

Dialogue with Dr. Ved Prakash Mishra

It is a dialogue with Hon. Dr. Ved Prakash Mishra Chairman Academic committee MCI New Delhi, Chancellor KIMS & U karad and Chief Advisor DMIMS U by Dr. Meenakshi Girish and Dr. Shubhada Gade, Editors of JETHS about the crisis medical profession is currently passing through, health care services and the futuristic medical education of 21st millenium.....!

MG: Do you think that there is a crisis facing medical profession today? Is there a need to strike a balance between medicine as a service and medicine as a business? While few decades ago it veered towards the former, now it seems to be tilted towards the latter. How we strike the balance is the crisis which confronts us today. Do you feel imparting right type of medical education can help in this crisis?

Hon. Dr. VP: Basically we need to understand one thing clearly, that value system of any society are never constant and static. They are open to continuous changes, the reasons and the basis for this change is multifold. We need to realise and appreciate one thing that a core shift has occurred in the nation from agrarian economy to the industrial economy and the dominant part is industrial economy and therefore value system of the industrial economy and agrarian economy can not be the same. There will be some change and this change is huge and substantial. It is in the context of this change in the value system one needs to ponder as to where exactly the medical profession is to stand. Independent of the nature of the society, the health care system has been rendering services to the diseased in preventive, promotive, curative and rehabilitative aspect.

But the mute question is that, in spite of the nature of the services remaining constant, what shall be the barter mechanism which will be governing it? The core reality is that barter mechanism was never applicable to medical services in the form it being of market driven, price tagged and market guided economics. This is where the medical profession looks entirely different from rest of the professions. But then having said so, there are some cardinal considerations which are to be borne in mind. At one end we say the ethical conduct of the profession will be governed under the ethical code of conduct and but is it not a fact that medical services are now governed by Consumer Protection Act? Is it not true that by covering it under the CPA the tenets of 'consumerism' have come to operate? And if the laws of consumerism are to operate, is it not that the barter system has gripped the entire scenario? If the answer to this proposition is 'yes', then we are talking of a ethicality which was outside the domain of consumerism and now the ethicality is expected to be

of the same colour as that of consumerism. This cannot work. It is no more a doctor and patient, it is a healthcare provider and consumer relationship and therefore the terrains which were governing the two have undergone oceanic changes.

The third aspect is the level of knowledge and the information or the information boost as we call it. This information boost has resulted into an informed patient whose expectations from the health care services are broadened. There is a gap between health expectation and its delivery making the services which were earlier considered efficient at the same qualitative can now be viewed as inept and deficient. These are the cardinal shifts which have taken place over a period of time.

The real issue is ultimately how this yawning gap can be bridged. A solution has to come in the form of structured teaching activity. You have to train your doctors in such a way that they understand that against these realistic considerations what exactly will be the nature of health care services to be provided. I strongly believe that new teaching learning methodologies should evolve which emphasis on training in the 'affective domain'. Knowledge is handy so cognitive domain is not a matter of concern, but affective and psychomotor domains are indeed a matter of concern and they need to be appropriately blended in the context of technological evolution.

Technological advancement is yet another area which cannot be ignored. The whole gamut of skills in the medical profession has been invaded and eroded by technological skills. That 'healing touch' of which we are fond of talking has been virtually taken over by so called 'mechanical touch' of the technologies. The net result is you have to balance all these variations with structuring and designing of the curriculum matching it with appropriate teaching, training, orientation and commensurate modes of assessment, whereby these concerns are addressed.

MG: Dr. Atul Gawande in his writings, has said that much of health care related expenditure is actually unnecessary investigations and treatment in USA. The same is not true in U.K. where the pivot of healthcare is the G.P. It is a common feeling that a system which covets and respects the post of G.P. is the need of the hour to cutdown on unnecessary and

expensive treatment at the hands of specialist and super specialist. Do you feel that there is a case for M.D. in G.P. to bring back respect for the GPs' role in healthcare?

Hon. Dr. VP: Structuring in UK is so subtle that until and unless there is primary referral you can not go to secondary level and unless there is secondary referral you cannot go to tertiary care system.

MG: So does this not weigh in favour of having a MD in GP?

Hon. Dr. VP: The MD degree in any generic nature contemplates specialisation. An MD degree holder is a specialist of whatever generic name you tag it with. So rather than having a MD I would like to promote degree in 'family medicine', a branch which has been lost over a period of time and is required to be put in place in a country like India where population is huge and yet there is nothing like National Health Scheme coverage, and there is nothing like Health Insurance coverage.

You have to work out of primary health care competencies, secondary and tertiary health care competencies, and they all are need based and the referrals have to be subtle as they are in vogue in UK, then only it will work and yield results. As such, specialisation in family medicine will take care of this concern. I am talking of family medicine on the format of what we call as first contact or primary medicine care so that every patient doesn't have to go directly to secondary or tertiary care centre as the case may be. It has to be appropriately structured on the said count by the governing and regulatory authorities with diligent application of mind and evaluation of operational realities.

MG: Wouldn't a course in Family Medicine mean another form of specialisation?

Hon. Dr. VP: No. The undergraduate curriculum, which is generating first contact physician should have stringent emphasis on family medicine. The component of family medicine in the undergraduate curriculum should be dominant and then MD Family Medicine holder will be a Family Medicine practitioner who will be a specialist as well as a generalist.

SG: Isn't it time we de fossilised our medical curriculum. Considering the explosion in knowledge and information do you feel there is a need to prune the curriculum so that the essentials are taught at undergraduate level in order to make them competent to practice as general physicians in the society?

Hon. Dr. VP: Answer to this is yes and the reasons are – one, we have no scientific rationale and basis of curriculum update. Two, people at the helm of affairs have been dispensing this [curriculum update] mostly on the experiential basis.

The whole structuring and renewal of the curriculum has to be to bring uniformity in it across the nation. The number of medical schools are many and we have a affiliative character of medical education. The colleges are affiliated to examining universities. These universities are autonomous bodies and in order to evoke uniformity in such situation the curriculum has to be in the regulatory format. A regulation has to be notified under section 33 of IMC act wherein prior approval of Govt of India is necessary. Over a period of time the experience has revealed that timely notification of the curriculum due to the said modality is the casualty.

So my personal observation is the gestational period for notifying an academic requirement like curriculum is in tolerably high, so something prepared in 1993 if it is going to be notified in 1997, oceanic changes would have taken place in the interim period and that is the reason why in spite of the efforts by the experts, we have not been able to keep pace with time and that is the reason why MCI has taken a position that the Indian Medical Council Act, needs to be amended whereby under section 33 those regulations which are dealing with academics will be freed from the precondition of prior approval by the Govt of India. So if this amendment is brought out then the academic regulations will not be required to be approved by Govt of India. The General Body meeting held on 26,27th March meeting of the Medical Council of India has unanimously accepted this resolution of mine, now it is with the Govt. of India to be pursued for its approval by the parliament.

SG: So you say that the entire UG curriculum across the country should be uniform in order bring about a uniform competency in primary care across the nation?

Hon. Dr. VP: The core curriculum should be uniform throughout the country for the purposes of core competencies but the examining university should also have a autonomy to further upgrade them as per their needs but without compromising with the core or basic competencies.

Q: Core remains same, but variation in curriculum should be allowed?

Hon. VP: Every curriculum should be open to modifications for the local needs. If you do not give this liberty to the examining universities then whatever has been worked out in the regulation will

be put to use blindly as it is, which will fail to serve and deliver optimally.

MG: A lot of people have said that ethics and communication skills should be a part of medical curriculum. While changes have been made in the curriculum to include communication skills, what can be done to inculcate ethics through medical curriculum?

Hon. Dr. VP: Attitude, communication and ethics - this is the trinity of affective domain in medical education. We are already in the process of incorporating them in the form of modular teaching across the country. So it will be in the form of attitudinal and communication skills blended with medical text through the 'ATCOM Module'.

SG: The current scenario of post graduation through PG entrance exam is very depressing and controversial, and an entrance exam based entirely on theoretical knowledge learnt by rote seems to be the key to success and this system influences the way undergraduates learn medicine, do you feel there is a need for massive overhaul for PG entrance exam

Hon. Dr. VP: There has to be a unitary national entrance test at both UG and PG level. This is a must but then only entrance test would not suffice to tide over our problems. As such if the standardisation is to be done should 'exit test' not be of equal importance? What is the use of an 'entrance test' if it is not blended with an exit test. Why do we take things half-heartedly? It has to be coupled with 'exit test'. The entrance test is for the uniformity at the point of entry, whereas 'exit test' is for the uniformity for end certification at the time of exit. There should not be 'entrance test' in isolation. 'Entrance test' will always have to be blended with 'exit test'.

SG: If the curriculum is not uniform how throughout country how can there be a common test?

Hon. Dr. VP: I am talking of competency based curriculum where competencies will be measured in terms of awardable 'credit'. So whatever variations in the curriculum, the 'credits based' evaluation of competencies will provide uniformity across the nation and also they would be transferable in the international context.

MG: Another example of the fossilised thinking is the way we have retained internship. It no more serves the glorious aim it was first designed for and we think it is a colossal waste of time. Your comments?

Hon. Dr. VP: Internship should be a supervised period of 'hands-on training' of the competencies Nowadays students are surrendering their entire internship period for the preparation of MCQs for their postgraduate entrance test. I strongly feel that the PG entrance exam should be held immediately after the results of the MBBS examination and then internship should follow. Internship should also be evaluated and this evaluation of internship should result in award of marks which would be taken into account for the purposes of end certification.

Entrance to Post graduation should be based on a blend of weightage of score at MBBS examination and the 'entrance test'. It would be worthwhile to make internship credit based because the subtle principle is that 'Assessment drives learning'.

MG: What is wrong with the old system of admission to PG based on merit at UG level and which system would you favour?

Hon. Dr. VP: Comparisons are hollow. I prefer equal weightage to cumulative MBBS exam and entrance test. It should be 50:50. Not just knowledge in isolation is to be made the sole criterion. Frankly speaking the knowledge stands certified by the traditional entrance exam and credits awarded on the basis of competencies during UG should also be awarded due weightage. Which examination in surgery is based on the examinees surgical performance? You are certifying an MCh degree without any realistic surgical operation being performed towards examination. Every unit of activity has to be credited. Logbooks should be given more weightage and by this modality way time and duration of course becomes irrelevant because of the operational credit award system where under, a rapid learner moves faster as against a contemporary slow learner.

SG: The pressure cooker environment of medical education coupled with the pressures, pleasure and pain of adolescence can put a lot of stress on young shoulders. Isn't the western system of entering the medical education after completing the graduation a better way?

Hon. Dr. VP: The whole system has to be dealt by the modalities of stress management. If we follow UK system of spending 7 more years for super specialisation a child entering medical profession at 17 will have his degree at the age of 34 years. Education in this country even today is a matter of livelihood balance I still believe that the degrees that we hold were the sources of our livelihood. Please consider the socioeconomic status of this country

where a higher education dropout rate even today is 72% as against 12-Five year development plan stand completed.

MG: Research in medical field is still a long way from what it is in the western world though undergraduates are encouraged to take on research projects, do you think any other steps can be taken to improve the research environment in our country

Hon. Dr. VP: Research skills need to be an integral part of undergraduate curriculum. There ought to be credit system for the said skills at the undergraduate level itself.

MG: The teachers of today have to compete...and it is an unequal competition...with whatsapp and facebook for the attention of students. How do you think digitalisation can make medical teaching interesting and relevant?

Hon. VP: There is no question of imparting knowledge at this level. Gone are those days where teacher used to be considered as the 'repository' of knowledge and learners the committed 'receivers'. Technology has absolutely bridged this gap between teacher and students. A peep into the document pertaining to 'Higher education of 21st century for 21st Millennium' which would reveal what has been brought out therein. It states about the role of teacher in 21st Century as no more a sage on the center stage, but a facilitator in the 'green room'. You don't need a 'teacher', what you need is a 'mentor'. A teacher is not supposed to be working on the 'intelligent quotient' of the child. He has to be a custodian of his 'emotive quotient' and catalyst towards his 'skill quotient'.

SG: Do you feel that educational research in not getting its due in the current scenario?

Hon. Dr. VP: Educational research is a new concept in this country. In terms of the governing regulations prescribed by the Medical Council of India, the teachers have to have publications in the indexed journals for their placement and promotions. Publication by a teacher on the educational research ought to be given the same weightage as if it were a publication in his / her speciality.

MG: Any suggestion for the budding doctors of today.

Hon. Dr. VP: Advices are easy to offer and difficult to practice. Conceive, to believe to achieve is the real dictum for every individual has immense potential, but the unfortunate part is he falls short on realistic actualization of the same. I am tempted to

quote what Swami Vivekananda had said "arise, awake and stop not, till the goal is achieved".