LETTERS

Corruption in medical education: time to introspect

A recent editorial in *IJME* (1) highlighted the scandalous actions of office bearers of the Medical Council of India (MCI). The MCI's image was tarnished following reports of corruption concerning its president. When a person noted for corruption has manned the post for so long, the standard of medical education is inevitably adversely affected, as mentioned in the editorial.

Criticism is essential, but it must bring out the deficiencies of governance and indicate the road to recovery. It is not possible for a huge country like ours to depend only upon the government to start, run, and maintain medical education in India. It is also the responsibility of individuals, associations like the Indian Medical Association, private and public college management associations, and academic bodies.

It is true there are many deemed universities which run medical colleges. Many students study in such institutions. Professors who served in government institutions as directors of medical education too join such institutions. Such institutions are monitored by inspectors from the MCI every year to regulate their functioning. There are many good inspectors who visit these colleges, scrutinise and write honest and accurate reports. These reports over the years have made most institutions improve their infrastructures, staffing patterns, hospital services and teaching facilities.

It is also true that during inspection time, many institutions bring in hired patients and hired equipment to fulfil MCI norms. To deal with this, we must reorganise the structure of medical inspection teams to include medical graduates and non-clinical professors with experience in the respective departments Such experienced professors have the knowhow to improve the preclinical departments.

Every medical college has preclinical, paraclinical and clinical departments along with a teaching hospital. Therefore an inspection team could include: 1. a professor of a preclinical subject to inspect the preclinical departments (they could be medical or non-clinical Ph D professors); 2. a professor of a paraclinical subject; 3. a professor from a clinical department; 4. a professor qualified in hospital administration, and 5. a medico-legal professor. These inspection teams can be formed in every medical university in different states. Teams from the south can visit the north, and vice versa

With all our drawbacks, we have unique institutions both in the public and private sectors. We are a democratic country. One of the drawbacks of the democratic system is the election of office-bearers by the electoral process. We cannot have Aldous Huxley's Democracy by Aristocrats.

People with money channel their capital and influence into starting institutions. Every businessman wants to make easy money. For that matter, every one of us does. Yet it is our responsibility to maintain the standard of medical education in India by instituting, say, a Common Qualification Examination for all graduates of India.

Yes, we are a great nation with many stalwarts to boast of in the field of medicine. Extraordinary students join the medical profession through merit and through the All India Entrance Examination in the primary centres of medical education --. The graduates who come out of the All India Institute of Medical Sciences (AIIMS), New Delhi, Postgraduate Institute of Medical Education and Research (PGIMER) in Chandigarh, the Chennai Institute of Medical Sciences, and other private and public institutions make Indians proud. These medical professionals serve, want to serve, and are committed to serving the public with integrity and honesty. A few incidents cannot tarnish the image of medical education in India. The Medical Council of India is a body that maintains the standard of education of all medical colleges, particularly upcoming institutions. Institutions like AIIMS and PGIMER need no guidelines for these institutions have set high standards for themselves. . These standards make them comparable to the best institutions in the world.

Medical education is rooted in practical and social values unique to our country. Ethics is built into Indian culture which, time and again, gets tainted with the soot that emanates from policy makers and political gamblers. Let us be proud of our medical education. Professors who teach in private and public medical schools have character and integrity. In a world filled with corrupt corporate institutions, including global banks, there is a ray of hope because of the great medical educators of India.

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Boundary violation?

I have been practising medicine for 50 years and I have always considered myself a stickler for medical ethics. I learned from your issue of April-June, 2010 (1) that, at least in two aspects, I have been guilty of unethical practices. I have no intention of changing my habits in the rest of my professional life, and so must continue to violate the boundaries you have laid down. From the day I saw my first patient, I always thought I should be a friend to my patients. I must confess that many of them have become lifelong friends of mine, some over several decades. I stay in their houses when I go to their cities, and they stay in mine when they come to Chennai. We actively socialise. I attend weddings in their families, and they attend functions in mine. We exchange presents on occasions. I receive presents, and I give presents too.

I have been a patient too, and have been treated by doctors all my life for ailments major and trivial. When I was a child

and a young man, Dr K S Sanjivi was physician to me and all the family, and he became a dear friend to all of us. I have never met anyone I regarded as a more ethical person, and he was and still is my role model. Perhaps the idea of a doctor as a friend is old fashioned. In that respect, I would rather not be modern, if that means being cold and professional.

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White coated corruption

Vijay Mahajan has succinctly put into words the decrepit and deplorable state of medical education and practice in India (1). One need not even scrutinise the references for most of the facts that he states: they are common perceptions to all concerned.

He also gives a list of remedies to all the ills affecting medicine in India today. His remedies are not new; they have been acknowledged by change makers over centuries. Yet, we do need to remind ourselves of the need to "refuse bribes", "follow medical ethics" and "treat poor patients same as the rich".

The crucial point, however, is, do we -- as a medical community and indeed, as a nation -- have the capacitance in spirit to execute these "good" changes? Do we have the integrity, honesty and purity to acknowledge and then resist endemic corruption? I sometimes feel that as a people, we Indians have a genetic trait of being corrupt, lazy, sloppy, dirty and generally inefficient, at least in our own country.

I remember a conversation that took place many years ago over lunch in a resident doctor's mess in a public teaching hospital in Mumbai. The talk was on alcohol, or, rather enjoying alcohol. One female resident doctor remarked on how everyone in her family enjoyed alcohol and that on their recent visit to Gujarat they had carried bottles of premium scotch in their car. Gujarat being a dry state, their smuggling was discovered at the border patrol. She gleefully added that they bribed the patrol police with a bottle of the same stuff and were allowed to carry the remainder of the cache ahead.

On this, another doctor remarked on how she and her family (all educated, well to do, city dwellers) could indulge in such illegality, bribery and corruption.

I can still remember her answer, even after 20 years. She said, "What is wrong in being dishonest and corrupt?"

She, in essence, represents the corrupt blood that seems to flow within every "second" Indian. It does not matter whether he or she is a doctor, a policeman, a judge, a banker or a bureaucrat, nor whether he is rich or poor, a rural peasant or an urban sophisticate. The streak of pettiness, one-upmanship, dishonesty and selfishness seems to run in all.

Given this state of affairs, who is going to "refuse favours from pharmaceutical companies" or "make a commitment to rational drug use"?'

Vijay Mahajan also lists steps to be taken by the government to improve the scenario. Steps such as "transparency in the allocation of funds" or "enquiries by people of integrity into medical corruption" are good on paper.

The problem, once again, is that our government is by our own corrupt people, for our own dishonest people and of our own valueless people shorn of grit or integrity.

There is a vernacular saying which translates as: "When the fence itself swallows the farm, where should the farm complain?"

How can such a government effect all the laudable, grand reforms which our profession needs desperately?

To give only a few examples of corruption in government offices: several private medical colleges are founded and run by politicians, where the emphasis is on money making using education as an instrument; the government gives subsidies to distilleries to produce alcohol while common people die of thirst, hunger and debts; the former director general of police of Haryana is convicted of molesting a minor; a murder convict is chief minister of Jharkhand, etc.

There are millions of untold slips between the cup and the lip in India and reforms will likely remain on paper.

The only durable way out is strengthening the spirit through the values of honesty, truth, integrity and love. It will take a revolution of the heart to change the scenario. No amount of recommendations or paper reforms will salvage the situation.

While stringent laws are made to, and do deter, many a defaulter, many wannabe culprits are unabashedly immune to the intimidating powers of the law. They know that they can pay their way out of their punishments.

The roots of this disease are deep, and therefore the solution will have to be deeper. I would think that time-tested, age-old golden practices in spirituality like yoga, vipassana and religion without the rituals would go a long way in building the character of our society.

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Surgical training in India

The letter on surgical training in India (1) ought to open the eyes of surgical teachers in myriad departments in the country. In the absence of a structured theory and practical curriculum, it is left to the devices of teachers and their goodwill, the enthusiasm of students and their willingness to learn, and

certain other factors. All this together is not enough to produce a surgeon with standard skills and knowledge.

The lack of standardisation across country produces "surgeons" of varied skills and competence. Teachers have their fads and hobbies and often neglect certain areas. In many departments, teaching activities like seminars, case presentations, journal clubs, mortality morbidity conference are given the go by.

About private medical colleges offering surgical training, the less said the better.

It was my good fortune to visit the College of Physicians and Surgeons of Pakistan in Karachi some years ago. There I was surprised to see a formal surgical laboratory with mock surgical tables covered in green cloth where trainee surgeons were taught basic and advanced surgical skills in two courses covering a few days each.

The course had a formal curriculum and attending the course was mandatory for all surgical trainees in the country, regardless of their place of training. Special models were made for trainees to practise procedures like tracheostomy, venesection. Suturing and ligature were taught on models. Bowel anastomosis was taught on preserved bowel segments.

All trainees underwent a course in using computers, presentation skills and research methodology. It is my belief that such a system of training does not exist in our country. There is much to learn from our colleagues across the border.

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Rural doctors

Regarding your editorial on rural doctors (1), by conducting a short term course to treat our village population, the government will compromise on the quality of treatment..

Instead of conducting a course for freshers, the government should train physiotherapists who have undergone a four and a half year course and covered almost all the subjects that an MBBS student reads. There are many unemployed physiotherapists in India, and even many of those who are employed earn barely Rs 4,000-5,000 a month.

The government should take the initiative and call physiotherapists for interviews and give them six months' training in the treatment of common diseases. I think they will be far better than students who have undergone only a short course.

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Rural doctors: A solution, or yet another problem in the making?

A stark difference exists in the healthcare facilities available to the rural and urban population in India (1). The country is currently facing a severe shortage of all categories of staff in the rural health system (2). While the comment made by Mahatma Gandhi that India lives in its villages holds true even today, rural India has suffered severe neglect as far as provision of adequate healthcare facilities is concerned. In recent years, planners have launched several endeavours to improve the status of healthcare in rural India. The mission document of the National Rural Health Mission enumerates many strategies to achieve better healthcare for rural India. This includes the formulation of transparent policies for deployment and career development of human resources in healthcare; the provision of 24-hour service in 50% of PHCs by addressing the shortage of doctors, especially in high focus states (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu & Kashmir), and reorienting medical education to support rural health (3). The government has toyed with many ideas to combat the lack of trained medical professionals in rural areas. A proposal to ensure a compulsory rural posting for medical graduates is yet to see the light of day. Yet another proposal to attract young graduates to practise in rural areas included the provision of extra marks in postgraduate entrance examinations (4). The status of this proposal is also unclear. However, the government has moved swiftly to propose the creation of an entire new system of medical education, tentatively labelled Bachelor of Rural Health Care (BRHC). The proposal has received a go ahead from the Medical Council of India and is intended to address the dearth of medical practitioners in the rural parts of the country (5). From this point of view, the proposal is welcome, especially considering the lack of interest of medical graduates in serving the rural population.

However, the ethical issues involved in the creation of this new course need to be examined.

It seems that entry to the purported four-year course will be restricted to students who belong to certain notified areas (6). This provision is probably based on the argument that people from urban areas are unlikely to serve in rural areas. This is a fallacious argument. Many reformers who have worked for the poor have actually been from the privileged classes. The provision is also against the constitutional promise of equality to all, irrespective of the place of birth. This provision needs to be scrapped so that every Indian is eligible to enter this course on the basis of merit.

Going by the admissions of the powers that be, the skills of such rural practitioners will be inferior to those of MBBS doctors (6). Does this course then not amount to providing inferior services to the rural population? Is not the inability of government to ensure an appropriate working atmosphere and infrastructure in rural areas partly responsible for the lack of doctors' interest in rural postings? The current initiative is likely

to save money for the government, as these rural practitioners are likely to be paid less than their MBBS counterparts. The failure of the rural healthcare system in India is not limited to the lack of trained manpower. Rampant corruption and the poor infrastructure are in no way less responsible. The mere provision of practitioners will not cure all the deficiencies of the current system of rural healthcare. Will enough trained human resources, without adequate infrastructure and provisions of diagnostic investigations and drugs, ensure a reasonable healthcare system? On the contrary, the provision of an adequate infrastructure will attract trained doctors, including MBBS graduates, to work in rural areas.

While the current debate has focused on the need for trained manpower for rural healthcare, the real concerns of rural practitioners have been neglected. The current stand of the government is that these graduates will receive a one-year licence that will be renewed for five years, on condition that they remain in the rural area of their states (6). This is again inconsistent with the provisions of the Constitution which allow all citizens to practise in any part of the country; and is hence, a form of discrimination. There is currently no provision for such graduates to pursue a postgraduate course, which is again an infringement of the right of individuals to further their skills and knowledge (7). These graduates will be forced to practise only in sub-centres and at most in PHCs, again an encroachment on the right to practise at the place of choice (8).

Such loopholes and ethical issues must be handled appropriately. There is an urgent need to consult all stake holders before we end up creating more problems than solutions.

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Corrections

The authors of the NBC abstract "Exploring gender issues and needs of family care providers of PLHAs: case study from Pune, India" (Abstracts. *Indian J Med Ethics*. 2010; 7(4):277) are: Rewa Kohli, Latika Karve, Vridula Purohit, Vinod Bhalerao, Shilpa Kharvande, Sheela Rangan and Seema Sahay.

In the Clinical Trials Watch column in the October-December 2010 issue, the total number of trials given in the phases section of the "year missing" column was given as 10. The total number of trials in this category was 4.