

Speaking for Myself

Reforming medical education in India: Evolution before revolution

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The need to reform India's medical education system has been discussed for many decades. Much time is spent on debating the inadequacies of the current approaches. Many justifications and possible solutions have also been highlighted in the literature.¹

The bidirectional and reciprocal relationship between medical education and health service is often highlighted. A contextual curriculum, which aligns with healthcare needs, is also underscored. Early clinical exposure, competency-based curriculum, horizontal integration between disciplines to teach specific systems and particular diseases and vertical integration between basic sciences and clinical specialties are emphasized.¹ Regular clinical postings to secondary hospitals to expose students to the reality of healthcare setting in rural India are also highlighted. Clerkship and residential programmes and simulation and skill laboratories to prepare students have been recommended. Interdisciplinary approaches and family medicine have also been stressed. E-learning websites, distance education and telemedicine programmes, to harness modern technology are suggested.

Nevertheless, converts to the need for an ideal medical curriculum for India, and innovators of new approaches essentially sing to the choir. There is always a fervent hope of a revolution in Indian medical education despite acknowledging the humongous challenges. However, much less time is spent analysing the contexts, which usually produce such dramatic change. While many of the issues required for such change are mentioned although subliminally, the debates do not deliberate the major characteristics and contexts required for success in changing the curriculum. Some issues for a successful revolution in medical education in India are briefly summarized.

EVOLUTION BEFORE REVOLUTION²

Many innovations to medical education, in medical schools in India, are often described as small revolutions within these institutions. However, a careful reading between the lines often suggests a slow evolution of ideas and practice even within the examples provided. For example, institutions, which had developed programmes for teaching medical students in primary care and secondary hospitals, did not occur overnight. They were preceded by many years of linkages with such facilities, collaborative efforts between their staff and prolonged exposure of medical college teachers to the context of the realities of healthcare in India. Many innovations were possible because much of the spadework was done by many of their predecessors, which permitted meaningful changes to occur much later. While modern innovators claim credit for their success, they often fail to acknowledge the giants on whose shoulders they stood and those who allowed them to see beyond the horizon.

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It is obvious that revolutions do not happen in a vacuum; they occur in specific contexts, often with a slow build-up of momentum for change. In fact, the faculty in medical schools, who discuss recently established changes in their curriculum also often briefly mention many small and prior improvements in teaching–learning methods supporting the contention that it is not individuals or simple good intentions and efforts, which result in major changes. Even small changes to the curriculum require pioneers, facilitators and a favourable environment, which usually evolve over time, overcome inertia and allow experimentation using newer approaches that permit revolutions. Without a critical mass of teachers within departments and institutions and without a substantial history of such efforts, major changes in the curriculum are not possible. To demand such revolutions in medical colleges across India without similar facilitatory environments within institutions is delusional.

THE RICH GET RICHER³

The catalogue of innovations such as exposure to secondary care hospitals, family medicine departments and the incorporation of service–learning projects are only possible in institutions, which had well-functioning secondary hospital facilities and departments of family medicine. Not all medical colleges today have a critical mass of motivated staff and well-functioning facilities, which are not part of tertiary care medical schools and yet draw huge patient loads and have teaching facilities for relocating medical education to expose medical students to the reality of primary and secondary care so that they develop skill and confidence in managing common problems seen in the community.

Similarly, the recognition and the setting up of skill and simulation laboratories and using them to assess competencies before exposing medical students to clinical situations and patients mean that institutions, which are rich, both in terms of money, equipment, facilities, motivated faculty, and already enriched environments are the medical schools which have set up such teaching innovations. To expect such technology-based learning laboratories in cash-strapped institutions—both government and private—is being unrealistic. Only when a critical mass of medical schools acquire such facilities will it be practically possible to implement such programmes across medical schools in the country. Changing the medical curriculum will have to have a slow build up in order that the majority of institutions are able to come on board and use the newer approaches recommended.

SERVICE DELIVERY FOR TRAINING

People-centred care is focused and organized around the health needs and expectations of people and communities, rather than on diseases is critical for universal health coverage.⁴ While

holistic care by basic doctors is ideal, training such physicians require model service delivery programmes within teaching institutions with interdisciplinary and multidisciplinary staff collaboration situated in shared facilities in order that students are simultaneously exposed to such holistic approaches. The current specialist and specialty-based departments in medical colleges will have to reorganize their services to be centred on the needs of patients with particular conditions to provide a one-stop facility for care and management.

For example, interdisciplinary facilities such as clinics for people with diabetes where physicians, ophthalmologists, dieticians, health educators, physiotherapists and social workers work synergistically to manage patients with diabetes and its many complications will allow students to learn holistic care and manage them when working in small hospital settings. Talking about interdisciplinary care without demonstrating a working model and template to medical students will not result in the transfer of the necessary skill and confidence for holistic care.

THEORIZING PRACTICE

Common problems routinely seen in primary and secondary care need to be understood within their specific context. Despite the general and mistaken belief that theory drives practice, it is actually practice, which defines the medical theory. The practice–theory gap demands that clinical criteria, guidelines and protocols often developed in tertiary and specialist care, which drive all medical practice, need to be rewritten when they fail to deliver healing and cure in the different contexts of primary and secondary care.⁵

There is a need to acknowledge that specialist cultures shape our concepts of disease, their explanations and our approach to managing illness; education set in tertiary medical settings will not empower physicians working in primary care and secondary health facilities nor provide the skills to identify common problems and manage them. There is a need to re-work the current international–specialist approaches, keeping in mind the complex nature of the reality in India. Contexts not only change medical practice but they should also be able to change medical theory.⁵

The milder, mixed, subsyndromal and non-classical presentations commonly seen in primary and secondary care differ from the severe, complex, chronic and rare disorders presenting to tertiary facilities. The differences in patient populations and settings should result in a medical theory that is suited to the context of primary medical care for India.

THE POLITICAL ECONOMY OF HEALTHCARE

Despite medicine's lofty rhetoric of curing disease, relieving suffering and healing the sick, the discipline is nested within the political and economic landscape of capitalism. Despite its scientific base, medicine is a system sanctioned by the society in which it practices. Scientific knowledge comprises beliefs

shared by experts.⁶ The social nature of science argues that scientific authority belongs to communities both within and outside medicine. Such knowledge structures enhance and maintain the exercise of power and social control.⁷

The latest rightward shift in India's politics and economics situates medical education and healthcare industries in the country within its capitalistic goals favouring specialist and tertiary care medicine; it undergirds the hospital, healthcare, pharmaceutical and insurance industries. These forces seem to disempower basic doctors to increase specialist and tertiary care practice and profits.

Medicine in India needs to theorize medical practice, which is relevant to healthcare needs of the country. It needs to address the felt need of the vast number of generalists who work in primary and secondary care and general medical settings.

THE WAY FORWARD

Context and local knowledge are critical to understanding illness. Healthcare in India should be able to choose a different framework for the management of common problems. Contexts should not only change medical practice but should also be able to change medical perspectives.⁵

Seeing the bio-psycho-social world through the 'practice lens' will allow academics and teachers to understand the complex dynamics of health and disease in communities.⁵ There is a need to rethink medical practice and for critical reflection on the medical culture in the country.⁸ There is an urgency to narrow the practice–theory gap. The medical fraternity in India needs the political will to theorize medical practice rather than practice theory that is contextually not appropriate for the country. It needs to shift medical education from the tertiary care ivory towers to teaching and training in primary and secondary care to better understand the complex reality of healthcare needs in India and provide appropriate and cost-effective solutions.

Conflicts of interest. Nil

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