

News from here and there

Over 4000 postgraduate medical seats approved for the academic year 2017–18

Securing a postgraduate (PG) medical seat of their choice has been a distant dream for most medical graduates (MBBS) in India because of limited PG seats and the shortage of teaching medical faculty. The Government of India has recently approved a record number of additional 4193 PG seats in various medical colleges and hospitals across India for the academic session 2017–18. Of these, 2046 seats have been increased in medical colleges. An amendment in the teacher–student ratio has enabled the creation of 1137 additional seats in 71 government medical colleges. The increase includes 2147 additional seats of Diplomate of National Board (DNB). With this move, a total of 35 117 PG seats have become available. The notification of adding 5000 PG medical seats is likely to be made soon.

Unique identification number for doctors in India

Speaking at the 22nd National Conference of Bronchology and Interventional Pulmonology (BRONCOCON 2017), organized at the Christian Medical College (CMC), Vellore, Tamil Nadu, on 3 March 2017, the president of the Medical Council of India (MCI), Dr Jayshree Mehta stated that the MCI was planning to give unique identification numbers to all doctors in India. Compared to the 22 medical colleges that existed then and 500 doctors passing out each year when the MCI was established in 1933, there are 460 medical colleges at present and more than 63 985 doctors pass out each year. Given these huge numbers, the move of assigning unique identification numbers will facilitate an assessment of how many doctors practise in the country and make it easier to track the movement of doctors from one state to another.

ALLADI MOHAN, *Tirupati, Andhra Pradesh*

Have the best years of surgical training passed?

In May 2017, the *BMJ* published two articles addressing the issue of perceived quality of present surgical training versus that four decades ago and the calibre of doctors receiving the said training. Currently, residents have shorter working hours and fewer years of surgical experience, and this is deemed to be inadequate by older generations of doctors. Whether there is truth in these concerns or whether there is an element of generational bias remains to be seen. The reference of bygone eras as a golden age now lost, has however, put an additional stress on younger physicians who struggle to cope with the expectations.

One article (Limb M. Generations divided on whether today's medical training is up to the job. *BMJ* 2017 May 18;357:j2374. doi: 10.1136/bmj.j2374) reviewed a survey conducted by the UK Medical Careers Research Group at Oxford University's Nuffield Department of Population Health (Smith F, Goldacre MJ, Lambert TW. Adequacy of postgraduate medical training: Views of

different generations of UK-trained doctors. *Postgrad Med J* 2017 May 8. pii: postgradmedj-2016-13456. doi: 10.1136/postgradmedj-2016-13456). It looked at how different generations of UK doctors viewed the quality of their training. The cohorts included junior doctors towards the end of their first year after qualifying; middle stage doctors about 12 years after postgraduate qualification; and experienced senior doctors in their fifties or sixties. The study, conducted between 2010 and 2014, involved approximately 19 000 doctors who graduated between 1974 and 2012 as correspondents. About 38% of senior doctors working in UK hospitals said that they did not think that specialty training enabled new consultants to practise adequately, and only 21% said they thought it was sufficient. Senior general practitioners echoed similar concerns with 28% saying that they did not think that general practice training was adequate for those taking up posts in general practice. Apropos these results, the researchers found that only 12%–16% of all juniors felt inadequately trained. The researchers said that it was not clear whether the survey responses reflected actual levels of clinical experience, 'generational bias', or a need for alteration of current training practices to tackle deficiencies. Recent changes in the educational system with shorter training periods leading to lower levels of experience among doctors was postulated as one of the causes for a lack of confidence by the authors of the survey, and they recommended further research to examine the clinical significance of these results.

The second article (*BMJ* 2017;357:j2430) covered the William Pickles lecture given by Clare Gerada, a partner at the group of general practices that run the National Health Services (NHS), at the Royal College of General Practitioners' spring general meeting in London on 12 May 2017. She suggested that there was an element of generational bias with older doctors projecting their times of medical training as a 'golden age' of medicine. This comparison of past versus present quality of training was responsible for deterioration of the mental health of younger doctors, who struggle to cope with the expectations. Dr Gerada argued that the socioeconomic scenario of medical practice was vastly different across decades and did not lend itself to comparison. Earlier generations were not hindered by the demands of a marketized healthcare system with litigations and regulations, which are seen in current times. However, trainees in earlier eras faced favouritism, bullying and patronage drawbacks and merit-based growth was perceived to be relatively limited. She recommended future GP training be extended to 5 years from the current curriculum of 3 years to increase confidence and aptitude levels in practising doctors.

Dr Mario Vaz, Professor, Division of Humanities and Health, St John's Research Institute, Bengaluru said, in an email, 'I believe that over the years, possibly because of mushrooming of colleges in India and lowering of the bar at examinations, teachers and students have tended to focus less on basic and essential practical/clinical skills. Only a small fraction of doctors are likely to graduate with the competence to practice medicine rationally and independently. On the other hand, there is little doubt that students do have to deal with information overload—our curriculum is sorely in need of reform. Ironically, this idea

is not new (to quote from an article by Dr Louis Monteiro, when he was Dean of T.N. Medical College, Bombay [now Mumbai] in 1959): “Scientific advances in the medical sciences and the related fields of biology and behavioural sciences have been phenomenal and have been included within the curricular structure by a process of accretion. The net effect has been to over-burden the curriculum, which can now be likened to the prehistoric dinosaur, which amassed a body-size beyond the point of stability and collapsed under its own weight” (Monteiro L, Panse VN. Experimental course in pedagogy for medical teachers. *Med Edu Bull* 1959;4 (3):11–13).’

MAHARRA HUSSAIN, *Dubai, United Arab Emirates*

Deep cuts for science and medicine in US budget proposal

US President Donald Trump sent his 2018 budget proposal to the US Congress on 23 May 2017, proposing a reduction of US\$ 1.5 trillion in non-defence spending and another US\$ 1.4 trillion in Medicaid spending, while boosting defence spending by over half a trillion dollars over a decade. This spending plan (for the fiscal year that begins in October 2017) calls for significant cuts to spending on medical and scientific research, public health and disease-prevention programmes, environmental research programmes, and health insurance for low-income Americans and their children. The plan takes a wide sweep at a number of agencies including the National Institutes of Health (NIH) (facing an 18% or US\$ 7.7 billion cut), the National Science Foundation which gives grants for non-medical research in science and engineering (11% cut), Environmental Protection Agency (31% cut to the enforcement of programmes that support clean air and water), the Centers for Disease Control and Prevention (17% cut), and the Food and Drug Administration (31% cut).

The cuts will affect all the institutes in the NIH (e.g. National Cancer Institute [US\$ 1 billion], National Heart, Lung and Blood Institute [US\$ 575 million], and the National Institute of Allergy and Infectious Diseases [US\$ 838 million]). The reduction in NIH funding specifically targets the overhead payments that are currently made to universities on top of the direct research costs for a project. These so-called indirect administrative costs, comprising about 30% of NIHs total grant funding, are currently independently negotiated between individual institutions and the government. These variable rates are proposed to be replaced by a uniform 10% rate with a view to reduce the ‘the risk for fraud and abuse’. The proposal also calls for the elimination of the Fogarty International Center, which trains scientists and clinicians to work in developing countries. At the same time, the proposed plan would create a US\$ 272 million National Institute for Research on Safety and Quality that would study the outcomes of treatments and health services, taking on the role of the erstwhile independent Agency for Healthcare Research and Quality (AHRQ), which, in turn, would be eliminated. Money would also be set aside to fund the Brain Research Advancing Innovative Neurotechnologies (BRAIN) Initiative (US\$ 86 million) and the Precision Medicine Initiative (US\$ 100 million), which is a 10-year effort to track the health of a million Americans.

As expected, there was a great hue and cry from many quarters, calling these proposals an ‘assault on science’, ‘devastation’, a ‘horror’ and a ‘machete chop’, with intense criticism by scientists, physicians and politicians from both the Democratic and Republican parties. Since, under US laws, the actual budget is drawn up and passed by Congress, it is likely to not see the light of day, at least in its current form.

HARESH MANI, *Falls Church, Virginia, USA*

The National Medical Journal of India is looking for correspondents for the ‘**News from here and there**’ section. We are particularly interested in getting newswriters from the north and northeast regions of India as well as from other countries. By news, we refer to anything that might have happened in your region which will impact on the practice of medicine or will be of interest to physicians in India. The emphasis of the news items in this column, which are usually from 200 to 450 words, is on factual reporting. Comments and personal opinions should be kept to a minimum if at all. Interested correspondents should contact SANJAY A. PAI at sanjayapai@gmail.com or nmji@nmji.in