

Current Needs in Medical Education in Perspective of Medical Students and Teachers -A Qualitative Study

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ABSTRACT

Background: Medical education system has some limitations and it is the high time to address it. Hence this study was planned to assess the limitations and suggestion to overcome it in the view of students, interns and faculties for the betterment of learning process. **Methodology:** Three focussed group discussion were conducted with of medical professors and students, and CRRIs of Madha Medical College to understand the needs of medical education in India. A general pattern was followed in all Focussed Group Discussions. Topics for discussion include – primary limitations of current medical education system and suggestion to improve the curriculum. **Results:** The medical schooling is more of memory based rather than activity based. Since the basic sciences are pillar stones of medical education, there is an inevitable need of constant revising of basic sciences throughout the course. A medical student should have a basic understanding about emergency life support care. In order to improve the curriculum all irrelevant theory topics should be excluded giving more importance to clinically relevant topics. **Conclusion:** Based on the findings of this study we conclude that further there is a need to refine the existing guidelines and curriculum with respect to current needs of community, more clinical learning and foundation course.

Key word: limitations, suggestions, medical education, qualitative study

INTRODUCTION

Medical education is the bedrock on which high-quality healthcare is built. Training is important but education is vital. The newly graduated doctor needs extensive knowledge and practical skills and that is where training is important.¹

World wide there are 2980 medical colleges under operation.² Making Medical Education affordable and broad based to suit the needs of the country. There is an existing gap in number of doctors to cater to the healthcare needs of the country. The current doctor: patient ratio of 1:1681 is below WHO recommended

figure of 1:1000. Thus, India needs about 7 lac doctors by 2022 in order to meet WHO standards. India is known for its high-quality medical standards and many Indian doctors are practising in other countries.³ There are 479(253 private) medical colleges and 60845 students studying medicine every year. In regard to PG medical education, there are 54 super speciality courses, 45 PhD, 61 PG diploma courses and 77 PG degree courses.⁴

The Medical Council of India (MCI) prescribes the minimum standards of medical education required for

granting recognised medical qualifications time to time.⁵ Graduate medical curriculum is oriented towards training students to undertake the responsibilities of a physician of first contact who is capable of looking after the preventive, promotive, curative & rehabilitative aspect of medicine.⁶ Postgraduate curriculum will be competency based.⁷

The most significant challenge of medical education is the maintenance and improvement of quality standards. MCI introduces new teaching elements which includes Foundation Course, Integration: Horizontal and Vertical, Early Clinical Exposure, Student Doctor Method of Clinical Training, Electives, Skill Development & Training, Secondary Hospital Exposure⁸ and national faculty development programme.⁹

The recent development has impact on medical education. NEET, a common entrance test for all medical colleges at UG and PG level, Online application & approval system for medical colleges, Private investment in medical field, Companies being permitted to set up Medical Colleges,¹⁰ development of National Medical Commission Bill and medical recruitment system are some of the recent advancement.

Some challenges like mismatch of competencies to patient and population needs, poor team work, persistent gender stratification of professional status, narrow technical focus without broader contextual understanding; episodic encounters rather than continuous care; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labour market; and weak leadership to improve health system performance were already identified. It is widely recognized that it is not enough to adapt the curricula in line with the changing environment and technologies.¹¹

The activity helps to understand the expectations of a medical students and teachers for the betterment of learning environment. Also it creates room to ventilate one's inner ambitions which is not happening currently. This also serves as a self-evaluation of medical education as one group is receiver, and another is provider. The FGD is the excellent tool to identify the strengths, weakness and opportunity and points of improvement. This can come up with recommendations to improve the

medical education for the benefit of professionals as well as the community. This helps to get more innovative ideas which can be adopted locally.

AIM OF THE STUDY

This study aims to bring forth necessary improvements that should be imparted in the current medical education system to improve the quality and quantity of doctors produced taking into consideration the views of professors and students.

MATERIAL AND METHODS OF STUDY

This qualitative study was conducted by the department of community medicine in Madha Medical College and Research Institute during the period of June to August 2018. Since the study tries to accentuate the views of medical professors and students, 3 separate discussions were conducted – one with the professors of Madha Medical College, next with the interns of Madha Medical College and last one with the students. We had chosen 10-12 participants randomly in each group. Each FGD extended 1 hour to 1.30 hours. A standard discussion framework was prepared to guide the FGD. A set of standard questions using open and closed end questions prepared in each domain. Ensured to follow a specific question format and adopt neutral and non-directive methods to elicit responses from the participants. A detailed ground rules will be prepared for healthy discussion. A facilitator was chosen to run the FGD who was responsible for enforcing the ground rules and keeping all participants engaged. A notes taker recorded the important points discussed. The entire FGD was recorded using a audio recorder. A written consent was obtained from all the participants before the discussion begins. The room was chosen with protection of noise and other disturbances. An invitation to all the selected participants were sent in well advance.

A general pattern was followed in all Focussed Group Discussions. Common topics for discussion include – modification of present curriculum, teaching methodology and evaluation of medical students. Learning methodology was discussed more in students' discussion. Primary limitations of the present system were discussed among students and interns. From these discussions the key points were elicited along with that some current statistical data (regarding shortages of seats and medical faculties).

The data set were prepared by reviewing the notes and hearing the video records. The points of FGD were grouped and ready for analysis.

Approval to conduct the study was obtained from scientific research committee and department of medical education of Madha Medical College &RI and Ethical committee.

OBSERVATIONS AND RESULTS

The primary limitations of current medical education system were the first agenda for the discussion.

One student said, “Since the basic sciences are pillar stones of medical education, there is an inevitable need of constant revising of basic sciences throughout the course. Revised assessments of basic sciences can also help the students to make their understanding on clinical subjects far better”. Another concern which the students raised was regarding the PG admission and in their view, “the admission to PG seats should be based more on skills and interest rather than just theoretical knowledge and enough clinical assessments should also be done to select a candidate for a particular PG seat”, which shows the students understanding about the clinical training rather than knowledge.

One of the interns started with mentioning about the manpower and added that, “The first and foremost aim of medical education is to provide adequate health care to the nation. Since the number of doctors produced are in no way close to the required number priority should be given to increase the number of medical seats. Increment in medical seats can only meet the scarcity of doctors”.

Another key component addressed by the interns is that “More than theoretical knowledge clinical knowledge has more importance rather it has prime importance in manifesting a doctor. For that more concentration should be given to clinical postings from second year itself. Students can elicit the responses directly from the patients with simultaneous explanation of theory underlying it”, which was found to be consistent with the ideas of students as well.

Second agenda discussed was that suggestions to improve the pitfalls in present curriculum.

One of the students pointed out that “In most of the private medical colleges exposure to patients is very less and MCI should make sure that in these colleges there is a minimum availability of cases so that the students won’t remain ignorant on important clinical findings they should elicit in their practice”. Whereas another student said that “enough space should be given for basic life support and workshops from first year itself. A medical student should have a basic understanding about emergency life support care. So it should be a part of the curriculum with enough importance”.

One intern stated that “The correlation between subjects should be explicitly explained in the beginning itself. The way basic subjects can help the clinical subjects in the final part of the course, i.e. the influence of basic subjects in the entire course should be taught to the students in the initial part”. In addition to this another intern reported that “Foundation course is needed for the students before entering the course which will help them to get a clear cut idea about the vast topics they should cover and ethics they should follow throughout their practice”.

One of the faculty said that “All irrelevant theory topics should be excluded giving more importance to clinically relevant topics. This can reduce the burden of memorising for students and provide them enough opportunity concentrate more on practically or clinically needed topics”.

Another professor stated that “At the end of every basic-subject class, if a clinical professor summarises its clinical application it can create a crystallised idea about the significance and profound importance of the preclinical subjects among the students. Emergency treatment as a part of the curriculum should be brought in. A doctor will be judged by his ability to act sensibly and spontaneously in critical situations. This kind of training should be given to the students to make them prepared to deal with any dangerous circumstances”.

DISCUSSION

Change in rules brought about after the reforms of the 1990s made it easier to open private medical colleges. This has increased the number of medical colleges but

Table 1. Needs of Current Medical Education System as per discussions

S. No.	Arguments/Needs /Demands	Supports	Objections	Disagreements	Suggestions
1	Increase in number of Medical Colleges	90%	10%	Lifting the quality Of existing Medical Colleges prior to the increment In number of seats	More number of Government Medical Colleges
2	More concentration on Clinical exposure from second year	100%	-	-	More exposure to patients from second year
3	Cut down the duration of second year to one year by increasing the fourth year duration to 1.5years	10%	90%	The existing system is far better in creating the basic knowledge	More Clinical sessions for fourth year subjects
4	Requirement Of Foundation Course	90%	10%	-	Correlation between the preclinical and clinical subjects and the opportunities of application should reach the students at the beginning itself.

Figure 2: Images of FGD



leads to many undesired consequences. This commercialization of medical education had a profound impact on quality of graduate doctors, as anyone with money can buy seats in these colleges was incompetent to deal with this influx of commercialization and capitation fee skyrocketed, leading to corruption and black money circulation.¹²

As MBBS students are unable to find jobs, they are forced to specialize in a field leading to a Super-Specialty craze. Brain drain to developed countries is also one of the reasons for unavailability of doctors in India. MCI regulations prevent experienced MBBS doctors from carrying out procedures like cesareans and ultrasound tests. Experienced nurses are barred from administering anaesthesia. This leads to failure of utilizing the experienced manpower to increase the service delivery.¹³

Another casualty of the Super-specialty craze is Research and teaching, as no one is choosing research or teaching as their preferred career. Single breed of doctors can't cater to all the needs, especially in a country as diverse as India. So medical colleges should sensitize students about all the available opportunities and the attached perks and perils. This

will introduce various options available to the students to explore and choose the field best applicable to them.¹²

No uniform quality standards of graduating doctors across India.¹⁴ There should be an exit test that will bring parity to standards graduating from all medical colleges across India. Newly graduated doctors are unaware or indifferent to their social responsibility. Colleges play a major role in infusing the young students with an empathetic attitude towards society. But instead, they are encouraging rote learning without the consideration of humanitarian dimension. Hippocratic oath is largely morphing into hypocrisy.

Thus, sanctity of education was lost as medical education became a field for unscrupulous practice and profit gain than imparting education and providing quality doctors. This has resulted in an unhealthy competition which in-turn lead to unreasonable medical practices and unwarranted diagnostics as graduates from these institutions wanted to recover their capitation fees at the earliest. Eventually, this leads to complete crowding out of the societal and humanitarian dimension of medical education from colleges.

Especially in the private medical colleges, the students who come, majority of them are from a rich class and that is why their parents and the concerned authorities are unable to discipline them the way we should discipline the medical students the same state of affairs is also seen in government colleges throughout the country. There might be some exceptions to this are there, but overall, in majority of the government medical colleges also there is a shortage of medical teachers and whatever the teachers are there they are also doing the indirect private practice and this indirect private practice results into their running away from the teaching time.

We need more MD/MS and DM/Mch seats than MBBS seats. We don't need more MBBS graduates who unable to get PG seats either end up buying seats or leave the country. Around 50000 MBBS doctors are produced every year in India. But only one third have the opportunity of doing a post-graduation in clinical disciplines. If the Government does not employ resources to employ them, the chaos would continue, and the profession would soon lose its charm. Recent opening up of AIIMS in various states,

with two more upcoming is a good move by the government. Initially there were only undergraduate seats, now even post-graduation courses have been started. What is important is that the progress should continue at a reasonably fast pace without compromising on the quality of education and health care facilities.

In India, shortage of basic doctors (MBBS) is exaggerated as only 12% Primary Health Centres, the corner stone of rural health services, are without doctors.¹⁵ On the other hand, the rural sector is facing acute shortage of specialists with 80% per cent posts of specialists (surgeons, physicians, paediatrics, gynaecologists, etc.) at the Community Health Centres, the first contact point of a villager with specialists, are lying vacant. So, there is no doubt about the fact that doctors are required to work in the rural areas. But forcing a MBBS or MD/MS graduate to work in a rural setup without any proper facilities and pay is neither justified nor would it be of any great help. The government needs to provide good infrastructure and facilities, proper living and sanitary conditions and a decent salary to doctors.¹⁴

Healthy discussions which witnessed strong arguments, objections and suggestions were conducted, from which detailed views of professors and students on various issues were elicited. Then only we can have a good a health system.

CONCLUSION

The medical education needs lots of reform starting from admission into medical school to exit from there. The list of needs revealed includes curriculum which reflect current needs of community, more clinical learning and foundation course.

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