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Quality of Indian Doctors : A Matter for Concern?

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Abstract

Data from human development report, U.N. development program, updated in 2005, indicates that, out of 177 countries assessed, the Human Development Index ranking for India is 127. This reflects poorly on country's health and social statistics. Our health care system revolves around the quality and capabilities of medical manpower available to us. Unless the society, the academicians, and the government can ensure that only the best talented students would get the opportunity to enter medical courses, and are trained by the best available faculty, under the best possible support systems and environment, it would not be possible to break the shackles of mediocrity and expect better health care delivery as well as performance. Therefore, there is an urgent need today of combining our efforts and for corroborative working.

Keywords: human development index, medical education, academic hierarchy, brain drain

Introduction

The Human Development Index (Health status, education and poverty) ranking for India is 127 out of 177 countries assessed in the world (data from human development report, U.N. development program, updated in 2005). This reflects poorly on country's

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health and social statistics. The medical education system in India is one of the largest in the world. In the year 2005, there were a minimum of 258 medical colleges in India, producing 27676 doctors each year. Since a sizable numbers of our doctors leave the country to settle abroad and migrate to western world, the quality of Indian medical education and the physicians it produces indeed therefore has worldwide impact and ramifications (1).

In addition to the above there is a general impression in peoples' minds that performance capabilities of an average Indian doctor today have declined and are not commensurate with the expectations of the society. The quality status with the exception of very few, does not match the high moral, ethical and professional standards set out for this group of personnel. The service orientation has largely been replaced by greed and the sole objective appears to be to make large amounts of money in the shortest possible time period.

Disappointingly the Alma Ata declaration of "Health for all by year 2000" has also remained an unfulfilled dream for all of us. Inability to achieve the set goal has further eroded peoples' trust, not only in the functioning of the administrators and the political leadership but also in the competence of medical manpower.

Dutta (2) while commenting upon the 'National health policy: approach of the Government and Indian medical association', has outlined many things but his package did not include quality control of medical manpower. Bajaj (3) has emphasized the need for maintaining National standards in medical education and supported the idea of a matrix for establishing quality of medical education as proposed by the past president of ECFMG. In my experience as medical educationist of over four decades, I have strongly felt that quality control of medical personnel remains a core issue in the development of health care services in any country and particularly so in India, and is not solely dependent on education alone.

The basic pre requisite for quality control is honesty and sincerity of purpose by all concerned. In a society which is so openly corrupt as ours, it may well be out of place to write about quality controls. None the less, the need for quality controls cannot be overlooked any more, if progress has to be made. Medical profession is no longer a vocation, because it is also the part of the same society which harbours individuals and organizations with total moral and ethical degradation. For things to improve there has to be an upgradation in holding moral values in

all compartments of the society. The society at large, its leadership and medical administrators have to rise above their own selfish interests so as to help the ailing medical fraternity to get out of the present rot and serve the nation better.

Admissions to M.B.B.S. and Postgraduate Courses

In order to enter a medical college and /or an institute, a student after 10 + 02 and having attained the age of seventeen years, is required to appear and pass a premedical test, held at national as well as state level.

The ingenious Indian mind is always at work with certain percentage of back door entries being made invariably by foul means. The vernacular press is full of such happenings every year near the time of entrance tests held by different states and organisations. This results in a number of students with substandard merit, successfully getting admission to medical courses.

The remedy lies in making these competitive examinations as clean and transparent as possible, in order to allow only meritorious students to clear these tests, both at M.B.B.S. and postgraduate level. For the want of space and the risk of deviation from my central theme, I would like to leave this aspect here and not go into the details of foul means and practices used for this purpose, except to emphasize the point that the dilution of merit begins by such entrants.

A greater setback to the merit pool at the entry point is the practice of mandatory reservation of seats for various categories of candidates belonging to certain casts and religions. There may well be compelling socio-political reasons for such reservations of seats even in vital professional courses, but the society must consider this issue rather dispassionately and in details if the quality of care is to be ensured.

Since the percentage marks for clearing the examinations are lower for the reserved category students, the pool of selected candidates consists of two streams, one with high merit and other with low merit, clubbed together. This mixture of heterogeneous categories results in significant merit dilution and lowering of standards. It is almost impossible for teachers and the taught to improve the low merit over the years and bring the low merit group at par with high merit students. In order to create an equilibrium and uniformity in the two groups, the over all merit as a whole suffers. Since the objective had been to improve merit further, this amounts to be a major start point

failure and reflects badly on the final quality of the finished product. The society therefore has no other option but to finally and firmly decide now whether to continue with the practice of reservation of seats in professional courses in the present form, particularly when the product has to play such a vital and important role in alleviation of human suffering and is directly responsible for saving lives.

On the other hand, if reservations have to stay, the system ought to be modified in such a manner that the gap between the two merit groups is reduced to the minimum. This could easily be managed by bringing the cut off marks of both the reserved as well as the open category candidates at par with each other, so that they are able to compete with each other on a one-to-one basis. In order to make it possible for reserved category students to secure high merit marks equal to open category candidates, their support systems ought to be upgraded so that they are able to perform better. The state may provide complete financial, social and material wealth support *i.e.* money, furnished houses and fulfillment of day to day requirements of all the prospective reserved category candidates and their families but make them perform in the competitive examinations at par with rest of the students, in order to uniformalise the merit.

Alternatively reservations should only be provided once in life time at step one for any such candidate, in order to ensure that there would not be any dilution of merit at the higher levels of specialization. This hard choice has to be made if professionalism has to survive in this country.

The Faculty Selections, Promotions and the Phenomenon of Brain Drain

The faculty is the show piece of an Institution. They are the torch bearers and play a pivotal role in shaping the best quality of finished product. Unfortunately, it is a well known fact that no faculty selection is fair in our country. Merit is either not a criterion at all, or at best a secondary consideration. Money power, connections and patronage always seem to get a better priority over selection of deserving candidates. Inbreeding, automatic promotion schemes, not taking lateral entries at higher levels of faculty positions, domination of a select group of candidates from a particular geographical area and reservations lead to the selection of not necessarily the best candidates. Such manipulations are done in a manner that merit becomes a primary casualty.

The class of faculty which therefore comes up is in sharp contrast second rate with inadequate proficiency and capabilities of training and teaching medical graduates, the so called future of India.

On the other hand, these selections and / or promotions have a tremendous demoralizing effect on the meritorious faculty/ candidates, who are otherwise a hard working, sincere and honest lot trying to improve their contributions for the betterment of the society. The left out faculty thus not only lose all their desire for coordinated team approach but they also give up any firm commitment to work.

Total violation of the concept of academic hierarchy i.e. lecturers , assistant professors, and professors, with or without headship of the department, has also created an atmosphere in many institutions of free autonomy of working and has made most of these departments a battlefield for one upmanship, rather than a happy and healthy place of work. It would be an eye opener to see how many teachers partake fully and sincerely in academic teaching activity regularly, keep their time schedules and assignments. It is the selection of faculty on other considerations which remains a major cause of discontent amongst the rest of the members. The negativity of mindset further inflicts and potentiates 'no work' culture and at the same time kills new input of fresh ideas from the otherwise talented faculty.

Migration abroad, the so called brain drain of qualified professionals from India's premier institutions and other places, is also the direct result of this mounting frustration amongst the meritorious doctors, who find that they neither get their deserving placements, promotions, infrastructure support and required facilities to work as per their capabilities and merit, nor do they get the opportunity and exposure to innovate and/or experiment with the latest technological advances. No wonder then they look for better pastures off the Indian shores. This in turn further dilutes the performance capabilities of left over faculty. The sad part of the picture is that even the meritorious students now are seeking admissions in foreign universities and thus adding to the loss.

The end result is a compromised pool of students and a compromised pool of teachers. It should not be difficult to for any one to imagine the quality of out going product when both the faculty as well as the students do not have the best available merit and work ethos. Fair and impartial selections and promotions of meritorious faculty alone , based on best performance record and to provide them with the best possible infrastructure

support and equipment is the way to improve the overall situation and ensure best quality of care delivered by these professionals.

The Training Programme

A significant number of medical institutions in the country even today do not have a structured training program for undergraduate as well as postgraduate students (4). If a program does exist on paper, its implementation and or upgradation has often legged behind. I am in agreement with Dave (5) that the entire medical educational system in India perhaps requires revision in light of our own health care needs. In a survey of surgical residency program, training, teaching and evaluation in general surgery, based on opinion polls in five medical colleges in northern India, Gupta *et al.* (6) have also concluded that the main emphasis remains on theory alone and the program lacks opportunities for students to acquire open and laparoscopic surgical skills, learning of research methodology, sense of critical appraisal, ethics and so many other important aspects.

Surprisingly some of the institutions do not even have a well defined course curriculum available in details. The curriculum planning and course design is a vital force in providing good teaching and learning for the students and must take care of all its constituents. Unfortunately some of the curriculum only mention the administrative schedule and do not include any syllabus. Violations of set procedures of starting a new superspeciality course and deviations from defined curriculum have been frequently seen. Short cuts are made in meeting many of the pre course essentials. The requirement of creation of an independent superspeciality department in existence for three years before starting a postdoctoral degree program, constitution of board of study, interaction with national associations/ bodies and the recommendations of MCI and peers in the speciality field are some such examples which have not been followed by some of the Institutions and have gone unnoticed or unchallenged in recent times.

The unfavourable ratio of teachers and taught is yet another deficiency which is commonly present. The number of teachers is often not adequate as per MCI norms. For the medical council inspections, teachers have often been hired or borrowed on short term contracts and they disappear soon after approval and/or recognition is received.

Clinical Proficiency, Patient Care, Research and Ethical Standards

The standards of patient care expected by the society from the medical fraternity are indeed and ought to be

very high. Any neglect is intolerable, often highlighted in vernacular press and even taken up by consumer courts. However, at times like these one forgets the common proverbial saying that 'you reap what you sow.'

The diluted merit of the teachers and taught, the unhealthy work culture and environment naturally influences and affects adversely the quality of patient care program, as well as the research potential of the faculty.

The main thrust areas in medical research are laboratory based, experimental (including animal studies) and problem oriented clinical research pertaining to patient related data collection and analysis. In a country like ours majority of medical institutions have relatively lagged behind in laboratory and experimental research, particularly in clinical disciplines. The main emphasis is usually on clinical research. Unfortunately even in this area one has failed to make any great mark in international and national arena. Although, the number of scientific papers published may well be in thousands per year, but very few of them attain a significant Citation Index and /or have a high Impact Factor. This is largely the result of poor record keeping (7), lack of appropriate data collection, proper and honest audit of one's results (8) and the prevalent practice of plagiarism. All these factors influence the quality improvement of publications and indicate the poor quality status of the man doing such research.

The ethical conduct and control of medical manpower is also a consideration of vital importance (9). The extension of boundaries of the malpractice arena has engulfed all moral, financial and legal limits. The commonly prevalent malpractices include patient snatching, undercutting (as there are no uniform fee structures), kick backs and reward systems, toutism, advertising, making false indications for admissions and interventions, cooking up data, making tall claims and running down other colleagues *etc.*

The medical curriculum till date does not include ethics as part of teaching subjects. By and large no ethical monitoring of personal conduct of an individual seems to exist. A large number of medical colleges and postgraduate institutions do not even have a properly constituted and functional ethical committee and if one does exist, its activity is often confined to research projects monitoring and reviews. Further the authority to implement an adverse decision on any so- called violation of ethical limits by a single or group of individuals does not really lie with the committee.

The Infrastructure Support

A compromised manpower *i.e.*, students with suboptimal merit and faculty which has a poor research potential, ethical standards and work ethos could hardly be expected to have an excellent grade of performance. There is further worsening of this situation, when one realizes that even the best of our public medical institutions are unable to provide a good infrastructure support. The equipment is usually old, outdated and not necessarily in good functional state. The new equipment is not easy to procure because of cumbersome government procedures, red tapism and financial constrains. The nonfunctional machinery is neither repaired nor updated or replaced for want of expertise, good workshop facilities and budgetary difficulties. The resultant deficiency further erodes the capability of medical manpower to learn, practice and innovate new methodology in order to deliver adequate and better patient care.

The Reject Pool

The author has always felt greatly concerned about the quality value of those medical graduates who get an MBBS degree from substandard private or public medical colleges in India or from abroad. A fairly large number of these doctors do not progress any further in order to improve their qualifications. This group along with those who are unable to make it to postgraduate courses by an open competition, inspite of having made repeated attempts, constitute the so called 'reject pool'.

The size of this 'pool' is indeed quite large. This MBBS manpower often or usually gets distributed to middle or small set ups in rural and urban areas and work unsupervised as general duty / resident medical officers for years before finally settling down on their own in general practice.

No one has ever bothered to monitor the quality of experience gathered by this group in their formative years. This experience plays a vital role in making of a good or bad doctor for life. All the experience gained by them is by their own effort, since the training is totally unstructured and there is absolute lack of guidance or help available to them for picking up correct methods and knowledge in order to deliver good medicare in later years. The healthcare potential and performance capabilities of this manpower would therefore always remain compromised and well below average.

The Regulatory Controls

In order to verify the capabilities of a medical person to be able to deliver quality care after graduation and /or postgraduation, many countries in the world have strict controls (10). Regular participation in continuing medical education programs, compulsory audit of one's results, record keeping , ethical monitoring and periodic recertification by competent authorities are some of these measures(11,12). The Indian government is yet to implement any such measures and regulatory controls which would ensure the best possible training and quality of experience gathering to these young graduates and postgraduates.

The Finished Product

As evident from the above narration, the qualified Indian doctor today is well below average and lacks in capabilities. He, therefore, has no confidence and the basic professional expertise expected from a medical graduate par excellent. The health care he is thus able to provide is at best of mediocre and of substandard quality. As a surgeon, trainer and a teacher of over forty years duration, I find that the large majority of these individuals with the exception of very few who get the chance of working in large institutions or corporate hospitals, are not able to perform difficult and major procedures on their own or have a very high rate of procedure related complications (13). The management outcome is often poor and eventually limits further their practice thus making them to perform only simple and safe surgery. This automatically down- grades the type of surgical care offered by them and thus results in under utilization of surgical expertise *vis-à-vis* their role in alleviation of human suffering as per their potential and expected level of talent.

Conclusions

The write up is not meant to be a negative report but a factual narration of the ground realities. Our health care system revolves around the quality and capabilities of medical man power available to us. Unless the society, the academicians, and the government can ensure that only the best talented students would get the opportunity to enter medical courses, and are trained by the best available faculty, under the best possible support systems and environment, it would not be possible to break the shackles of mediocrity and expect better health care delivery as well as performance. Therefore, there is an urgent need today of combining our efforts and for corroborative working.

The author does not mean any gender bias by using the word 'man power', 'he' or 'him'. Please read this as either a male or female doctor.

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