

COMMENT

“Exit exams” for medical graduates: a guarantee of quality?

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Abstract

Despite a great deal of opposition from many segments of the medical community, the Medical Council of India (MCI) has proposed to the Ministry of Health and Family Welfare, Government of India that a pan-India exit examination be introduced for graduating MBBS doctors. Whether the proposal should be put forward was considered twice, once in 2010 and again in 2013, and finally the plan was ready to be taken forward seriously in 2015. The proposal has elicited appreciation and criticism from different segments of the medical community. It aims to improve the quality of medical professionals and create an all-India chapter of doctors. People are ready to welcome the move if it is integrated with the final year MBBS examination and licentiate examination and serves as an entrance examination for medical graduates. Further, the Supreme Court's order that the National Eligibility and Entrance Test (NEET) be made compulsory aims to create a fair, transparent and non-exploitative system. This move has the potential to reduce corruption and foster a merit-based system of medical education. However, making NEET compulsory would have an impact on the proposed exit examination. Given this background, we analyse the pros and cons of the new initiative on the basis of articles published in newspapers and journals, with a special focus on its impact on improving the standards of quality in the medical profession.

In India, many regulatory bodies in the field of higher education act as the apex organisation for the approval, accreditation and regulation of higher education. The University Grants Commission conducts the National Eligibility Test (NET) to determine minimum eligibility criteria for teaching in universities and higher educational institutions. Similarly, the Bar Council of India (BCI) conducts an eligibility test, the All-India Bar Examination, for law graduates to register under a bar association. The duty of regulatory bodies is to ensure a supply of efficient manpower to different systems for the provision of better and more effective services in the domain concerned. Recently, the Medical Council of India (MCI), the country's apex statutory body for medical

education, proposed improving the quality of medical graduates by means of an examination, to ensure better medical services throughout the country. The deterioration in the quality of medical professionals warrants strict regulation of the supply of medical professionals through the maintenance of a certain minimum quality. In response to this need, the MCI proposed a radical plan for an “exit exam” for graduating MBBS doctors that would test their suitability to pursue postgraduate studies approved by the MCI (1–8). Passing this examination would also provide the option of *suo moto* transfer of registration from a state chapter of the MCI to the all-India chapter, which would enable one to practise anywhere in the country (2,4,6,7,8). The opportunity to practise across the country would be an incentive for meritorious candidates. Candidates who fail the examination would be entitled to practise only within the jurisdiction of the state in which they were registered earlier (2).

The level of the exit examination is similar to that of the postgraduate entrance examination. It has been seen that the existing foreign medical graduate exit examination is very similar to the postgraduate medical entrance examination, which is criticised for being tough and irrelevant as it does not test the skills of practising doctors. Instead, this examination merely makes candidates competition-oriented, so that their major aspiration is to gain entry into the medical profession in India, in a manner similar to undergraduate students vying to enter the postgraduate courses. As the professionals who clear the exit examination would have the privilege to practise throughout India, they are supposed to acquire a wide range of knowledge of the cultural and belief systems of the country. This is very pertinent as India is a big subcontinent with diverse cultural systems that influence the people's health-seeking behaviour and determine their health status. However, the exit examination does not assess such knowledge; instead, it focuses only on the technical skills of a professional. The evaluation of the competence of doctors should not be limited to their professional capability, as they must be sensitive and understand the community and local nuances to be able to intervene effectively, both at the individual and population level.

If the exit examination proposed by the MCI becomes a reality, it will have many repercussions on the healthcare system. This paper examines the overall effect of the proposal on the healthcare system. It is possible that until such time as there is a substantial improvement in the quality of medical professionals, the new system will succeed only in bringing a

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To cite: Dehury RK, Samal J. “Exit exams” for medical graduates: a guarantee of quality? *Indian J Med Ethics*. Published online on January 12, 2017.

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large number of disqualified candidates into the states (2). Further, merely holding a test for graduates from medical colleges will have only a minimal impact on improvement in the standards of quality.

It has been seen that university tests measure the learning outcomes imparted in the course which are suited to the requirements of the professional jobs in medical colleges. Different medical universities and colleges have different pedagogy systems. They also adopt their own system of evaluation, based on the requirements of the academic council and the guidelines of the MCI. One single test for practising doctors with multiple skills may not serve the purpose. If an exit examination were in place, the independence of universities and boards would be compromised. It would force all innovative teaching organisations to follow a uniform syllabus to prepare their undergraduate medical students to qualify for the exit examination and thus be in a position to save their prestige. This may lead to a problem similar to that which occurred with the Choice-Based Credit System (CBCS), enforced by the University Grants Commission (UGC). The quality of manpower is not necessarily measured by uniformity in approach, which is what the exit examination is likely to breed. Rather, diversity plays an important role in the measurement of the parameters of quality. Medical education is not only a matter of training students to treat patients or for specific tasks. It has a great role to play in solving the challenges of public health, creating social values, as well as research and development. Hence, we must give due consideration to the option of developing an open system that encompasses the various emerging areas related to the medical sciences.

Medical education in India is imparted mostly by the state governments and private trusts, and very few institutes are run by the Central government. Although there is a uniform mechanism for assessing the minimum quality of medical professionals across medical colleges to earn them recognition by the MCI, there is no provision for output-based efficiency measures. There are wide differences in the provision of infrastructure and manpower across various medical colleges. There are glaring differences even between the investments made by the various medical colleges of the government sector; usually, the Central government colleges enjoy much better funding than the provincial ones. Some trust-run medical colleges are doing a remarkable job, whereas others are akin to money-minting institutions. A medical college hospital that is run successfully plays a large role in the exposure of medical graduates to the clinical management of medical conditions, which invariably reflects on the quality of these graduates. An overall evaluation shows that government-run medical college hospitals provide a wider range of exposure than privately managed ones.

India has 398 colleges providing the MBBS degree in the privately run, government- and trust-run categories. These produce 52,105 graduates every year. Of these, 27,170 are produced by 215 private medical colleges, while almost 25,000

are produced by government colleges, as reported by the MCI(9). It has been observed that the teachers of government colleges often take up assignments with private and trust-run colleges for higher pay. Some private colleges do not have affiliated hospitals of their own and depend heavily on government hospitals for demonstration and clinical practices(10). Private medical colleges charge exorbitant fees in comparison to government colleges. In 1992, the Supreme Court had intervened and asked these colleges to make their fee structure affordable. However, the Court passed further orders that allowed private medical colleges to charge slightly higher fees (11). In spite of all these efforts, some private colleges charge capitation fees and tuition fees of up to Rs 1 crore (12,13). Students have to pay Rs 16–18 lakh towards the tuition fees for the entire course, as decided by the respective states' committees for fixing fees. The private and trust-run colleges have reserved 15% of the seats for the management quota and NRI quota (14). It has also been observed that private colleges are promoted by entrepreneurs and politicians with a strong lobby in the government (14).

There is a glaring difference between Central and state government, government and private, and new and older medical colleges, insofar as pedagogy and the clinical exposure given to students is concerned. This may lead to discrimination against graduates of various groups of medical colleges. The teaching methods are below par in the money-minting private organisations. The private institutions depend mostly on guest lecturers and contractual teaching staff. The MCI has served notice to many private institutions regarding the poor quality of infrastructure and manpower. This illustrates the differential quality of exposure of medical students across different categories of colleges (10, 14). Many private colleges have no affiliated hospital of their own and make special arrangements with other hospitals to get clearance from the MCI. On the other hand, government institutions have very sound hospital facilities for the clinical and practical training of medical students. They have to look after the public, which compels them to provide the basic minimum tertiary care services, keep themselves up to date with all aspects of medical education, possess adequate infrastructure, teaching faculty and medical equipment, etc, unlike private medical colleges. This translates into good exposure for medical graduates studying in public medical institutions.

The proposed exit examination differentiates between medical graduates only on the basis of cut-off marks. This may indirectly encourage students to cram and reproduce knowledge in the qualifying examination rather than internalise knowledge by understanding concepts (2). The growing number of coaching centres caters to students competing to clear these and various other entrance examinations in the country. The question may be raised as to whether the learning methods enhance the cutting-edge skills required of graduates to effect an improvement in the health system. The enhancement of the quality of education depends mostly on setting a high standard at the entry level and enforcing it throughout the medical curriculum.

The talent pool in India is spread across the country, maybe with uniform density. Catching the rural talent and giving these people higher education is still a challenge, something which many examination boards have admitted. Whether it is the all-India pre-medical examination or Indian Institute of Technology (IIT) joint entrance examination, the distribution of successful students is skewed against some states. There is a similar trend in the case of the rural–urban divide and the state boards versus Central boards (CBSE, ICSE). Hence, the proposed examination plan must normalise these anomalies and find a way of bringing out talent from across the country. Instead of selecting candidates on the basis of absolute scores in entrance examinations, account should be taken of gender, the deprivation index, rural–urban factors and state board weightage. Expert panels may be set up to draft the methodology for the inclusion of such factors. This would also provide scope for the equitable distribution of human resources across the country.

The pattern of the exit examination is a bit similar to that of the Foreign Medical Graduate Examination (FMGE), which is voluntary in nature (6,8). In terms of rigour, this examination is supposed to be similar to the postgraduate medical entrance examination. The FMGE acts as a check against low quality among foreign medical graduates. However, it has been observed that graduates of well-known foreign medical colleges do not clear the examination, probably because of its similarity to the postgraduate medical entrance examination. The mismatch between the course curriculum in FMGE and the curriculum of the degree-awarding foreign institution probably explains this.

The MCI's draft proposal of 2015 for an exit examination also suggests that the examination would be used as a qualifying standard for pursuing postgraduate degree courses approved by the Council (1). The existence of another stricter postgraduate medical entrance examination would create a critical situation for medical graduates (3). Hypothetically, it is possible that students qualifying in the postgraduate medical entrance examination may fail the exit examination. This would clearly mean a violation of the right to pursue higher education on the basis of merit. As mentioned earlier, undergraduate medical education is weaker in some states and it may be difficult for them to fill the postgraduate medical seats due to multiple examinations (1, 2). The exit examination follows the pattern of the postgraduate entrance examination very closely, and is hardly oriented to the clinical and practical approach which is necessary to serve the public. As mentioned earlier, this examination also promotes the memorisation of data and information, and gives the student no grounding in the skills required for treatment. On the other hand, students have to once again go through a faulty examination system, similar to the one before their admission to a medical college.

The exit examination could have a very serious effect on the professional growth of graduating students. It is possible that those who do not clear the exit examination will repeatedly try to do so. This will inevitably lead to a scarcity of human health

resources, especially medical doctors, for the health services. Also, the incubation period for medical graduates to be ready to serve the healthcare system will get further prolonged. The medical graduates after passing out may even switch for other career options to avoid the exit examination, which would be a great loss, considering that medical education is highly subsidised in India. Ambitious graduates may think of other career options to avoid the possibility of being reduced to second-grade practitioners in case they cannot clear the exit examination (1). As it is, there is a loss of human resources because many undergraduate students repeatedly attempt to clear entrance examinations to pursue postgraduate studies. The exit examination may compound this, depleting human resources as undergraduates repeatedly prepare for the examination. Students have high aspirations and take challenges to uphold their prestige and find opportunities, and this, in the long run, would breed mere competition without any value addition. Many students are likely to remain absent from practice, resulting in the wastage of precious skills. In the case of other professional courses, such as law, accounting and engineering, there are stringent regulations that require a person to practise. These courses do not dissuade undergraduates from pursuing postgraduate studies on the basis of merit. The exit examination represents a gross violation of the provision for equal opportunity as far as upgrading skills and learning of new developments in the medical line are concerned. Eventually, those who cannot clear the examination will become demotivated; their morale will be lowered and they will suffer financially, which could lead to an exodus of medical graduates to other professions.

An improvement in the quality of medical education requires various measures for monitoring the educational infrastructure. Medical teachers, paramedics and laboratories should be available, and the hospitals should be functional. The curriculum should evolve over time and there should be continuous evaluation by the medical university and MCI. There has been a long-standing need to revamp the governance structure of the MCI to improve its functioning, and this should now be taken up on an urgent footing. The MCI is in a deplorable condition due to its leniency and corruption, and because it has subverted the standards of medical education. Another priority is hand-holding of provincial medical colleges, especially in the backward provinces, to improve quality. The MCI may have failed to control quality because India is a huge nation with a diverse mass of students, and various cultures, classes, castes and groups. An additional 3–5 zonal-level support systems might help to monitor the standards of quality.

The recent bill of the Government of India to scrap the MCI in favour of a new umbrella regulatory commission tells many stories. The MCI, due to political and governance issues, failed time and again to consolidate its position in terms of improving educational standards. Unlike various statutory and regulatory bodies, such as the Election Commission, Central Vigilance Commission, Telecom Regulatory Authority of India and Insurance Regulatory and Development

Authority, the MCI failed to achieve its desired goals with reasonable effectiveness. On the basis of various studies and observations, independent agencies arrived at the conclusion that the MCI could not achieve its goal, given its present structure. Through their regulatory bodies and the political will of the government, many developing countries have established a rural health workforce that serves them well in the circumstances. The MCI, on the other hand, has failed to deal with the dire shortage of doctors in the rural areas by designing a rural medical curriculum and creating a rural healthcare workforce. Taking cognisance of the matter, the Government of India disbanded the MCI in 2010. The tenure of the Board of Governors was extended many times in the hope that better results would be achieved in medical education. Such a measure is, however, of a temporary nature and the government took no radical step. The recent Supreme Court verdict permitting the establishment of new medical colleges – overruling the MCI's rejection of such permission – was a step towards curbing the arbitrary functioning of the MCI. The Government of India is considering the establishment of a National Medical Commission Bill to replace the MCI and opinions are being sought on the Draft National Medical Commission Bill, 2016. Such centralisation has its own pros and cons. The quality of doctors could be enhanced by strict monitoring at the time of their entry into medical colleges and during the study period, irrespective of the regulatory authority (15,16). However, the privatisation and commercialisation of medical education could be avoided to nurture institutes on ethical grounds by focusing on the quality of manpower.

The Supreme Court's order to make the National Eligibility and Entrance Test (NEET) compulsory has the potential to create a fair, transparent and non-exploitative system. It could also reduce corruption and foster a merit-based educational system (17). On the other hand, it is perceived to be biased against candidates who are from small towns and the rural areas and hardly have any access to educational infrastructure. For people to be able to reap the benefits of NEET, a better schooling system should be set up across rural India. Students studying in the vernacular medium should be empowered from the start to be able to face the challenges of high-voltage competitive examinations. Quality medical manpower is a requisite for a vibrant healthcare structure for universal access to health (18). For quality manpower, the system should be inclusive and provide equal opportunity to all. The test should emphasise merit and justice. Overall, NEET having been made compulsory will have an impact on the proposed exit examination.

It is an irony that despite the existence of a statutory regulatory body like the MCI and other approving authorities, such as the provincial governments, universities and boards, it has been a consistent problem to maintain the quality of medical education in India. To improve standards in medical education how far 'exit exam' would be helpful is really questionable.

There could be a high probability of emigration of highly skilled doctors from India once another accreditation is imposed in the name of a qualifying "exit exam".

Limitations: As the government has not released any documents on the subject, government documents could not be analysed. This comment is based on information gathered from newspaper and journal articles, which may be a limiting factor.

Competing interests: None declared

Statement of submission of similar work: No similar work has been submitted by the authors.

Ethical approval: Not required. (The study is based on secondary literature and observations. There is no need for ethical clearance because this paper does not deal with human subjects involved in the collection of sensitive data.)

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