

Reforming Medical Curriculum in India in Recent Years: Conflicts of Political, Regulator, Educationist and Professional Natures and Strategies for their Resolution

Rita Sood, All India Institute of Medical Sciences, India

N. Ananthakrishnan, MGMCRI, India

ABSTRACT

India has the largest medical education system in the world with 335 medical schools producing about 40,000 medical graduates every year. Most medical schools follow the traditional discipline based medical curricula with division of course into pre-clinical, para-clinical, and clinical phases spread over four and a half years followed by one year of internship. The relevance of training to the societal needs has often been questioned. Attempts have been made repeatedly at reforming the undergraduate curricula and, less frequently, the post graduate medical curricula. Though curricular innovations have been initiated and institutionalized in few medical schools in India over the past two decades, repeated attempts to bring about change at a national level have not met with success. In this paper, the authors share the various conflicts that were often observed during such curriculum reform initiatives and strategies to resolve these conflicts.

Keywords: Consortium of Institutes, Curricular Innovations, Curricular Reforms, Inquiry Driven Strategies, Medical Education

INTRODUCTION

The medical education system in India is, perhaps, the largest in the world. At present India has 335 medical schools with an annual intake of medical graduates approaching 40,000 and the annual intake of postgraduates seats nearing 25,000 (MCI, 2011). In the last two decades, there has been a rapid proliferation of medical

schools in the country largely in the private sector which has led to lack of uniformity and dilution of standards in medical education (Supe & Burdick, 2006; Sood, 2008). The relevance of the training being imparted is questioned and attempts have been made repeatedly at reforming the undergraduate medical curriculum and less frequently the postgraduate curricula. In the last twenty years at least three attempts, two major and one minor, have taken place for redesigning the undergraduate medical curriculum, one in the 1990s as part of the effort of

DOI: 10.4018/ijudh.2012010101

a consortium of medical schools and the other two more recently in 2008 and 2010. The last was a part of the efforts of a new set of governors of the Medical Council of India (MCI) to reform medical education in the country. At this time, there was a simultaneous effort to look at the postgraduate educational system also and suggest measures to improve the same with the ultimate goal of improving the quality of the output along with securing an increase in numbers to meet the needs of specialists in the country. All these efforts were top down measures and encountered significant conflicts between the various stakeholders – political, educationist, profession and regulatory agency. Significantly all these efforts were conspicuous by the absence or negligible involvement of the consumers namely the public and the students. Both authors were part of three of these four exercises and one was part of all four. This paper will attempt to focus on how the exercise of curriculum development is often reduced to a tussle between several competing powerful influences while the real stakeholders, the medical students and the populace at large, are kept out of the loop. Measures that can be taken to overcome these conflicts would be detailed. Some of these strategies are country specific and may not be applicable across the globe.

Current Scenario

Indian medical schools follow the traditional model of training. Students are eligible to enter the medical college after twelve years of school and are by and large admitted through an MCQ based entrance test. Some states such as Tamil Nadu and Pondicherry, however, have dispensed with this procedure and are admitting students based on their twelfth standard school marks. Undergraduate medical education is of four and a half years duration followed by a year of rotational internship. The medical curriculum is traditionally discipline-based and is divided into three phases—pre-clinical, para-clinical and clinical. The first two and a half years (pre and para clinical) focus on the basic sciences as applicable to medical practice. The last two years

are fully devoted to the clinical disciplines. However, exposure to patients in the form of clinical postings to major clinical disciplines starts at the end of the first year.

The postgraduate degree course is divided into broad specialties and super or subspecialties. Entry to the latter is after qualifying in the broad specialties although there are a few institutes which admit students to the super specialty courses directly after the MBBS (MCI, n.d.). The numbers admitted thus are negligible. Each runs for three years. In addition, there is a two year program in some of the broad specialties that does not include a research project and leads to a Diploma in the subject.

The existing undergraduate curriculum in medical schools is often over loaded with a large content of theoretical knowledge, delivered mostly through didactic sessions. There is very little integration of basic sciences with clinical disciplines. Students are expected to assimilate and integrate all the information acquired over the years and apply it to patient care (Sood & Adkoli, 2000). Presence of a large number of students in each class compounded by perpetual shortage of faculty in most medical schools is a further inhibitory influence towards small group learning (Ananthakrishnan, 2007). Assessments are usually conducted in the traditional way using essays, long and short cases. These are largely knowledge based and test mere factual information. There is not enough intellectual stimulation and testing of students' critical thinking abilities is minimal. Skills assessment is inadequate and attributes of professional and ethical behavior and communication skills are hardly evaluated (Sood, 2008).

ATTEMPTS AT REFORMING THE UNDERGRADUATE CURRICULUM

First Comprehensive Attempt at Reform

The issue of relevance and quality of medical education in India has been debated from time to time since the constitution of the Bhoré

11 more pages are available in the full version of this document, which may be purchased using the "Add to Cart" button on the publisher's webpage: www.igi-global.com/article/reforming-medical-curriculum-india-recent/64324

Related Content

Bifurcation Analysis of a Model Accounting for the 14-3-3s Signalling Compartmentalisation

S. Nikolov, J. Veraand O. Wolkenhauer (2012). *Quality Assurance in Healthcare Service Delivery, Nursing and Personalized Medicine: Technologies and Processes* (pp. 61-70).

www.irma-international.org/chapter/bifurcation-analysis-model-accounting-signalling/58727

The Internet and Managing Boomers and Seniors' Health

Christopher G. Reddick (2008). *Healthcare Information Systems and Informatics: Research and Practices* (pp. 68-91).

www.irma-international.org/chapter/internet-managing-boomers-seniors-health/22119

Nursing Homes and E-Health

Shuyan Xie, Yang Xiaoand Hsiao-Hwa Chen (2011). *Healthcare Delivery Reform and New Technologies: Organizational Initiatives* (pp. 311-330).

www.irma-international.org/chapter/nursing-homes-health/50167

Analysis of Cell Viability in Microfluidic Spheroid Arrays by Image Analysis and Neural Networks

Jonas Schurr, Christoph Eilenberger, Florian Selinger, Peter Ertl, Josef Scharingerand Stephan Mark Winkler (2022). *International Journal of Practical Healthcare Innovation and Management Techniques* (pp. 1-22).

www.irma-international.org/article/analysis-of-cell-viability-in-microfluidic-spheroid-arrays-by-image-analysis-and-neural-networks/315769

Improving Healthcare System Usability Without Real Users: A Semi-Parallel Design Approach

Farath Arshad, Nonso Nnamoko, James Wilson, Bibhas Royand Mark Taylor (2015). *International Journal of Healthcare Information Systems and Informatics* (pp. 67-81).

www.irma-international.org/article/improving-healthcare-system-usability-without-real-users/125674