Ethical Viewpoint

Detention at 1st MBBS level, Early and Unethical – A 'Systems Approach' to the Indian Medical education system

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ABSTRACT

Input is learner/student. Process is the evaluation and teaching by the system specialist-the educator. Output is goal of MCI "a doctor who can communicate, diagnose, cure and behave with ethical principles". Learner selection is by an MCQ entrance exam. There is no aptitude test.40% of the students enters on pure merit, the rest on various reservations. Since 1st year is shortened to 10 months and the real aptitude is exposed only at the end of second year, after clinical and ethical classes, detention at 1st year level is too early. Labelling as "additional batch" and denial of "interaction with their peers" (the coping strategy to manage affect component of stress) are risk factors for poor learning capacity .They add to stressors among medical students. In attribution retraining- an effective learning method, one goal is to concentrate on the task rather than distracted by fear of failure, here it is fear of early detention. These factors make some chronic additional. No way to leave the course for which have to pay liquidated damages no way to go forward, and no scope for lateral entry. They are trapped and are unable to take a self-decision. Is it ethical? (IHRC 22) According to International human rights commission this situation is violation of human rights; article 12 and 26. Being additional batch too early is a modifiable risk factor. The Protection of Human Rights Act 1993 CHAPTER III states that - functions and powers of the commission says to review the factors that inhibit the enjoyment of human rights and recommend appropriate remedial measures.

Keywords – additional batch, stressors.

The medical educators, educational planners and educational administrators of India have been putting a lot of efforts to streamline medical education based on the felt need that curriculum must be a need based one to meet the health care problems of the society. Thus MCI (Medical Council of India) recommendations-1981; Medical education policy-1993, implementation of MEU or medical education units (curriculum of graduates and need based revised curriculum for graduates in 1992) were introduced. All these aimed to attain the goal of IMC (Indian Medical Council), goal of medical education curriculum, and the institutional goals; all of which ultimately aim for a "dream doctor".

Medical college is a system. A system is an arrangement and set of relationships among multiple parts functioning as a whole. And in this system, input is the learners, resource, atmosphere, process is the planning, implementing teaching and evaluation of inputs by system specialist-educators and output is young doctors. A harmonious, balanced and integrated functioning of all components of system will have a synergistic action. The ultimate aim of medical education system is the output, a "dream doctor" who can communicate, diagnose, effective at prevention & promotion of health, and also behave with ethical principles. Currently our young doctors are under criticism by the society.

Especially doctor-patient relationship is at great risk. Thus as medical educators, we should be able to sow the seeds of ethics in the soul of student so that it should make a behavioural change in them. They should practice this in their student life itself which will naturally extend into their social life too. Emerging social changes like rapid advances in technology, changes in demographics, environmental factors and life style require always a revision in education system in such a way that student is trained to deal with existing & future problems. So a graduate doctor has to perform many intellectual, communicative and psychomotor skills which are complex and difficult for most of students to master within the short duration of the course of medical education.

Studies have well documented that any kind of negative stress compromise with the quality of life of an individual, especially a student [1]. Various studies have shown the adverse effect of stress among students of medicine and other health related professional careers [2-5]. Medical students undergo tremendous stress during various phases of their educational course. Psychological stress has long been regarded as having an indelible adverse effect on learning and quality of performance. Among medical students, academic stressors include the volume of material to be learned, academic performance and examinations which is continuous throughout their study period of 5 years. First MBBS is the stepping stone of this tough course. The first year in college is mentally exhausting for the incoming student. In the first year of medical college, a student has to face the challenge of getting uprooted from the family and quickly get adapted to a completely new learning environment. Therefore, failure in examination leading to detention at the 1st MBBS level has a negative impact on the mind of a budding medical student.

Detention at the first year itself demotivates a student. Thus a student loses his self-esteem, develops lack of interest in the course and therefore develops depressive symptoms. On a personal level, this distress contributes to substance abuse, suicidal tendencies. Students in extreme stress or depression need serious attention, as the affected are unable to cope rationally with this distress. This may lead to a vicious cycle of undesirable consequences at both academic and professional levels. Thus the quality of a student who is going to be a doctor and serve the community in the near future is at great peril. Thus, we, as medical educators should be able to understand the prevalence and identify the causes of student distress that can positively and negatively affect the student health. The first year is particularly exhausting for many students, having to adjust quickly to a fast paced and highly competitive environment and to master a large amount of complex materials. Many students are unable to cope with this amount of stress resulting in academic failure. So at the end of first year, the learner pool gets divided into regular batch and additional batch.

What is the effect of additional batch system on components of medical education system? A systems approach of analysis will unveil the facts. The effects are on the educators, evaluation process, and expected outcome pool i.e. "dream doctors".

Medical educators who are the system specialist is entrusted with the responsibility of making a good student into the very best, better student into good one, average student into better one. But what about the poor students ?

Students differ in intelligence, aptitude and rate of learning. The fact is that the poor are separated as additional batch and we are not able to provide them anything effectively.

What is the effect on outcome pool? When additional batch's subsequent para-clinical and clinical subject exams are conducted, as examiners know them as additional batch, it is a bias for

the validity of evaluation. There is possibility of influence of sympathy on evaluation also whereas for regular batch evaluation goes perfect. As per University rule, any sort of identification will be considered as malpractice. So as these additional students join the outcome pool at the end of the course without any demarcation, our efforts to improve the quality of outcome is diluted. Being labelled as "additional" is an additional stressor for a medico which is a modifiable risk factor for low quality performance for the rest of student life which will again negatively affect the outcome pool of our medical education system. This too early detachment from peers leads to loss of self-esteem also. These students are at great risk of developing depression in due course. Some of them even turn into "chronic" failures. For those who are stuck at 1st MBBS level, especially those from other states who got seat on All India quota basis, are trapped. There is no way to leave the course as the defaulter has to pay heavy liquidated damages.

Medical course is a popular vocational choice in tertiary education. Some of the students choose this carrier just because of social status; some due to parent's desire, some thinking it as God's decision take up this course. As a result some of them fail to keep up with the arduous attributes of medical education resulting in academic failure. But should these students be blamed alone? The society, parents, medical educators- each and everyone plays a role in their failure. Thus these students are denied of human rights. They are denied to take a self-decision. Is this ethical? According to IHRC (International Human Rights Commission) Article 26-"Education shall be directed to the full development of human personality and to the strengthening of respect for human rights and fundamental freedom. It shall promote understanding, tolerance and friendship" [6]. But are we following this ? We need to introspect.

Medical education quality is not merely scoring academic grades but also developing empathy and co-operation which can develop from real life situation-the 5 year student life. Appropriate strategies such as problem solving, positive interpretation, and social support can enable students to respond in a manner that leads to adaptation. Developing and fostering resilient environments within the health profession is of paramount importance. The definition of 'resilience' has been adapted from the developmental psychology literature as the ability to maintain personal and professional wellbeing in the face of on-going work stress and adversity. Studies have shown that one of the methods for "coping the stress" is by peer group support. Detainment of learners splits & spoils. In attribution retraining, one goal is to concentrate on the task rather than distracted by fear of failure [7-8]. Co-operative learning is an accepted learning method in which student interaction enhances intellectual growth and also social and personal development which are essential qualities of doctor. Do the strong have the moral responsibility to hold them together? Are we giving them a wrong message to separate the weak policy?

During first year there are students who haven't even visited a hospital. First year now mainly depend on memory power where actually a majority of students need problem based learning to understand concepts. The importance of participatory experience in the learning process is stressed by the famous Chinese aphorism "If i hear it, I forget; If I see it, I remember it, If I do it, I know it". Learning is influenced by application of theory to practical problems and confrontation with real life problems. Other- wise learning becomes mostly on memory power which may be even short term which is not going to help for solving situations.

Therefore to conclude,

1) Don't keep weak students separately by an 'identification mark'. Keep them in regular pool so that they can improve and will be evaluated honestly.
2) If detainment is unavoidable, make it at the end of 2nd MBBS, after letting the students expose to some amount of clinics and ethical classes. Real aptitude will be exposed only when they come to clinics which cannot be decided at 1st year MBBS level.

To bridge the gap between achievements in the field of health care and the medical education, medical education policy recommended the following steps to needs to be taken (8):

1) Clear delineation of goals and objectives of education
2) Adoption of innovative teaching and learning methodology
3) Adjustment in course structure
4) Updating course content
5) Rationalising assessment strategy
6) Emphasis on structured and skill oriented internship

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Acknowledgements - Nil
Source of Funding – Nil
Conflict of Interest – Nil