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Accreditation in India: The road not taken

In India, in recent years, accreditation by national agencies has come to play a major role in higher educational institutions (HEIs) usurping the role hitherto played by regulatory agencies because of its importance in admissions. While the need for quality control has great merits, it has come at a great cost to education by the very nature of the process and the weightage for various activities of an educational institution on a day-to-day basis.

The two major accrediting agencies in India are the National Assessment and Accreditation Council (NAAC) and the National Institutional Ranking Framework (NIRF). The criteria for ranking have been imported from foreign accrediting agencies without reference to the Indian scenario and without reference to different educational streams.

In the NIRF ranking criteria, there are five areas: (i) teaching/learning and resources; (ii) research and professional practice; (iii) graduation outcomes; (iv) outreach and inclusivity; and (v) perception. All these carrying equal weightage of 100 marks out of 500 or 20%.[1] In the Research category weightage is almost exclusively for number of publications in one of two major indexing data bases, Scopus and Web of Science and the UGC care list. PubMed, in which most health sciences publications are indexed, does not find a place. Since there is focus on numbers, unhealthy practices such as hiring professional writers to produce papers, number-based targets, and paid publications amounting to as much as ₹50 000 per paper have replaced traditional practice. Quality research has no value, only quantity as measured by numbers.

In the NAAC system, of a total of 1000 marks, 250 marks are for research-related activities and innovations such as intellectual property rights (IPR). The weightage for other metrics are: (i) curricular aspects 150 marks; (ii) teaching/learning and evaluation 200 marks; (iii) infrastructure and learning resources 100 marks; (iv) student support and progression 100 marks; (v) governance, leadership and management 100 marks; and (vi) institutional values and best practices 100 marks.[2]

Neither gives any value to quality of teaching/learning as evidenced by program outcomes, program specific outcomes or course outcomes. Since the criteria are uniform across streams, there is no weightage for patient care activities in HEIs devoted to healthcare and no provision of quality of these services or feedback from patients and relatives. IPRs such as patents and copyrights are infrequent in HEIs devoted to healthcare. There is major weightage for placements and activities such as industry collaborations. While these may be relevant to engineering streams they are of little merit for the healthcare stream. Placements are rare in the medicine stream as most students pursue postgraduation or are self-employed.

The result has been that less than 10 healthcare only-related HEIs find a place in the ranking framework in the top hundred ever since accreditation started in India. For a ranking process to be fair, the weightage for different aspects should be based on the nature of the institution and not be uniform across streams. Also, all activities such as teaching/learning, research and patient care should receive equal weightage for healthcare institutions and criteria which are less relevant to them such as placements and industry collaborations, startups, etc. should have less value. Therefore, the guidelines need to be revised and specific ranking criteria for each stream of education need to be drawn.

A new NAAC accreditation system is said to be coming with 10 metrics instead of 7.[3] These are under three categories and include: (i) input metrics (curricular design, faculty resources, infrastructure, and financial resource and management; (ii) process metrics (learning and teaching, extended curricular engagements, and governance and administration); and (iii) outcome metrics (student outcomes, research and innovation outcomes, and sustainability outcomes).

Though these new criteria are a great improvement on the old scheme, once again there is no weightage to the major activity of a healthcare-related HEI, namely patient care activities. In fixing weightage, factors such as the stream of education and the applicability of the metric to that stream must be kept in mind. These new guidelines should be stream-specific. A similar process is also long overdue for the NIRF criteria.

One hopes that we will go on a new path and not stick to the beaten track or import metrics from abroad without local relevance.

Robert Frost in his poem 'The road not taken' ends by saying 'Two roads diverged in a wood, and I took the one less traveled by, And, that has made all the difference.' We need to be innovative and fair in our accreditation process and ignore what others do and take the road less taken. Otherwise, it will increasingly result in demotivation or what is worse, fudging.

Conflicts of interest. None declared

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Sebaceous carcinoma arising in a sebaceous cyst: Impossible, because 'sebaceous cyst' is a histogenetic misnomer

We read with interest the letter by Kumar *et al.* on malignant transformation in a sebaceous cyst.[1] Though they state that such a transformation is 'uncommon but not impossible', we most emphatically state that it is indeed impossible. As Nigel Kirkham states, 'It seems impossible to get across to general surgeons that 'sebaceous cyst' does not exist.'[2]

The term 'sebaceous cyst' is misleading and is in fact, a misnomer. Most 'sebaceous cysts' are either epidermal cysts with an epidermal lining or are pilar/trichilemmal cysts with keratinization.[2] This misnomer is frequently used in place of more appropriate terminologies such as epidermoid cyst or epidermal inclusion cyst.[2,3] Histologically, these cysts are lined by squamous epithelium which produces and forms the cyst's lamellated keratin content. There is no component of a sebaceous gland in these cysts.

Although rare, there are several case reports of malignant transformation in an epidermoid cyst into squamous cell carcinoma.[3,4] However, these cysts cannot develop into sebaceous carcinomas because they lack sebaceous glands, as previously stated.

A truly sebaceous cyst would have a lining of sebaceous glands. One such example is the Steatocystoma simplex, which is a cyst derived from the pilosebaceous junction and contains lobules of sebaceous glands within the lining of the cyst, along with squamous epithelium.[6]

Sebaceous carcinomas, on the other hand arise from the epithelium of the sebaceous gland. Histologically, they display sebaceous differentiation coupled with basaloid cells and clear cells.[5] Given the components of a sebaceous carcinoma, it is clear that an epidermoid cyst cannot evolve into a sebaceous carcinoma.

We hypothesise that a malignant conversion of a long-standing sebaceous adenoma or a steatocystoma complex or disordered sebaceous hyperplasia into sebaceous carcinoma could be an alternate explanation for the case reported by Kumar *et al*.[1]

We note that there is no pathologist among the authors and that their diagnosis is not supported by any histology image. Epidermoid cyst and sebaceous carcinoma are both diagnosed on histopathology and have distinct morphological characteristics.[3–5] Had there been a pathologist as a co-author and if an image had been provided, we suggest that such an error might have been easily avoided.

We further observe that the authors have used the abbreviation 'SC' for sebaceous carcinoma and then proceed to use the same abbreviation for 'common, benign, intradermal or subcutaneous dermatological lesions', which we presume are epidermoid cysts or as they refer to it, 'sebaceous cysts'.

Conflicts of interest. None declared

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Author's response

We thank the letter writer[1] for a detailed analysis of our manuscript.[2] We also appreciate the truth behind the histogenetic background regarding sebaceous cyst. However, the terminology sebaceous cysts still has a mention in surgical texts books.[3] It is noteworthy to quote a line from the said textbook: 'Epidermal cysts, derived from hair follicle infundibuli or traumatic inclusion are commonly known as sebaceous cysts. They are usually distinguished from epidermal cysts by pathologists, rather than clinically.'[3] Therefore, surgeons should consider this when diagnosing a sebaceous cyst.

As for the abbreviation 'SC' we do apologize for the typographical error, which occurred inadvertently. The first 'SC' abbreviation is for sebaceous carcinoma but the second 'SC' should be read as sebaceous cyst which should have been either written or abbreviated differently.

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