

Council or Commission: Are we between Scylla and Charybdis?

The National Medical Commission Bill, 2017 has been approved by the cabinet of Government of India and it has now been referred to this standing committee of Parliament for Health before it is brought to the floor of the house for consideration and passing.¹ Meanwhile the waters are being muddied by extraneous talks of a short course to permit dentists to practice general medicine and allowing Ayush practitioners to practice allopathic medicine. These are not part of the NMC act and one does not know whether these are official positions which the commission is to implement. One can only hope that politics would not enter the medical education field, which as it is considerably affected. Such extraneous discussions would divert attention from the main purpose of assessing the new commission and offering suggestions for a better agency than the council.

Since 1956, When the Medical Council was established by an Act of Parliament, medical education in India has been governed by the council which was an all-encompassing body responsible 360° for medical education in all aspects, regulatory, academic, registration and ethical monitoring. Now, it may be replaced by the commission which essentially consists of four units, viz. the Undergraduate Medical Education Board (UGMEB), the Postgraduate Medical Education Board (PGMEB), the Medical Assessment and Rating Board (MARB) and the Board of Medical Registration and Ethics (BMR).

The functioning of the council, whose last rights are being planned, is too well known to bear repetition. With its overwhelming attention being devoted to its regulatory functions which in course of time became a policing activity, the council had little time to devote to academic activities and curriculum planning. In its defence, one must say that the rules under the MCI act required approval of the Government of India for the least measure even if it involved no policy change but mere minor alterations in curriculum. Some of these proposals took years to obtain sanction from the ministry and became obsolete even before implementation. The Vision 2015 document is still pending approval and notification as are other measures. The new act does specify that the boards would be autonomous in functioning subject only to the policies and regulations of the NMC. One hopes that this will hasten the process of implementation from the conception stage.

However, the act shows that there is a considerable overriding role of the Central government in the functioning of the NMC which is deemed to be autonomous at each and every step. This will seriously compromise autonomy. Even in matters such as recognition of foreign degrees the central government can override the views of the NMC and in fact there is a mention that the government can even without the approval or against the approval of the NMC permit people to practice medicine or surgery in India. This completely destroys the freedom and autonomy of the NMC.

Far reaching changes did occur in the medical educational process such as the 1997 guidelines on undergraduate medical education. It must be mentioned that no further major changes in curriculum have seen the light of day in the following twenty years since then. There is hardly any change in the curriculum of the postgraduate courses for nearly thirty years with only peripheral and cosmetic changes finding place in the post graduate regulations of the council. Much energy of the council was wasted on its perpetual tussle with the National Board of Examinations regarding parity of the qualifications of the council and the board. Important recommendations made during the period of stewardship of the governors remained unconsidered. Ultimately the process and outcome of medical education in the country is far from satisfactory and has lagged behind more well informed and more responsive countries.

With the inevitability of change looming ahead of the medical education profession, it is time to study the acts governing the commission to determine whether the change is one for the better. Some of the issues are highlighted below.

For the Medical Advisory Council (MAC), which is the supreme advisory body, and the National Medical Commission (NMC), which is the executive wing, it is necessary to have a larger membership for inputs from various quarters so that a balanced and broad view is obtained. At present of the members of the NAC, 25 are from the NMC. This overlapping membership between the two would prevent an independent opinion being taken on any issue since the advisory council and the executive wing would have a large proportion of common members and common interests.

The proposed UGMEB and PGMEB have both regulatory and academic functions. The UG board would finalize the requirements of a college wishing to offer the MBBS degree and the PG board would finalize the requirements of a college offering postgraduate degree. Since more than 95% institutions offering medical courses offer both the UG and PG courses such a dual fixation of norms is likely to create confusion. Medical education is a continuum from UG to PG and Postdoctoral courses and it is necessary to have a link between those planning UG and PG education. Such a link is not seen to be present in the new dispensation. Also, one of the major problems with the Council was that curricular changes required the active participation of those involved in medical education for a long period. With over representation from those outside academics, this function suffered. The new commission also has a similar composition with no weightage for medical educationists. It may be better to combine the regulatory activities of the PG and UG boards with the assessment board and leave a single board to deal with academic and curricular issues which can be called the Academic Board. This last section can fully devote itself to academic issues rather than get caught in discussion and litigations concerned with regulatory activity. It will also have time and energy to bring about evaluation reforms without which no curricular initiative will have lasting effects.

Merging of the NBE course with the PG courses of the MCI will raise several issues. It is not clear whether the two streams, although merged, remain functionally separate with separate requirements or both will have the same requirement. At present the NBE courses are conducted outside medical colleges with no requirements for basic science and para-clinical departments, whereas, these are mandatory for MCI courses. The purpose of the NBE training is to create a cadre of specialists to man the secondary health care centers and the tertiary health care centers where as the MCI's primary role was to train specialists for medical colleges. Since the NBE courses are being conducted in an environment with quite distinct requirements from the MCI courses, it is not clear how the merger issue will be solved. There is also no mention in the requirement of inter-professional education. This is considered a very important aspect of team building abroad. In light of the above issues, it may be better overall to have the following four divisions of the proposed commission.

- i. A Curricular and Academic board,
- ii. A Board for UG and PG regulations finalization and assessment of compliance to requirements, accreditation and ranking
- iii. A Board of medial registration and medical ethics,
- iv. An Inter professional education board

Another rather troublesome feature of the Commission's Act is the proposal to have a National Licentiate Examination for professionals graduating from the Medical Institutions under the purview of the commission. If the university examinations are to continue, which has to be the case, since no national level single examination can test both skills and knowledge of over 50,000 outgoing graduates, it appears that there will be a big mass of graduates who would have cleared the university examinations but are unable to clear the National Licentiate examination. Such a group would be unable to be licensed, unable to practice and unable to join post-graduation. What would become of them? How would they be employed?

One of the desirable features of the NMC Act is the proposal to have the MARB conduct accreditation of all recognized institutions providing training in medicine and rank them on a National Framework. The current ranking by the NIRF is grossly unfair to medical institutions and Health Science Universities since many of the criteria used for ranking are inapplicable to these. Examples of such criteria are weightage for intellectual property, campus placements for medical graduates and many other such parameters.

Another desirable feature is the proposal to shift to a competency based dynamic, flexible and responsive curriculum. It remains to be seen whether this remains only on paper.

In conclusion – are we moving after a sixty year battle with Scylla towards a similar struggle with Charybdis – only time will tell. The jury is still out.

Reference

1. The National Medical Commission Bill, 2017. http://164.100.47.4/BillsTexts/LSBillTexts/Asintroduced/279_2017_Eng_LS.pdf, (accessed on 21 December 2017).

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Early-life home environment and risk of asthma among inner-city children.

Environmental exposures in early life appear to play an important role in the pathogenesis of childhood asthma, but the potentially modifiable exposures that lead to asthma remain uncertain. Present study examined the relationship of prenatal and early-life environmental factors to the occurrence of asthma at 7 years of age among 442 children. It was found that higher house dust concentrations of cockroach, mouse, and cat allergens in the first 3 years of life were associated with lower risk of asthma (for cockroach allergen: odds ratio per interquartile range increase in concentration, 0.55; 95% CI, 0.36-0.86; $P < .01$). House dust microbiome analysis using 16S ribosomal RNA sequencing identified 202 and 171 bacterial taxa that were significantly (false discovery rate < 0.05) more or less abundant, respectively, in the homes of children with asthma. A majority of these bacteria were significantly correlated with 1 of more allergen concentrations. Other factors associated significantly positively with asthma included umbilical cord plasma cotinine concentration and maternal stress and depression scores.

Conclusion: Among high-risk inner-city children, higher indoor levels of pet or pest allergens in infancy were associated with lower risk of asthma. The abundance of a number of bacterial taxa in house dust was associated with increased or decreased asthma risk. Prenatal tobacco smoke exposure and higher maternal stress and depression scores in early life were associated with increased asthma risk.

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