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NATIONAL MEDICAL COMMISSION IS NO CURE-ALL, MANY IMPORTANT QUESTIONS REMAIN

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There are six reasons why governments would like to regulate medical education. One, to ensure that doctors are appropriately trained and skilled to address the prevailing disease burden; two, to ensure that medical graduates reflect a uniform standard of competence and skills; three, to ensure that only those with basic knowledge of science and aptitude for the profession get in; four, to ensure ethical practice in the interest of the patients; five, to create an environment that enables innovation and research; and six, to check the corrosive impact of the process of commercialisation on values and corrupt practices. The question is whether the National Medical Commission Bill passed by Rajya Sabha on Thursday addresses these concerns.

The problem of inappropriately trained doctors of varying quality has been known since decades. The report of the Mudaliar Committee set up in 1959 had devoted substantial space to pointing out how doctors had neither the skills nor the knowledge to handle primary care and infectious diseases that were a high priority concern then as now. Likewise, standards vary greatly with competence levels dependent upon the college of instruction. In professionalising the MCI, with experts for all levels of education and practice, the NMC Bill can be a gamechanger.

It has the potential to be more nimble in setting curricula, teaching content, adding new courses and providing the much needed multisectoral perspectives. More importantly, the NMC has the potential to link the disease burden and the specialties being produced. In the UK, for example, it is the government that lays down how many specialists of which discipline need to be produced, which the British Medical Council then adheres to. In India, the MCI has so far been operating independently. This gap can be bridged by the NMC. Given the right people, it is also possible that the NMC can encourage and incentivise innovation and promote research by laying down rules that make research a prerequisite in medical colleges.

It is in curbing unethical practice and commercialisation of medical education that the Bill falls short. Today, there are 536 medical colleges with 79,627 seats. Of them, 260 or 48.5 per cent are private with 38,000 seats. The bill allows differential pricing with freedom for the college managements to levy market determined fees on 19,000 students, under what is called the management quota. This is admission for those with the ability to pay. There are colleges that are rumoured to arrange admission and the degree for a fee.

To counter such practices, the Bill has proposed mandating the NEET and NEXT. I was Secretary, Health, when these two concepts came into the policy dialogue. The NEET was mooted by the then board of governors for three reasons: One, to reduce the pain of students having to take an estimated 25 examinations to gain admission in a college; two, given the abysmal level of high school education, to ensure a minimum level of knowledge in science, and three, to reduce corruption by restricting student admission to those qualifying the NEET. Measured against these three goals, the experience has been mixed, demanding a rethink.

The NEXT is an idea borrowed from the UK that has for over seven years been struggling to introduce it. In all such countries, the licensing exams are stretched into modules, not a multiple choice questions type of exam. The underlying belief is that in centralising the qualifying examination, a college with the largest number of failed students will automatically close down. Following from this, the Bill has virtually given up inspections for assuring the quality of education.

It is a fact that the MCI required a college to be inspected 25 times to get final recognition, each being a rent seeking exercise. That “inspector Raj”, as the Health Minister noted, will be done away with, is indeed a positive step. But in relying only on the NEXT as the principal substitute is to abdicate governance. Undoubtedly, there are grey areas giving scope for corrupt practices and production of substandard doctors. It would have been preferable to have tested the waters, examined the implications and then introduced the reform rather than including it in a law that is difficult to amend.

The excessive reliance on a battery of diagnostic tests is reflective of both commercial considerations as well as weak knowledge. Students spending lakhs to become doctors resort to unethical practices to recoup their investment and pollute the system. In the US, despite tight regulations and remunerative payment systems, there is still substantial unethical practice. The Bill, in reducing oversight, allowing extensive discretionary powers to government to set aside decisions of the NMC, making it virtually an advisory body, gives scope for the current state of affairs to continue, only at a higher premium nullifying the major need for reform of the MCI. This is the most worrying aspect of the NMC. In other words, the MCI got into disrepute only when commercialisation of medical education set in in the 1990’s, and the amendment of the MCI Act in 1993, reducing the autonomy of the MCI and making it subservient to government. This has now been taken to another level in the Bill.

The Bill has other irritants — like permitting a registered medical practitioner to prescribe medicines. Left vague, much will depend on the rules. While there is a need to decentralise, to give to non-medical personnel some powers and authority, it needs tight regulation and supervision. Given our inability to enforce the Drugs and Cosmetics Act, as seen in the rising rate of the antimicrobial resistance problem, the issue of which comes first needs to be carefully examined. Prudence may be advisable. Another irritant is the continuance of the two parallel streams of producing specialists. By not bringing the DNB under the purview of the NMC, the DNB system is left open to abuse.

No law is perfect. It is dependent upon the people who interpret and implement it. Government has, under this Bill, arrogated to itself an unprecedented power to appoint people in the various arms of the proposed structure. The quality and integrity of these people will then define the future of the health system in India. We hope for the best as the long, bitterly fought battle to reform the 86-year-old MCI comes to a close.

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