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Attempts at regulation of medical education by the MCI: issues of unethical and dubious practices for compliance by medical colleges and some possible solutions

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Introduction

There are, at present, over 335 medical colleges in the country conducting the MBBS course (1). Of these, well over 50 per cent are run by private organisations. Further, an overwhelming majority of institutions set up within the last two decades are privately run and not state sponsored. This itself indicates that governments, both central and state, do not have adequate resources to invest for this purpose Many of these private institutions are managed by organisations and trusts which are recent entrants to the field and do not have a long history of experience in running educational institutions, leading one to suspect that altruism and a drive to promote education is not the sole factor guiding the start of these institutions. Medical education has become a promising and profitable business.

The problems that plague medical education in the country are related to these twin facts: the mushrooming of medical colleges in the last two decades, and the shift of medical education from public to private hands. In 2009, there were 284 colleges listed on the Medical Council of India (MCI) website (2). This figure has risen over two years to 335. The problems and difficulties with ensuring quality in the medical education system in India, run across institutions and are not specific to any. The regulatory agency is aware of these issues and has often responded by what can be best be described as knee jerk reactions, without making serious attempts to correct the malady at its root. It is not surprising that these measures have little, if any, effect. Sometimes, the problems are worsened by these attempts.

This paper will attempt to analyse the deficiencies in regulatory control of medical education in the country and the measures that are taken by individual institutions to beat the system and suggest possible solutions to cure the malady. If urgent measures are not instituted, the quality of physicians in the country in future will fall far short of the ideal. It must be emphasised that the problems listed here are not universal to all private institutions, and that many of the issues pertain to government institutions as well.

Current problems

Absence of quality in admissions and high capitation fees

These two issues are closely linked and must be dealt with together. The poor quality of many of the students admitted to private institutions is well known. This occurs because admissions to these institutions are linked, not to the merit of the candidates in a competitive examination, but to their ability to pay the capitation fees, which currently may run up to as much as Rs 40 lakh for the MBBS course in some colleges. Running medical colleges is an expensive proposition and the managements have to raise sufficient funds to do so. The fee structure fixed by the government is not realistic. The hospitals attached to the medical colleges often do not have enough patient intakes and do not make enough money to support the college for several years. Hence, colleges have to resort to alternative methods of collecting funds. The only solution that seems viable to them is to hike the fees to astronomical levels to allow for both sustenance and profit. Since entrance examinations are mandatory they are conducted, but the marks and the rank lists are not often displayed until the negotiations for admissions are complete. Since there is no strict monitoring of these entrance examinations, particularly in deemed universities, such a practice escapes detection.

The fact of high capitation fees is well known and has been subjected periodically to exposés in the media and half-hearted attempts at investigation. Recently, *The Times of India* mentioned that as much as Rs two thousand crore may be generated this year as black money because of these capitation fees in the state of Tamil Nadu alone, with advance booking being taken for postgraduate seats at the time of MBBS admissions (3).However, for obvious reasons, hard evidence is difficult to come by, since the monetary transaction is in cash and without a receipt, and parents / guardians are reluctant to testify since this would expose their wards to the wrath of the management.

There are essentially two issues: lack of quality in admission and the matter of raising sufficient funds to run an institution and allow for profit. Running a medical college in the private sector is not mere philanthropy. It is a business like any other. Strict regulation of the fee structure and setting aside a large quota of seats for government-sponsored candidates, as happens in some states, compounds the issue. Since only a small pool is left to the managements of these institutions, abnormally high capitation fees are fixed for this group and quality becomes the casualty. In deemed universities, which are not compelled to give any quota to the government, these capitation fees can apply to all candidates.

These issues can easily be resolved, provided there is a strong political will. During the tenure of the previous board of governors of the MCI, this matter was discussed in great depth in the working groups for undergraduate and postgraduate medical education, for well over a year. One of the recommendations made was that all admissions to medical colleges should take place through a single national entrance examination which takes into account the syllabi of all the +2 boards in the country. This entrance examination would be held two weeks after completion of the final year examination, before the start of internship. This change in scheduling was suggested since the existing system results in the whole one year-period of internship being spent by candidates in preparing for the entrance examination, without focusing on the acquisition of skills for which the internship is meant. A single national examination would also avoid the strain on candidates of having to apply and appear for multiple entrance examinations at several institutes / states. The national ranking list would comprise all candidates who have secured the minimum prescribed marks by the current guidelines and would also provide information on their states of nativity and eligibility for any reservation. This single national ranking examination would be used by all states, universities and institutions for their admission process. The existing reservation system would not be affected, since seats can still be filled up from the list by admitting students of the appropriate reserved category according to their ranking in the all-India merit list. The candidates can join their respective postgraduate courses on satisfactory completion of their internship by a process of counselling.

In order to allow institutes to raise finance, 50% of the overall seats should be provided to the government for filling up the government quota with fixed fees and the remaining 50% should be free of any regulatory control on fees; provided the candidates are admitted from the national ranking list on merit. The government should ensure liberal conditions for these candidates to obtain loans from nationalised banks for their education. As regards the government quota, this should be legally ensured at the time of issue of the no-objection

certificate by the state health authority, and not left to annual negotiations every year between the government and the managements.

Adoption of this system would ensure that:

a. internship is restored to its rightful place as a period of development of skills;
b. quality would be ensured in admissions;
c. the farce of closing one's eyes to capitation fees would be abolished;
d. black money transactions would be eliminated;
e. managements would have sufficient funds to run their institutions; and
f. multiple examinations and the consequent strain on candidates would be avoided.

Delayed admissions

Although the last date for admissions has been mandated by the Supreme Court, in point of fact there is no way this can be regulated or enforced, particularly in deemed universities. This results in students being admitted several months after the last date with a consequent loss of curricular time. The records are corrected to make it appear as if the candidates have been admitted prior to the last date. In postgraduate courses, occasionally, the admissions are given as late as nine months after the last date. As can be understood, this seriously compromises the available period of time for the course to be completed for the candidate and consequently affects quality.

The regulatory agency should ensure that all admissions are reported to it the day after the last date prescribed by the Supreme Court. The database including biometric data should be maintained by the MCI and no admissions should be permitted after this date. Once the admissions are frozen by record in the MCI on the last date, the institutions would not have the option of admitting candidates late and then correcting the records to show that they have been admitted prior to the last date.

Skewed distribution of medical colleges

The 335+ medical colleges in the country are distributed in a skewed fashion, with nearly 70% falling in the states of Maharashtra, Karnataka, Kerala, Tamil Nadu, Andhra Pradesh and Pondicherry, and only 30% in the rest of the country. This, in spite of the MCI's requirement that to start a new medical college at any site, one would have to obtain a no-objection certificate from the concerned state health authorities which would be issued after making a need appraisal for another medical college at that site. The state authority would have to certify that there is sufficient clinical load in that area to sustain a medical college (4). Perhaps because of easier access to these NOCs in the southern states or the greater profitability potential of starting an institution in these states, medical colleges have got clustered in these states. In the city of Pondicherry with a population of less than 10 lakhs there are eight medical colleges, some within a stone's throw of one another. This process of clustering has an enormous impact both on the availability of faculty in these medical colleges and on the patient load, since there are neither enough trained faculty nor enough patients requiring health care to meet the requirements of all the medical colleges in terms of MCI norms. Until a proper policy is laid down by the Government of India in this regard, and the NOC criteria are strictly enforced, clustering will continue to occur. The problem that clustering of medical colleges causes to the availability of clinical material and faculty is dealt with subsequently.

Shortage of faculty

One of the major issues where dubious practices are adopted by institutions at the time of MCI inspection is regarding the presence of an adequate number of faculties according to requirements. It is well known that large-scale import of teachers occurs in private institutions on the day before, or on the day of, inspection to be presented to the assessors as existing faculty. Government institutions are not without fault as they deal with this issue by large-scale transfers of teachers from one institute to another just before inspection, only for the teachers to be returned to their parent institution after the inspection is over. The practice has, unfortunately, extended even to super-specialty courses and there are examples, though not common, of the MCI having sanctioned super-specialty courses based entirely on imported faculty with not a single permanent faculty member who works full time in the institute concerned. Allotment of postgraduates to an institute based on the number of professors and associate professors in that institution is an added incentive to the institutions to 'import' more faculty for inspection to increase their quota of postgraduate seats. The impact on education in the long term can well be understood.

Shortage of faculty is the direct result of an enormous increase in the number of medical colleges, particularly in the last couple of decades, with the increase in postgraduate seats not keeping pace with this increase. The reluctance of postgraduates to enter the teaching profession has compounded the problem. Measures by the MCI such as physical verification, ignominiously referred to as 'head counting', at the time of inspection (assessment) and maintenance of a national database of teachers and their institutions have not entirely put an end to the problem. These measures only ensure, to some extent, that no teacher is presented by two or more colleges in the same year. Even this is only a half measure. During the current year itself many teachers are under investigation by the MCI, because their names appear in more than one college faculty (5).The vast majority of teacher 'imports' consists of private practitioners not attached to any medical college who make their services available at an exorbitant fee to present themselves as teachers for a couple of days during inspection. This is not prevented by the MCI's database of teachers. Since their names are not recorded in any other institution, they escape detection. Year after year, the same practitioners are called by the concerned institutions during inspection. The second measure adopted by the MCI to overcome the shortage

of teachers is to marginally reduce the number of teachers required by some departments (6). This measure compounds the problem since it is an admission that the earlier norms were not fixed after proper application of mind. Further, it ignores the fact that many of these teachers, particularly in the basic sciences, are involved not only in teaching the MBBS course, but also in allied disciplines like nursing and dental courses run by the same private institution. Hence reduction in the number required only adds to the workload of the existing teachers.

The problem is not impossible to solve. . An increase in the postgraduate seats, which is the strategy adopted by the MCI, would take several years to make up for the deficiency of teachers, by which time the number of medical colleges would have increased further, since there is no moratorium on new medical colleges. To make up the teacher shortage, there must be an increase in availability of teachers in the short term and in the long term. Several measures can be adopted for this purpose.

Short term measures as an immediate solution

These measures are:

1. Relaxing the eligibility criteria for teachers as a temporary measure;
2. Giving special weightage and incentives for teachers in critically short subjects by higher increments, accelerated promotion or starting with a higher designation;
3. Allowing doctors with postgraduate degrees who have worked in medical colleges without teaching designations to be recruited as teachers, subject to fulfilling a minimum number of years in that specialty;
4. Recognising foreign qualifications and degrees which are now under reciprocal de-recognition largely for political reasons;
5. Employing retired teachers on a part time basis;
6. Sharing of faculty in critical departments such as Forensic Medicine between adjacent medical colleges;
7. Allowing adjunct faculty from the clinical side to teach pre- and paraclinical disciplines where there is a critical shortage of faculty as a temporary measure; Some examples of this would be surgeons teaching anatomy, physicians or paediatricians teaching physiology, pharmacologists teaching toxicology and pathologists teaching forensic medicine.
8. Allowing honorary faculty to fill the gaps on a temporary basis (these can be from the pool of private practitioners who have postgraduate qualifications);
9. Removal of all restrictions on teachers with non-medical qualifications in the basic disciplines (these are now subject to several restrictions as regards promotional avenues, number allowed as a percentage of the total faculty strength of the department, and source of non-medical postgraduate qualification – whether from a faculty of medicine or a faculty of science- the former being allowed and the latter prohibited from joining a medical college although the syllabus of both courses is essentially the same); and
10. Recognition of all qualifications given by the National Board of Examinations as equal to the corresponding postgraduate degrees.

These short term measures have already been recommended to the MCI over a year ago. No specific action has been taken although the shortage of teachers has reached critical dimensions.

Long term measures

Three measures are proposed. First, there must be an alteration of the student teacher ratio from the current fixed norm of 1:1 for an associate professor and 1:2 for a professor, depending on the needs of individual departments and their capacity to train postgraduate students. These current norms may be appropriate for a clinical discipline but a teacher in a pre-clinical or a para-clinical discipline may be allowed to take more postgraduate students.

Second, special incentives should be given to postgraduate students joining the basic disciplines where there is a shortage of teachers, such as a lower fee, immediate appointment to the faculty on qualification or joining the faculty with a higher rank, etc.

Third, there must be a critical review and fixing of fresh norms for teachers in various pre and para-clinical and clinical disciplines which are realistic and take into account the current numbers of teachers available.

Strict action on the part of the regulator to implement some of these suggestions supported by strong political backing will go a long way towards eliminating the unhealthy practice of 'importing' teachers to fool the assessors.

Shortage of clinical material for teaching purposes

A medical college draws its sustenance and its reputation for excellence as a teaching institution from the quality and quantity of clinical material available therein for training undergraduates and postgraduates. It is well known that there is a tremendous shortage of clinical material in many of the medical colleges, since treatment is not free or only nominally free. Clustering of medical colleges has worsened this problem. Hence the number of patients available for teaching is sub-optimal. This is sought to be overcome by the unhealthy practice of bringing in truckloads of patients on the day prior to inspection from the neighbouring villages, who are then paid for their services once the assessment is over. Several inspectors have stated to me that many of the so-called patients lying in the wards do not have any specific illness and they may not even have been admitted in the relevant disciplines called for by their symptoms. In one institution, I was told, removal of the sheet covering an apparently sleeping patient in one of the gynaecological wards revealed a male!

Together with this practice, figures for daily outpatient attendance are falsified and inpatient records and operation

and procedure statistics are doctored to show sufficiency as per MCI norms. Since the inspection by the MCI is not really a surprise inspection, there is sufficient time for the institutions to resort to this practice. One way of rectifying this is to make sure that the inspection is really an unannounced surprise inspection without prior notice. Alternatively, a re-inspection may be carried out without notice shortly after the first, to ensure that the figures shown at first inspection are genuine. Also, the MCI inspectors may verify the genuineness of the operation lists and other procedures by crosschecking them with investigation data, pathology records, etc. Unfortunately, MCI inspectors would then have to work not only as assessors but as detectives and spies as well!

The provision of a well-equipped skill laboratory can to some extent mitigate the problem although it would not be sufficient to substitute for a lack of clinical material. Skill laboratories can serve for training students and allowing them to practice prior to handling patients, but can in no way simulate real patients.

Yet another method of increasing availability of clinical material is to make it mandatory that 50% of beds are earmarked for free patients who would not have to pay for admissions, procedures or investigations. The state can ensure this in return for permitting another medical college. The major reason why patient load is minimal at several of these institutions is the fact that treatment becomes prohibitively costly and beyond the reach of the common person.

Shortage of equipment and learning resource facilities

To those in the medical education profession it is well known that much of the life-saving equipment is brought on hire for the MCI inspection. In fact, this has now almost become a cottage industry with several agents contacting medical colleges to supply equipment and books as per the MCI list for a few days during the inspection process. A major reason for this lacuna is the prohibitive cost of equipment, medical books and journals. In fact, the annual subscription for journals alone in a medical college may run as high as Rs 50 lakh or more. Much of the equipment is not indigenously manufactured and is very expensive. Customs duty exemption is not available for all the items on the MCI list. The institutes hesitate to procure the items since substantial investment is required and the returns are not guaranteed in the short term.

Solutions are not hard to come by. The first priority is to revisit the list of required instruments in the MCI list, which has not been revised for years. A drastic revision is called for, removing all obsolete equipment which is particularly prominent in the list required for the basic science departments. As regards equipment required for clinical facilities, MCI should seriously consider whether outsourcing of some investigations which are not required to be done in-house for training purposes, should be allowed. This list will include many types of equipment required for biochemical investigations. Implementation of this suggestion would go a long way in reducing expenses on purchase and maintenance of this equipment and the human resources required to run it. Exemption, of course, would have to be made for equipment for departments such as radiology and pathology which necessarily have to be done in-house. Even here, one would have to seriously consider whether costly services, such as magnetic resonance imaging, should be permitted to be shared with other health care facilities, with students being sent offsite for training purposes. The central government should also consider whether the duty on medical college equipment can be reduced or waived in view of the country's need to increase the doctor- patient ratio to 1:1,000 which is the goal sought to be achieved.

As regards library facilities, permitting electronic libraries instead of hard copies would tremendously reduce the capital expense on purchase of books and journals. Through the Union Ministry of Health, arrangements can be made with the National Medical Library to procure and supply electronic learning resources at subsidised rates for medical colleges and permit them to subscribe to journals through national facilities such as Electronic Resources in Medicine in India . In fact, what the MCI should insist on is not sufficient numbers of hard copies of books and journals but a greater availability of computer hardware and terminals to permit e-learning. Investment on this will certainly be cheaper in the long term for the institutions.

Neglect of research

An earlier publication from one of the authors had pointed out the woeful dearth of research activities in medical colleges (7). This is in spite of the fact that a research laboratory has been made a mandatory requirement for all departments in medical colleges (8). However, the equipment for these research laboratories has not been clearly specified. The MCI is aware of the lack of research in medical colleges and has recently revised the guidelines for criteria for the promotion of teachers to include publication of research papers (9). However, enforcement has been postponed for some years and the old system has been allowed to continue for unknown reasons. With rapid advancement in medical knowledge, research training has to become compulsory for all medical graduates, if not faculty.

One method of ensuring this is done is to ensure that the guidelines for promotion mandating a minimum number of research papers are strictly enforced and strengthened. Medical postgraduates with PhD degrees should be encouraged to join medical colleges to give a fillip to research activities. For enabling this, one may have to consider incentives such as allowing them to join in a higher post compared to those without research degrees, or giving weightage to the period spent in acquiring a PhD degree for promotion purposes. Also, a minimum number of indexed publications from the college should be insisted upon at the time of mandatory renewal of permission which now takes place, or is supposed to, once in five years. Postgraduate dissertations need to be taken up with a lot more seriousness than is done at present.

Unhealthy practices in evaluation

The most odious, and perhaps the most dangerous, of the unhealthy practices in medical education is the interference in the evaluation system. Ever since internal assessment became compulsory and was included in the summative evaluation process, manipulation of internal assessment marks has become the norm in many institutions. It is not uncommon to see that almost all candidates get more than 90% in internal assessment so that they may get a push in the final examinations, should they fall on the borderline between passing and failing.

The Central University of Pondicherry, at one time, tried to investigate the genuineness of internal assessment in the affiliated colleges after seeing the high scores obtained by almost all candidates. In spite of the liberal internal assessment marks, there was a hue and cry from the candidates about possible bias in internal assessment, since they did not trust the system to be fair due to lack of transparency. As usual, the MCI acted tangentially. Instead of correcting the deficiencies in the system, it responded by reducing the weightage for internal assessment in the summative process (10). In a skill-based profession such as medicine, where comprehensive assessment is not possible in the summative process due to paucity of time, one would have expected the weightage given to internal assessment to be increased rather than decreased. The interference in the assessment process has now permeated to the final examinations although only in a limited number of institutes. Due to the large number of medical colleges becoming deemed universities, the same administration has control both of the teaching-learning process and evaluation, with no external monitoring. This makes manipulation of the final results easier. However, manipulation of the final results is not seen exclusively in private universities. Recently, there was an investigation into the addition of as many as 45 marks in the final year examination to the marks of individual candidates to enable them to pass in the Tamil Nadu Dr MGR Medical University, , whereas the MCI permits only a maximum of five marks. This happened in a premier medical university in the country. Closing one's eyes to this process would result in the release of a large number of sub-standard graduates into the healthcare system.

There are no easy solutions to this problem. Proper internal assessment is a question of the attitude of the faculty to this important modality of evaluation in the medical field and development of a trust in the system by the candidates. The institution of more objective and transparent methods of evaluation can, to some extent, reduce this problem. Surprise inspections by the regulatory agency to see the internal assessment record may also mitigate this evil. Quality control in the summative process is easier and one can seriously think of having either total external evaluation or three external examiners, instead of two, as at present. Examiners may be appointed centrally, from a national list of approved examiners. Likewise, attendance rules must be made stricter and exemption from minimum mandatory attendance should be the exception rather than the rule.

Conclusion

In conclusion, it may be stated that there are a number of ills and unethical practices which plague the medical education system in the country at present. There is a total system failure and blame cannot be apportioned to the managements of the colleges alone. The Union Government and the political class have not exhibited awareness of the issue, nor responded with vigourous corrective measures; and the erstwhile MCI, before it was superseded, had reacted with half measures without thinking through the issue, implementing solutions which sometimes compounded the problem. The regulatory agency in the past has also not shown the will power or the ability to enforce the rules, such as they are. The profession is apparently apathetic to the state of affairs and the public is totally ignorant of the downhill slide in the quality of doctors. A greater awareness in the medical community of the danger of ignoring these issues and their impact on the health of the nation would go a long way towards correcting some of these deficiencies. The new board of governors of the MCI has an unenviable task ahead of it as did its predecessor board. However, there are solutions to many of these issues. These need to be enforced straightaway if medical education is not to fall in to a bottomless pit.

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