unpremeditated nature and mostly due to infrastructural or manpower limitations. Like any other social institution, violence is not considered normal in healthcare. "Normalised violence" is bit of an overstatement. Personal feelings derived from hearsay evidence should not be the basis to jeopardise a time-tested system.

The Indian medical education system is high on reliability as we do see millions of people getting treated every day in every corner of the country. Discrimination is a cultural phenomenon and is a reflection of society as a whole. A better approach would be to formally identify and deal with 'root causes" rather than casually shifting blame upon a highly esteemed system of education for events that are beyond its reaches.

There is a fundamental difference between medical postgraduates and medical undergraduates. Medical postgraduates are registered medical practitioners—doctors and employees with a salary structure. Every senior doctor has a responsibility to get patient-related work done by juniors because that is the central idea running the healthcare machinery. Although citing pressure of work is a terrible excuse for making discriminatory slurs, there is no denying that such things do happen. The important thing to note here is that holding the medical "education" system, which is just one component of healthcare, responsible for discriminatory attitudes of employees is a bit impulsive. I did not get "time to bathe, eat and sleep" during my residency because we understood and were taught that a patient's right to healthcare cannot be denied under any circumstances. It was a lot of physical hardship but we generally tend of think of that as a professional hazard due to a huge patient inflow, rather than a flaw in medical education/ training.

The demise of Dr Tadvi is a sad incident but we must have faith in our judiciary and refrain from prematurely passing judgement against individuals and systems. The three detained individuals in Dr Tadvi's case did not have "unaccountable power". It was unfortunate that Dr Tadvi did not report to authorities that she was facing discrimination or else the college administration would have taken a strict stance as discrimination is neither tolerated nor propagated in any educational institution. I request the author to avoid making highly opinionated statements that might inflame sentiments and patiently wait till the trial is over.

***Declaration**:*

I declare no competing interests and no funding.

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Response to "Casteism in a medical college: a reminiscence"

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I was a student of the Government Medical College (GMC), Nagpur, from 1970 to1975. Based on my own experiences, I agree completely with Anurag Bhargava's comments regarding casteism at GMC Nagpur (1). Caste stigma gets attached to you early in life and stays with you till you reach the grave. I am still afraid to visit my so-called alma mater and I will explain why in this letter.

Casteism is rampant in the Vidarbha region. Caste plays a vital role in the assembly and parliamentary elections, too. When I was in GMC Nagpur, there were several groups formed by different castes among the students. Almost all these groups were dead set against the Brahmin community, who, though their numbers were fewer, were educated and served in academic institutes. At the same time, almost all the Brahmin professors and tutors used to favour students of their caste. During my time, if an external examiner from the Brahmin community were to conduct a viva voce, all the non-Brahmin students would take it for granted that they had to repeat their term. This was basically the result of deep-rooted casteism in that region.

Let me give my own example. When I appeared for the final MBBS examination, I topped in the surgical viva and written test. My internal examiner was very impressed with my performance. but the external examiner was from the Brahmin community. Being born in an illiterate farmer's family, I have been named "Himmatrao". The external examiner asked me my first name. Attaching "rao" to a name is common in the Maratha community and thereby he indirectly confirmed my caste and that I was not a Brahmin. Despite my good performance, I was given low marks

Recurrence of such incidents results in enmity towards the Brahmin caste among students of the other castes. Caste divisions turn into watertight compartments, especially in provincial towns (in 1970 we used call Nagpur a "big village") like Nagpur. Caste undermines and eats away society and breeds injustice.

During my admission into primary school, seeing that I was a farmer's son, the headmaster entered my caste as "Kunbi"—which is a farming community— thoughI was born a Maratha. Much later, I scored the required number of marks in the premedical examination, making me eligible for admission in the open merit category. Yet, being listed as a Kunbi, I was admitted under the "other backward community" (OBC) category. Because of poverty, I remained isolated. Because of my poor English and Marathi, I tried to avoid communication and participation in group discussions. I could not even find a friend in my peer group.

Eventually, I suffered depression during my second year MBBS, and stopped attending medical college. My mother and elder brother came to stay with me. I lost my memory for a while. A psychiatrist, Dr NJ Saoji of Nagpur, tried his best to cure me.

During this time, my classmates were not helpful, and once, a professor suddenly remarked, "Hey psycho! Don't talk!" during my turn in a group discussion. It was painful to experience the stigma attached to mental illness; even medical persons do not share the suffering of mentally ill victims, what can one expect from non-medicos? In such a situation, the human brain is more sensitive and becomes an easy prey to negative thoughts (2). I started worrying that I would be removed from medical college. As mental illness is not always obvious and I seemed physically healthy, my illiterate parents thought I was putting on an act to avoid completing my MBBS. My mother even took me to a village healer, where I stayed for one month without any improvement. Later, I received ten sessions of electro convulsive therapy and felt better. Thereafter, I was even able to pass my MBBS.

Though my marks made me eligible for admission into postgraduation at GMC Nagpur, I decided not to continue my education in Nagpur. My brother too, refused to stay in Nagpur, but he insisted that I should be near Mumbai to learn to face the competition. I accepted a medical officer's post at a primary health centre in the Konkan region, involved myself in scorpion and snake bite research, and published 28 short papers and letters in the *Lancet*, and a research study in *BMJ*, as also two letters and a review in *NEJM*. I completed my MD in medicine. In my experience, in the Konkan and in cities like Mumbai nobody asks about your caste. Everybody is busy with work and has no time to spare for such matters. Here intelligence and efficiency are valued and rewarded, irrespective of caste, and in general, everybody is ready to co-operate and help.

I consciously avoided my son's being admitted into the medical course in an OBC category reserved seat because of my own suffering. My son was very depressed when he saw students with lower marks being admitted into reserved seats, until he finally got a seat in the Akola government medical college. Even today I am moved, when I remember his agony at the time. Because of strict principles and ethical objections, I was dead against his occupying a reserved OBC seat. In addition, with both his parents being doctors, he had no right to occupy a seat which could be given to a poor student. Surprisingly enough, my son cleared all the NEET examinations for the MD and DM admissions in his first attempt .Therefore, in my view, if India wants to end caste discrimination, reservations should be based on economic status with financial support for accommodation, fees, food , books and dress and scholarship for pocket expenses and not on caste. In fact, the "Caste" column in the school certificate should be deleted.

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National Medical Commission Bill: Opportunity to end educational apartheid?

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The Government has superseded the Medical Council of India (MCI) with an interim board of governors that has assumed the powers and functions of the Council, pending passage of the National Medical Commission Bill (1). While a systemic revamp of medical education is intended, uncertainty prevails on whether medical academia will now be more inclusive.

Medical education in India has not had smooth sailing in recent decades. Corruption, mostly in granting permission to new medical colleges and the practice of hiring ghost faculty are common (2). Furthermore, the MCI and the National Board of Examinations (NBE), the two acrimonious poles of Indian medical education have been at loggerheads. The MCI conveniently used riders to subjugate the Diplomate of National Board (DNB) holders, effectively keeping them out of academic positions amidst a nation-wide dearth of medical teachers. The "inspector raj" of the MCI was ruthless in finding fault with DNB holders, often humiliating them in full public view. The author has personal experience of such "arbitrarism", whereby the DNBs were subjected to the highest scrutiny, and ghost faculty passed over.

The NBE was established in 1975 in an era when overseas qualifications were commonly sought. Although successful in maintaining a high quality of training and examinations, it lacked both the will and the ability to safeguard the interests of the vast pool of DNBs. Its lackadaisical response to alleged harassment or discrimination against DNBs in medical academia has been limited to its notifications of equivalence (3).

Some of the reasons cited by the MCI to validate its policies on "equivalence" (in reality, non-equivalence) of NBE and MCI degrees were lack of training at a sacrosanct "recognised medical college", inadequate research experience or bed strength (4).

A resident at a medical college is exposed to other specialties and interdisciplinary areas. However, to assume that a resident at an NBE-accredited institute would have no such exposure is preposterous. Let us consider the interdisciplinary exposure (to Obstetrics and Gynaecology) of Ophthalmology residents, working at medical colleges and NBE-affiliated corporate hospitals. The residents at medical colleges frequently encounter pre-eclampsia or eclampsia while attending referral calls; in contrast, despite possibly fewer encounters, the superior infrastructure at the corporate hospital would expose its residents to a different class of procedures; they may thus witness a case of visual disturbance (palinopsia) caused by an ovulation-inducing drug, clomiphene in an assisted fertility clinic.

Interestingly, the MCI did not have any issue with overseas qualification such as the Fellowships of the Royal College(s),