LETTER TO THE EDITOR

The Acute Need of Revamping the Indian Medical Education System: Diagnostic Dilemmas and Therapeutic Challenges

Baijaeek Sain

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Each year approximately 18.7 lakhs students appear for the National Eligibility cum Entrance Exam (NEET) – Undergraduate (UG) after high school or sometimes take a gap year or two with the sole aim of becoming a doctor and securing an MBBS seat at any institute across the country. While climbing this first hurdle, some are blessed with merit and with supra-added rigorous preparation for two to three years alongside spending little less than a fortune on coaching institutes and learning apps, are able to secure a Government Medical College seat. Others, unfortunately, lose the dream of studying medicine or their parents are too keen on financing their medical education at any private medical school-sometimes within the country or in the blessed nations of Vladimir Putin, Ukraine or China. These 18.7 lakhs after a fierce battle and bloodshed of brain cells finally get through to the bottlenecked approximately 40,000 odd undergraduate medical seats across the nation while some fly out to the neighboring or hosting nations.

Before they join medical school, their naïve innocence leads them to believe that once they clear that hurdle, they can enjoy the rest of their lives, when in reality they continue their quest and fight to become an MBBS doctor. But 4.5 years down the lane, they are again brought back to this battlefield where the competition has now become even more fierce with approximately 2–3 lakh qualified undergraduate doctors sitting to write down the NEET-postgraduate (PG)/INI-CET exams. They are then squeezed through to the bottleneck and the hamster wheel results in only about 1/10th of the total getting their dream specialization clinical branch or sometimes a para-clinical specialization. Now what happens to the rest of them? They simply go on taking their next chance in this musical chair until they are blessed with their hard work in finding a clinical specialty seat of their own choice. Thus over a period of few years, the cumulative number of candidates has now snowballed into a bigger number. Apparently according to recent trends, if you don't secure a clinical specialty seat then you are not going to become a top-notch doctor whom patients will look up-to and come for a visit.

Having said that, this bottleneck effect and rat race becomes like a cumulative house of cards and subsequently, according to recent trends, a first-year undergraduate medical student starts preparing for the NEET-PG from day-1 of UG medical school. They are well supported via app-based learning methods who constantly support and motivate them with knowledge with newer versions and editions and sometimes even make them master the core clinical skills that are required for a student to be learned in a clinical ward, coming easily through a tablet or smartphone. Hence convenience is always at its peak. The end result, therefore, leads to undergraduate medical students starting to become independent in their classroom and clinical teaching and finding it a waste of time to relax with their peers and enjoy the apps or academies.

Department of Trauma and Orthopaedics, Imperial College Healthcare NHS Trust, London, United Kingdom

Corresponding Author: Baijaeek Sain, Department of Trauma and Orthopaedics, Imperial College Healthcare NHS Trust, London, United Kingdom, Phone: +44 (0) 20 3311 1234, e-mail: baijaeek.sain@nhs.net

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Going back to the history of the development of medical education and delivery, the Indian Medical Education system was basically a derivative of the colonial rule to impart skills that one required in order to cure their people without having to fetch British professionals overseas during the late 18th and early 19th century. The root of it can still be found in and around the walls of the oldest Medical College, Kolkata in Eastern India or Ronald Ross building at IPGMER, or to some extent among old medical schools of eastern India and thereafter across the entire nation. To resist this, certain freedom fighters even established schools like the National Medical Institute (now known as Calcutta National Medical College) to counteract and balance the independence of medical education across independent India. The main agenda of either of these two sides was to make a good doctor and therefore an indispensable healer. Fast forward and looking at the present day, the immediate threat posing to us is the question that, are we still and essentially producing good healers? The answer is debatable, but the facts should give readers of this article food for thought.

In this quest of attaining a post-graduate seat, the essence of medical education is not only lost but we are at an imminent threat of making general practitioner doctors an extinct species. The concept of a previously known family physician doctor is now almost pushed into the Jurassic era. The quench and thirst for specialization, sub-or-super specialization is thus a trending exponential curve that is spreading faster than the rate of the four waves of the COVID-19 pandemic. Each specialty is now saturated with its own set of population clans and slowly we are trending towards a judgment day where a specialist has to be at a micro-level of maybe a particular organ or tissue in order to stand out as a good and successful clinician.

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The 4.5 years of undergraduate medical training revolves around a set of 14–19 subjects with exposure at a limited depth starting from preclinical and paraclinical sciences to clinical specialties. The concept is profoundly based on building strong pillars and hard concrete strength of the basic concepts spread across the branches of medical science and modern medicine in order to let the floors built on it to be strong, sound, and stable during daily clinical practice. However, the deviated track chosen in recent years is nothing but detrimental. Since time immemorial, the previously formulated Medical Council of India medical council of India (MCI) had taken no steps to incorporate skills of clinical learning or the art of medical practice through communication. The newly designated national medical commission (NMC), although appears to be concerned but seems little too inadequate to put its focus on the same. Nevertheless, it has now raised another burden of an exit exam to meet the standards of a general undergraduate medical student seeking a professional registration for regular practice followed by subsequent eligibility of specialization.

The target-oriented goals in medical education thus stand at a point where securing the degree has become quintessential over securing the knowledge of basic, sound, and resonating medical practice. While some might say that this is the era of evidence-based medicine where practical and application-based knowledge is the need of the hour, it fails to justify the quote which says "the eyes cannot see what the mind does not know." It starts with an MBBS followed by any MD/MS/DNB with any superadded diplomas thereby proceeding to any DM/MCh/other relevant super specialty. The quality of clinical work learned or the relevant clinical experience gained thus becomes totally redundant while one spends nearly more than a decade to secure these block letters in a parenthesis succeeding the names.

The present picture thus stands at an alarming state where the goal of a doctor is to become a specialist physician. Now whether this is going to asphyxiate the primary healthcare of a developing country where the need for a doctor is 1:10,000 among the population or the need for only specialty-guided treatment, is thus the debate of the hour and the main dilemma in today's time.

If we take a look at the National Health Service (NHS) across the United Kingdom, it has a similar set of figures of medical students graduating every year. However more than the crazy suffix of degrees, they have tried to make a hierarchy of learning and development of clinical skills and experience. The Health Education in England (HEE), Health Education in Wales (HEIW) and Health Education Scotland had therefore, many decades ago, established regional deaneries in order to maintain the core structure of any medical training program determining the outcome of clinical experience among budding trainee doctors. Even doctors who are unable to secure eligibility or a training number among these health boards, are given equal opportunities to progress and determine their career growth. The primary focus is not only to create specialists but to create the equal number of eligible professionals to cater to primary health care mainly as GPs. The Royal Colleges too have transformed various methods of diploma exams with desired experience and eligibility to facilitate qualifications but everything kept aside, the primary focus has always been on a patient centered and patient-specific mindset in a background of holistic medical approach.

Over the years, the fierce competition among Indian medical graduates is not only going to be an issue of encroachment over specialization but the osteoporotic healthcare system blown away and fractured by a pandemic over the last two years will create serious implications on the future of healthcare across the nation. Certain factors like work-life balance, professional burnouts, and stress does not exist in the dictionary of any concerned authority responsible for the delivery of medical education and healthcare in India. As our ancestors have constantly laid down the road, it's high time that the medical education system adopts a more practical approach to develop and train future doctors and revise their footsteps.

The therapeutic challenge in this aspect is primarily going to be creating resources for application-based medical knowledge and training curriculum, generating funds for supporting doctors in training across all stages of their career, and lastly adequate facilities accounting to prevent profuse burnout among doctors across their entire career development at each and every stage. Furthermore, given the strata and hierarchy of medical professions right from the bottom of the ladder to the top, there needs to be the accountability with well-defined limitations across all grades to ensure patient care and safety. This needs to involve not only a freshly graduated medical intern but also the consultant and everyone who stands in between at each and every step to ensure good medical practice.

There can be various ways to incorporate practical education and teaching through clinical based learning, developing a curriculum for case-based discussions or clinical examination pockets often known as an objective structured clinical examination (OSCE) followed by setting a trend among students and trainee doctors to pursue clinical excellence through adequate research, clinical audits and a well-built overall aptitude is required to face the growing needs of the nation during its current crisis amidst severe healthcare challenges. Simultaneously, the implementation of these goals can be made with little steps over a limited period of time and thus making the entire train move by moving various compartments. This is a little too far-fetched, but to meet the growing demands of a developing nation, a stitch in time should eventually save a burst across myriads of healthcare professionals looking forward to practicing in a safe and healthy environment in this country and therefore adding a method to this madness.

The author is currently a Clinical Fellow training in Trauma and Orthopaedics at Imperial College Healthcare NHS Trust, London United Kingdom after having finished medical training from India.

Orcid

Baijaeek Sain http://orcid.org/0000-0002-5634-5265