# *Speaking for Myself*

## It seems to be anyone's and everyone's ballgame— Except for medical students, educators and regulators

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Over the past 6–7 years, several measures have been initiated to improve the standard of medical education. Some have been ill-conceived, some have been issued after insufficient preparation only to face foreseen and unforeseen hurdles, and some have been talked about but have still to see the light of day. Nowhere does one see an active role of the profession or the student or the educators in any of these initiatives.

First came NEET (the National Eligibility cum Entrance Test). On the face of it, this was an excellent attempt to standardize intake into professional courses. However, it came with unforeseen consequences. Students stopped focusing on their 11th and 12th standard courses as the marks did not count if one passed the final school-leaving examinations, shutting any opportunity of learning basic science relevant to the profession. Coaching centres charging high fees mushroomed in cities, which put students from rural areas at a disadvantage. The politician got into the picture with the demand for reservation of candidates from rural areas. The examination was first held in English, which resulted in an expected demand for availability of testing in all regional languages. Translations were not scrutinized for accuracy resulting in ridiculous translations, leading to wrong answers and endless litigations. All this is in the public domain. A cut-off percentile of 50% was fixed at the onset as the minimum for eligibility, which in successive years had to be lowered to 30% or so to fill all the available undergraduate seats thus negating the concept of standardization of intake. The trade-off between fixing uniform standards and the need to fill all the available seats could have been foreseen, especially as the standard of schooling varies between different states and between different boards. In one year, the super specialty NEET score had to be reduced to the 20th percentile to fill up seats in unfilled specialties such as neurosurgery. Lately, the demand from state governments has been for a separate quota within NEET (UG) for students studying in government versus private schools.

The concept of NEET is laudable and was primarily for setting standards for entry into medical education. The tremendous pressure from various quarters (as mentioned above), some of which could have been foreseen in our country, has destroyed the spirit of a uniform national entrance test. We may have to make changes—perhaps giving some weightage to plus 2 marks, taking care of difficulties faced by students from rural areas and tackling the problem of falling percentile cut-offs, which is the most serious of all.

Then came NEXT (the National Exit Examination). This was an attempt to introduce a standardized exit examination after the MBBS course to ensure uniform standards for all outgoing graduates. The NEXT was also intended to replace the NEET once it is in place as the selection modality for postgraduate courses replacing the PG NEET examination. The threat of NEXT appears only to disappear and reappear again. The major issue with NEXT is that it does not do away with the university examinations, which are still required to certify skills. This issue has created problems. A large number of students pass the university examination (nearly 75%) and become eligible for the MBBS degree. However, if the success percentage in NEXT is less, then there will be a huge number of graduates who would have cleared the university examination but could still not be registered to practise as they have been unsuccessful in NEXT. What would happen to them till they clear the examination? What job would they be eligible to do? These questions have not been answered. This case is similar to those who pass their undergraduate medical degree in China, Russia or other European countries and on return are unable to clear the national entry test, leaving many of them without a job.

One of the major duties of the government is to provide access to healthcare to the whole population. The measures taken to do this, however, have been less than praiseworthy. Due to the obsession with the reduction of the physician/population ratio from the current 1:1700 to 1:1000, several measures have been taken ignoring the quality of education. In 2015, a separate course of 4 years was suggested for producing 'a barefoot doctor'. This was to be called Bachelor of Rural Health Care. A committee was set up and a detailed syllabus was prepared. Sharp reactions, mostly from politicians, about differing standards of medical care in urban and rural populations and lack of growth opportunities for those entering the new stream led to the shelving of the proposal. Nothing has been heard about it since then.

Presently, more and more medical colleges are being started without regard to estimating whether there is a patient demand, which meets the minimum requirement of medical education. The number of seats in MBBS, which used to range between 50 and 100 per year per college, has been raised to 250 in many instances. At the same time, there has been a reduction in the regulatory requirement of faculty leading to an adverse faculty–student ratio. Moreover, due to the lack of availability of eligible teachers in many subjects, the teacher availability has been further reduced. Tremendous stress from the regulators to educate more and more and demands of accreditation agencies towards research along with major deficiency of teachers have resulted in an unstable phase in medical education.

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Mushrooming medical colleges offering incentives have led to the faculty constantly moving from one college to another resulting in falling educational standards. This is shown by the vastly differing pass rates in NEET (UG) of graduates from different medical schools.

In 2017, a welcome initiative of the then Medical Council of India (MCI) was to introduce 'Competency-based undergraduate Medical Education' (CBME). This came after a gap of 20 years after the previous major revision in 1997. It had several welcome features like a separate vertical thread on Attitude, Ethics and Communication (AETCOM), which would run from the first semester onwards. There was a major thrust towards horizontal and vertical integration and a list of nearly 3000 competencies with a separate list of competencies which require internal certification before the summative examination. However, there were major issues. The list of competencies was not clear definitions of measurable outcomes but in many instances were statements of intent that previously in pedagogy used to be called objectives. The list of 'must be able to do departmental skills' had no reference to the need after graduation or to the duration of the course in that subject. Methods of assessing AETCOM did not match the requirement. The major shift towards small group teaching could never be implemented satisfactorily in view of falling faculty numbers, diminished availability of physical facilities, increasing student strength up to 250 per year which resulted in some ridiculous instances of a small group being defined as 50 students! Also, the shift towards CBME was not associated with a major shift in the summative process, leaving an undesirable gap between what is needed and what exists. The colleges are still struggling. Then came the proposal 'under consideration' to reduce the duration of the MBBS course from the current 5½ years including internship to four and half years including internship.

The proposal has come not from the regulator but the Union Minister of Ayush Systems of Medicine of Government of India! Whether detailed planning has been done or need assessed in view of a new system of CBME being introduced only 3 years ago is not clear. Will it ever become clear? In every other developed country, the duration of medical education or the period required to specialize is higher than that in India!

A shift to a more needed outcome-based postgraduate medical education is coming in slow streams. This is also likely to face difficulties since it is not accompanied by a list of 'Entrustable Professional Activities' for each department or well-defined outcomes or levels of achievement, which are acceptable or any major change in the summative process. A committee set up by the then Board of Governors in 2013 worked for a year to define problems in postgraduate medical education, estimate the number required in each specialty based on morbidity data provided by the WHO since there were no authentic national records of morbidity across the country. It gave detailed recommendations of what requires to be done to bring about a change in postgraduate medical education in India to meet the requirements of the country. For reasons best known to the regulators, it has never been made public or discussed and seems to have been archived. Meanwhile, there is a requirement to send postgraduates to district hospitals for 6 months in the 2nd year of training without any detailed description of who will be responsible for their training during this period to ensure that the purpose is fulfilled or the objectives of training or details of monitoring or assessment during this period.

Finally has come the straw that will break the back of medical education in India. This proposal allows Ayurvedic graduates to perform surgical procedures outside their expertise such as cholecystectomy, etc. Ayurvedic physicians in India from ancient days have shown their skills in managing diseases such as complex anal fistulas. Modern medicine has adopted this. However, in the current day of modern anaesthetic practices and complex surgical procedures, what would be the position of ayurvedic physicians doing major abdominal surgery. Will they be legally protected? Are they trained for these? Seeing the list of procedures they would be allowed to perform, one is appalled.

During all these processes, the medical students have been silent, the faculty has been silent, the medical educators have been silent, the regulators have been silent, and the profession and professional associations except for the Indian Medical Association (IMA) have been mostly silent.

I am reminded of Martin Niemoller's famous words. Niemoller was a parson in Germany during the Nazi days and he wrote these words after the war.

> *First they came for the socialists, and I did not speak out—because I was not a socialist.*
> *Then they came for the trade unionists, and I did not speak out—because I was not a trade unionist.*
> *Then they came for the Jews, and I did not speak out—because I was not a Jew.*
> *Then they came for me—and there was no one left to speak for me.*

The quotation is not very appropriate to the current situation since we are a democracy but is quoted to illustrate why everyone needs to speak out and seek clarifications when measures which may affect their profession or the nation's health are raised. The issues raised by me are not innovative or original. I am sure many educators, regulators and professionals would have had the same misgivings. However, on every issue that affects medical education, all the above groups need to speak out and give their opinions and not wait because they are already qualified or the move does not affect their specialty or for any other reason.

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