Letter from Mumbai

POSTGRADUATE PRACTICAL EXAMINATIONS: LESSON TAUGHT BY Dr RUSTAM N. COOPER

Dr Rustam N. Cooper (1893–1966) was a beloved teacher at Seth Gordhandas Sunderdas Medical College and King Edward VII Memorial Hospital in Bombay (present Mumbai). Meticulous in teaching and in surgery, he set a sterling example on the assessment of candidates appearing for the examination leading to the Master of Surgery (MS) degree.

As a young resident surgeon in Sir Jamsetjee Jejeebhoy Hospital, I had an invaluable experience when I was asked to help as an assistant in the conduct of the practical examination held by the University of Bombay in my hospital.

This gave me an opportunity to study four giants in Indian surgery as they examined candidates. The examination included evaluation as each student studied and discussed a 'long case', three 'short cases', pathology specimens, selected X-ray films, surgical instruments and at a viva voce examination. A 'long case' permitted the candidate to examine the patient over a prolonged period (30 minutes). A 'short case' permitted the candidate to examine the patient over a short period (5 minutes). Pathology specimens were selected from the pathology museum and showed diseased organs or parts of body that had been studied at autopsy and preserved for the education of generations of students. The viva voce examination ranged over a wide variety of surgical matters.

While the other three examiners (from Chandigarh, Madras and Calcutta) asked questions, listened to answers and memorized their conclusions, Dr Cooper followed a different pattern.

At the start of the examination, he requested a clip board and sheets of blank paper. He drew several columns on each sheet. Rows were made, one row for each candidate. As the candidate approached the examiners, he would note the code number allotted to that candidate. He would then listen to the candidate and ask questions when he needed clarification or additional information, as indeed, did the other examiners. From time to time, he would write something in the columns. As that segment of the examination was concluded (let us say the 'long case') he would enter a number at the end of his earlier notations. For the next case, he would start afresh in the next column. At the end of that candidate's examination, in the last column, he would place a number—average of the earlier numbers.

This was done for each candidate.

At the end of the day, the examiners huddled together to make the final assessment of each candidate, starting with the first entrant into the hall.

While the other examiners deemed the candidate passed or failed from memory, at times offering one or more reasons, Dr Cooper would turn to his clip board and give his assessment of the candidate under discussion under each of his heads. 'I found the history of the patient's illness as narrated by the candidate to be excellent (or poor or pathetic as the case may be)'. He would then quote statements made by the candidate and replies to queries by examiners to support his assessment. 'His general examination of the patient was excellent (or poor or pathetic as the case may be)' with similar quotations from statements and so it went right up to the time the candidate left the hall. He then gave his final decision on whether the candidate had passed or failed by reading the number in the last column.

The contrast was evident. While the other examiners maintained mental images of the performance of each candidate, Dr Cooper had documentary evidence of the performances at every stage of the examination. He could not be challenged as regards his conclusion.

At the end of the entire examination, I was emboldened to ask him about his system. He kindly explained that he had learnt this while studying in Britain. He showed me the sheets he had filled up. Each column had a heading. 'History', 'Clinical examination—general', 'Clinical examination of the diseased part', 'Reasons for requesting tests', 'Differential diagnosis', 'Final diagnosis', 'Proposed treatment', 'Prognosis' and 'Replies to questions'. At the end of each column, he had placed a number between 1 and 10; 10 denoted outstanding performance. The final column averaged the numbers in each column.

'As you can see, I enter in brief—almost in shorthand—the important statements made by the candidate under each head, validity of his findings, reasoning as regarding tests, treatment and prognosis and answers to our queries. I find that this makes for objective assessment. If I was deprived of this clip board, I would be forced to commit each candidate's performance to memory. Since we are examining several candidates and memory can play tricks, I may end up doing injustice to the candidates. This way, I make assessments as the examination proceeds, and each candidate's findings are separated from the rest.'

When I reached the stage of being an examiner, I followed his practice and often drew appreciative comments from other examiners. I wonder if present and future examiners will follow Dr Cooper's system.

PAPERLESS INTERVIEWS DURING SELECTION COMMITTEE MEETINGS

Candidates appearing before selection committees at our reputed institutes are required to submit reams of paper in addition to the application form. Their enthusiasm often prompts them to add to the required minimum added documents. As members of these committees, we are often provided a thick file for each candidate. The photocopies of published papers and list of total presentations at conferences form an important segment. A sincere attempt at studying the contents would take at least an hour—time that is simply not available as the file is given to us as the candidate is walking in for the interview. Most committees also require the candidate to give an oral presentation justifying the claim to the advertised post. This is supplemented by slides projected on a screen.

This universal experience has led to suggestions to ensure justice to the candidate while relieving the members of the committee of guilt of not being able to study everything in each file. One recommendation is to ask each candidate to list only the five most important publications in her/his estimation with bibliographical references to each of them.

Candidates can also be requested not to repeat in their oral presentation what has already been provided in the files submitted with the application except where some vital details need to be provided to the selectors.

To make the entire process paper-free, each candidate must make his submission in .docx .xlsx or .pdf files. In turn, the institution must provide laptop computers to each selector. These should be connected to high-speed internet. All the submissions by each candidate must already be loaded on it. This enables the selector not only to scroll through the candidate's submissions but, when in doubt, search online for the veracity and adequacy of statements made during the interview and study papers and reviews by others on the subject being discussed. It also makes it possible for the selectors to check which of the journals in which the candidate has published papers belong to the category of predatory publications.

This modified procedure will enable the selectors to make a more comprehensive assessment of the work done by each candidate and the quality of replies to questions.

MEDICAL EDUCATION IN REGIONAL LANGUAGES: A PRESCRIPTION FRAUGHT WITH PROBLEMS

Once again, we learn of satraps promulgating legislation to ensure that medical colleges in the states teach subjects in the local language. Northern states favour Hindi while southern states push for Tamil, Telegu and Malayalam.

It is a pity that we do not learn from history.

In the 1830s and 1840s, as the East India Company set up medical schools in their three Presidencies (Bengal, Madras and Bombay), it decreed that instruction in each of them was to be in the regional language. Teachers in these schools were asked to translate English texts into the regional languages and use them in their classes. As can be expected, this resulted in markedly substandard education. When Sir Robert Grant, Governor of Bombay, decided to set up what was later entitled the Grant Medical College, he analysed the demise of the medical school set up earlier by Governor Mounstuart Elphinstone. Based on his findings, his medical advisor, Dr Charles Morehead, and he insisted that the language of instruction in the proposed medical college would be English. The college, posthumously named after him, flourished from its foundation in 1845 onwards. Education in regional languages once again raised its head in the 1870s. Dr Morehead, then retired and settled in Britain wrote to the college authorities in Bombay arguing against such a change. After a short period of experiment, instruction in the regional languages was stopped while that in English continued successfully.

It is beyond comprehension why proponents of regional languages ignore obvious facts.

1. We are fortunate in having inherited competence in English that is envied in several countries, most notably in China and Japan.
2. The literature of medicine is immense in scope. Even the use of the most powerful computers will not permit translation into regional languages of more than an infinitesimal fraction of books, journals, seminar proceedings and other repositories of medical knowledge. Add to that the fact that explosive growth of scientific knowledge augments collected data at a furious pace. Regional texts must, inevitably, be dwarfed substitutes of what is available to those studying in English.
3. English is the language in which exchanges of ideas, projects, techniques and recent advances occur. How will a student graduating in Bihar in his regional language converse with a scientist in Tamil Nadu or Maharashtra, leave alone an expert in London or Bonn or Stockholm or Tokyo? How will this young and impressionable individual learn from journals such as this or that published by the Association of Physicians of India and other national medical societies, leave alone the likes of *The Lancet*, *New England Journal of Medicine* or *Journal of Neurosurgery*?

It is high time powerful voices in academia, the medical profession in India and the various scientific societies and associations are raised to scuttle this retrograde legislation and chauvinistic way of thinking.

SUNIL PANDYA

Letter from Glasgow

SOCIAL CARE: A NEW BEGINNING OR ANOTHER FALSE DAWN?

During lockdown in the first wave of the pandemic in 2020, I did my bit to help. I returned to work that summer providing public health support to the (rapidly expanded) contact tracing team in Glasgow, and I volunteered to deliver lunches to vulnerable people who were shielding at home. I volunteered with the Mel Milaap Centre which, pre-pandemic, had provided day care social services for elderly South Asians in northwest Glasgow.[1] With the lockdown came the realization that these vulnerable people would still need lunches and so the food delivery service, open to all who needed it, was developed. At a time when the population was confined to their home unless they were essential workers, shopping for food, or exercising it was eerie driving through largely deserted roads in Glasgow making my lunch deliveries. With the poverty and social inequalities that Scotland and the UK still experience, it was humbling to see how people were coping with the pandemic. This was despite the huge disadvantages they faced and, in my opinion, they were steadfast in supporting each other in their communities.

Social care provides support to vulnerable people, for example the elderly, the infirm, or people with learning disabilities with a spectrum of services including information, advocacy, financial support, day centres, support at home, and residential social care homes. More broadly during the lockdown, if there was one thing I wanted to see, given the large numbers of preventable deaths in social care homes, was improved care homes so that it was fixed once and for all.[2]