Title: National Medical Bill – An opportunity to end educational apartheid

(Running title for purpose of tracking): Manish Jain on NMC bill, and educational apartheid

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National Medical Bill – An opportunity to end educational apartheid?

**Abstract:**

Medical education in India has hitherto been regulated by two conflicting bodies, the now defunct Medical Council of India and the National Board of examination. The perceived objective of the proposed National Medical Bill is a revamp of the medical education in India. While skepticism prevails over the scope of the proposed bill, the issue of unquestioned parity of the degrees granted by these two bodies has been eclipsed, at least in the public domain. The current article discusses the perennial and tacit acrimony between the two bodies and highlights the potential opportunity to abrogate the educational apartheid that has so far hindered the growth of professionals with a national board qualification in medical academia.

**Key words:** National Board of Education, National Medical Bill, Diplomat of National Board, medical teachers' eligibility

Sir,

The Government has superseded the Medical Council of India (MCI) by an interim board of governors that would assume the powers and functions of the council, pending the passage of the National Medical Bill (1). The ultimate intended objective of this step is thought to be a systemic revamp of the medical education system. Uncertainty prevails over whether this portends a better future for medical education (2) and whether medical academia would be inclusive and accommodating.

Medical education in India has not had smooth sailing in recent decades. Corruption, mostly in granting permission to new medical colleges and the practice of hiring ghost faculty have been common (3,4). The MCI and the National Board of Examinations (NBE) have been two acrimonious poles of Indian medical education. The National Board of Examinations was established in 1975 with the prime objective of improving the quality of medical education (5). That was an era when the overseas qualifications of Royal Colleges and Boards were commonly sought. The NBE although successful in ensuring the quality of training and maintaining a uniform, high standard of examinations for its graduates, lacked the will to effectively safeguard the interests of the vast pool of Diplomate of National Board (DNB); its response to alleged harassment or discrimination of DNBs in medical academia has been lackadaisical and restricted to dissemination of notifications of equivalence through its web page, prospectus and correspondence (6).

MCI on its part, used one or the other riders to subjugate the DNBs and keep them off the medical education (7). This happened despite the nation-wide dearth of medical teachers that culminated in the aforesaid ghost faculty recruitment. The “inspector raj” of the MCI was ruthless and cruel in finding faults with DNBs, often humiliating such faculty in full public view. The author has experience of such “arbitrarism”, whereby unlike other faculty and ghost faculty present on the day of inspection, those with DNB were singled out to be subjected to the highest scrutiny.

Some of the reasons cited by the MCI to validate its policies about “equivalence” (or, non equivalence, thereof) of NBE and MCI degrees were lack of residencies at a sacrosanct “recognised medical college”, lack of research experience, inadequacy of bed strength of the hospital (7).

A resident at a medical college is understandably exposed to other specialties and may have better exposure to some of the interdisciplinary areas of medicine. Let us consider a hypothetical example of an Ophthalmology resident at a medical college with its multidisciplinary frame work who may have more frequent encounters with pregnant women with pre-eclampsia or eclampsia during his training; however, to presume that his counterpart at an NBE accredited institute would never have such exposure is preposterous. Some of these NBE accredited institutes are among the finest hospitals evident through their research and publication history and have much better access to scientific journals and technical infrastructure than an average medical college in the public sector. Many Government aided medical colleges lack even the basic amenities, while others lack the cutting-edge medical technology, such as assisted fertility that corporate hospitals might offer. An Ophthalmology resident working at a corporate hospital may therefore have better experience in interdisciplinary care and consequently, higher chances of encountering a case of visual disturbance (palinopsia) caused by an ovulation-inducing drug clomiphen prescribed by the assisted fertility clinic.

More recently, the erstwhile MCI cited the bed strength of the hospital where residency was completed (8). Thus, a resident from a hospital with a bed strength of 500 would squeeze through when it comes to placement at a medical college, while others who had their residency at a hospital with fewer beds would be filtered off. At first glance, such a predicament of an NBE graduate from a semi urban hospital may appear logical. However, it must be understood that no two clinicians have the same set of skills or expertise.

In fact, the doctors working in semi urban or rural areas may have their own unique exposure to multiple problems prevalent in the region. A notable example is a case of Kumar who had a stint with the National Polio Surveillance Project (NPSP) and the humanitarian organization Médecins Sans Frontières (MSF) or Doctors Without Borders (9).  Working as a resident in a hundred-bedded rural hospital in Uttarakhand largely for the strata of the society that usually belonged to the lower end of the social spectrum, one third of his work involved working in the emergency room (ER), managing myocardial infarction and pulmonary edema, severe asthma/chronic obstructive pulmonary disease as well as suturing lacerations, inserting chest tubes, doing emergency caesarean sections, and counseling hyperventilating patients. The same resident would have acquired an entirely different set of skills at a large corporate hospital or an approved medical college; nevertheless, none of those colleges would impart him what he acquired through his tryst with rural India. His NPSP experience guided him on how people survived perennial floods and poverty, whereas MSF consolidated his belief that malaria, acute respiratory infection, diarrhoea, malaria and malnutrition were a sad reality of India, in spite of the inflated claims that India was cruising as a nation at a rapid pace. More such cases exist, albeit with scant reference in the medical literature.

Now if this graduate had to compete with a graduate from, let us say a college in Eastern Uttar Pradesh, which was recently in news for poor infrastructure in pediatric intensive care unit, the MCI graduate would find it much easier to qualify for a teaching at a medical college (10).

Through its riders, the erstwhile MCI always treated NE graduates as pariahs in medical education; Interestingly, if one acquired a western qualification such as a Fellowship of the Royal College of Surgeons (FRCS) despite being a resident at the same institute that is accredited by both the Royal Colleges and the NBE, but berated by the MCI for not being a multidisciplinary hospital with a minimum stipulated number of beds, the FRCS degree would entitle him to be a medical teacher – not his DNB!(7) In a reply to author's query under the right to information (RTI) act aimed to seek explanation for this disparity few years ago, the MCI said, the issue was beyond the its purview. However, the scope of functions of the NBE, an autonomous organisation founded through an act of Parliament, too fall beyond the purview of MCI.

Medicine is a rapidly evolving science, neither NBE nor MCI graduates are omniscient. An MCI graduate would never be asked to complete additional bridging years of residency at a rural or corporate hospital to iron out his deficiencies in a public sector MCI recognised college. Further, doctors are expected to complete the continuing medical education (CME) modules any way.

Forty-three years after the foundation of the NBE, if there is still a doubt about the quality of education the board imparts, it is as much of a failure as the MCI, implying a need to scrap it as well. The proposed NMC bill should ensure an absolute parity among all medical graduates regardless of all “ifs and buts” including the bed strength, since the hospitals accredited have already had a scrutiny. It is unfortunate that such pervert discrimination has prevailed against the NBE graduates for so long through an implicit tug of war between the two organisations. It is high time that the dignity of NBE graduates is restored and the “educational apartheid” thus perpetuated abolished. They constitute a vast pool of untapped talent and the proposed bill should serve as an opportunity to rectify a mistake of the past.

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