



# INDIAN MEDICAL ASSOCIATION (HQS.)

(Registered under the Societies Act XXI of 1860)

Mutually Affiliated with the British & Nepal Medical Associations

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## MEMORANDUM

### IMA opposes Govt. proposal of "Bachelor of Rural Medicine & Surgery (BRMS) – 3 ½ yrs. Course"

1. Central Council of Indian Medical Association (The Supreme decision making body) during its annual meeting on 27<sup>th</sup> December 2009 held during 84<sup>th</sup> All India Medical conference at Hyderabad (AP) deliberated on the proposal of starting Bachelor of Rural Medicine & Surgery (BRMS) a 3 ½ yrs. course contemplated by Health Ministry (Government of India) to cope with the shortage of doctors in rural area.
2. Medical Council of India (MCI) for this purpose is trying to evolve an alternative model for teaching, training & learning in medical schools attached to district hospital, where there are no medical colleges. It is contemplated to have a separate register for these graduates (BRMS).
3. After deliberating at length for over 2 hrs., it was opined unanimously that the scheme is totally ill-conceived, impractical, retrograde, discriminating, and undemocratic step. Being started in the name of rural masses, it will produce substandard half baked doctors who due to compromised education and training at institutions with compromised infrastructure & teaching facilities, will be able to provide at best only compromised care to the rural masses.
4. How can there be two different standard for health care, one 'State of Art' (comparable to best in western countries) for urban population and second a substandard care for rural masses, jeopardizing the latter's health & life. This is highly discriminating and against the fundamental right of health of every citizens of the country.
5. While appreciating the GOI concern for 'Rural Masses' and agreeing that there is shortage/maldistribution of medical & paramedical manpower in rural and remote areas and doctors are reluctant to go and serve in these area, it is pointed out that just providing the requisite numbers of doctors is not enough and this alone can't work as shortcut solution to the real problem.



6. The necessary political will, visionary political leadership, responsive administrative machinery, financial support & budgetary allocations are essential in addition to looking after the adequate facilities for producing trained health care worker (HCW), basic infrastructure, and public health provision like nutrition, safe drinking water, sanitation as well as providing safety and community support in rural areas, etc. Prime Minister (Dr. Manmohan Singh) while inaugurating the National Rural Health Mission (NRHM) on April 12, 2005 confessed that "We have grievously erred in designing our health programme -----, most importantly we have paid inadequate attention to public health issues". Aren't we repeating the mistake again?
7. At CHC level short fall of specialist manpower, facilities and infrastructure is glaring. Obstetrician 56%, Surgeon 56%, Physicians 59% Pediatricians 67% with no provision for anesthetists. How will present scheme of things help in meeting this specialist services, over & above the shortage of para medical health workers, facilities as well as infrastructure.
8. MCI is the custodian of standards of medical education as a statutory body setup by 'Act of Parliament' and is responsible for assuring uniform standard of medical education. MCI stopped all Licentiate courses like LMP, LMS, LCPS, etc., created 2 yrs. condensed course to bring them at par with MBBS & all medical schools were upgraded to medical colleges. How can it contemplate now a short term 3 ½ yrs course against its own charter.
9. 3 ½ yrs. BRMS course is going to produce half baked inferior quality doctors who will lack confidence & credibility to lead the team of other health worker like Nurses having diploma (3½ yrs.) / Bsc Nursing (4+1yrs.) or Pharmacist (4yrs. course).
10. This BRMS course is nothing except providing back door entry of substandard doctors to practice of medicine. These rural medical graduates over the time will form a parallel stream/organization and through political patronage or intervention of law, will succeed on grounds of discrimination & free themselves of all restrictions provided in the present scheme. Otherwise also the record of enforcing rule of law in our country is very poor.

11. As the Modern Medical Science is fast advancing, even the present day Modern Medicine Doctors after undergoing a training of 4½ years plus one year internship find it difficult to cope up with knowledge explosion. Early detection of complicated disease conditions and appropriate treatment will suffer if the service of the qualified doctor is denied to the Rural Population.
12. As per the objective of Indian Medical Association - **“To work for the abolition of compartmentalism in medical education, medical services and registration in the country and thus to achieve equality among all members of the profession”**, the Association has vehemently opposed whenever any state government tried to introduce short term medical courses in one or other form, this being the consistent policy of IMA.
13. IMA is the largest voluntary organization of medial practitioners of modern scientific system and is an important stake holder in all issues pertaining to health and medical education. On such an important issue having bearing on nation’s health delivery system and standard of medical education, how come Government of India has not taken IMA into confidence. We till date have not received any official communication & our observations are based on information on internet or media.
14. Under the circumstances IMA has strong objection to the proposal of starting scheme of Bachelor of Rural Medicine & Surgery (BRMS) and central council adopted the following resolution unanimously:

**“IMA strongly opposes the implementation of  
BRMS short term medical course”.**

### **SUGGESTIONS:**

Some of the suggestions & alternatives which should be considered for improving rural healthcare are:

1. Increasing age of retirement to 65 or allowing re-employment of doctors after retirement on attractive salary & incentives in rural areas only.
2. Holding district level selections – to enable locally available/ resident doctors whose families are already settled in that area.
3. Giving incentives & attractive salaries and allowances on line of army for working in remote areas.
4. Linking rural service for in service carrier prospects and promotions and posting of spouse in same place/district.
5. Compulsory working for 1yr. in rural areas before permanent registration by MCI and 2-3 years compulsory service in rural areas before allowing post graduate admission.
6. Providing reservation atleast 25 seats in medical college to students from notified “Rural Districts” nominated by district/state authorities with Bond for 5 yrs. service in rural area.
7. Opening more medical colleges in rural areas, by allowing Pvt.-Public participation with support of corporate sector.
8. Giving soft loan to the practitioners who establish themselves in rural area and provision for soft loan to be made for personal requirement like building house, hospital, clinic, vehicle etc.
9. Weakest point in Rural Health Services is CHC. All CHCs should be upgraded to IPHS (Indian Public Health Standard) and funds provided for infrastructure equipments, mobile dispensary OT/LR & blood bank storage facility etc. in addition to medical/parame dical manpower.

10. Specialist shortage in CHC can be facilitated by internal mobilization/ pooling/deputation/leasing for Pvt. Sector for short term.
11. Reservation for P.G. Admission for doctors who have served in rural areas for a minimum of 5 years.

To sum up, the solution for meeting the HRH (Human Resource on Health) challenges for provision of Health Services in Rural Areas includes :

1. Creation of sustainable “Health Care System” with provision of training & enhancing skills.
2. Outreach program for vulnerable population of remote area.
3. Motivation, compensation & incentives.
4. Work culture commitment and community support and safety.
5. Medical & Financial provision to provide proper facilities and working conditions.
6. Budgetary allocation for health should be increased both at State and Central Level from present 0.9% of GDP which is very very inadequate.
7. Intra sectorial cooperation – coordination between all stake holders from doctors to rural masses through Panchyat/District.

Lets hope that ministry of health and MCI will not take its stand as a prestige issue because any intervention in health care delivery sector should be planned on long term basis and not on adhocism or whims. It must have wider consultation with all stakeholders, experts, IMA and other medical organizations before introducing or pushing through BRMS Course.



(Dr. G. Samaram)  
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