



REPORT NO.

92

**PARLIAMENT OF INDIA**  
**RAJYA SABHA**

**DEPARTMENT-RELATED PARLIAMENTARY STANDING  
COMMITTEE ON HEALTH AND FAMILY WELFARE**

**NINETY-SECOND REPORT**

**THE FUNCTIONING OF MEDICAL COUNCIL OF  
INDIA**

**(Ministry of Health and Family Welfare)**

*(Presented to the Rajya Sabha on 8th March, 2016)*

*(Laid on the Table of Lok Sabha on 8th March, 2016)*



**Rajya Sabha Secretariat, New Delhi**  
**March, 2016/ Phalguna, 1937 (SAKA)**

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\*To be appended at Printing Stage.

**COMPOSITION OF THE COMMITTEE**  
**(2014-15)**

1. Shri Satish Chandra Misra - Chairman

**RAJYA SABHA**

2. Shri Ranjib Biswal  
3. Shri Rajkumar Dhoot  
%4. Shri Vijay Goel  
^5. Dr. Bhushan Lal Jangde  
5. Shrimati B. Jayashree  
6. Dr. R. Lakshmanan  
7. Shrimati Kahkashan Perween  
&8. Dr. Vijaylaxmi Sadho  
9. Chaudhary Munvvar Saleem  
10. Dr. T.N. Seema  
@11. Shri Jairam Ramesh

**LOK SABHA**

12. Shri Thangso Baite  
13. Dr. Subhash Bhamre  
14. Shri Nandkumar Singh Chouhan (Nandu Bhaiya)  
15. Dr. Ratna De (Nag)  
16. Dr. Heena Vijaykumar Gavit  
17. Dr. Sanjay Jaiswal  
18. Dr. K. Kamaraj  
19. Shri Arjunlal Meena  
20. Shri J. J.T. Natterjee  
21. Shri Chirag Paswan  
22. Shri M.K. Raghavan  
23. Dr. Manoj Rajoriya  
24. Shri Alok Sanjar  
#25. Dr. Mahesh Sharma  
26. Dr. Shrikant Eknath Shinde  
27. Shri Raj Kumar Singh  
28. Shri Kanwar Singh Tanwar  
29. Shrimati Rita Tarai  
30. Shri Manohar Untwal  
31. Shri Akshay Yadav  
\*32. Shrimati Ranjanaben Bhatt  
\*\*33. Dr. Pritam Gopinath Munde

**SECRETARIAT**

Shri P.P.K. Ramacharyulu Joint Secretary

Shri Pradeep Chaturvedi Director

Shrimati Arpana Mendiratta Joint Director

Shri Dinesh Singh Joint Director

Shri Pratap Shenoy Committee Officer

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% resigned from the membership of the Committee w.e.f. 2<sup>nd</sup> December, 2014

^nominated as a member of the Committee w.e.f. 19<sup>th</sup> December, 2014

&ceased to be member of the Committee w.e.f. 28<sup>th</sup> November, 2014.

@ nominated as a member of the Committee w.e.f. 28<sup>th</sup> November, 2014.

# ceased to be member of the Committee w.e.f. 9<sup>th</sup> November, 2014.

\*nominated as a member of the Committee w.e.f. 22<sup>nd</sup> December, 2014.

\*\* nominated as a member of the Committee w.e.f. 22<sup>nd</sup> December, 2014.

**COMPOSITION OF THE COMMITTEE**  
**(2015-16)**

1. Prof. Ram Gopal Yadav - **Chairman**  
**RAJYA SABHA**

2. Shri Ranjib Biswal
3. Shri Rajkumar Dhoot
4. Dr. Bhushan Lal Jangde
5. Shrimati B. Jayashree
6. Dr. R. Lakshmanan
7. Shrimati Kahkashan Perween
8. Shri Ambeth Rajan
9. Shri Jairam Ramesh
10. Dr. T.N. Seema

**LOK SABHA**

11. Shri Thangso Baite
12. Dr. Subhash Ramrao Bhamre
13. Shrimati Ranjanaben Bhatt
14. Shri Nandkumar Singh Chauhan
15. Dr. Ratna De (Nag)
16. Shri Devendra *alias* Bhole Singh
17. Dr. (Smt.) Heena Vijay Gavit
18. Dr. Sanjay Jaiswal
19. Dr. K. Kamaraj
20. Shri Arjunlal Meena
21. Shri J. Jayasingh Thiyagaraj Natterjee
22. Shri Chirag Paswan
23. Shri C. R. Patil
24. Shri M.K. Raghavan
25. Dr. Manoj Rajoria
26. Dr. Shrikant Eknath Shinde
27. Shri R.K. Singh
28. Shri Kanwar Singh Tanwar
29. Shrimati Rita Tarai
30. Shri Manohar Untwal
31. Shri Akshay Yadav

**SECRETARIAT**

Shri P.P.K. Ramacharyulu	Additional Secretary
Shri Pradeep Chaturvedi	Director
Shri Dinesh Singh	Joint Director
Shri Rajesh Kumar Sharma	Assistant Director
Shri Pratap Shenoy	Committee Officer

## **Introduction**

I, the Chairman of the Department-related Parliamentary Standing Committee on Health and Family Welfare, having been authorized by the Committee to present the Report on its behalf present this Ninety-second Report of the Committee on the Functioning of Medical Council of India (MCI).

2. The previous Committee had identified the subject 'Medical Council of India' at its meeting held on 18<sup>th</sup> September, 2014. However, it could not conclude its examination of the subject. The present Committee also took up the subject for detailed examination at its meeting held on 23<sup>rd</sup> September, 2015.

3. The Committee examined the subject, in its sittings held on 25<sup>th</sup> September, 2014, 28<sup>th</sup> January, 2015, 12<sup>th</sup> May, 2015, 25<sup>th</sup> May, 2015, 27<sup>th</sup> July, 2015, 6<sup>th</sup> October, 2015 and 1<sup>st</sup> March, 2016. During the course of the examination it took oral evidences of representatives of the Ministry of Health and Family Welfare and experts on the subject. The Committee also received written submissions from experts. The Committee wishes to appreciate the contribution made by various official witnesses/ experts (**Annexures I and II**) who richly deserve Committee's encomia for sharing their perspectives and valuable views with the Committee and suggesting remedies to the problems afflicting Medical Education and Practice in the country through their evidences and written submissions. The Committee also benefitted from discussions with certain stakeholders and representatives of the State Governments during its study visit to Tamil Nadu and Karnataka from 8<sup>th</sup> June to 12<sup>th</sup> June, 2015 and local study visit to Vardhaman Mahavir Medical College (VMMC), New Delhi and Shri Guru Govind Singh Tercentenary Medical College (SGGSTMC), Gurgaon on the 2<sup>nd</sup> February, 2016.

4. The Committee had also invited views from various stakeholders in response to which 46 Memoranda had been received (**Annexure-III**). The Memoranda were forwarded to the Ministry of Health and Family Welfare for comments which informed the Committee that the same had been forwarded to the MCI which has formed a Committee to examine the issues raised in the memoranda. The President, MCI informed that the report is already prepared and has passed through EC (Executive Committee) and now will go to GB (General Body) in March, 2016. On a direction by the Committee to expedite the said GB body meeting, the President, MCI promised to expedite the same. Till the presentation of this report the comments have not been received, and Committee expresses its dissatisfaction over such casual attitude of the Ministry and the MCI.

5. During the finalization of its Report, the Committee relied upon the following documents/ papers:-

- (i) Status Note on MCI received from Department of Health and Family Welfare;
- (ii) Oral Evidence tendered by Secretary, Department of Health and Family Welfare alongwith the President, MCI;

- (iii) Oral Evidence tendered by Experts/ Stakeholders;
- (iv) Written submissions made by Experts/ stakeholders; and
- (v) Replies to the questionnaires received from the Department of Health and Family Welfare;
- (vi) Websites of Ministry of Health and Family Welfare and MCI;
- (vii) Articles published in various fora; and
- (viii) Other relevant documents

6. The Committee considered the Draft Report and adopted the same in its meeting held on 1<sup>st</sup> March, 2016.

7. For facility of reference and convenience, the observations and recommendations of the Committee have been printed in bold letters in the body of the Report and also reproduced at the end of the Report in ‘Observations/Recommendations-at a Glance’ .

**NEW DELHI**  
**01<sup>st</sup> March, 2016**  
**Phalguna 11, 1937 (Saka)**

**ROF. RAM GOPAL YADAV**  
**Chairman,**  
**Department-related Parliamentary**  
**Standing Committee on Health and Family Welfare**



# REPORT

## Chapter –I

### Background

1.1 Despite having the most number of medical colleges in the world, and currently having approximately 9.29 lakhs doctors enrolled on the Indian Medical Register, India is way behind in achieving the targeted doctor population ratio of 1:1000 as per WHO norms. Shortage of doctors, who are the most important cog in the health care delivery system, has derailed both access to and quality of health care, especially to the vulnerable and poorer sections of the country.

1.2 Though there have been substantial improvements in health outcomes over the years, there are still large gaps in health care accessibility in many parts of the country and Universal Health Care still remains a distant dream. Issues concerning medical education, access to adequate health care to all people and the entrenched inadequacy of health and clinical governance in the country have been engaging the attention of the Committee for quite some time. The Committee has been given to understand that the following issues have been widely debated in various fora across the country:

- I. failure of the current system to produce doctors including specialists and super specialists in adequate numbers and of requisite quality;
- II. deficiency of teachers in medical colleges;
- III. poor regulation of Undergraduate (UG) and Postgraduate (PG) education;
- IV. disconnect between medical education system and health system;
- V. opacity in the functioning of the existing regulatory body of medical education (i.e. Medical Council of India);
- VI. lack of accountability of Medical Council of India (MCI);
- VII. geographical mal-distribution of medical colleges;
- VIII. failure of the MCI in discharging its mandated responsibilities;
- IX. allegations of rampant corruption in the MCI;
- X. constitution and composition of the MCI;
- XI. absence of proper screening and admission procedures in private medical colleges;
- XII. need for common entrance test for admissions to MBBS, Postgraduate and Super-specialty medical courses;

- XIII. prevalence of capitation fee in private medical colleges in flagrant violation of the law;
- XIV. barriers to expansion of medical education;
- XV. lack of a robust accreditation system for UG and PG Medical education;
- XVI. gross inequity between rural and urban India in terms of availability of health care services;
- XVII. ethical issues;
- XVIII. need for reforms in the regulatory framework of medical education and practice;
- XIX. over-investigation and over-treatment in private hospitals;
- XX. inadequacy of self-regulatory processes for medical profession.

1.3 Since the Medical Council of India is mandated to play a pivotal role in regulating medical education and practice in the country, the Committee decided to holistically examine its role and functioning with the ultimate aim of suggesting veritable solutions to the inadequacies that are currently plaguing our medical education and health care delivery systems.

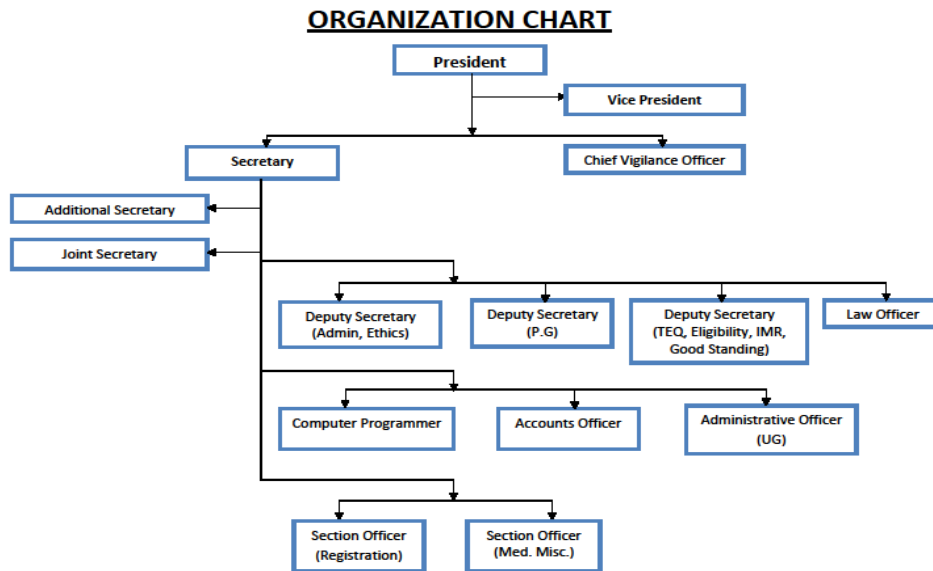
1.4 At the initial stage of examination of the subject, the Committee called for a background note on the functioning of Medical Council of India (MCI) from the Ministry of Health and Family Welfare.

### **Background of MCI furnished by Ministry**

1.5 The Ministry of Health and Family Welfare in the background note submitted to the Committee stated that the Medical Council of India was established in 1934 under the Indian Medical Council Act, 1933, with the main function of establishing uniform standards of higher qualifications in medicine and recognition of medical qualifications in India and abroad. The Act was repealed and replaced by a new Act in 1956. The Indian Medical Council Act, 1956 was further amended in 1964, 1993, 2001.

### **Organization Chart of MCI**

- i) According to the Ministry the following is the organization chart of MCI.



### Objectives:

- ii) The Ministry stated that the Council has the following objectives:
- a. Maintenance of uniform standards of medical education, both under graduate and postgraduate.
  - b. Recommendation for recognition/de-recognition of medical qualifications of medical institutions of India or foreign countries.
  - c. Permanent registration/provisional registration of doctors with recognized medical qualifications.
  - d. Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications.

### Functions and Duties:

- iii) As per the note submitted by the Ministry the following are the functions and duties of the Council:
- a. Permission to establish a new medical college or opening of a new or higher course of study or training or increase in admission capacity in any course of study or training, including exercise of power to finally approve or disapprove the same.
  - b. Inspection/visitation with a view to maintain minimum standard of medical education in India.
  - c. Recognition/de-recognition of
    - i) Indian Qualifications

- ii) Foreign Qualifications
- d. Registration
  - i) Permanent Registration
  - ii) Provisional Registration
  - iii) Registration of Additional Qualifications
  - iv) Issue of Good Standing Certificates to doctors going abroad
  - v) Issue of Eligibility Certificate to candidates going abroad for pursuing primary medical qualifications.
- e. Indian Medical Register: Maintenance of an Indian Medical Register of persons who hold any of the recognized medical qualification or for the time being registered with any of the State Medical Councils or Medical Council of India.

#### **Further Amendments to the Indian Medical Council Act, 1956:**

- iv) Explaining about the further amendments to the Indian Medical Council Act, 1956, the Ministry explained as under:
  - a) Following an announcement by the President of India in June, 2009 that Government would establish a National Council of Human Resources in Health (NCHRH) as an overarching regulatory body for health sector to reform the current regulatory framework and enhance the supply of quality skilled personnel, the Hon'ble Prime Minister in his Independence Day speech to the nation in the year 2010 mentioned about constitution of two separate councils in the higher education and health respectively so that reforms in these two areas can be accelerated. But no such action was taken at that stage because of an observation of the Prime Minister, when the matter was presented to him, that further public consultation may be necessary.
  - b) The issue acquired momentum again in 2010 when former President, MCI was arrested and the MCI was suspended and placed under the administration of a Board of Governors nominated by the Government. The National Council of Human Resources in Health (NCHRH) was then revived as a possible way to regulate the MCI.
  - c) The Central Government amended the Indian Medical Council (IMC) Act, 1956 through the Indian Medical Council (Amendment) Ordinance, 2010 on 15<sup>th</sup> May, 2010 and superseded the Medical Council of India (MCI) for one year and subsequently notified constitution of Board of Governors

(BoG) to perform the function of the Council during the interregnum. In July, 2010 the Replacement Bill for the Ordinance was passed by the Parliament and Indian Medical Council (Amendment) Act, 2010 received the assent of the President on 04<sup>th</sup> September, 2010. Subsequently, the term of the BoG was extended to one year at a time by amending the Act in 2011 and 2012. As per the amendments in the Act, the Council has to be reconstituted within a period of 3 years from the date of the supersession, i.e. by 14<sup>th</sup> May, 2013.

- d) In the meantime, the Ministry of Health & Family Welfare proposed to set up a National Commission for Human Resources for Health (NCHRH) as an overarching regulatory body which would subsume various functions of the existing councils including MCI. The NCHRH Bill was introduced in the Rajya Sabha on 22.12.2011 which was referred to Department related Parliamentary Standing Committee for examination and report. The Committee after taking into consideration the views of various stakeholders, recommended in its Report dated 30.10.2012 that the Ministry may withdraw the Bill and bring a fresh Bill after appropriately addressing the apprehensions of the stakeholders.
- e) Since the chances of enacting the proposed NCHRH before the completion of the term of the BoG i.e. 14<sup>th</sup> May, 2013 were remote and seeking another extension for BoG beyond the 14<sup>th</sup> May, 2013, the Ministry prepared a Bill to amend the IMC Act, 1956. The IMC (Amendment) Bill, 2013 was approved by the Cabinet on 07.03.2013 and introduced in the Rajya Sabha on 19.03.2013. However, the Bill could not be taken up for consideration during the Budget Session, 2013.
- f) In the above circumstances, the Ministry again extended the term of BoG for a period of 180-days i.e. upto 10<sup>th</sup> November, 2013 by way of IMC (Amendment) Ordinance, 2013 on 21<sup>st</sup> May, 2013. Subsequently, the Indian Medical Council (Amendment) Bill, 2013 to replace the Ordinance was introduced in the Rajya Sabha on the 19<sup>th</sup> August 2013. The Bill however could not be taken up for consideration and passing. As the said replacement Bill could not be passed at the expiration of six weeks from the reassembly of Parliament in terms of sub-clause (a) of clause (2) of Article 123 of the Constitution, the aforesaid Ordinance ceased to operate on the 16<sup>th</sup> September, 2013.

- g) In view of the position explained above, the Indian Medical Council (Amendment) Second Ordinance 2013 was notified on the 28<sup>th</sup> September, 2013 making it effective w.e.f. 14<sup>th</sup> May 2013, so that the work already done by the Board of Governors of the Medical Council of India as per provisions of earlier Ordinance is validated and may continue. As per the provisions of the Indian Medical Council (Amendment) Second Ordinance 2013, the Government re-constituted the Council on the 06<sup>th</sup> November, 2013 vide its notification dated the 05<sup>th</sup> November, 2013.
- h) The Department-related Parliamentary Standing Committee on Health and Family Welfare, in its 73<sup>rd</sup> report, presented to the Chairman Rajya Sabha on the 20<sup>th</sup> November, 2013, recommended some modifications in the Indian Medical Council (Amendment) Bill, 2013 and desired that the Government may incorporate the modifications in the Bill replacing the Indian Medical Council (Amendment) Second Ordinance, 2013.
- i) The Ministry of Health and Family Welfare examined the Report and modified the Indian Medical Council (Second Amendment) Bill 2013, for replacing the Indian Medical Council (Amendment) Second Ordinance, 2013, after incorporating such recommendations of the Committee which are acceptable to this Ministry. The Indian Medical Council (Second Amendment) Bill 2013 was approved by the Cabinet in its meeting held on the 5<sup>th</sup> December, 2013, which was to be introduced in the Rajya Sabha.
- j) The Indian Medical Council (Second Amendment) Bill, 2013 to replace the said Ordinance could not be introduced in the Rajya Sabha, despite all efforts, during the winter session 2013 of Parliament as the House was adjourned sine die on Wednesday, the 18<sup>th</sup> December, 2013.

**Re-constitution of MCI:**

- v) The Ministry stated that the Medical Council of India was reconstituted on 06.11.2013 as per provisions contained in section 3(1) of IMC Act, 1956. The strength of MCI as on 29<sup>th</sup> January, 2016 was 104 members. The details of provisions under which the Council was reconstituted and the strength (as per Status Note dated 29<sup>th</sup> January, 2016) was as under:

Section	Total number of representation	Present strength
3 (1) (a) – State Recommendation	30	27
3(1) (aa) – UTs Recommendation (In rotation from 5 UTs)	1	1
3 (1) . (b) – Elected by Govt. Universities/Health Universities	68	52
3 (1) (c) – Elected by Registered Medical Practitioners in the States	22	16
3 (1) (e) – To be nominated by Central Government	8	8
<b>Total</b>	<b>129</b>	<b>104</b>

### **Committees of MCI**

- vi) The Ministry further stated that as per provisions contained in Section 9(1) of IMC Act, 1956, MCI has constituted an Executive Committee and various sub- committees viz., Academic Sub-Committee, Ethics Sub-Committee, Migration Sub-Committee, TEQ-Equivalence Sub-Committee, Registration Sub-Committee, Finance Sub-Committee, Administration & Grievance Sub-Committee, etc. Further, as per provisions contained in section 20 of IMC Act, 1956, a Post-Graduate Medical Education Committee has been constituted for assisting the Council in matters relating to Post-Graduate Medical Education.

### **Funding pattern of the Council:**

- vii) According to the Ministry, the funding pattern of the Council is that Ministry of Health & Family Welfare, Govt. of India provides grant under Plan & Non-Plan Schemes. During the year 2015-2016, an amount of Rs.110 lakhs has been earmarked as Grant-in-Aid to the Council. The Council generates sufficient revenue by way of various types of fee like Inspection Fee u/s 10A, Annual Inspection Fee and fee for issuing of various Registration Certificates.

### **The major reforms needed:**

- viii) The Ministry in the back ground note, submitted to the Committee, indicated that the following the major reforms are needed:
- a) There is need to restructure the MCI. The model favoured is that of a lean and professional body with a mix of medical and lay people. There should be a full time Chairman, full time members and ex-officio members representing the Government to bring about synergy in its functioning. The Apex Body should have four distinct bodies under it, one each

for Licensing, Accreditation, Under Graduate Curriculum, and Post Graduate Curriculum.

- b) There is need to incorporate ICT tools and revisit the minimum standards requirements under the Act. Virtual classrooms, e-learning, e-journals are some of the modern tools that must find place while considering various requirements/resources for medical college.
- c) The Code of Ethics for medical professional needs to be well defined and at par with the global standards.
- d) A common Entry and Exit exam at the national level is required to ensure quality of medical education.

**Steps taken for revamping the functions of MCI:**

- ix) The Ministry explained to the Committee that a Group of Experts was constituted under the Chairmanship of Dr. Ranjit Roy Chaudhury to study the existing IMC Act, 1956 governing the Medical Council of India (MCI) and *inter-alia* make recommendations to the Government to streamline the functioning of MCI. The Committee was later informed that the Group of Experts had submitted its Report to the Ministry in the month of February, 2015 which was under consideration of the Ministry.



## Chapter-II

### Health Systems and Challenges in the Delivery of Health Services

2.1 The Committee would, at the outset like to assess the state of affairs in health care delivery systems in the country, for, medical education cannot be seen as an end in itself, but should be geared and attuned to providing general, appropriate, accessible and affordable healthcare to all countrymen.

#### Access to Health Care Services

2.2 Though India has made considerable progress towards improving healthcare indicators such as life expectancy, child mortality, maternal and infant mortality over the years, yet the outreach and services delivery for the urban and rural poor has been inadequate and the gaps in health outcomes continue to widen.

2.3 “Despite being home to 17.5% of the global population, India accounted for 20% of the global burden of disease in 2013 - only a slight improvement from 21% in 2005. India accounts for 27% of all the neonatal deaths and 21% of all the child deaths (younger than 5 years) in the world. Diarrhoea, pneumonia, preterm birth complications, birth asphyxia, and neonatal sepsis account for 68% of all deaths in children younger than 5 years in the country.”<sup>1</sup>

2.4 The following paragraph, which is an extract from the Report of the Group of Experts constituted by the Ministry to study the Indian Medical Council Act, 1956 highlights the magnitude of the gaps in our healthcare services:-

"While many important healthcare indices, such as life expectancy, infant and maternal mortality have improved significantly since independence, we lag woefully behind developed countries and even other countries with similar socio economic status as ours, in these indicators. India's Under 5 Child Mortality (Probability of dying before reaching age of 5 per 1000 live births) as in 2011 was 61, as compared to Nepal 50, Bhutan 54, Bangladesh 46, Peru 18, Maldives 15, China 15, Brazil 16, Thailand 12, Sri Lanka 12, Chile 9, USA 8, Cuba 6, UK 5, Japan 3 and is slightly better than only Pakistan 88. Maternal Mortality figures (number of maternal deaths per 100,000 live births) are worse: India 200, Bhutan 180, Nepal 170, Brazil 56, Thailand 48, Sri Lanka 35, China 37, Chile 25 as compared to USA 21, UK 12, Japan 5, Singapore 3."

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<sup>1</sup> *The Lancet* dated December 12, 2015: *Assuring Health Coverage for all in India*.

2.5 As per written submissions furnished by the experts, India faces a high degree of inequity in access to health care services. There are urban-rural inequities and there are also geographical inequities. With rapid privatization of medical education and healthcare since the 1980s, around 70% of medical professionals work in the private health sector and around 70% of these are concentrated in urban well-to-do areas. As per an article published in the Lancet, "a consequence of the insufficient reach of the public sector has been the growth of a massive, heterogeneous and mostly unregulated private health-care sector. In 2014, more than 70% of outpatient care (72% in the rural areas and 79% in the urban areas) and more than 60% of inpatient care (58% in rural areas and 68% in urban areas) was in the private sector.... Private practitioners are now therefore the first point of contact in both rural and urban areas for many ailments, including fevers and acute illnesses, care of neonates, and treatment of diseases such as tuberculosis. However, a substantial proportion of, and in some areas even the majority of private providers might be unqualified or under-qualified. For example, a study in rural Madhya Pradesh found that only 11% of the sampled health-care providers had a medical degree, and only 53% of providers had completed high school. Informal care providers, with no formal medical training or registration with government for medical practice, are estimated to represent 55% of all providers and are also frequently the first point of contact, especially in rural areas."<sup>2</sup>

2.6 The major source of professional healthcare for rural and also many urban poor households is through the public sector which is insufficient in infrastructure, human resources, equipment and drugs (especially at the primary level). The first point at which a doctor is available in rural public health system is at the Primary Health Centre (PHC) and there are 25308 PHCs<sup>3</sup> as on 31st March, 2015 for a rural population of 83.3 crore plus. This is just a drop in the ocean. These PHCs suffer from staff shortages. The shortfall of allopathic doctors at PHCs as compared to requirement based on existing infrastructure is 11.9%.<sup>3</sup> "Moreover, as compared to requirement for existing infrastructure, there was a shortfall of 83.4% of surgeons, 76.3% of obstetricians & gynaecologists, 83.0% of physicians and 82.1% of paediatricians. Overall, there was a shortfall of 81.2% specialists at the CHCs as compared to the requirement for existing CHCs."<sup>3</sup>

2.7 There has been a steady increase in vacancies in the positions of doctors at Primary Health Centres over the last five to ten years (27% in 2015)<sup>3</sup> and an even more shocking increase in the vacancies of specialists at secondary facilities. "The current position of specialists manpower at CHCs reveal that as on 31st

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<sup>2</sup> *The Lancet* dated December 12, 2015: *Assuring Health Coverage for all in India*

<sup>3</sup> *Rural Health Statistics, 2015.*

March, 2015, out of the sanctioned posts, 74.6% of Surgeons, 65.4% of obstetricians & gynaecologists, 68.1% of physicians and 62.8% of paediatricians were vacant. Overall 67.6% of the sanctioned posts of specialists at CHCs were vacant."<sup>4</sup> Thus, there are very few surgeons, anesthetists, gynecologists and paediatricians in the public health system, and people who live far from cities and towns have no option but to travel long distances to avail surgical care.

2.8 Explaining about the status of health services in the country, Dr. Devi Shetty, Former Member, BoG, MCI who deposed before the Committee on 27<sup>th</sup> July, 2015 submitted that:

“I am not really that concerned about the medical education but I am very concerned about the impact it has on the lives of common people of this country. Every ten minutes a pregnant lady dies during child birth and ten lakh children die within the first year of life. Why?" It is because the common hospital these people approach, is the community health centre which takes care of the health of 1,54,512 people.”

2.9 The strong link between poverty and ill health is a documented fact. According to the government’s draft National Health Policy 2015, “over 63 million persons are faced with poverty every year due to health care costs alone. People have no financial protection for the vast majority of health care needs. In 2011-12, the share of out-of-pocket expenditure on health care as a proportion of total household monthly per capita income was 6.9% in rural areas and 5.5% in urban areas. This led to an increasing number of households facing catastrophic expenditure due to health costs (18% of all households in 2011-12 as compared to 15% in 2004-05).” Public funding is estimated to be of the order of only 19.67% of the expenses of health care in the country (as per National Health Accounts Estimates-2004-05) and most of private expenditure is out-of-pocket (OOP) expense, which has the potential of pushing even the non-poor into poverty. This clearly indicates that the expansion of medical education has not fulfilled the increasing health needs of the people.

**2.10 The Committee observes that though there have been substantial improvements in certain health outcomes, especially in life expectancy, maternal and infant mortality, these achievements should not mask India's failures in achieving the desired level of health care delivery. As per the Report of the Working Group on Tertiary Care Institutions for the 12<sup>th</sup> Five Year Plan, rates of infant and maternal deaths still remain high, nearly one million Indians die every year due to inadequate healthcare facilities, 700**

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<sup>4</sup> *Rural Health Statistics, 2015.*

**million people have no access to specialist care and 80% of specialists are working in urban areas. Despite India's economy today being one of the world's fastest growing and third largest in terms of Gross National Health Income, our health system continues to face a huge need gap in terms of access to adequate healthcare and availability of health professionals and facilities. India also has the dubious distinction of lagging behind countries like Nepal, Bhutan, Bangladesh, Peru, Maldives, China, Brazil, Thailand, Srilanka and Chile on important health indicators including child mortality and maternal mortality. If 63 million persons are faced with poverty every year due to health care costs alone (as per Draft National Health Policy, 2015), it clearly indicates that health care is moving away from the reach of the people in general and the poor in particular. This also indicates that India has not been able to leverage its economic growth to achieve the desired health outcomes. The fact that there is an acute shortage of doctors in the country and the effective delivery of health care services cannot be guaranteed without the availability of doctors in adequate numbers, testifies to the point that the system of medical education, as regulated by the Medical Council of India, has not been able to address the many unmet health care needs of our health system and needs reforms urgently.**

### **Shortage and uneven distribution of Doctors**

2.11 The Committee has been informed by an expert that in large measure, the failure to improve the health of our people is strongly linked to failure to expand the trained human resource- both in quantity and quality.

2.12 In a reply to a question the Ministry has informed the Committee that as per MCI records there are 9.29 lakh doctors registered in the Indian Medical Register as on 31.03.2014. Assuming 80% availability, it is estimated that around 7.4 lakh doctors may be actually available for active service. It gives a doctor-population ratio of 1:1674 against the WHO norm of 1:1000. At present, every year around 55000 doctors and 25,000 PG doctors are passing out from various colleges. At this rate of growth, the country should have a doctor (allopathic)-population ratio of 1:1250 for a population of 133 crores by 2020 and 1:1075 by 2022 (population: 136 cores). However, the Committee has been informed by an expert who deposed before the Committee that doctors cannot be produced overnight and if we add 100 medical colleges every year for the next five years, only by the year 2029, will the country have adequate number of doctors.

2.13 The following observation made by the Group of Experts constituted to study the IMC Act on 1956, outlines the inadequacy of availability of medical professionals in India:-

"India has significantly lower numbers of doctors, nurses, midwives, community health workers and other allied groups for health care delivery, as compared to the recommended global norms. The shortfall of doctors is in spite of the massive expansion in the number of medical colleges, from 23 in 1947 to the current 398; the total number of medical seats in 2014 is 49,930. As of 2010-11, India has only 6.5 doctors per 10,000 of population, as compared to 17.6 in Brazil, 14.6 in China, 27.7 in UK, and 24.2 in USA. This is far short of the global average and even below the target of 1 for 1000 of population recommended by the High Level Expert Group Report on Universal Health Coverage for India".

2.14 The then Health Secretary during deposition before the Committee admitted that the doctor population ratio in India vis-à-vis WHO norm was indeed abysmal. He further submitted that it takes more than Rs. 200 crore to set up a medical college and about Rs. 1500 crore to set up an AIIMS and because of resource constraints, it was not possible to set up enough medical colleges and AIIMS-like institutions to take care of the backlog.

2.15 The representative of the IMA during evidence tendered before the Committee submitted that India's assessment of requirement of doctors was based on the western concept where a specialist hardly sees 15 patients per day. In India even a general practitioner sees 500-1000 patients daily. He suggested that the manpower requirement should be assessed assuming that a doctor sees 50-100 patients daily.

2.16 An expert who appeared before the Committee submitted that India was very, very short of doctors and to meet this shortfall, India needs to have not four hundred, but one thousand medical colleges.

2.17 The representative of the MCI during evidence informed the Committee through a power-point presentation that there were 9.29 lakh doctors that were registered on the Indian Medical Register. When asked whether this figure also included doctors who had gone abroad, the representative of the MCI replied in the affirmative. When further asked about the actual number of doctors practicing in India, the representative stated that the process to collect such data had been undertaken. The Joint Secretary who was present during the evidence informed the Committee that those doctors who studied here and moved out were not captured in the figures.

2.18 Besides acute shortage of medical doctors, there are serious issues concerning mal-distribution of doctors and imbalanced growth of medical colleges in the country. In reply to a question, the Joint Secretary of the Ministry

during evidence submitted that "the capacity that we are seeing on UG and PG seats, almost sixty five percent is concentrated in the South and the West of the country. So, the deficit areas are really the north and the East of the country." The Health Secretary, who was also present during the deposition informed that the doctors were distributed in an uneven manner and ensuring that the doctor goes to rural areas remains a challenge and for that several measures have been taken.

2.19 Some experts who deposed before the Committee pointed out that:

- (i) "there was a lot of geographical mal-distribution of medical colleges with clustering in some parts and lacking in others."
- (ii) "We are unable to meet this demand and supply mismatch because the Medical Council of India is standing as a big barrier in the development of new medical colleges and the same thing applies to the geographical mal-distribution...". He also informed the Committee that "Six states which represent 31 per cent of India's population have 58% of the MBBS seats; on the other hand eight states which comprise 46% of India's population have 21% of the MBBS seats."
- (iii) "We have to decentralize health care manpower planning from the Centre to the State Governments. Each State Government should get one of the top global consultancy firms and find out what is the requirement of specialists, nurses, paramedics, etc."
- (iv) "health being a State subject, the planning for having adequate number of doctors should be the State's responsibility. The States should open new medical colleges and raise funds for the purpose."

2.20. During the Committee's study visit to Coimbatore, Ooty and Bengaluru some of the stakeholders suggested that to address the issue of uneven distribution of medical colleges in the country, the Central Government should fund medical colleges in areas where there are very few medical colleges.

**2.21 The Committee agrees that there is an acute shortage of medical doctors in the country besides their geographical mal-distribution. The Committee takes note of the submission of Ministry of Health and Family Welfare that the total number of doctors registered on the Indian Medical Register is 9.29 lakhs out of which 7.40 lakhs are available for active practice and that the doctor - population ratio in India is 1:1674 as against the WHO norm of 1:1000. However, given the fact that the Indian Medical Register is not a live database and contains names of doctors who may have passed away or retired from active practice, by now, as well as those with a permanent address outside India and that there is no mechanism in place for filtering out such cases, the Committee is highly sceptical of the Ministry's claim of having one doctor per 1674 population. In view of the above, the Committee**

feels that the total universe of doctors in India is much smaller than the official figure and we may have one doctor per 2000 population, if not more. The Committee observes that the imbalances in availability of affordable and quality health care cannot be corrected without augmenting the capacity of production of medical doctors including specialists and super-specialists in adequate numbers and of requisite quality and competence. Apart from the unfinished agenda of communicable diseases, India is witnessing the rapidly rising burdens of non-communicable diseases (Cardiovascular diseases, Cancer, Diabetes, Chronic respiratory disorders, Mental illness, Liver and Kidney diseases), which call for the availability of many more category of doctors and specialist doctors. The Committee is constrained to observe that the MCI has been unresponsive to health system needs with the result that shortage in number of basic doctors and specialists, maldistribution of medical colleges and doctors across the states continue to plague the delivery of effective and equitable health services. At the present rate of production of doctors, the shortfall in basic and specialist doctors will not be met for many years. The Committee, therefore, recommends that urgent measures may be taken to spell out policy stance in great detail and with clarity to augment the capacity of production of doctors including specialists and super-specialists at the scale and speed required to meet India's health needs.

2.22 The Committee is concerned to note that the medical colleges in the country are distributed in a skewed manner, with nearly sixty five percent medical colleges concentrated in the Southern and Western States of the country which has resulted in great variation in doctor-population ratio across the states. The States of North, North-East and Central India have a severe shortage of doctors because of very few medical colleges they have. The Committee also notes with concern that six states with 31% of India's population account for 58% of the MBBS seats, while eight states which comprise 46% of India's population have 21% of the MBBS seats. The Committee is of the opinion that the mere increase in medical seats to enable correction of this doctor-population imbalance will not automatically address this skew because experience shows that doctors normally settle in the cities they go to for their medical education and do not return to serve in their own urban or rural areas. Also, even if compulsory rural service is introduced throughout India, graduates of each state would be required to serve only in their state, as per present state health regulations, and the states with very few medical colleges would continue to be disadvantaged. The Committee would, therefore, recommend that an institutional mechanism be put in place to ensure better distribution of medical colleges across the country. State level doctor-population ratio should guide the setting up of new medical colleges and also the increase in UG and PG seats.

**2.23 The Committee also observes that the present approach in the matter of healthcare manpower planning is a top-down one. Since health is a State subject and State Governments are major stakeholders in the delivery of healthcare services, medical manpower planning should be bottom-up also. The Committee, accordingly, recommends that each State should plan for an optimal number of doctors, with a target of 1:1000 doctor-population ratio.**



## Chapter III

### Constitution and Composition of MCI

3.1 The Composition of the Medical Council of India is structured in terms of Section 3 of the IMC Act, 1956. The representative of the Medical Council of India during his deposition before the Committee submitted the following:-

"Section 3 basically contemplates that the Central Government shall be responsible for constituting a Medical Council of India in terms of representation. Section 3(1) (a) contemplates that each State would make a nominee from amongst the registered medical practitioners of that State to be nominated by the Central Government. Subsequent sub-section says that this would not only be attributable to a State, but even Union Territories would be entitled on the basis of rotation. Section 3(1) (b) contemplates that every university that has got a medicine faculty, through its Senate, will be in a position to elect one representative by the Board of Management or the Senate, as the case may be. Then, subsequent sub-section contemplates that every State will be in a position to elect one representative from among the registered medical graduates in that particular State, who will represent the registered medical graduates of that State and finally, the Central Government, under Section 3(1) (e), is entitled to nominate eight persons from amongst whomsoever they deem necessary, who will be nominated members of the Medical Council of India. So, the Council has a representative character of elected and nominated members. Elected members are with reference to universities and registered medical graduates, and nominated members are with reference to State Governments and the eight nominees by the Government of India. So, this is the composition which is stipulated in Section 3."

3.2 As per the information made available by one of the experts, currently there are 102 members of MCI which 35 are nominated and 67 are elected. Of these elected 67 members, 1/4<sup>th</sup> (16) are from registers of medical graduates. Rest 3/4<sup>th</sup> (51) are elected from university members. Within the category of nominated members, about 1/4 (8) are nominated by the Central Government to represent it and rest 3/4 (27) are nominated by the Central Government in consultation with different State Governments.

3.3 It has also been informed by the expert that, even State Governments and Central Government have nominated doctors from corporate private hospitals to represent themselves in the current MCI.

3.4 The Committee notes from the information furnished by an expert that there is a trend of rapid expansion of private medical colleges. Currently, there are 412 medical colleges of which 53% (217) are from private sector and 47% (195) from Government. Therefore, if the current arrangement continues, the private sector will get overrepresented on the MCI with the passage of time.

### **Composition of MCI - Elected versus Nominated Regulator**

3.5 On being asked to clarify its position on the issue of elected versus nominated regulator, the Indian Medical Association (IMA) in its written submissions on the issue was of the view that:

“Medical Council should be in-fact made more representative in character by having one elected representative per 20,000 doctors, whereas now it is one per state medical council. The council should have representatives of not only the academic institutions, but also of the whole medical profession. Then only the medical needs of the society and the ground reality of the problem that a basic graduate faces, as a primary care physician, can be addressed to effect changes in the curriculum. With the emergence of medical universities, the number of elected representatives from the teaching institutions has also become less. Instead of every University electing representatives proportionate to the medical colleges, now one representative per Health University is only elected. Here again the elected representatives from the academic institutions should be proportionate to the number of medical colleges. If all the medical council members are nominated by the central government, they can only implement the policies of the government. The various pronouncements made by the Hon'ble High Court and Supreme Court from time to time on the said issue have specifically brought out that the composition of Medical Council of India should be representative in character in as much as that not more than 1/3rd members of the council should belong to nominated category whereby the ratio of elected: nominated members should be 2/3rd :1/3rd and if this ratio is to be breached then the same should be to the side of more elected members and less nominated members, which would augur well with the desired autonomy for effective dispensation of the task and the fulfillment of statutory objectives by the Medical Council of India. The autonomy of the medical profession and the watch-dog role it should play to ensure what is best for the medical profession and public health will be lost. In a democratic republic, to conceive an institution with only nominated members will be contrary to the very basic principle of democracy. It will only lead to autocracy in these institutions.”

3.6 Most of the experts who deposed before the Committee were in favour of nominated regulators on the following grounds:-

- i. Elections are unlikely to produce regulators of repute and moral authority;
- ii. No regulatory body of medical education in the world has elected people. In the UK, USA, Japan, Canada, Australia, regulators of medical education are appointed through transparent processes.
- iii. Since Governments are accountable to the people for the performance of health system, they should be empowered to appoint regulators of medical education.
- iv. The possibility of use of money in elections gives advantage to private management sponsored candidates getting over-represented. Since the number of private medical colleges is increasing, the over-representation of private medical college representative would affect the role and responsibilities of MCI as there is possibility of dilution of standards.
- v. The MCI as presently elected has been mired in multiple controversies and corruption and what is of greater concern is it has failed to address the needs of the health system in the country.
- vi. The MCI as presently constituted is not accountable or transparent in its functioning.
- vii. Government appointed regulatory bodies such as the National Board of Examinations, Board of Governors of MCI, the Delhi Medical Council etc., have performed commendably without getting embroiled in alleged corruption and malpractices.

3.7 During the Committee's study visit to Vardhman Mahavir Medical College, New Delhi, the representatives of the College submitted that the regulatory body should be dominated by medical teachers and the representation of private practitioners should be reduced. It was further submitted that the MCI is presently an elected body. Many academicians do not tend to fight election and thus the body does not get the talent which it should otherwise be able to get. This aspect needs to be looked into and methods should be evolved to attract the best talent in the field of medical education.

3.8 Some of the medical stakeholders through their written submissions favoured a regulatory body nominated by the Government.

3.9 The Committee's attention has also been drawn to the following submissions made in the Ranjit Roy Chaudhury Committee Report:-

“In large parts of the world, health delivery is a state subject. The licensing of doctors lies within the Government in most of the EU countries. Only in a few of these (Austria, France, Ireland, UK) is there a separate independent regulator. Even these bodies have

membership of professionals appointed through transparent processes, often with a significant representation from non-medical professionals and the general public. In the UK, GMC has a 12 person Council, in which the non-medical representation is up to 50% and includes medical students. This is because, UK is the only EU country besides Ireland, where the Council also oversees medical education. In all other European countries, this is done directly by the concerned Ministry in the Government. Elections from within the profession, has been discontinued around the globe. Indirectly, elected representation may be there in some countries such as in Canada and S Africa”.

**3.10 The Committee has carefully and comprehensively examined the issue of elected versus nominated regulator and done a rigorous analysis to evaluate whether the architecture of regulatory oversight for the medical profession in India should be elected or nominated one.**

**3.11 The Committee observes that the main objective of the regulator of medical education and practice in India is to regulate quality of medical education, tailor medical education to the healthcare needs of the country, ensure adherence to quality standards by medical colleges, produce competent doctors possessing requisite skills and values as required by our health system and regulate medical practice in accordance with the professional code of ethics. The Medical Council of India, when tested on the above touchstone, has repeatedly been found short of fulfilling its mandated responsibilities. Quality of medical education is at its lowest ebb; the current model of medical education is not producing the right type of health professionals that meet the basic health needs of the country because medical education and curricula are not integrated with the needs of our health system; many of the products coming out of medical colleges are ill-prepared to serve in poor resource settings like Primary Health Centre and even at the district level; medical graduates lack competence in performing basic health care tasks like conducting normal deliveries; instances of unethical practice continue to grow due to which respect for the profession has dwindled. But the MCI has not been able to spearhead any serious reforms in medical education to address these gaps.**

**3.12 Medicine deals with human life. Regulators are therefore, required to have the professional excellence and moral authority to address complex issues related to content, standards, quality, competencies and skills of medical education and practice. But the MCI, as presently elected, neither represents professional excellence nor its ethos. The current composition of the Council reflects that more than half of the members are either from**

corporate hospitals or in private practice. The Committee is surprised to note that even doctors nominated under Sections 3(1) (a) and 3(1) (e) to represent the State Governments and the Central Government have been nominated from corporate private hospitals which are not only highly commercialised and provide care at exorbitant cost but have also been found to be violating value frameworks. They indulge in unethical practices such as carrying out unnecessary diagnostic tests and surgical procedures in order to extract money from hapless patients and meet revenue targets (as documented by the BMJ, one of the top international medical journals in an article titled “The unethical revenue targets that India’s corporate hospitals set their doctors” dated 3<sup>rd</sup> September, 2015) and flouting government rules and regulations, especially about treating patients from underprivileged backgrounds.

**3.13** The Committee also observes that the number of private medical colleges is growing and therefore their representation in the MCI is certain to increase while the Government representation will decrease in that proportion. In such a scenario, the needs of the country and the health system have taken a backseat while the interests of practicing doctors have become primary. Thus, the current composition of the MCI is biased against larger public health goals and public interest.

**3.14** The paramount consideration for the regulation of medical education should be to ensure that it safeguards the quality of medical education, well serves the needs of India's health system and enables the health needs of the people to be met. This is far more important than protecting the elected character of the regulatory framework. Electoral processes, by their very nature, bring about a lot of compromises and tend to attract professionals who may not be best-fitted for the heavy academic responsibilities of a regulatory body. It is, therefore, highly unlikely that professionals of the highest standards of eminence and integrity would be thrown up through electoral processes. The Committee feels that perhaps this is one of the reasons why election from within the profession has been discontinued around the globe.

**3.15** The Committee is, therefore, of the opinion that the governance of medical education in India must be accountable to the people of India. Ultimately, popularly elected governments are answerable to the people for the performance of the health system, not the MCI. Also, a regulatory body nominated by the government need not always be suspect in quality or subservient in conduct. Following the dissolution of a corruption-ridden MCI, the new Board of Governors of MCI appointed by the Government in 2010, included professionals of the highest standards of integrity and

excellence who came up with a Vision Document 2015 wherein the Board had recommended a number of reforms of far-reaching impact in the field of medical education and practice. Similarly, the National Board of Examinations whose governing Board is nominated by the Ministry of Health and Family Welfare has acquitted itself creditably and has not been tainted by a scandal in its 33 years of history. The Committee also wonders that if none of the countries like the USA, U.K, Australia or Japan has elected regulatory body for medical education, why should India be the only one to have elected regulators for medical education.

**3.16** After serious reflection borne out of the above analysis and keeping in mind the disastrous experience with an elected regulatory body, the Committee is convinced that if the quality of medical education has to be maintained and medical profession disciplined in the context of mushrooming of private medical colleges and the resultant commercialization of medical education, regulators of the highest standards of professional integrity and excellence will have to be sought by the Government through a rigorous selection process. The Committee, accordingly, recommends that the regulatory framework of medical education and practice should be comprised of professionals of the highest standards of repute and integrity, appointed through a rigorous and independent selection process. This process must be transparent. Nominations could be sought but the reason for the final selection should be made public. The Committee also concurs with the recommendation of the Ranjit Roy Chaudhury Committee Report that:

**"In keeping with global standards, and as is the practice in other educational fields in our country (AITCE and UGC) regulatory structure should be run by persons selected through a transparent mechanism rather than by the current process of election and nominations. Of course, keeping in mind the federal nature of the country, adequate provision must be made for the representatives of the States to participate in the regulatory processes."**

### **Need for Diversity in the Membership of Regulatory Body**

**3.17** The Committee has been informed by experts who deposed before it and also by those who made written submissions that the MCI is a self-regulatory professional body and the Council membership is composed entirely of medical doctors and more than half of these are either from private medical institutions or in private practice. The current composition of the Council reflects that the Council is dominated by specializations in the discipline of surgery and medicine

and within them, their super-specializations. The dominance of these specializations and super specializations might have a bearing on the introduction of these specialties and super-specialties departments. It has been impressed upon the Committee that setting up of the standards and evaluation of these standards by the same professionals, may result in a conflict of professional interests. These need to be accounted for and balanced by introducing more specialist doctors who are not directly involved with delivery of clinical care but who understand the needs of medical practice as well as of the health system as a whole. Specialists from the disciplines of public health, community medicine, health economy, health/hospital administration, forensic medicine, medical jurisprudence and toxicology could fulfill this criterion. Inclusion of the specialists of public health might help in addressing some of the problem areas where MCI has failed. It has also been impressed upon the Committee that non-inclusion of public health experts, social scientists and health economists, etc in the MCI is one of the important reasons for the inability of the MCI to address some of the problem areas like UG curricula being not suitable for requirements of practice in rural and resource poor settings; disconnect between health system and medical education system; complete lack of training in ethical practice; and clustering of medical colleges in certain states and in metro/mega cities, etc.

3.18 An expert who deposed before the Committee submitted that “.....we also need health economists to come in to find out what is cost-effective and what is not cost-effective. Otherwise, the young doctors will prescribe all kinds of expensive medicines and use all kinds of expensive tests unnecessarily.”

3.19 The Committee has also been informed that the General Medical Council of UK which is supposed to be the father of the Medical Council of India has 50% non-doctor members. Similarly, the Canadian and Australian Medical Councils also have non-doctors as their members. It has been impressed upon the Committee that inclusion of experts from other disciplines will enrich the working of the Council and help bring the concerns of the population whom the profession is supposed to serve, into the ambit of discussion of the Medical Council of India.

**3.20 The Committee observes that currently the MCI is an exclusive club of medical doctors as the IMC Act does not call for diversity of backgrounds in the members. The Committee also observes that across the world, a perspective has gained ground that self-regulation alone does not work because medical associations have fiercely protected their turf and any group consisting entirely of members from the same profession is unlikely to promote and protect public interest over and above their own self-interest and therefore check-and-balance mechanisms are required. Besides, in today’s dynamic world, inputs from people with excellence and competence**

**in other disciplines are also needed to add value to the working of an oversight body. It is for these reasons that in most countries such as the UK, Australia, etc. regulators are drawn from diverse groups.**

**3.21 Keeping all these factors in mind and considering the fact that checks and balances in the MCI are not underpinned on sturdy systems and procedures, the Committee is of the considered view that the composition of the MCI is opaque and skewed and diversity needs to be brought into this because having only medical doctors in the Council is not an enabling factor for ensuring reforms in medical education and practice. The Committee is convinced that if the medical regulator has to perform all its mandated functions in full measure and ensure that education in health disciplines fulfils its social mandate, it needs a vibrant framework with the right kind of capacity which can be achieved only by opening Council membership to diverse stakeholders such as public health experts and social scientists, health economists, health NGOs with an established reputation legal experts, quality assurance experts, patient advocacy groups, to name but a few. Such diversity and transparency will have the added advantage of reducing the monopoly of doctors in the MCI, thereby reducing the scope of cronyism and corruption. The Committee, therefore, recommends that urgent measures be taken to restructure the composition of MCI on the lines suggested above.**

#### **Power to the Government to issue Policy Directives to MCI**

3.22 The Health Secretary during his deposition before the Committee had submitted that the Government should have the power to give directions to the MCI on policy matters. The Joint Secretary, Department of Health and Family Welfare during the course of evidence reiterated the above view.

**3.23 During the examination of the Indian Medical Council (Amendment) Bill, 2006, and the Indian Medical Council (Amendment) Bill, 2013, the Committee had examined this issue but not favoured it on grounds that such sweeping powers might hamper the MCI in its day-to-day working and would subject the MCI to interference and pressure from the Central Government.**

**3.24 The Committee has examined the issue afresh and given serious thought to the desirability of empowering the Central Government to issue directions to the regulatory body on matters of policy. The Committee notes that though all powers of approval/disapproval as per the MCI Act 1956 rest with the Central Government and all permissions are issues in its name, yet the Central Government has no power to disagree with the MCI. After comprehensive consideration, the Committee observes that the Government**



**is the most important stakeholder in shaping health system in all its dimensions and attending to a range of reforms in medical education and practice. To push its policy and vision of health, the Government is, therefore, entitled to give directives to the MCI on policy matters of national importance. The Committee, therefore, recommends that the Government should have the power to give policy directives to the regulatory body. However, what exactly would be policy matters should be clearly and unambiguously defined so that such directives do not impinge on the functioning of MCI or violate its academic autonomy and any possibility of its misuse is obviated. The directive itself should be in the form of a ‘speaking order’ giving background and reasons and that should be made public immediately on issue.**

### **Restriction on the term of Council Members**

3.25 On being asked whether there is any restriction on the term of the Council Member, the representative of the MCI during his evidence before the Committee on the submitted that as per the existing IMC Act, there is no restriction on the terms.

3.26 An expert through written submission impressed upon the Committee that term limits of members of the MCI should be fixed with no more than two terms of five years each for any member.

3.27 The Committee also takes note of the observation made in the Ranjit Roy Chaudhary Committee Report that “A member may not have more than two terms in office.”

**3.28 The Committee takes note of the fact that currently there is no restriction on the term of a Council member. The Committee feels that due to lack of embargo on the term of the Council members, the vested interests tend to get entrenched. The Committee, therefore, agrees with the recommendation of the Roy Chaudhary Committee that a member of the Council may not have more than two terms in office. Such a provision will also bring a blend of experience and fresh thinking in the functioning of the regulatory body.**

## **Chapter- IV**

### **Establishment of Medical Colleges**

4.1 Establishment of Medical Colleges Regulations, 1999 governs the establishment of medical colleges. These regulations contain all details regarding eligibility criteria for organizations to apply, procedure for applying, infrastructure required (like land, building, manpower, equipment, hospital size, means of financing the project, etc.), upgradation and expansion, etc.

4.2 The Committee has been informed that through the amendment of 1993, Section 10A was inserted by which "permission for establishment of new medical college, new course of study" was brought under the Central Government and the MCI. Thus, the legal framework of the IMC Act, 1956 vests ultimate power in the Central Government which grants permission for the establishment of medical colleges. However the actual power to grant permission for the establishment of a medical colleges vests in the MCI as a result of a Supreme Court ruling date 23/9/2003 in P.C. Kesavan Kuttinayar V/s Harish Bhalla and others case wherein the Hon'ble Supreme Court had ruled that whenever the verification of the claim of the applicant/college is required, the Central Government cannot overrule the MCI's recommendations. Prior to the amendment of 1993, States could start a medical college under state universities and run them for a period of five years until the final examination which was to be inspected by the MCI and given approval for the course.

4.3 As regards the procedure for establishment of a medical college, the Committee has been informed by one of the experts through written submissions that the MCI does the desk evaluation of the application for establishment of a medical college, followed by a physical inspection to verify the information supplied by the applicant. Inspectors appointed by the MCI do the physical verification. Elaborating further on this issue, the Health Secretary during his deposition before the Committee informed that the MCI inspects medical institutions before recommending establishment of medical colleges.

4.4 In reply to a question regarding mandate of MCI in establishment of Medical colleges the Committee has been informed by the Ministry of Health and Family Welfare that opening of a new medical college is done when an application is forwarded to the MCI and then the technical evaluation is done. The recommendation of MCI is recommendatory.

4.5 In reply to a question regarding closing of Government medical colleges, the representative of the MCI during his deposition reiterated the above position, stating that the MCI is not responsible for opening or closing of a medical college.

The MCI only ensures the fulfillment of the minimum standards requirements which are mandatory in character and adherence to which is non-compromisable.

4.6 In reply to another question, the representative of the MCI during his deposition submitted that the primary deficiencies which are taken note of by the MCI during inspections, are the clinical workload deficiency, the faculty deficiency and the infrastructure deficiencies. These are three cardinal considerations on the basis of which recommendation for de-recognition is made.

4.7 On being asked as to who takes the final decision regarding de-recognition, the Health Secretary during his evidence on submitted that the recommendation for setting up of a new medical college comes to the Ministry of Health and Family Welfare which takes the final decision. But normally, the Ministry goes in accordance with the recommendations of the MCI. This is the usual practice.

4.8 As submitted by MCI, it received 105 applications for establishment of new Medical Colleges for the academic year 2014-15(Govt.31, Pvt.74). Of these, 16 (06 Govt., 10 Pvt.) were approved and 89 (25 Govt., 64 Pvt.) were disapproved. One Govt. Medical College was approved by Ministry of Health and Family Welfare.

4.9 Regarding increase of MBBS seats, MCI received 42 applications for increase of seats for the academic year 2014-15(Govt.04, Pvt.38). Of these, 10 (01 Govt., 09 Pvt.) were approved and 32(03 Govt., 29 Pvt.) were disapproved.

4.10 Regarding applications for renewal of permission against increased intake, MCI received 124 (Govt.–81, Pvt.–43) applications for the academic year 2014-15 of which 100 (Govt.–74, Pvt.- 26) were approved and 24 (Govt.–05, Pvt.-19) were disapproved.

4.11 It would be pertinent to mention that the deficiencies pointed out in inspections on the basis of which permission to medical colleges were denied, pertained to air-conditioning, library not stocking sufficient journals, thickness of partition walls and shortage of faculty.

4.12 Several of the experts who appeared before the Committee submitted that the mandated infrastructure requirements such as land, examination hall, size of examination hall, library etc. are very irrational and rigid and there was an urgent need for flexibility in infrastructure requirements. It was argued that the flexibility in infrastructure requirements would bring down the cost of medical education, which is a huge burden. An expert submitted before the Committee that today 20 acres of land is required to build a medical college which costs

around Rs. 500 crore. This leads to high capitation fee and deprives talented children from poor families of the opportunity of getting medical education.

4.13 Most of the medical colleges/ institutions and stakeholders who made written submission opined that the physical space, infrastructure requirements and faculty requirements as mandated by the MCI are huge and irrational and an unnecessary burden. They also stated that starting a new medical college involved huge costs and resources. They further submitted that the size of Library, Examination Hall, Auditorium etc. have no direct bearing on the quality of medical education. They, therefore, pleaded that the infrastructure and faculty requirements should be rationalized keeping in view the modern-day requirements

4.14 During the Committee's study visit to Coimbatore, Ooty and Bengaluru, various stakeholders who deposed before the Committee pleaded that the requirement of manpower and infrastructure for establishment of medical colleges and increase in UG/ PG seats were rigid and outdated and the Minimum Standard Requirements (MSRs) including requirement of a unitary campus of not less than 20 acres of land should be relaxed.

4.15 During the Committee's study visit to Shree Guru Gobind Singh Tricentenary Medical College, Gurgaon, the management of the College submitted that instead of insistence on 20 acres of independent land, the emphasis should be laid on the availability of adequate facilities within the University set up which can be shared. It was further pointed out that many outdated articles figure in the Minimum Standard Requirements (MSRs) concerning UG course equipments. For example, despite ban on animal experiments in the country, many of the labs like mammalian amphibian and experimental pharma labs are redundant but still required to be maintained. These labs alongwith equipments and instruments should be deleted from MSR.

4.16 Several of the medical institutions/ stakeholders who made written submissions expressed similar opinion, stating that animal experiments in the country are banned and therefore Animal House, Ambhibian Lab, Mammalian Lab and related equipments and instruments should be dispensed with.

4.17 An expert who appeared before the Committee submitted that "as a Senior Professor and Academic Chief of Maulana Azad Medical College, in the last six or seven years, I have had 24 university and MCI inspections in my Institute and I was the coordinator for all of them. Every time we have seen only the physical infrastructure. Never have we gone to the curriculum or the competency of either the faculty or the student."

4.18 During the Committee's study visit to Coimbatore, Ooty and Bengaluru, some of the stakeholders submitted that during inspections by MCI, focus is only on faculty, infrastructure and clinical material and that academic standards of institutions should also be analysed in a more comprehensive manner.

4.19 It was also submitted by all stakeholders that the behaviour and attitude of inspectors created fear psychosis and there was need to sensitize inspectors about their job.

4.20 During the Committee's study visit to Shree Guru Gobind Singh Tricentenary Medical College, Gurgaon, the management of the College submitted that inspections should be on the lines of National Assessment and Accreditation Council inspections where it is interactive supported to the college inspected. It was also submitted that inspectors should not be permitted to humiliate at the time of Assessment.

4.21 It was also submitted that the teaching staff have legitimate right for having leaves. Many inspections fail because leaves other than permitted by Executive Committee decision are not taken into consideration. It was suggested that the following leaves should be accepted:-

1. Marriage (self, siblings/children)
2. Death (Spouse/siblings/parents/children)
3. Hospitalization (self, spouse, parents/siblings/children)
4. Other leaves: (atleast 10% staff has to be permitted same sort of leave like casual leave, earned leave) etc.
5. 20% of deficiency of faculty/residents should be acceptable.

4.22 Some of the medical colleges and stakeholders who made written submissions also expressed similar views, stating that genuine leave granted by the authority should be taken into consideration.

4.23 On being asked to indicate the action taken to address the complaint regarding bad behaviour of assessors of medical college, the President, MCI submitted that the names of such assessors have been removed from the list of assessors and only those having ten years experience are selected. She further submitted that assessors are being sensitized to be soft while assessing medical colleges.

4.24 The Committee has been informed by an expert that a large number of young graduates are being deprived of the opportunity of getting medical education which they aspire for and are going to Russia, Belarus, Kazakhstan, China and a number of other places. More than 4000 students go every year. The

MCI does not go there; it does not measure the classroom; it does not measure the library, the area of the hospital. The standards that the MCI is imposing here as Minimum Standard Regulations (MSRs) are not applied there. When the students come back, they are just asked to appear for a theory examination with pathetic results. If they pass the examination, they are pushed through internship and after internship, they qualify for practice in India. Thus, the MCI is adopting different standards and depriving thousands of young students of the opportunity to be trained as doctors.

4.25 Another expert who deposed before the Committee was of the opinion that flexibility in infrastructure would bring down the cost of medical education. For instance, an auditorium of 650 or 1,000 or 1,200 capacities for lecture theatres for an Under-Graduate college were not needed. Similarly, labs and infrastructure can be shared as it will cut down the cost of the infrastructure, which is a huge burden on anybody, whether Government or private. An exercise done in this regard five years back has still not seen the light of day. The expert was also of the opinion that the Government must take the responsibility on themselves and open more medical colleges rather than handing over the responsibility to private players.

4.26 The Committee took up the matter of relaxation in infrastructure norms with the MCI. Subsequently, the Committee was informed by the Health Secretary that the MCI had recommended relaxations in the MSR. For example, the number of medical journals had been reduced to 60 from 100; the need for an auditorium had been removed and it had been combined with the examination hall; the size of the examination had been reduced; the number of beds required at the stage of recognition in respect of 100 and 150 seat medical colleges had been reduced; the number of teaching faculty had been reduced. However, the land requirement of 20 acres for the establishment of a medical colleges has not been relaxed. The Ministry has also made a suggestion to MCI to make changes in the PG Teachers Regulations to provide for more students per unit in the clinical disciplines.

4.27 The Committee has also been informed by the Ministry that in view of the anomalies in the Minimum Standard Requirements (MSR), the Government had on 22<sup>nd</sup> June 2015 set up a Group of Experts headed by Professor Ranjit Roy Chaudhury to study the norms for establishment of medical colleges prescribed now and to make recommendations to review the Minimum Standard Requirements (MSRs). The Committee had been asked to study global best practices while making their recommendations. The said Group of Experts has since submitted its Report to Ministry, a copy of which has been made available to the Committee. The first part of the Report deals with global best practices in this field and then goes on to deal with the constraints and difficulties facing the

situation in our country. The requirements are then discussed under the headings of infrastructure-land, Built physical Infrastructure, Equipment, Staff, Clinical opportunities and Academic Output. Broad recommendations are made in each of these areas. In the foreword to the Report, it has been stated that “If implemented, these measures will reduce the cost of setting up of medical colleges and the cost of medical education without impairing the quality of medical education being provided.” The Report concludes by stating that “these changes can be introduced only if the independent Accreditation Council is established with the authority to monitor and supervise the standards. In the absence of this provision, the rationalization of the requirements will be exploited to advantage of management and the detriment of the students. The aim should be to adopt a long term 10 year policy for transformation of medical education, with interim goals for phased implementation in a manner that all the concerned parties will benefit and the overall objectives get realized.”

4.28 An expert during evidence opined that there was a need to prepare district hospitals to become medical college hospitals. He was also of the opinion that large public hospitals should be emulated on the lines of railway hospitals to become medical college hospitals. Similarly, there was a need to prepare a number of large private hospitals to become medical college hospitals. The current regulations and the minimum standards that are imposed are barriers in that process. Another expert during evidence submitted that "every District Hospital should become a medical college. Without that you are not going to have healthcare in eastern and most of the central India, because bright students from these States come to Bengaluru, they become doctors in either the St. John's Medical College or the Kasturba Medical College, they never go back to their own town." However, the representatives of IMA who appeared before the Committee submitted that the move to convert district hospitals into medical colleges was not a good idea because district hospitals were meant to provide health care to the local people.

4.29 During the Committee’s study visit to Coimbatore, Ooty and Bengaluru, the Health Secretary, Government of Tamilnadu impressed upon the Committee that District Hospitals should be upgraded as medical colleges to create more seats for medical courses. Some of the stakeholders/ medical colleges through written memoranda submitted that District Hospitals should be upgraded as medical colleges.

4.30 During the Committee’s visit to Vardhman Mahavir Medical College (VMMC), New Delhi, the representatives of the College submitted that new medical colleges should only be attached or linked to District Hospitals. This will increase the level of services in these hospitals and also utilize the already existing clinical material in them.

4.31 In reply to a query, the Ministry had informed the Committee that the Ministry had put in place a Centrally Sponsored Scheme wherein 58 medical colleges would be set up during the 12<sup>th</sup> plan period which will lead to 5800 additional MBBS seats on an annual basis. On being asked as to how many medical colleges had been set up so far, the Secretary during evidence informed the Committee that this scheme was introduced only previous year and the Ministry had released money to 19 medical colleges. But during 2015-16, the Ministry did not get the budgetary provision. Once the Ministry received budgetary provision for the Scheme, money to other medical colleges would be released, he added.

**4.32 The Committee observes that as per MCI norms, establishment of a medical college is based only on physical space, infrastructure and rigid conformation for faculty requirements. The minimum land requirement of 20 acres, the number of class rooms, lecture halls, examination hall as mandated drive up the cost of establishment. Since the land is the most expensive commodity, the initial investment itself is very high, which means that even Governments cannot open medical colleges easily and promoters are more likely to be those with commercial interests rather than those with genuine interest in medical education.**

**4.33 The MCI focuses heavily on nitty-gritties of infrastructure and human resources but does no substantial evaluation of quality of teaching, training and imparting of skills. Though at the behest of the Committee, the Minimum Standard Requirements Regulations for the establishment of Medical colleges have been recently modified by MCI, yet they continue to be unrealistic. These requirements will prevent district hospitals and large public sector hospitals (like Railways Hospitals, Army Hospitals, etc.) and large private sector hospitals and multi-specialty hospitals from becoming teaching hospitals for UG medical education. This will greatly limit the scope for the scaling up of medical education, even when expansion of the existing capacity is a greatly felt need.**

**4.34 The Committee also observes that many young students who aspire for medical education but are deprived of this opportunity in the country, go abroad for medical education in Russia, Belarus, Kazakhstan, China and a number of other places. When these students come back after qualifying in their examinations in foreign countries, they are required by MCI to appear for a Multiple Choice Questions (MCQs) formatted, theory based examination conducted by the National Board of Examinations. Those who pass the examination are required to do one year of internship and are then recognized by MCI to be fully qualified doctors, eligible to practice in India**



on par with a medical graduate who qualifies from an Indian Medical School. The Committee is giving this example to buttress the argument that MSR should not become a fixation by which MCI strangles the scope for scale up of medical education, even as it blithely ignores the irrelevance of those standards for the foreign medical graduates who train in institutions which may markedly deviate from them.

**4.35** Taking all the above facts into account, the Committee is of the considered view that the existing Minimum Standard Requirements as mandated by the MCI are irrational and artificially rigid standards which are proving to be big impediment in the establishment and expansion of medical colleges. The Committee is of the considered view that a Rs. 500 crore of rupees investment in a medical college would not be able to educate children from poor families for obvious reasons. The Committee, therefore, recommends that physical infrastructure requirement be pruned down in such a way that it should have just about 30 to 40 percent standing value in the total assessment of a medical college.

**4.36** The Committee takes note of the observations and recommendations of the committee of experts set up to study the norms for establishment of medical colleges and make recommendations to review the Minimum Standard Requirements (MSRs). The Committee has gone through the report of the committee of experts and is in general agreement with the recommendations of the committee. The Committee would however, recommend that the Ministry / regulatory body may implement them in accordance with the plan of action as suggested by the expert committee.

**4.37** The Committee lends its full support to the move to convert district hospitals into medical colleges. The Committee is of the view that if a district hospital is converted into a medical college, it will not only be equipped with specialists of all disciplines, providing the healthcare services across the whole spectrum but will also produce some doctors in its area of operation and will thus help reduce geographical mal-distribution of doctors.

## Chapter-V

### Undergraduate (UG) Medical Education

#### Oversight

5.1 The Committee gathers from the information furnished that “Regulations of Graduate Medical Education, 1997 lays, out the objectives, training approach and curriculum and examinations. It begins with: “Graduate medical curriculum is oriented towards training students to undertake the responsibilities of physician of first contact who is capable of looking after the preventive, promotive, curative and rehabilitative aspect of medicine.” Sub-clause 2 of the Regulations *inter-alia* reads as under:-

“The training, though broad-based and flexible should aim to provide an educational experience of the essentials required for healthcare in our country.”

5.2 This sub-clause was amended on 15<sup>th</sup> December, 2008 and the following inserted: “Training should be able to meet internationally acceptable standards.”

5.3 As per the information given in the Regulations on Undergraduate Medical Education 1997, the objective of Medical Graduate Training Programme at the end of undergraduate programme is that the medical graduate should be able to *inter-alia* achieve competence in practice of holistic medicine, encompassing promotive, preventive, curative and rehabilitative aspects of common diseases and become exemplary citizen by observation of medical ethics and fulfilling social and professional obligation.

5.4 The Committee has been informed by experts that the Regulations on Undergraduate Medical Education, 1997 provide detailed guidelines on the curriculum, skills and competencies and how these should be assessed by the institutions, but the MCI does not by itself conduct any evaluations of the final graduate or of the curriculum as it is being implemented and taught, especially the skills. Thus, there is no evaluation of the actual implementation of MCI’s detailed guidelines for UG medical education. MCI only does an inspection of the first final examination of every new medical college.

5.5 From the oral evidence tendered before the Committee by different stakeholders, the following facts emerged:-

- i. UG training needs radical changes.

- ii. The syllabi of medical education should ideally be revised once in 4-5 years, according to the needs of the population but it has not been changed for the last fourteen years. Areas like family medicine, geriatrics, pain and palliative, emergency care have not been incorporated into the syllabi due to which the medical graduates are not getting exposure to these areas.
- iii. When the syllabi are revised, it takes five years or more to notify them because the MCI has no power to notify them without the approval of the Government. To avoid such undue delay, the MCI should have the power to notify academics-related regulations without the approval of the Government.
- iv. Our present system does not give respectability to a general practitioner.
- v. The skill training of an MBBS doctor is very important. But that is not happening in the present curriculum. Most of it is theoretical, the practice comes in the internship. But today's MBBS doctor prepares for PG in internship. So, today's MBBS is zero in knowledge and does not have basic competencies like conducting a normal delivery or suturing wounds. It was suggested that the PG entrance examination should be shifted immediately after final MBBS examination.
- vi. There has been no innovation in medical education over the years. We have not changed the concept of teaching.
- vii. Our MBBS doctors do not have the confidence to work in primary and secondary health facilities because they work in a sheltered environment in a tertiary care hospital. It is, therefore, necessary that a medical student in fourth year or pre-final year should be exposed to secondary hospital where umbrellas of protection are less.
- viii. The MCI keeps a rigid control over all aspects, especially the curriculum including hours of teaching, etc. The "maintenance of standards" is interpreted only in terms of a central curriculum, which is static.
- ix. There has been no scope for local flavour or innovation. We are trying to produce doctors with a tubular training uniform across the board, with absolutely not even one percent relaxation from college to college. Flexibility in curriculum should be handed over to health universities. There should be provision for diversity in the type of colleges-rural, urban, even with differences in curriculum. There should be different kinds of training formats to meet different specific needs. The current format is too centralized. There is absolutely no recognition for the process of teaching, innovation, and evaluating the final product.

- x. More emphasis should be placed on skilled training and evaluating competencies.
- xi. Eighty percent of our curriculum is on ten to fifteen percent diseases and fifteen percent of the curriculum is on the other eighty five percent of the diseases.
- xii. There is a mismatch between the training of doctors and the requirements of the country.
- xiii. There is need to have a reorganisation of functions in a manner that curriculums are not put down as dictates. There should be provision of diversity in the learning process, teaching process and the curriculum so that we can meet various aspirations.
- xiv. A few years back, there was what is called a reorientation of medical education. This reorientation was envisaged in such a way that the undergraduates from the second year itself, will be exposed to the community and community needs. Accordingly, they will be trained, both on the clinical side as well as on the public-health side. But for some reasons, this reorientation of medical education was scrapped and that is one of the reasons why today our doctors do not come up to the expected standards. The doctors we are producing, are neither good clinicians nor good public health or medical administrators.
- xv. Today, there is a need to focus on basic doctors as per the need of the nation.
- xvi. The curriculum has been designed in such a way that we have ignored the family practitioner concept. We have also ignored the concept of basic doctors and general Practitioners.
- xvii. The MCI has failed in setting curriculum which suits the context and problems of our country; especially those of rural health services.
- xviii. The undergraduate medical course should also incorporate soft skills. Young doctors are required to be taught ethics, care, concern, courtesy, compassion and communication, not only in the classroom, but also through appropriate role modelling.

5.6 During the Committee's study visit to Vardhman Mahavir Medical College, New Delhi, the representatives of the College submitted that the curriculum of most of the subjects are old. Recommendations for revising the curriculum have been made by various Committees, but they have not been implemented. Curriculum revision and inclusion or exclusion of a subject from the professional examination should be done once again on a major scale and then periodically every 5 years. Teaching methodologies should become uniform and defined and strictly adhered to.

5.7 The management of Shree Guru Gobind Singh Tricentenary Medical College, Gurgaon to which the Committee undertook a study visit, shared the

views of the representatives of Vardhman Mahavir Medical College, stating that syllabus and course curriculum should be updated as per the requirements and unnecessary details should be taken out.

5.8 Some of the medical colleges and stakeholders who made written submissions also pleaded that the syllabus should be revised and made more skill oriented.

**5.9 The Committee is concerned to learn from the experts and other stakeholders that the medical graduates emerging out of the medical colleges in the country, lack confidence and skills in performing basic healthcare tasks and even basic skills like conducting a normal delivery, providing early care for a fracture or suturing a wound are not within the competency of a graduate doctor. Realising this deficiency, graduate doctors seek post-graduate qualifications in order to acquire clinical expertise. Since, as against the approximately 55000 UG seats, there are only 25,000 PG seats as of now, a large number of graduate doctors do not get into PG and become redundant second class citizens because they are neither competent to practice independently nor do they have the social status.**

**5.10 The Committee also takes note of the fact that one of the critical gaps in the system is the separation between the medical education system and the health system. The primary reason behind this separation is that our medical graduates work and train in tertiary care settings. Since the vast majority of patients seek healthcare services in small clinics and out-patient departments of small hospitals and a small proportion visits and an even smaller number are admitted to tertiary care institutions, which often deal with exotic and rare diseases, the graduate doctors are not exposed to primary and secondary health care conditions which is crucial to learn about common health problems in the country. Due to this skew in training, the graduate doctors are not equipped to manage common diseases and illnesses in the population. The MCI has failed to address this separation between the medical education system and the health system in the country. The Committee feels that the medical education that is imparted to a graduate doctor is only for basic treatment and if he is not competent enough to do even that, there is basic problem in the system which needs to be addressed.**

**5.11 The Committee also observes that the most important flaw in the oversight of undergraduate medical education by the MCI is that the “maintenance of quality is assessed only in terms of fulfilling physical/infrastructural requirements and there is simply no overall evaluation of the standard of medical education. Ironically, “maintenance of uniform standard of medical education” is the first objective of the MCI, as stated in**

the IMC Act, 1956. There is also no effort to assess the method of teaching/ learning, the evaluation process, the learning outcomes etc. The curriculum is still didactic. The world has moved to competency-based curriculum long back and we are still having workshops to decide whether we should switch-over to it or not.

**5.12** Considering all these facts, the Committee is constrained to observe that the existing system of the graduate medical education in the country has failed us and unless total revamping of the undergraduate education system is undertaken, the present system will not be able to generate the medical manpower required to deliver the ambitious programme of Universal Health Coverage. The Committee, therefore, recommends complete restructuring of the undergraduate education. The emphasis should be shifted to learning outcomes based on a curriculum that will train a holistic doctor with the requisite skills. The training of MBBS doctors should also be in primary care centres and secondary hospitals including district level hospitals. The curriculum should be designed keeping in mind the disease profile of the country and the gaps in the present system. The Committee simultaneously observes that India is a fast developing country and needs health services across a wide spectrum- from the basic diarrhea treatment to the best tertiary care in the world. The country therefore, needs to have doctors who are competent and trained to provide health care services across this whole spectrum. It should therefore be ensured that the graduate doctor produced by the system is a competent basic doctor who also has the background to specialize. The Committee is convinced that unless these fundamental changes are carried out in the undergraduate medical education, India will not be able to meet the health challenges of the 21<sup>st</sup> century.

**5.13** The Committee takes note of the submission that today's graduate doctor after doing his internship is not confident of practicing because his entire period of one year internship goes into studying for the PG entrance exam. The Committee observes that skill training which is very important for a medical professional, is not being acquired in internship. The Committee, therefore, recommends that the PG entrance exam should be held immediately after the final MBBS examination so that the graduate doctor could concentrate on practical skills during his internship.

**5.14** The Committee also observes that the medical education in India is increasingly depersonalized and has failed to instill humane values of care, concern, courtesy and compassion. The Committee feels that young doctors should not only have practical skills but also a lot of soft skills. The Committee, therefore, recommends that soft skills (including ethics) should be made one of the cornerstones of the syllabus of medical education.

## **Capitation Fee and the need for a Common Entry Examination**

5.15 The MCI Regulations on Graduate Medical Education, 1997 declares that “the selection of students shall be based on merit only...” A 2010 MCI amendment had recommended a common entrance examination for admission to MBBS course each year.

5.16 The Committee has been informed that keeping in view deteriorating standards of medical Education, the National-Eligibility-cum-Entrance Test (NEET) was introduced in the year 2012 and the NEET was conducted. However, about 90 medical colleges defied the MCI on regulating entry into medical colleges and conducted their own examination and obtained a stay from the Court. In May, 2012, the Supreme Court issued an interim order, making NEET voluntary and permitting the medical colleges to take admissions based on their own examinations.

5.17 In reply to a question regarding the current status of NEET, the Ministry in a written reply has furnished the following information:-“ At present All India Pre-medical Test (AIPMT) and All India Post Graduate Medical Examination (AIPGME) are conducted centrally. The Ministry had introduced the single window entrance test viz. National Eligibility and Entrance Test (NEET). Accordingly, the MCI had notified NEET for admission to UG and PG courses in medicine. Various court cases were filed against NEET in various courts across the country. The Hon’ble Supreme Court, in its final judgment delivered on 18.7.2013, quashed the Medical Council of India's (MCI) notifications for holding NEET for MBBS, BDS and post-graduate medical courses.

5.18 Since, the Government is of the firm opinion that it would be in the larger interest of the society and the students aspiring to study medicine to have NEET, the Government has filed a Review Petition against majority judgment of the apex court on 14.8.2013. Simultaneously efforts are on with the State Governments to introduce AIPMT and AIPGME. Many States have already adopted these exams.”

5.19 The Committee has been informed that in the absence of a streamlined common entrance test, private medical colleges/ universities have developed their own screening and admissions procedure. The majority of seats are allotted for a capitation fee ranging from Rs. 25 lakhs to Rs. 50 lakhs or even more.

5.20 The experts who deposed before the Committee also advocated the introduction of common entry and exit examination, stating that a common unitary test will not only help in merit-based admissions and standardization but

also tackle the problem of capitation fee and everybody will have faith in the system.

5.21 During the Committee's study visit to Vardhman Mahavir Medical College (VMMC), New Delhi, the representatives of VMMC submitted that quality of doctors produced across the country can be ensured by applying single window system of entry in UG and PG courses.

5.22 Several of the medical institutions / stakeholders through written submissions expressed their support for common entry examination for the purpose of promoting merit and quality.

5.23 On being asked about the updated status of the proposal for Common Entrance Test (CEE) for Undergraduate and Post-Graduate in the Government and Private Medical Colleges, the Health Secretary during his deposition informed the Committee that the common entrance exam is not there under any statute. The Hon'ble Supreme Court had declared it illegal and the Health Ministry has challenged it before the Hon'ble Supreme Court. The Health Secretary/ Joint Secretary detailed the action taken pursuant to the challenge which is quoted below:-

“Now, in that case, there were many students who were parties. There were about 190 students who had also filed that case before the hon'ble Supreme Court. Private colleges and some students were also there. So, now, the direction of the Court was that we have to service that notice on all the students. We did not have the addresses. So, we tried to get it from the MCI. The MCI could not give all the addresses. So, we went to the Registry of the hon'ble Supreme Court requesting that we should be allowed to put it in a newspaper so that everybody can be informed, because getting address of each person or each institution is very difficult. Now, that petition is to be heard. The hon. Supreme Court had given us one date and, on the next date, it is going to be heard. They have allowed the petition and the Registry has also vetted the public notice which is to go out.”

5.24 The Health Secretary further informed that it would require an amendment to the Act because the proposal for holding CEE is being put under rules and the same would require an amendment to Section 33 of the IMC Act, 1956 for which the Ministry would approach Parliament.

5.25 On the issue of exorbitant and totally arbitrary fees charged by private medical colleges, the Health Secretary submitted that the CEE would help in checking the capitation fee.



**5.26 The Committee notes that though the MCI has sent its recommendations for a unitary Common Entrance Test for admission to MBBS and PG courses long back, the Government is still grappling with sorting out issues for the implementation of the unitary Common Minimum Test. In the absence of a streamlined and transparent process of admissions, private medical colleges/ universities have developed their own screening and admission procedures which are primarily monetary based. It is public knowledge that the majority of seats in private medical colleges are allotted for a capitation fee going upto Rs. 50 lakh and even more in some colleges despite the fact that the capitation is not legal. This capitation fee is exclusive of the yearly tuition fee and other expenses. The Committee observes that the issue is not just about capitation fee. This has serious implications for our whole system of medical education and healthcare. One clear implication of this skewed process of admissions by way of sale of seats is that there may be a large number of students entering the system, who may not be upto the required standards. On the other hand, this system is keeping out the most meritorious but underprivileged students who can neither pay for seats, nor the high annual fee in private medical colleges. If a unitary Common Entrance Exam is introduced, the capitation fee will be tackled in a huge way; there will be transparency in the system; students will not be burdened with multiple tests; and quality will get a big push. The Committee, therefore, recommends that the Government should move swiftly towards removing all the possible roadblocks to the Common Medical Entrance Test (CMET) including legal issues and immediately introduce the same to ensure that merit and not the ability to pay becomes the criterion for admission to medical colleges. The Committee also recommends that introduction of CMET should be done across the nation barring those States who wish to remain outside the ambit of the CMET. However, if any such States wish to join the CMET later, there should be a provision to join it.**

### **Common Exit Test for the passing out Graduate Doctor**

5.27 The Committee has been informed that the existing number of medical schools, medical graduates and post graduates is huge. Today, India turns out to be the largest producer of trained modern medicine manpower in the world. There are more than 400 medical colleges, 55000 MBBS seats and 25000 post-graduate seats, but there is no exit test.

5.28 Several of the experts who deposed before the Committee during the course of the examination of this subject, favored introduction of a common exit examination to ensure certification of the competencies of the graduate doctor.

5.29 An expert who appeared before the Committee submitted that

“...our basic doctor should be a leader of a community in a small area where he can manage everything. Therefore, we want this exit examination. An Indian Medical Doctor should be certified in such way that nobody should ask, ‘he has passed from Delhi, All-India Institute of Medical Sciences; he has passed from Jammu and Kashmir or Kerala or from Bihar. From wherever he has passed, he is an Indian Medical Doctor. If we can have one simple test (i.e. exit exam) by which nationally we can follow and standardize that this is the minimum standard for our basic doctors.”

5.30 On being asked about any proposal for the introduction of a common exit examination for medical students, the Ministry in a written reply has informed that “A proposal for introduction of a common exit examination has been made by the Medical Council of India. The Ministry has sought formulation of relevant procedural guidelines for the same, which are in the process of making.”

5.31 During the Committee’s study visit to Coimbatore, Ooty and Bengaluru, some of the stakeholders supported the proposal of introduction of Exit examination for passing out MBBS doctors, saying that the move will standardize the competencies of medical graduates and solve the disparity between different medical colleges across the country. It was also suggested that the marks obtained in Exit Examination can be considered for admission to PG programmes eliminating the need for another entrance exam.

5.32 During the Committee’s study visit to Vardhman Mahavir Medical College, New Delhi, the representatives of the College suggested that instead of an exit exam, there should be common MBBS final year exam where the candidates from all Government Colleges and Private Medical Colleges get same paper at same time and are evaluated clinically at a centre other than their institute.

5.33 Several of the medical institutions/ stakeholders who made written submission favoured a common exit test. However, some of the medical colleges/ stakeholders were not in favour of the common exit exam.

**5.34 The Committee takes note of the fact that the MCI’s assessment of medical colleges is limited to ensuring rigid conformation to infrastructural and faculty norms and an inspection of the five year examination of new medical colleges. The MCI is not involved in any standardized summative evaluation of the final product- the medical graduate-coming out of new or old medical colleges. The final evaluation, and therefore, the final quality of**

every medical student, is left entirely to the medical colleges/ universities to assess. The Committee is, therefore, of the considered view that an entrance test alone will not do justice to the entire process and there is an urgent need to introduce a common exit test for MBBS doctors, which will go a long way in standardizing the passing out medical graduates and certify the competencies which are expected to be generated out of him. The Committee accordingly, recommends that urgent action be initiated to introduce a common exit test for MBBS doctors as an instrument of quality assurance and to ensure that the qualities and competencies of a doctor before he starts practicing are guaranteed and standardized in terms of various quality norms.

### **Regulation of Fee in Medical Colleges**

5.35 The Committee has been informed that the fees charged by private medical colleges is arbitrary and exorbitant. When the Committee took up the issue of regulation of fee in medical colleges with the Ministry of Health and Family Welfare, the Ministry informed the Committee through written submissions that in case of Government medical colleges, the respective State Governments are responsible for fixation of fees. However, in the case of private unaided medical colleges, the fee structure is decided by the committee set up by the respective State Government under the Chairmanship of a retired High Court Judge in pursuance of the directions of the Hon'ble Supreme Court of India. It is for the committee to decide whether the fee proposed by an Institute is justified and the fee fixed by the committee is binding on the Institute.

**5.36 The Committee observes that though the constitutionally designated fee regulation committee of the respective State Government fixes the fee to be charged by private medical colleges, yet the yearly tuition fee and other expenses that have to be paid thorough a year duration work out in the range of Rs. 12-13 lakh or even more which is certainly exorbitant and beyond the paying capacity of poor but meritorious students and the same, therefore, needs to be rationalized. As of now, the Union Health Ministry does not play any role in fixation of the tuition fee. The Committee is of the opinion that since the Ministry of Health and Family Welfare plays a critical role in supporting the regulation of medical education, it should be enabled to play a role in regulating fee structure in private medical colleges so that the right quantum of tuition fees to be charged by private medical colleges is ensured and there is uniformity in fees across the country amongst the public and private sector medical colleges/institutions. The fee structure should be strictly be enforced and action should be taken against erring managements.**

## Chapter VI

### Post Graduate (PG) Medical Education Oversight

6.1 The Medical Council of India provides oversight to PG education through its Post Graduate Education Committee.

6.2 In a written submission, the Ministry has furnished the following information about the Post Graduate Committee:-

6.3 As per Section 20 of the IMC Act, 1956 –

- i. The Council may prescribe standards of Postgraduate Medical Education for the guidance of Universities, and may advise Universities in the matter of securing uniform standards for Postgraduate Medical Education throughout India, and for this purpose the Central Government may constitute, from among the members of the Council, a Postgraduate Medical Education Committee (hereinafter referred to as the Post-Graduate Committee)
- ii. The Postgraduate Committee shall consist of nine members, all of whom shall be persons possessing postgraduate medical qualifications and experience of teaching or examining postgraduate students of medicine.
- iii. Six of the members of the Postgraduate Committee shall be nominated by the Central Government and the remaining three members shall be elected by the Council from amongst its members.
- iv. For the purpose of considering postgraduate studies in a subject, the Postgraduate Committee may co-opt, as and when necessary, one or more members qualified to assist it in that subject.
- v. The views and recommendations of the Postgraduate Committee on all matters shall be placed before the Council and if the Council does not agree with the views expressed or the recommendations made by the Postgraduate Committee on any matter, the Council shall forward them together with its observations to the Central Government for decision.

6.4 In reply to a question, the representative of MCI during his evidence before the Committee, submitted that the Government nominates six members to the PG Committee but the restriction is that these six members have to be from amongst the Members of the Medical Council of India.

6.5 The Committee has been informed by experts that to give permission for PG seats, the MCI has laid down strict qualifications for PG teachers, based on their degrees and experience and has a set of requirements in the form of beds,

patient load, work load and infrastructure, both equipments and space. All this has been laid down with the rationale that if the facilities are available, the student will learn. The MCI is not involved in the evaluation of the teaching and learning process. The degrees are given by the various universities to which the medical institutions are attached. This leads to vast variations in the quality of post graduates.

6.6 The Committee has also been informed by experts in their written submissions and oral evidences that Section 19 A of the IMC Act, 1956 states that the Council may prescribe the minimum standards of medical education required for granting recognized medical qualifications (other than PG medical qualifications) by universities or medical institutions of India. Thus MCI is categorically proscribed to deal with post-graduate medical education as a regulator. It is however permitted to advise universities on uniform standards for the country through Section 20 of the same Act which states that a nine member Post Graduate Medical Education Committee formed by the Government of India with six of its nominated members will assist the Council in matters relating to PG medical education. This advisory role has been converted to a regulatory power, sanctioning PG seats in medical colleges.

6.7 An expert during evidence submitted that "We are having an opportunity to train a large number of post-graduates in different hospitals across the country, but we are not utilizing those resources in the country. Ideally, we should have one major regulatory body for all post-graduate medical education in this country, combining NBE and MCI together. But again, we need to have specialty Boards there. The United States has a separate specialty Board for paediatrics, for surgery, for medicine, and within those specialty Boards, they have obstetrics and gynecology, radiology, etc. Then, within those specialty Boards, they have sub-specialty Boards for cardiac surgery, neurosurgery, etc. Now, some post-graduate Committee, sitting even without adequately empowered by the Act deciding what kind of cardiac surgeons, neurosurgeons, urologists, cancer radiologists and cancer surgeons should be produced in this country, is not going to work. So, there needs to be a radical transformation of post-graduate medical education as well if you have to have the kind of specialists we need for this country."

**6.8 The Committee is concerned to note that the approval for PG seats is based on rigid criteria for teachers, teaching beds, patient attendance & infrastructure and there is no mechanism in place to evaluate the PG trainees for their skill and competence prior to their certification as a designated specialist. The present MCI system of oversight of PG medical education does not at any stage evaluate the teaching and learning process or have any benchmarks for quality. Instead of devoting its attention to addressing the**

**issue of quality and competence which has a direct bearing on the safety of patients seeking treatment, the MCI is obsessed with enforcing rigid regulations that stifle improvement and innovation. The Committee takes note of the information made available to it that in the USA there are different specialty Boards to monitor and certify training, while the MCI has a single nine-member Post Graduate Medical Education Committee to prescribe standards of Post Graduate Medical education. The Committee finds it inconceivable that a single nine-member Post Graduate Committee has the breadth of expertise to provide guidelines, let alone set standards, to span multiple specialty disciplines. The Committee is, therefore, convinced that an overhaul of the whole system is required, and accordingly, recommends that the PG medical education system should be restructured in such a way that training is assessed by the quality of the product and not by the infrastructure and a robust system be put in place for evaluation of skills and competencies. The Committee also observes that there is a need to separate regulation of graduate and post-graduate medical education as these two phases of medical education need different kind of expertise. The Committee, therefore, concurs with the suggestion that there should be separate UG and PG Boards for the regulation of UG and PG medical education.**

**6.9 The Committee also recommends that post-graduate education should be governed by a body like NBE, integrating the two systems of PG medical education that currently exist and function through a well-coordinated array of specialty sub-boards which define desired competencies and set standards for each major discipline.**

### **Capitation fee in PG Education & need for Common Entry and Exit Tests**

6.10 The Committee has been informed by experts that of the 25000 PG seats, a large number of seats are for the non-clinical specialties (Anatomy, Physiology, etc) which are less sought after as the employment opportunities in these specialties exist only in the colleges themselves. This leads to cut-throat competition for seats, especially in the clinical care branches. Due to judicial intervention, there is a common entrance for part of 25000 seats, but the private centres ensure that all seats are not put on the common entrance test as PG entrance is a lucrative business and private medical colleges charge huge capitation fee under the table. The Committee has been informed that for a PG seat, the capitation fee ranges from 1.00 crore to 1.50 crore or even more due to which it is almost impossible for the meritorious ward of an honest person to become a PG doctor.

6.11 The experts suggested that the capitation fee-based admission in PG courses must go because it was compromising quality of medical education and there should be a transparent system. It was impressed upon the Committee that there should be common entry and exit examinations for the PG courses also.

**6.12 The Committee has already commented on the need for a Common Entrance and Exit Test for UG medical education in the previous Chapter. The Committee is of the view that the grounds which mandate introduction of common Entrance and Exit examinations for UG medical education are also valid for PG education. Post Graduate seats are in great demand. The Committee has been given to understand that in the absence of a transparent and streamlined process of admission, PG seats are sold from Rs. 1 crore to Rs. 1.50 crore per seat. The Committee has already dwelt on the issue of capitation fee and its ill-effect. The Committee would, therefore, refrain from repeating those details. Keeping all these factors in mind, the Committee recommends that the Government in consultation with the MCI should swiftly move towards introducing a common entry test for admission to post-graduate and super-specialties also. The Committee also recommends the introduction of a common exist test for the passing out Post-Graduates to certify and standardize their competencies.**

### **Merger of the current DNB and MD/ MS Programmes**

6.13 The Committee has been informed that India is the only country with two parallel systems of PG Training. The National Board of Examinations was created by the Government of India in 1982 to enable the non-medical colleges to conduct post-graduate training, acknowledging the fact that competent specialists in these centres could train post graduate students with all the competency available at their hand. It has a national single entrance system and a single common exit exam making the standard more uniform across the country. However, the NBE is not a statutory body and hence the DNB is a diploma, not a degree.

6.14 Some experts who deposed before the Committee favored merger of the MD/ MS and DNB, stating that:

- (i) “there should be an independent UG Board; there should be a PG Board which should amalgamate DNB system and the university system of post graduate medical education..... ”
- (ii) “No country in the world has two streams of PG medical education, which is causing so much confusion. The National Board people are saying that they are equal to MD. The MD people are saying that

they are not equal. He was of the view that there should be one regulatory body for all Post-graduate education.”

- (iii) “ideally, there should be one major regulatory body for all PG medical education, but till this is done, the equivalence of the DNB and MD/ MS should be continued to be recognized.”
- (iv) “in the USA, there are different specialty Boards which regulate core disciplines like medicine, surgery, paediatrics, Obstetrics and Gynaecology, Radiology etc. and that it is not possible for the 9-member PG Education Committee of the MCI to regulate PG medical education in a comprehensive manner. He suggested that India also needs to have specialty Boards to regulate PG education.”

**6.15 The Committee takes note of the submission that India is the only country in the world having two parallel systems of Post-Graduate Certification. The Committee also takes notice of the information made available to it that despite the Government of India's order making DNB equivalent to the MD/MS for all employment, the inspectors of MCI go and threaten medical colleges of de-recognition if they employ a person with DNB certificate. The Committee observes that there needs to be radical transformation of Post Graduate Medical Education if we have to have the kind of specialists we need for the country. The Committee, therefore, recommends that the current system of PG medical education should be restructured taking the best of both systems that is, all India common entrance exam for all seats and common exit evaluation for all candidates as practiced by DNB and the training and evaluation processes of the university based system into one national qualification. There should be only one regulatory body for post graduate medical education and the training should be made more robust. Till then, DNB students be given equitable status of MS/MD only after completing two years of teaching experience in medical colleges.**

### **Need for PG in Family Medicine**

6.16 The Committee has also been informed by an expert during his evidence that the medical education system in the country has been devised in such a way that the concept of Family Physician has been ignored.

6.17 An expert who deposed before the Committee in her post-evidence written submissions stated that “the target for the future should be to have PG opportunities for all medical graduates. In order to do this, the target should be to make 30-50% of all seats in Family Medicine. Although the specialty exists on the MCI list, the present rigid MCI framework (30 beds, separate department, 3 faculty members etc) has not allowed colleges to start this course. Also, except in



practice, there are few career options and young people are biased by the available career options when they opt for a specialty. Central and State Governments should take a policy decision that wherever MBBS level posts are advertised, MD in Family Medicine will be preferred with a substantial salary advantage. Over a time, the Medical Officers at all levels will be post-graduates and this will enhance the level of primary care and decrease the load on tertiary care. Without this, Family Medicine is not going to get established.”

**6.18 The Committee agrees with the suggestion that there is an imperative need to promote PG degree in Family Medicine because Family Medicine combines a broad set of clinical competencies and therefore Family Physicians are more equipped to manage most of medical problems encountered at primary level. The Committee recommends that the Government of India in coordination with State Governments should establish robust PG Programmes in Family Medicine and facilitate introducing Family Medicine discipline in all medical colleges. This will not only minimize the need for frequent referrals to specialist and decrease the load on tertiary care, but also provide continuous health care for the individuals and families.**

### **Shortage of specialists**

6.19 The Committee has been informed that there is shortage of qualified specialists and super specialists in India. When the NRHM was launched in 2005 and it was decided that 'Specialist Pediatrician' and 'Obstetrician' would man Community Health Centres. The Ministry of Health and Family Welfare took a decision that all Government colleges would double their PG intake. Almost ten years later, CHCs still have no specialists, as in the climate of overall shortage, the market absorbed all additional seats that got trained. The Committee has been informed by the experts that the recent increase in PG seats has been indiscriminate which is likely to impact on the quality of PG doctors in future.

6.20 Some of the experts who deposed before the Committee opined that there was a need to equalize UG and PG seats. They submitted that there are currently close to 25000 PG seats compared to 55000 UG seats. Besides, there are 6000 or so DNB seats and with the very rapid expansion of multi-specialty hospitals, even these will not suffice to fill the shortage of specialists, leave alone the requirement for teachers. The USA has got more PG seats than UG seats (i.e 19000 UG seats and 32000 PG seats) Young MBBS graduates, if they have money, go to USA to get a PG degree. However, those whose fathers are poor and who study under a lamppost, cannot get a PG degree.

**6.21** The Committee observes that India is a country of 1.24 billion that will reach 1.7 billion by the middle of the century. Therefore, only 24000+ PG seats are unquestionably much less than national needs. It is, therefore, critical for the country to augment the production of specialists both as a development imperative and a pathway for ensuring quality universal health care to the masses. Within the existing framework, it will not be possible to expand rapidly beyond the present strength. The Committee, therefore, recommends that the existing norms governing the allotment of number of PG seats to an Institute on the basis of the bed strength and number of PG teachers be rationalized and all the clinical facilities (both public and private) be utilized to impart training so that the production of PG doctors is scaled up. The Committee has also noted that the recent increase in PG seats has been indiscriminate and in future we may have a lot of Post Graduate doctors who may not be competent in the specialty in which they claim to be specialized. The Committee recommends that the increase in PG seats should not be indiscriminate and great caution should be exercised on maintaining quality of training and certification. The Committee also observes that while the increase in PG seats will produce more specialists and also help to provide required faculty for medical colleges, it may result in fewer graduate doctors opting for primary health care. The Committee, therefore, recommends that the framework of Post Graduate Education be designed in such a way that it remains aligned with principles of universal health care.

### **Requirement of Research Thesis as part of PG Training Process**

6.22 An expert who appeared before the Committee submitted that the MCI and the NBE require the PG students to produce research theses. However, about 90 to 95 percent of these are never published and many of them are not publishable because they don't address the right kind of questions with the right kind of methodology. On the other hand, there is huge paucity of relevant data that may prove helpful in the management of prevalent diseases in the country. For example, there is no reliable data on the number of patients suffering from malaria, the number of pregnant women with high blood pressure, or the number of patients with antibiotic resistance. If these problems are addressed in research thesis by PG students through well-developed protocols, it will lead to having regular sets of relevant data and the whole health information system will be vitalized. The Indian Council of Medical Research can guide such studies by linking with student researchers and faculty guides from select institutions across India. However, the current MCI rules do not permit such externally guided multicentre research despite the obvious value of such studies.

**6.23 The Committee observes that though research is a mandate of post-graduate training and evaluation in both MCI and NBE PG Programmes, seventy years of having a thesis as part of the PG programme has done nothing to produce nationally relevant data for the management of the diseases prevalent in the country or to establish robust research enterprise within the medical colleges and institutions. The absence of clinical research on common problems prevalent in the country and the resultant lack of local information has created a disconnect between official statistics and the problems on the ground. The Committee, therefore, recommends that the component of research thesis as part the PG programme needs to be holistically restructured in such a way that post-graduate students are guided to conduct research relevant to national health program priorities and generate nationally representative data periodically.**

**6.24 The Committee also recommends that the Indian Council of Medical Research should guide such studies by linking with student researchers and faculty guides, from select institutions across India.**

## Chapter VII

### Deficiency of Teaching Faculty

7.1 The Committee has been informed by experts that though the number of medical colleges has increased greatly in recent times, faculty has not registered a commensurate increase. Though data on the exact extent of shortage of faculty is limited, the Committee has been informed that there is acute shortage of faculty and the present deficiency of teachers in medical colleges may be to the tune of approximately 30 to 35% or even more. As per the Report of the National Commission for Macroeconomics and Health, "there is an overall shortage of teachers entailing adverse impact on the quality of instruction. The situation is so severe that even governments feel compelled to indulge in irregular practices of mass transfers of teachers of different specialties from one college to another on a temporary basis at the time of inspection by the Medical Council of India. Keeping fake rolls of medical teachers and showing expenditure under the salary head is a common tactic adopted by managements of private medical colleges."

7.2 On being asked about the qualifications and eligibility criteria for being designated a teacher in a medical college or institution, and whether any assessment has been made to arrive at the number of teachers required for the existing medical college, the MCI in a written reply has informed the Committee that the eligibility criteria for a designated undergraduate teacher in a medical college are given in the Regulations of the Council on "Teachers Eligibility Qualifications 1998." With regard to Postgraduate courses faculty members, only those who possess a total of eight years experience, out of which at least five years teaching experience as Assistant Professor/Lecturer gained after Postgraduate degree, shall be recognized as Post Graduate Teachers. It has also been informed that the assessment of the cumulative shortfall of specialty/subject-wise full-time teaching faculty for the undergraduate and post graduate courses taken together is under way.

7.3 A representative of the IMA during his evidence suggested the use of Information Technology to tide over the shortage of faculty stating that putting a catheter on a patient need not be taught on a patient; it can be simulated and in this way teacher can be engaged in more than one classroom.

7.4 An expert during her deposition submitted that the country has a huge pool of talented clinicians and specialists who do not belong to the teaching cadre. She suggested that the specialists of Government and private hospitals, who are interested in teaching, should be allowed to become part-time or adjunct faculty. For example a medicine physician can be allowed to teach physiology; a surgeon can come and teach anatomy. If this pool of specialists can be tapped as adjunct

faculty, the problem of paper faculties during inspections will go away and the shortage of faculty will be wiped out.

7.5 In reply to a question as to how the MCI would deal with the issue of faculty in respect of district hospitals which are planned to be converted into medical colleges under a centrally-sponsored scheme of the Government of India, the representative of the MCI during evidence submitted that the matter would come before the MCI for deciding the criteria for equivalence of the teacher. It was also submitted that “there is already a benchmark. The 2004 Regulation is in vogue wherein the issue cropped up in regard to Safdarjung Hospital and RML Hospital. Therefore, the Council had already taken a view on the basis of which the Government of India approved a notification, and a regulatory notification has been issued that in case of hospitals which are not teaching, there the professional experience will be double the number of years of the teaching experience which is stipulated under Teachers' Eligibility Qualification Regulation so that the parity would be worked out in the sense of the cadre of teaching, Associate Professor, Professor and Assistant Professor. So, there is already a benchmark which has been worked up. This benchmark is expected to be availed as and when the need arises.”

7.6 On being pointed out by the Committee that if a PG doctor is having 20-30 years of practicing experience, why can't he be eligible for the post of Assistant Professor, the President, MCI during her evidence submitted that “if the honorary system was there all these people could come in but the honorary system has been discontinued.” She admitted that in the current scenario there was a need to utilize whatever workforce is available for the teaching faculty and assured to come out with some solutions.

7.7 Responding to a query regarding the issue of shortage of faculty and employing doctors with 25-30 year's experience on the clinical side as teaching faculty, the representative of the MCI submitted during evidence that -

"in a teaching set-up, an Assistant Professor becomes Associate professor at the end of four years, with two years of two publications. In the case of the professional set-up, the number of years required will be eight, not four, subject to fulfillment of the academic qualification and the publication of the research done. I can submit to the Committee that when the ESIC contemplated starting medical colleges, ESIC's medical colleges were virtually started by virtue of this very regulation, where clinical experiences in the hospitals which were managed by the ESIC, were equated for the purposes of granting parity for the conversion of the said people into the teaching cadre."

7.8 When asked whether the said regulation was applicable to the non ESIC Government hospitals also, the representative of the MCI stated that "the ambit of this regulation has to be broadened because it was issue based."

7.9 On being asked as to what are the grounds of distinction between somebody who is a post-graduate teaching in a medical college and somebody who is a PG practicing medicine in a hospital, the representative of the MCI stated that "the distinction is made on three prescribed counts. One is the pedagogical skills, the second is the teaching training and third is the research skills. "

7.10 An expert who is a renowned heart surgeon, and who appeared before the Committee submitted that the MCI guidelines regarding designating a teacher are so rigid that he and even Dr. Naresh Trahan, the eminent heart surgeon of the Medanta Medicity, Gurgaon, cannot become a heart surgery teacher in India. He informed the Committee that when he was a young medical student, almost all his charismatic teachers were practicing busy physicians, stating further that all the specialist training programmes happened outside medical colleges in the USA and Europe. He wondered, if this was what the USA and Europe had done, why were we doing it differently? He also stated that in order to tide over the shortage of faculty, there was a need to have a re-look at the policy of retirement of teachers. However, another expert who is an eminent hematologist of the country disagreed with the above point of view, saying that he stuck to the existing system. However, he suggested that there should be a rigorous system through which eminent people could become teachers.

7.11 Another expert who deposed before the Committee submitted that the biggest impediment in opening more medical colleges was the shortage of faculty. He supported the idea of employing District Hospitals specialists as adjunct faculty on the ground that the country needed to utilize all available resources to take care of the shortage of faculty. He shared his personal experience, stating that some of his best teachers during his student days were honorary professors who were very good Practitioners. He also favoured the idea of shared classroom, using the IT strength.

7.12 He further stated that the National Board of Examinations was established in 1982 to enable non-medical colleges to conduct post-graduate training so that an Army Hospital, a Railway Hospital, Sir Ganga Ram Hospital etc. could train post-graduate students with all the available expertise at hand. But, the MCI has now said that they cannot become teaching faculty in medical colleges. Repeatedly, the MCI has obstructed. The Government has issued clarifications and even courts have upheld the equivalence of the DNB with MCI certified degrees. Yet, the inspectors of the MCI go and threaten Medical Colleges that if they employ a person with DNB, the MCI will not recognize their college.

7.13 During the Committee's study visit to Coimbatore, Ooty and Bengaluru, some of the stakeholders submitted that the Regulations governing PG Teacher-Student ratio should be relaxed for certain specialties like Radio Diagnosis, Psychiatry, TB and Respiratory Diseases, Community Medicine and Anatomy.

7.14 During the Committee's study visit to Vardhman Mahavir Medical College (VMMC), New Delhi, the Principal of VMMC submitted that in areas where the country is very short of specialists (e.g. Radiotherapy, Psychiatry and Super-specialties) - the requirements for teaching manpower can be made little lax.

**7.15 The Committee takes note of the fact that there is acute shortage of teaching faculty which not only entails adverse impact on the quality of medical education but is also a barrier to the establishment of new medical colleges. The MCI's policies are largely responsible for this state of affairs, because very rigid norms have been provided in the "Regulations on the Teachers Eligibility Qualifications 1998" and only full-time teachers are acceptable to the MCI. It does not recognize qualified specialists in district hospitals, reputed private and public sector hospitals not attached to medical colleges and non-medical public health specialists as capable of teaching in a medical college on a part time basis. The MCI also does not allow for sharing of faculty across government medical colleges in a state, through Information Technology enabled "common classrooms". It also does not permit surgeons to teach anatomy and physicians to teach physiology part time, though their understanding of these basic disciplines is very clinically relevant.**

**7.16 The Committee is constrained to observe that had the MCI been able to unleash reforms of far-reaching impact to tide over faculty shortages, these barriers would have been removed to a large extent. The Committee therefore, recommends that keeping in mind that the country has a huge pool of talented doctors in both public and private sector hospitals, the MCI should look outside this rigid teaching faculty definition and find out-of-the-box solutions to tap the pool of practicing doctors who are interested in teaching as adjunct or part time teaching faculty. Of course, this should be done with some defined parameters and till a certain percentage only.**

**7.17 The Committee would also like the Government to have a re-look at the retirement policy of teachers and work out a re-employment policy. The Committee does not see any reason why a retired specialist at the age of 60 cannot be re-employed as a teaching faculty on a full time or part time basis.**

**7.18** The Committee takes note of the submission made by the President of MCI that "If the Honorary system is there, all these experienced people can come in. We must utilize whatever workforce, experienced or trained or a degree holder is available" and expects that the words of the MCI President would be matched with the action on the ground. The Committee recommends that early action may be taken in this regard.

**7.19** The Committee observes that the norms and standards as stipulated in the Regulations on the "Teachers Eligibility Qualifications 1998" had been fixed at a time when Information Communication Technology Tools were not so advanced. Despite tremendous advancement in IC Technologies and the advantage of our IT strength, ICT tools, virtual classrooms, and e-learning have not been incorporated in the medical curriculum in tune with the modern times. It is true that there are certain practical skills which have to be learnt bedside in a teaching hospital or a district hospital. But classroom teaching can be shared substantially with IT connectivity. The Committee therefore recommends that immediate action needs to be initiated to allow for sharing of faculty across government medical colleges in a state, through information technology enabled common classrooms. Subsequently, this facility may be extended to private medical colleges also, with check-and-balance mechanisms. The Committee is of the considered view that this measure will not only go a long way in making up for faculty shortages, but also take care of the current practice of engaging of ghost faculty by private medical colleges.

**7.20** The Committee also recommends that the ambit of the Regulation by virtue of which the clinical experience of the specialists in the ESIC hospitals were equated with the teaching experience for the purpose of adopting them into teaching cadre, should be extended to other Government Hospitals also so that the CMOs and other experienced doctors who have worked in the Government Hospitals for long and have experience of dealing with thousands of patients can come into the teaching faculty.

**7.21** The Committee takes serious note of the fact that the MCI has continued to oppose the induction of specialists who have passed the nationally standardized DNB examinations conducted by the National Board of Examinations and declared that they cannot become teaching faculty in medical colleges, despite the Government of India and even courts declaring the equivalence of post-graduate degree awarded through MCI certified and NBE certified Programmes. Since lack of teaching faculty is the main impediment in expanding and opening more medical colleges, there is an imperative need to utilize all available expertise to augment the required pool of teaching faculty. The Committee in the earlier part of this Report,



**has recommended the merger of the DNB with MD Programmes. But till then, DNB certificate holders may be utilized in teaching faculty provided they have at least two years of teaching experience.**

**7.22 The Committee takes note that the assessment of the cumulative shortfall of teaching faculty for the undergraduate and post-graduate courses is underway. The Committee recommends that the assessment be expedited so that the database so generated could be utilized for Human Resource planning and forecasting.**

## **Chapter VIII**

### **Need for an Accreditation Body for Medical Education**

8.1 On being asked about the existing system of accreditation of medical education in the country and whether the accreditation is done by MCI or an independent body, the Ministry in a written reply has informed that the MCI has informed that there is no system of accreditation of medical education in the country as of now. The General Body of the Medical Council of India at its meeting dated 21-22 June, 2001 had decided to take steps to get accreditation component included as part of the Indian Medical Council Act, 1956 to initiate action to assess certain willing institutions for accreditation with the Council. The said decision was communicated to the Ministry of Health & Family Welfare. The General Body of the Council at its meeting held on 26-27<sup>th</sup> March, 2015 has resolved that “by insertion of an independent clause after section 11 of the Indian Medical Council Act as 11(a), the Council be vested with authority and jurisdiction towards accreditation of medical colleges in the country on the same footing as University Grants Commission is vested with the statutory authority to accredit institutions of higher education through creation of autonomous authority for the same and All India Council for Technical Education is entitled to accredit educational institutions in the faculty of Engineering & Technology through creation of National Accreditation Board.” The decision so taken by the General Body of the Medical Council of India has been communicated to the Ministry for the needful.

8.2 The representatives of Indian Medical Association during their deposition before the Committee submitted that the merit of the entire college or hospital cannot be decided with just a single inspection but if there is an accrediting body which subsequently inspects, this deficiency can be corrected. They therefore suggested that there was a need for an accreditation body for the purposes of accreditation of medical colleges. They further submitted that the IMC Act 1956 does not have provisions for accreditation of medical colleges and suggested that through a suitable amendment to the IMC Act, the provision for accreditation of medical colleges be made on par with the AICTE Act, 1987 or the UGC Act, 1956.

8.3 During the Committee’s study visit to Coimbatore, Ooty and Bengaluru, some of the stakeholders suggested that assessment of quality of teaching and learning process as followed by National Assessment and Accreditation Council (NAAC) should be adopted to improve standards of medical education. Some of the medical colleges/ stakeholders who made written submissions shared the above view.

8.4 Some of the experts who deposed before the Committee were of the view that the functions of standard setting and accreditation should not be vested in the same body and should be separated.

8.5 In this regard the Report of the Group of Experts constituted by the Ministry to study the Indian Medical Council Act, 1956 has made the following recommendations:-

“The concentration of power in a single agency, which lays down the educational standards, approves the creation of institutions for UG and PG education and also oversees professional conduct of practicing physicians, has not served its purpose. The structure of the present Council is such that its actions are uni-directional, leaving no room for dialogue. Its structure violates the general principle in education, which is that laying down the educational standards and accrediting organizations based on their capability in achieving these standards need to be done by different agencies”.

**8.6 The Committee observes that robust accreditation processes are the foundation of quality management in most educational systems and therefore there is an imperative need for having an accreditation body for medical colleges. However, the Committee is not amenable to the suggestion that the MCI should be empowered to do the task of accreditation through an amendment to the IMC Act. The Committee observes that the same body giving permission and approvals for medical colleges and also ascertaining quality leads to conflict of interest. The Committee, therefore, recommends that a robust independent accreditation body be established and entrusted with the task of ensuring quality of medical education. The Accreditation Body so created should be oriented towards seeing whether the type of medical education given is appropriate for the country; whether the product that comes out of medical colleges is a product that is needed; whether the teaching methods are upto the mark and latest. The Committee also recommends that such an organization should be autonomous.**

## Chapter IX

### Regulation of Professional Conduct of doctors

9.1 The Committee has been informed by the Ministry that Section 20A of the Indian Medical Council Act, 1956 empowers the MCI to prescribe standards of professional conduct and etiquette and a code of ethics for medical practitioners. The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 lays down the duties and responsibilities of the physician in general.

9.2 Clause 6.8 of the Regulations deals with code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry and clause 6.8.1(h) *inter alia* provides that a medical practitioner shall not endorse any drug or product of the pharmaceutical and allied healthcare industry publically.

9.3 Regulation 8.7 and 8.8 of the Code of Medical Ethics provides for relationship between the MCI and State Medical Council. Such relationship encompasses the following:-

*“8.7 Where either on a request or otherwise the Medical Council of India is informed that any complaint against a delinquent physician has not been decided by a State Medical Council within a period of six months from the date of receipt of complaint by it and further the MCI has reason to believe that there is no justified reason for not deciding the complaint within the said prescribed period, the Medical Council of India may-*

*(i) Impress upon the concerned State Medical council to conclude and decide the complaint within a time bound schedule;*

*(ii) May decide to withdraw the said complaint pending with the concerned State Medical Council straightaway or after the expiry of the period which had been stipulated by the MCI in accordance with para (i) above, to itself and refer the same to the Ethical Committee of the Council for its expeditious disposal in a period of not more than six months from the receipt of the complaint in the office of the Medical Council of India.”*

*“8.8 Any person aggrieved by the decision of the State Medical Council on any complaint against a delinquent physician, shall have the right to file an appeal to the MCI within a period of 60 days from the date of receipt of the order passed by the said Medical Council:*

*Provided that the MCI may, if it is satisfied that the appellant was prevented by sufficient cause from presenting the appeal within the aforesaid period of 60 days, allow it to be presented within a further period of 60 days.”<sup>5</sup>*

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<sup>5</sup> Source: [www.mciindia.org](http://www.mciindia.org)

9.4 The representative of the IMA during his deposition before the Committee submitted that there was still no code of conduct for the nursing homes, hospitals, clinics, pharmacy and chemists. The MCI had taken action against a super-specialty Hospital for certain lapses. The Hospital went to the Delhi High Court stating that “we do not come under the MCI.” The High Court ruled that the Hospital indeed did not come under MCI.

9.5 Another expert who deposed before the Committee submitted that ensuring ethical practice by the doctors once they are produced, is one of the most important mandates of the Council. However, the MCI has completely failed to take action against the doctors who are not following the code of ethics.

9.6 She further submitted that diversity needed to be brought into the composition of the Ethics Committee of the MCI, which should have external members, preferably non-doctor lay members. She cited the example of the Ethics Sub-Committee in the UK, which is headed by judges because they would understand larger dimensions of ethical issues.

9.7 She also submitted that as of now the whole focus of the MCI was on the licensing of medical colleges and ethics was completely ignored in that process. She argued that there was a need for bifurcation of these two tasks and they should not be put under the control of one single body, stating that in Australia, the Australian Medical Council sets the curriculum and does licensing of medical colleges, and the Australian Medical Board is tasked with the registration of doctors and ethics. Something similar should be structured in India also. In the UK, when the disciplinary action needs to be taken, the GMC vets and does the initial documentary investigation and then passes that on to a Tribunal. The hearings are done by the Tribunal. The adjudication decisions and final disciplinary action is decided by the Tribunal. The Tribunal is a separate body independent of the GMC.

9.8 She also highlighted the gaps between the State Medical Councils and the MCI when disciplinary action needs to be taken or complaints come. She stated that very often the State Medical Councils sit on complaints. There is a six-month period within which action should be taken and if it does not get taken, then it lapses. There is nothing on paper to say what the different roles of the Central Council and State Medical Councils are and what the responsibility of State Medical Council exactly is. There is no clarity on what the Central Council can do if the State Medical Council does not implement after the Central Council has adjudicated. All this needs to be clarified.

9.9 She also suggested that a code of ethics is needed not only for individual doctors but also for institutions providing medical care, because when something

goes wrong, it is all a blame-game between the doctor and the hospital. Today, the MCI is only looking at the individual doctor, but not the medical institution. The Regulatory Body should be dealing with both of them.

9.10 The Committee was informed by an expert through written submissions that besides taking up complaints including those referred by the State Medical Councils, the Ethics Committee of the MCI also takes up those cases wherein convictions in courts had happened as the licenses of doctors convicted would need to be revoked. However, the indictment record of the Ethics Committee has been quite low, just 109 doctors has been black-listed from 1963-2009.

9.11 The Committee's attention has also been drawn to two articles published in the BMJ, one of the top international medical Journals, which highlighted the unethical practice of doctors in the country. The articles titled "Corruption ruins the doctor-patient relationship in India" by Mr. David Berger published on the 8<sup>th</sup> May, 2014 and "The unethical revenue targets that India's corporate hospitals set their doctors" by Ms. Meera Kay published on the 3<sup>rd</sup> September, 2015 in the BMJ (formerly the British Medical Journal) have documented how kickbacks and corrupt practices are ruining the doctor-patient relationship and how doctors face pressure from hospital management to overprescribe surgeries or investigations which cause hazards for the patient.

9.12 The Committee's attention has also been drawn to a Report titled "Voices of Conscience from the Medical Profession" which was released by Support for Advocacy and Training to Health Initiatives (SATHI), an NGO on the 28<sup>th</sup> February, 2015 at the All India Institute of Medical Sciences. The Report contains interviews of 78 doctors by the whistle-blowing doctor from Maharashtra, Dr. Arun Gadre and exposes the realities of the private sector such as irrational drug prescriptions, bribes for referrals and unnecessary diagnostics and surgeries, the distorting influence of corporate and multi-specialty hospitals on ethics of the medical profession and the growing grip of pharmaceutical companies on private medical practice.

9.13 The Committee's attention has also been drawn to an article written by Ms. Rema Nagarajan in the Times of India under the title "Change in MCI's code to exclude doctors' association not notified" published on June 9, 2015. The article *inter alia* states that the MCI in its executive committee meeting held in February 2014 had decided to drop the words "and professionals association of doctors" from clause 6.8 of the Code of Ethics Regulations, which meant that professional associations of doctors would be beyond the purview of the MCI.

9.14 It has also been stated in the article that when the MCI was being run by the Board of Governors appointed by the Government of India following the

dissolution of MCI in the wake of allegations of massive corruption against the then head of the MCI, it had argued in the Delhi High Court that “what is not allowed to be done directly, cannot be permitted to be done indirectly”.

9.15 Following the February, 2014 decision of the MCI, several doctors, health activists and organisations of health advocacy groups, including Smt. Brinda Karat, ex-MP (Rajya Sabha) Jan Swasthya Abhiyan, Indian Journal of Medical Ethics, All India Drug Action Network and Medico Friends had written to the Ministry of Health and Family Welfare, stating that “We cannot conceive how an action that is ethically impermissible for an individual doctor can become permissible if a group of doctors carry out the same action in the form of an association.”

9.16 The Committee’s attention has been drawn to an article titled “MCI code of ethics gives doctors way to accept freebies” published on the 10<sup>th</sup> February, 2016 in the “Times of India” wherein it has *inter alia* been reported that the amendment to clause 6.8 of the MCI code of Ethics Regulations, 2002 has been notified on the 1<sup>st</sup> February, 2016 and the words “and professional association of doctors” deleted from the said clause, thereby exempting professional association of doctors from the jurisdiction of MCI.

9.17 The Committee had received a representation from a doctor from Kerala and his spouse stating that they had complained to the Medical Council of India in 2008 and 2010 that the Indian Medical Association was endorsing commercial products of private companies, which was in violation of the MCI Code of Ethics Regulations, 2002. He also informed the Committee that he had been issued show cause notices by IMA for complaining to the Press, the MCI and the Ministry of Health and Family Welfare. However, the reconstituted MCI has not taken action against the office bearers of IMA despite its earlier Ethics Committee decision in its meetings held on the 9<sup>th</sup> November, 2010 and 28<sup>th</sup> and 29<sup>th</sup> June, 2013 holding the office bearers of IMA guilty of violation of MCI Code of Ethics Regulations and recommending removal of their names from the Indian Medical Register. The MCI has instead issued notices to him and his non-medico wife asking them to appear in person before it.

9.18 When the Committee took up this matter with the President, MCI during her deposition before the Committee, she submitted as under:

“The complaint has been withdrawn now. Our Ethics Committee has decided to close the case. Minutes are under preparation. It will come to EC (i.e. Executive Committee) and we will inform them.”

9.19 The Ministry of Health and Family Welfare has informed that presently Indian Medical Council (IMC Professional Conduct, Etiquette and Ethics)

Regulations, 2012 is applicable only on individual doctors and not association of doctors.

**9.20** The Committee observes that the oversight of professional conduct is the most important function of the MCI. However, the MCI has been completely passive on the ethics dimension which is evident from the fact that between 1963-2009, just 109 doctors have been blacklisted by the Ethics Committee of the MCI. The Committee does not intend to taint the entire medical community and there is no doubt that there are outstanding doctors and surgeons in all parts of India in all kinds of health settings who have unblemished credentials and who are serving people with compassion, selflessness, integrity and accountability. But it is equally indisputable that due to crass commercialization of the health sector, many unprincipled doctors and private sector hospitals have lost their moral compass and overcharge or subject their hapless patients to unnecessary surgeries and diagnostic procedures. The instance of unethical practice continues to grow due to which respect for the profession has dwindled and distrust replaced the high status the doctor once enjoyed in society. What is of greater concern to the Committee is that the medical profession has not been transparent in dealing with complaints.

**9.21** The Committee notes with concern that although the MCI Code of Ethics Regulations, 2002 contains detailed prescriptions of what constitutes duties and responsibilities of the Physician, the Code is idealistic in nature and there is no mechanism in place to oversee its implementation.

**9.22** Considering all these factors the Committee recommends that the Code of Medical Ethics needs to be well-defined to take care of the concerns of public safety and malpractices or medical negligence by doctors so that the doctor-patient relationship which has taken a severe beating, can be repaired and retrieved. For that to happen, there needs to be stronger mechanism for ethical oversight of medical practice and the legislation governing the oversight of professional conduct of doctors should be made more specific with provision for transparency and time-lines. There should also be an appeal mechanism in place so that the patient does not feel stone-walled.

**9.23** The Committee observes that the whole focus of the MCI has been on the licensing of medical colleges and ethics is completely lost out in this process. It is a matter of surprise that despite the worst kind of gross unethical practices happening by way of ghost faculty, fake patients and hired instruments and substantial amount of money (not white, of course) reportedly changing hands at the time of inspections, there is little proactive



action on the part of the MCI to deal with this malady. Against this backdrop, the Committee is of the firm view that the two major areas, i.e., medical education and practice of ethical conduct by the medical profession should be bifurcated so that they receive full attention. The Committee is of the considered view that in order to earn back the respect the medical profession has lost, concerted action is needed with proactive steps being taken and implemented. The Committee accordingly recommends that a separate Board of Medical Ethics be set up to take up the task of developing mechanisms for promotion of ethical conduct by medical practitioners. This Board may be constituted on the lines of the GMC of UK and the Australian Medical Council, which have bifurcated these two tasks and put persons of requisite competence in the mechanisms so created for the governance of ethical practice by doctors. Such a Board must plan for continuing renewal of codes of ethics, their dissemination through interactive channels and active promotion of adherence to them. For this, organising workshops, conferences, etc. should be on-going activities.

**9.24** The Committee notes that the Ethics Committee of the MCI presently consists entirely of medical doctors and is thus a self-regulatory body. But all over the world, it has now been realized that the medical profession (or any profession for that matter) tends to protect its own flock. The Committee, therefore, recommends that the new Board of Medical Ethics should also have non-doctor lay members from different fields.

**9.25** The Committee observes that the current accountability mechanisms are not sufficient to ensure observance of ethical practices by the health facilities in India. Though the Clinical Establishment (Registration and Regulation) Act of 2010 is there, it has been adopted by a few States only which means there is no appropriate legislation to regulate private clinical establishments in most of the States currently. It has been seen in practice that individual doctors and the hospitals where they work, pass the onus to the other when anything goes wrong with a patient. The Committee feels that for individual doctors to practice ethically, they require an ethical working environment. The Committee, therefore, recommends that the new Board of Medical Ethics should be mandated to develop standards and norms of professional conduct and codes of ethics for medical practice not only for individual doctors, but also for institutions of health service delivery, i.e., hospitals, clinics, nursing homes, rehabilitation centres, associations, etc.

**9.26** The Committee observes that it is a well-known fact today that there is a lot of inappropriate drug dispensing and unnecessary procedures and commission-linked diagnostics by medical practitioners and health institutions in India mainly due to financial incentives. In this situation,

formulation of treatment guidelines for various health conditions and disseminating them widely through publicity and media is imperative for protection of patient interests and rights. The Clinical Establishment (Registration and Regulation) Act, 2010 can provide an umbrella legislation in this regard as it has the power to prescribe guidelines for all healthcare facilities. In the absence of a unified legislation, there are a few different legislations that regulate some healthcare services such as the Pre-Conception and Pre-Natal diagnostics Technologies Act, 1994 enacted to stop female foeticide and arrest the declining sex ratio and the Medical Termination of Pregnancy (MPT) Act, 1971 which lays down the conditions under which pregnancies can be terminated. Other health services are not governed by any standards of treatment and pricing guidelines or reporting frameworks.

**9.27** The Committee also recommends that the Government should put in place a system of auditing of medical practices. A beginning can be made by reviewing patient records for diagnosis and treatment, use of antibiotics and caesarean sections in the private hospitals.

**9.28** The Committee observes that there is some lack of clarity in the functioning of State Medical Councils and the MCI when it comes to taking disciplinary action. Though there is a six month period prescribed within which disciplinary action should be taken by the State Medical Councils which are mandated to implement the adjudications of MCI, many times the State Medical Councils sit on the adjudications beyond six months and no action gets taken allowing the errant doctor to go scot free. The Committee, therefore, recommends that the relationship between the MCI and the State Medical Councils be clarified in unambiguous terms to ensure that the complaints against doctors are attended to in time and action taken without delay.

**9.29** The Committee is astonished to note that the MCI has notified on 1<sup>st</sup> February, 2016 an amendment to clause 6.8 of the Regulations, deleting the words “and professional association of doctors” and exempt professional association of doctors from the ambit of MCI Code of Ethics Regulations, 2002. The Committee observes that exempting professional association of doctors from the ambit of Ethics Regulations is nothing short of legitimizing doctors’ associations indulging in unethical and corrupt practices by way of receiving gifts in cash or kind under any pretext from the pharma industry or allied health industry. The Committee agrees with the view point of public health activists that “an action that is ethically impermissible for an individual doctor cannot become permissible if a group of doctors carry out the same action in the name of an association.” The Committee could not

**uncover any rational reason as to why the MCI has taken such a retrograde decision. It seems that the MCI has become captive to private commercial interests, rather than its integrity in public interest.**

**9.30 The Committee also finds it intriguing that instead of intervening to thwart attempt of MCI at subverting the system, the Ministry has meekly surrendered to MCI. The Committee recommends that the Ministry should take immediate action in the matter to ensure that the illegality committed in terms of violation of ethical standards of 2002 Regulations, either by an individual doctor or a group of doctors in the form of an association is not kept out of the jurisdiction of MCI and the words “and professional association of doctors” are restored to clause 6.8 of the MCI Code of Ethics Regulations 2002 so that no immunity, whatsoever, is accorded to any association or society of doctors. If there are any other legal infirmities in the framework of the 2002 Regulations, they should be removed.**

**9.31 The Committee taking note of the submissions of the President, MCI that the existing Ethics Committee has closed the case against the whistleblower doctor from Kerala and his wife recommends that completion of all formalities concerning the closing of the case be expedited by the MCI. The Committee desires to be informed of the final outcome / fulfillment of the assurance made by the President MCI, to the Committee in this regard, within one month from the presentation of this Report.**

## **Chapter X**

### **Maintenance of Indian Medical Register (IMR)**

10.1 The Committee has been informed that Section 23 of the IMC Act provides for the “Registration in the Indian Medical Register”. Registration in IMR is either on receipt of Report of registration of a person in State Medical Register or on application made in the prescribed manner by a person to have his name entered into the IMR.

10.2 The Committee has been informed that MCI has to maintain such Register, revise it from time to time and publish it in the Gazette of India in such other manner as may be prescribed. Further, information as to the change in name or registration of additional qualifications or address or removal of name is also to be provided by the State Medical Council to the MCI as and when received. Further, information as to the change in name or registration of additional qualifications or address or removal of name is also to be provided by the State Medical Council to the MCI as and when received.

10.3 The Committee has also been informed that Section 28 of the Indian Medical Council Act, 1956 deals with the obligation of the persons enrolled on the Indian Medical Register to notify change of place of residence or practice, to the Council and the State Medical Council. Failure on the part of persons enrolled in the IMR to notify such change may forfeit their right to participate in the election of members to the Council or the State Medical Council by the Central Government.

10.4 An expert during evidence informed the Committee that the present figures of registered doctors maintained by MCI are based on a static register. Even the persons registered in the year 1974 and who are no more, still exist in the said register and there is no mechanism to remove the names.

10.5 Another expert informed that the current register also contains names of those with a permanent address outside India.

10.6 During the Committee’s study visit to Coimbatore, Ooty and Bengaluru, some of the stakeholders suggested that registration of doctors should be streamlined and single national registry should be maintained so that the registered doctor could practice anywhere in the country.

10.7 During the Committee’s study visit to Shree Guru Gobind Singh Tricentenary Medical College, Gurgaon, the representatives of the College submitted that registration should be common for the country and should be

honoured even if the person moves from one states to other state. Some of the medical institutions/ stakeholders who made written submissions expressed similar views.

10.8 On being asked whether it was compulsory for a medical doctor to register himself, the representative of the MCI during evidence replied in the affirmative, stating further that without registration he cannot practice. When asked whether the Indian Medical Register also included the people who have got MBBS degrees and gone abroad, the MCI representative again replied in the affirmative. On being further asked “how do you net out the people who have taken MBBS degree here and gone abroad” he replied that the “process has been undertaken”.

10.9 In reply to a question, the Committee has been informed that the Council is in the process of implementing the system of e-Governance and integral part of which would be live IMR/ updation of IMR, conversion of existing registration numbers to Unique Permanent Registration Number (UPRN), etc. by involving State Medical Councils also so as to invoke an online update in due course of time.

**10.10 The Committee observes that the current Indian Medical Register (IMR) does not depict the real picture since the same includes names of all medical practitioners who have ever registered themselves in the IMR, be they dead or alive, in India or abroad. This register cannot be of much help to planners and policymakers for HR planning and forecasting. The Committee is, therefore, of the view that the Indian Medical Register needs a live database so that a realistic assessment of the number of doctors actually practicing in the country and how they are distributed across the public and private sectors and across rural and urban areas, could be made.**

**10.11 The Committee takes note of the submission that the Council is in the process of implementing the system of e-Governance and integral part of which would be live IMR/ updation of IMR, conversion of existing registration numbers to Unique Permanent Registration Number (UPRN), etc. by involving State Medical Councils also so as to invoke an online update in due course of time. The Committee therefore recommends that the IMR be made online and a live database be created in such a manner that there is automatic update between States and the Centre. If the name of a doctor is removed at one place, it should reflect in other site also. The Committee also recommends that the Ministry should direct the Council to complete the process within a stipulated time.**

## **Need for Mandatory Re-Certification and Continuing Medical Education**

10.12 In majority of the countries in the world, medical education is not perpetual and needs to be reviewed after five years. However, in India, recertification and mandatory Continuing Medical Education (CME) is missing in the existing regulatory framework. In reply to a question, the Ministry informed that as per the Indian Medical Council Act, 1956, registration was one time requirement and any change in it requires an amendment to the Act.

10.13 In reply to a question, on whether the doctors are getting information from pharma people who have their own commercial interest, the representative of the IMA submitted during his evidence before the Committee that "we are forced to depend on pharmaceutical companies because there is no system where the Drug Controller of India informs us about the introduction of a new drug as FDA does in USA. We don't have a compulsory pharmaco-vigilance department. Ultimately the doctors have to depend on pharma companies. Whenever there is sponsorship from pharma companies, there will always be a bias." The representative suggested that there should be programme for updating of the knowledge of doctors once they leave their medical colleges and the responsibility should be taken by the MCI, medical colleges and the Ministry of Health and Family Welfare.

10.14 The Committee was informed that in the USA there is a system according to which every five years doctors have to get certified by a Board.

10.15 During the Committee's study visit to Coimbatore, Ooty and Bengaluru, the representatives of the Government of Tamil Nadu *inter alia* submitted that in majority of countries, medical registration was not perpetual and needed to be renewed after every five years. It was impressed upon the Committee that there was need to introduce a similar system in the country for ensuring maintenance of standards.

10.16 An expert who appeared before the Committee stated that re-registration occurred all over the world, but not in India. She underscored the need for introduction of re-registration and re-training to all, for robust medical education. Another expert submitted that the education of practicing doctors was being done by the pharma industry because the MCI has failed to fill this gap. She also advocated the introduction of mandatory continuing medical education so that the health system's requirements, and not the pharma sector's commercial interests, are strengthened.

**10.17 The Committee agrees with the need for mandatory recertification and Continuing Medical Education and a structured programme of**

**periodical update of the knowledge of doctors as quality assurance mechanisms and observes that the MCI (or any other body) in consultation with the Ministry of Health and Family Welfare should take the responsibility in this regard. The Committee observes that in the absence of a structured mechanism for recertification and Continuing Medical Education, pharma companies are filling the gap due to which doctors are dependent on them for the update of their knowledge. This influences them in their professional practice. The Committee, therefore, recommends that the renewal of registration and Continuing Medical Education be made mandatory so that the health system's requirements get strengthened and doctors practice more appropriate and rational technology instead of picking up the technologies pushed by the interested agencies.**

## Chapter XI

### Need for Attractive Remuneration for Doctors and Medical Faculty

11.1 During the course of examination of the functioning of the MCI, the need for adequate remuneration for doctors and faculty working in the public sector was emphasized by the experts who deposed before the Committee.

11.2 It was impressed upon the Committee that un-remunerative pay structure of doctors and faculty was one of the factors which was resulting in less students being attracted towards this profession. It was also pointed out that the entry of corporate sector into the healthcare industry has attracted many high performing doctors from public health facilities to private hospitals and medical colleges owing to financial incentives.

11.3 The Representative of Indian Medical Association during his deposition before the Committee made the following submissions in this regard:-

*“We make a big hue and cry that people are not opting for teaching posts. But, there are various considerations where there is no regulatory mechanism. Even today, when we are talking of payment of scales and service conditions, it is the UGC scales that become accruable and there is nothing with the MCI or any mechanism associated with the medical education for the purposes of regulating the service conditions of medical teachers, accruable pay-scales of medical teachers and all other incentives and benefits which, of course, would be adding as a big incentive for people to take up the assignment as full-time faculty in medical education”.*

11.4 Experts who deposed before the Committee while echoing these views stated as under:-

- i. “.....the medical profession should be made more attractive. In 2011 or 2012, there used to appear three lakh candidates in the Rajasthan, the State I come from, for the PMT examination. I was told that in the next year less than 50,000 students appeared. Nobody wants to join medicine stream today. You want more medical colleges. You want more doctors. But nobody wants to join! Our children say, No, no, we do not want to be like that. No question! The reason is that an MBBS and an MD or a DM requires 12 years of study. By then, he will be around 30 or 31 years old. He is already married with children, while he is doing his DM. And, on the other side, an engineering or a business school guy has four years plus two years. At twenty-five, he is good.



He is an earning member of the family. The medical courses are voluminous because the doctors can get patient with any type of medical problem, and the teachers have the habit of asking most difficult things. So, students keep reading.....But if you compare medicine with other branches, the courses are very limited in other branches. Medicine is unlimited. The other problem is that one in one-thousand becomes a super-specialist. We take exam for two seats; 290-300 students appear. That is for post-M.S. For MBBS, you get MBBS, but from MBBS to MD, the ratio is generally 1:100, 1:40 and like that. But from there, finally, to become a super-specialist of a heart or a lung or a brain, the ratio is one in 1000. In other streams, this is not there. There are equal number of PG and job opportunities. He can be an MBA; he can be an engineer.

- ii. “When the student passes out, after his super-specialization, he gets Rs. 70,000 to Rs. 1,00,000, while the other guy gets close to five lakh rupees, three lakh rupees immediately. As far as working hours are concerned, doctors have to be there all the time. The others have flexi hours. You can work from home. All the time, there are chances of litigations on doctors. There is nobody to save them. The profession is under deep trouble because of this. And then there is public distrust.”
- iii. “Doctors are beaten up. So, the students are not trying to become doctors today. So, what we need is to bring up medical profession and give young doctors new options. In 2010, the Board of Governors (BoGs) of MCI had seven main agendas. This was the seventh agenda, “The Remuneration Packages”. We had requested Mr. Narayan Murthy to head a Committee. The report was sent to the Health Ministry, which was never picked up. The report of Narayan Murthy Committee, 2011 says, 'Pay the doctor his worth.' What are three main things? Medical profession needs higher commitment, skills, accountability than any other stream. So, the pay should be as per the number of years of training. Suppose the engineer or an MBA is trained for six years. When he starts his service, he gets amount equal to six years of training. The medical student, if has read for nine years for his M.S., give him three additional increments in UPSC, when he joins. If he has become a super-specialist by putting six extra years, give him six increments at the time he joins. This was a clear recommendation, and I think, if you implement it, this will make a huge change in our profession.”
- iv. “Today, Government colleges do not have teachers. Everyone is in private. My student who passes out gets four times more pay after my thirty-five years of work—four times more pay on the day he passes.

So, why should he continue in Government service? So, what we want, in Government service, give him increments as it is. Second, anybody who is doing clinical, teaching and research—there are three heads—pay him three times. Believe me, this is the biggest fear that I have. Tomorrow, five years down the line, there will be no good teachers in the medical colleges. You will have colleges. But the new AIIMS would not have teachers. To keep teachers there, you must pay them their worth”.

**11.5 The Committee notes with serious concern that medicine is no longer a priority for the brightest among the youth and the disinterest of our brightest to opt for teaching jobs in public sector health institutions is increasing due to various factors, one of which is certainly inadequate remuneration packages. The Committee observes that the whole medical education system will collapse if there are not good teachers for our medical colleges. Let us also not forget that today’s medical student is tomorrow’s physician and no society can afford to leave healthcare in the hands of mediocre doctors. All these facts warrant that measures to attract good talent towards medical profession and retain them, by way of offering attractive remuneration packages are required to be immediately initiated. The Committee fully endorses the view that medical profession demands much higher commitment, knowledge, skills, competence and accountability and doctors have to work under very trying conditions. It is, therefore, imperative that the pay structure of doctors and faculty should be so designed as to provide compensation to medical fraternity commensurate to their years of training and research.**

## **Chapter XII**

### **Corruption in the MCI**

12.1 The Committee keeps on hearing that there is corruption in the MCI and money changes hands for increase of seats, recognition, etc.

12.2 The Health Secretary during his deposition before the Committee informed the Committee that following allegations of corruption against the former President of MCI, the Medical Council was superseded in May, 2010 and a Board of Governors was installed.

12.3 On being asked about the kinds of corruption that is happening in the MCI, the President, MCI during evidence before the Committee admitted that corruption was there when there was sanctioning of medical colleges, or increasing or decreasing seats. The Committee has also been informed that the private medical colleges arrange ghost faculty and patients during inspections by MCI and no action is taken for the irregularity. The Committee has also been given to understand that MCI is proactive in taking action on flimsy grounds against Government Medical Colleges which are 100% better.

12.4 On being asked about the steps taken by the Ministry to tackle corruption in the MCI which has been there for the past 20-25 years, the Health Secretary during evidence submitted that the entire IMC act was under review. He also informed that the MCI Act as it exists today does not empower the Government to take action even in proven corruption charges. However, in the IMC (Amendment) Bill 2013, there is a provision that if there are proven charges then the Member can be removed. Such a provision was in the 2010 Ordinance also during the Board of Governor's time.

12.5 An expert through written submissions has raised the issue of lack of transparency and corruption in the electoral process of the Council formation.

12.6 Another expert who deposed before the Committee highlighted the issue of corruption and also suggested the following solution to stem the corruption in MCI:

“The large issues of non-transparency and corruption also stem from the issue of licensing of colleges. Therefore, can we put these two apart? Could it be so that within the MCI we create two sections, or do we have two separate bodies?”

12.7 The expert has also supplied a copy of an article titled "Vyapam is the symptom, Criminalization of Medical Education is the Disease" dated 12th July, 2015 written by Professor Rama Baru and Ms. Archana Diwate of the Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi which was published in the WIRE, wherein the authors have highlighted malpractices at the MCI. It would be pertinent to mention here that Prof. Rama Baru was a member of the Ethics Committee of MCI a few years ago and is thus privy to information about corrupt practices at the MCI.

12.8 The Committee also takes note of a news report published in the Times of India on 18<sup>th</sup> December, 2013 under the caption "Now MCI includes 17 tainted members", wherein it has been reported that 17 members who were part of the previous MCI which was dissolved by the Government in 2010 on grounds of rampant corruption have made a comeback in the new MCI.

12.9 The Committee is also in possession of a letter dated the 4<sup>th</sup> March, 2014, written by the Joint Secretary, Ministry of Health and Family Welfare to the President, MCI wherein he had raised the issue of appointment of some Advisors to the President in contravention of the legal provisions and requested to cancel "all such appointments which are not authorised by the Act, with immediate effect".

12.10 The Committee's attention has also been drawn to the media report wherein Dr. Harshvardan, the ex-Union Health Minister soon after taking over the charge of the Ministry of Health and Family Welfare had stated that the Medical Council of India has been a "big source of corruption" so much so that it has weakened the very edifice of medical education in the country.

**12.11 The Committee is shocked to find that compromised individuals have been able to make it to the MCI, but the Ministry is not empowered to remove or sanction a Member of the Council even if he has been proved corrupt. In a day and age when the need for sturdy systems and enhanced transparency based regimes are being increasingly emphasized, such state of affairs indicate that the MCI has not evolved with the times. Such state of affairs are also symptomatic of the rot within and point to a deep systemic malice. Otherwise how could it happen that the MCI, which has laid down elaborate duties and responsibilities of the "Physician" under the MCI Code of Ethics Regulations, 2002, could have at its very top a person who was arrested on charges of corruption in 2010. The former Union Health Minister, who must have an insider's view of the functioning of the MCI, making scathing comments about corruption in the MCI, speaks volumes of the decay in the MCI and is an eye-opener on the need for urgent reforms in the structure and functioning of MCI.**

**12.12 The Committee is all for professional autonomy, but autonomy sans accountability tends to degenerate into autocracy and therefore cannot be acceptable. The MCI is funded by the Government and therefore the Government must have the leverage to enforce accountability in the MCI. Since the real cause of the problem is systemic and cannot be fixed without setting the system right, the Committee recommends that the Ministry should take expeditious action to amend the statute or enact a new legislation in a manner that it comprises within its ambit accountability provisions as well and empowers the Government with legal authority to intervene in matters of corruption. In the same vein, the Committee would like to emphasize that bonafide conduct/ decisions of the Council members should be duly protected.**

**12.13 The Committee takes note of the admission of the President of MCI that corruption is there when there is sanctioning of medical colleges or increasing or decreasing of medical seats. However, the Committee finds the inaction of the MCI enigmatic in this matter. If the MCI is aware of the fact that denial of recognition of a medical college or grant of seats and then its permission /enhancement or reduction leads to corruption, then the Committee wonders why it has failed to put in place a framework or system which can plug these loopholes. The Committee is of the view that there is too much power concentrated in a single body (i.e. the MCI), and it has failed to create a transparent system of licensing of medical colleges. The MCI currently sets standards for recognition; inspects and licenses medical colleges; overseas Registration and Ethical Conduct of Doctors. It now proposes to undertake accreditation as well. Such concentration of powers creates a serious conflict of interest and provides a fertile ground for misuse of authority. The Committee, therefore, favours bifurcation of the functions of MCI and recommends that different structures be created for discharging different functions.**

**12.14 The Committee also takes note of the allegations reported in the media report that the former vigilance officer of MCI was harassed and had to quit for lack of cooperation from the President and several officials of the MCI in his efforts to deal with corruption. The facts brought to the notice of the Committee force the Committee to seek a thorough probe into the whole gamut of issues due to which the said Vigilance Officer had to resign.**

**12.15 The Committee wonders to find that certain persons were appointed as Advisors to the President in transgression of law and the Joint Secretary in the Ministry of Health and Family Welfare vide his letter dated the 4<sup>th</sup> March, 2014 had to write to the President to cancel “all such appointments**

**which were not authorized by the Act.” The Committee takes serious note of such flouting of law and would like the matter to be thoroughly probed and an action taken report furnished to the Committee within three months from the presentation of this Report.**

### **Inspections and Corruption**

12.16 The Committee has been informed by an expert that the desk evaluation of the application for establishment of a medical college is done by the Executive Committee followed by physical inspection to verify the information supplied by the applicant. Inspectors appointed by the MCI do the physical verification. One permanent inspector, an MCI permanent staff, leads, along with 3-4 external Inspectors chosen by the Executive Committee of the MCI.

12.17 The Committee has also been informed that a copy of the Inspection Report is not provided to the University concerned, though section 17.3 of the IMC Act requires this.

12.18 As informed by the Ministry, as per the Delhi High Court order dated 20<sup>th</sup> December, 2013, all the assessment should be conducted as surprise inspection. However, it is in the Committee's knowledge that some medical colleges have prior information of inspection dates and are thus able to keep ready the required number of ghost faculty and fake patients. The Reuters in a report titled "why India's medical schools are plagued with fraud" published on the 16<sup>th</sup> June 2015 has documented such malpractices, stating that "recruiting companies routinely provide medical colleges with doctors to pose as full-time faculty members to pass government inspections. To demonstrate that teaching hospitals have enough patients to provide students with clinical experience, colleges round up healthy people to pretend they are sick."

12.19 The Committee would also like to highlight the following facts which were brought out in an article titled "The Murky world of medical college inspections" by Ms. Rema Nagarajan in the Times of India on the 17<sup>th</sup> November, 2014: -

"Of 261 inspections, inspectors from medical colleges in Gujarat were involved in about 100 and another 40 involved faculty from Bihar. Yet inspectors from Tamil Nadu, the state with the highest number of government medical colleges, were involved in just seven inspections. There were 24 inspectors involved in 40 inspections from just two medical colleges in Haryana, a state with just three government colleges, while only six faculty members were involved in seven inspections from Kerala, a state with nine medical colleges. Out of 33 inspections done by inspectors from Delhi, 21 were from just one medical college, Maulana Azad Medical

College (MAMC), though Delhi has six medical colleges. Of those from MAMC, just two doctors were involved in 11 inspections..... Despite hundreds of faculty members from 183 government medical colleges being available, the assessment reports show that about 20 inspectors have done as many as four to nine inspections each. Some of those who did seven or nine inspections were mostly sent to private medical colleges. These 'serial inspectors' were part of almost half the inspections conducted this year i.e. 2014. "

**12.20 The Committee observes that the current system of inspections is flawed and opaque in the sense that there is no provision for constructive feedback and the whole procedure is oriented towards penalizing rather than improving. The Committee also observes that though Section 17.3 of the IMC Act, 1956 requires to forward "a copy of any such report to the university or medical institution concerned..." no such report is submitted to the university concerned. This opaqueness means that these inspections give enormous scope for money to exchange hands. It is ironical that the evaluation of quality of teaching and training and the final product, i.e. the doctor, does not figure in inspection reports.**

**12.21 The Committee also observes that MCI regulations do not provide any clear-cut-criteria for recruiting suitable evaluators. The obvious fallout of this is an arbitrary and partisan selection of inspectors. The Committee is amazed to take note of media report titled "The murky word of medical college inspections" that despite hundreds of faculty members from 183 government medical colleges being available, certain 'serial inspectors' were part of almost half the inspections conducted in the year 2014 and of the 261 inspections done during 2014, inspectors from medical colleges in Gujarat were involved in as many as 100 inspections and another 40 involved faculty from Bihar. The Committee observes that this cannot be a mere coincidence but reeks of a serious scam. The Committee, therefore, recommends that in order to unravel the truth, an in-depth probe may be conducted into the arbitrary appointment of inspectors in the year 2014 and an action taken note furnished to the Committee within three months from the presentation of this report.**

**12.22 The Committee has recommended the establishment of a robust and autonomous accreditation mechanism separately. Since the existing system of inspections of medical colleges has not been able to promote quality and resulted, instead, in slashing of thousands of medical seats on flimsy grounds, the Committee recommends, even at the cost of repetition, that the current system of annual inspection be scraped and an autonomous accreditation body on the lines of the National Accreditation and Assessment Council**

**which is an autonomous body established by the University Grants Commission and is mandated to assess and accredit institutions of higher education, be established in the domain of medical education to deal with issues of quality.**



## **CHAPTER-XIII**

### **Concluding Comments**

**13.1 The Committee observes that the Medical Council of India as the regulator of medical education in the country has repeatedly failed on all its mandates over the decades. The Committee in the earlier part of this Report has dealt with these failures in some detail. In this section, the Committee before suggesting remedy to the problem, would like to briefly touch upon the following prominent failures of MCI in order to put things into proper perspective:-**

- (i) failure to create a curriculum that produces doctors suited to working in Indian context especially in the rural health services and poor urban areas; this has created a disconnect between medical education system and health system.**
- (ii) failure to maintain uniform standards of medical education, both undergraduate and post-graduate;**
- (iii) devaluation of merit in admission, particularly in private medical institutions due to prevalence of capitation fees, which make medical education available only to the rich and not necessarily to the most deserving;**
- (iv) failure to produce a competent basic doctor;**
- (v) non-involvement of the MCI in any standardized summative evaluation of the medical graduates and post-graduates;**
- (vi) failure to put in place a robust quality assurance mechanism when a fresh graduate enters the system and starts practicing;**
- (vii) very little oversight of PG medical education leading to huge variations in standards;**
- (viii) heavy focus on nitty-gritty of infrastructure and human staff during inspections but no substantial evaluation of quality of teaching, training and imparting of skills;**
- (ix) Abysmal doctor-population ratio;**
- (x) failure to create a transparent system of medical college inspections and grant of recognition or de-recognition;**
- (xi) failure to guide setting up of medical colleges in the country as per need, resulting in geographical mal-distribution of medical colleges with clustering in some states and absence in several other states and the disparity in healthcare services across states;**
- (xii) acute shortage of medical teachers;**

- (xiii) failure to oversee and guide the Continuing Medical Education in the country, leaving this important task in the hands of the commercial private industry;
- (xiv) failure to instill respect for a professional code of ethics in the medical professionals and take disciplinary action against doctors found violating the code of Ethics, etc.

**13.2** The Committee simultaneously observes that the onus of failure of medical education system cannot be laid exclusively on the Medical Council of India. The successive Governments have also their share in it. The fact that there is imbalance in the distribution of medical colleges across States is not so much MCI's fault; it is the fault of the successive Governments that they have not pushed the MCI in that direction. There is also failure on the part of State Governments.

**13.3** The need for radical reforms in the regulatory framework of the medical profession has been on the agenda for several years now. The National Commission for Human Resources for Health Bill, 2011 which was introduced in the Rajya Sabha on the 22<sup>nd</sup> December, 2011 was reported upon by this Committee and the 60<sup>th</sup> Report thereon presented to Parliament on the 23<sup>rd</sup> November, 2012. In its 60<sup>th</sup> Report, the Committee had recommended to the Ministry of Health and Family Welfare to re-examine the concerns expressed by it and bring forward a fresh Bill. Rather than seizing the opportunity to come up with a better Bill, the Ministry remained apathetic to the state of affairs and did not respond with vigorous corrective measures.

**13.4** Due to massive failures of the MCI and lack of initiatives on the part of the Government in unleashing reforms, there is total system failure due to which the medical education system is fast sliding downwards and quality has been hugely side-lined in the context of increasing commercialization of medical education and practice. The situation has gone far beyond the point where incremental tweaking of the existing system or piecemeal approach can give the contemplated dividends. That is why the Committee is convinced that the MCI cannot be remedied according to the existing provisions of the Indian Medical Council Act, 1956 which is certainly outdated. If we try to amend or modify the existing Act, ten years down the line we will still be grappling with the same problems that we are facing today. Nowhere in the world is there an educational process oversight, especially, of medical education done by an elected body of the kind that MCI is. Managing everything of more than 400 medical colleges is too humongous a task to be done by the MCI alone because the challenges facing medical education of the 21<sup>st</sup> century are truly gigantic and cannot be addressed with

**an ossified and opaque body like MCI. Transformation will happen only if we change the innards of the system.**

**13.5 Game changer reforms of transformational nature are therefore the need of the hour and they need to be carried out urgently and immediately. Because, if revamping of the regulatory structure is delayed any further on any grounds including political expediency, it will be too late as too much momentum will have been built to offset attempts at reversing the direction later, with the result that our medical education system will fall into a bottomless pit and the country will have to suffer great social, political and financial costs.**

**13.6 Keeping all these facts in mind, the Committee is convinced that the much needed reforms will have to be led by the Central Government. The MCI can no longer be entrusted with that responsibility in view of its massive failures. The people of India will not be well-served by letting the modus operandi of MCI continue unaltered to the detriment of medical education and decay of health system. The Government must therefore fulfill its commitment to preserve, protect and promote the health of all Indians by leading the way for a radical reform which cleanses the present ills and elevates medical education to contemporary global pedagogy and practices while retaining focus on national relevance.**

**13.7 The expert committee led by (late) Prof. Ranjit Roy Chaudhury constituted by the Government in July, 2014 to suggest reforms in the regulatory framework of medical profession has submitted its report in February, 2015, a copy of which has been supplied to this Parliamentary Committee. The expert committee has recommended major changes in the ethos of the regulatory body and major structural reconfiguration of its functions. The expert committee has suggested the formation of a National Medical Commission (NMC) through a new Act. The NMC will have four verticals (i) UG Board of Medical Education and Training, (ii) PG Board of Medical Education and Training (iii) National Assessment and Accreditation Board and (iv) National Board for Medical Registration. Besides these vertical heads, the expert committee has also recommended the formation of a National Advisory Council which will consist of members from the State Governments, Union Territories, State Medical Councils, Medical Universities and members of NMC. The Committee has been informed that the creation of National Medical Commission and the structure (at Appendix) envisaged has been endorsed by a group of eminent medical educationists, experts and public health persons.**

**13.8 The Committee has done a rigorous analysis of the suggested new regulatory structure and found that several of its concerns have been addressed in the suggested new model of regulation of medical education and practice. The Committee is therefore in general agreement with the suggested regulatory structure, and recommends to the government to examine the structure proposed by the Ranjit Roy Chaudhury Committee subject to the recommendations made by this Committee in this report.**

### **Summing up**

**13.9 To sum up, the Committee observes, even at the risk of sounding repetitive, that the need for major institutional changes in the regulatory oversight of the medical profession in the country is so urgent that it cannot be deferred any longer. The Committee is, however, aware that any attempt at overhauling the regulatory framework will face huge challenges from the deeply entrenched vested interests who will try to stall and derail the entire exercise. But if the medical education system has to be saved from total collapse, the Government can no longer look the other way and has to exercise its constitutional authority and take decisive and exemplary action to restructure and revamp India's regulatory system of medical education and practice. The Committee, therefore, exhorts the Ministry of Health and Family Welfare to implement the recommendations made by it in this report immediately and bring a new Comprehensive Bill in Parliament for this purpose at the earliest.**

## **OBSERVATIONS / RECOMMENDATIONS - AT A GLANCE**

### **Health Systems and Challenges in the Delivery of Health Services**

**The Committee observes that though there have been substantial improvements in certain health outcomes, especially in life expectancy, maternal and infant mortality, these achievements should not mask India's failures in achieving the desired level of health care delivery. As per the Report of the Working Group on Tertiary Care Institutions for the 12<sup>th</sup> Five Year Plan, rates of infant and maternal deaths still remain high, nearly one million Indians die every year due to inadequate healthcare facilities, 700 million people have no access to specialist care and 80% of specialists are working in urban areas. Despite India's economy today being one of the world's fastest growing and third largest in terms of Gross National Health Income, our health system continues to face a huge need gap in terms of access to adequate healthcare and availability of health professionals and facilities. India also has the dubious distinction of lagging behind countries like Nepal, Bhutan, Bangladesh, Peru, Maldives, China, Brazil, Thailand, Srilanka and Chile on important health indicators including child mortality and maternal mortality. If 63 million persons are faced with poverty every year due to health care costs alone (as per Draft National Health Policy, 2015), it clearly indicates that health care is moving away from the reach of the people in general and the poor in particular. This also indicates that India has not been able to leverage its economic growth to achieve the desired health outcomes. The fact that there is an acute shortage of doctors in the country and the effective delivery of health care services cannot be guaranteed without the availability of doctors in adequate numbers, testifies to the point that the system of medical education, as regulated by the Medical Council of India, has not been able to address the many unmet health care needs of our health system and needs reforms urgently. (Para 2.10)**

**The Committee agrees that there is an acute shortage of medical doctors in the country besides their geographical mal-distribution. The Committee takes note of the submission of Ministry of Health and Family Welfare that the total number of doctors registered on the Indian Medical Register is 9.29 lakhs out of which 7.40 lakhs are available for active practice and that the doctor - population ratio in India is 1:1674 as against the WHO norm of 1:1000. However, given the fact that the Indian Medical Register is not a live database and contains names of doctors who may have passed away or retired from active practice, by now, as well as those with a permanent address outside India and that there is no mechanism in place for filtering out such cases, the Committee is highly sceptical of the Ministry's claim of having one doctor per 1674 population. In view of the above, the Committee**

feels that the total universe of doctors in India is much smaller than the official figure and we may have one doctor per 2000 population, if not more. The Committee observes that the imbalances in availability of affordable and quality health care cannot be corrected without augmenting the capacity of production of medical doctors including specialists and super-specialists in adequate numbers and of requisite quality and competence. Apart from the unfinished agenda of communicable diseases, India is witnessing the rapidly rising burdens of non-communicable diseases (Cardiovascular diseases, Cancer, Diabetes, Chronic respiratory disorders, Mental illness, Liver and Kidney diseases), which call for the availability of many more category of doctors and specialist doctors. The Committee is constrained to observe that the MCI has been unresponsive to health system needs with the result that shortage in number of basic doctors and specialists, maldistribution of medical colleges and doctors across the states continue to plague the delivery of effective and equitable health services. At the present rate of production of doctors, the shortfall in basic and specialist doctors will not be met for many years. The Committee, therefore, recommends that urgent measures may be taken to spell out policy stance in great detail and with clarity to augment the capacity of production of doctors including specialists and super-specialists at the scale and speed required to meet India's health needs. (Para 2.21)

The Committee is concerned to note that the medical colleges in the country are distributed in a skewed manner, with nearly sixty five percent medical colleges concentrated in the Southern and Western States of the country which has resulted in great variation in doctor-population ratio across the states. The States of North, North-East and Central India have a severe shortage of doctors because of very few medical colleges they have. The Committee also notes with concern that six states with 31% of India's population account for 58% of the MBBS seats, while eight states which comprise 46% of India's population have 21% of the MBBS seats. The Committee is of the opinion that the mere increase in medical seats to enable correction of this doctor-population imbalance will not automatically address this skew because experience shows that doctors normally settle in the cities they go to for their medical education and do not return to serve in their own urban or rural areas. Also, even if compulsory rural service is introduced throughout India, graduates of each state would be required to serve only in their state, as per present state health regulations, and the states with very few medical colleges would continue to be disadvantaged. The Committee would, therefore, recommend that an institutional mechanism be put in place to ensure better distribution of medical colleges across the country. State level doctor-population ratio should guide the setting up of

**new medical colleges and also the increase in UG and PG seats. (Para 2.22)**

**The Committee also observes that the present approach in the matter of healthcare manpower planning is a top-down one. Since health is a State subject and State Governments are major stakeholders in the delivery of healthcare services, medical manpower planning should be bottom-up also. The Committee, accordingly, recommends that each State should plan for an optimal number of doctors, with a target of 1:1000 doctor-population ratio. (Para 2.23)**

### **Constitution and Composition of MCI**

**The Committee has carefully and comprehensively examined the issue of elected versus nominated regulator and done a rigorous analysis to evaluate whether the architecture of regulatory oversight for the medical profession in India should be elected or nominated one. (Para 3.10)**

**The Committee observes that the main objective of the regulator of medical education and practice in India is to regulate quality of medical education, tailor medical education to the healthcare needs of the country, ensure adherence to quality standards by medical colleges, produce competent doctors possessing requisite skills and values as required by our health system and regulate medical practice in accordance with the professional code of ethics. The Medical Council of India, when tested on the above touchstone, has repeatedly been found short of fulfilling its mandated responsibilities. Quality of medical education is at its lowest ebb; the current model of medical education is not producing the right type of health professionals that meet the basic health needs of the country because medical education and curricula are not integrated with the needs of our health system; many of the products coming out of medical colleges are ill-prepared to serve in poor resource settings like Primary Health Centre and even at the district level; medical graduates lack competence in performing basic health care tasks like conducting normal deliveries; instances of unethical practice continue to grow due to which respect for the profession has dwindled. But the MCI has not been able to spearhead any serious reforms in medical education to address these gaps. (Para 3.11)**

**Medicine deals with human life. Regulators are therefore, required to have the professional excellence and moral authority to address complex issues related to content, standards, quality, competencies and skills of medical education and practice. But the MCI, as presently elected, neither represents professional excellence nor its ethos. The current composition of the Council reflects that more than half of the members are either from**

corporate hospitals or in private practice. The Committee is surprised to note that even doctors nominated under Sections 3(1) (a) and 3(1) (e) to represent the State Governments and the Central Government have been nominated from corporate private hospitals which are not only highly commercialised and provide care at exorbitant cost but have also been found to be violating value frameworks. They indulge in unethical practices such as carrying out unnecessary diagnostic tests and surgical procedures in order to extract money from hapless patients and meet revenue targets (as documented by the BMJ, one of the top international medical journals in an article titled “The unethical revenue targets that India’s corporate hospitals set their doctors” dated 3<sup>rd</sup> September, 2015) and flouting government rules and regulations, especially about treating patients from underprivileged backgrounds. (Para 3.12)

The Committee also observes that the number of private medical colleges is growing and therefore their representation in the MCI is certain to increase while the Government representation will decrease in that proportion. In such a scenario, the needs of the country and the health system have taken a backseat while the interests of practicing doctors have become primary. Thus, the current composition of the MCI is biased against larger public health goals and public interest. (Para 3.13)

The paramount consideration for the regulation of medical education should be to ensure that it safeguards the quality of medical education, well serves the needs of India’s health system and enables the health needs of the people to be met. This is far more important than protecting the elected character of the regulatory framework. Electoral processes, by their very nature, bring about a lot of compromises and tend to attract professionals who may not be best-fitted for the heavy academic responsibilities of a regulatory body. It is, therefore, highly unlikely that professionals of the highest standards of eminence and integrity would be thrown up through electoral processes. The Committee feels that perhaps this is one of the reasons why election from within the profession has been discontinued around the globe. (Para 3.14)

The Committee is, therefore, of the opinion that the governance of medical education in India must be accountable to the people of India. Ultimately, popularly elected governments are answerable to the people for the performance of the health system, not the MCI. Also, a regulatory body nominated by the government need not always be suspect in quality or subservient in conduct. Following the dissolution of a corruption-ridden MCI, the new Board of Governors of MCI appointed by the Government in 2010, included professionals of the highest standards of integrity and



excellence who came up with a Vision Document 2015 wherein the Board had recommended a number of reforms of far-reaching impact in the field of medical education and practice. Similarly, the National Board of Examinations whose governing Board is nominated by the Ministry of Health and Family Welfare has acquitted itself creditably and has not been tainted by a scandal in its 33 years of history. The Committee also wonders that if none of the countries like the USA, U.K, Australia or Japan has elected regulatory body for medical education, why India should be the only one to have elected regulators for medical education. (Para 3.15)

After serious reflection borne out of the above analysis and keeping in mind the disastrous experience with an elected regulatory body, the Committee is convinced that if the quality of medical education has to be maintained and medical profession disciplined in the context of mushrooming of private medical colleges and the resultant commercialization of medical education, regulators of the highest standards of professional integrity and excellence will have to be sought by the Government through a rigorous selection process. The Committee, accordingly, recommends that the regulatory framework of medical education and practice should be comprised of professionals of the highest standards of repute and integrity, appointed through a rigorous and independent selection process. This process must be transparent. Nominations could be sought but the reason for the final selection should be made public. The Committee also concurs with the recommendation of the Ranjit Roy Chaudhury Committee Report that:

"In keeping with global standards, and as is the practice in other educational fields in our country (AITCE and UGC) regulatory structure should be run by persons selected through a transparent mechanism rather than by the current process of election and nominations. Of course, keeping in mind the federal nature of the country, adequate provision must be made for the representatives of the States to participate in the regulatory processes." (Para 3.16)

The Committee observes that currently the MCI is an exclusive club of medical doctors as the IMC Act does not call for diversity of backgrounds in the members. The Committee also observes that across the world, a perspective has gained ground that self-regulation alone does not work because medical associations have fiercely protected their turf and any group consisting entirely of members from the same profession is unlikely to promote and protect public interest over and above their own self-interest

and therefore check-and-balance mechanisms are required. Besides, in today's dynamic world, inputs from people with excellence and competence in other disciplines are also needed to add value to the working of an oversight body. It is for these reasons that in most countries such as the UK, Australia, etc. regulators are drawn from diverse groups.

(Para 3.20)

Keeping all these factors in mind and considering the fact that checks and balances in the MCI are not underpinned on sturdy systems and procedures, the Committee is of the considered view that the composition of the MCI is opaque and skewed and diversity needs to be brought into this because having only medical doctors in the Council is not an enabling factor for ensuring reforms in medical education and practice. The Committee is convinced that if the medical regulator has to perform all its mandated functions in full measure and ensure that education in health disciplines fulfils its social mandate, it needs a vibrant framework with the right kind of capacity which can be achieved only by opening Council membership to diverse stakeholders such as public health experts and social scientists, health economists, health NGOs with an established reputation legal experts, quality assurance experts, patient advocacy groups, to name but a few. Such diversity and transparency will have the added advantage of reducing the monopoly of doctors in the MCI, thereby reducing the scope of cronyism and corruption. The Committee, therefore, recommends that urgent measures be taken to restructure the composition of MCI on the lines suggested above.

(Para 3.21)

During the examination of the Indian Medical Council (Amendment) Bill, 2006, and the Indian Medical Council (Amendment) Bill, 2013, the Committee had examined this issue but not favoured it on grounds that such sweeping powers might hamper the MCI in its day-to-day working and would subject the MCI to interference and pressure from the Central Government. (Para 3.23)

The Committee has examined the issue afresh and given serious thought to the desirability of empowering the Central Government to issue directions to the regulatory body on matters of policy. The Committee notes that though all powers of approval/disapproval as per the MCI Act 1956 rest with the Central Government and all permissions are issues in its name, yet the Central Government has no power to disagree with the MCI. After comprehensive consideration, the Committee observes that the Government is the most important stakeholder in shaping health system in all its dimensions and attending to a range of reforms in medical education and practice. To push its policy and vision of health, the Government is,

therefore, entitled to give directives to the MCI but only on policy matters of national importance. The Committee, therefore, recommends that the Government should have the power to give policy directives to the regulatory body. However, what exactly would be policy matters should be clearly and unambiguously defined so that such directives do not impinge on the functioning of MCI or violate its academic autonomy and any possibility of its misuse is obviated. The directive itself should be in the form of a ‘speaking order’ giving background and reasons and that should be made public immediately on issue. (Para 3.24)

The Committee takes note of the fact that currently there is no restriction on the term of a Council member. The Committee feels that due to lack of embargo on the term of the Council members, the vested interests tend to get entrenched. The Committee, therefore, agrees with the recommendation of the Roy Chaudhary Committee that a member of the Council may not have more than two terms in office. Such a provision will also bring a blend of experience and fresh thinking in the functioning of the regulatory body. (Para 3.28)

### **Establishment of Medical Colleges**

The Committee observes that as per MCI norms, establishment of a medical college is based only on physical space, infrastructure and rigid conformation for faculty requirements. The minimum land requirement of 20 acres, the number of class rooms, lecture halls, examination hall as mandated drive up the cost of establishment. Since the land is the most expensive commodity, the initial investment itself is very high, which means that even Governments cannot open medical colleges easily and promoters are more likely to be those with commercial interests rather than those with genuine interest in medical education. (Para 4.32)

The MCI focuses heavily on nitty-gritty of infrastructure and human resources but does no substantial evaluation of quality of teaching, training and imparting of skills. Though at the behest of the Committee, the Minimum Standard Requirements Regulations for the establishment of Medical colleges have been recently modified by MCI, yet they continue to be unrealistic. These requirements will prevent district hospitals and large public sector hospitals (like Railways Hospitals, Army Hospitals, etc.) and large private sector hospitals and multi-specialty hospitals from becoming teaching hospitals for UG medical education. This will greatly limit the scope for the scaling up of medical education, even when expansion of the existing capacity is a greatly felt need. (Para 4.33)

**The Committee also observes that many young students who aspire for medical education but are deprived of this opportunity in the country, go abroad for medical education in Russia, Belarus, Kazakhstan, China and a number of other places. When these students come back after qualifying in their examinations in foreign countries, they are required by MCI to appear for a Multiple Choice Questions (MCQs) formatted, theory based examination conducted by the National Board of Examinations. Those who pass the examination are required to do one year of internship and are then recognized by MCI to be fully qualified doctors, eligible to practice in India on par with a medical graduate who qualifies from an Indian Medical School. The Committee is giving this example to buttress the argument that MSR should not become a fixation by which MCI strangles the scope for scale up of medical education, even as it blithely ignores the irrelevance of those standards for the foreign medical graduates who train in institutions which may markedly deviate from them.**

**(Para 4.34)**

**Taking all the above facts into account, the Committee is of the considered view that the existing Minimum Standard Requirements as mandated by the MCI are irrational and artificially rigid standards which are proving to be big impediment in the establishment and expansion of medical colleges. The Committee is of the considered view that a Rs. 500 crore of rupees investment in a medical college would not be able to educate children from poor families for obvious reasons. The Committee, therefore, recommends that physical infrastructure requirement be pruned down in such a way that it should have just about 30 to 40 percent standing value in the total assessment of a medical college.**

**(Para 4.35)**

**The Committee takes note of the observations and recommendations of the committee of experts set up to study the norms for establishment of medical colleges and make recommendations to review the Minimum Standard Requirements (MSRs). The Committee has gone through the report of the committee of experts and is in general agreement with the recommendations of the committee. The Committee would however, recommend that the Ministry/ regulatory body may implement them in accordance with the plan of action as suggested by the expert committee.**

**(Para 4.36)**

**The Committee lends its full support to the move to convert district hospitals into medical colleges. The Committee is of the view that if a district hospital is converted into a medical college, it will not only be equipped with specialists of all disciplines, providing the healthcare services across the**

**whole spectrum but will also produce some doctors in its area of operation and will thus help reduce geographical mal-distribution of doctors. (Para 4.37)**

### **Undergraduate (UG) Medical Education**

**The Committee is concerned to learn from the experts and other stakeholders that the medical graduates emerging out of the medical colleges in the country, lack confidence and skills in performing basic healthcare tasks and even basic skills like conducting a normal delivery, providing early care for a fracture or suturing a wound are not within the competency of a graduate doctor. Realising this deficiency, graduate doctors seek post-graduate qualifications in order to acquire clinical expertise. Since, as against the approximately 55000 UG seats, there are only 25,000 PG seats as of now, a large number of graduate doctors do not get into PG and become redundant second class citizens because they are neither competent to practice independently nor do they have the social status. (Para 5.9)**

**The Committee also takes note of the fact that one of the critical gaps in the system is the separation between the medical education system and the health system. The primary reason behind this separation is that our medical graduates work and train in tertiary care settings. Since the vast majority of patients seek healthcare services in small clinics and out-patient departments of small hospitals and a small proportion visits and an even smaller number are admitted to tertiary care institutions, which often deal with exotic and rare diseases, the graduate doctors are not exposed to primary and secondary health care conditions which is crucial to learn about common health problems in the country. Due to this skew in training, the graduate doctors are not equipped to manage common diseases and illnesses in the population. The MCI has failed to address this separation between the medical education system and the health system in the country. The Committee feels that the medical education that is imparted to a graduate doctor is only for basic treatment and if he is not competent enough to do even that, there is basic problem in the system which needs to be addressed. (Para 5.10)**

**The Committee also observes that the most important flaw in the oversight of undergraduate medical education by the MCI is that the “maintenance of quality is assessed only in terms of fulfilling physical/infrastructural requirements and there is simply no overall evaluation of the standard of medical education. Ironically, “maintenance of uniform standard of medical education” is the first objective of the MCI, as stated in the IMC Act, 1956. There is also no effort to assess the method of teaching/**

learning, the evaluation process, the learning outcomes etc. The curriculum is still didactic. The world has moved to competency-based curriculum long back and we are still having workshops to decide whether we should switch-over to it or not. (Para 5.11)

Considering all these facts, the Committee is constrained to observe that the existing system of the graduate medical education in the country has failed us and unless total revamping of the undergraduate education system is undertaken, the present system will not be able to generate the medical manpower required to deliver the ambitious programme of Universal Health Coverage. The Committee, therefore, recommends complete restructuring of the undergraduate education. The emphasis should be shifted to learning outcomes based on a curriculum that will train a holistic doctor with the requisite skills. The training of MBBS doctors should also be in primary care centres and secondary hospitals including district level hospitals. The curriculum should be designed keeping in mind the disease profile of the country and the gaps in the present system. The Committee simultaneously observes that India is a fast developing country and needs health services across a wide spectrum- from the basic diarrhea treatment to the best tertiary care in the world. The country therefore, needs to have doctors who are competent and trained to provide health care services across this whole spectrum. It should therefore be ensured that the graduate doctor produced by the system is a competent basic doctor who also has the background to specialize. The Committee is convinced that unless these fundamental changes are carried out in the undergraduate medical education, India will not be able to meet the health challenges of the 21<sup>st</sup> century. (Para 5.12)

The Committee takes note of the submission that today's graduate doctor after doing his internship is not confident of practicing because his entire period of one year internship goes into studying for the PG entrance exam. The Committee observes that skill training which is very important for a medical professional, is not being acquired in internship. The Committee, therefore, recommends that the PG entrance exam should be held immediately after the final MBBS examination so that the graduate doctor could concentrate on practical skills during his internship. (Para 5.13)

The Committee also observes that the medical education in India is increasingly depersonalized and has failed to instill humane values of care, concern, courtesy and compassion. The Committee feels that young doctors should not only have practical skills but also a lot of soft skills. The Committee, therefore, recommends that soft skills (including ethics) should

be made one of the cornerstones of the syllabus of medical education. (Para 5.14)

The Committee notes that though the MCI has sent its recommendations for a unitary Common Entrance Test for admission to MBBS and PG courses long back, the Government is still grappling with sorting out issues for the implementation of the unitary Common Minimum Test. In the absence of a streamlined and transparent process of admissions, private medical colleges/ universities have developed their own screening and admission procedures which are primarily monetary based. It is public knowledge that the majority of seats in private medical colleges are allotted for a capitation fee going upto Rs. 50 lakh and even more in some colleges despite the fact that the capitation is not legal. This capitation fee is exclusive of the yearly tuition fee and other expenses. The Committee observes that the issue is not just about capitation fee. This has serious implications for our whole system of medical education and healthcare. One clear implication of this skewed process of admissions by way of sale of seats is that there may be a large number of students entering the system, who may not be upto the required standards. On the other hand, this system is keeping out the most meritorious but underprivileged students who can neither pay for seats, nor the high annual fee in private medical colleges. If a unitary Common Entrance Exam is introduced, the capitation fee will be tackled in a huge way; there will be transparency in the system; students will not be burdened with multiple tests; and quality will get a big push. The Committee, therefore, recommends that the Government should move swiftly towards removing all the possible roadblocks to the Common Medical Entrance Test (CMET) including legal issues and immediately introduce the same to ensure that merit and not the ability to pay becomes the criterion for admission to medical colleges. The Committee also recommends that introduction of CMET should be done across the nation barring those States who wish to remain outside the ambit of the CMET. However, if any such States wish to join the CMET later, there should be a provision to join it. (Para 5.26)

The Committee takes note of the fact that the MCI's assessment of medical colleges is limited to ensuring rigid conformation to infrastructural and faculty norms and an inspection of the five year examination of new medical colleges. The MCI is not involved in any standardized summative evaluation of the final product- the medical graduate-coming out of new or old medical colleges. The final evaluation, and therefore, the final quality of every medical student, is left entirely to the medical colleges/ universities to assess. The Committee is, therefore, of the considered view that an entrance test alone will not do justice to the entire process and there is an urgent need to introduce a common exit test for MBBS doctors, which will go a long way

**in standardizing the passing out medical graduates and certify the competencies which are expected to be generated out of him. The Committee accordingly, recommends that urgent action be initiated to introduce a common exit test for MBBS doctors as an instrument of quality assurance and to ensure that the qualities and competencies of a doctor before he starts practicing are guaranteed and standardized in terms of various quality norms. (Para 5.34)**

**The Committee observes that though the constitutionally designated fee regulation committee of the respective State Government fixes the fee to be charged by private medical colleges, yet the yearly tuition fee and other expenses that have to be paid thorough a year duration work out in the range of Rs. 12-13 lakh or even more which is certainly exorbitant and beyond the paying capacity of poor but meritorious students and the same, therefore, needs to be rationalized. As of now, the Union Health Ministry does not play any role in fixation of the tuition fee. The Committee is of the opinion that since the Ministry of Health and Family Welfare plays a critical role in supporting the regulation of medical education, it should be enabled to play a role in regulating fee structure in private medical colleges so that the right quantum of tuition fees to be charged by private medical colleges is ensured and there is uniformity in fees across the country amongst the public and private sector medical colleges/institutions. The fee structure should be strictly be enforced and action should be taken against erring managements. (Para 5.36)**

### **Post Graduate (PG) Medical Education**

**The Committee is concerned to note that the approval for PG seats is based on rigid criteria for teachers, teaching beds, patient attendance & infrastructure and there is no mechanism in place to evaluate the PG trainees for their skill and competence prior to their certification as a designated specialist. The present MCI system of oversight of PG medical education does not at any stage evaluate the teaching and learning process or have any benchmarks for quality. Instead of devoting its attention to addressing the issue of quality and competence which has a direct bearing on the safety of patients seeking treatment, the MCI is obsessed with enforcing rigid regulations that stifle improvement and innovation. The Committee takes note of the information made available to it that in the USA there are different specialty Boards to monitor and certify training, while the MCI has a single nine-member Post Graduate Medical Education Committee to prescribe standards of Post Graduate Medical education. The Committee finds it inconceivable that a single nine-member Post Graduate Committee has the breadth of expertise to provide guidelines, let alone set standards, to**



span multiple specialty disciplines. The Committee is, therefore, convinced that an overhaul of the whole system is required, and accordingly, recommends that the PG medical education system should be restructured in such a way that training is assessed by the quality of the product and not by the infrastructure and a robust system be put in place for evaluation of skills and competencies. The Committee also observes that there is a need to separate regulation of graduate and post-graduate medical education as these two phases of medical education need different kind of expertise. The Committee, therefore, concurs with the suggestion that there should be separate UG and PG Boards for the regulation of UG and PG medical education. (Para 6.8)

The Committee also recommends that post-graduate education should be governed by a body like NBE, integrating the two systems of PG medical education that currently exist and function through a well-coordinated array of specialty sub-boards which define desired competencies and set standards for each major discipline. (Para 6.9)

#### **Capitation fee in PG Education & need for Common Entry and Exit Tests**

The Committee has already commented on the need for a Common Entrance and Exit Test for UG medical education in the previous Chapter. The Committee is of the view that the grounds which mandate introduction of common Entrance and Exit examinations for UG medical education are also valid for PG education. Post Graduate seats are in great demand. The Committee has been given to understand that in the absence of a transparent and streamlined process of admission, PG seats are sold from Rs. 1 crore to Rs. 1.50 crore per seat. The Committee has already dwelt on the issue of capitation fee and its ill-effect. The Committee would, therefore, refrain from repeating those details. Keeping all these factors in mind, the Committee recommends that the Government in consultation with the MCI should swiftly move towards introducing a common entry test for admission to post-graduate and super-specialties also. The Committee also recommends the introduction of a common exit test for the passing out Post-Graduates to certify and standardize their competencies. (Para 6.12)

The Committee takes note of the submission that India is the only country in the world having two parallel systems of Post-Graduate Certification. The Committee also takes notice of the information made available to it that despite the Government of India's order making DNB equivalent to the MD/MS for all employment, the inspectors of MCI go and threaten medical colleges of de-recognition if they employ a person with DNB certificate. The Committee observes that there needs to be radical

**transformation of Post Graduate Medical Education if we have to have the kind of specialists we need for the country. The Committee, therefore, recommends that the current system of PG medical education should be restructured taking the best of both systems that is, all India common entrance exam for all seats and common exit evaluation for all candidates as practiced by DNB and the training and evaluation processes of the university based system into one national qualification. There should be only one regulatory body for post graduate medical education and the training should be made more robust. Till then, DNB students be given equitable status of MS/MD only after completing two years of teaching experience in medical colleges. (Para 6.15)**

**The Committee agrees with the suggestion that there is an imperative need to promote PG degree in Family Medicine because Family Medicine combines a broad set of clinical competencies and therefore Family Physicians are more equipped to manage most of medical problems encountered at primary level. The Committee recommends that the Government of India in coordination with State Governments should establish robust PG Programmes in Family Medicine and facilitate introducing Family Medicine discipline in all medical colleges. This will not only minimize the need for frequent referrals to specialist and decrease the load on tertiary care, but also provide continuous health care for the individuals and families. (Para 6.18)**

**The Committee observes that India is a country of 1.24 billion that will reach 1.7 billion by the middle of the century. Therefore, only 24000+ PG seats are unquestionably much less than national needs. It is, therefore, critical for the country to augment the production of specialists both as a development imperative and a pathway for ensuring quality universal health care to the masses. Within the existing framework, it will not be possible to expand rapidly beyond the present strength. The Committee, therefore, recommends that the existing norms governing the allotment of number of PG seats to an Institute on the basis of the bed strength and number of PG teachers be rationalized and all the clinical facilities (both public and private) be utilized to impart training so that the production of PG doctors is scaled up. The Committee has also noted that the recent increase in PG seats has been indiscriminate and in future we may have a lot of Post Graduate doctors who may not be competent in the specialty in which they claim to be specialized. The Committee recommends that the increase in PG seats should not be indiscriminate and great caution should be exercised on maintaining quality of training and certification. The Committee also observes that while the increase in PG seats will produce more specialists and also help to provide required faculty for medical colleges, it may result**

**in fewer graduate doctors opting for primary health care. The Committee, therefore, recommends that the framework of Post Graduate Education be designed in such a way that it remains aligned with principles of universal health care. (Para 6.21)**

**The Committee observes that though research is a mandate of post-graduate training and evaluation in both MCI and NBE PG Programmes, seventy years of having a thesis as part of the PG programme has done nothing to produce nationally relevant data for the management of the diseases prevalent in the country or to establish robust research enterprise within the medical colleges and institutions. The absence of clinical research on common problems prevalent in the country and the resultant lack of local information has created a disconnect between official statistics and the problems on the ground. The Committee, therefore, recommends that the component of research thesis as part the PG programme needs to be holistically restructured in such a way that post-graduate students are guided to conduct research relevant to national health program priorities and generate nationally representative data periodically. (Para 6.23)**

**The Committee also recommends that the Indian Council of Medical Research should guide such studies by linking with student researchers and faculty guides, from select institutions across India. (Para 6.24)**

### **Deficiency of Teaching Faculty**

**The Committee takes note of the fact that there is acute shortage of teaching faculty which not only entails adverse impact on the quality of medical education but is also a barrier to the establishment of new medical colleges. The MCI's policies are largely responsible for this state of affairs, because very rigid norms have been provided in the "Regulations on the Teachers Eligibility Qualifications 1998" and only full-time teachers are acceptable to the MCI. It does not recognize qualified specialists in district hospitals, reputed private and public sector hospitals not attached to medical colleges and non-medical public health specialists as capable of teaching in a medical college on a part time basis. The MCI also does not allow for sharing of faculty across government medical colleges in a state, through Information Technology enabled "common classrooms". It also does not permit surgeons to teach anatomy and physicians to teach physiology part time, though their understanding of these basic disciplines is very clinically relevant. (Para 7.15)**

**The Committee is constrained to observe that had the MCI been able to unleash reforms of far-reaching impact to tide over faculty shortages,**

these barriers would have been removed to a large extent. The Committee therefore, recommends that keeping in mind that the country has a huge pool of talented doctors in both public and private sector hospitals, the MCI should look outside this rigid teaching faculty definition and find out-of-the-box solutions to tap the pool of practicing doctors who are interested in teaching as adjunct or part time teaching faculty. Of course, this should be done with some defined parameters and till a certain percentage only. (Para 7.16)

The Committee would also like the Government to have a re-look at the retirement policy of teachers and work out a re-employment policy. The Committee does not see any reason why a retired specialist at the age of 60 cannot be re-employed as a teaching faculty on a full time or part time basis. (Para 7.17)

The Committee takes note of the submission made by the President of MCI that "If the Honorary system is there, all these experienced people can come in. We must utilize whatever workforce, experienced or trained or a degree holder is available" and expects that the words of the MCI President would be matched with the action on the ground. The Committee recommends that early action may be taken in this regard. (Para 7.18)

The Committee observes that the norms and standards as stipulated in the Regulations on the "Teachers Eligibility Qualifications 1998" had been fixed at a time when Information Communication Technology Tools were not so advanced. Despite tremendous advancement in IC Technologies and the advantage of our IT strength, ICT tools, virtual classrooms, and e-learning have not been incorporated in the medical curriculum in tune with the modern times. It is true that there are certain practical skills which have to be learnt bedside in a teaching hospital or a district hospital. But classroom teaching can be shared substantially with IT connectivity. The Committee therefore recommends that immediate action needs to be initiated to allow for sharing of faculty across government medical colleges in a state, through information technology enabled common classrooms. Subsequently, this facility may be extended to private medical colleges also, with check-and-balance mechanisms. The Committee is of the considered view that this measure will not only go a long way in making up for faculty shortages, but also take care of the current practice of engaging of ghost faculty by private medical colleges. (Para 7.19)

The Committee also recommends that the ambit of the Regulation by virtue of which the clinical experience of the specialists in the ESIC hospitals were equated with the teaching experience for the purpose of adopting them

into teaching cadre, should be extended to other Government Hospitals also so that the CMOs and other experienced doctors who have worked in the Government Hospitals for long and have experience of dealing with thousands of patients can come into the teaching faculty. (Para 7.20)

The Committee takes serious note of the fact that the MCI has continued to oppose the induction of specialists who have passed the nationally standardized DNB examinations conducted by the National Board of Examinations and declared that they cannot become teaching faculty in medical colleges, despite the Government of India and even courts declaring the equivalence of post-graduate degree awarded through MCI certified and NBE certified Programmes. Since lack of teaching faculty is the main impediment in expanding and opening more medical colleges, there is an imperative need to utilize all available expertise to augment the required pool of teaching faculty. The Committee in the earlier part of this Report, has recommended the merger of the DNB with MD Programmes. But till then, DNB certificate holders may be utilized in teaching faculty provided they have atleast two years of teaching experience. (Para 7.21)

The Committee takes note that the assessment of the cumulative shortfall of teaching faculty for the undergraduate and post-graduate courses is underway. The Committee recommends that the assessment be expedited so that the database so generated could be utilized for Human Resource planning and forecasting. (Para 7.22)

### **Need for an Accreditation Body for Medical Education**

The Committee observes that robust accreditation processes are the foundation of quality management in most educational systems and therefore there is an imperative need for having an accreditation body for medical colleges. However, the Committee is not amenable to the suggestion that the MCI should be empowered to do the task of accreditation through an amendment to the IMC Act. The Committee observes that the same body giving permission and approvals for medical colleges and also ascertaining quality leads to conflict of interest. The Committee, therefore, recommends that a robust independent accreditation body be established and entrusted with the task of ensuring quality of medical education. The Accreditation Body so created should be oriented towards seeing whether the type of medical education given is appropriate for the country; whether the product that comes out of medical colleges is a product that is needed; whether the teaching methods are upto the mark and latest. The Committee also recommends that such an organization should be autonomous. (Para 8.6)

## **Regulation of Professional Conduct of doctors**

**The Committee observes that the oversight of professional conduct is the most important function of the MCI. However, the MCI has been completely passive on the ethics dimension which is evident from the fact that between 1963-2009, just 109 doctors have been blacklisted by the Ethics Committee of the MCI. The Committee does not intend to taint the entire medical community and there is no doubt that there are outstanding doctors and surgeons in all parts of India in all kinds of health settings who have unblemished credentials and who are serving people with compassion, selflessness, integrity and accountability. But it is equally indisputable that due to crass commercialization of the health sector, many unprincipled doctors and private sector hospitals have lost their moral compass and overcharge or subject their hapless patients to unnecessary surgeries and diagnostic procedures. The instance of unethical practice continues to grow due to which respect for the profession has dwindled and distrust replaced the high status the doctor once enjoyed in society. What is of greater concern to the Committee is that the medical profession has not been transparent in dealing with complaints. (Para 9.20)**

**The Committee notes with concern that although the MCI Code of Ethics Regulations, 2002 contains detailed prescriptions of what constitutes duties and responsibilities of the Physician, the Code is idealistic in nature and there is no mechanism in place to oversee its implementation. (Para 9.21)**

**Considering all these factors the Committee recommends that the Code of Medical Ethics needs to be well-defined to take care of the concerns of public safety and malpractices or medical negligence by doctors so that the doctor-patient relationship which has taken a severe beating, can be repaired and retrieved. For that to happen, there needs to be stronger mechanism for ethical oversight of medical practice and the legislation governing the oversight of professional conduct of doctors should be made more specific with provision for transparency and time-lines. There should also be an appeal mechanism in place so that the patient does not feel stonewalled. (Para 9.22)**

**The Committee observes that the whole focus of the MCI has been on the licensing of medical colleges and ethics is completely lost out in this process. It is a matter of surprise that despite the worst kind of gross unethical practices happening by way of ghost faculty, fake patients and hired instruments and substantial amount of money (not white, of course) reportedly changing hands at the time of inspections, there is little proactive action on the part of the MCI to deal with this malady. Against this**

backdrop, the Committee is of the firm view that the two major areas, i.e., medical education and practice of ethical conduct by the medical profession should be bifurcated so that they receive full attention. The Committee is of the considered view that in order to earn back the respect the medical profession has lost, concerted action is needed with proactive steps being taken and implemented. The Committee accordingly recommends that a separate Board of Medical Ethics be set up to take up the task of developing mechanisms for promotion of ethical conduct by medical practitioners. This Board may be constituted on the lines of the GMC of UK and the Australian Medical Council, which have bifurcated these two tasks and put persons of requisite competence in the mechanisms so created for the governance of ethical practice by doctors. Such a Board must plan for continuing renewal of codes of ethics, their dissemination through interactive channels and active promotion of adherence to them. For this, organising workshops, conferences, etc. should be on-going activities. (Para 9.23)

The Committee notes that the Ethics Committee of the MCI presently consists entirely of medical doctors and is thus a self-regulatory body. But all over the world, it has now been realized that the medical profession (or any profession for that matter) tends to protect its own flock. The Committee, therefore, recommends that the new Board of Medical Ethics should also have non-doctor lay members from different fields. (Para 9.24)

The Committee observes that the current accountability mechanisms are not sufficient to ensure observance of ethical practices by the health facilities in India. Though the Clinical Establishment (Registration and Regulation) Act of 2010 is there, it has been adopted by a few States only which means there is no appropriate legislation to regulate private clinical establishments in most of the States currently. It has been seen in practice that individual doctors and the hospitals where they work, pass the onus to the other when anything goes wrong with a patient. The Committee feels that for individual doctors to practice ethically, they require an ethical working environment. The Committee, therefore, recommends that the new Board of Medical Ethics should be mandated to develop standards and norms of professional conduct and codes of ethics for medical practice not only for individual doctors, but also for institutions of health service delivery, i.e., hospitals, clinics, nursing homes, rehabilitation centres, associations, etc. (Para 9.25)

The Committee observes that it is a well-known fact today that there is a lot of inappropriate drug dispensing and unnecessary procedures and commission-linked diagnostics by medical practitioners and health institutions in India mainly due to financial incentives. In this situation,

**formulation of treatment guidelines for various health conditions and disseminating them widely through publicity and media is imperative for protection of patient interests and rights. The Clinical Establishment (Registration and Regulation) Act, 2010 can provide an umbrella legislation in this regard as it has the power to prescribe guidelines for all healthcare facilities. In the absence of a unified legislation, there are a few different legislations that regulate some healthcare services such as the Pre-Conception and Pre-Natal diagnostics Technologies Act, 1994 enacted to stop female foeticide and arrest the declining sex ratio and the Medical Termination of Pregnancy (MPT) Act, 1971 which lays down the conditions under which pregnancies can be terminated. Other health services are not governed by any standards of treatment and pricing guidelines or reporting frameworks. (Para 9.26)**

**The Committee also recommends that the Government should put in place a system of auditing of medical practices. A beginning can be made by reviewing patient records for diagnosis and treatment, use of antibiotics and caesarean sections in the private hospitals. (Para 9.27)**

**The Committee observes that there is some lack of clarity in the functioning of State Medical Councils and the MCI when it comes to taking disciplinary action. Though there is a six month period prescribed within which disciplinary action should be taken by the State Medical Councils which are mandated to implement the adjudications of MCI, many times the State Medical Councils sit on the adjudications beyond six months and no action gets taken allowing the errant doctor to go scot free. The Committee, therefore, recommends that the relationship between the MCI and the State Medical Councils be clarified in unambiguous terms to ensure that the complaints against doctors are attended to in time and action taken without delay. (Para 9.28)**

**The Committee is astonished to note that the MCI has notified on 1<sup>st</sup> February, 2016 an amendment to clause 6.8 of the Regulations, deleting the words “and professional association of doctors” and exempt professional association of doctors from the ambit of MCI Code of Ethics Regulations, 2002. The Committee observes that exempting professional association of doctors from the ambit of Ethics Regulations is nothing short of legitimizing doctors’ associations indulging in unethical and corrupt practices by way of receiving gifts in cash or kind under any pretext from the pharma industry or allied health industry. The Committee agrees with the view point of public health activists that “an action that is ethically impermissible for an individual doctor cannot become permissible if a group of doctors carry out the same action in the name of an association.” The Committee could not**



**uncover any rational reason as to why the MCI has taken such a retrograde decision. It seems that the MCI has become captive to private commercial interests, rather than its integrity in public interest. (Para 9.29)**

**The Committee also finds it intriguing that instead of intervening to thwart attempt of MCI at subverting the system, the Ministry has meekly surrendered to MCI. The Committee recommends that the Ministry should take immediate action in the matter to ensure that the illegality committed in terms of violation of ethical standards of 2002 Regulations, either by an individual doctor or a group of doctors in the form of an association is not kept out of the jurisdiction of MCI and the words “and professional association of doctors” are restored to clause 6.8 of the MCI Code of Ethics Regulations 2002 so that no immunity, whatsoever, is accorded to any association or society of doctors. If there are any other legal infirmities in the framework of the 2002 Regulations, they should be removed. (Para 9.30)**

**The Committee taking note of the submissions of the President, MCI that the existing Ethics Committee has closed the case against the whistleblower doctor from Kerala and his wife recommends that completion of all formalities concerning the closing of the case be expedited by the MCI. The Committee desires to be informed of the final outcome/fulfillment of the assurance made by the President MCI, to the Committee in this regard, within one month from the presentation of this Report. (Para 9.31)**

#### **Maintenance of Indian Medical Register (IMR)**

**The Committee observes that the current Indian Medical Register (IMR) does not depict the real picture since the same includes names of all medical practitioners who have ever registered themselves in the IMR, be they dead or alive, in India or abroad. This register cannot be of much help to planners and policymakers for HR planning and forecasting. The Committee is, therefore, of the view that the Indian Medical Register needs a live database so that a realistic assessment of the number of doctors actually practicing in the country and how they are distributed across the public and private sectors and across rural and urban areas, could be made. (Para 10.10)**

**The Committee takes note of the submission that the Council is in the process of implementing the system of e-Governance and integral part of which would be live IMR/ updation of IMR, conversion of existing registration numbers to Unique Permanent Registration Number (UPRN), etc. by involving State Medical Councils also so as to invoke an online update in due course of time. The Committee therefore recommends that the IMR**

be made online and a live database be created in such a manner that there is automatic update between States and the Centre. If the name of a doctor is removed at one place, it should reflect in other site also. The Committee also recommends that the Ministry should direct the Council to complete the process within a stipulated time. (Para 10.11)

The Committee agrees with the need for mandatory recertification and Continuing Medical Education and a structured programme of periodical update of the knowledge of doctors as quality assurance mechanisms and observes that the MCI (or any other body) in consultation with the Ministry of Health and Family Welfare should take the responsibility in this regard. The Committee observes that in the absence of a structured mechanism for recertification and Continuing Medical Education, pharma companies are filling the gap due to which doctors are dependent on them for the update of their knowledge. This influences them in their professional practice. The Committee, therefore, recommends that the renewal of registration and Continuing Medical Education be made mandatory so that the health system's requirements get strengthened and doctors practice more appropriate and rational technology instead of picking up the technologies pushed by the interested agencies. (Para 10.17)

#### **Need for Attractive Remuneration for Doctors and Medical Faculty**

The Committee notes with serious concern that medicine is no longer a priority for the brightest among the youth and the disinterest of our brightest to opt for teaching jobs in public sector health institutions is increasing due to various factors, one of which is certainly inadequate remuneration packages. The Committee observes that the whole medical education system will collapse if there are not good teachers for our medical colleges. Let us also not forget that today's medical student is tomorrow's physician and no society can afford to leave healthcare in the hands of mediocre doctors. All these facts warrant that measures to attract good talent towards medical profession and retain them, by way of offering attractive remuneration packages are required to be immediately initiated. The Committee fully endorses the view that medical profession demands much higher commitment, knowledge, skills, competence and accountability and doctors have to work under very trying conditions. It is, therefore, imperative that the pay structure of doctors and faculty should be so designed as to provide compensation to medical fraternity commensurate to their years of training and research. (Para 11.5)

## **Corruption in the MCI**

**The Committee is shocked to find that compromised individuals have been able to make it to the MCI, but the Ministry is not empowered to remove or sanction a Member of the Council even if he has been proved corrupt. In a day and age when the need for sturdy systems and enhanced transparency based regimes are being increasingly emphasized, such state of affairs indicate that the MCI has not evolved with the times. Such state of affairs are also symptomatic of the rot within and point to a deep systemic malice. Otherwise how could it happen that the MCI, which has laid down elaborate duties and responsibilities of the “Physician” under the MCI Code of Ethics Regulations, 2002, could have at its very top a person who was arrested on charges of corruption in 2010. The former Union Health Minister, who must have an insider’s view of the functioning of the MCI, making scathing comments about corruption in the MCI, speaks volumes of the decay in the MCI and is an eye-opener on the need for urgent reforms in the structure and functioning of MCI. (Para 12.11)**

**The Committee is all for professional autonomy, but autonomy sans accountability tends to degenerate into autocracy and therefore cannot be acceptable. The MCI is funded by the Government and therefore the Government must have the leverage to enforce accountability in the MCI. Since the real cause of the problem is systemic and cannot be fixed without setting the system right, the Committee recommends that the Ministry should take expeditious action to amend the statute or enact a new legislation in a manner that it comprises within its ambit accountability provisions as well and empowers the Government with legal authority to intervene in matters of corruption. In the same vein, the Committee would like to emphasize that bonafide conduct/ decisions of the Council members should be duly protected. (Para 12.12)**

**The Committee takes note of the admission of the President of MCI that corruption is there when there is sanctioning of medical colleges or increasing or decreasing of medical seats. However, the Committee finds the inaction of the MCI enigmatic in this matter. If the MCI is aware of the fact that denial of recognition of a medical college or grant of seats and then its permission /enhancement or reduction leads to corruption, then the Committee wonders why it has failed to put in place a framework or system which can plug these loopholes. The Committee is of the view that there is too much power concentrated in a single body (i.e. the MCI), and it has failed to create a transparent system of licensing of medical colleges. The MCI currently sets standards for recognition; inspects and licenses medical colleges; oversees Registration and Ethical Conduct of Doctors. It now**

**proposes to undertake accreditation as well. Such concentration of powers creates a serious conflict of interest and provides a fertile ground for misuse of authority. The Committee, therefore, favours bifurcation of the functions of MCI and recommends that different structures be created for discharging different functions. (Para 12.13)**

**The Committee also takes note of the allegations reported in the media report that the former vigilance officer of MCI was harassed and had to quit for lack of cooperation from the President and several officials of the MCI in his efforts to deal with corruption. The facts brought to the notice of the Committee force the Committee to seek a thorough probe into the whole gamut of issues due to which the said Vigilance Officer had to resign. (Para 12.14)**

**The Committee wonders to find that certain persons were appointed as Advisors to the President in transgression of law and the Joint Secretary in the Ministry of Health and Family Welfare vide his letter dated the 4<sup>th</sup> March, 2014 had to write to the President to cancel "all such appointments which were not authorized by the Act." The Committee takes serious note of such flouting of law and would like the matter to be thoroughly probed and an action taken report furnished to the Committee within three months from the presentation of this Report. (Para 12.15)**

**The Committee observes that the current system of inspections is flawed and opaque in the sense that there is no provision for constructive feedback and the whole procedure is oriented towards penalizing rather than improving. The Committee also observes that though Section 17.3 of the IMC Act, 1956 requires to forward "a copy of any such report to the university or medical institution concerned..." no such report is submitted to the university concerned. This opaqueness means that these inspections give enormous scope for money to exchange hands. It is ironical that the evaluation of quality of teaching and training and the final product, i.e. the doctor, does not figure in inspection reports. (Para 12.20)**

**The Committee also observes that MCI regulations do not provide any clear-cut-criteria for recruiting suitable evaluators. The obvious fallout of this is an arbitrary and partisan selection of inspectors. The Committee is amazed to take note of media report titled "The murky word of medical college inspections" that despite hundreds of faculty members from 183 government medical colleges being available, certain 'serial inspectors' were part of almost half the inspections conducted in the year 2014 and of the 261 inspections done during 2014, inspectors from medical colleges in Gujarat were involved in as many as 100 inspections and another 40 involved faculty**

from Bihar. The Committee observes that this cannot be a mere coincidence but reeks of a serious scam. The Committee, therefore, recommends that in order to unravel the truth, an in-depth probe may be conducted into the arbitrary appointment of inspectors in the year 2014 and an action taken note furnished to the Committee within three months from the presentation of this report. (Para 12.21)

The Committee has recommended the establishment of a robust and autonomous accreditation mechanism separately. Since the existing system of inspections of medical colleges has not been able to promote quality and resulted, instead, in slashing of thousands of medical seats on flimsy grounds, the Committee recommends, even at the cost of repetition, that the current system of annual inspection be scrapped and an autonomous accreditation body on the lines of the National Accreditation and Assessment Council which is an autonomous body established by the University Grants Commission and is mandated to assess and accredit institutions of higher education, be established in the domain of medical education to deal with issues of quality. (Para 12.22)

### **Concluding Comments**

The Committee observes that the Medical Council of India as the regulator of medical education in the country has repeatedly failed on all its mandates over the decades. The Committee in the earlier part of this Report has dealt with these failures in some detail. In this section, the Committee before suggesting remedy to the problem, would like to briefly touch upon the following prominent failures of MCI in order to put things into proper perspective:-

- (i) failure to create a curriculum that produces doctors suited to working in Indian context especially in the rural health services and poor urban areas; this has created a disconnect between medical education system and health system.
- (ii) failure to maintain uniform standards of medical education, both undergraduate and post-graduate;
- (iii) devaluation of merit in admission, particularly in private medical institutions due to prevalence of capitation fees, which make medical education available only to the rich and not necessarily to the most deserving;
- (iv) failure to produce a competent basic doctor;
- (v) non-involvement of the MCI in any standardized summative evaluation of the medical graduates and post-graduates;

- (vi) failure to put in place a robust quality assurance mechanism when a fresh graduate enters the system and starts practicing;
- (vii) very little oversight of PG medical education leading to huge variations in standards;
- (viii) heavy focus on nitty-gritty of infrastructure and human staff during inspections but no substantial evaluation of quality of teaching, training and imparting of skills;
- (ix) Abysmal doctor-population ratio;
- (x) failure to create a transparent system of medical college inspections and grant of recognition or de-recognition;
- (xi) failure to guide setting up of medical colleges in the country as per need, resulting in geographical mal-distribution of medical colleges with clustering in some states and absence in several other states and the disparity in healthcare services across states;
- (xii) acute shortage of medical teachers;
- (xiii) failure to oversee and guide the Continuing Medical Education in the country, leaving this important task in the hands of the commercial private industry;
- (xiv) failure to instill respect for a professional code of ethics in the medical professionals and take disciplinary action against doctors found violating the code of Ethics, etc. (Para 13.1)

The Committee simultaneously observes that the onus of failure of medical education system cannot be laid exclusively on the Medical Council of India. The successive Governments have also their share in it. The fact that there is imbalance in the distribution of medical colleges across States is not so much MCI's fault; it is the fault of the successive Governments that they have not pushed the MCI in that direction. There is also failure on the part of State Governments. (Para 13.2)

The need for radical reforms in the regulatory framework of the medical profession has been on the agenda for several years now. The National Commission for Human Resources for Health Bill, 2011 which was introduced in the Rajya Sabha on the 22<sup>nd</sup> December, 2011 was reported upon by this Committee and the 60<sup>th</sup> Report thereon presented to Parliament on the 23<sup>rd</sup> November, 2012. In its 60<sup>th</sup> Report, the Committee had recommended to the Ministry of Health and Family Welfare to re-examine the concerns expressed by it and bring forward a fresh Bill. Rather than seizing the opportunity to come up with a better Bill, the Ministry remained apathetic to the state of affairs and did not respond with vigorous corrective measures. (Para 13.3)

**Due to massive failures of the MCI and lack of initiatives on the part of the Government in unleashing reforms, there is total system failure due to which the medical education system is fast sliding downwards and quality has been hugely side-lined in the context of increasing commercialization of medical education and practice. The situation has gone far beyond the point where incremental tweaking of the existing system or piecemeal approach can give the contemplated dividends. That is why the Committee is convinced that the MCI cannot be remedied according to the existing provisions of the Indian Medical Council Act, 1956 which is certainly outdated. If we try to amend or modify the existing Act, ten years down the line we will still be grappling with the same problems that we are facing today. Nowhere in the world is there an educational process oversight, especially, of medical education done by an elected body of the kind that MCI is. Managing everything of more than 400 medical colleges is too humongous a task to be done by the MCI alone because the challenges facing medical education of the 21<sup>st</sup> century are truly gigantic and cannot be addressed with an ossified and opaque body like MCI. Transformation will happen only if we change the innards of the system. (Para 13.4)**

**Game changer reforms of transformational nature are therefore the need of the hour and they need to be carried out urgently and immediately. Because, if revamping of the regulatory structure is delayed any further on any grounds including political expediency, it will be too late as too much momentum will have been built to offset attempts at reversing the direction later, with the result that our medical education system will fall into a bottomless pit and the country will have to suffer great social, political and financial costs. (Para 13.5)**

**Keeping all these facts in mind, the Committee is convinced that the much needed reforms will have to be led by the Central Government. The MCI can no longer be entrusted with that responsibility in view of its massive failures. The people of India will not be well-served by letting the modus operandi of MCI continue unaltered to the detriment of medical education and decay of health system. The Government must therefore fulfill its commitment to preserve, protect and promote the health of all Indians by leading the way for a radical reform which cleanses the present ills and elevates medical education to contemporary global pedagogy and practices while retaining focus on national relevance. (Para 13.6)**

**The expert committee led by (late) Prof. Ranjit Roy Chaudhury constituted by the Government in July, 2014 to suggest reforms in the regulatory framework of medical profession has submitted its report in February, 2015, a copy of which has been supplied to this Parliamentary**

**Committee. The expert committee has recommended major changes in the ethos of the regulatory body and major structural reconfiguration of its functions. The expert committee has suggested the formation of a National Medical Commission (NMC) through a new Act. The NMC will have four verticals (i) UG Board of Medical Education and Training, (ii) PG Board of Medical Education and Training (iii) National Assessment and Accreditation Board and (iv) National Board for Medical Registration. Besides these vertical heads, the expert committee has also recommended the formation of a National Advisory Council which will consist of members from the State Governments, Union Territories, State Medical Councils, Medical Universities and members of NMC. The Committee has been informed that the creation of National Medical Commission and the structure (at Appendix) envisaged has been endorsed by a group of eminent medical educationists, experts and public health persons. (Para 13.7)**

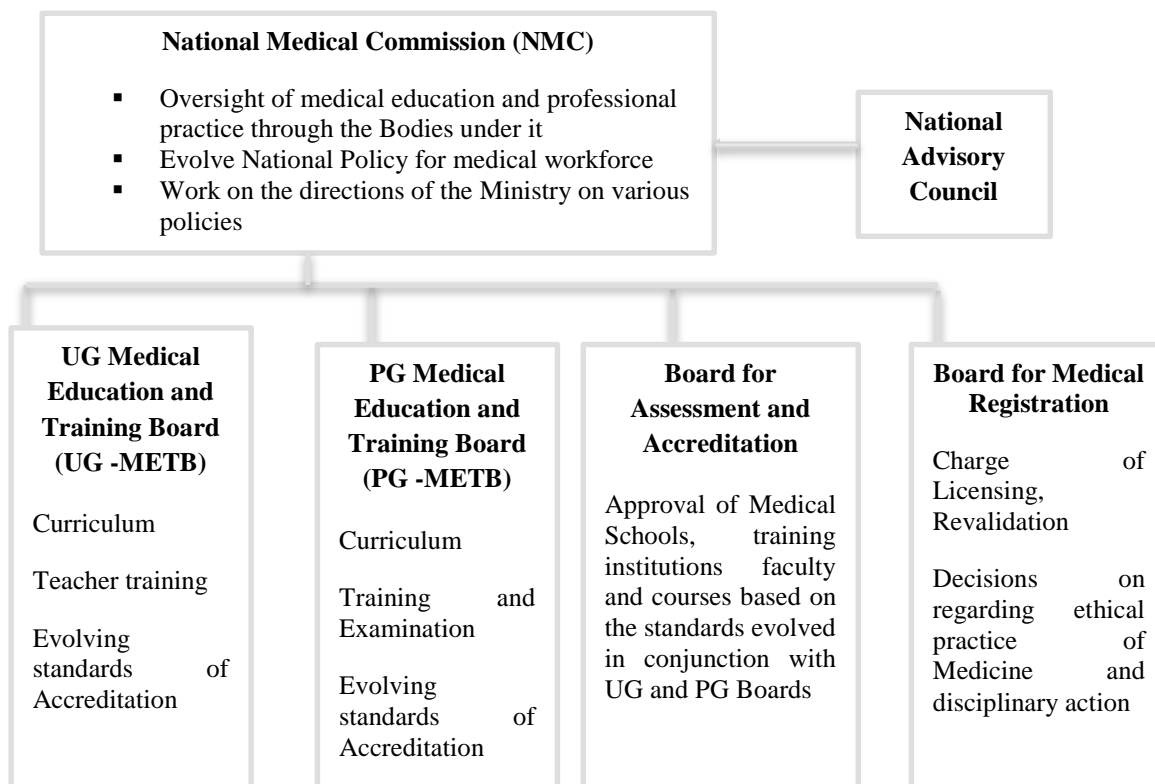
**The Committee has done a rigorous analysis of the suggested new regulatory structure and found that several of its concerns have been addressed in the suggested new model of regulation of medical education and practice. The Committee is therefore in general agreement with the suggested regulatory structure, and recommends to the government to examine the structure proposed by the Ranjit Roy Chaudhury Committee subject to the recommendations made by this Committee in this report. (Para 13.8)**

**To sum up, the Committee observes, even at the risk of sounding repetitive, that the need for major institutional changes in the regulatory oversight of the medical profession in the country is so urgent that it cannot be deferred any longer. The Committee is, however, aware that any attempt at overhauling the regulatory framework will face huge challenges from the deeply entrenched vested interests who will try to stall and derail the entire exercise. But if the medical education system has to be saved from total collapse, the Government can no longer look the other way and has to exercise its constitutional authority and take decisive and exemplary action to restructure and revamp India's regulatory system of medical education and practice. The Committee, therefore, exhorts the Ministry of Health and Family Welfare to implement the recommendations made by it in this report immediately and bring a new comprehensive Bill in Parliament for this purpose at the earliest. (Para 13.9)**



### The new regulatory structure as proposed by the Ranjit Roy Chaudhary Committee

1. The present proposal is to establish a National Medical Commission, with four separate, independent bodies under it, each of which would solely focus on its area of influence, as shown below-



2. **The National Medical Commission (NMC)** will be an umbrella body for supervision and facilitation of medical education and oversight of medical professional practice. Under this umbrella Commission, four independent bodies will be established to fulfill the functions, related to undergraduate and postgraduate medical education, accreditation of teaching courses and Institutions and medical registration. This will serve as the central Body providing oversight over medical professionals and their practice, with the overall objective to protect the interest of the doctor, patient and the general public.

3. The National Medical Commission will have complete autonomy in all academic matters. The NMC will

- a) Assess the changing requirements of the health care scenario and develop roadmap for meeting these requirements (the number of doctors, specialists, type of training etc.)
- b) Provide oversight and supervise the bodies under it

- c) Provide a platform for appeal against the decision of the Registration Board on issues related to registration and malpractice and ethical issues.
- d) Grant approvals for the establishment of medical educational institutions and make final decisions on their accreditation, on the recommendations of the National Board of Assessment and Accreditation.

## **Constitution**

The Commission shall consist of:

- a. Full time Chairperson, who shall be a person of eminence, integrity and administrative capability with at least a post-graduate degree in the discipline of medicine and having not less than twenty-five years experience in the field of medicine;
- b. Three full-time members, who shall be persons of eminence, integrity and administrative capability with at least a post-graduate degree in the discipline of medicine and having not less than twenty years' experience in the field of medicine;
- c. One full-time member, who shall be a person of eminence, integrity and administrative capability, not having a qualification in the discipline of medicine, but having not less than twenty years' experience in any of the fields of public health, health economics, health sciences, higher education and accreditation, public administration, law or social sciences
- d. One ex-officio member who shall be the nominee of the Ministry of Health, not below the rank of Addtl Secretary
- e. A representative of the State Governments or Union Territories elected by the National Advisory Council, from amongst its members

4. The members will be selected by a five member Selection Committee consisting of eminent medical professionals, appointed by the Government. The term of office will be four years, except for the member elected by the National Advisory Council, who will have a term of two years. A member may not have more than two terms in office. The Chairman will function through its Secretariat. The positions to provide assistance in administrative, scientific and legal matters will be created and financial outlay will be provided to maintain the Secretariat. In such a large country, there will also be need to establish regional offices of the Commission to make the oversight efficient and facilitate the interaction with the States. The Commission shall make recommendations to the Government on the process of appointment of nominated members on the various Boards.

## Functions

5. The functions of the Commission will be to take measures to facilitate equitable access to services provided by medical practitioners as well as access to medical education and training in accordance with public need, to develop and maintain appropriate standards of medical education and training, and to protect the public interest by enforcing the highest professional and ethical standards among medical practitioners. The Commission shall:

- a. Carry out studies and collect data required to assess the need for medical practitioners, including specialists in different medical disciplines, across the States and Union Territories;
- b. Assess the requirement, including the number, type and geographical location of educational and training facilities in the field of medicine;
- c. Formulate strategic action plans to effectively maximize the utilization of available resources for the purposes of medical education and training without compromising on its quality;
- d. Formulate strategic action plans to implement such policies and priorities of the Central Government in relation to medical education and training and the medical profession that may be framed from time to time;
- e. Facilitate coordination among the National Boards established under this Act, give binding directions to them, and exercise supervisory functions over them;
- f. Grant and withdraw permission for the establishment of medical educational institutions, for the introduction of new courses of study, or for the increase in admissions capacity of such institutions, on the recommendations of the National Assessment and Accreditations Board;
- g. Confer grades on medical educational institutions on the recommendations of the National Assessment and Accreditations Board;
- h. Approve curricula and standards for the conduct of examinations prescribed by the National Undergraduate Board and National Postgraduate Board;
- i. Ensure that State Councils effectively enforce the highest professional and ethical standards against medical practitioners and enforce such action itself, under appropriate sections of this Act in case of inaction on the part of State Councils;
- j. Direct the National Registration Board and State Councils to remove a medical practitioner from the National Register and applicable State Register respectively;

- k. Regulate, in accordance with the law, for the time being in force, the entry and operation of foreign medical educational institutions in consultation with the National Undergraduate Board, the National Postgraduate Board, the National Assessment and Accreditation Board or such other authority as may be specified by the Central Government;
- l. Initiate programs to establish and promote international collaborations

### **National Advisory Council**

6. An Advisory Council will be constituted under the NMC with the following membership:

- Chairman and members of NMC
- Vice – Chancellor or his Representatives of all Medical Universities
- One nominee from each State that does not have a Medical University, from amongst Universities under which Medical colleges function
- 1 Nominee from amongst all Union Territories that do not have a Medical University
- 1 elected member of each State Medical Council

7. The Chairman of NAC will be elected by the Council from among its members, but will not be the Chairperson and or one of the members of the NMC. The Council will be convened twice a year and will discuss all major policy changes that are being considered. Its role will be advisory and decisions will not be binding on the NMC. Any advice that is not accepted by the NMC will be explained in writing to the advisory Council.

8. The term will be of 5 years and a member may not be nominated for more than two terms.

9. The National Advisory Council through its representation from the State Universities and State Medical Council will provide a platform for the States to put forward their views and concerns before the National Regulator and through the elected representation in the NMC, UG Board, PG Board and Board of Registration allow their participation in the decision making processes of these Bodies

### **10. The Boards Under the National Medical Commission.**

**1. UG Board of Medical Education and Training (UGBET):** will oversee all activities related to under-graduate medical education. It will

- Develop competency based curriculum (including assessment) in consultation with all stake holders, such that the medical graduate has

appropriate knowledge, skills and attitudes for providing health care as per societal needs

- Develop modalities to encourage humane and ethical practice of medicine and develop a spirit of enquiry
- Develop minimum requirement for implementing the curriculum with flexibility and optimal utilization of available resources so as to reduce the cost of education without compromising the quality of education.
- Advice and collaborate with the Accreditation Council to establish the norms of Accreditation
- Develop faculty to effectively implement curriculum using technology and newer techniques of teaching- learning.
- Provide oversight to the selection process for the UG seats

The **UGBET** shall consist of:

- a. A President, who shall be one of the full-time members of the Commission with medical qualification, to be chosen by the Commission according to such procedure as it may determine;
- b. Three part-time members, who shall be persons having at least a post graduate degree in the discipline of medicine and having not less than twenty years' experience in medical teaching and training at the undergraduate level, including curriculum design and development and the conduct of examinations
- c. One member, elected by the National advisory Council from amongst its members

11. The term of office will be for four years, except for the member elected by the National Advisory Council, who will have a term of two years. No member may have more than have two terms in office.

The UG board will

- a. Determine, coordinate and maintain standard of medical education,
- b. Determine standards of proficiency at qualifying examination (student assessment) for universities and institutions,
- c. Facilitate faculty development/ training,
- d. Facilitate and implement educational research, and international student exchange programs.
- e. Develop the essential and desired requirements for imparting this education.

12. The focus of the Board will be to expand the access to medical education by optimal utilization of the training opportunities. It will evolve guidelines by

which the health facilities outside the medical colleges will be utilized for enhancing the training opportunities. Linkages of public sector hospitals, district hospitals and other hospitals with medical colleges will be encouraged so that all experienced clinicians can participate in training.

13. Establishing whether the standards of UG training are being met and verification of its implementation and granting approval will be carried out by accreditation board. The Accreditation Board will have to approve all ancillary training facilities that are co-opted.

14. The UG Board shall however, suggest ways to bridge the deficiency in faculty, and facilitate and support faculty development programs in order to bridge this major deficiency in the current system. It will also provide guidelines on utilizing maximally available resources (human, hospital, infrastructure and other) for medical education so as to reduce cost of medical education. The board will work in co-ordination with various professional bodies, health care providers and others and will give due attention to these suggestions while formulating competencies, standards of proficiency and other matters relating to medical education.

15. The final exit examination will be conducted by the respective Universities and the Board will work in close collaboration with them to ensure that assessment norms are being followed. The State Medical Universities will be involved in identifying training sites, promoting linkages and taking the steps required to expand UG education within the State. They will also play a leading role in teacher training and providing the support for new organizations to meet the recommended standards.

16. To implement the program the Board will work through various Committees, and these will have representation from various State medical Colleges, practicing medical professionals, voluntary agencies in the health sector and other stake holders who can contribute to meaningful and relevant development of UG medical education. The overall endeavor will be to attain a minimum standard for all graduates in the country, through support and facilitation for underperforming Centers.

### Highlights

- The UG Board will replace the current centrally dictated, one curriculum formula with a more dynamic, evolving educational process.
- There will be no need of “essentiality certificate” from State Government for establishment of new colleges.

- The UG Board will evolve an integrated, dynamic learning environment, that is more skill based and relevant for clinical practice at the primary level.
- The Board will facilitate the change-over from the present structure by providing the hand holding function, especially for faculty development.
- Whereas it will set the standard, it will not be involved in assessing the colleges, the idea being to separate the two functions, namely recommending what needs to be done from whether it is being done.

### **Expected Outcomes**

- A more dynamic and modern, educational environment that will produce doctors with the skills and ethos required for health care delivery across various sectors – primary, secondary, peripheral etc.
- Wider use of training facilities (infrastructure and teachers) and decreasing the emphasis on physical infrastructure, which in turn will decrease the cost of training, bring down the cost to the students.

**2. PG Board of Medical Education and Training (PGBET):** will oversee all matters related to post-graduate medical education. It will

- Develop standards for postgraduate education and training in each specialty/subspecialty
- Develop standards for essential and desirable requirements for the training institutions in terms of infrastructure and faculty/trainers
- Advise and collaborate with the Accreditation Council to establish the norms of Accreditation
- Oversee the process of selection of candidates for postgraduate Education and Training, taking into consideration National and Regional Policy decision for various affirmative actions through a National test to be conducted immediately after the final MBBS examination
- Establish specialty curriculum with modern methods of learning and training processes in consultation with the respective and concerned Professional Associations and Bodies, and will assess the competence for fitness to practice through a common exit examination
- It will be legally empowered to grant degrees

The PGBET will consist of

- a. A President, who shall be one of the full-time members of the Commission with medical qualification, to be chosen by the Commission according to such procedure as it may determine;

- b. Three part-time members, who shall be persons having at least a post graduate degree in the discipline of medicine and having not less than twenty years' experience in medical teaching and training at the postgraduate level, including curriculum design and development and the conduct of examination
- c. One member, elected by the National Advisory Council from amongst its members.
- d. The term of office will be for four years, except for the member elected by the National Advisory Council, who will have a term of two years. No member may have more than have two terms in office.

The PG Board shall

- a. Determine, coordinate and maintain appropriate standards of medical education at the PG level;
- b. Facilitate the efficient maximization of available resources to ensure equitable access to medical education and ensure adequate availability of specialists in different disciplines across the States and Union Territories;
- c. Establish competencies required for qualifications in the specialty, including knowledge, advanced clinical and research skills, the capacity for self-education, professional attributes and ethical values;
- d. Develop training processes that promote ethical practice with the well being of the patient of prime concern
- e. Lay down the curriculum to be imparted by medical educational institutions based on the above competencies and assist medical educational institutions in the design of new courses of study at the postgraduate level.
- f. Promote and encourage research as a component of medical education at the postgraduate level
- g. Lay down standards for the conduct of examinations in medical educational
- h. Lay down the standard of proficiency required from candidates at qualifying examinations
- i. Conduct final qualifying exit examination for all postgraduates in conjunction with Universities.
- j. Frame guidelines for the minimum requirements for the conduct of postgraduate courses in medical education in different specialized disciplines, including physical infrastructure, faculty and clinical workload and on methods of instruction in postgraduate medical education, taking into account the need for mentoring by faculty members and the application of advancements in technology to modern medicine.
- k. Conduct workshops and seminars to promote the training and development of faculty of postgraduate courses in medical education.



- l. Frame guidelines, for the effective maximization of available resources-physical infrastructure, faculty and hospitals through linkages between Institutions in order to enhance the learning experience
- m. Endeavour to widen the scope of PG training without compromising on the quality, with the objective of reducing the cost of PG medical education and removing regional imbalances in the provision of postgraduate medical educational institutions.

17. The PG Board would be in charge of Policy decisions regarding the areas under its mandate. It would facilitate the States and Medical and other Universities, to attain these standards by a variety of means. The State and Medical and other Universities would identify new training facilities (various public and private sector hospitals with capabilities to provide training), and help to develop linkages between various centers. The Board in collaboration with the Universities will work towards filling in gaps in training requirements by developing new paradigms such as rotational training in non-teaching hospitals, up-gradation of institutions to achieve capability for accreditation for PG training both in infrastructure and faculty requirement. However, while the PG Board would provide the inputs for establishing the standards, approval of all facilities for fulfilling these standards would be with Accreditation Body.

### **Highlights**

- The PG Board would in effect, function as the current NBE does.
- It will oversee the entrance and exit examinations for all PG training, thereby ensuring equitable access to training and a uniform standard of training.
- By shifting the entrance examination for PG to the beginning of internship, the emphasis on skill acquisition during the period of internship will be restored.
- It will provide logistic and training support for the change-over from the current system
- Whereas it will set the standards, it will not be involved in assessment of training centers, the idea being to separate the two functions, namely recommending what needs to be done from whether it is being done

### **Expected Outcomes**

- A single specialist certification, in line with rest of the world
- Uniform entrance with transparent admission process
- Rapid expansion in training opportunities and PG seats
- A more facilitative environment that will decrease cost of training

- As the demand supply gap will narrow the premiums placed on admissions will ease off.
- The overall standard would be maintained by the common exit examination

3. **National Assessment and Accreditation Board (NAAB):** The responsibilities of this Board in medical education and training will include:

- Setting national standards, requirements and outcomes for both Undergraduate (UG) and Postgraduate (PG) Medical education, with inputs from the UG and PG Boards which includes accreditation of institutions, undergraduate and postgraduate courses and programs.
- Identifying where these are not being met through quality assurance and ensuring that those responsible take appropriate action
- Driving improvement in standards in medical education and training across the country for uniform standards in curriculum, assessment of competence.

The **NAAB** will consist of

- a. A President, who shall be one of the member of Commission;
- b. Two part-time members, who shall be persons having at least a post graduate degree in the discipline of medicine and having not less than twenty years' experience in medical teaching and training or the accreditation of medical educational institutions, and
- c. Two part-time members, who shall be persons not having a qualification in the discipline of medicine but having not less than twenty years' experience in higher education, including teaching, training or the accreditation of educational institutions

18. The legal framework will secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession. The Board will lay down the by-laws specifying the procedure for accreditation, including the appointment of review or site-visit teams. Furthermore, the legal framework should include rules regarding declaration of conflict of interest and handling of complaints.

19. The accreditation agency will have an accreditation board, and an administrative staff or unit. All main groups of stakeholders will be represented in the accreditation committees, such as academicians, management of educational Institutions, members of the medical profession, including physicians in hospitals, community clinics and general practice, and other stakeholders, such as government authorities in charge of medical education or of the health care system, regulatory bodies, students, related health professions, the public, etc.

The Board will

- a. Develop and publish standards to be applied in carrying out the process of assessment and accreditation, in a transparent process of consultation with all relevant stakeholders and taking into account the guidelines framed by the National Undergraduate Board and the National Postgraduate Board.
- b. Make public the standards or criteria that will be applied to assess whether permission ought to be granted for the establishment of a medical educational institution or for the introduction of a new course of study or for an increase in the admissions capacity of an existing medical educational institution.
- c. Submit a report and make recommendations to the Commission on whether permission for the establishment of a medical educational institution ought to be refused or conditional permission or full permission ought to be granted on the basis of assessment carried out for the purposes. All medical educational institutions will need to have accreditation
- d. Lay down standards for essential and desirable infrastructural requirements, including the extra infrastructure required in existing hospitals and healthcare facilities. These will be used as the basis for the accrediting process – for the self-evaluation, external evaluation, recommendations and final decision on accreditation. The effort will be to work towards global standards for quality improvement in basic medical education, with the necessary national and/or regional specifications or a comparable set of standards.
- e. Set up such committees or appoint such staff in consultation with the Commission as it may consider necessary to carry out assessment and accreditation.
- f. Regulate its own procedure in carrying out assessment and accreditation and levy fees and other charges on medical educational institutions in relation to the process of assessment and accreditation;
- g. The main elements in the accreditation process will be self-assessment, site-visit, and Report. The accreditation agency will support the medical schools by issuing instructions regarding the structure and content of the self-evaluation report. Institution will receive either full accreditation for the maximum period conferred, if all criteria or standards are fulfilled.

20. Conditional accreditation, to be reviewed after a shorter period to check fulfilment of the conditions. Conditional accreditation can be used in cases where a few criteria or standards are only partly fulfilled or in cases where more criteria or standards are not fulfilled.

21. In case of failure of any Institution to attain full accreditation, the students will be allowed to get registration by alternate mechanisms, approved by the NMC, such as clearing the Qualifying examination conducted for graduates from Foreign Medical Schools/Colleges.

## Highlights

- This is a new process, and is in keeping with global standards.
- This system will operate in place of the current system of LOP, annual inspection and final recognition.
- It will look beyond just physical infrastructure and will look at the teaching/learning process and the quality of the graduates etc.
- It will hand hold institutions, and facilitate the expansion of the educational opportunities)
- It will work in close co-ordination with Universities

## Expected Outcomes

- Dissociation of the laying of standards and approval of the standards (in consonance with global norms)
- A two way process with transparency, which will help Institutions to bridge gaps, improve quality.
- Shifting of the emphasis from the essential physical/manpower based approvals of Institutions to a more dynamic approval based on quality of teaching
- Over time achieve global standard of education by providing incentives for accreditation grades.

## 4. National Board for Medical Registration: (NBMR) Their role will be to:

- Provide Conditional License to Practice and License to Practice
- Maintain a Dynamic Registry of Medical Practitioners under various categories: through an electronic register with live updates (additions/deletions) from all State registers and compulsory re-registration every 5 years. All registration will be with the State Councils and Central registration will only be for foreign graduates.
- Organize Continuing Medical Education (CME) and Continuing Professional Development (CPD) programs and evolve mechanisms for making these available to all medical graduates through various innovations, including the use of distance and online learning and evaluation; with the overall target of making CME and CPD mandatory for re-registration by 2020.
- Evolve ethical guidelines for practice and professional conduct and take active measures to promote these
- Provide oversight over ethical practice; the mechanisms for registering violations will go beyond the present practice of specific complaints against a specific doctor. Scope for third-party complaints will be introduced and relationship between Central and State Councils will be clearly defined, in a

manner that while the profession is not unduly harassed, the public confidence in the process of appeal is strong.

- Allow for suo moto hearing of complaints that are not addressed within stipulated time frame of 90 days, by State Council
- Recommend appropriate actions with regards to complaints including fines and withdrawal of License; processes for addressing complaints – such as constitution of the committee, time lines etc. will be defined in the Act.

The Board will consist of

- a. A President, who shall be the non-medical full-time members of the Commission
- b. Two part-time members, who shall be persons having at least a post graduate degree in the discipline of medicine and having not less than twenty years' experience in the field of medicine;
- c. Two part-time members, who shall be persons not having a qualification in the discipline of medicine, but having not less than twenty years' experience in the fields of public administration, law, or the social sciences.
- d. Two part-time members, elected by the National advisory Council from amongst its members

22. The term of office will be for four years, except for the member elected by the National Advisory Council, who will have a term of two years. No member may have more than have two terms in office.

23. Subject to the provisions of this Act, the National Registration Board shall maintain an exhaustive and up-to-date record of the names of all persons in India who have recognized qualifications and are entitled to practice medicine in the form of a National Register.

#### **National Registration Board will**

- a. maintain and publish the National Register in electronic form;
- b. ensure that the names of medical practitioners are automatically entered in or removed from the National Register as soon as such names are entered in or removed from the State Registers;
- c. remove the names of medical practitioners from the National Register on the directions of the Commission;
- d. enter or remove the names of medical practitioners from the National Register on any other grounds that may be specified in this Act;
- e. levy fees or other charges to be paid by the persons seeking enrolment in the National Register or persons already enrolled in it;

- f. Provide a mandatory framework for the conduct of Disciplinary Committees at all State Medical Councils by which the Constitution of the Committee will be as per the guidelines and will have strong representation of non-medical lay persons.
- g. Widen the scope of complaints and manner of redressal to ensure that while public grievances are dealt to satisfaction, sufficient protection is provided to the medical professionals.
- h. Develop mechanisms to have continuous interaction with State Councils, through bi-annual meetings and promote active dialogue between the councils and its members.
- i. Protect the interests of the doctors against undue harassment.

### **Highlights**

- A single National Register that will upload registrations from across the country
- More robust and time bound redressal of complaints, that will protect both doctors and patients
- Active promotion of ethical practices within the profession
- Provide continuing education, and ensure that professional competence is upgraded and maintained

### **Expected outcomes**

- Development of a live register
- More robust grievance redressal system that will help to restore public faith

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