Impressions of Medicine in India

The push for postgraduate degrees

TESSA RICHARDS

Dr Patel (the name is fictional) has been qualified eight years and runs a private practice in a small town in south India. Recently she approached the local medical college to see if she could enrol for a postgraduate degree course. Why? Because business has gone downhill; her patients are simply walking out of the surgery when they learn that she has only MB BS. With so many doctors to choose from they prefer to go next door, to the doctor with an MS or MD or maybe an FRCS or MRCP and, no doubt, a good number of other initials after his name. Well it proves he's the better doctor doesn't it?

This simple (and true) anecdote goes a long way to explaining why all newly qualified doctors in India want a postgraduate degree or diploma—they need one as a licence to compete. Not all succeed but many do, and with about 13 000 doctors qualifying each year the implication of providing further education at this level is daunting. Institutions are already struggling to cope with their massive service commitments and large numbers of undergraduates. Furthermore, the wisdom of acceding to this demand has been questioned for—in the words of one doctor I spoke to, "Does India really need this number of highly trained doctors . . . what is it that we want our doctors to do?"

The questions were rhetorical for to him the answers were evident. For 40 years successive reports have made it clear that India's health problems can never be solved by a Western based curative health service. Yet this "inappropriate and irrelevant" system (to quote from India's National Health Policy December 1983) is flourishing. The towns are full of well qualified doctors providing or seeking to provide the sort of specialist care that is available in the West. And with access to virtually all the latest diagnostic and therapeutic hardware there is no doubt that many succeed. That this form of medicine is available to comparatively few, and primarily only those who can afford it, is an unpalatable truth which most doctors have learnt to live with.

India's major health care problems are in the rural communities but very few doctors want to go there for it takes a very special sort of doctor to opt to work in a small village, many bumpy dirt track miles away from the nearest town, in a health centre where the facilities are basic and the supply of drugs limited and intermittent. They may have no clean water supply, no sanitation, no suitable housing, no consumer goods, poor quality or not enough food, no suitable schools for their children, no like minded neighbours—the list goes on. Furthermore, the basic salary is low and the local people are poor so there is little scope for "compensating" in private practice. To make matters worse, there is likely to be lively competition from established traditional healers, who may not only offer their services more cheaply but have no qualms about dispensing Western medicines in addition to their own remedies.

Thus it is not surprising that almost all doctors try to find a niche in the city. The basic government salaries are equally meagre but the lifestyle is more acceptable and there is more money around, which at least offers the opportunity for private practice. A second important attraction is the opportunity to practise the sort of medicine that has been inculcated at undergraduate level. Some doctors opt entirely for private practice, others enter state government service, often with an eye to combining this with part time practice, a few join central government health schemes and hospital services, but either way, a postgraduate degree is regarded as essential.

How to go about it

To be eligible to apply for a place on a postgraduate course a doctor must have completed the intern year, which provides a rotation through medicine, surgery, obstetrics and gynaecology, and specialties such as infectious diseases, dermatology, chest medicine, and ophthalmology. A variable amount of the time must also be spent in a primary health centre (a posting that seems to be taken more seriously in some places than others). Interns are paid a salary of about 500 rupees/month (£35) and are provided with lodging but not board. In some states students must then work for a further six months to a year, as a house surgeon or physician in a specialty relevant to the subject that they want to study at postgraduate level.

Demand for postgraduate places far exceeds supply; for example, in Kerala last year 5000 people were chasing 750 places. Getting accepted on to an official postgraduate rotation is important for three reasons: firstly, it guarantees a series of hospital jobs which are recognised to provide suitable experience for the degree or diploma the doctor plans to take; secondly, he or she will be able to attend teaching sessions orientated towards the exam; and, thirdly, he will get a regular if not princely salary. Some of those who fail to get an official postgraduate place obtain attachments which are essentially junior hospital jobs on the fringes of the bona fide courses. These doctors attend the hospital on an ad hoc basis and may go to the lectures and teaching sessions, but it is a privilege that must be paid for and the doctors have little or no direct clinical responsibility. Most spend the majority of their time studying for the exams and clearly this gives far from ideal experience. In some states selection is based on performance in the MB BS exams. Others set an entrance examination, usually with multiple choice questions. Candidates are also assessed by interview and their references, community service, publications, etc, taken into account.

A certain proportion of the postgraduate places are subject to the same sort of reservation as those on the undergraduate course. This quota varies from state to state and university to university, but members of scheduled castes and tribes and backward communities usually have a reservation of about 30% and their entry requirements are less stringent. This policy is unpopular with the open merit candidates, as illustrated by one young doctor I met who was working in a rural primary health centre and trying (with little optimism) to get a postgraduate MD place. "It means

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that non-academic doctors get selected for rare postgraduate seats and (as a generalisation) they look upon getting such a seat as a right rather than a privilege." He went on to explain about an additional quota of seat reservations, this time for service candidates. These are doctors who have "done time" in state government medical posts. The size of this reservation is (once again) variable, and does not apply in the independent hospitals. In Madras state it has risen from 30-70% of the total seats over the last three years and it is not hard to see why.

Jobs in the state government services are eagerly sought after, for they offer a salary and security and there is scope to be selected to work in a variety of different hospitals. Nevertheless, in some States over 80% of successful applicants are sent to primary health centres usually in the rural areas. Here they put in about 1000 working days (some may stay five years), before they can apply for a transfer to a hospital or for one of the precious postgraduate

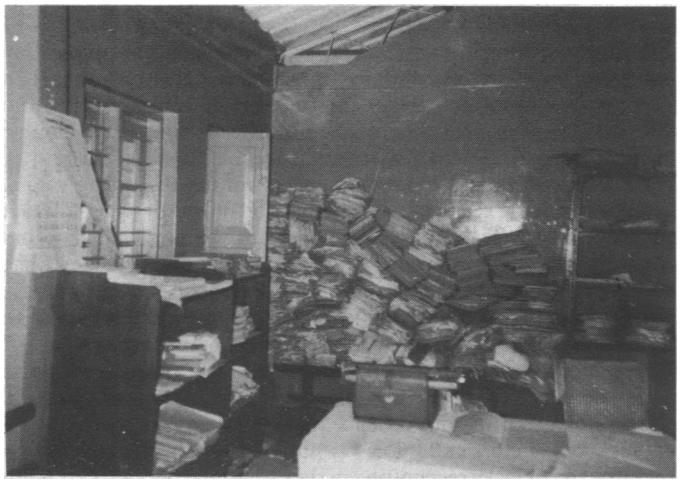

FIG 1—Medical records (not just a British problem) at a primary health centre.

places. In principle this system is perhaps no bad thing, for even if a young doctor's heart is set on becoming a neurosurgeon an awareness of the way of life, home conditions, and priorities of people in the rural communities may help put specialist care in perspective. But on the negative side doctors have to spend an inordinately long time doing a job that few are genuinely interested in. Furthermore, the community may benefit very little for there is said to be little accountability in these posts.

Appointments to government service posts are made by the Public Services Commission. These are state based organisations which sit only once every one and a half to two years. At this time they have to sift through thousands of application forms and there is no doubt that influence in the right quarters is a major determinant of a successful application.

A moment's reflection should make it clear that the number of postgraduate places freely available for candidates from the "forward communities" are akin to hen's teeth—difficult if not impossible to find. To be in the running, you need to have passed all the undergraduate exams first time and preferably won a prize or two. It is survival of the best on paper and this explains the undergraduate preoccupation with passing exams at the expense of seeking clinical experience. It helps to decide on a career as early on as possible, and although many young graduates end up applying for a battery of different courses I was told that this can make for sticky interviews. Not surprisingly an MD in general medicine and MS in general surgery are the most sought after postgraduate degrees, and failure to get on to courses leading to these may lead to some odd situations. Thus I was given the example that a doctor may settle for an MS in ENT and then undertake general surgical duties. And, more worryingly, a doctor may do an MS in anatomy or MD in physiology and then go and practise general surgery or general medicine although, my informant reassured me, "usually people are not that crazy."

The intensity of competition for postgraduate seats varies not only with the subject but also among universities and different colleges. Thus in the privately run colleges and those run by central government the ratio of applicants to graduate seats is more favourable, largely because they have fewer undergraduates, a relatively large number of recognised training posts, and fewer reserved seats.

At the bottom line of this series of obstacles is a fact that several doctors mentioned to me: for every seat that is awarded by fair means another goes to a candidate who has been able to apply pressure in the right quarters. This is usually by having influence with the appropriate state government officials and this then percolates down to the appropriate academic channel. Direct financial inducements may also be used to promote an application. This allegation is disturbing, and although primarily voiced by the younger doctors (who may have an understandable bias) the frequency with which they were echoed by informal asides from senior medical staff suggests that there may be more than a grain of truth in it.

The postgraduate course

There are about twice as many vacancies for a diploma course as there are for an MD or MS course, although the latter attracts the most applicants. Successful applicants usually rotate through recognised posts within teaching hospitals although other large hospitals and special centres are recognised. The MS and MD are roughly equivalent to the British FRCS and MRCP and the minimum period of training before a doctor may sit the exam is three years. During this time the student must prepare a thesis. The higher specialist exams (the DM or MCh) require a minimum of two years' further study in a designated specialty and for candidates at this level it helps to have published something but it is not vital.

The standard required to pass the MS or MD exams is hard to gauge; some doctors complain of the high failure rate and insist that the exams are harder than MRCP or FRCS. Indeed, in some states students have staged successful strikes to raise the percentage pass rate. Others suggest that the exams are not nearly difficult enough and that in many colleges it is rare if ever that a student's thesis is turned down. One nihilist described the MS and MD as a glorified MB BS. Thus it seems impossible to make a general statement about standards unless it is to confirm that standards vary considerably from one state to another and one university to the next.

Professional unease about postgraduate standards is widespread and once again concern is not confined to academic circles. The *Telegraph* (Calcutta) of Thursday 10 January 1985 carried an article entitled "Postgraduate medical education in limbo." This looked at the state of postgraduate education in West Bengal and identified some of the problems. It began gloomily enough: "One look at the state of postgraduate medical teaching in the city (Calcutta) and it should convince anyone that the prospects of the city, state, and the region continuing to get good medical specialists in the future are bleak." It went on to highlight the lack of proper organisation and administration to oversee the training programmes. Lack of facilities and teaching staff were another problem: "Undergraduate colleges are ill equipped to train their own students let alone postgraduate ones." But perhaps the most worrying statement was that some "postgraduate students do not take an active part in managing patients or teaching graduates. They are hardly ever present on the campus. They mostly attend classes and collect data for theses. There is hardly any practical training . . . whatever proficiency they had gained during housemanship is blunted."

The article also emphasised that the postgraduate students' salary was poor and their accommodation scarce. To try to compensate for this "some try to take up jobs in remote health centres or start private practice even though they are supposed to be full time students." The article concluded on an even more dismal note: "The standard of thesis has gone down, although the percentage of successful students has risen."

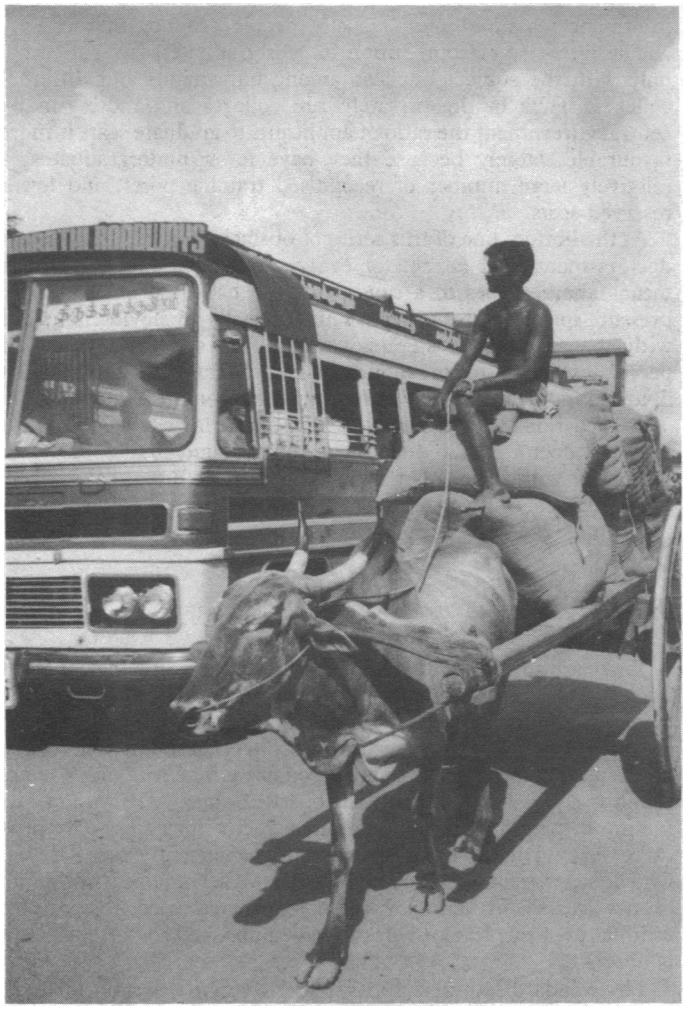

FIG 2—Contrasts in transport.

I quote this article not for relish in an unedifying tale but because it does represent the view of several doctors that I spoke to. One or two were disarmingly frank about the sort of pressures and inducements that both they and their families are exposed to. And while it would be wholly incorrect to extrapolate from one newspaper article and a number of anecdotal opinions, it seems that the state of postgraduate education in some areas is far from satisfactory. One senior doctor I talked to drew cold comfort from the fact that the profession has reached the stage where it is prepared to talk openly about falling standards in medical education, and he welcomed the fact that this theme had been taken up by the press. In his view it meant that now there is a chance that the authorities who are in a position to do something about it will be persuaded to do so.

A new postgraduate degree

It was concern about the variable standard of the MS and MD degrees which was one of the main reasons behind the introduction, in 1976, of a new centrally run postgraduate examination called the diplomate. Another reason for its introduction was to give those doctors who did not get on to MS or MD degree courses an opportunity to get a postgraduate degree of similar standing. A third and unofficial reason was because of the mutual cold shouldering between England and India in 1975, which resulted in the MRCP and FRCS becoming degrees non grata within official government service circles.

The new exam, or to give it its proper title the Diplomate of the National Board of Examinations, is controlled by the National Board of Examinations in Delhi and is conducted in all the various disciplines of medicine and surgery. Candidates from all over India (and outside) may sit the exam provided that they fulfil the entry requirements. Broadly these include possession of an Indian degree (or a degree that is recognised by the Indian Medical Council), completion of internship, a year's postregistration experience, and three to five years' experience in the specialty concerned. This experience must have been gained in recognised posts, and this, as with the state degree courses may have been a limiting factor in the numbers of doctors eligible to apply for the exam. It would seem, however, that the board is continually recognising more institutions and does not share the state government officials' reluctance to recognise private hospitals, many of which have excellent facilities and top class staff.

After talking to the secretary at the National Academy of Medical Sciences I got the impression that those who are undecided about whether they have had sufficient or appropriate experience to take the exam should get in touch with the academy. It is clearly quite prepared to consider applications from candidates who have pursued varied careers, including those who have spent most of their working life in private practice. It is, however, necessary for a Fellow of the Academy of Medical Sciences to sign the application form and thus vouchsafe that the doctor concerned has had adequate experience in the said specialty. Those doctors who already possess the MS or MD are automatically considered eligible to sit the exam.

Grass roots opinion about the standing of the diplomate varies. Some see it as an excellent examination, and no one denied that it set a high standard. There are signs that it is growing in popularity and may become India's most prestigious postgraduate exam. The secretary at the academy expressed his hope that it would achieve wider recognition and went on to say that "The diplomate could be the bridge between India and the UK at the postgraduate level." Others were less optimistic and even went so far as to say it was a complete waste of time. The majority seemed undecided. And, while reasons for this ambivalence vary, clearly one of the problems is that some doctors still know very little about the exam. Another reason is that it lacks recognition in the eyes of the public. This is not surprising since the designation of the exam has been changed three times since its introduction in 1976, and even the profession has been confused. Just when they had got to grips with the unwieldy MNAMS (member of the national academy of medical science) it was changed, in 1983, to the DipNBE (x) (Diplomate of the National Board of Examinations where x stands for the specialty concerned).

Perhaps the most objective way of assessing the popularity of the diplomate is to look at the numbers of people taking it over the last few years (table). The figures do not suggest any great rush to acquire the diplomate, but I was interested to hear several young doctors say that they were proposing to take it alongside the MS or MD, and many senior staff were confident that the numbers would swell.

Numbers of candidates sitting the Diplomate of the National Board of Examination

Year	Part I (Pass rate %)	Part II (Pass rate %)
1981	721 (34)	482 (30)
1982	598 (29)	490 (32)
1983	536 (28)	514 (24)
1984	626 (36)	502 (28)

Conclusion

Irrespective of the future of the diplomate it can hardly be regarded as the answer to India's postgraduate training problems. And these are problems which have become increasingly acute over the last decade. Growth in the number of doctors has coincided with a sharp decline in the prospects of obtaining postgraduate training abroad and the competition at home has got out of hand. Clearly something needs to be done about the variable standards of the postgraduate degrees and the inadequate provision of postgraduate

training posts, but these are not problems that can be looked at in isolation. The problems of postgraduate education are in many ways similar to those that bedevil undergraduate education, and many doctors feel that it is time for a total reorientation of medical training. A few suggest abandoning attempts to emulate the West and stop presenting India's image abroad as a country that is abreast, if not in front, of all the latest advances in high technology medicine. It is not that they aren't, nor that they can't (several of the larger hospitals, especially those in the private sector, can provide the sort of care that is available in any specialist Western unit) it's just that this form of medicine exists in parallel with an inadequate system of health care which leaves 80% of the population with little or no access to Western medicine and this must change.

Changes have been introduced to try to reorientate the student and young graduates towards community health, but few doctors I talked to believe that it has achieved anything worth while. Nor did they hold out much optimism for the future. Many spoke of lack of leadership from the top and criticised those in positions of authority, especially the state directors of health services and health education for failing to implement existing recommendations. Key positions in both central and state health administrations are, so I was told, seldom given to those with the ability and drive to push for change. And even if they were, the opposition to change is formidable. One doctor used the analogy of the lobster pot to make his point. India, he said, is the one country that does not need to put a lid on the pot, no lobster will ever climb out; the others will always hold him back.

The Indian Medical Council came in for criticism from some doctors although with many and disparate medical colleges to keep track of it clearly has a difficult task monitoring standards of education and introducing changes in the curriculum. That many doctors are bluntly stating that it is failing on both counts was disquieting; as was the view of a doctor at the ministry of health who described the council as a paper tiger too weak to get its decisions implemented. Thus although the council has taken some colleges to task about falling standards and issued threats of closure and derecognition of degrees there is a widespread belief that in practice this means very little. If a state government supports a given college and the university concerned awards degrees, graduates may practise freely within the state (and usually outside it too) irrespective of whether it is officially "recognised" or not. This illustrates the autonomy and power of the state governments and it seems that there is little hope for improvement in the standard of medical education or of an effective reorientation of the medical course until these—and indeed the health of the community as a whole—are regarded as politically desirable objectives.

Letter from . . . Chicago

Hearts from monkeys and machines

GEORGE DUNEA

The recent breakthrough in heart transplants—hearts from monkeys and hearts from plastics—gave rise to a multitude of different reactions. Some people hoped it would open the way for heterotransplantation of the brain, an organ where rejection or mechanical breakdown might be unimportant and leave recipients no worse off than before. Economists warned about a baboon supply crisis and suggested using skunks, rats, and jackasses. Somebody suggested giraffes for stiffnecked politicians and ostriches for birdbrained legislators. In the interest of national safety a reporter proposed that all politicians given plastic brains should have to make full disclosure of the fact; and there were fears that recipients of baboon brains might behave badly at formal dinners, throwing nuts, munching bananas, or swinging from priceless chandeliers and making faces at the distinguished guests.

The monkey transplant stirred up the professors of ethics. These wise arbiters of human behaviour, though not necessarily seeing eye to eye, all had something important to say. Some approved of this "dramatic advance," but others thought it was "very, very unfortunate" and wished the money had been spent to feed Ethiopians. Animal rights supporters, mostly carnivorous and in leather shoes, picketed the Seventh Day Adventist University, whose motto is "To make man whole," but were met by opposing demonstrators who had no objection to achieving wholeness with a little help from the animal kingdom. The newspapers also had a ball about the 14 day old Baby Fae and its walnut sized new heart, publishing pictures and charts, explaining how the baboon aortic arch had only two branches, how Mother Fae was separated and her husband on welfare, her boyfriend loving to ride motorcycles, the truckers and cowboys at the local pub playing pool, listening to the jukebox, and dropping coins into the Baby Fae collection coffee can.

Then came the bureaucrats, promising to investigate if everything was done right—not that they thought anything was wrong. Some people said the surgeon should have found a human heart, and there was talk about prolonging suffering and about helping the doctors more than the baby. But the man in the street seemingly took the position that "science cannot wait for ethics to catch up." In a national poll 63% of adults approved of the surgery and said they would have tried it to save their own child's life. In a Chicago poll, likewise, most people came out for the transplant, saying that they could not see how it could hurt, as long as there was no cruelty to the animal.

Plastic and aluminium heart

So for three weeks we read how Baby Fae lived with its baboon heart, how the respirator was discontinued and feedings resumed, how the baby was well and pink and warm, finally how rejection set in and the kidneys shut down. Then the surgeon declared that the baby had not died in vain and that he would do it again. But now another surgeon stole the show, this time with a heart of plastic and aluminium that had taken 20 years and $200 million

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