COMMENTS

The real crisis in medical education

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Abstract

In the light of the agitation against reservations for other backward castes in medical colleges we must ask some questions. How does India plan for its medical personnel? Is caste only a phantom from the past? And what is merit?

Our students of public health come from different social, economic, and educational backgrounds. Both teachers and students are challenged to examine their assumptions, recognise their underlying ideologies, and enter into discussions that shatter the myths acquired during our socialisation. This is needed in medical schools, where there is minimal and inadequate teaching of social sciences.

When young doctors recently went on strike to protest against the proposal to introduce reservations in medical colleges, some well-known doctors pronounced in a televised programme that selection through quotas introduces a "risk" to patients and a scalpel in the hands of such doctors is not desirable. Underlying this statement was the assumption that all "quota" students lack skills and knowledge and that merit has only one criterion – a high percentage of marks.

Although the doctors have gone back to work and the media has found other concerns, such myths need to be examined because they reflect strong biases. To carry on the debate, we must ask some questions: How does India plan for its medical personnel? Is caste only a phantom from the past? And what is merit?

The real crisis in medical education

The resource input in the health sector in India has been the worst ever during the 1990s. Despite promises of a 2-3 per cent hike during the tenth plan period, the figure stands at 0.9 per cent of the gross domestic product at the end of the plan. The policy of privatisation of medical care has seriously undermined health services and further limited the access of the underprivileged. There are 6,30,000 registered doctors in the country (1). A large proportion of doctors educated here have migrated to other countries. Private and corporate hospitals are mushrooming in the cities, yet 700 public health centres function without even a single doctor (2).

Policy makers confess that doctors will not go where they are needed the most because of inadequate working conditions. Instead of investing to improve the conditions, policy makers, under the political compulsions of health sector reforms, have decided that rural services must depend on Accredited Social Health Activists (ASHA), Ayurvedic Unani Siddha and Homeopathy (AYUSH) and registered medical practitioners (RMP).

Under these circumstances, a strike by doctors against the policy of reservations had to be handled with care. Without thinking about the severe shortage of nurses and paramedical personnel, or the fact that increasing seats for specialists would further skew the distribution of medical personnel, the state chose the softest option of doubling the number of seats for higher education.

The total investment in medical education, training and research over 2006-7 is Rs 1,436.64 crore of the Rs 12,545.88 crore put into the health sector (3). Of this, the highest share is for education and research institutions. If the investment for doctors' training is doubled, what will be left for other personnel? Where will the resources come from in an already tight health budget? These concerns are left out of the debate.

The present crisis in higher education arises out of the neglect of public sector educational institutions since the 1990s, when subsidies shifted from the public to the private sector, and personnel planning was sidelined. Planners have been making deliberate compromises that feed the growing medical industry with junior specialists to support the consultants of tertiary care private and corporate hospitals. This explains why the corporate and private sectors support the striking doctors. Instead of fighting for the revival of secondary and basic level services for the nation and a socially responsible and accountable tertiary care support system, the striking doctors were supporting a system in which super-speciality-based tertiary services are reserved for the rich and ASHA, AYUSH and RMP are meant for the poor. This situation calls for a debate on the responsibility of the state-aided private sector and its public accountability.

The myth of "merit"

The truth about caste is evident in the matrimonial columns of newspapers, in the statistics on caste and achievement in higher education, access to health care and other services, and the profiles of technical bureaucrats. More important, over the past 50 years, the system of quotas for the scheduled castes and scheduled tribes has been wilfully sabotaged. No attention has been paid to schools where children of these castes are derided and suppressed. Their drop-out rates are held against them and there are no efforts to search for means to strengthen educational support structures. Those who still make the grade are denied opportunities in the name of "merit".

Shining India's young doctors and their patrons ignore the fact that since independence, in effect, there is an undeclared system of reservations for the upper castes. To claim that caste is no more an issue and equity must be worked out only in terms of class is to ignore the caste-class overlap. It serves as a diversion to save the future of "our children". The stalwarts of industry, of the Knowledge Commission, and professionals settled abroad have all risen in defence of "merit" – a concept that demands deeper scrutiny.

Medicine is both a science and an art. Other than technical competence, its definition must incorporate the capacity to cope with new challenges, work as a team, communicate concern and sympathy, and possess an awareness of the social circumstances of patients and of national concerns. Can such qualities be ensured by percentages alone? Are all doctors outside quotas necessarily "meritorious"? Does merit lie in fluent English, accent and mannerisms? How then do we judge merit?

The MBBS degree is given only to those who acquire a minimum of 50 per cent marks. Graduating doctors must be able to handle matters of life and death effectively – there are no concessions here. They work as interns, house physicians and residents and make up the backbone of any hospital; consultants bask in the reflected glory of the hard labour of junior doctors. How can they be judged not good enough to benefit from the quota system? What is it in our higher education that stops them from improving further?

The patrons of privatisation

The patrons of the protestors, who also invariably support privatisation, have nothing to say about who goes to the private colleges that charge capitation fees as high as Rs 20-30 lakh. Almost half the medical colleges in the country admit students on the basis of their ability to pay high fees, rather than their marks. What is the merit of these students? Or those who take off to the US, UK, Canada, Europe, New Zealand, Australia, Ireland, and, lately, China?

With the new economic order, resources for international educational institutions have shrunk and these institutions have been pressured to attract foreign students. To ensure a medical career for their children, the expanding Indian middle class is ready to pay two to three times the normal fee as foreign students. Thus India offers a great market for higher medical education. The numbers of Indians as foreign students in other countries has been rising since the 1990s and this cannot be projected as a fall-out of the policy of affirmative action.

The defenders of privatisation say that it helps make public sector services available to the common man. Can the same logic then be applied to higher education? Does the resolve of the "meritorious" to hold on to public sector medical colleges and retain the freedom to join the private sector afterwards explain the contradictions within the present policy of medical education?

Or does this reveal that merit comes partly by the virtue of belonging to a highly privileged set that aggressively pushes its interests at the cost of others? Does it not show that some doctors have the benefit of capitation fee colleges and foreign degrees and also want to assert their rights over public institutions for higher education? Does it not demonstrate that the government prefers to promote professional migration at the cost of national health services and the basic needs of ordinary Indians?

Some of those fighting against quotas argue that they are only against the rich and privileged "creamy layer" of the other backward castes. Before we refine the criteria for the "creamy layer" as prescribed by the Supreme Court, we need to ask: Why should the economic criteria be applied to only to the reserved categories and not to the general candidates? Is corruption an exclusive preserve of the backward castes or is this a case of the "creamiest against the creamy"?

If we can question some of our constitutional provisions, we can also hope to amend them. The only answer to the present conundrum is to have affirmative action for the socially deprived and workable criteria for economic backwardness for all. What are we fighting for? Our individual right to enter the medical market through the cheaper route of state medical institutions? Or our duty to be responsible citizens, concerned about the health services, the ethics of professional education, appropriate personnel planning in a democracy, and a less hierarchical India? It is time for many of our doctors to lose some of their innocence and a lot of their arrogance.

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