approval and opportunities for private practice. Examples of such specialties are anatomy, forensic medicine and community medicine. Some faculty in these specialties saw an opportunity and appeared on the rolls of more than one private college. The regulator, the Medical Council of India, also saw an opportunity and, it is widely believed, collected large sums of money to turn a blind eye to this and other malpractices (3). A coterie captured the MCI and the regulator became the problem.

Responding to public pressure against the egregious acts of the MCI, the previous government promulgated an ordinance by which the elected body was replaced by a board of governors. The government expressed its intention to establish a new body to oversee medical education. This new body never came into being, and, on the lapse of the ordinance, the MCI was reconstituted in its existing form. Many of the old coterie returned. Those alleged to have been responsible for corruption retained power.

Under public pressure, and being forced to hear some acerbic remarks from the Supreme Court, the current government at the Centre constituted a four-member committee chaired by the Vice-Chairperson of Niti Aayog, Arvind Panagariya, to provide a plan for a body replacing the Medical Council of India (4). This committee has circulated a draft bill. In its current form the bill is unlikely to be able to provide any solutions to the medical care needs of the country.

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Planning medical education

One of the benchmarks for planning medical education worldwide is the report of Abraham Flexner, commissioned by the Carnegie Foundation, on the state of medical education in the United States of America (5). Released in 1910, it has greatly influenced medical education not only in the USA, but all over the world. Among the fundamental insights of Flexner are: "Medical education is expensive. It can in no event be taught out of fees." (5: p 142) and "Medical education is a social function; it is not a proper object for either institutional or individual exploitation." (5: p 127). At the time Flexner prepared his report, there were a large number of "proprietary" medical schools in the USA, similar to the private capitation fee colleges in India. They were all shut down in the years after the report. Establishing for-profit medical colleges is considered such a bad idea in the developed world, for reasons so well enunciated by Flexner, that it is not even a point of discussion. It is surprising, therefore, that this bad idea finds such a prominent place in the recommendations of the Niti Aayog (4). Even more shocking is the proposal to allow prospective students to bid for seats. Even the most ardent proponents of the market economy consider medical education not a suitable area for market forces.

It should be obvious that training of medical professionals should serve the objective of medical care delivery in the country. Therefore there is a need to integrate medical education with medical services. We need an understanding of what the health needs of India are in order to formulate plans which integrate medical education with medical care.

The Bloor report (6) suggested a framework to understand this issue based on a study of medical systems in Australia, France, Germany, Sweden and the United Kingdom. It is certainly necessary to make a detailed study in India. Without data we can have no meaningful recommendations.

Medical needs in India

India is faced with the situation that large sections of its population cannot access necessary medical care. The primary barriers are physical and financial. The Bhore committee vision of primary health centres accessible in all areas has not been fulfilled. In many places even if the health centre exists, there are no doctors or even nursing staff present. Secondary and tertiary care facilities are overcrowded and understaffed.

On the other hand, towns and cities are full of doctors chasing the few patients who can pay. Thus we see the amazing phenomenon of corporate hospitals employing marketing professionals to sell their services. Advertisement through the press, cinema halls and the internet is common. So are unethical practices like giving kickbacks for referrals and diagnostic services, doing procedures on patients just to earn money, and unscientific practices which are financially rewarding.

In brief, those who need care do not get it. Those who have means may be subjected to procedures which are unnecessary and potentially harmful.

The idea that these problems can be addressed by solutions like a short course graduate programme was carefully examined by Flexner. He wrote: "...long continued over production of cheaply made doctors cannot force distribution beyond a certain well-marked point." (5: p 15). Also, "...a century of reckless overproduction of cheap doctors has resulted in general overcrowding; but it has not forced doctors into these hopeless spots." (5: p 15)

Policy advisers who suggest such solutions are well advised to read Flexner's exhaustive report.

Planning for human resources in medical care

The confused attitude of successive governments in India led to the present situation: on the one hand, too many doctors trained in high technology medicine (which is lucrative, because it is largely privatised) chasing the few patients with the ability to pay; and on the other, not enough doctors to deal with the basic medical needs of the majority of the population.

We should resist the easy path of superficial solutions. The Niti Aayog has been hasty; it has prepared a bill without adequate thought as to what the objective is (4). The present MCI has outlived its utility. It needs to be replaced. But the problem is not one of a nominated body versus an elected body. It is not one of Central Government control versus state government oversight. Merely tinkering with these may bring some probity to the council but it will fail to change the big picture. It will be another lost opportunity.

What needs to be done

Many of Flexner's recommendations are still relevant, more than a hundred years later. Some of these are:

Financing of medical education. Flexner was of the opinion that medical care is a social cause. Medical education has to be supported by the state. It should on no account be commercialised.

Medical universities have three responsibilities: the definition and enforcement of entrance standards, the upholding of scientific ideals, and responsibility for adequate support (of the staff). Flexner was very clear that full-time faculty are required to properly train medical students, and advised that teachers in universities should be adequately remunerated and no private practice allowed. There must be stringent entry and exit norms for students, so as to train a high quality workforce.

Only one university should be permitted in each town. Flexner said that experience has shown that there is an unhealthy competition for faculty if more than one university is present in a town. Experience in India, with private universities poaching faculty from the government colleges bears this out.

Every state should have its own medical university. This is because students prefer to study in their own provinces. Flexner specifically warned against overproduction of doctors by some states in the USA. Currently, we are witnessing the same problem in the southern states and Maharashtra.

There should be no short-term courses to fill shortages. Experience in the USA showed that such poorly trained personnel did not go to areas of shortage.

Integration of all the then-existing systems of medicine on the basis of science. Flexner stated, "It is precisely the function of [the] scientific method – in social life, politics, engineering, medicine – to get rid of such hindrances to clear thought and effective action." Also, "Scientific medicine therefore brushes aside all historical dogma.... all are required to undergo rigorous cross examination. Whatsoever makes good is accepted..."

This idea is relevant to India, we must examine and integrate Indian systems of medicine, instead of the compartmentalised approach we now have.

From the Bloor report, two messages are important for India:

First, in general, there is a lack of attention to basic economic principles. The role of incentives is largely ignored and supply elasticities in the labour market are, for the most part, unknown and poorly researched. It is often assumed that manipulating price alone will control expenditure, without paying attention to volume.

Second, there is a need to better integrate planning across the professions, with special attention to skill mix and geographic balance. Effective development of skill mix requires legislative change and incentives for physicians that encourage advancement.

Clearly, much work needs to be done so as to create a medical education system in India which addresses the desired outcome of training high quality medical persons able and willing to deal with the health problems of people in places where they are needed.

The report of the High Level Expert Group chaired by Dr Srinath Reddy can be a basis for discussion (7). Government must be clear on its objectives. If the plan is to provide high quality medical services to all, it must work on a road map likely to lead to this objective. It is useful to study the experience of other countries and the reports of their future plans. The present system is broken. Patching it won't work. A radical new path is required. Does the present government have the resolve to do it?

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