Politics of Medical Education in India

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The impoverishment within the public health system is in stark contrast to the phenomenal rise of private healthcare, its international standards, medical tourism and its focus on servicing the rich. A meaningful change within medical education and the public health system, both predictors of healthcare delivery and of national standards of health, seems to be light years away. While the challenge of reforming medical education in India requires a revolution, much of the debate refuses to identify the elephant in the room, that is, the politics of medical education and public health.

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The quality of higher education across many disciplines in India is said to have declined over the past few decades (Misra and Singh 2015). Anecdotal evidence suggests similar trends in medical education. Many have argued that the medical education system in the country has failed to deliver excellence in transmission of relevant knowledge, acquisition of skills, communication of professional attitudes, and in transfer of ethics and values (Zachariah et al 2010; Mathew et al 2010). They also contend that much of the teaching and training, carried out in tertiary care setting with its focus on specialist perspectives, lacks relevance for the care of the majority of Indians, who are poor and who live in rural parts of the country.

Reforming medical education and public healthcare delivery in India has been debated for many decades. The Bhore Committee, set up by the Government of India, argued for the need to improve the public health system in 1946.[1] Despite lofty ideals, reforms to medical education and the public health system have been marginal. However, the country has moved on from its predominantly agrarian economy and is on the threshold of becoming a global economic powerhouse in the 21st century. Nevertheless, medical education has yet to see any meaningful change.

Academic Issues

The state of medical education in India, as with other disciplines, is determined by multiple and diverse factors. Many of the ills which plague the system are common across higher education in India (Misra and Singh 2015). The determinants of its quality include its setting, quality of the intake, standard of teachers and teaching, curriculum, examination systems, governance within universities and the environment within the health system. The complex interactions of these factors determine outcome. There has been much debate on these concerns. Many of the issues identified are the usual culprits: substandard intake, specialist setting for training, untrained teachers, poor teaching methods, archaic examination procedures, poor governance within higher education and an impoverished and demoralised public health system.

Computerised entrance exams, which are in current practice, tend to assess students on their knowledge of irrelevant trivia and their capacity for rote learning, rather than on their grasp of concepts and principles. They are unable to evaluate aptitude and motivation. Low student–teacher ratios, pedestrian pedagogy, substandard faculty, the absence of periodic faculty appraisal, limited library and online resources, obsolete and irrelevant syllabi, the obsessive focus on passing examinations, and continually declining academic autonomy add to the woes of medical education. The sole focus on science in the curriculum to the complete exclusion of humanities does not allow future doctors to understand regional reality and to be sensitive to the needs of local communities (Jacob 2010). Rigid and hierarchical structures within academia do not help either.

The absence of an apprenticeship model of education and a lack of emphasis on critical thinking and on acquisition of skills and competencies has resulted in producing doctors with undergraduate degrees who are incapable of independent practice. Undergraduate medical education seems to prepare doctors only to write postgraduate entrance examinations for specialisation, completely undermining the goal of basic healthcare delivery through family medicine, general practice and primary care. Systemic problems of higher education in India, particularly the attitude of universities in limiting their role to conducting exams and awarding degrees, compound the situation. Crass commercialisation of medical education, with mushrooming

of for-profit institutions, adds to the complexity of the issues involved.

The Medical Council of India (MCI) faces serious charges of corruption. The dissolution of its governing board and subsequent ad hoc arrangements do not bode well for the country and the regulatory authority for medical education and practice. The narrow perspectives of the MCI, its obsession with professional interest rather than overall healthcare, the non-inclusion of diverse stakeholders in its discussions, its focus on trivia for accreditation rather than actual standards of education, its conflicts of interests and the lack of separation of its accreditation and regulatory functions stifle innovation. The absence of links to healthcare delivery and lack of regulation of health professionals add to the toxic mix.

Recent Changes

Nevertheless, the recent past has seen many efforts at changing medical education including initiatives to teach within the community in primary and secondary care settings (Joseph and Abraham 1993; Krishnan et al 2014), reservations for marginalised communities and harnessing of local and rural talent, changes to the medical curriculum,[2] formal training of teachers, improvements in teaching–learning methods (Vyas et al 2008), modification of the examination systems, reorganisation of universities, compulsory rural service, etc.

Despite these efforts, many of which are localised rather than scaled up to the national level, it is fair to say that the reforms have neither worked as well as hoped for nor have they produced meaningful or significant improvements in the system.

Valiant efforts at curricular change, changes in textbook design, experimentation with problem-based and integrated learning (Vyas et al 2008), and introduction of clerkship programmes and objective-structured clinical and practical examinations have had a limited impact on the system. Centres set up to impart medical education technology, with their narrow vision and limited perspectives, are hopelessly inadequate for the task.

Despite attempts at implementing the Bhore Committee aspirations, the public health system in India is impoverished and its staff is demoralised. India's disproportionate contribution to the global burden of disease, its poorer health indices compared to other low- and middle-income countries (including some of its neighbours) and large disparities between regions and social classes are widely recognised (Patel et al 2015). Very low levels of public expenditure, poor regulation of the health system, rapid commercialisation of and corruption in healthcare and fragmentation of governance of healthcare have been identified as causal. Universal health coverage remains an aspiration, despite governmental promises over many decades.

The impoverishment within the public health system is in stark contrast to the phenomenal rise of private healthcare, its international standards, medical tourism and its focus on servicing the rich. High out-of-pocket healthcare expenditure for the average Indian and significant indebtedness are compounded by poor and variable quality of care (Patel et al 2015).

Medicine and Politics

Poor health indices and the bankrupt public healthcare system in the country periodically impinge on the national consciousness, resulting in sporadic calls for change. Such calls for a radically new architecture are often published in medical literature and directed at the medical and healthcare fraternity (Patel et al 2015). Yet, a meaningful change within medical education and the public health system, both predictors of healthcare delivery and of national standards of health, seems to be light years away.

While the challenge of reforming medical education in India requires a revolution, much of the debate refuses to identify the elephant in the room, that is, the politics of medical education and public health. Rudolf Virchow is often misquoted by highlighting his part quotation that, "Politics is nothing but medicine writ large" (Ashton 2006). In fact, what Virchow *actually* said was that,

> Medicine is a social science and politics is nothing else but medicine on a large scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find the means for their actual solution (Friedlander).[3]

Nevertheless, modern medicine claims public health goals, but is not able to deliver (Jacob 2009). On the other hand, politics and finance, which are required to bring about large-scale changes in the health of populations, have public health goals on their agenda, but continue to focus on short-term electoral gains and profits. The collapse of the Soviet Union resulted in a reduction in emphasis on egalitarian ideals and increased focus on capitalistic economic systems. India, in its efforts to quickly increase its gross domestic product, reduced the importance of public sector institutions and encouraged private enterprise. The failure to increase public healthcare spending and the reductions in national health budgets significantly affected the already precarious state of health services. The original aims and methods of strengthening primary healthcare systems are all but forgotten (WHO 2008).

The diminished political and administrative will to improve healthcare in the public sector and the consequent marked reduction in public funding have resulted in a deterioration of standards in public medical education and health systems. In addition, the rise of private medical educational institutions and the flourishing system of specialist healthcare has meant that ensuring a supply of basic doctors who can independently practise in primary care is not a priority. The private sector not only prefers specialists working out of tertiary care centres, but also does not seem to want basic doctors capable of independent primary care, family and general practice. The MCI, now dominated by the private sector and by specialists, may claim to have national interests at heart, but does not seem keen to improve the quality of medical education, the goal of which should be to produce competent basic physicians.

Corruption in the regulatory body coupled with similar trends in Indian politics and society mean that quality medical education is always on the back burner. Even those who talk about it and those who run pilot projects know that scaling

up innovative efforts to the national level is next to impossible in the current sociopolitical and economic context.

Genuine and wide-ranging improvements in medical education, despite sporadic and gallant efforts, will have to wait for substantial changes in India's political philosophy, and economic policies, which should wholeheartedly endorse egalitarian goals of health for all. Till such time, relevant medical education for the country will remain a dream. The demands on medical education, healthcare delivery and public health are fundamentally shaped by the country's sociopolitical environment. As long as universal healthcare for all Indians is not a serious political imperative, the hope of substantial and meaningful reforms to Indian medical education and its public health system will remain on paper as just good intentions.

NOTES

1 Government of India (1946): *Report of the Health Survey and Development Commitee —1946,* available at National Health Portal: http://www.nhp.gov.in/bhore-committee-1946_pg, accessed on 25 February 2015.

2 Medical Council of India (2011): Vision 2015, New Delhi, available at: http://www.mciindia.org/tools/announcement/MCI_booklet.pdf, accessed on 11 December 2015.

3 E Friedlander and Rudolf Virchow on Pathology com/virchow.htm, accessed on 25 February 2015.

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