Speaking for Myself

Medical education in Hindi and indigenous languages in India: Issues and challenges

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ABSTRACT

In October 2022, the launch of first year MBBS books in Hindi language in the state of Madhya Pradesh in India kick started the debate on the introduction of Hindi/local language in medical education, which is currently being imparted in English. Opinions have been divided among the supporters of Hindi and local languages as well as opponents of this move. However, several issues need to be addressed before wider implementation of the policy of imparting medical education in Hindi/local languages. Right from infrastructure, human resource, economic impact, academic impact, international effects to legal issues have to be kept in mind and stakeholders must discuss these before implementation. A subsequent reversal of this policy, either through executive orders or judicial intervention, could lead to irreparable loss to students enrolled and trained in Hindi/local language.

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INTRODUCTION

The issue of imparting medical education in a local or native language is not new. Across the globe, various countries such as Russia, China, Japan and Germany impart medical education in their local languages. In October 2022, the syllabus for the first year MBBS was launched in Hindi in medical colleges of the state of Madhya Pradesh, India for the first time. This news was covered by all the leading media channels across the country and the government released the MBBS course in Hindi at a big public function.[1] The decision of the government was hailed as freedom of education by the Chief Minister of Madhya Pradesh, who said that those who want to study in English can do so, and that there is no compulsion to receive medical education solely in Hindi.[2] Similarly, instruction in Tamil is also being introduced in Tamil Nadu in India.

Doctors, medical students and health experts have mixed opinions and reactions about Hindi textbooks for MBBS students in Madhya Pradesh. While some called it a ‘stepping stone’ and ‘breakthrough’ in medical education, others termed it as a ‘gimmick’, ‘propaganda’ and ‘linguistic politics’. Strong arguments have been made in favour as well as against imparting medical education in local languages.[3–6] The decision of the government is considered as a step to promote the local languages, but this decision has raised more issues and challenges which must be discussed. Every decision and policy matter that has long-term consequences, both nationally and internationally. should be backed by feasible, practical and scientifically sound rationale.

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THE DEBATE

Studies indicate that those who study medicine in a native language have more confidence in communicating with local patients. In a study from Lebanon, despite having their medical education in a foreign language other than English, the majority of students in Lebanese medical schools are confident in conducting a medical history in their native language.[7] In another study among Arabic-speaking medical students, the authors proposed that simplified Arabic combined with English terminology may present a viable option for written texts in medical education in the local Arabic-speaking student population.[8] An editorial observes that although international communication among clinicians and scientists is now almost exclusively in English but patient contact, communication among colleagues within individual countries, teaching and some scientific activity are conducted in the local language.[9]

In another study among final year Arab medical students, most students thought that learning in English did not affect their academic learning and performance. However, a good proportion supported being taught medicine in Arabic and English.[10] In a study from Arab countries, all decision-makers expressed a positive attitude towards the choice of English for medical instruction, but there was also overall support for a future Arabic curriculum after the obstacles are overcome. The availability of medical resources was the main factor that made decision-makers agree upon English as the choice of language.[11] Other supporters of medical education in the local language argue that with the doctors speaking the native language, the compliance of patients to medical instructions will be better.[5]

However, supporters of continuation of the English language in medical education argue that this step reflects misplaced nationalistic sentiments, which would erode the competitive advantage Indian health professionals have in the global scientific arena due to a better command on English.[12] Many from the medical fraternity claim that it will dilute the quality of medical education, intensify the language barriers and create divisive sentiments.[13,14]

A considerable segment of medical graduates today are employed in allied sectors of research, business and administration, pharmaceuticals and the like. These sectors are entrenched in English and are thus likely to be much less welcoming to those who have studied in a regional/local language. There is a risk of engendering an implicit hierarchy

among medical graduates, whereby non-English medium graduates might be seen to be in some way inferior to their English-medium counterparts.[12] However, the advocates of this policy of imparting medical education in local languages state that countries such as Germany and China have long been doing so successfully and India can also go ahead on the same path. Though this move will restrict doctors to a particular state and thus lead to hurdles in inter-state jobs.

ISSUES AND CHALLENGES

More deliberations and clarifications are needed for a few issues and challenges before the policy of imparting medical education in Hindi or local languages is adopted and implemented for the whole country. This will help in making rational and logical policies as per our local resources, challenges, strengths and weaknesses.

1. The issue of introduction of Hindi or local languages in medical colleges run by the Central Government such as the All India Institute of Medical Sciences (AIIMS), Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Puducherry, etc. in various states needs more clarity. The constitutional position on the power of states to impose Hindi or local languages in the MBBS course in these medical colleges run by the Central Government too needs clarity. Does the state government have a role to play in determining the medium of instruction in all medical colleges within a state? Will the institutions of the Central Government in different states have to comply with the rules of the state government? What will be the obligation of private medical colleges and private deemed universities? Will it be voluntary or mandatory for them to introduce teaching in local languages? What if private medical colleges want to teach in English alone and petition the courts against government orders.
2. There are issues about doctors who will join, in future, medical jobs in the Central Government such as the Army Medical Corps (AMC), Ex-Servicemen Contributory Health Scheme (ECHS), Central Government Health Scheme (CGHS), railways, medical services through the Union Public Service Commission (UPSC) and other Central Government public sector undertakings (PSUs). How will doctors trained in different local languages, who join these services, do justice with patients in other states who speak different languages? The common medical cadres such as CGHS, AMC and in PSUs function with professionals from different backgrounds. Healthcare is most often team work and frequently needs immediate decisions and instructions in emergency situations where a common language acceptable to all members in a team is required to save the life of a patient. Would those trained in different languages be able to function together? Would they require to undergo a new short course to learn the state's language to practice and teach? Will it be optional to learn the new language or will it be mandatory?
3. The present medical course across the country is in English and the competencies have been standardized by the National Medical Commission (NMC). Will every state government translate the syllabus to a local language? This may lead to variations in translation and a somewhat modified syllabus. Clarity on how and who will standardize the competencies and syllabus in different languages would be required? Will the NMC standardize the course in Hindi and regional languages or will it be the prerogative of the states and its universities? Will it be mandatory for the respective states to get their translated medical syllabus standardized and approved by the NMC or will this be an optional requirement? Medicolegal or medical negligence issues may arise in the future because of differences in the language of instruction. This would need deliberation and a clear policy.
4. The government is opening new AIIMS and other Central Government medical institutes across the country where students join from any part of the country after passing a common entrance test. If most of the states start imparting education in different local languages, there is a possibility that most state quota students might opt for instruction in the local language. The students in the all-India category might be a small group left in the class who are interested in instruction in the English language. Will they have to compulsorily learn the local language? The language issue could deter students from different states joining a Central Government institution in another state and the all-India quota of the undergraduate and postgraduate (PG) courses in various government medical colleges might remain unfilled.
5. The availability of the infrastructure and trained human resource would be another issue. The medical education system has to think of it in terms of dual medium of teaching, i.e. will there be two lectures on the same topic—separately for those wishing to learn in Hindi/local language and those seeking instruction in English? If teaching occurs in dual languages at the same time, then more classrooms and laboratories will be needed. Do we have such infrastructure available?
6. If private medical colleges are also asked to impart medical education in Hindi/local language too by the state, then the cost of medical education will escalate. Private medical colleges will have to scale up the infrastructure for dual classes and enrol new faculty members, which in turn will increase the financial burden on colleges. For provision of salaries and perks to the additional faculty members or providing incentives to existing faculty members to conduct dual classes will result in an enhanced fee from students.
7. A plan would be required for each state to ensure uniform training of all teachers in the state to be well versed with the dominant local language. The issue of subjectivity in language cannot be ruled out because of varied background of the faculty members. A teacher from a north Indian state will be 'isolated' in a department in a south Indian state because the majority of teachers would teach in the local language and vice versa.
8. What would be the future of the NEET PG and proposed NEXT examinations? At present, these examinations are in the English language. Will a multi-language option be available in these examinations? How will students instructed in Hindi/local language face these examinations? This is important as the students who pass MBBS in Hindi/local language in the coming years will have to face the proposed NEXT and NEET PG test after MBBS and they could be at a disadvantage if the option of Hindi/local language is not provided.
9. Another issue pertains to the promotion of future medical faculty/teachers who pass MBBS in Hindi/local language.

As there are minimum criteria in publications for promotion, faculty who have trained in Hindi/local language may have difficulty in publishing in English language medical journals. The NMC would be required to provide a new set of guidelines to promote such faculty as presently publications are mandatory for promotion.

Publications are also required for academic excellence and selection to higher posts or selection in reputed medical institutions. Also, due to the increasing importance of impact factor for the evaluation of academic performance and career progression, publications in good journals are required. There is hardly any Hindi/local language medical journals. English-language journals achieve high impact factors because journals in other languages are unlikely to be read and cited as frequently.[9] Creation of curricula for medical education in different languages will be a herculean task as India is a multi-lingual country. Being limited to a particular state and its population, it will be a huge task to prepare a repository of medical terminology in different languages.

10. Working in an environment such as corporate hospitals and medical colleges is complex as doctors from different states and different backgrounds work together as a team. Surgeons, anaesthetists, cardiologists, nursing and paramedical staff work together in an operation theatre. If they understand and speak in different languages, it could create many problems and may lead to medical negligence because of difference in understanding of instructions and commands of each other.
11. India is becoming a hub for international medical tourism because of its quality and comparatively economical health and medical services. In the long run, the impact of medical education in Hindi and other local languages should be analysed in view of the impact of this policy on medical tourism in the next few decades.
12. The patient has a right to know the qualifications of his/her treating doctor. Also the doctor is supposed to display his/her qualifications on the front board of his hospital and prescription letterhead. Should the patient also have the right to know whether his/her treating doctor has acquired his/her MBBS degree in English, Hindi or a local language? This is important because it is directly connected to the patient's autonomy to decide about the treating doctor and it might be a legal issue about non-disclosure of complete information about the qualification.
13. A one-month Foundation Course for the Undergraduate Medical Education Programme by the NMC is being conducted at the start of the session where students are taught to get used to the medical college environment to overcome initial home sickness and cultural, geographical and background shock.[13] About 40 hours have been earmarked during this course to acquire one of the skills based on felt need and include the provision of conduct of special sessions on English language and computer skills. These English language sessions provide an opportunity for students from diverse backgrounds and language competency to undergo training in speaking and writing English, fluency in local language and basic computer skills.

    It is also mentioned that the English language skills training will be conducted as per the felt need and may continue beyond the foundation course.[15] Similarly, the importance of 'Communication skills' has been stressed upon under the Attitude, Ethics and Communication (AETCOM) module to be taught across all professional years of MBBS.[16] The local language could be also introduced in the foundation course and thus the need of the whole medical course in a local language will not be needed. The introduction of Hindi/local language MBBS courses seems to be a parallel decision and it could have been postponed for few more years by allowing the existing and newly introduced foundation course to reflect its result before introducing Hindi or local language courses in medical education.
14. The issue of involvement in multicentric research projects needs attention. Various national and internal research collaborations need a common language platform for communication and conducting a project. The student's scholarship research project under the Indian Council for Medical Research-Short Term Studentship (ICMR-STS) will be an issue among Hindi/local language undergraduate medical students as at present most of the interactions and research proposals are accepted in English by the ICMR.
15. As most medical literature in journals, articles and websites are available in English, the issue of updating the knowledge of doctors trained in Hindi/local language cannot be ignored. How would students from a Hindi/local language background update themselves with the ever-changing medical updates needs attention as most of the online and offline continuing medical education (CMEs) meetings and workshops are pan Indian in nature and are conducted in English. The opportunities for updating knowledge by a medical professional in local language are limited and this could be detrimental for them in the long run.
16. MBBS students studying in Hindi will be entering PG medical courses (MD/MS/DNB) in the coming years. The possible disadvantages to Hindi/local language students cannot be ignored as PG courses are currently available only in English.
17. The medicolegal cases would be another issue as most medicolegal reports (MLR) are in English. In case of medicolegal cases, during the court proceedings, cross-examination in courts could be an issue as most evidence is presented only in English. The police and judiciary would have to be sensitized about new terms in Hindi/local language. The software for MLR entry would have to be updated for Hindi/local language too.
18. Doctors from different countries, states and cities with different backgrounds participate and interact in national and international medical conferences and workshops. How would doctors who are trained in languages other than English interact with each other? The technology of translation is not easily assessable in most conferences as it adds to the cost and only a few organizers will be willing to opt for it.
19. As resource materials/literature/medical books and journals for references and medical research and treatment guidelines are mostly available in English, those who study in Hindi/local languages could find it difficult to get medical references in Hindi. About 9 of 10 new journals included in Medline at present are in English.[9] If a Hindi-medium doctor doing postgraduation writes a thesis for submission, the review of the thesis will need a person conversant with Hindi/local language. This could raise a logistic issue for evaluation agencies.

20. Many doctors aspire to join foreign universities for further studies and to settle abroad. The MBBS curriculum in non-English languages would limit the options of students seeking overseas medical education in the USA and the UK where examinations such as USMLE (United States Medical Licensing Examination) are conducted in English.[13] Similarly, medical students exchange programmes could get a setback because of non-English medium.
21. It is argued that nobody stops any medical student to learn English and explore their professional horizons across the country or even beyond. But, in the long run, the majority of medical professionals who will be dominating in a particular state will be from local language background and in a country like India with such diversity, one cannot ignore the possibility that in future political groups might ask for the state health and medical education jobs to be reserved for local language medical doctors and thus widen the gap in healthcare delivery on the basis of language.
22. An MBBS degree from many medical institutions in India is not recognised in western countries and any move to indigenise the medium of medical education will be a step backwards in this regard.[13] This might hamper job opportunities for meritorious students who have learned the art and science of medicine in indigenous languages.
23. In a democratic country like India various parties have the opportunities to form a government every 5 years after winning the elections. Most of the parties have their own ideologies about various issues related to governance, education, health system, etc. including language of medical education. The governments keep changing at the Central and state level, so the life and future of thousands of medical students will be affected if the decision of imparting medical education in indigenous language is scrapped by the new government as the previous students enrolled in Hindi/local language will be left in the lurch. They might even find it difficult to register with state medical councils.

CONCLUSION

In India, many state governments promote the introduction of English at the primary school level and consider it a major achievement in the education sector. The global village concept is gaining acceptance by every passing day. English is at the forefront as the language for interaction in this global village. India has been a beneficiary of global jobs, research, business in the western world because Indians are comfortable in English language. Even countries such as China are introducing English at the primary school level so that their future generations could compete in this global village.

Despite many new health initiatives under the National Health Mission, India is still struggling to provide quality primary healthcare to the masses; so the energy and direction of our efforts should be directed towards providing quality healthcare services to the masses. Also, there is not a 'serious' demand from medical students for the introduction of MBBS syllabus in Hindi and other local languages. While Japan and China are quoted as examples for provision of medical education in local languages, it should be noted that both countries have a homogeneous language across their nations and they do not have as much diversity in languages and scripts as in India.

Every decision will have supporters and opponents. Although political will is important to make any policy change and ensure implementation, it would help if complex decisions such as those related to medical education are taken in consultation with relevant stakeholders and experts in the field. The decision should be backed by scientific and legal facts along with detailed deliberations on the issues and challenges that could be encountered in the near and distant future. The undergraduate medical course is not a water-tight compartment but a permeable one which interacts with many other stakeholders and thus simultaneous changes have to be made in other sectors too for desired results.

Each language has its strengths and shortcomings; so a mixture of a mother language and English could be a suitable solution as concluded in a study from Palestine.[17] A draft on the medium of medical education should be prepared and must involve all stakeholders including doctors' associations, medical associations of various specialties, etc. Public opinion too should be sought on this issue. An ideal solution would be to have a comprehensive law by the Central Government approved by both houses of Parliament and approved by competent authorities. Then the course should be reintroduced in a phased manner for its wider implementation.[18]

In the present scenario, various issues need detailed deliberations. The focus should be to promote and strengthen teaching of AETCOM in the current medical education system via the foundation course so that the language issues are resolved with more informal introduction of local languages in the future.

Conflicts of interest. None declared

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Basic medical sciences are pre-clinical subjects, not non-clinical subjects: Say 'No' to the prefix 'Non-'

FARIHA SABEEN

ABSTRACT

Few medical institutions in India, such as the All India Institute of Medical Sciences (AIIMS), use the term pre-clinical in their websites and brochures, but many institutions still use the word 'non-clinical'. In my opinion, the non-clinical departments should be renamed pre-clinical departments. In western countries, the curriculum is divided into pre-clinical and clinical. For example, in Oxford University, the initial instruction in courses such as Anatomy and Physiology is regarded as pre-clinical instruction. Non-clinical departments in western countries are the departments of human resource, accounts and information technology (IT).

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INTRODUCTION

I came across the word 'non' for the first time when I was six years old. In my *Textbook of Environmental Sciences*, there was a chapter named 'Living and non-living things'. I remember the definitions which I learnt by heart: living things are those which can breathe, eat, feel, grow and move (such as humans), whereas non-living things are those which do not have life in them (e.g. stone). My tender brain saved this information and I understood that non is used as an alternative for not. Later, when I grew up, and my vocabulary improved, I found that non is a Latin word, which means not.

Fast forward several years, I got busy in my studies, worked hard and finally my dream of getting admission in a medical college was fulfilled. I do not belong to a medical family as none of my parents or siblings were doctors, I was not aware of the medical syllabus (needless to say there was no high-speed internet back then so I couldn't Google it). I went to the medical book store to buy my first-year books, over-excited and happy. The owner of the book store shouted to his assistant, 'Bring the first-year medical books kept in the non-clinical section'. I was surprised. Wasn't I going to become a doctor? Then why was he saying the 'non-word'? My brain related it to not, no, none and many more negative words. Puzzled, I took the books and came back home. The following day was the first day of my journey to become a doctor. Full of enthusiasm, I went to my first lecture. It was an introductory session by our principal. He explained the medical curriculum in detail. He said, 'The first and second year of medical college comprises non-clinical subjects and the third and final years comprise the clinical subjects.'

Yet again, the non-word disturbed me. Next week, in the physiology laboratory, we were being taught to examine pulse. I asked my batch-mate sitting beside me, 'If physiology is a non-clinical subject, why are we being taught to examine the pulse of a patient?'

She shrugged her shoulders. Slowly over time, I realized that everything taught in the first year is after all related to patient care. For instance, the knowledge of anatomy helps in major surgeries, the knowledge of physiology of the various systems helps in diagnosing diseases and likewise, the knowledge of biochemistry provides the basis for practical advances in medicine.

Time flew and I got promoted to second year. Meanwhile, my grandmother became ill. She was prescribed many medicines. I read the names of the composition on the medicine boxes and matched from my pharmacology book. It gave me immense pleasure; I felt the excitement of becoming a doctor. Once again, I asked my same batch-mate (now my friend), 'If pharmacology teaches the names of the medicines, why is it considered non-clinical?', she gave me an irritated look.

While preparing for my microbiology final examination, the names and nature of lots of bacteria, viruses and protozoa confused me a lot. I gathered all my courage and again asked the same friend, 'If microbiology teaches so much about the causative agents of such deadly diseases, then how is it non-clinical?', this time she couldn't take it. Pressure of the examinations and lack of sleep were taking a toll on her. She got annoyed and said, 'You ask too many questions.' And that was it. I decided not to indulge in this useless discussion.

MBBS came to an end and I passed with flying colors. After completing my internship training, I started working as a medical officer in various multispecialty hospitals. My relatives were also proud of me. They often called to discuss about any

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