Training of Doctors for India*

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Promise of a New Dawn,

When one thinks of medical care of health services, among the images that come to mind, the doctor always seems to play a major role. Medical professionals, particularly doctors, have held the centre stage in the health care scenario for long. This is so particularly from the points of view of planners, administrators and doctor themselves.

“However it is from the perspective of the poor and underprivileged – the 350 million and more people in India – for whom the health and wellbeing still remain a distant dream, that the training of doctors and Health For All (HFA) need to be reviewed”

Other points of view, based on field experiences, have been gaining ground during the past few decades. In 1978, the world wide acceptance of the goal of Health for All (HFA) by 2000AD, with its concern for equity and social justice, seemed to promise a new dawn. It initiated fresh thinking on several issues including that of the role of a doctor. It has developed multidimensional strategies of which Reorientation of Medical Education is one. Its terminology has now become part of the consciousness and statements of Governments. NGO’s, medical educators, health professionals, development workers and social activists. Even the private sector uses it to its own benefit!

However it is from the perspective of the poor and underprivileged – the 350 million and more people in India – for whom health and wellbeing still remain a distant dream, that the training of doctors and HFA needs to be reviewed.

This article attempts to focus on a few questions concerning medical education: What has been the Indian experience? What are the challenges we face? What are the positive initiatives that have been developed? And what are the negative trends?

The need for a “new” doctor

The health status of people and populations is determined largely by socio-economic – political-cultural- ecological factors. At the family and individual level these translate into income, occupation, residence, education and a host of cultural factors. While curative medicine plays an important healing and supportive role in times of disease, the other roles that a doctor can play need strengthening. For example, they could be pacesetters in making available knowledge, concerning the promotion of health and the causative factors for ill health, using the people’s idiom and culture. Thus they could ‘teach’, ‘educate’ and ‘liberate’ from unnecessary illness and suffering in the truest sense.

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**Community Health Cell, Bangalore
Several groups play a role in shaping health and more specifically health care services.

People themselves are crucially important in making decisions in being capable of looking after themselves and others, in living healthy lifestyles if circumstances permit, and in participating actively in and shaping their own health. This calls for different styles of functioning, different perspectives, and different attitudes especially of the health professionals. Doctors probably require a change of self image from being centre stage to moving to the periphery to playing catalyst, to learning from people and building on their existing knowledge and skills.

The contribution and role of the silent majority of health workers is also gaining increasing recognition. We have a virtual army of different levels of health workers, nurses, pharmacists, laboratory technicians, health supervisors, multipurpose workers, health educators, ANM’s trained ‘dais’ or birth attendants, community health guides etc. For every medical officer of Government Primary Health Centre there are over twenty workers. The GoI statistics say that about 53000 of all these grades of workers are trained annually in the country. Doctors need to be trained to work with all the health personnel as democratic team leaders, outside the hospital setting as well as in it, and also to be able themselves to provide relevant training to others.

We have a rich tradition of indigenous system of medicine viz, Ayurveda, Siddha, Unani, and also other systems of medicine, eg; Homeopathy, Acupuncture etc. Besides these, there is also a wealth of local folk health practices. Doctors need to move away from the present condescending, superior and largely ignorant position to a more open minded and scientific approach involving these systems and their practitioners in Health Care. This can only occur if serious efforts are made towards integration during the training phase in medical college itself.

As a result of far reaching changes that are taking place in the philosophy and practice medicine and health care services, there seems to be a need for a redefinition and rediscovery of the role of doctor in this more complex and decentralized scenario. Their formation needs to prepare them more adequately for the new challenging roles they are called upon to play.

**Prescription for Change:**
In India, reflections regarding the type of health care services and medical education we need, predated the HFA declaration at Alma Ata. They go back to the freedom movement.

**The National Inspiration**
The Sokhey Committee on National Health was set up by the National Planning Committee in 1940. It included many medical professionals who were active in the Independence struggle. A demand was made for the provision of comprehensive health care by the state to all the people. They suggested the training of one health worker per thousand people within 5 years. A longer term target was to have one doctor per thousand people. This has not been achieved fifty years later. They also recommended that the Ayurvedic and Unani systems should be part of our national health system. This too has not moved much beyond apologetic rhetoric.

The landmark report by the *Health Survey and Development Committee* (Bhore Committee, 1946) recommended the training of a ‘basic doctor’ to provide comprehensive health care to
the vast rural population of the country. The earlier licentiate course was closed down. Several important recommendations were made which formed the blue print for change in Health Care and Medical Education. (See box 1)

(Box 1)
The Bhore Committee, 1946
- Expand medical education- more colleges
- Social and Preventive Medicine departments in medical college.
- A years “internship” after graduation.
- Reduce didactic instruction and increase self learning skills
- Set up All India Institute of Medical Sciences to train ‘teachers”
- Reserve 25- 30% seats for women
- Provide subsidy and freeships for 30%
- Stress research for full time teachers
- Refresher course for GPs
- Increase training of Nurses

The Fifties and Sixties were witness to a tremendous effort in infrastructural development and expansion of training capacity. The Mudaliar Committee (1959) recommended the need for consolidation and the Patel report (1968) spelt out in greater detail the quantities of a “basic doctor”. Numerous conferences and meetings to discuss reorientation also took place.

Rethinking change, in 1974 the Government of India setup an expert committee to review the Indian medical education scene.

The report of the Group on Medical Education and Support manpower (Shrivastava Report, 1975) made a very strong indictment of the system and identified the challenges ahead (see box 2)

(Box 2)
Diagnosis of the Problem
“the stranglehold of the inherited system of medical education, the exclusive orientation towards the teaching hospital, the irrelevance of the training to the health needs of the community, the increasing trend towards specialization and acquisition of postgraduate degrees, the lack of incentives and adequate recognition for work within rural community.

Socio-cultural circumstances in which their skills would be needed, and would be strongly encouraged to take career directions consistent with HFA and PHC. The overall emphasis would be upon appropriate technology and comprehensive health care management.
New demands would be made upon administrative structures for better coordination between faculties, professional bodies and communities because community oriented medical education is like a three legged stool which cannot do without any of these”.

*SOURCE: Reorientation of Medical Education, WHO SEARO Regional Publications No. 18 (1988)*

**From Rhetoric To Reality**
Over 40 years of experience are over. Where are we today?

**How many Doctors?**

There has been a quantum growth in medical education and in the training of health personnel of different levels since 1947. From 15 medical colleges admitting 1200 students (other than medical schools) before 1946, we today have around 140 medical colleges (of the allopathic system) in the country. These form one tenth of allopathic medical colleges worldwide. Unfortunately, we do not know the exact number of colleges as of now. With rapid growth of capitation fee colleges and other new colleges in the 80’s many of which are not recognized by the Medical Council of India, we have only an approximation - viz, 140. The summary picture given in the figure below pertains to 125 colleges only. The actual numbers will therefore be higher.

**Where are the Doctors?**

Mere numbers do not imply equitable distribution. Medical colleges are clustered in and around the large cities like Bombay, Calcutta, Madras, Delhi, Bangalore, etc it is useful to take a look at the GOI statistics on the doctor – population ratio in different states and Union Territories. The figures for 1988 show a wide variation in different regions, the attraction of the export market for medical manpower, are some of the factors .... responsible for the present day aloofness of medicine from the basic health needs of our people”.

Srivastava report 1975

The committee went on to offer its own prescription for change which reinforced and went beyond the “Bhore” blue print (see box 3)
The Group considered it important to create a structure - a Medical and Health Education Commission charged with the responsibility of bringing in the change process.

Unfortunately the major part of the recommendations of the Shrivastava report were not implemented. In fact presently, 15 years later, the majority of “medical educators” (teachers) are not even aware of the report or its contents.

The 1982 statement on National Health Policy of the G.O.I, recognized that effective health care services depend largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel. It also stressed the need for a National Medical and Health Education Policy which would
- Chart out changes in curricular content,
- Assess requirement of health personnel according to regional needs,
- Ensure social motivation of all personnel towards health services, and
- Establish inter-relations between health personnel of various grades.

The first attempt to have a national level policy has been the Educational Policy for Health Sciences, 1989, (Bajaj report) which is still in the form of a draft report. The absence of a national policy or commission on Medical Education/ education of health personnel leads to adhocism and anarchy at the ground level, with market and political forces playing the major role, resulting in adverse effects on the quality of medical education and medical care. The Medical Council of India, MCI, provides guidelines and recognition, but lacks adequate statutory powers to be a regulatory body. Health being a State subject, medical colleges can start and function, having received affiliation by a local university and sanction from the State Government.

There is a Bill in Parliament to provide the MCI with more powers. It raises issues like providing autonomous colleges and institutions to allow them to innovate more freely. However, with all political instability of the past 2 years, it has not seen the light of the day. During the 1980’s a few states (Andhra Pradesh, Tamilnadu and Karnataka) have started or initiated the process of forming a State Level Health University to which all medical colleges are affiliated. This helps in providing some standardization of curriculum, examinations, etc. It is hoped that they will also be able to move ahead with new directions, and innovations.
At the national level therefore we have very clear and unambiguous statements regarding future directions. This is reinforced at the South East Asia Regional level by the WHO SEARO reflections on Reorientation, and at the international level (See box 4), by the Edinburg Declaration of the World Federation of Medical Education (reprinted elsewhere in this issue). However the most important aspect of Policy is the experience of translating policies to programmes of change? Are the prescriptions still rhetoric or reality?

(Box 4)

**TRAINING THE NEW DOCTOR .. THE SEARO REFLECTIONS**

“The new doctor will be the leader of a health team comprising various disciplines and professionals, working in partnership with the community it serves. Training would prepare the doctor for the application of a limited technology to preventive as well as curative interventions for patients predominately from lower economic and rural groups. The leadership role would not be symbolic but rather based upon managing, coordinating and training skills.

Medical education to support this development would have to become community-oriented, which would mean students learning about care in, of and for the community. Curricula would change to stress content relevant to Health for All and Primary Health Care. Teaching methods would become more flexible, integrated and problem oriented. Students would work in teams and in communities. Their goal would be life long, self-educative skills. Standards would be competency based and linked to local priority problems. Students would be selected to represent more closely the

Doctors are not evenly distributed in a State according to the population, but are clustered in the urban areas with the rural areas being underserved. Even so, a clear pattern emerges showing that the Northern States, including those holding the bulk of India’s population, fall into the fourth group.

**Who are the Doctors?**

We are doing fairly well in terms of the number of seats for women students, with 36.4% of seats in 1987 going to girls. This trend has in fact been increasing over the years.

A compilation has been done regarding seats reserved for students from the scheduled Castes, Schedules Tribes and Other Backward Castes for the year 1984-85, covering 106 medical colleges recognized by M.C.I. It revealed that 30.6% of seats were reserved for these three categories.

As an approximation, one can also say from Figure 1 that about 45% of undergraduates complete their post graduation.

**How good are the Doctors?**

It is the area of quality of medical education, and its relevance to the health needs of the large majority of our population, that presents the greatest problem and also the greatest challenge to medical educators.
It has been the experience of people and NGO’s/Volags involved in health work in the periphery, that doctors fresh from medical colleges are ill equipped to cope with even the medical problems in a rural area. Much less when it comes to issues like being the manager of a health centre, handling accounts, running a small pharmacy and laboratory handling X-ray, equipment, training health workers, coping with rivalries and conflicts in the villages, and working in different cultural situations. Understanding and intervening sensitively along with multidisciplinary groups in the broader societal factors that impinge on health is most often considered as “none of our business” or impossible.

The young graduates who are trained to believe that they are the cream of Indian society having entered medical college in the face of stiff competition and having labored for 51/2 years before graduation, are aghast when they come face to face with realities. They are neither professionally competent nor emotionally prepared to face such a situation. Trained in a very structured, hierarchical, compartmentalized environment with a surplus of medical personnel and a specialist for every organ, they feel incompetent to make important decisions concerning life and death independently. There is a long list of jobs for which they have never been trained.

Being used more to “Chart Care” then “Patient Care” even the so called “good students” often find themselves handicapped when it comes to carrying out basic nursing procedures, calculating drug dosages for children, handling normal and complicated deliveries, setting fractures, treating snake bites and a host of similar every day medical problems.

Where lies the problem?
Feedback from medical graduates who have worked in peripheral health institutions in the late 70’s, 80’s and early 90’s reveals the urgent need for skill development during their under graduate years. However, unless medical teachers themselves get exposed to the realities of medical practice in the periphery and are themselves skilled to handle such situations it would be wishful thinking to expect them to train young students adequately.

It is important to shift the base for clinical training from being 100% in the exceptional environment of a large teaching hospital, to smaller hospitals, dispensaries and health centres. This should not be confused with the community based training under the Department of Community Medicine which is essentially to equip students with skills in epidemiology, sociology, health education and communication understanding the life situation of people in rural areas and urban slums etc.

The present system of medical education in India was built on the British model. The curricular content, text books, college and hospital structure and environment, examination system etc, are all patterned and firmly set on the Western System as it prevailed 50-100 years ago.

A universal culture seems to prevail among medical students. Whatever may be the background of the student, a certain process of westernized socialization occurs. While certain aspects may be positive, it produces an alienation from our poor and a yearning to work in the familiar comfortable surrounding of a hospital with all its infrastructure and backup services of personnel and technology.
The Challenge before us
The Shrivastava report sums up this paradox and dilemma succinctly by stating that….
“The greatest challenge to medical education in our country, is therefore, is to design a system that is deeply rooted in the scientific method and yet is profoundly influenced by the local health problems and by the social, cultural and economic settings in which they arise. We need to develop methods and tools of instruction which have relevance to the resources and cultural patterns of each area. We need to train physicians in whom an interest is generated to work in the community and who have the qualities for functioning in the community in an effective manner. In addition to medical skills, they should be trained in managerial skills and be able to improvise and innovate”.

Innovations/Initiatives Within the System.
During the past 44 years, there have been several attempts to introduce changes within the medical curriculum to make it more meaningful to our situation. Some of these have been at an All India level, through guidelines provided by the MCT, expert committee reports, and meetings of Deans and Principals of Medical Colleges. Some have been lobbied for by professional bodies eg, the Indian Academy of Pediatrics (IAP), the Indian association for the Advancement of Medical Education (IAAME), and the Indian Medical Association (IMA).
Some have been introduced at the State level eg., through the Health Universities of Tamilnadu and Andhra Pradesh. Others have been developed at an institutional level. Yet others have grown around particular departments and individuals. The MCI guidelines (the latest was published in 1982) provide the overall framework for curriculum and examination system and also the minimum requirements in terms of staff and facilities. The guidelines are of a general nature and flexible enough to allow for innovations and modifications.

Some of the key initiatives have been:

Teaching preventive and Social Medicine:
Department of preventive and social medicine (later called community medicine) were introduced during the early fifties. Field practice areas in urban slums and rural areas were developed for the purpose. Programmes such as the Family Health Advisory Service, where each student followed up 3-5 families for period of 1-2 years, clinic socio case conferences, and field visits to different institutions were introduced. However, in general, these efforts have not made a dent in the situation for various reasons. In fact medical students and doctors always rate PSM about the lowest among all disciplines. Much worse has been sometime counterproductive effect it results in, creating long lasting negative impressions and a decision never to get involved with this sort of work or situation. Another adverse effect has been that community orientation has got compartmentalized into a departmental responsibility, while the rest of the 22 or so departments of a medical college continue their individual patient or system/organ oriented work.

However the PSM departments in a few colleges have done creative work and have been more inspiring. Foremost among them are CMC-Vellore, MGIMS- Sevagram, SJMC-Bangalore, AIIMS-New Delhi, JIPMER- Pondicherry, CMC- Ludhiana, and BHU – Varanasi. They have introduced rural or community oriented camps where students live and learn in villages for a period of 2-3 weeks, block posting, health education and child to child programmes, socio-
epidemiological projects, actually organizing health programmes of various types in rural situations, collaboration with other departments etc.

The ROME Scheme
The Reorientation of Medical Education (ROME) Scheme was launched by the Janata Government in 1977, based on earlier expert committee recommendations. Three Government Primary Health Centres (PHC’s) were attached to each medical college. It was hoped that the entire faculty would be involved in the training of students in the periphery. They would thus develop a community orientation and also upgrade skills at the PHC level. Over time, each college could take responsibility for an entire District. Unfortunately, the programme remained more at the level of mobile clinic services provided by interns and junior doctors, utilizing the 3 large white mobile vans procured from the U.K by Raj Narain.

These “White Elephants” cannot manoeuvre the smaller roads leading to the more remote villages; they are confined to the highways. The implementation of the scheme in its entirety also has not moved ahead and has not brought about changes that were hoped for.

Training the “Teacher”
Action was also initiated to introduce the principles of educational sciences into medical education. The National Teacher Training Centre (NTTC) was set up at JIPMER Pondicherry during the 70’s by the Government of India in collaboration with WHO. It did commendable work in organizing workshops and training programmes for medical teachers from colleges across the country. Subsequently a NTTC was also started at PGI, Chandigarh and later at B.H.U- Varanasi. Some colleges now have medical education cells with core groups of trained teachers who organize programmes at their own institutional level, AIIMS- New Delhi more recently has developed a Centre for Medical Education Technology (CMET) with a fairly large number of teachers trained at the professor and Assistant professor level, who form its adjunct faculty. CMET has all the equipment necessary for the development of teaching aids. All these centres are also working on making assessment/examination methods more objective and rational.

Socializing ‘Mother and Child’ Care
The development of the concept and practice of social or community Pediatrics (Child Health) was also initiated during the Seventies. Osmania Medical College, Hyderabad was a pace setter; so also have been the colleges in Ahmedabad, Trivandrum, and Madras. The Indian Academy of Pediatrics has recently published recommendations for the teaching of pediatrics’ relevant to our social situation.

Attempts have also been made towards the development of social obstetrics with the support of WHO. Integrated teaching of Mother and Child Health (MCH) by the departments of obstetrics and Gynecology, Pediatrics and PSM was introduced in some colleges.

Expanding medical horizons
More recently some colleges eg; MGIMS- Sevagaram, PGI Chandigarh, JIPMER-Pondicherry, CMC Vellore and others have been spearheading the introduction of Rational Therapeutics through the Department of Pharmacology, Medicine, etc. The need for a greater emphasis in the under graduate medical curriculum to psychology, Behavioral Sciences and
Psychiatry is also gaining ground. The development of epidemiological skills is also being strengthened by initiatives and networks linked to CMC –Vellore and AIIMS New Delhi. A few colleges are also concerned about a more planned approach to training in Medical Ethics. Some ground work has also been done to work out a curriculum for the teaching of Management to medical undergraduates.

**Selecting and Motivating**

CMC Vellore and SJMC Bangalore have introduced selection methods, which strive to understand attitudes and motivation rather than only intellectual ability. They also have a scheme through which young graduates work in peripheral health institutions of the voluntary health sector for 2 years after graduation. Having completed this, doctors get a preference for entrance into post graduate courses. Over the years some of these postgraduates have become staff members. It is hoped that their experiences in the periphery will influence their teaching.

Most of the experiments and innovations have been confined to a relatively small number of institutions- the top ten medical colleges. These colleges also attract ‘good’ students who tend to go in for superspecialization. It would probably not be a surprise to find that most doctors going abroad come from these colleges. The mainstream colleges should therefore be the focus for major efforts in reorientation. Another phenomenon is that creative and committed work usually continues as long as the key person who initiated it, is around. After they move on, the work gradually reaches a different level of routinized, meaningless functioning or gets lost to history. We need to develop a commitment to the cause and a process rather than individualized functioning and kingdom building.

**Networking for change**

In addition to changes attempted by individual colleges and small groups of faculty there is an emerging trend in the 1980’s for networking and exploring the problems and the solutions together.

**Asking the right question**

In 1987 a symposium on “Medical Education for Primary Health Care Needs- experiences in successes and failures” was held at AIIMS- New Delhi. One of the key resource groups was the Centre for Educational Development University of Illinois (USA), which has been spearheading changes worldwide. Four participating medical colleges – AIIMS (New Delhi) BHU (Varanasi), CMC (Vellore) and JIPMER (Pondicherry) formed a working consortium on “Inquiry Driven strategies for innovations in Medical Education in India, Health Services Research and Context Evaluation. Each took on an area of study concerning medical education. There was sharing of information and views at different workshops. It is now hoped to enlarge the consortium and spread its scope with each of 4 colleges taking on 4 more colleges. The idea is to build the ‘Case’ and substance of change step by step asking the right questions and initiating studies to find answers and approaches.

**Exploring Community approaches**

The Miraj Medical Centre has put up a proposal for the development of a Christian Institute for Health Sciences. The group decided to be much more community oriented and community based. The manifesto articulates in alternative vision in objectives, methodology, student/staff selection, curriculum development, evaluation, development of peripheral health facilities etc.
Recognising the Social Paradigm.
The Medico Friend Circle (mfc) is an all India group of people interested and involved in health issues within a broader social perspective. In a recent publication entitled “Medical Education Reexamined (1991) they explore various dimensions of medical education, building on the perceptions of their members who come from diverse medical, social activist and developmental backgrounds. Using the framework of the 1982 MCI curriculum they have formulated an innovative alternative anthology of ideas which stresses the “societal causes of ill health and the community orientation” of the medical solutions.

The Alternative Track
In 1988, the MCI and WHO initiated homework with a few medical colleges on the possibility of an experimental parallel curriculum which would be “community oriented” and “problem solving” in its approach. Inspite of running into “bad weather”, one member of the group, CMC- Ludhiana has gone ahead with preparation for change, having received the Punjab University’s green signal to lay the new track. As faculty and students prepare for change CMC – Ludhiana has discovered the trails ahead with status quo forces. The process in its initial teething troubles has discovered the need for a “voluntary incrementalism”.

Searching for a value orientation
1989 saw the Christian Medical Association of India (CMAI) facilitating a network of Medical College, viz, CMC-Vellore, CMC Ludhiana, SJMC – Bangalore and Miraj Medical Centre. Their objective was to learn from one another pioneering experience and strengthen each other. At the same time they have been exploring the need for greater social relevance and a new orientation in medical education upholding ethical values in medical practice, research and health care delivery.

Exploring new linkages
Learning from the grassroots
The voluntary health sector, working primarily with the more under privileged sectors of society, has been growing during the past 3 decades. Non formal training programmes in health related subjects were begun by different groups, independent of each other, in different parts of the country. Some of these date back about 25 years, while others are more recent. The motivating factor was to train people to intervene sensibly and sensitively in the situation that prevails in each local region. There is a tremendous variety in the types of training that evolved from the training of dais and community health workers, health educators, community organizers, multipurpose workers, development workers, with a health training as well, to community health training and reorientation for doctors and nurses. From a six week’s course the range of courses and alternative courses go right up to an M.Phil and Ph.D programme in Community Health offered by JNU University.

These programmes have developed their own curricular content and alternative training methodologies. Since they were unfettered by regulations and accreditations, they were rather creative in their experience and internalized into the medical education system, particularly for the community orientation and community health aspects. The Kottayam experiment a forgotten experience is given elsewhere in this issue.
Some newer areas developed are social analysis at a macro-level and also methods of understanding and analyzing local situations. Simulation games have been developed to enable this. Another important area is the understanding and acceptance of oneself, one’s needs, motivations and aspirations.

Identifying and utilizing local health traditions, resources and medicinal plants has been done by several groups in different parts of the country.

Methodologies have been developed to enable and empower women who anyway are the main providers of health care in the family and community.

Medical skills have been demystified and health workers have been found very capable even in performing minor surgery and tubetomies. There is therefore an urgent need for interaction between the classical medical educators and this very alive and dynamic process at the grassroots which will be to their mutual benefit.

**Recognizing fellow physicians**

The wealth of resources available in the Indian and others system of traditional medicine which are culturally acceptable, closer to the people and more holistic in approach is gradually being recognized by health planners. Given below is a picture of the manpower available and training capacity.

![Graphs showing manpower and training capacity](source: Health Information of India, 1988)

Medical educators can no longer ignore the other systems of medicine. Western medicine trained doctors in the community cannot ignore or their fellow physicians from the other systems. This calls for a courageously new commitment to integration in a medically plural situation, a task which the people have already begun. Now withstanding the lofty exhortations of G.O.I. reports and the newly converted rhetoric of WHO – this continues to be a sadly neglected...
aspect of health care policy exposing the deeply embedded ‘Cultural Colonialism’ of the allopathic tradition and the lack of an open ended rationalism. How long can we continue to ignore this plural partnership?

Medical Education And Society in India.
The training of doctors does not take place in isolation, but is moulded by powerful forces that operate in Indian Society.

Doctors at what cost
Medical education in India is highly subsided. Doctors are educated at a tremendous cost to the public exchequer. This was done with the hope that they would provide medical care to “the vast rural population” (Bhore Committee). However, most of the graduates remain in urban areas and a large number - presently about 5000 a year i.e. 40% of graduates - migrate (R. Duggal). Even today, large proportions of our rural population have to make do with substandard medical care or no care at all from the state sector.

Private or Public?
There is an increasing trend particularly in the 1980’s towards the privatization of medical education. Private colleges today account for about 25% of all medical colleges. “Capitation Fee” colleges have sprung up as business enterprises. Upto Rs. 5 lakhs are collected as “Capitation fees” per student on entrance. The facilities and staff requirements are more often than not inadequate and hence the colleges are not recognized by the MCI.

Thus a profession, that was once a vocation, is being commercialized and made into a business where medical care is bought and sold like any commodity. This is becoming increasingly evident in the type of doctor patient relationships that prevail, in prescribing practices and in the mushrooming of high tech diagnostic services and five star curative centres.

Unemployment in the midst of need
The total number of qualified medical doctors (allopathic) registered with the various State Medical Councils in India, in 1987 was 3,31360. In 1988, the total number of doctors working at the primary health centre/community health centre level was 26,230 i.e, about 7% of the total number of doctors. The taluk and District Hospitals and Hospitals/ dispensaries/ health centres of the NGO/voluntary sector also employ doctors. Private practitioners also sometimes work in villages. However even an optimistic would not be more than 20-25% of doctors working in rural areas.

Paradoxically, we also have unemployment and underemployment of doctors. The number of medical graduates on the live register of the employment exchanges are as follows.
1986 - 25,613
1987 - 31,029
1988 - 27,599

This is more than the number of doctors working at the PHC level! The actual numbers are much higher!
In conclusion
There have been several changes for better and for worse in the field of medical education in India. There has been tremendous increase in the total number of trained personnel. Clinical competence is on the whole good. Over the years the varying needs at the grassroot, secondary, and tertiary level have become more and more clear. Opinion and pressure have gradually been growing at the local, national, regional and international level regarding the need for a new type of physician viz, one.

- Who can understand health problems in a community context,
- Who can build on the strengths of the community, working with them, facilitating growth, learning
- Who shares information and knowledge with the patient and the public,
- Who can function democratically within a health team, and
- Who is open to different systems of medicine and healing and health practices

Never before have we been so close to embarking on this challenging path. We already have before us pioneers and trail blazers. At a wider level we have also with us competence in various fields, knowledge about local reality and a self confidence to intervene creatively. Perhaps what is needed is coming together of various elements who are committed to the training of the new doctor. A critical mass of these “live elements” could spearhead change in the years ahead.

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