

LETTERS**Unjust exclusion from medical education of medical teachers with MSc (Medicine) and PhD (Medicine) qualifications**

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I would like to bring to the notice of academia and the public the plight of medical teachers (unjustly called “non-medical teachers”) with MSc (Faculty of Medicine) and PhD (Faculty of Medicine) qualifications, who are being systematically excluded from teaching posts by the erstwhile Medical Council of India (MCI), and now, by the National Medical Commission (NMC).

Before discussing the current situation, let me briefly describe the significance of this specially created course. The MSc course was first started in India at Madras Medical College in 1963, on the recommendation of the Mudaliar Committee, appointed by the Government of India. This step was intended to address the chronic shortage of teachers in basic medical sciences such as Anatomy, Physiology, Biochemistry, Microbiology and Pharmacology [1, 2]. Subsequently, many prestigious institutions such as the All India Institute of Medical Sciences, New Delhi, the Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry, Kasturba Medical College, Manipal, and various health universities in the different states, such as Dr NTR University of Health Sciences, Vijayawada, have introduced these courses and have been producing MSc (Medicine) postgraduates in these disciplines for decades.

Although, the course was initially included in the First Schedule of the Indian Medical Council Act, 1956 (Act 102 of 1956), dated December 30, 1956 [3] as a recognised medical qualification, these qualifications were unscrupulously removed by later amendments.

As per the NMC guidelines in the NMC Gazette dated October 28, 2020, the MSc (Medicine) qualification has been completely derecognised with the statement “appointment of these teachers is subject to non-availability of medical persons;” vide NMC Notification No NMC/MCI 35(1)98-med. (ii)123627, Schedule II, Point 5, Page 67 [4]. In addition, the latest NMC Gazette on Teacher Eligibility Qualifications in Medical Institutions Regulations, 2022, dated February 14, 2022, does not include any mention of the MSc (Medicine) and PhD (Medicine) qualifications for appointments in the Microbiology and Pharmacology departments. This will affect the livelihood of hundreds of teachers immediately, vide NMC Notification No. F. No. NMC/MCI-23(I)/2021-MED, Point 3.3, Page 27 [5]

It is a well-known fact that faculty shortages in these basic

medical subjects has always haunted medical colleges. Especially at a time when numerous new medical colleges are opening throughout India, denying recognition to the MSc (Medicine) and PhD (Medicine) degrees is going to have a disastrous effect. Without a strong foundation in these subjects, it is very difficult to move to an understanding of the other subjects in medicine. Therefore, it will lead to the production of inadequately qualified medical professionals and be harmful to the community at large.

The whole world is striving to achieve the best possible progress in various fields by encouraging an interdisciplinary approach. Teachers with an MSc (Medicine) degree bring in the much required diversity in perspectives which is very important for young medical students (since they come from varied disciplines at their graduation level including Life Sciences, Physiotherapy, Veterinary Science, Pharmacy, Homeopathic Medicine, Ayurvedic Medicine, Dentistry, Allopathy etc [1, 6, 7]. This diversity in perspective helps students, develop into well rounded and socially conscious physicians. By denying this diversity, the NMC is diminishing the richness of medical education.

By providing them with equal opportunities, professionals with an MSc or PhD in Medicine can be a significant potential pool for research and development in medicine for the country. Denying them equal opportunities to earn a livelihood, by treating the MBBS as superior to non-MBBS postgraduate degrees, not only hampers their professional growth but will also adversely impact medical education and society as a whole. It reflects the mindset of a society which rates medicine as a superior profession when compared to others. Such a mindset discourages young medical doctors from developing an attitude of respect to other professions which is very regressive.

It is time to recognise the services rendered by these professionals to Indian medical education over decades and recognise these qualifications instituted by the same authorities. This will give them their rightful place in the system.

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In search of ethical pandemic technology

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The duration of the pandemic over the last two years has witnessed the steering of multiple technological interventions by governments. These interventions — ranging from contact tracing applications to vaccine certificates — have been developed in the specific context of the pandemic, and were meant to address its unique requirements. This family of technological interventions may be termed “pandemic technology” — having diverse uses such as preventing the transmission of Covid-19, and aiding the relaxation of pandemic-induced restrictions. We propose a four-rung ethical paradigm for the deployment of such technology. We call it the STEP model and its four pillars consist of (i) sunset clauses, (ii) trust, (iii) equity, and (iv) privacy preservation.

While the proliferation of pandemic technology has occurred at a rapid pace, concerns remain on its largely unregulated status and inequitable uptake. The unsupervised spread of pandemic technology bears the risk of curtailing individual freedoms, and marginalising already vulnerable communities. Adopting the suggested model would therefore enable the development of privacy-preserving pandemic technology that is trustworthy and equitable, now and in future pandemics.

Essentially, the model implies that:

(i) Pandemic technology should be constrained by a mandatory sunset clause. This necessarily means that the intervention should also be backed by law. A sunset clause ensures that the law would automatically lapse after a particular date, thus de-commissioning the intervention. This is essential to ensure that intrusive emergency measures introduced during the pandemic do not spill over unjustifiably, beyond the horizon of the pandemic [1].

Designing the sunset clause contemplated above is a two-step

process. Regulation must hard-code the following objects into law:

First, the clause must fix a mandatory date on which the law ceases to exist, unless extended by competent authorities. Second, the clause must contain a provision for period review, to account for any risks that the continuous deployment of pandemic technology may entail.

(ii) The deployment of pandemic technology must inspire **trust**, by checking for the following — reliability, verifiability and accuracy. Technology providing assessments of an individual’s health (such as digital immunisation certificates) must be operable in both online and offline capacities, ensuring that the benefits of such technology are not lost to those without access to a smartphone or the Internet. Such technology must strive for universal interoperability, embracing open standards that can be adapted by relevant authorities for seamless access to services [2].

Ensuring trust involves communicating the scientific merits and limitations of each intervention to individuals using such technology. For example, immunisation certificates may carry a note stressing the importance of social distancing even among vaccinated individuals. This can help to avoid lowering the risk-perception of Covid-19 among people, potentially mitigating the impact of any novel variants of the virus that may emerge in the future.

(iii) The principle of **equity** must guide the deployment of pandemic technology. Here, the state must focus on equitable uptake of such technology. The state should develop strategies to overcome the digital divide prevalent in India and assume full responsibility for the uptake of such technology among the disadvantaged.

(iv) Pandemic technology must be deployed while preserving **privacy**. In the absence of a comprehensive data protection legislation in force in India, it remains critical for the state to lead with regulation that adapts universally accepted privacy principles to secure the personal data of individuals.

There is precedent that convinces us to remain optimistic on this frontier. The Aarogya Setu’s Data Access and Knowledge Sharing Protocol, 2020, [3] serves as a useful regulatory example on outlining permissible uses of data collected and processed by pandemic technology. A broader framework, building on the principles outlined in this protocol can guard for privacy risks and ensure the responsible use of personal data for public health objectives.

It is important to acknowledge that the pillars of the S.T.E.P. model will robustly intersect when applied to technology. We do not view this as a limitation — interaction among the discussed principles is desirable — with each pillar nourishing the others to secure pandemic technology against misuse. The adoption of these principles could