

Correspondence

New essential criteria for medical faculty in India: A paradigm shift

In India, the doctor (allopathic medicine only) to population ratio is <1 per 1000.¹ The National Medical Commission (NMC) has set to achieve the WHO-mandated ambitious target of doctor–population ratio of 1:1000 by 2031, necessitating a paradigm shift in the health policy. Apart from upgrading district hospitals to community medical colleges and increasing medical graduates, one of the key areas required for the goal was to expand the pool of available clinical teachers, who could supervise undergraduate and postgraduate trainees.

It is imperative to critically analyse the premise of existing medical education and training for its betterment and its impact on the community in India. There is an urgent need to transform age-old guidelines for hiring teaching medical faculty to make them at par with global standards. Although guidelines have been confronting periodic challenges and exigencies, the Minimum Qualifications for Teachers in Medical Institutions (Amendment) Regulations in India were laid down by the NMC in 2020 with major novel and advanced requirements.²

The 'welcome' changes

A major update in the new criteria by NMC is that a teacher with 8 years of experience in a broad specialty (such as medicine) and 5 years of experience in a superspecialty (such as pulmonary medicine) will be recognized as a postgraduate teacher. This can fill the large deficit in the senior faculty strength of most hospitals, which in turn will allow residents to join the hospital improving the doctor–patient ratio and eventually patient care.

Academic publications are one of the criteria used to evaluate and qualify for career progression.³ According to the new NMC guidelines, the two main criteria for promotion of teachers are the duration of service and the number of publications. Academic and professional evolution in the respective specialty is essential for career progression. Providing clarity and value to academic and research output in the form of scientific articles is a welcome step taken by the NMC. Although the emphasis attributed to publications and the criteria of weightage to each published article was introduced for the first time in 2009, the current amendment supports the quality of academic output over quantity. The new guidelines also recognize collaborative authorship including the efforts undertaken by the corresponding author involved in the entire manuscript submission process. In the manuscript types, apart from the original articles, importance has been given to systematic reviews, meta-analyses and case series. Rather than just the first author, the first three authors and the corresponding author have been empowered to receive credit for each publication. Removing the criteria of nationality of journal where the index article is published in, raises the profile of indigenous journals. For the first time, e-journal publications have been recognized with the inclusion of the Directory of Open Access Journals as an acceptable database. This will support the open access model of publishing with its inherent advantages of wider accessibility and increased readership.² Another change has been necessitating the acquisition of certificates in medical education technology and biomedical research from designated expert institutes.

The benefits

The new essential criteria would help in developing teaching and research skills of the faculty. The new undergraduate curriculum is based on competency, skill and performance.⁴ This mandates minimum desirable qualities in a medical teacher, especially training in competency-based teaching. The biomedical research course run by the Indian Council of Medical Research has been made mandatory by

the NMC. This course has 23 online modules, assignments and a final examination. It reinforces the importance of basic research questions, role of research methodology and application of analytical and non-analytical statistics as well as the importance of medical ethics. The medical education course is held at certain designated teaching institutes and faculty are trained for 3 days in various methods of teaching competencies that include attitude, ethics and communication, and demonstration–observation–assistance–performance (DOAP).⁵ Training in assessment methods including long essay-type questions, structured short answer questions, multiple-choice questions, problem-based questions, case-based questions and direct observation of practical skills is also given to the faculty and practice sessions are held. Such faculty training will improve teaching, training and evaluation methods of medical students with the ultimate goal to create an Indian medical graduate who is a clinician, leader, communicator, lifelong learner and a professional.⁵ These changes will also transform the role of the medical teacher from 'sage on the stage' to 'guide on the side'.⁶

The roadblocks

It is difficult to assess the skills of ethics and attitude; and this assessment needs to be made objective. The medical education course is available at limited centres across the country, which will delay the training of all medical college faculty. The biomedical research course and medical education course will need to evolve with time and trends. Covid-19 has shifted education to e-learning.⁷ Training on skills, language, ethics and attitude needs to be integrated with electronic formats of teaching including online networking platforms, online group discussions, e-simulations and video-DOAP modules. Lack of time, and commitment among the management of medical colleges to bring changes in the existing system, and inertia for change among the faculty remain the major roadblocks.

The path ahead

'Change is the only constant.' The minimum essential qualifications for medical teachers, as mandated by the NMC, focus on quality of research and medical education. Improved teaching and assessment methods can help realize the goal of producing a dynamic Indian medical graduate with a set of core competencies, who will fulfil the duty of providing health benefits to the community and in turn to the nation. These series of small, successful challenges to conventions may bring a considerable change. The requirement for a strong medical education programme steered by faculty with sharp professional acumen and strategic managerial skills will continue to rise in India.

In addition, the reward system for faculty may also need to be tweaked. Presently, teachers are rewarded for the number of years spent in teaching and the number of additional degrees accrued, rather than for their performance. 'Performance-based reward programmes' will provide adequate recognition and dedication to the delivery of quality medical education. This will encourage teachers and motivate their students to aspire to be better. 'Group-based reward programmes' or 'knowledge and skill-based rewards' and awards to celebrate distinction in academic publications achieved by individual faculty will reinforce the idea of achievement. This will 'attract, develop and retain effective teachers' and benefit students.

Conflicts of interest. None declared

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Gender discrepancies in organ donation in India: The invisible road to exploitation of womanhood?

Gender inequities in accessing medical treatment are a global issue. This bias also extends to major, life-saving procedures such as organ transplantation. Women constitute the majority of living kidney donors, but receive fewer live kidney transplants compared to men.^{1,2} Similar disparities exist in relation to accessing and outcomes of liver transplantation.³ In India, the difference is even more stark; women constituted less than one-third of living organ recipients in 2019 but more than three-quarters of living donors.^{4,5} We propose some explanations for observed gender differences in organ donation in India as well as some recommendations:

Possible explanations for gender differences in organ donation:

- Economic implications:** In most Indian families, men are the sole breadwinners. Consequently, the financial implications of being indisposed for weeks following organ donation would serve as a deterrent for men to donate.
- Greater sense of self-sacrifice among women:** Globally, women, in general, have a greater sense of responsibility and self-sacrifice than men.⁶ In India, women see caring for their family members as an extension of their domestic duties. Thus, they are more likely than men to step up and volunteer to donate during a family crisis.
- A third unproven hypothesis is that women are more willing to donate because they have already experienced a major medical event such as childbirth, and they trust the medical system.⁷ Scientific evidence, however, indicates that pregnancy serves as a possible

'sensitizing event' triggering immune response in donors,⁸ thus posing increased risk of post-transplant complications in recipients.

- Gender bias by institutions/specialists in harvesting living organs:** Studies have shown that gender bias on the part of institutions or physicians, which reflects in the content of doctor–patient interactions, may also contribute to gender disparity in transplant;² such factors may be amplified in the Indian setting.

Recommendations to improve gender disparity in organ donation:

- Ensure support through women-centred organizations with adequate information and education about organ donation and human rights. An Indian study has shown that men are more informed than women about organ transplantation.⁹
- Mental health professionals should be involved in the multi-disciplinary organ transplant team—this will help in a more complete assessment of the aspects related to the emotional state of the donor and ensure the due process of informed consent.
- Pre-transplant evaluation should also cover psychosocial and economic aspects to uncover undesirable motivations for donation such as underlying abuse, threat, coercion, violence and related consequences. Referral to a counsellor before organ transplantation is routinely practised and must be encouraged.

Ethical aspects of organ transplantation in India have not received the attention they deserve. An approach based on education, support and advocacy is needed to improve gender parity in organ donations. More research into this aspect is also warranted to uncover the various levels at which bias may operate and inform remedial action.

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