

Suggestions on

Draft National Medical Commission Bill 2016

Submission to:

NITI Aayog

(Government of India)

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Suggestions on Draft NMC Bill 2016

The National Medical Commission draft Bill is a much needed and long overdue endeavor by the NITI Aayog and the Government of India aiming to reform the current Medical Council of India. The Bill is comprehensive and well-drafted aiming to regulate medical profession and improve the quality of medical administration. The Bill aims to create four verticals to oversee undergraduate and post-graduate education, establish a medical assessment and rating Board and also a Board for medical registration. The Bill is rightly providing for convergence and effective coordination. Public consultation of this draft Bill is the fine example of upholding democratic values in India. NITI Aayog must be highly commended for this exercise.

In particular, the Bill reflects the lessons learnt from the past experience. Medical Council of India, as an elected, democratic apex regulatory body has woefully failed in discharge of its key functions. Therefore, the provisions to appoint members of National Medical Commission (NMC) by the government following the recommendation of a high-level search and selection committee are salutary and welcome. Similarly, the four autonomous Boards for undergraduate education (UGMEB), post-graduate education (PGMEB), assessment and rating (MARB) and medical registration (BMR), and the effective convergence in the form of NMC are well-designed and well-integrated. The shift of emphasis from licensing to assessment, rating and transparency is perfectly justified and necessary. The recommendation of the NITI Aayog Committee (Para 3.8) that the NMC should not engage in fee regulation of private colleges is very wise and mature. As the Committee pointed out, once a merit-based, transparent admission system is in place, there is no need to regulate fee structure. Similarly, a nation-wide entrance test (NEET) for under-graduate admission, and a National Licentiate Exam for granting license to practice

medicine and enrolment into the Medical Register, and also for admission into post-graduate courses are both vital in improving transparency, ensuring fairness, eliminating corruption and promoting competence. We commend NITI Aayog for these and other significant reforms to improve standards of medical education and professional regulation.

It is imperative to examine and critically analyse the shortcomings of the current system in order to propose a better system. A brief description of such analysis follows.

Shortcomings of the MCI

Problem 1: Rampant corruption at the level of President of the MCI in allotting and monitoring the medical colleges and creation of a huge center of power by nexus with the political class

Root Causes:

1. Centralisation of power in the constitution of the MCI
2. Lack of transparency in the process of establishment of medical colleges
3. Lack of clear definitions of the standards of the medical colleges
4. Lack of robust accountability mechanisms to combat corruption

Problem 2: Ineffectiveness in setting up and maintaining modern standards, curriculum and training programmes relevant to the needs of the population.

Root Causes:

1. Lack of initiatives in this direction
2. Problem 1 leading to many medical institutions with dismal standards

3. Lack of collaboration with several specialty professional organisations
4. Lack of adequate infrastructure for the institution

Problem 3: Ineffectiveness in controlling the medical malpractice

Root Causes:

1. Lack of adequate infrastructure for the institution
2. Courts of law are (perhaps should be) the principal deterrence for the medical malpractice in the prevailing state of affairs
3. Magnitude of the problem

The Bill has addressed these three challenges of rampant corruption, failure to establish and maintain standards of medical education and ineffective regulation of medical profession. The provisions of the Bill substantially reflect the excellent reports of the Group of Experts headed by (Late) Dr. Ranjit Roy Choudhury and the Parliamentary Standing Committee on Health and Family Welfare, and further improves upon them.

We endorse most of the features of the draft National Medical Commission Bill 2016. However, we are making the following seven specific suggestions with respect to the Bill. Only the first suggestion relates to altering the present draft; all other suggestions are additional provisions in keeping with the spirit of the Bill and NITI Aayog Report.

1. Second Appeal:

The Bill provides for second appeal on orders of MARB and later the NMC to the Government with respect to the UG and PG education.

Section 27: Permission for establishment of a New Medical College Sub-section 3(para 3):

“Provided further that the person/college shall be free to make a second appeal to the Government in case no decision is received within one year from the date of his submission or the scheme is disapproved.”

This provision of second appeal to the Government is redundant and counterproductive as the members of both the Medical Accreditation and Rating Board (MARB) & National Medical Commission (NMC) are appointed by the Government itself through Search-cum-Selection Committee on the basis of qualifications as per the provisions of the law. While fifteen of the twenty members of NMC are directly appointed by the Union Government, the remaining five are appointed on rotation basis from the Medical Advisory Council (MAC), which itself is nominated by State Governments and Union Home Department (in respect of Union Territories). Therefore, second appeal by the person/college to the Government is not required and may lead to undue political interference and pressures and will undermine the credibility of the process in the eyes of the public. There is already one appeal allowed on MARB decisions, and NMC can be trusted to make final decision.

Recommendation: We firmly believe that the second appeal should not lie with the government. National Medical Commission’s decision should be deemed as final. Therefore the provision in Section 27 relating to second appeal should be deleted.

2. Composition of the four vertical Boards- UGMEB, PGMEB, MARB & BMR

The Bill seeks to give great authority and autonomy to the four Boards. They have far reaching powers and functions. All these Boards are appointed by the Union Government based on recommendations of a high power search and selection committee. However, three of these Boards – UGMEB, PGMEB and MARB are comprised of a full time President who shall be assisted by staff from the NMC secretariat. In effect, each is a single-member Board. Given the complexity of the nation, the wide range of powers given to these Boards, the prevailing corruption and past unsatisfactory performance, it would be wiser to have a three-member body in all these Boards, as is the case with BMR. However, only the President of each of these Boards shall be a member of NMC as proposed in the Bill. Such multi-member Boards will bring a wide range of backgrounds and expertise in medical education and profession, and will substantially improve the quality of decision making.

3. Undergraduate and Postgraduate admission in Private colleges

Para 3.7 of the NITI Aayog Committee Report explicitly endorses NEET and common licentiate examination for admission into medical colleges. Para 3.8 recommends that private college fees should not be regulated. It is proposed that up to 40% seats in private colleges should have regulated fee as per NMC norms, and the balance seats the institution should be given full freedom to charge the fees that they deem appropriate. All these are excellent recommendations based on past experience and future needs. However, these recommendations do not find place in the Bill. Given the ubiquitous corruption and lack of transparency in respect of admissions to private medical colleges and fees charged for unregulated seats, we believe that the following provisions should be incorporated in the NMC law.

The admission to all seats in private colleges - undergraduate or post-graduate, 40% seats (it is better to have a definitive percentage, rather than leaving it to discretion) with regulated fee and balance seats with discretionary fee – all these seats should be filled by NEET examination for UG admission, and by the Common Licentiate Examination for PG admission. Only those candidates willing to pay the higher fee will be considered for admission to seats with unregulated fee, but admission shall be merit-based among the eligible candidates.

4. Standards of Medical Education

Common Licentiate Exam (in the lines of USMLE of USA) is a very good intervention that would ensure the minimum standards for a medical graduate and would measure the outcome based standards of the medical colleges. In addition, this will serve as the national entrance test for the post graduate courses.

However, greater attention needs to be paid to the undergraduate examination system. We must understand that a fact-based assessment is a crude tool considering that medical expertise is mostly skills based rather than possessing the factual knowledge. Most of the developing countries moved towards the Objective Structured Clinical Examinations (OSCE) in addition to the MCQ based tests. These are very important tools in improving the clinical and communication skills of the doctors. These can be easily implemented in India in centralised manner –for example at state or a particular region level by a large group of examiners. These tests are to ensure basic standards resulting in ‘pass or fail’ outcomes rather than adding up to the score for the PG entrance process which will be solely based on an MCQ (or other alternatives such as Extended Matching Questions – EMQ) based test. OSCEs have less scope for subjectivity considering that a candidate faces multiple examiners (10-15) in one test. The UGMEB can contemplate organising these tests and these can be administered at different stages of the medical undergraduate

course. OSCEs should fully replace the current ‘patient based clinical exam’ conducted by the individual medical colleges which are providing ample opportunities for rampant corruption and compromise of medical standards.

Medical specialty organizations and associations in India have evolved significantly in the recent years and have been providing excellent continuing medical education to the medical specialists. We must avail the expertise of these professional associations constructively in improving the standards of postgraduate training in the respective specialties. Involving the stake holders with expertise directly in devising and updating the training standards of rapidly evolving medical specialties is very essential. This also serves as a mutually reinforcing mechanism strengthening the specialty associations and raising the training standards.

Medical specialty associations should be given the responsibility and ownership of the curriculum and assessment system for each respective specialty and subspecialty. PGMEB should set out the standards and requirements that medical specialty associations must apply when developing and monitoring curricula and assessment systems. PGMEB sets out the general direction whereas the specialty associations should have the mandate to set out the specific and detailed standards relevant to the respective specialties. Therefore, we recommend :

(1) Extending 22 (2) as follows :

*“To develop a competency based dynamic curriculum (including assessment) at post-graduate level in consultation with stakeholders **and expert bodies/specialty associations** such that post-graduates have appropriate knowledge, skills, attitude, values and ethics for providing health care, imparting medical education and conducting medical research.”*

(2) Insertion after point 22 (5) as point 6

(6) To set out standards and requirements that medical specialty associations must apply when developing curricula and assessment systems. These shall be revised and updated periodically

5. National Board of Examinations (NBE)

The NITI Aayog Committee Report in Para 3.7 (e) (iii) suggested an important role to be played by NBE in shaping the functions of the PGMEB, and proposed that they could continue to conduct voluntary examinations with institutions / candidates willing to take part in such a process. However the transitory provisions in Section 42 of the draft Bill provide for immediate merger of NBE with PGMEB.

MCI woefully failed in anticipating national requirement and promoting post-graduate medical education. In all major nations, almost all medical graduates have the opportunity to specialize, get trained and obtain post-graduate diplomas and degrees. In India, typically around 25,577 (49%) medical graduates have that opportunity given the limited post-graduate training facilities and seats. Among the PG seats, only 50-60% are in clinical medicine, and therefore only about 12-15% of medical graduates are able to specialize in clinical care. As a result, there are serious deficiencies in competence and expertise in medical care. NBE has been created to meet the legitimate needs of the society and to ensure quality training of post-graduates in a flexible and effective manner. Most objective observers and experts agree that NBE has been doing a very creditable job with honesty and efficacy. MCI historically had no flexibility or institutional ethos to expand PG education. Many institutions of excellence and credible, high-quality private hospitals which do not want to start medical colleges are nevertheless excellent institutions for PG education, and would be quite willing to provide PG training in a flexible, efficient environment. Given this historical background, and the early successes of NBE in the face

of MCI's colossal failure, it is in the national interest to continue NBE for a period of time, but ensure effective integration with NMC and the Boards. The government should review the situation after, say five years, and then take a policy decision on merger of NBE with the new NMC.

Therefore, it is imperative that NBE should expand PG education and training, and all Diplomates of National Board (DNB) trained under NBE guidelines are treated on par with corresponding PG degree for MCI/NMC. We should also ensure that there is effective coordination and cooperation between NMC and NBE in expansion of PG medical education. The strengths of NBE should be fully leveraged, and DNB should not be relegated to a secondary status. Therefore, we propose incorporation of the following provisions relating to NBE in the NMC Act:

- a) Section 42(3) should be deleted and NBE should be continued for the time being.
- b) The President of NBE should be ex-officio member of NMC.
- c) There should be effective coordination mechanisms between NBE and the NMC, the PGMEB, MARB and BMR.
- d) The diplomas awarded by NBE should automatically be recognized by NMC and these qualifications should be included in the First Schedule under Section 32(1) of the draft Bill.

Such a measured approach will ensure that the strengths of NBE are fully deployed in the service of the nation for the next few years. At the same time, there will be effective coordination and convergence between NMC and its boards and NBE. This will facilitate seamless and swift integration of NBE with NMC when the time is ripe.

6. State Medical Councils

The proposed Bill rightly provides for an appeal to the Board of Medical Registration whose decision shall be binding on the State Medical Council in section 29 Clause 1 Sub clause iii

“Where the name of any person has been removed from a State Register on a ground other than non-possession of the requisite medical qualifications, he may appeal in the prescribed manner to the BMR, whose decision shall be binding on the State Council subject to the provisions of Section 29”

However, the draft Bill is silent on the composition of the State Medical Council (SMC). While the NMC along with BMR will be the overarching regulatory body for medical profession, the actual functions of execution of NMC guidelines, disciplinary action against erring doctors, and imposition of penalties including removal from State Register are performed by the SMCs. The role of NMC and BMR is largely limited to guidance and advice, prescribing standards of professional conduct and hearing appeals. The current MCI Act 1956 empowers the states to constitute State Medical Councils. Most of the State Councils having major representation of elected members have tended to behave as a trade unions protecting the doctors instead of acting as a regulatory body to improve the standards of medical care and protect society from professional malpractices. Therefore, the NMC Act should clearly outline the framework of appointments into the State Medical Council similar to NMC with some flexibility for the States. The law also should provide for nominees of National Medical Commission in the State Medical Council. Parliament has the power to make such a law under the Articles 13, 19 (6) & Items 65 & 66 of List I of the Seventh Schedule of the Constitution.

7. Ensuring overall Accountability

Given the enormous importance of NMC's role in regulating standards of medical education, professional ethics and medical care in India, we believe a regular framework for reporting and accountability should be institutionalized in the law itself. Therefore, we suggest that the NMC Act should provide for a mandatory annual reports to the Parliament, so that there can be effective accountability through Parliamentary debate and Committee hearings.

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