Editorial Perspective

What Ails Medical Education?

GRIEVANCES are being voiced from various platforms against medical education in India for quite some time. Its products, the doctors, are alleged to be found wanting while serving in the rural milieu. The medical curriculum is being blamed for such deficiencies in medical graduates and erudite schemes are being prescribed from time to time. But curiously, the role of medical teachers has eluded the attention of the commentators. That teachers have a profound role on the nature and quality of education goes without saying. This role has been discussed and analysed from various aspects in different forums. The role of medical teachers in medical education, however, has escaped such analysis, presumably because it is taken for granted that there is nothing special to discuss. On the other hand, in the general debate on pay and service conditions of teachers, even during the All India Teachers' strike in 1987, medical teachers were kept, by an apparent consensus, outside the purview of the exercise on the assumption that they are something special. Political authority and officials look upon medical teachers not primarily as teachers, but as doctors first—taking the job of teaching as a secondary one and medical graduates as by products of health care system. Here we will explore the elements which might clarify the role of teachers in medical education. The prevailing picture in West Bengal has served as a model which may differ in many respects from state to state but shares their essential characteristics.

The world of medical education is small. Teachers and students soon become known to each other. An intimate relationship develops between the teacher and the taught in many instances. Thus teachers influence the students not only in their academic life but also in other spheres of life by their personality and behaviour.

The subject of medical education is composed of a number of disciplines each of which being a speciality by itself has its own conclave of functioning. Teachers of each discpline have their separate associations, journals and/or academic forums. At the same time, all disciplines are integrated at the under-graduate level into medicine (MBBS) where teachers of different disciplines have to interact with each other. However, any integrated method of teaching at the under-graduate level has not been evolved as yet. In the post-graduate education, each discipline functions separately.

In the clinical discipline, teachers also act as specialist doctors and consultants, ie they are engaged in treating patients in hospitals attached to the colleges. This has been instrumental in the development of a sustained relationship between the teachers and students. The young doctors with graduate and post-graduate qualifications, enter the world of medical practice and retain their link and relationship with their teachers which is often life-long— the implication being that the teacher-student relationship is extended beyond the boundaries of Alma Mater.

In the earlier days, doctors were inducted into the teaching job in various ways. In government institutions, doctors were appointed as teachers in medical colleges at a ripe age after they had served their due period in non-teaching hospitals spread all over the state. A good number of doctors who acquired post-graduate qualifications, were also offered teaching posts on an honorary basis. In the non-government medical colleges, almost all teachers were on honorary terms or managed to secure a token salary. This honorary system, though advantageous to the employer, had not been resented by the employees. Appointment to a teaching job in a medical college is a very prestigeous position in the medical profession. It brings renown, uplifts status and quickly establishes the teacher in the field of private practice. People look upon medical teachers as the most learned, accomplished and skilful among the doctors; such an attitude works as a one-way ticket to success in private practice. There are, of course, certain grounds for such belief. Medical teachers belonging to clinical disciplines, are daily engaged in the treatment of patients in indoor and outdoor services. They are in a position to experiment with different curative technologies on the hospital patients, perfect them in hospital practice and then apply those technologies profitably in their private practice. Hospital job not only trains the doctor to be a skilful one but also keeps him abreast of continuing developments in the curative technology.

State of Medical Education

Western medicine was imported in India and initially the curriculum and contents of education were necessarily borrowed. Over the years the curriculum underwent many changes and the teaching methods steadily adopted themselves to the Indian reality. A look at this Indian reality will reveal that production of doctors was stepped up rapidly, after independence with a view to expanding the facilities of curative medicine to the largest sections of the people. To employ the increasing number of doctors, state health services underwent rapid expansion; employees state insurance (medical benefit) scheme was launched, and private industrial sector opened up medicare facilities for the employees. In the seventies, the rate of expansion stabilised and a paradoxical situation emerged. It was found that the employment market for doctors was squeezed, opportunities abroad were reduced, the field of private practice turned tremendously competitive, doctors' list in the employment exchange started swelling and junior doctors resorted to agitation for employment. Paripassu, the

cology, biochemistry etc, do not deal with patients and hence are treated as unavoidable nuisances. Para-clinical subjects eg pathology and radiology, though do not make direct interventions in treatment, have nevertheless to come in contact with patients and hence, are given some importance. PSM comes nowhere amongst these divisions and hence, ignored like the non-clinical ones. In the practice of medical care also, doctors (and teachers) belonging to clinical disciplines are looked upon by the entire society as the real persons of importance. Policy-makers, planners and administrators are concerned with clinical subjects only. Progressive commentators on health leave out non-clinical and para-clinical subjects from their deliberations, people at large do not even recognise the teachers dealing with these disciplines as doctors. Students search for ideals among the clinical teachers. In West Bengal, only teachers of clinical discipline and radiology are allowed the privilege of private practice so that these all-important persons do not suffer from financial deprivation. These privileged teachers thus can live as members of the upper economic class of the society and pose as role models for the students.

A look at the remuneration enjoyed by the medical teachers is relevant here. On the salary scale, medical teachers are situated below the level enjoyed by general college and university teachers. General teachers have been enjoying UGC pay scale since 1973, whereas medical teachers in West Bengal were given the benefit of UGC scale only in 1981. General teachers now enjoy a much higher pay-scale as recommended by the Mehrotra commission while medical teachers are still lagging behind in the old UGC scale. In the report of the second Pay Commission (1977-80) of the government of West Bengal, the member-secretary observed

> It is doubtful whether conditions of service of the teaching posts on the UGC pay-scale are exactly the same as those teaching posts in West Bengal Health Service. The teachers in the other academic institutions who are in receipt of UGC pay-scale have a limited number of instructional periods in a week. They enjoy vacation and holidays which are not similarly available to the teaching posts in the medical line. This difference apart, the holders of teaching posts in West Bengal Health Service have to do hospital duties which are onerous in nature. The tremendous pressure of population on hospital services has made their duties all the more onerous. There exists a good case for distinguishing the teachers in the medical institutions from their counterpart in the other academic institutions.

The points for distinction are as in the table:

	Average age of eligibility for lecturership.	UGC pay scale granted in	Duty period	Job requirement.	Age of superannuation.	Pay-scale
College Teachers	25 Years	1973	18 hrs/ week.	Teaching	60 yrs.	Rs.2200 -5700
Medical Teachers	38 Years	1981	30 hrs/ week & 24 hrs a day on-call.	Teaching & whole-time medical service in the hospital	58 yrs.	Rs. 700 -2500

In West Bengal, the clinical teachers have been given the option of private practice in lieu of a 30 percent cut in their salary; in addition—they are debarred from the highest pay-scale (ie their pay-scale is limited to Rs. 700—1900). Consequently, the amount of gratuity and pension also is small. The clinical teacher, therefore, is asked to perform the whole-time job of teaching, whole-time job of a clinician in the hospital and then a whole-time engagement in private practice— a task obviously impossible for a human being. The teacher, in reality, is confronted with a choice to prefer one whole-time job among these three and he, like the average citizen, opts for the profitable one ie private practice. It is a somewhat universal picture that the clinical teachers are accustomed to look upon their salary as a sort of fringe benefit and concentrate on private practice with a fierce dedication to earn as much as they can while the opportunity exists. No wonder, when the state governments in Bihar, Orissa, Andhra Pradesh, Assam etc, withdrew the privilege of private practice, clinical teachers fought at every stage to retain it. In West Bengal, private practice for medical teachers was prohibited in 1982. A case was instituted at the high court and the order was stayed. Soon after, the health portfolio which was under RSP—a constituent of the Left Front, was taken away by the major partner of the Front—CPI(M). The new health minister showed reluctance in implementing the order and the merry atmosphere of private practice continues. Needless to mention, private practice not only offers a return of several times more than the salary figure but also demands a sincere and engaging attention from the clinician. It is simply not possible for a clinician successful in private practice to do justice to the job of teaching and hospital tasks. He has to make a choice, set up a priority.

Then again, among the medical teachers, non-clinical teachers, deprived of status and respect and envious onlooker of their clinical colleagues, fortunes are a frustrated lot who have lost interest both in teaching and in their subject. A good number of them find solace in unauthor-

ised clandestine private practice while others lament. West Bengal has two post-graduate medical colleges where all teachers are forbidden private practice. Their conduct follows the line of the under-graduate non-clinical teachers, ie either clandestine private practice or disinterest in job.

This system of private practice to compensate the clinical teachers has given rise to the following problems:

i) Practising teachers are inclined to settle in Calcutta where the market for private practice is lucrative and are reluctant to accept transfer to another medical college, particularly a distant rural one as it would disrupt the practising network which they have diligently built up with years of effort. The rural medical colleges (there are three in West Bengal) therefore, suffer from a perpetual shortage of teachers.

ii) There is always a long waiting list of doctors possessing eligibility for a teaching post in clinical disciplines and under the unavoidable influence of the law of demand and supply, this situation has resulted in rampant corruption in the matter of teaching appointments. The competition for a teaching post in clinical disciplines has further intensified due to preference for a Calcutta posting. Consequently, clinical teachers try their utmost to retain their Calcutta-posts and resort to questionable means including inciting students to launch agitation demanding the retention of their favourite teachers.

iii) Non-clinical disciplines perpetually suffer from dearth of teachers, not to speak of competent teachers. Aspiring teachers vie for a teaching post in the clinical discipline and barring a few, opt for the non-clinical discipline only when they fail in their endeavour. They accept such postings reluctantly and then try somehow to live with it.

iv) Appointments in the post-graduate colleges are likewise resisted as these are compulsorily non-practising. Teachers in these institutions being non-practising not only suffer financially but also are placed on a lower level of social recognition than the practising ones. Thus they become frustrated and reluctant. Standard of post-graduate medical education has, therefore, deteriorated considerably. In the absence of any incentive, research work, required to be conducted by students, have been turned into paper exercises only. Practical training for students is lopsided. Even among the post-graduate students there is keen competition for the clinical disciplines resulting in corrupt practices in admission and examination, while non-clinical disciplines suffer from dearth of applicants.

What is To Be Done?

The standard of teaching has steadily deteriorated over the years. Zealous attempts to politicise health service has undermined the morale of the doctors including teachers. Non-clinical teachers have little interest in teaching. Teachers of clinical disciplines look upon such appointments as a means of personal aggrandisement and of earning money. Students are merely after the degrees which they would use as capital for their business in medical practice. They have learned the bitter truth that connections in places of influence will fetch them their desired objective—an under-graduate or post-graduate degree/diploma. In such a context, attempts to devise a meaningful methodology of teaching or to revise the curriculum have little relevance. Whatever might be the objective of such an exercise it should not be forgotten that it is the teachers, after all, who are expected to implement the programmes. If objective conditions are not set up so that the teachers participate actively, no programme will succeed.

Another aspect of this messy situation is worth pointing out. The degradation of standards of education makes its own impact on standards of medical practice. Commercialisation apart, scientific excellence in medical care is conspicuous by its absence. Bereft of a rational approach, medicine is being practised as a shot in the dark. Unscientific drugs are being used at random. Modern safer and more effective investigative and operative technologies have not reached even the upper strata of medical practitioners. The less said about clinical research the better. In fact, in the absence of a continuous updating of knowledge, a sort of quackery is rampant even among practitioners holding post-graduate qualifications, not to speak of general practitioners.

Frankly speaking, in the practice of modern medical science, science is the real victim in India. Low levels of scientific knowledge among the medical profession, particularly teachers, have rendered them easy prey to the profiteering campaign of drug and equipment industry. Medical literature, produced mostly by teachers, has not made any positive significant contribution to the development of medical science in the country. An unsavoury example may be cited to give an idea about the hollowness of the medical establishment. Two years ago at the national conference of the orthopaedic surgeons, a paper was presented as a critique of a number of original research articles published during last several years in the orthopaedic journal. Analysing the crucial contents of the articles and citing evidence, this paper revealed that all articles were the products of plagiarism without acknowledgement from the articles published in foreign journals. Scrutiny may show that the picture is no different in other specialities.

Independence or autonomy of teachers, updating of standards and 'check and balance' in career prospect are the areas needing consideration and overhauling. Independence starts with the removal of financial dependence on private practice. The last two Central Pay Commissions

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repeatedly stressed that scientists and technologists ought to be accorded higher status and emoluments. The Shrivastava Committee, MCI and other highly placed authorities unequivocally recommended non-practising terms for the medical teachers. The administration has not taken their recommendations in the right spirit. There has developed a nexus of mutual interest between the political-bureaucratic authority and the teaching community. Politicians of all shades and bureaucrats enjoy the free services of teacher-specialists who also make the costly medicare facilities of the state hospitals available to the former out-of-turn. It is indeed difficult to find a political leader or a high government official who is not personally obliged to a medical teacher. In fact, one of the topmost physicians of Calcutta openly maintained unauthorised private practice throughout the entire length of his service career occupying non-practising posts, which included the topmost posts in the post-graduate medical college and the health service in West Bengal: this enterprising doctor professionally served the chief ministers and ministers during both Congress and Left Front regimes. Unless this pernicious system of private practice is removed, other measures will be infructuous. All discriminations in the matter of pay, promotion and retirement benefits should be resolved. More and more university control should be introduced replacing government control. There should be a declared policy of transfer in transferable services. Lastly and most importantly, there ought to be a system of assessment of performance accompanied by incentives and disincentives. This is perhaps the most controversial area and difficult to operate. Because, credibility of assessment depends upon the credibility and competence of assessors. Still, a structural framework for elements and procedure for assessment could be devised and be given a trial. If this is done, then the present system of examinations based on subjective assessment could be thrown away and be replaced by periodic objective assessment of students at every crucial level of curriculum and training.

The task of updating of knowledge should not be left to individual initiative. Updating includes revision and is dependent on research. It may be emphasised that the teaching community is the most effective force in research and the poor state of medical research in India is actually a reflection of the teaching community.

The Bhore Committee observed in 1946.

"No special facilities are available for the training of teachers in the different subjects of the medical curriculum. . . Broadly speaking medical research receives little or no attention in the medical colleges of India. The authorities responsible for staffing and financing the medical colleges are usually ignorant of the importance of research in relation to the achievement of a correct attitude of mind in the students. . . " The role of teachers in shaping the make-up students is crucial and nowhere is it more pronounced than in the field of medical education. The attitude towards both science and society is involved. The student is influenced not only by the teachings and preachings of the teacher but is influenced most by the teacher's practice. The teacher's admonition against indiscriminate use of antibiotics or random use of steroids cuts little ice with the student when the latter discovers the very teacher's indiscriminate and random prescriptions in private practice. The student thus learns the difference between theory and practice and this influence is intensive and sustained, shaping the professional career and attitude of the student. The teacher's conduct, in its turn, is detemined by his/her position in the society and the profession. Social and economic compulsions dictate terms. In the conflict between pursuit of science and commercial gain, the latter generally prevails. Medical education cannot wait for the development of the intrinsic goodwill of the teachers. Unless measures are taken to ensure job satisfaction, medical colleges will always remain short of dedicated teachers. Unless the standard of teachers is improved, teaching can never improve and consequently medical care cannot improve. However, grandiose or rational might be the curriculum or methodology of teaching. Unfortunately this profound role of teachers in medical education is yet to be recognised in India.

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Appeal to Subscribers/Readers

We regret that the last few issues of the *Radical Journal of Health* have been delayed. This has been because of printing and other difficulties, none of which fortunately are insurmountable. We hope to bring the publication up-to-date in the next couple of months. Please bear with us!

The RJH is for you and is sustained mainly by the support of regular readers like you. So far the journal is being subsidised by donations from concerned individuals. We would not like to pass on the burden of the extra cost to our readers by increasing the subscription rates. The Socialist Health Review Trust, the publisher of RJH has started a campaign for creating a corpus fund which can continue to asborb the extra cost as far as possible.

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