Volume : 3 | Issue : 1 | Jan 2014 • ISSN No 2277 - 8160

Research Paper Education

Quality Assurance of Medical Education in India : Perspectives and Recommendations

Dr Lalitbhushan S Waghmare	Dean , Interdisciplinary Sciences, Professor, Physiology, Datta Meghe Institute of Medical Sciences (DU), , Sawangi (M), Wardha, Maharastra, India, Pin : 442004
Dr Tripti K Srivastava	Professor, Physiolgy, Jawaharlal Nehru Medical College, , Datta Meghe Institute of Medical Sciences (DU), Sawangi (M), Wardha, Maharastra, India, 442004
Dr S R Tankhiwale	Professor, Medicine, JNMC, Datta Meghe Institute of Medical Sciences (DU), Sawangi (M), Wardha, Maharastra, India
Dr Zaheer Quazi	Professor, Community Medicine, JNMC, Datta Meghe Institute of Medical Sciences (DU), Sawangi (M), Wardha, Maharastra, India

ABSTRACT *World Federation for Medical Education (WFME) recognizes need for Quality Assurance worldwide. Different countries have varied approaches towards quality assurance of medical education but, unlike other areas of medical regulation, there is little sense of growing international convergence in this area. The palpable fallacy is that general quality assurance instrument for medical education is used on a "voluntary" basis. In absence of mandatory regulatory mechanisms such as accreditation; validation and audit by the external agencies regarding quality assurance; the concern about production of sub-standard health manpower prevails. Accreditation processes can encourage Institutional improvement and help promote high-quality education experiences. This paper reviews the accreditation status of medical education Institutes in the country and recommends certain changes like 1. Change from Inspection to Accreditation, 2. Support for Faculty Development and 3. Health Profession Education Policy in the health care system to meet the expectations of the Nation and the globe.*

KEYWORDS : Accreditation, Quality Assurance, Medical Institutes

Introduction

The Government of India recognizes "Health for All" as a national goal and expects medical training to produce capable "Physicians of First Contact" towards meeting this goal. However, the Indian health care and medical education is facing standard challenges.[1]

The burden of diseases in India is still large. Even though there has been some improvement, national statistics reveal wide disparities between different states as also rural/urban areas with regard to access to basic medical services and quality health care. These are attributed to physician shortage, both generalist and specialist, inequitable distribution of manpower and resources, and deficiencies in the quality of medical education. [1,2,3]India has the highest number of medical schools in the world.[4] This unprecedented growth has occurred in the past two decades in response to increasing health needs of the country.[5] The most significant challenge for regulatory bodies has been to balance the need for more medical colleges with the maintenance of quality standards.[6,7] The globalization of education and health care and India's potential as destination for education and quality health care has brought the issue into sharper focus.

The need for quality assurance programmes for medical education worldwide has been recognized by the World Federation for Medical Education (WFME), which has committed itself to the project "International Standards in Medical Education Assessment and Accreditation of Medical Schools' Education Programs"[8]. The primary objectives of the said project are to stimulate all medical schools to identify their own needs and those of the communities they serve, to assess their strengths and weaknesses, and to consider their potential for reorientation to existing and emerging health imperatives. However this general quality assurance instrument for medical education is purely used on a voluntary basis worldwide.

The technical report of International Comparison of Ten Medical Regulatory Systems states that the bodies responsible for quality assurance in medical education vary from country to country.[9] While in some (India, South Africa, Pakistan) the formal regulation of medical education is primarily the remit of the medical regulatory body, in others responsibilities are shared between medical councils, local authorities, and ministries or health and/or education (Spain, Poland, Germany, Egypt, Greece). The evolution of medical education regulation and quality assurance is at different stages in some of the countries, and face different challenges. In Pakistan, for example, one of the key concerns regarding the regulation of medical education is that many new private medical schools were started by professionals who are members of the regulatory body, thus compromising the transparency and reliability of regulatory and quality assurance processes. In Egypt, there are growing calls – including from international bodies such as the WHO – to centralise some of the functions of medical education regulation, such as the setting of curricula which is still the preserve of individual medical schools.

The situation in India regarding medical school quality oversight is of great importance because of the large number of medical schools in the country. Aim of this paper is to analyze the glitches in Quality Assurance in Indian Medical Schools. It recommends time-bound implementation of certain changes in the existing system / policies so as to meet the expectations of the nation and the globe.

Methodology for Situation Analysis

It was an exploratory cross-sectional qualitative study through Snow ball technique sampling which included leading practitioners, Community based organization, students (both Under Graduate and Post Graduate), faculty, and eminent medical educationists. The data collection was via focus group discussions and in-depth Interviews. The issue focussed were to determine the legitimate expectations of the stakeholders regarding QA practices and quality of education provided by the medical schools in the country.

The quantitative analysis of the data is represented in Fig 1.

The qualitative observation arising out of focus group and key informant interviews unleashed the reasons for paucity in accreditation standards. The foremost reason being that medical education has adjusted inadequately both to changing conditions in the health care delivery system, and to the needs and expectations of societies [10] .The lack of a systematic process for evaluating quality of medical education was another major concern . Want of required thrust on research and structured mechanism for faculty development in absence of mandatory regulatory mechanisms such as accreditation, validation, audit etc by the external agencies substantiated the cause . Various accrediting

bodies differ in their conceptualization and implementation of what seems to be the same or a similar accreditation standard. Words or phrases such as "should," "shall," or "it is expected that" could be interpreted differently, depending on the exact phrasing of the standard, the various cultural or institutional contexts, or the understanding of particular individuals.

There are 314 Indian medical schools currently listed with MCI having a cumulative intake of 35783 per annum, of which close to 60% are private institutions.[1] Mandatory recognition and accreditation are conducted by the Medical Council of India (MCI), a governmental agency. The MCI prescribes minimum standards that are based on the size of the medical school; these standards focus mainly on infrastructure and human resources and less on the quality of education or outcomes. The National Assessment and Accreditation Council (NAAC), an autonomous body established by the Indian agency University Grants Commission; also accredits higher education institutions in India, although, as of the end of 2008, only seven medical schools had successfully achieved this voluntary marker of quality.[3] Students are admitted in medical schools primarily on the basis of entrance exam results. There is, therefore, little emphasis in the MCI or NAAC accreditation standards on entrance requirements or specific prerequisite courses. The involvement of faculty in research activities is encouraged in the NAAC standards but is not emphasized by the MCI.

Recommendations

Based on the qualitative inputs and thorough review of existing practices, the authors recommend a time-bound implementation of certain changes as mentioned herewith in the existing system / policies so as to meet the expectations of the nation and the globe.

1. *Change from Inspection to Accreditation :* The present system of recognition of a medical college by Medical Council of India (MCI) focuses mainly on number of teachers, building, infrastructure and other facilities which are not the measures related to quality of medical education. There is hardly any interaction between inspectors and faculty, students, parents or patients to find out academic achievements and quality of care. Inspection should give way to a comprehensive system of quality assurance and accreditation with focus on academic quality.

Emphasis should shift from quantitative judgment to a continuous monitoring of the quality through institutional self study and peer appraisal.

2. *Health Profession Education Policy:* Serious efforts should be made to develop a National Health Profession Education Policy. Representatives of Regulatory Councils (like Medical, Dental, Nursing and other Councils), National Board of Examinations, medical educationists and other stakeholders through advocacy and discussions, persuade Parliamentarians and Health ministry officials to develop a Health Profession Education Policy. Medical Education Policy should be a component of this policy. The medical education policy should set guidelines for medical HRD (human resource planning and development). The plan should lay down after thorough review and debate: (a) criteria for starting medical colleges in the country in future in an equitable way; (b) admission procedures to medical colleges including age at admission, (c) fee structure; (d) realistic norms on requirements of teachers; (d) procedures for recruitment of teachers including eligibility; weightage for aptitude for teaching; (e) faculty development and career development avenues; (f) long term, medium term and short term strategies to overcome shortages and mismatches of teachers.
3. *Support for Faculty Development:* Faculty development is constrained by lack of commitment at various levels – Central and State Governments, regulatory bodies, college management and teachers. For instance, financial grant given to NTTCs was not only low but also the release was irregular. Unfortunately, Ministry of Health and Family Welfare stopped financial grant from 2002 which was a retrograde step. As of now teachers have to fulfill their teaching and clinical commitments and then spare time for faculty development activities. Their work does not receive any recognition or reward from college management. While University Grants Commission has given importance to faculty development and has established 46 Academic Staff Colleges, a little is done in health profession education. Periodic teacher training should form an essential requirement for career development, promotion and empanelment as examiners. Medical Council of India though has gone a fair distance in this regard by establishing Regional Centres and Nodal centres for Faculty Development, other regulatory bodies for health profession like DCI/ CCIM/ INC are lagging way behind.

Conclusion

There should be mandatory regulatory mechanisms such as accreditation, validation and audit by the external agencies regarding quality assurance in Medical Education with certain changes like 1. Change from Inspection to Accreditation, 2. Support for Faculty Development and 3. Health Profession Education Policy in the health care system to meet the global expectations. Accreditation processes can encourage Institutional improvement and help promote high-quality education experiences resulting in generation of the optimally trained manpower commensurate with global expectations and requirement.

Notes On Contributors

The Authors are Part of Internal Quality Assurance Cell (IQAC) of the University which has recently acquired reaccreditation as "A" Grade by National Assessment and Accreditation Council (NAAC). The corresponding Author is Co – ordinator and Member Secretory of IQAC .

Figures

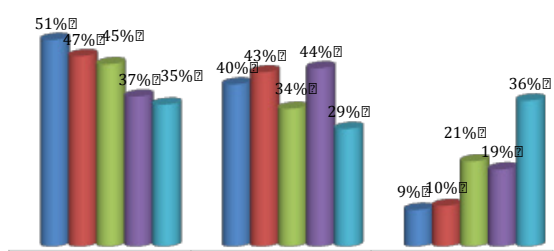

Fig 1 : Quantitative analysis of Focus Group Discussion on thematic areas

REFERENCES

1. Medical Council of India. Website Available at: http://www.mciindia.org/ Accessed January 2011 | 2. Narasimhan V, Brown H, Pablos-Mendez A, et al. Responding to the global human resource crisis. Lancet 2004; 363: 1469-1472 | http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)16108-4 | 3. Health in the Asia and the Pacific Chapter 11 Health Resource: 424-478. WHO's Regional Offices for South-East Asia and the Western Pacific. Available at http://www.wpro.who.int/NR/rdonlyres/7C707E26-2A31-4A6B-94A7-A3D484331061/0/16_Chapter11Healthresources.pdf. Accessed on 15th Dec 2010 | 4. Bansal P, Supe A. Training of medical teachers in India: Need for change. Indian J Med Sci [serial online] 2007 [cited 2008 Oct 1]; 61:478-84. Available from: http://www.indianjmedsci.org/text.asp?2007/61/8/478/32930 | 5. Deshpande S R, Deshpande N. Crass commercialization and corruption of the Indian medical education system and the resultant decay of the Indian Health Education in the last two decades. A case for urgent international review and monitoring. Electron. Physician 2009, 1:9-16, Available at: http://www.ephysician.ir/2009/9-16.pdf | 6. Yashpal wants a super regulator; death to deemed universities http://www.academics- | india.com/yashpal_report.htm Accessed on10.2.2011 (On Prof Yashpal Committee to Advise on Renovation and Rejuvenation of Higher Education in India; released on June 24, 2009). | 7. Ramachandran R.University Business: Systemic flaws and corrupt practices result in the mushrooming of deemed and private universities, many of them with dubious credentials. Cover story in Frontline July 17, 2009:www.Frontline.in.Pages 4-30. | 8. WHO Guidelines for Quality Assurance of Basic Medical Education in the Western Pacific Region published July 2001 | 9. Han de Vries, Paul Sanderson, Barbara Janta, Lila Rabinovich, Fragiskos Archontakis, Sharif Ismail, Lisa Klautzer, Sonja Marjanovic, Bhanu Patruni, Samir Puri, Jan Tiessen Technical report on International Comparison of Ten Medical Regulatory Systems (Egypt, Germany, Greece, India, Italy, Nigeria, Pakistan, Poland, South Africa and Spain), 2009 , UK General Medical Council | 10. Sood R. Medical education in India. Med Teach. 2008; 30:585–591 |