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Original Research Article

Perceptions and opinion of the medical students about the National Medical Commission Act: a cross sectional study from a medical college in North Kerala

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ABSTRACT

Background: The National Medical Commission (NMC) Act, 2019 has come into force from August 2019 with the aim of addressing the shortcomings in the process of regulating medical colleges in the country and also in the wake of allegations of corruption against the 63-year-old Medical Council of India. However, it has been criticized for various reasons viz., it is over-centralized, it would lead to increased profiteering, corruption etc. In this context the present study was undertaken to find out the perceptions and opinion of the medical students about the NMC act.
Methods: This was a cross-sectional study done at a Medical College, Wayanad District, between August-January 2019. All the undergraduate medical students of the college were the study subjects. Data was collected using a predesigned and pretested self-administered questionnaire. The subjects were asked to give response to questions pertaining to NMC on a Likert scale of 1 to 5. Completed responses were obtained from a total 655 students.
Results: The subjects strongly agreed with the 6 limitations of the NMC (median score 1) and agreed with 9 (median score 2) out of the total 15 limitations. The number of subjects agreeing (agree and strongly agree) was highest [574 (88.3%)] for "NMC is over-centralized".
Conclusions: The subjects agreed (strongly agree+agree) to all the limitations of the NMC. There was no disagreement to any of the limitations.

Keywords: Kerala, Medical students, NMC, Opinion, Perceptions

INTRODUCTION

The National Medical Commission Act, 2019 received President of India's assent on 8th August 2019 and has come into force from that date. The act provides for setting up a National Medical Commission (NMC) in place of the MCI to develop and regulate all aspects of medical education, profession and institutions in India. The act also seeks to annul the Indian Medical Council Act, 1956 in the wake of allegations of corruption against the 63-year-old Medical Council of India (MCI).

It is also aimed at addressing the shortcomings in the process of regulating medical colleges in the country. Some of the key features of the act are:

- It stresses on "enhancing the interface between systems of medicine"- such as Central Council of Homoeopathy and Central Council of Indian Medicine.
- It envisages creation of a cadre known as "Community Health Providers (CHPs)" who would

be granted a licence to practice medicine at mid-level.
- It aims to bring in uniformity in medical education standards in India by introducing a MCQ based EXIT exam which will be both the licentiate exam for practicing medicine as well as entrance exam for postgraduation.
- The act seeks to do away with the practice of yearly inspections which would end Inspector Raj and facilitate addition of more UG and PG seats.
- Unlike the erstwhile MCI, the new commission, is envisaged with the power to determine fees for 50% seats in private medical colleges.

However, there has been widespread criticism against various sections of the act from the medical fraternity viz.

- NMC is over-centralized, lacks representativeness.
- The MAR board and the central govt. may relax the minimum requirements for colleges as per their discretion which would seriously compromise the quality of medical education.
- Private college managements would be free to charge any quantum of fees for over 60% of seats which may increase profiteering, corruption, and reserve medical education only for the rich.
- No requirement for annual renewal of permission (as existed under MCI) would seriously compromise the quality of medical education.
- Allowing CHPs to prescribe drugs would endanger patient safety and dilute the standards of healthcare in the country.[1,2]

There are no studies conducted in the country to find out the perceptions and opinion of the medical students about the NMC act. Hence, in this context the present study was undertaken.

Objective

The objective was to find out the perceptions and opinion of the medical students about the NMC act.

METHODS

Study type

This was a cross-sectional study done at a Private Medical College, Wayanad District, Kerala, between August-January 2019.

Study subjects

All the undergraduate medical students of the college (i.e., Phase I MBBS to interns) willing to participate in the study were the study subjects.

After obtaining approval from the college administration, the students were approached individually in their hostel rooms and briefed about the purpose of the study. Participation in the study was voluntary.

Oral informed consent was taken from the subjects and data was collected using a predesigned and pretested self-administered questionnaire, the first part of which had questions pertaining to basic socio demographic details and the second part had questions pertaining to the NMC act.

There were 15 questions pertaining to the limitations of the NMC act and the subjects were asked to give a response to each of the questions on a Likert scale of 1 to 5 (1- strongly agree, 2- agree, 3- neither agree nor disagree, 4- disagree, 5- strongly disagree).

Completed responses were obtained from a total 655 students. The respondents were asked not to mention their names for maintaining anonymity and also to encourage participation and elicit truthful response. Data were kept confidential.

Statistical analysis

Data were entered in MS Excel and analyzed using Statistical Package for Social Sciences v22.0. Descriptive statistics such as median, interquartile range and percentage were used in the analysis of the responses.

RESULTS

The total number of subjects were 655 of which 258 (39.4%) were male and 397 (60.6%) were female. 150 (22.9%), 146 (22.3%), 148 (22.6%), 138 (21.1%) and 73 (11.1%) were from Phase I MBBS, Phase II, Phase III Part I, Phase III, Part II and internship respectively.

The mean age of the subjects was 21.67±3.4 years. 649 (99.1%), 2 (0.3%) and 4 (0.7%) subjects were domiciles of Kerala, Karnataka and other states respectively.

Table 1 shows that the subjects strongly agreed to the limitations 1, 8, 12, 13, 14, 15 of the act and agreed to limitations 2, 3, 4, 5, 6, 7, 9, 10, 11. There was no disagreement to any of the limitations of the NMC act

Table 2 shows that the number of subjects agreeing (agree and strongly agree) was highest [578 (88.3%)] for “NMC is over-centralized” and the number of subjects disagreeing (disagree and strongly disagree) was highest [44 (6.7%)] for “the EXIT exam indirectly leads to abolishment of the in-service quota and medical graduates would no longer be interested to serve in rural areas”.

Table 1: Median scores of the responses for various aspects of NMC act.

Aspect of the NMC bill	Score Median (IQR, Max, Min)
1. NMC is over-centralized	1 (1,5,1)
2. No autonomy to the autonomous boards	2 (1,5,1)
3. Commission lacks representativeness	2 (1,5,1)
4. Chairman NITI Aayog and Secretary, Health inexperienced in the medical field and cannot regulate the profession effectively	2 (1,5,1)
5. The MAR board and the central govt. may relax the minimum requirements as per their discretion which would seriously compromise the quality of medical education	2 (1,5,1)
6. The MAR board empowered to close down non-compliant institutions, but the period before closure may be too long during which the learner would be trained under severely compromised conditions	2 (1,5,1)
7. No requirement for annual renewal of permission, colleges free to increase seats even beyond 250 and even start Postgraduate courses as per there will, without approval from NMC, all of which would severely compromise the quality of medical education	2 (1,5,1)
8. Private college managements would be free to charge any quantum of fees for over 60% of seats resulting in increased profiteering, corruption, and reserving medical education only for the rich	1 (1,5,1)
9. MCQ based EXIT exam may eventually produce doctors good in solving MCQs but lacking clinical acumen	2 (1,5,1)
10. The EXIT exam focusing only on the Phase III, Part II subjects would lead to neglect of all the preclinical, paraclinical and other clinical subjects	2 (1,5,1)
11. The EXIT exam indirectly leads to abolishment of the in-service quota and medical graduates would no longer be interested to serve in rural areas	2 (1,5,1)
12. Common EXIT exam for both IMGs as well as the FMGs indirectly benefits those graduating from foreign countries, rather than those graduating from our own country	1 (1,5,1)
13. Allowing of AYUSH practitioners to practice modern medicine is detrimental to both AYUSH as well modern systems of medicine	1 (1,5,1)
14. Those who do not have the basic knowledge about the Human Anatomy, Physiology, Pathology etc., may become CHPs which would endanger patient safety	1 (1,5,1)
15. The AYUSH practitioners completing the bridge course would end up having dual registration and hence may escape disciplinary action	1 (1,5,1)

Table 2: Distribution of responses for various aspects of NMC act.

Aspect of the NMC bill	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
1. NMC is over-centralized	328 (50.1)	250 (38.2)	50 (7.6)	20 (3.1)	7 (1.1)	655 (100)
2. No autonomy to the autonomous boards	254 (38.8)	259 (39.5)	113 (17.3)	22 (3.4)	7 (1.1)	655 (100)
3. Commission lacks representativeness	294 (44.9)	227 (34.7)	107(16.3)	18(2.7)	9 (1.4)	655 (100)
4. Chairman NITI Aayog and Secretary, Health inexperienced in the medical field and cannot regulate the profession effectively	306 (46.7)	186 (28.4)	134 (20.5)	21 (3.2)	8 (1.2)	655 (100)
5. The MAR board and the central govt. may relax the minimum requirements as per their discretion which would seriously compromise the quality of medical education	294 (44.9)	221 (34)	118 (18)	11 (1.7)	9 (1.4)	655 (100)
6. The MAR board empowered to close down non-compliant institutions, but the period before closure may be too long during which the learner would be trained under severely compromised conditions	284 (43.4)	223 (34)	125 (19.1)	18 (2.7)	5 (0.8)	655 (100)
7. No requirement for annual renewal of permission, colleges free to increase seats even beyond 250 and even start Postgraduate courses as per there will, without approval from NMC, all of which would severely compromise the quality of medical education	305 (46.6)	198 (30.2)	118 (18)	19 (2.9)	15 (2.3)	655 (100)

Continued.

Aspect of the NMC bill	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
8. Private college managements would be free to charge any quantum of fees for over 60% of seats resulting in increased profiteering, corruption, and reserving medical education only for the rich	329 (50.2)	181 (27.6)	106 (16.2)	20 (3.1)	19 (2.9)	655 (100)
9. MCQ based EXIT exam may eventually produce doctors good in solving MCQs but lacking clinical acumen	308 (47)	188 (28.7)	127 (19.4)	24 (3.7)	8 (1.2)	655 (100)
10. The EXIT exam focusing only on the Phase III, Part II subjects would lead to neglect of all the preclinical, paraclinical and other clinical subjects	323 (49.3)	200 (30.5)	103 (15.7)	18 (2.7)	11 (1.7)	655 (100)
11. The EXIT exam indirectly leads to abolishment of the in-service quota and medical graduates would no longer be interested to serve in rural areas	290 (44.3)	203 (31)	118 (18)	27 (4.1)	17 (2.6)	655 (100)
12. Common EXIT exam for both IMGs as well as the FMGs indirectly benefits those graduating from foreign countries, rather than those graduating from our own country	336 (51.3)	196 (29.9)	93 (14.2)	18 (2.7)	12 (1.8)	655 (100)
13. Allowing of AYUSH practitioners to practice modern medicine is detrimental to both AYUSH as well modern systems of medicine	345 (52.7)	190 (29)	91 (13.9)	14 (2.1)	15 (2.3)	655 (100)
14. Those who do not have the basic knowledge about the human anatomy, physiology, pathology etc., may become CHPs which would endanger patient safety	367 (56)	182 (27.8)	84 (12.8)	7 (1.1)	15 (2.3)	655 (100)
15. The AYUSH practitioners completing the bridge course would end up having dual registration and hence may escape disciplinary action	332 (50.7)	190 (29)	109 (16.6)	17 (2.6)	7 (1.1)	655 (100)

DISCUSSION

NMC is over-centralized

The National Medical Commission is over centralized and the Central government, has almost complete control over the NMC ranging from appointing all the 77 members for the various bodies; being the appellate for a variety of routine technical matters rejected by the autonomous bodies and the whole NMC such as, granting permission to set up colleges; granting exemptions to criteria; approving courses; setting aside any punishment against a doctor found negligent; allowing doctors trained abroad to do surgery and practice without having to go through any screening or taking the licentiate examination; recognizing degrees and qualifications; and finally having powers to issue directions to state governments and the NMC to comply with any orders it seeks to issue, not to speak of setting the Commission itself aside. Such wide-ranging powers that will be exercised by the central ministry rob not just the federal nature of the law but reduce the NMC to an advisory role.[3]

NMC may increase profiteering and corruption

As per section 10(1)(i) of the act, commission would be framing guidelines for determination of fees in respect of such proportion of seats not exceeding 40% in the private medical institutions. This operationally would mean that the fee regulation would be limited to a maximum of 40% seats in the private medical institutions and furthermore it could be anything from nil up to 40% which is paradoxical in nature. It also brings into fore as to what would be the chargeable fees for those percentage of seats for which no guidelines would be framed by the commission. This operationally would mean that the present 15% which is available to private institutions including deemed universities for charging higher fee, would stand augmented to the entire remainder which could be anything between 60% or more which is a real travesty of its type. Assuming that an investment of Rs. 400 crores is required to set up a medical college and with a view to attract investment, the act permits 60% of seats to be open for managements with unfettered freedom to charge any quantum of fees in order to recoup the investment. This may increase profiteering, corruption

and reserve medical education only for the rich and well off. [3]

However, Dr Desai argues that allowing private medical colleges to fix prices for 60% or more of their seats is a very progressive step and could have the following positive effects: existing institutions can invest in better facilities and faculty and be profitable, new entrants (hospital groups, corporates, foreign educational institutes) will be encouraged to set up private medical colleges bringing healthy competition in the sector which has so far been the stronghold of a select few, capitation fees and management quotas in medical colleges will go, faculty and staff will be better paid as colleges compete for the best talent and have financial freedom.[5]

Dr. Harsh Vardhan also argues that there was no provision to regulate fees in the erstwhile Indian Medical Council Act 1956, because of which States had to resort to signing of MoUs with private medical colleges at the time of granting essentiality certificate and thereby gain a handle to regulate fees of state quota seats. In view of the lack of a regulatory mechanism, the Hon'ble Supreme Court had to pass orders for setting up of fees committees in each state to be chaired by retired high court judges. This committee decided only the fees but not the other charges levied by private colleges. Deemed to be universities used to refuse to submit before this committee and remained virtually unregulated. Under NMC Act, 50 % of the seats in private medical colleges (including the deemed universities) would be regulated, which means that almost 75% of total seats in the country (50% of the total MBBS seats in the country are in government colleges, which have nominal fees+ 50% of the seats in private colleges) would be available at reasonable fees. Not only the fees, but also the other charges can be regulated under NMC act. In addition, states would also have the freedom to sign MoUs with private medical colleges in order to regulate fees for remaining 50% seats.[6]

Common EXIT exam indirectly benefits those graduating from foreign countries

The act proposes a common licentiate exam for both Indian as well as foreign educated graduates. NMC instead of giving more advantage to candidates graduating from our own country keeps both Indian and foreign degrees at par and thereby indirectly gives more advantage to those who are graduating from foreign countries like China, Pakistan, Bangladesh, Russia, etc. the degrees of some of which may be of lesser standard compared to Indian degree.[4]

Crosspathy detrimental to both systems

In view of the shortage of qualified doctors in the country and the urgent need to address the primary health care needs of the country the Act has introduced a system under which the commission and the heads of the councils of AYUSH can design bridge courses legalizing AYUSH practitioners to prescribe allopathy medicines. Such AYUSH practitioners would neither be specialists in their specialty (AYUSH) nor the modern system of medicine (allopathy). Such crosspathy seriously endangers the credibility of all the systems of medicine and may be detrimental to both systems. India has a very rich heritage of Ayurveda, yoga, siddha and others. More systematic research in these systems is needed to come out with standard protocols for management of various diseases. Rather than addressing this burning need the NMC compels the AYUSH practitioners to complete the bridge course and start prescribing allopathic drugs which would be detrimental to both AYUSH as well as modern system of medicine (allopathy).[3]

The justification for allowing this is shortage of MBBS doctors in rural areas and even in urban areas, the number of Family physicians has been steadily declining with most MBBS graduates preferring to pursue specialisation and super-specialisation.

Hence Dr. Desai argues that the idea of a bridge course may not be as illogical as it is being made out. If well implemented, the decision has significant potential to upgrade the quality of healthcare in rural India. But however, at the same time, it is also important that the government lay down detailed criteria for diagnoses, treatments and drugs that can and cannot be administered by practitioners who have taken the bridge course and lay down clear guidelines for when the patient must be referred to specialist consultants. Moreover, today, even in the absence of any such bridge course, quackery is rampant and poor citizens are being treated by completely unqualified practitioners. The bill provides for a separate national register to be maintained for AYUSH practitioners who qualify the bridge course. This could help bring more regulation and organisation to the practice of alternative medicine and can help curb quackery.[5]

CHPs may endanger patient safety

The bill provides for a creation of a new cadre known as "community health providers" to the extent of 1/3rd the number of registered practitioners, but does not prescribe the eligibility conditions for CHPs. Hence, all those with some connections with modern medicine like pharmacists, optometrists, health workers, health assistants, ASHAs who do not have the basic knowledge about the human anatomy, physiology, pathology etc. may get licence to practice modern medicine. This will endanger patient safety and dilute the standards of healthcare in the country especially the rural areas.[4]

But Dr. Harsh Vardhan argues that, universal health coverage in the country requires a large number of health professionals. Doctors are a scarce resource in our country and need to be optimally utilized. They are

indispensable for secondary and tertiary care; the only area where other health professionals could supplement them is in preventive and primary healthcare. NMC contemplates to make available health professionals who can provide basic preventive and primary health care, in remote areas where doctors are not available. The eminent doctors in NMC would decide on their qualifications through regulations which would be finalized after extensive public consultation and debate. The utility of such mid-level health providers has also been confirmed by the WHO after studying their impact on healthcare in many developed and developing countries.[6]

Confusion over jurisdiction of disciplinary action

The AYUSH practitioners would already be registered with their respective councils. On completing the bridge course their names would be included in a separate register maintained by the commission, which would mean that they would be having dual registrations with two registering councils. The disciplinary jurisdiction on such persons with respect to breach of ethics is not clearly indicated in the act. Because of this confusion, such practitioners may indefinitely escape disciplinary action.[3]

The subjects strongly agreed with these limitations of the act.

No autonomy to autonomous boards

As per section 44(1)(2) of the act, autonomy is expected to be a hallmark of the NMC Act, 2019 and the boards thereunder are called as, "autonomous boards". But in reality, the same would be a misnomer as under the act, the central govt. would be entitled to give directions to the commission and autonomous boards on all the questions of policy which would be binding for the commission and autonomous Boards to comply. Further, it is clearly stipulated that the decision of the central government whether question is one of the policy or not, would be final and is not open for any discussion and deliberation whatsoever. As per the section 45 of the act, the central government would be within its rights to give such direction it may deem necessary to the state government for carrying out all or any of the provisions of this act and the state government shall comply with such directions is also undermining the authority of the state government which is inconsistent with the cardinal principles governing the federal polity as stipulated in the Constitution of India. Similarly, as per section 10(1)(f) of the act, State Medical Councils also have to comply all such directions or policy of the National medical commission.

Commission lacks representativeness

As per section (4) of the act, the National Medical Commission, will have an effective membership of 25 of which only 5 members (part time) would be elected. As per section (11) of the act, the Medical Advisory Council shall consist of about 60 members. All are nominated members. As per section (16) of the act, there would be 4 autonomous boards to be known as the UGME board, PGME board, MAR (medical assessment and rating) board and EMR (Ethics and Medical Registration) board. Each board would consist of 3 members only and all these members will be nominated by Central Government. Totally these four boards shall consist of 12 members. They will constitute further sub committees to assist them. As such it is evident that the proposed commission will have 20% elected members (part time) and 80% nominated members. It is for this reason it will not have a desired 'representative character' with reference to 'elected and nominated/appointed members' whereas present Medical council of India had 75% elected members and 25% nominated members. Small and medium healthcare establishments provide more than 70 % healthcare needs of the country. They did not have any representation in the MCI which was institution dominated and neither is it represented in the new National Medical Commission. This is fraught with danger of ignoring the ground realities of the medical profession in India, its needs and hence the reforms so passionately sought to be brought will remain on paper. Also, modern scientific medicine has divided itself into specializations and sub specialization. Representation of various specialties is essential to prevent overlooking specific areas and their needs which is lacking in the NMC.

But Dr. Harsh Vardhan argues that 19 (10 Vice Chancellors of State Health Universities and 9 elected members of State Medical Councils) out of 33 members, which is more than half of the total strength, would be from the States and only a minority of members would be appointed by the central government thereby ensuring that the NMC is representative, inclusive and respecting the federal structure of Indian polity.[6]

Chairman NITI Aayog and Secretary, Health inexperienced to regulate the medical profession

The doctors who have experienced the medical education system, gone through residency pains and faced the scorching furnace of clinical practice only are best suited to understand the needs of the profession and to regulate it by being part of MCI/NMC. Chairman NITI Aayog and secretary, health may be good administrators in their own right but cannot be expected to understand the requirements of the profession. Bureaucrats whether medical or non-medical remain in their ivory towers in total disconnect of the ground realities of the field of healthcare. Their desire to control medical education as well as practice of medicine through the NMC act will be disastrous for the country.[3] But Dr. Rohan Desai argues that 16 out of 25 NMC members (60%) would be doctors and the number could go upto 20 (80%) including the

Director General, ICMR and 3 members from state and UT nominees in the Medical Advisory Council who can be doctors. The chairperson of NMC must also be a postgraduate doctor.[5]

The MAR board and the central govt. may relax the minimum requirements as per their discretion

As per section 29(b) of the act, the MAR board is to look into 'whether adequate faculty and other necessary facilities have been provided to ensure proper functioning of the medical college or would be provided within the time limit specified in the scheme' while granting permission to start Medical college or PG courses. This vests the board with a wide discretionary power to accord approval on a hypothetical assumptive presumption that the stipulated minimum requirements would be completed in due course of time. This by itself entitles the MAR board to permit learners to be taught and trained in compromised conditions impacting and prejudicing the desired quality of medical education.

Added to this is the proviso 2, Section 29(d) of the act, the MAR board can relax the criteria for opening of the medical colleges at its discretion with the previous approval from the central government which yields not only a wide authority but also provides adequate scope for availing the discretion for extraneous considerations. More so, the regulatory stipulations which are mandatory in nature and binding in character cannot be open for any concession or condonation vide discretionary authority. The said discretionary authority is not only vested with the autonomous board but also with the central government. Such dual/double discretions to waive the applicability of statutory stipulations governing prescribed requirements per se end up in providing ample scope for a free-flowing corruption to dwell and get deep rooted.

Section (26)(1)(f) of the act empowers the MAR board to take such measure, including imposition of monetary penalty, against a medical institution for failure to maintain the minimum essential standards specified by the UGME Board or the PGME Board, as the case may be. The material point for consideration is that all the three monetary penalties are not to be less than one half and not more than ten times the total amount charged by such institution for one full batch of students of undergraduate course or postgraduate course as the case may be. It yields such wide period and discretionary power to the board and in the name of charging fine the permissibility of the period turns out to be substantial before the closure is invoked meaning that during the impending period the learner would be taught and trained in compromised ambience resulting in impoverished teaching and ending up in generation of half-baked health manpower, which would be ill conducive to the healthcare delivery system

No requirement for annual renewal of permission would severely compromise the quality of medical education

The NMC act proposes that the colleges would be needing permission only once initially during inception and after that there would be no requirement for annual renewal of permission (as existed under MCI) and the colleges would be free to increase seats even beyond 250 (the current upper limit under MCI) and even start postgraduate courses as per there will, without approval from NMC. This would severely compromise the quality of medical education as the colleges (including the government ones) would be arranging for the infrastructure, clinical material and faculties only during the initial inspection and after that may not be keen on maintaining the same

MCQ based EXIT exam may eventually produce doctors lacking clinical acumen

The NMC Act proposes introduction of MCQ based EXIT exam as the licentiate exam for practicing medicine as well as entrance exam for postgraduation. Because of this, students would neglect clinics and would only focus on solving MCQs which may eventually produce doctors who are good in solving MCQs but lack clinical acumen and skills. This would also lead to mushrooming of coaching institutes which train students in cracking the EXIT exam. Students would neglect clinics, classes and internship in medical colleges and concentrate only on these coaching classes. Ultimately students would be only on rolls in medical colleges and colleges would become dummy.[3,4]

But Dr. Harshvardhan argues that after clearing NEXT, students will be able to concentrate better on internship than earlier when they used to spend most of their internship time in PG entrance preparation and hence would not lead to compromise of their clinical skills.[6]

The EXIT exam would lead to neglect of all the preclinical, paraclinical and other clinical subjects

The proposed EXIT exam would be based only on the Phase III, Part II subjects (medicine, surgery, orthopaedics, OBG and paediatrics) unlike the erstwhile NEET-PG which had questions from all the 19 subjects covering all phases of MBBS. Hence this would lead to neglect of all the preclinical, paraclinical and other clinical subjects, the knowledge of which is very much essential for a student to become a good practitioner.

The EXIT exam indirectly leads to abolishment of the in-service quota and medical graduates would no longer be interested to serve in rural areas

In the old system the medical graduates after serving 3-5 years in government service used to become eligible for in-service quota for doing postgraduation (under which the government used to pay the full fees of the course plus salary for the course duration), which used to

encourage medical graduates to serve the government and in rural/remote areas. But under the new system, the EXIT exam would be both licensing as well as entrance exam for post-graduation. This may indirectly lead to abolishment of the erstwhile in-service quota. Hence, medical graduates would no longer be interested to serve in rural/remote areas.[4] The subjects agreed with these limitations of the act.

Limitations

The limitations of the study were that since the study subjects were from a single college, the findings cannot be generalized to the medical students' community of the entire country.

CONCLUSION

The subjects strongly agreed that NMC is over-centralized, would result in increased profiteering, corruption, and reserve medical education only for the rich, common EXIT exam for both IMGs as well as the FMGs indirectly benefits those graduating from foreign countries, rather than those graduating from our own country, allowing of AYUSH practitioners to practice modern medicine is detrimental to both AYUSH as well modern systems of medicine, those who do not have the basic knowledge about the human anatomy, physiology, pathology etc., may become CHPs which would endanger patient safety and the AYUSH practitioners completing the bridge course would end up having dual registration and hence may escape disciplinary action

The subjects agreed that there is no autonomy to the autonomous boards, Commission lacks representativeness, Chairman NITI Aayog and Secretary, Health inexperienced in the medical field and cannot regulate the profession effectively, the MAR board and the central govt. may relax the minimum requirements as per their discretion which would seriously compromise the quality of medical education, the MAR board is empowered to close down non-compliant institutions, but the period before closure may be too long during which the learner would be trained under severely compromised conditions, because there would be no requirement for annual renewal of permission, colleges would be free to increase seats even beyond 250 and even start Postgraduate courses as per there will, all of which would severely compromise the quality of medical education, MCQ based EXIT exam may eventually produce doctors good in solving MCQs but lacking clinical acumen, the EXIT exam focusing only on the Phase III, Part II subjects would lead to neglect of all the preclinical, paraclinical and other clinical subjects and the EXIT exam indirectly leads to abolishment of the in-service quota and medical graduates would no longer be interested to serve in rural areas.

There was no disagreement to any of the limitations of the NMC act. Though some of the concerns with respect to the act (e.g., fees regulation, bridge course for AYUSH practitioners, CHPs, NEXT exam, proportion of medical members in NMC, representativeness etc.) have been addressed by few of the experts and government, majority of the concerns remain unaddressed. Hence, there is a need for further detailed deliberations with respect to these concerns involving all the stakeholders.

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