MCI's VISION 2015 and PG medical selection: continuing to produce square pegs for round holes?

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The need for better methods of selection for postgraduate (PG) medical seats in different specialties has never been more keenly felt than in the current scenario. Multiple entrance exams, management quota and paid seats, the urgency to get into a PG seat at any cost and the mushrooming of PG entrance exam coaching centres have added to the angst and woes of medical students. Currently the Indian medical education system is one of the largest in the world with around 250 colleges fully recognised by the Medical Council of India (MCI). The increasing demand for doctors trained in basic skills and the need to maintain the educational system on par with global standards is quite challenging, considering all the hurdles which come in the way of improving quality.

One author of this editorial is a postgraduate teacher who has been involved in PG entrance examinations for several years and the other a medical student who has appeared for 30 entrance exams in the last two years! We have also taken the opinions of several students who have either got or not got a PG medical seat after going through several entrance exams across the country. Based on this, we speculate on the problems of the current system, review the VISION 2015 proposed by the Medical Council of India (MCI) to see if it improves the situation, and suggest some alternative strategies based on a review of literature on advanced and superior methods of selection in some other countries (1).

Regarding the paper pattern for entrance exams, the current preference for multiple choice questions (MCQs) as a method of selection was initiated to enhance objectivity. However, even as late as the 1980s and '90s, many institutions had recognised the need for getting to know the candidate either through an interview or through a brief clinical assessment. If candidates had qualified in the theory entrance exam, they had to undergo a face to face interview or some form of clinical assessment in several institutions. The suitability and aptitude of the candidate for the particular specialty would be discussed before the actual selection. While not being entirely fool proof, it was probably more gratifying for the selection panel and the student and resulted in a better fit.

However, all these initiatives had to be abandoned in the name of objectivity and the use of only the MCQ test was proposed by the MCI as the preferred method. An ability to solve MCQs, however, does not reflect the abilities of a good doctor.

Unfortunately, what was considered as the best method has now resulted in a bit of a Frankenstein-like situation. Students start worrying about a PG seat in the final year of medicine, and the internship is spent not in gaining clinical skills but in preparing for the entrance examinations. There are many students who, by their own admission, have not touched a patient during their internship, nor written a single prescription.

Objectivity -- but at what cost?

The scope of the PG centralised entrance test (CET), as it is conducted today, does not include assessment for aptitude in the specialty desired by the candidate. Hence, students tend to neglect their undergraduate education and concentrate on the CET. The only deciding factor is the marks obtained in the CET, with the entrant accepting the subject available to her, not necessarily the subject she has an aptitude for, or the one she likes. As a result, many students drop out of courses that they join and several continue half-heartedly. All manner of scams are being revealed because of this method, including impersonation, students with high marks giving up their seats for a price, and of course much money changing hands. This is unheard of in most developed countries. Pursuing a medical specialty should be a calling and not a financial deal, and the consequence should not be the demoralisation of the medical student community.

Is there an alternative?

Several options exist and we have models from several countries which we can emulate. One possibility is to use marks obtained in the MBBS exams. Since it would be difficult to assess in depth the expertise of the student in the desired subject, it would be useful to consider the marks obtained by the student in that subject at the university examination. Monitoring the growth in knowledge of students indicates the contributions made by the different training phases (2). An aptitude test would also be useful, because that would match students to courses that require special skills, such as surgical courses, or those that require an abiding interest and aptitude, such as psychiatry (3).

VISION 2015 – does it provide any solutions?

The VISION 2015 document of the MCI suggests having an entrance examination soon after the final MBBS examination and just before internship. This has been proposed so that students are not preoccupied by the entrance exams during internship, and focus more on clinical skills (1). Several students we spoke to felt that the new policy of having an exam after the final MBBS will only add to the students' burden, as the exam is in an MCQ pattern while the final MBBS exam is in a different format. They felt that two months of preparation time would be insufficient and, in the process, students might neglect the final MBBS exam and, in turn, perform poorly at both exams. Most students we spoke to, including the second author of this paper, had written an average of 30 entrance exams in a span of two years before getting admission into a PG course. In their experience, preparation to answer MCQs is completely different from that for a theory paper. It is an interesting observation because it gives us some idea that MCQs may not actually be testing the three attributes that they should be: knowledge, skills and aptitude of the doctor. Instead they seem to test the ability to think in a multiple choice format.

VISION 2015 also states that, at the end of internship, the licentiate examination would assess skills. A laudable goal indeed and much needed. However, this may not solve all the problems. It is not yet clear if this would happen as a common exam or would be assessed at the level of individual medical colleges. What of students who did not qualify for PG seats before internship? What if students who feel they are not completely prepared for entrance exams take a year off before exams for studies? These situations may again lead to a waste of resources, with the hospitals lacking interns and patient care being affected.

VISION 2015 is silent about assessing aptitude, matching courses to candidates and also about enhancing objectivity in assessment by methods other than the MCQ format of entrance examinations. There is also a lack of recognition of the postgraduate as a professional and a leader, and a focus only on technical knowledge. Ideally, students who have some leadership experience and those who have participated regularly in social/community health outreach programmes should receive extra credit in selection criteria. This will bring recognition to non-academic activities, which positively hone the personality and outlook of a doctor and are as important as knowledge. Research experience, conference presentations and/or publications in journals should also provide bonus points to PG examination candidates. This will help encourage more medical student involvement in research activities (4, 5). Rural work experience for a minimum number of years after completion of the MBBS is already being used as a criterion by some state governments for providing priority in PG course admissions. This is one way of encouraging fresh doctors to spend some time serving in underprivileged rural areas.

VISION 2015 addresses various reforms which have to be implemented to improve the existing educational system. However, the students we spoke to felt that it would only minimally help in decreasing the existing burden on students in the race to get a PG seat. More exams would only mean more stress.

The idea of having a new pattern of examinations with clinical questions is encouraging. However, we strongly feel that more evidence is needed regarding the nature of questions and responses that actually tap knowledge and skills. Even though hundreds of PG entrance exams have been conducted over the last several years, there is no database or research to guide examiners who set questions for these exams. Which questions appear to be the more discerning, what is the distribution of the nature of questions, what should be the right proportion of clinical versus theoretical questions and should all the questions simply be in the `one of four choices' format, or will any other format of MCQ work better? It is time that the MCI actually looked at some of these issues and gathered evidence to guide future examiners.

Examinations at this level need to focus on an in-depth assessment of the student's knowledge and competency. Questions with multiple responses (with the possibility of more than one answer being correct) are much better than single correct response MCQs in this regard (5). When a candidate attempts such a question with multiple answer options, it tests her in-depth knowledge, observation skills and efficiency in time management. It often simulates a clinical situation where patients might present with co-morbid conditions or multiple symptoms and signs relating to a medical condition.

Students also felt that the newer changed terms in the VISION 2015, for various courses will not help to improve the quality of education. The proposed framework suggests introduction of a two year Master of Medicine (M Med) programme as the first level of specialisation with the focus on skill development and providing care to the community. These PG students will be trained mainly to enhance clinical skills rather than being engaged in basic research. A second exam after M Med will select students for an MD/MS. This would be a burden for students and many M Med students may again neglect learning skills in the process of trying to get a good score for an MD/MS seat. Another issue not clearly addressed is whether M Med is like a diploma course in a particular specialty, or a general training course in basic skills. If students have to prepare for another common exit exam after M Med, they will have no time to learn anything in a particular specialty in a period of one year after M.Med. Some of them might spend more than a year preparing for the PG entrance exam again.

Some questions, which are not addressed by the VISION 2015, but are important in the lives of medical students we interviewed included:

- Would entry to all seats come through the common entrance test?
- Would there be reservations for seats as in the current selection pattern?
- What is the pattern of counselling?
- What would the fee structure be? Would each state's fee structure be different?
- Will the current management quota for seats in private colleges continue?
- What about the private deemed universities and their seats?
- What if some states do not want to be bound by the common entrance exam?
- How will transparency be monitored?

Well-planned methods of selection in other countries

Most other countries with well-planned postgraduate or residency programmes focus on the assessment of clinical skills and aptitude in addition to an MCQ paper for theory.

Several centres in the United States have one exam related to clinical skills. Here, they video record the whole exam session and assess the student for all aspects of patient care -- history taking and examination, arriving at a diagnosis, explaining the prognosis and also prescribing treatment. The US is also planning to introduce new guidelines and more marks for communication skills from 2012. Students write letters to their universities of interest and once they get good percentile marks in the first and second steps of the medical licensing examination, they have interviews with deans of the various universities or the experts in the field. They are also required to send a letter of recommendation from doctors with whom they have previously worked. This process, which is called \`matching', is a good practice because candidates get to choose the subject of specialisation and also the university where they want to study, and the universities are allowed to choose the students who they feel will fit in with their system.

In some other countries, while there is no separate live assessment of clinical skills, there is an exam which includes interpretation of videos, data tables, pathological slides and other investigations. This is a particularly good method for assessing aptitude and if one uses the objective structured clinical examination format this can be objective.

However, this will require much thought, planning and training of large numbers of examiners across the country and some form of standardisation. It is sad to see the medical graduate's plight, following soon after a rigorous course like MBBS. The anxiety of getting a PG seat and the inadequacies in the process of selection are a daunting combination.

It is customary in many decision-making bodies the world over to have consumers as part of the process. Maybe it is time to have students and junior faculty as part of the VISION 2015 committee, to give an insider's view about what is actually happening in the field. This may help the potential PG student and bring about more modern and evidence-based methods of selection.

References

1. Medical Council of India. VISION 2015 [Internet]. New Delhi:2011 Mar [cited 2011 Dec 1]; Available from: www.mciindiia.org
2. van Leeuwen YD, Mol SS, Pollemans MC, van der Vleuten CP, Grol R, Drop MJ. Selection for postgraduate training for general practice: the role of knowledge tests. *Br J Gen Pract*. 1997 June;47(419):359–62.
3. Parulekar SV. Postgraduate entrance test reforms. *J Postgrad Med*. 2011;57:263-4.
4. Bhan A. Conduct of postgraduate medical entrance examinations: Amendments needed. *J Postgrad Med*. 2010;56:332-3.
5. Iyer DS, Bhan A. Postgraduate medical entrance system needs reforms. *Natl Med J India*. 2009 May-Jun;22(3):162-3.