Indian Association of Preventive & Social Medicine

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To,
Dr. Jadgish Prasad
DGHS
MOHFW (Govt of India)
Nirman Bhavan
New Delhi.

Sub : Submitting feedback on MCI committee "Report on Deployment of Fresh Medical Graduates for Rural Services"

Dear Sir,

Let me take an opportunity to introduce Indian Association of Preventive & Social Medicine (IAPSM) first. IAPSM is a National Professional Body consisting with 4200+ who are specialists in the field of Community Medicine/Preventive & Social Medicine/Public Health from all over of India.

We happen to come across a MCI committee report on Deployment of Fresh Medical Graduates for Rural Services. Being an important stakeholder in Health care services, Medical Education and Public Health/Community Medicine, we thought it is our moral responsibility to critically go through the report and share views and feedback with Ministry of Health & Family Welfare and Medical Council of India to facilitate better decision. IAPSM has constituted a committee of members representing from different parts of India for same. They are senior experts and experienced faculties in Medical Colleges.

Herewith, please find views/feedback from the IAPSM committee for your kind perusal. I am sure views and suggestions from committee will be useful and will help in taking appropriate decision in this regard.

Yours sincerely

Secretary General
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Feedbacks from Indian Association of Preventive & Social Medicine (IAPSM) Committee

on

"Report of the Committee On Deployment of fresh MBBS for Rural Services" by Medical Council of India, Ministry of Health & Family Welfare, Government of India

Executive Summary

The huge structural and functional diversity that exists between various States and teaching medical institutions (Govt and Private) in the country has hindered the progress of primary health care in rural India. At present there is very little coordination between the Govt's National Health Mission (NHM) and the Community Medicine departments of teaching institutions which have a mandate to teach and practice primary health care. The proposal on compulsory Rural House Officer ship is an opportunity for the medical interns to learn by doing from the existing health system and will help improve in providing health care at district and sub district level. There are several positive steps that can be undertaken as mentioned in the MCI's report. There are a few bottlenecks in the proposed scheme that needs to be redressed by involvement of all stakeholders. While the scheme would be beneficial for both the health system and medical interns, the feasibility issues (safety, posting mechanisms, number of students per batch versus centres of posting, monitoring machinery/mechanism) needs to be undertaken on pilot basis before formalizing the scheme so that it can be implemented in an effective manner.

The intention of the MCI and MOHFW, Govt of India to provide quality health services to a multitude of population in rural areas is a laudable idea but the means of achieving the same by employing coercive and half hearted methods without taking all stake holders on board are not likely to achieve the intended purpose as four precious years have already passed since the submission of this report without any appreciable gains. Hence the proposed scheme should be thoroughly deliberated with specific practical proposals and action plans in a time bound manner for its effective implementation.

1. Good Points:

(i) Permanent Registration

- The system of permanent registration after completion of rural posting will ensure all interns to be in the system without exceptions / escape from the loop.

(ii) Eligibility for PG entrance and exit exams

- Eligibility for PG entrance only after completion of rural internship.
- Every part of M.B.B.S. Course will be followed by U.G. exit exam. Cumulative marks of these three examinations will be considered for P.G. entrance. This will save P.G. time for entrance preparation of interns, who will be more focussed on performance & practical learning.

(iii) Clinical exposure / professional improvement

- All domains of learning related to internship training and objectives in medical education are addressed.
- Clinical exposure in district Hospitals provided to the fresh graduates will benefit by enriching their clinical and management skills.
- This sort of posting will give a rich first hand experience and exposure to public health systems and rural health care issues to all the medical graduates
- This would be a good opportunity to enhance communication skills
- The posting of interns in batches of 2-3 will give them mutual support and some sense of security.
- The Exposure of the intern is at a wider level i.e. Medical College/ District Hospital/ Rural Health Centers So the better chances of developing competencies at a larger level.
- Conducting National Exit Examination for eligibility for Post-graduation is good provided merit is the guiding principle in the way it is conducted

(iv) Salary and allowances

- This seems quite attractive as the perks during the posting are same as of the Medical Officers posted under NRHM
- The stipend for the RHO as per NRHM scale is an incentive to motivate graduates to work in rural areas.
- It is appreciable that committee is considering additional allowances for rural house officers working in difficult rural areas.

(v) Supervision

- Establishment of Co- ordination centres at Central & State levels.

- Appointing a Community Medicine faculty to overlook the work of RHO is appropriate as they have adequate skill and knowledge to handle rural Postings / health problems .
- Organisation of Regional Workshop to sensitize and train health personnel.

(vi) Benefit to Rural people

- Deployment of fresh medical graduates to rural areas is a good recommendation because there are NO qualified doctors in the rural areas even after more than 60 years of Independence.
- A very good initiative for dealing with the problem of lack of Doctors in the rural areas, thereby the rural population will have professionally trained qualified medical manpower.
- A very large number of Medical Graduates will be available to work for Rural Health service; however these graduates will be partially trained.
- Students graduating from private medical colleges will also be made available to contribute towards improving rural health service.
- This provides a relatively longer period of exposure to the public health system, the rural health care in particular.

(vii) Public Private Partnership

- Setting up of NRHM and MCI Joint Committee to oversee the implementation of the Rural House Officership (RHO) Scheme.
- Opportunity for students from private medical college to work in the public sector and get motivated to join the public health service.
- The short term solution (Posting for six months) can act as a pilot project for taking a big step in form of NRHM posting for one year. If the short term solution fails, there is a need to revise the guidelines for the long term solution.

2. Feasibility issues:

- All stake holders (Centre & State Govts., MCI, NRHM, Medical College Managements, parents, students, opinion makers, political groups, community leaders, legal experts, medical & health professionals etc) have not been taken into confidence. Hence there could be delays and road blocks in implementing the scheme.

- All proposals are of general nature and no specific operational guidelines have been worked out before hand e.g. No guidelines of placement, rotation, evaluation, rewards and service norms acceptable to RHOs & interns, Centre & State Govts. have been worked out for 40,000 interns graduating every year. This involves a massive strategic and logistic prior planning, which is lacking at the moment.

- Keeping in view the prevailing geo-political, social, cultural and linguistic environment in the country, the outsiders will be apprehensive and reluctant to accept their appointments in other states, far away from their parents due to security considerations. Hence mass dislocation of interns from their comfort zones is bound to face stiff resistance from students as well as their parents.

- The proposed Exit Examinations after every professional examination for eligibility to appear for PG entrance examination presently is only at a proposal stage and no details of the same have been worked out. It can not be applied in retrospect to 2013 Batch.

- Registration of RHOs & interns 3 times in a period of 1 ½ years will be cumbersome and a costly exercise. Moreover, maintaining & updating this data base annually will be a herculean task.

- NRHM is already beset with its enormous administrative, technical and financial problems. Entrusting another 40,000RHOs / interns to NRHM may further complicate the matter.

- Some of the states are unable to pay the salary to their existing staff every month. Hence paying the salary with extra allowances timely to outside RHOs & interns is inconceivable. Moreover, payment of extra allowances to outside RHOs and interns is likely to be objected to by the RHOs & interns from the same state which may cause strong resentment among the locals.

- There seems to be no clarity as to who would monitor the process. What does mentoring by Community Medicine department would entail? In case the mentoring institution is geographically away from the place of posting of NRHM Interns then how could the community Medicine department certify the log book? What resources would be made available for travel and other related activities that would be essential for certification? Would some legal modification be done by MCI to vest authority in Community Medicine departments to deliver what is expected of them?

- Providing free non-returnable laptop is good but availability of network in remote rural settings is a big challenge.

- At Present accommodation for Medical Officer is not 100 percent. Arranging accommodation for 40,000 medical graduates is a great challenge.

- Number of Medical students is different in different states. In states with less number of interns, they will be able to cover all CHCs & District Hospitals but PHCs will not be covered. In this case it becomes necessary to identify the poor performing PHCs and thus limited interns will be deployed there on priority basis.

- No thought seems to have been given for those Indian students who graduate from foreign Medical Schools. How would they fit into the scheme?

- Does “Centre” mean that 24 hour helpline would be in Community Medicine department? Does “helpline” mean clinical support system? If so, then this onerous responsibility should be declined. Clarity on ambit of “helpline” should be sought

- Roles, responsibilities, and authority of the District Hospital Officers vis-à-vis Department of Community Medicine needs clarity. It is preferable that there is no overlapping responsibility/authority; else program would fall between the two and likely to be the cause of acrimony in future.

- Most governments have not been able to ensure that PHC MO stay at headquarters. Posting of interns has to be under supervision. Therefore the feasibility is questionable unless we honestly accept and remove those PHCs from the list of 24 hour stay, which are very remote and in unsafe areas. Instead the interns may commute from nearest taluka place.

- Each Medical College, depending on their MBBS students intake capacity, should be allotted some nearby districts permanently, so that manpower needs of these districts would be fulfilled. If we keep the allotment decisions, at the state level, uncertainty where the students will have to go in the state for NRHM Rural Health Officer position, will invite lot of operational problems and then malpractices subsequently. It is advisable that students while taking admissions to MBBS are well versed where they will have to serve after MBBS. This will also simplify placements at district level and will avoid administrative delays, which are likely if state has to take up this responsibility.

- Performance evaluation criteria should be more objective, and well designed. There should not be much scope for subjective evaluation.

- If possible, weightage for good performance should be at least 10% or more (not 5%) for PG admission. More weightage is equal to more concern to perform well, which is the need of an hour.

- Coordinating Committee, including members from DHO & Civil Surgeon Officials and key persons from Department of community Medicines would be responsible for handling important administrative issues.

- Roles and responsibilities of NRHM Rural Health Officers and their level of accountability should be spelled out clearly, to avoid confusions in rendering day to day duties.

- There is a dire need for MCI to revisit its guidelines to make UG teaching more skill oriented rather than knowledge oriented. Their assessments should focus on implementation of teaching guidelines rather than size of rooms and faculty alone.

- The long term solution is a bit not feasible as it will increase the total duration of MBBS course to six more months.

3. Negative Points:

(i) Doctors' unavailability in PHC:

- The unavailability of 'posted doctors' at PHC leads to unsupervised work by interns – more opportunity for regular doctors' to escape duties, by passing the responsibilities to the interns.
- There would be a tendency to shift responsibility to fresh graduates which can trigger conflicts.
- Most governments have not been able to ensure that PHC MO stay at headquarters. Posting of interns has to be under supervision
- The ground reality is that doctors do not stay at the PHCs for the entire duration of their shift; rather they dispose the OPD and are then not available. When interns are posted, MOs on duty become second on-call, interns handling cases on their own. The idea of supervised learning doesn't happen. This picture would not change during the postings of medical graduates.

(ii) Quality of training by mentors:

- Mentors at PHC may not be good in teaching skills to interns
- Academic career of Interns will be adversely affected because of non-academic environment in PHCs/ CHCs.
- Interns may learn wrong practices from these Doctors as there is always a difference between what you know and how you teach (There is a difference between a consultant and a mentor)
- Training of health service personnel to internalise the objectives

- Internship in community medicine is not only about disposing cases in the PHC but also an opportunity to learn other skills like team work, management, communication skills and attitudes under the guidance of faculty/ medical officers. Medical students should not be called graduates if they haven't learnt these skills during their internship.
- Mentoring of interns by a distant Medical college and NRHM functionary will be inadequate. Hence lack of effective supervision and monitoring will hamper the quality of training.
- 6 months of internship training in a medical college is grossly inadequate keeping in view the fast emerging technologies in almost all subjects. Half baked interns are likely to do unintentional harm to the patients in the periphery because of the professional ignorance, thus spoiling the image of the profession which is already on a downhill slope.

(iii) Financial Constraints:

- Huge financial burden to NRHM – there is a need to assess cost effectiveness before implementing all over the nation - Financial Constraints of the Centre & specially the States.
- The initiatives like payment of salary to RHO, Trainings, Workshop, meetings, counseling, coordination between State & Centre, Non returnable laptops, internet connections, Security & accommodations. Whether this financial burden will compromise other programs running under NRHM?
- Cost effectiveness of program: It is proposed that this program will be implemented at the same time all over India. Huge amount of money , Manpower & time will be spent, so it becomes necessary to assess its cost effectiveness in terms of Health outcomes. So it is advised that it should be started like a pilot project in some states & should be reviewed for its cost effectiveness.

(iv) Role of Interns in National Health Programs:

- RHO Section–I recommends that 1 year posting should begin at district level for 4 months followed by CHC (4 months) & PHC(4 months). As we are proposing a major step to change current internship program & hoping that Medical graduates will learn rural health problems & help to improve various health indicators in rural area. So it is needed to ensure that interns / RHOs not only involved in routine OPD & Ward work over the year but also they should get exposed to NHPs implementation and basic elements of primary health care for certain & compulsory duration.
- It is advised to involve each doctor /NRHM intern for 10 to 15 days in each at least 6 to 8 NHPs implementation. They will submit a report of their work signed by district program managers.

(v) Role of Community Medicine Department:

- Internship in Community Medicine department is dropped and role of community medicine in the training of the RHOs is totally ignored. This is not at all desirable and will adversely affect the training of interns/RHOs**.**
- The role of Community Medicine department is to be specifically and clearly mentioned with no gap for any confusion.
- There seems to be no clarity as to who would monitor the process. What does mentoring by Community Medicine department would entail?
- It would diminish the standing of the discipline in the eyes of medical graduates.
- Role of community medicine in the training of the RHOs is totally ignored
- Community Medicine internship in RHTC exposes the students to the village environment under close supervision of the faculty and PGs. Doing away with the internship in Community Medicine and leaving the interns at the mercy of PHC doctors for community based training will prove to be disastrous for Public Health. *It is an ill conceived & ill advised proposal to do away with Community Medicine internship training. As per existing MCI regulations, internship training for two months is compulsory in the parent medical college. The volte face by this committee to do away with the internship training in Community Medicine is intriguing.*

(vi) Posting of Interns outside their native state:

- Language and cultural barriers – if any one is forced to work in a field situation totally alien .
- Posting outside the state of domicile may invite problems of socio-politico-cultural nature.

(vii) Assessment of interns:

- Ensure uniformity and objectiveness in assessment.
- There could be a situation where the evaluating medical college is same from where the student had graduated. In addition, there could also be instance when the evaluating medical college is other than from where the student had graduated. If the evaluation is going to be added in the marks for deciding the result of PG entrance test, then extraneous pressure would be brought upon the evaluating agency.
- Continuous assessment of performance during the rural postings would be done as per the recommendations to be eligible for the 5% marks in PG exams. This assessment would be subjective thus diluting the rigor of an objective MCQ based PG exam
- Fair & objective assessment of internship training may be a casualty due to involvement of a number of assorted assessors.

(viii) Disciplinary action:

- Some disciplinary actions should be decided for those who do not perform well at Rural Health Officer position. This may go up to disqualifying for PG studies for major issues in performing this duty as per the expectations.
- Clarity on the authority to decide disciplinary action

(viii) Increasing the duration of training / Graduation:

- Biggest negative point is enhancement of MBBS training to 6 years. This is definitely bound to give a negative message to the parents & bright students, who may be forced to select a more suitable, remunerative profession thus causing set back to the medical profession.
- Increasing MBBS training to 6 years is bound to give a negative message to the parents & bright students, who may be forced to select a more suitable, remunerative profession thus causing set back to the medical profession. adding more time for successful completion of medical graduate course may dissuade students from choosing this already loosing shine profession

(ix) Facilities for Stay and Security:

- Facilities for stay will be one of the biggest bottle neck in the implementation of these recommendations. When mandatory rural residential postings for interns under the current system is not being implemented, residential postings for graduates would again follow the same course.
- Doctors are feeling insecure even in Metros. Exposing comparatively inexperienced interns and RHOs to rural and interior areas without adequate security will be making them soft targets of the undesirable elements in the society.
- Security consideration for the relatively inexperienced interns & RHOs specially those who are hailing from other states.

(x) Role of Foreign Medical Graduates:

- No thought seems to have given for those Indian students who graduate from foreign Medical Schools.
- It is not clear whether the same rules would be applicable to those who prefer to pursue further studies abroad, e.g. USMLE etc.

- Providing free laptop on non-returnable basis is not required.
- 5% weight-age for Post graduation is less
- Strong resistance from medical students, parents and professional bodies
- Status of rural and urban health training centre of medical colleges

- Role of private medical colleges is unclear
- There is no mention of any posting during internship or during RHOship which gives exposure/experience related to urban health.
- Issues such as conflict between District Hospital and Medical College, overlapping roles, communication gap etc can arise in mentoring interns. No clarity on who would monitor the process.

4. Recommendations:

(i) Learning form Role models

- The committee should have taken the view of those institutions which are providing effective community health services in rural areas as role models for implementation.
- In absence to inputs from these institutions, the recommendations of the committee don't have adequate grounds of practical feasibility.

(ii) Improvement of the existing system

- There should be no tinkering with the existing MCI guidelines regarding internship schedule.
- If the Facilities at Rural Health Care institutions are improved and adequate compensation is provided to doctors and corruption is reduced in selecting / posting Doctors, this problem may find a better solution in the form of Permanent Medical Officers instead of Interns / fresh MBBS Doctors taking up this responsibility temporarily.
- Just posting of medical graduates without ensuring availability/ filling up of vacant posts of health staff of all other cadres will not improve the 24x7 service delivery at the rural centers
- Rural postings can be made lucrative by strengthening the existing health system, ensuring the availability of basic facilities for stay- place, security, amenities etc, and availability of supportive staff.

(iii) Compulsory Rural Service

- Best implemented from the first batch of MBBS students who will be trained in MCI's ATCOM
- One year rural service could be made compulsory for graduates passing out from Govt. Medical Colleges, where, medical education is highly subsidized or even free in some states. They must repay to the society, on whose tax payers money, they have acquired the highly subsidized medical education.

- Rural service should be made lucrative&voluntary for those passing out from private medical colleges after investing huge money, often obtained through bank loans.
- Adding more time for successful completion of medical graduate course may dissuade students from choosing this already loosing shine profession as compared to other easy and lucrative professions. However it can be considered in terms of 9 months each of internship and RHO (3 months each District hospital CHC and PHC)

(iv) Responsibilities of the Centre, State & Medical Colleges

- Lot of home work is to be done by both the Central and State governments.
- Health is a state responsibility. MOH, GOI shall give only broad guide lines. It is upto the state governments to take decisions and devise it's own policy for the deployment and placement of the fresh medical graduates,e.g TN government had a separate recruitment board and as and when vacancy arises it recruits doctors for all it's health facilities.
- State Govts may have Memorandum of Understanding (MOU) with Medical colleges for running their PHCs e.g. PIMS Pondicherry is running one shift in Govt. PHC free of cost by employing doctor, interns, Staff Nurse, Pharmacist & Hospital Attender from its own resources incurring an expenditure of approximately Rs.10 Lakh annually.
- There need to be dialogues with the representatives of health service to identify their areas of concern
- It is preferable that there is no overlapping responsibility/authority, else program would fall between the stool.

(iv) Facilities and Leave rules for RHO's

- Centre & States should also lay emphasis on non medical matters for improving health services in rural areas such as creation of enabling environment by providing good accommodation, water& electricity, communication facilities, ensuring safety & security of the doctors, avoidance of discrimination on account of religion, region, caste, language and political affiliations and provision of good financial remuneration rather than forcing the doctors to do a job against their will.
- Good accommodation, water& electricity, communication facilities, ensuring safety & security of the RHO's should be developed prior to the implementation of the program.
- Providing free non-returnable laptop is good but availability of network in remote rural settings is a big challenge

- Providing 1 leave per month during medical college internship and 2 days per month during NRHM postings

(v) Corruption in deployment

- Task responsibility needs to be discretely specified, especially wherever it is mentioned - "Govt. to develop transparent mechanism" / support - mentor / compulsory rural deployment / payment of salary etc.
- In the name of posting Interns / Doctors to Rural areas, this would be become another source of corruption in the hands of unscrupulous individuals.

(vi) Salary for RHOs

- Minimum salary (not less than) has to be specified.
- The longer gestation period of eligibility for employment may be offset by offering two extra increments at the time of joining the medical services.
- Doubling of stipends and extra allowances may not be feasible in all states. If this system is to be implemented then it will have to ensure a buy in by all states.

(vii) Postings of RHOs

- It is compulsorily to post Doctors in their own state. In exceptional cases where Doctors have to be posted outside the state, he / she should have a choice among the available states for posting. (Priority for Home state for out of State Students)
- Best implemented from the first batch who is going to be trained in ATCOM
- Implementation in merit based transparent placement
- Most of the medical graduates are trained from the Southern states. There would be a mismatch between the number of health facilities and the graduates in these states. Even if these graduates are posted in states outside their college of graduation, a transparent, reliable system needs to be put in place for posting these graduates. It would require massive efforts and co-ordination from the state health department.
- Posting outside the state of domicile may invite problems of socio-politico-cultural nature.
- The RHOs may be divided into 3 groups of equal numbers – one group each to be placed at District Hospital, CHC and PHCs and they can be rotated after 4 months – thus at any given time, there will be RHOs in District Hospital, CHC and PHCs. This is better than the proposed posting in District Hospital first, CHC next and PHCs at the last.

(vii) Training of RHOs

- Guidelines for conducting the rural house officer training should be prepared and disseminated
- Job responsibilities is clarified but task responsibilities needs to be clarified. There would have to be clear guidelines on what is expected from interns and RHOs
- When interns are posted, MOs on duty become second on-call, with interns handling cases on their own. The idea of supervised learning doesn't happen. This picture would not change during the postings of medical graduates
- It would be important that the district hospitals have adequate facilities to train the interns. The district hospitals in some States don't have adequate specialist services which will deny the fresh graduates to develop their academic skills.

(viii) Job responsibilities of RHOs

- Apart from telemedicine work using laptop, along with hard copy there should be online submission of reports of daily activities by the RHOs.
- Ex- RHO & NRHM intern will submit their daily activities with photos on alternate day from their work place using laptop & internet on a centrally managed portal
- In a exceptional case like in a difficult areas if there is no internet connectivity then they can submit report weekly and at the end of posting tenure their punctuality can be assessed & weightage for PG admission marks can be given.

(ix) Weightage for PG examination

- The 5% weightage suggested for rural service is too low and should be raised. There is possibility of everyone scoring near 100% marks to get maximum advantage for PG admission.
- Attainment of 'certain necessary skills' should be mandatory and should be given due weightage in PG selection
- Instead of evaluating at the end of one year every quarter may be done and OCP (Overall Credit Points) may be given.
- The evaluation areas may be divided based on the objectives of the scheme both for the individual and the government. e.g. Attendance in the center may be taken with an evidence of Biometric assessment
- The proposal would mean that the students would have no chance to improve their prospect of PG seat if they did not do well during the proposed exit exam. Probably it would also mean **only one attempt at PG exam**. Apart from being unfair and restrictive, it could lead to legal tangles.
- No thought seems to have been given for those Indian students who graduate from foreign Medical Schools. How would they fit into the scheme?
- Evaluation should only be "satisfactory/unsatisfactory" rather than numeric value which cannot be standardized.

(x) Training in Medical College

- Management skills, team work skills, ego management skills and conflict resolution to be consciously and uniformly taught in all medical colleges.
- Mentoring would be required not only by faculty of Community Medicine but also faculty of other departments as needed.

(xi) Involvement of Community Medicine

- There is also lack of clarity on issue of mentorship which is likely to invite many problems.
- Mentoring by directorate and community medicine – need to develop clear mandate and accountability with feasibility. Developing suitable guideline to involve State Directorate/ District authority with community medicine needs clear guidelines.
- The HOD of Community medicine should be in charge. With full authority and responsibility community medicine department should be able to give marks.
- By removing/reducing the role of Community Medicine department in the proposed internship and RHOship model, the importance of the specialty of Community Medicine in medical education/training will be further downsized. This is not at all desirable and is detrimental to quality medical education.
- Internship in community medicine is not only about disposing cases in the PHC but also an opportunity to learn other skills like team work, management, communication skills and attitudes under the guidance of faculty/ medical officers. Medical students should not be called graduates if they haven't learnt these skills during their internship
- This being the case, the 6-month NRHM internship posting may be renamed as 'Community Medicine posting' and the internship in this period may be under the mentorship of Community Medicine department with assistance from Medical Officers, Specialists and District Health Systems.
- Seems that final evaluation is by NRHM directorate. It means that Community Medicine has no role to play. It would diminish the standing of the discipline in the eyes of medical graduates.

(xii) Neglecting Urban health

- In the name of providing manpower in rural areas, the trainings and posting in urban health systems will be compromised as there is no mention of urban health at all (while it is known that urban health is a rapid emerging issue in India with NUHM being rolled out in the country).

IAPSM Committee for reviewing & feedback on "Report of the Committee On Deployment of fresh MBBS for Rural Services" by MCI, MoHFW, GOI."

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