

MEDICAL EDUCATION IN INDIA – RECENT SCENARIO

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ABSTRACT

Background: Medical Education at under graduate level has been under constant control and vigil of the Medical Council of India. But in spite of additions, deletions and modifications effective implementation of curricular changes have not seen the light. The graduate Medical Education Regulations was given shape in 1997 from the initial form of 1957. Changes were envisaged in 2008. Despite lot of additions in 2008 effective implementation didn't materialize. Vision 2015 document had detailed suggested changes but unfortunately not implemented. Now this year the all new competency based medical education (CBME) is in for proper implementation through a well-designed support program with supervision and feedback (CISP) of the academic cell of MCI (Medical Council of India). Backdrop, Finer details, feedback are viewed and analyzed. **Conclusion:** The present CBME has clear definitions, ways to implementation and active feedback mechanisms. So success can be assured and the Indian Medical Graduate under CBME can be better wholesome and doctor of first contact not only at local levels primary secondary or tertiary levels but also with preparedness to face international competition.

Keywords: India; Medical Education; CBME; MCI.

INTRODUCTION

Backdrop: Western Medicine was first introduced in India way back in 16th century by the Portuguese. First Native Medical institution was established in Calcutta in 1822 where instruction was in vernacular as European texts were translated into local language. In next four years South Bombay had western medicine in Indian Medical School, but it didn't last more than six years. In 1835 India had the Calcutta Medical College and in three more years Sir JJ Hospital and Grant Medical College came into existence. But the first University affiliated Medical Institution in 1850 only.(1) Now the current position is 532 medical colleges catering to 76878 MBBS seats out of which Government contribution is 272 colleges (51%) covering 41388 MBBS seats. Private contribution is almost at par at 49%.(2)

Introspection into medical education: In mid 70s Shrivastava committee suggested reorientation of medical education by national priorities and needs and in 1986 Bajaj committee noted that medical school faculty though efficient in clinical specializations were deficient as educators.(3) Norman Walker and Colonel Nudham recommended the need to establish a central co-coordinating body in India and so Medical Council of India had its inception in 1933 in lines of Medical Council of UK (4) The Indian Medical Council Act (Aact 102 Of 1956) had assent of President of India on 30th December 1956.

Though Regulations on Graduate Medical Education date back to 1997, "Regulations on Graduate Medical Education (Amendment), 2008 Part-II brought out some important amendments as under.

“Training should be able to meet internationally acceptable standards”, “should have curriculum committee”, “ integration of Information and communications technology (ICT) in learning process”, and “ possess the attitude for continued self-learning and to seek further expertise or to pursue research in any chosen area of Medicine, action research and documentation skills”.(5)

Apart from these, a village attachment of at least one week and large number of hands-on sessions, practice on simulators including Zoë’s model. All these amendments incorporated in 2008 remained virtually unimplemented as chalked out implementation program were not enforced. Basic management skills in the area of human resources, material and resource management related to healthcare delivery, General hospital management, principal inventory skills and counseling were also added at that time. But systemic implementing mechanisms were not identified and insisted upon at that time. The system was subject-centric, time bound with negligible scope for feedback. Then came The Vision 2015 document, but this also passed uncared for at implementation stage.(6) This year the CBME (Competency based Medical Education) came up with properly implementable support program the CISP (Curriculum implementation support program) wherein MCI has systematically undertook Faculty Development Program involving every medical college through their Regional and Nodal Centers with feedback system in-built. Not only the first month was earmarked for dedicated efforts of implementing the foundation course but also well planned CBME highlighting each aspect of competency horizontal and vertical integrations ECE (early clinical exposure) Ethics professionalism attitudes and skill development apart from BLS (basic life support) and Language computers and sports.(7)

DETAILS OF IMPLEMENTED NEW CURRICULAM

Recent advances: Based upon decades of observations requirement for bringing in a drastic change in curriculum prioritizing on building skills and competencies with outcomes as target and changing assessment methods, the CBME is incorporated. Indian system relied upon didactic lecturing and predominantly unidirectional flow of lower order knowledge and hence assessment also had been excessively centered on rote memory recall of information and irrelevant concepts ignoring skills and outcomes. This has been dragging the

budding doctors away from reality of actual practice of medical profession. (8)

CBME: The rationale for CBME rooted from the colonial background as previously undergraduate medical curriculum has mostly been traditional as it was virtual replication of UK based system of teaching and evaluation. UK brought out changes of far reaching ways during these many years whereas India stuck to prevalent system. The new changes envisaged in the CBME included components like Foundation course, Electives, Integrated learning and ECE. It is not an overnight thought process but decades of observations put to steadfast action for resulting in a workable force in curriculum that is CBME. While modifications in syllabus are marginal it is the change brought in a palpable levels in curriculum as competencies incorporated in this CBME. Prior to this, it is observed and inferred that relevance to learning was very lower conspicuous by absence. Basic sciences were treated as raw building material for MBBS course; mainly because of lack of integration either at horizontal or vertical levels i.e. applicative aspects were not highlighted. The most important stakeholders, the students, had no nascent time exposure to clinical. The CBME allows patient interaction in planned and supervised settings. CBME is another form of outcome based education where learning outcomes assume more importance than learning process or pathways. Accepting this will usher in a positive paradigm shift in approach to medical education in India. Communication skills or task based learning sessions enriches and contextualizes the learning. Attitude, ethics and professionalism as integral to patient-doctor relationship added by socio cultural context of diseases ensuring patient centricity. The purpose of ECE is not to pre-pone the conventional clinical teaching. During ECE interacting with patient, observing doctor-patient communication are prioritized. 30 hours for each subject of first year allocated for ECE. (9)

Components of CBME:

Foundation course: The first month upon entry of MBBS student into the institution is planned to become welcome into the system by introducing this. It has all the ingredients needed for adaptation and acclimatization. This is timed to be before the formal start of classes. This positive step seems to have sprouted in medical education administrators as realization of the fact that unlike western counterpart Indian medical aspirants are relatively younger and naïve. So need for no curricular support. Its

introduction will bring about “feel good to be a medical professional” and ingrain pride to be a medical professional. In any medical college, the student population is perfect heterogeneous mix from varied backgrounds, languages, schooling and so levels of learning abilities. Newer learning modalities including self-directed learning are introduced. Computer skills, stress management, time management, ethics, attitudes and professionalism are also vital ingredients in this first month course. Communication skills are prioritized as strained relationship results from improper communication especially Doctor-patient relationship. Increased violence against doctors in recent decades and increased suicidal and mental depression cases have directed the medical educators to include stress management, professionalism, ethics and improved communication skills including importance of informed consent and basic life support induction during this Foundation course. Avoiding redundancy by breaking down the shells around each discipline and creating inroads for integration both horizontal and vertical are attempted smoothening walk over interdisciplinary path. ECE is an attempt to make basic science learning more relevant and contextual and at the same time exposing to professionalism ethics and patient interaction in hospital environment.(7)

CBME focuses on outcome, emphasizing on abilities, de emphasizing on time bound. This is learner centric. While traditional system was driven by curriculum, CBME drives the curriculum.

Competencies: Six domains of general competencies include patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and system based practice which is entrenched in American Council of Graduate Medical Education. In the UK three broad end results have been highlighted namely doctor as a scholar and scientist, doctor as a practitioner and doctor as a researcher. The Canadian Medical Education Directors and Specialists encompass seven roles for a specialist including Medical Expert, Communication manager, Health Advocate, scholar and Professional. The MCI has recommended that competency based learning must include designing and implementing a curriculum that would focus on the desired and perceptible activity in real life circumstances. Clinician, Leader and member of Health care team system, communicator, Lifelong learner and a Professional (9)

CISP: Capacity building of the faculty aiming at proper and uniform implementation of CBME is taken care of, by the Medical Council of India through Academic section and widespread Regional and Nodal Centers of Medical Education. Strict monitoring of this curriculum implementation support program is key to success.(10)

Electives: The concept of electives for two months is with a futuristic vision. This two months program is divided into two parts of one month each first is research oriented in pre and Para clinical disciplines including allied departments and the second month clinical oriented. These can be done in other institutions and laboratories. Choice is of learner. But this period will have to be in India.(10)

Newer introduction is incorporating learning hands-on in the skill labs to be developed as per guidelines of the Medical Council of India. Stress is on small group teaching. This is difficult to implement at the present recommended faculty strength. There is urgent need for increasing teacher student ratio to achieve desirable and effective small group teaching and hands-on learning.

Implementation: First month i.e. August was utilized for foundation course as per the Medical Council of India instructions. As all the members of Medical Education Unit were trained in revised basic course workshop and curriculum committee members already had rBCW were imparted training in CISP. So implementation of CBME was possible in a methodical manner.

Feedback: Salient feedback from important stakeholders, the students from the different medical colleges as under.

Foundation course need not be stretched to 4 weeks. 2 or 3 weeks time is sufficient.

Participating in role-play and other student activities helped them overcome stage fear. They acquired a sense of responsibility towards society after listening to lecture on Doctors role in the society. They enjoyed community field visits and understood PHC(Primary Health centre), CHC(Community Health centre) medical and paramedical staff role. They felt hand hygiene and biohazard management useful. They appreciated the usefulness and importance of basic life support and first aid. Students felt at ease with interactive lectures, role plays and other student activities. Group Dynamics was much appreciated as it provided learning platform for interaction they felt that they could develop speaking skills, power of observation and

understood and follow time management and stress management, Medical terminology and language were found useful. Career pathways and disaster management were stimulating and useful. Medical etiquettes were found to be interesting.

CONCLUSION

The Graduate Medical education Regulations of MCI has most of the components of present day CBME but what was lacking is proper directions and implementation program as strict as of now. Non-prioritizing didactic lectures encouraging small group teaching with a maximum of ten students in a group, horizontal and vertical integration creating relevance to basic sciences with contextualizing, initiating problem based and community clinical case based learning. The present CBME has clear definitions ways to implementation and active feedback mechanisms. So success can be assured and the Indian Medical Graduate under CBME can be better wholesome and doctor of first contact not only at local levels primary secondary or tertiary levels but also with preparedness to face international competition.

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