EDITORIAL

The Thorat Committee Report and the good doctor

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The Sukhadeo Thorat Committee, constituted to enquire into the alleged harassment of students from the scheduled castes and tribes in the All India Institute of Medical Sciences, found widespread evidence of such harassment (1). To make matters worse, the committee found that the faculty, largely from the forward castes, were also involved in systematic denigration of students from the scheduled castes and tribes. The complete report makes sad reading. The harassment is in many ways: soon after new students join the college they are the target of systematic verbal and, sometimes, physical attacks by higher caste students. They are frequently told that they are inferior and do not deserve to be in the institute. They are given very little space in sports and cultural activities. In the hostels, due to repeated harassment, these students have been ghettoised into two floors. There is very little healthy social interaction among students of higher castes and these students.

In the academic sphere they are the victims of scorn by the faculty. For example, the institute has a system of continuous evaluation of the students and an end semester examination. There is a widespread feeling among the students of the scheduled castes and tribes that they are discriminated against in these evaluations. Systematic bias is also encountered in the junior and senior residency posts and in recruitment to the faculty.

The basic proximate cause of this behaviour by the forward caste students appears to be that they feel that the students from the scheduled castes and tribes have been given an unfair advantage in selection to the course. They hold the view that the system of reservation or quotas is unfair and results in the selection of inferior students. This feeling is shared by many of the faculty. They feel that such students can never be good doctors. In short, casteism has a strong grip.

Competence, caring and equity in medical education

The assumption that reservation of seats for the less privileged castes would lead to a dilution of standards has been disproved by the experience of Tamilnadu, where 68 per cent of seats in medical courses are reserved for almost 40 years. Yet Tamilnadu has among the best health indices. Medical care is not the only reason for this but surely does play some part. In the curative sector, Chennai is a centre which draws patients from other states, notably from north India.

The primary purpose of medical education is to train doctors to treat and prevent illness among people. All over the world, competition to get into medical school is fierce and societies everywhere try to select the best possible students. What are the desirable qualities that should be looked for in students who will become doctors? To this apparently simple question there appear to be no simple answers (2).The qualities that patients see as desirable in doctors are humaneness, competence and accuracy, patients' involvement in decisions, and time for care (3, 4). In India, by and large, the only criterion used to select students is the marks scored in examinations. Earlier attempts to use interviews as an additional tool failed because of perceived widespread misuse by which the most influential candidate was selected, not the best one. This gave rise to the idea that merit, defined as performance in examinations, was the only fair criterion to apply. This has helped buttress the widespread notion among the forward castes that all forms of quotas for castes which had been the victims of oppression were unfair as the marks that they require to get into a medical college are lower than those required by student from the forward castes. It is another matter that the influential ensured a loophole for themselves by creating so-called self-financing colleges where those with money or influence could qualify for a medical degree.

Marks in qualifying examinations are a good method of ensuring selection of capable medical students who will make competent doctors. But they are not enough to ensure good doctors (5,6). In many countries, for example Canada, France, Australia and South Africa, policy makers have clearly stated that a secondary aim of medical education is to ensure equity and affirmative action (7). These objectives are seen as desirable in themselves to build a healthy society. Underprivileged people who enter the health sector not only ensure the economic security of their own families but also make a favourable impact on their community (8). Schemes to ensure that underprivileged sections of society will get adequate representation in medical school placement are in place in most countries in the world. They all make provision for the fact that disadvantaged sections of the student community will not score grades as high as the more privileged will, even if they are equally intelligent (6). The concept that those who require quotas are not as intelligent as those who do not shows an ignorance of the social determinants of success in examinations.

It ignores the effect of the advantages of class (and, in India, caste), facilities and opportunity, all of which have been well-documented. (6). To understand quotas as providing an unfair advantage is to be blind to the unfair disadvantages that certain communities in India have been victims of. To understand quotas as opening the gateway to training incompetent people ignores the basic fact that there is a minimum standard for qualification.

At independence, a section of those who were instrumental in policy making, notably Dr. B R Ambedkar, pointed out that certain sections of the populace were the victims of long-standing oppression of the most demeaning kind and ensured that some provision was made for them to catch up in the educational sphere and also in the struggle for jobs. Unfortunately, many influential people in society, particularly the bureaucracy and politicians, have never really accepted this view. In the 60 years since independence, many castes which were considered backward at independence have been able to assert themselves through new political formations. However, the dalits continue to remain marginalised.

Equity in service provision

There is clear evidence to show that doctors from less privileged backgrounds are more likely to serve underserved populations (9, 10). In a society like ours, which remains primitive in many ways, it is likely that the scheduled castes and tribes feel more comfortable seeking medical advice from one of their own community. A time will come when caste has no relevance in India, but the time is not yet.

Considering the dramatic maldistribution of doctors, with a majority being located in the cities, a policy which will encourage provision of medical services to the poorly served is welcome.

The All India Institute of Medical Sciences and caste

The All India Institute of Medical Sciences was set up in 1956 with the intention of nurturing excellence in all aspects of healthcare. It would seem to be obvious that this would include an understanding of the causes of sickness and health that go far beyond the germ theory and into the social and economic context of it. That this has not happened, and that in fact the institute was the centre of activity against providing affirmative action for the less privileged, should be a matter of great concern. The involvement of the faculty in the movement against quotas is particularly disturbing. They are expected to be role models for students. If they perpetuate ideas of caste superiority and the intrinsic unfairness of reservations, they do harm not only to their students but to society as a whole. An American clinical teacher has said, "Ultimately teaching is all about the learner, not the teacher. Thus effective clinical teachers aspire to a sort of selflessness whose tangible expression is kindness to learners, especially when assessing them (giving feedback)." (11) Doctors should have a broad view of the causes of ill-health. Nothing in the present way that doctors are trained helps in this. The All India Institute of Medical Sciences, instead of providing a lead in broadening the understanding of health and disease and showing the way in producing good doctors, has become a centre of bigotry. The ill-effects are felt all over the country. The time has come for a major shake-up in medical education in general and in the Institute in particular.

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