

1 always this will continue to be a very  
2 pleasant experience. Thank you.

3 DR. DOCKERY: Thank you. We look  
4 forward to seeing you again. Thank you.

5 END EXECUTIVE SESSION

6 DR. DOCKERY: We can ask our  
7 guests to please return. And next we will  
8 start with India. And I understand that the  
9 Pakistani representative is here and would be  
10 able to be heard today, so for those that  
11 would need to know, we will plan to hear  
12 Pakistan immediately after we complete India.

13 Dr. Hong-Silwany, welcome again.

14 DR. HONG-SILWANY: Thank you.  
15 Good afternoon, Mr. Chairman and committee  
16 members. I will now summarize the analysis  
17 for the Medical Council of India submitted on  
18 behalf of the Government of India. The  
19 materials are behind Tab G. I will refer to  
20 the accrediting council as the MCI or the  
21 council.

22 In March 1997 this committee first

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INDIA

1 determined that the standards and processes  
2 used by India were comparable to standards of  
3 accreditation applied to M.D. programs in the  
4 United States. In March 2003 you affirmed a  
5 prior determination of comparability. At the  
6 September 2004 meeting you requested that  
7 India submit a report on its accreditation  
8 activities involving its medical schools.  
9 This report was reviewed and accepted at the  
10 September `07 meeting.

11 The council is before this  
12 committee again for redetermination of  
13 comparability. Based on information provided  
14 by India, Department staff concludes that  
15 India's standards and processes for evaluating  
16 medical schools remain comparable to those  
17 used in the United States.

18 As you are aware, the Indian  
19 medical education system is a highly  
20 structured process that is based on  
21 educational inputs. Standards are prescribed  
22 in detail and regulation, and are verified by

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1 inspection teams during their site visits.  
2 Given the emphasis on educational inputs in  
3 the Indian system and the detailed standards  
4 that are specified for student examination  
5 format, content, and procedures, less  
6 attention has been directed toward the  
7 assessment of graduate performance outcomes in  
8 evaluating the effectiveness of the medical  
9 education curriculum and the quality of the  
10 clinical experience. However, goals,  
11 objectives, knowledge and skills are clearly  
12 outlined for every curriculum requirement.

13 The Indian system also requires a  
14 very comprehensive onsite inspection in order  
15 to assess the quality of a medical education  
16 program. As a result, it appears that India's  
17 system remains comparable to the process used  
18 to accredit medical schools in the United  
19 States.

20 Representatives from India are  
21 here today and this concludes my presentation.

22 I'm available to answer any questions you

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1 might have.

2 DR. DOCKERY: Thank you. Are  
3 there any questions from the committee before  
4 we welcome the representatives from India?  
5 Thank you.

6 Will the representatives from  
7 India please come forward? Good afternoon.  
8 Please use the microphone and introduce  
9 yourselves, and we would welcome any remarks  
10 that you would like to make.

11 DR. KUMAR: I am Dr. Ashwani  
12 Kumar, Professor of Microbiology at University  
13 College of Medical Sciences. I am the  
14 representative of Delhi University and Medical  
15 Council of India.

16 DR. MISHRA: I am Dr. Vedprakash  
17 Mishra. I am member of the Executive  
18 Committee of Medical Council of India and also  
19 former chairman of the Postgraduate Committee  
20 of Medical Council of India. I am Vice  
21 Chancellor with the Health Sciences University  
22 in Nagpur.

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1           At the outset, sir, we would like  
2 to record our sense of gratitude for this  
3 opportunity whereby we are before this learned  
4 committee for the purposes of re-validation of  
5 the parity which was accorded in the previous  
6 recommendation.

7           As far as the self-study for the  
8 evaluation report, which is there before us,  
9 there were concerns which were ventilated,  
10 which have been dealt by being part of the  
11 information. And I would just like to briefly  
12 put those three concerns which are put across.

13          The first concern was about the preventive  
14 and promotive healthcare aspects of the  
15 students admitted to medical school and  
16 medical colleges. Wherein we had brought it  
17 out very categorically that every student  
18 admitted to a medical school, which ultimately  
19 is affiliated to an examining university, the  
20 university by law stipulates that enrollment  
21 is subject to satisfaction of the physical  
22 status of the child, and simultaneously he is

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1 subjected to periodic health appraisals which  
2 are a condition precedent for the purposes of  
3 grant of affiliation by that university. So  
4 the bylaws are very speaking and that  
5 particular position is well in place in all  
6 the medical schools affiliated to various  
7 universities in the country.

8 The second proposition was  
9 pertaining to the grievance redressal of the  
10 students in the medical school to which we  
11 clarified that there is a grievance redressal  
12 cell, which is constituted in every medical  
13 school, and this is also a condition precedent  
14 for the purposes of grant of affiliation and  
15 of the regulation of the respective  
16 universities to which the medical schools are  
17 affiliated.

18 The third chairman's  
19 recommendation was pertaining to the concerns  
20 of the faculty vis-a-vis the contradictions or  
21 conflicts, if any, between the professional  
22 and personal propositions. They're also the

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1 two mechanisms, standing mechanisms which are  
2 available in India. One is a standing  
3 grievance committee which a university has,  
4 which is open to teach the faculty and medical  
5 schools and simultaneously there is a  
6 university and college tribunal which is  
7 constituted for each of the universities which  
8 is responsible for the process of adjudication  
9 pertaining to any one of these grievances of  
10 various magnitudes which are structured and  
11 defined.

12 And the fourth concern which was  
13 put across was about the orientation and  
14 training of the inspectors who are conducting  
15 the onsite inspection of medical schools in  
16 the country. To wit, the situation was that  
17 Medical Council has got full-time medical  
18 inspectors who are appointed on a full-time  
19 basis subject to fulfillment of the  
20 eligibility conditions and they are oriented  
21 in regard to what exactly the process of  
22 inspection is. The team, which comprises of

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1 the full-time inspector along with two  
2 inspectors who are drawn from a panel, which  
3 is prepared by the Medical Council of India.  
4 Out of the senior faculty members in public  
5 sector medical colleges who could be holding  
6 the rank of professor, maybe with minimum of  
7 seven years of experience, and they are  
8 oriented by the full-time inspector.

9 Other than this, Medical Council  
10 of India also conducts periodic update of how  
11 exactly the inspections are required to be  
12 conducted. Although the format of the  
13 inspection is heavily structured, it is almost  
14 like a checklist and therefore there is not  
15 much of a scope whereby a real rigorous  
16 training is required, but still, as an  
17 abundant caution and in order to ensure that  
18 objectivity, transparency and accountability  
19 is worked in the entire process of onsite  
20 inspection, structuring of the mechanism along  
21 with periodic orientation which is structured  
22 and carried out by Medical Council of India,

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1 for the group of inspectors who are out of -  
2 the panel of whom is made along with the full-  
3 time inspectors.

4 So these were the four concerns  
5 which were put across which have been replied  
6 to and in the context of that we are here to  
7 answer any questions, if any.

8 DR. DOCKERY: Thank you very much.

9 Are there questions from the Committee before  
10 we go into executive session?

11 MR. La PORTE: So just a quick  
12 follow-up on what you said. So if I  
13 understand, points one, two, and three that  
14 you address I think with regards to student  
15 health and grievances - I can't recall the  
16 third one - they would fall under the  
17 surveillance, I guess, of the University  
18 Grants Commission?

19 DR. KUMAR: Not - the University  
20 Grants Commission basically is the vital body.

21 Like Medical Council of India is for medical  
22 education, University Grants Commission is for

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1 higher education. But you're right, medical  
2 universities also fall under University Grants  
3 Commission and therefore the affiliating  
4 conditions and the various bylaws which the  
5 universities are expected to make will be in  
6 the context of a central, you know, a model  
7 act, or a model bylaw, which is stipulated by  
8 University Grants Commission.

9 MR. La PORTE: Right.

10 DR. KUMAR: So that basically  
11 ensures uniformity of bylaws all over the  
12 country and as you're right, it is the  
13 accreditation of these universities is subject  
14 to by the National Accreditation and  
15 Assessment Council which is a body created by  
16 University Grants Commission, autonomous in  
17 nature. Therefore it is a dual control. The  
18 educational component of medical education by  
19 Medical Council of India and the other  
20 associated conditions which are governed by  
21 University Grants Commission in regard to  
22 universities, they will be falling under those

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1 bylaws.

2 DR. DOCKERY: One question which I  
3 think is good to be answered in the public  
4 forum is when you were here before and as  
5 we've looked at the applications there's  
6 concern about the proliferation of private  
7 medical schools in India and how you were  
8 addressing that. Do you have any updated  
9 information in terms of how you're addressing  
10 those concerns?

11 DR. KUMAR: Absolutely. Yes.  
12 Chairman, because you have brought a very  
13 right concern because this is also the concern  
14 which the Medical Council of India is going to  
15 be sharing with this committee. Because if  
16 you take into consideration the report, it  
17 contemplates 284 medical colleges when we  
18 applied, but when I am before you, I have five  
19 more medical schools added and I have 289  
20 medical schools under Medical Council of India  
21 of which 137 are in public sector and  
22 remaining are in private sector. But as far

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1 as the standards, regulation and other  
2 propositions are concerned, regulations are  
3 common, mechanisms are similar, and therefore  
4 the standards which are required to be  
5 involved by the Medical Council of India  
6 irrespective of the nature of the college  
7 whether it is private sector or public sector,  
8 regulatory control is uniform, standards  
9 prescribed are uniform, monitoring measures  
10 are uniform, and therefore the parity of  
11 standards amongst the two are absolutely  
12 maintained as it is required to be.

13 DR. DOCKERY: Dr. Shah?

14 DR. SHAH: All medical schools are  
15 affiliated with the university, or are there  
16 any freestanding medical schools?

17 DR. KUMAR: There aren't. You  
18 see, ultimately we have an affiliated  
19 character, the three-tiered mechanism.  
20 Medical Council of India is a unitary body for  
21 controlling the entire standards of medical  
22 education, all medical colleges. But

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1 invariably it's a condition precedent that if  
2 a medical school is required to be open, first  
3 there has to be an affiliation with the  
4 university which ultimately will be examining  
5 the students and resulting in conferment of a  
6 degree. Because the recognition schedule  
7 which we have is university-based and not  
8 institution-based.

9 DR. DOCKERY: Thank you very much.

10 If we could ask our guests to please depart.

11 BEGIN EXECUTIVE SESSION

12 DR. DOCKERY: Dr. Caron,  
13 questions?

14 DR. CARON: Good afternoon  
15 gentlemen, I'm Dr. Caron from Orlando,  
16 Florida. Two questions I have. I'll go ahead  
17 and since you mentioned - we've just talked  
18 about the medical colleges being affiliated  
19 with institutions, with medical - I mean, with  
20 universities. The MCI is the accrediting  
21 body. You said though that the medical  
22 colleges themselves are subject to oversight

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1 by the universities. Well, is the MCI the  
2 entity that overlooks the university which  
3 then itself overlooks the medical college, or  
4 does the MCI go straight to the medical  
5 college and oversee the medical college?

6 DR. KUMAR: See, the distinctions  
7 are too very clear. When it comes to opening  
8 of a medical college, in that situation, as I  
9 told you, the condition precedent is that it  
10 must have affiliation from a university which  
11 will be conferring the degree on affiliation  
12 and thereby conducting the examination.

13 When the degree is recognized, the  
14 application for recognition of a degree is  
15 invariably through the affiliating university  
16 because the standards of examination are  
17 required to be certified. It's not just the  
18 infrastructure. The examination is actually  
19 observed by the Medical Council of India, and  
20 if the standards are said to be absolutely fit  
21 and fine, then the degree is recognized in the  
22 name of that examining university.

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1                   So there are two propositions.  
2                   One, the recognition of the medical college  
3                   for the purposes of degree is in terms of the  
4                   university to which it's affiliated. Say for  
5                   example, Dr. Vedprakash Mishra, who's a  
6                   graduate of Government Medical College,  
7                   Nagpur, but the degree is in the name of  
8                   Nagpur University, Nagpur. So medical college  
9                   affiliated to Nagpur University is recognized  
10                  by Medical Council of India for the purposes  
11                  of conferment of degree. Therefore, the self  
12                  regulations are two. When it comes to  
13                  prescribed standards by Medical Council of  
14                  India, periodically monitoring by Medical  
15                  Council, but simultaneously affiliation is  
16                  with the university and therefore university  
17                  is also conducting periodic propositions which  
18                  will maintain its affiliation.

19                  Contemplate the situation, sir.  
20                  If university disaffiliates a medical college,  
21                  that becomes de-recognized medical college for  
22                  Medical Council of India for all practical

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1 purposes. Therefore, these two prepositions  
2 have to go simultaneously. In order to be a  
3 medical college being recognized by Medical  
4 Council its affiliation, its umbilical cord  
5 with the university is to be intact and that  
6 university is also expected to be certifying  
7 that it is fulfilling their conditions of  
8 affiliation.

9 DR. CARON: Okay. So what you're  
10 saying then is that the MCI has the final say-  
11 so?

12 DR. KUMAR: MCI is the final  
13 because ultimately the schedule of recognition  
14 is appended to the IMC Act, as we called it  
15 Appendix 1, Schedule 1, Schedule 2, Schedule  
16 3. Therefore it is binding. The registered  
17 medical practitioner will be incorporated into  
18 the Indian Medical Register exclusively if his  
19 qualifications are schedule qualifications,  
20 and schedule qualification means that it has  
21 to be recognized by Medical Council of India  
22 through the affiliating university.

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1 DR. CARON: All right. Let's just  
2 - let me give you an example of maybe a  
3 problem that may occur. What if a medical  
4 college needed to be redressed by the  
5 affiliated university? Do they have to - or  
6 they need to be sanctioned, or the probation,  
7 or whatever. Do they have to go to the MCI  
8 and the MCI then put the restriction on the  
9 medical college, or can they - or do they -

10 DR. KUMAR: As far as the  
11 grievances redress mechanism is concerned, it  
12 is absolutely falling within the domain of the  
13 bylaws of the university because the  
14 institutional grievance - medical school is a  
15 condition which is prescribed by the  
16 universities, but universities will prescribe  
17 this condition as governed by University  
18 Grants Commission. And it is therefore every  
19 university will ensure that any medical  
20 college or for that matter any institution of  
21 higher learning, if it is to be granted  
22 affiliation to it, they need to have an

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1 institutional grievance cell which will be  
2 looking into the grievances of the students,  
3 and it is not only that they're looking into  
4 the grievances, the periodicity, the report  
5 generated out of those grievances cell are  
6 required to be furnished to the university for  
7 periodic update and appraisal from time to  
8 time.

9 DR. CARON: Okay. So then what if  
10 - going back to my original thought was what  
11 if the let's say medical college was falling  
12 below standards, not so much grievances, but  
13 below standard for whatever reason. Does the  
14 MCI itself - who would be the entity that  
15 would impose a sanction on a university for  
16 falling out of favor for whatever reason?

17 DR. KUMAR: Medical Council.  
18 Medical Council, sir. Because ultimately the  
19 recognition which is conferred is not a  
20 permanent recognition, it's a periodic  
21 recognition. The recognition which is  
22 conferred is for a period of five years, and

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1 therefore every five years there is a periodic  
2 re-inspection, which is required to be caused  
3 by the Medical Council which includes the  
4 inspection of the standards of examination.  
5 Therefore, it's not a system of one-time  
6 recognition. Hence, that particular  
7 periodicity of recognition keeps everybody on  
8 tenterhooks and everything which is required  
9 to be minimally complied is worked up by the  
10 various medical schools in the country.

11 But, in case there is any shortage  
12 of any deficiency mitigated in the standards  
13 or in the infrastructure, it's the Medical  
14 Council of India which has got the powers to  
15 then withdraw that particular recognition and  
16 a recommendation thereof is made to the  
17 Government of India.

18 Medical Council of India in terms  
19 of other provisions of the Act per se is not  
20 the body which will be in a position to  
21 withdraw the recognition. A recommendation  
22 for withdrawal of the recognition is required

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1 to be made to the Government of India, and  
2 then Government of India, hearing their  
3 affiliating university and the council and  
4 state government where the medical school  
5 would be, would be deciding as to whether that  
6 recommendation is to be executed otherwise.

7 Therefore, it's a three-tiered  
8 system mechanism which is clearly prescribed.

9 Medical Council at one end, the University  
10 Grants Commission at the other, and the  
11 Government of India as the third part of the  
12 triangle. So universities have to be taken  
13 into trust and confidence whether it is a case  
14 of recognition or it is a case of imposition  
15 of penalty, or even a penal action like  
16 withdrawal of recognition.

17 DR. CARON: Okay. As far as  
18 clinical rotations go, for students at the  
19 private and the public schools that are all  
20 affiliated with the universities, the MCI  
21 itself does onsite inspections. Are they -  
22 they're the entity that would do the onsite

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1 inspections and not the universities  
2 themselves?

3 DR. KUMAR: Yes. Universities  
4 will be doing onsite inspections for the  
5 limited purposes of continuation of  
6 affiliation, and that is - that affiliation is  
7 basically that the students enrolled will have  
8 to be examined. But, the standards - if you  
9 take into consideration starting off a new  
10 medical school, it's not one-time inspection  
11 which is going to suffice. Medical Council  
12 conducts annually inspection. First  
13 inspection is for the letter of permission.  
14 Second inspection will be after the students  
15 are required to be admitted to the second  
16 year, third inspection. For every year there  
17 will be an inspection and final inspection is  
18 expected to be caused when the first admitted  
19 batch is appearing for the university  
20 examination. That inspection, what is called  
21 as inspection under Section 11, Sub-clause 2  
22 of the IMC Act.

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1                   If this report is satisfactory and  
2 the executive committee and general body of  
3 the Council are satisfied that the standards  
4 through all these five inspections are  
5 through, then the college is expected to be  
6 recognized through its university for a period  
7 of five years. Therefore, the process is  
8 absolutely well laid out, structured, and  
9 because of the periodicity of the inspection  
10 which is annual in nature, things are brought  
11 into situation reasonably and substantially  
12 well.

13                   DR. CARON: One little note, or  
14 one question I just had for you personally  
15 from reading the data and looking at our own  
16 Department of Education data, there are no  
17 loans, no active loans in India. And I'm just  
18 curious because there's so many Indian doctors  
19 in the United States. I think it's - is it  
20 the largest groups of foreign graduates in the  
21 United States? And all these people have  
22 children, you know, kids and so forth, and I'm

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1 sure a lot of them have gone to medical  
2 school. I was just curious, why do you think  
3 none of them are heading back to their  
4 homeland?

5 DR. KUMAR: See, look, if you take  
6 into consideration India in terms of the  
7 number, including generation of the trained  
8 health manpower, then also you will see  
9 perhaps we are one of the largest clearing  
10 propositions for the trained health manpower.

11 With 289 medical colleges as of  
12 now, the annual intake capacity for the MD  
13 course is almost - is more than 32,000 per  
14 year. And if you take into consideration the  
15 proportionate number of the post-graduate  
16 avenues, it is about 13,140 post-graduate  
17 seats as of now which are there in about 172  
18 institutions which are running the post-  
19 graduate courses. So the number, 32,000 being  
20 the intake, on an average, 25,000 graduates  
21 are being produced every year. And if you  
22 take into consideration the total number of

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1 migrating graduates, it's not more than 10  
2 percent of the total that we have.

3 Say for example I was having the  
4 statistics on first of January, 2009 when we  
5 were updating the Indian Medical Register. We  
6 have got about 700,000 doctors in the Indian  
7 Medical Register as of now, and the total  
8 number of Indian doctors in America are said  
9 to be 60,000 in number, which turns out to be  
10 10 percent of the total graduates registered  
11 in the Indian Medical Register. This is  
12 number one.

13 With the changing trends, this  
14 particular influx will comparatively be  
15 reduced because of the multiple avenues of  
16 health tourism booking up in India, and the  
17 corporate mechanisms which are coming into  
18 place. Therefore, when it comes to quality  
19 healthcare, instead of the brain drain I have  
20 no hesitation in saying it will be brain gain  
21 now and here onwards.

22 DR. DOCKERY: Dr. Crane and then

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1 Dr. Maldonado.

2 DR. CRANE: Yes, good afternoon.

3 DR. KUMAR: Good afternoon, sir.

4 DR. CRANE: I was just interested  
5 for a moment, you piqued my interest in  
6 something, the numbers that you just gave.  
7 There are 289 colleges. There's 32,000  
8 graduates a year. That says to me that the  
9 average amount of students are a little over  
10 100 at each college. Some must have  
11 relatively few students, is that correct?

12 DR. KUMAR: No. See, medical is  
13 still one of the very chosen careers in India  
14 because of the prestige, because of the  
15 nature, because of the standards and including  
16 the prospects which are involved. Therefore,  
17 if you take into consideration the total  
18 number of applicants who are appearing for the  
19 examination and those who are opting out, you  
20 will be finding that the ratio is almost 1 to  
21 6. Means out of every six aspirants, only one  
22 is getting into medical school in India.

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1                   Therefore, practically - and if  
2 you see the regulatory position, our positions  
3 are very clear. After first of September 1993  
4 medical colleges which are getting opened up,  
5 they will have only three capacities. Either  
6 it will be a medical school of 50 intake, or  
7 it will be a medical school with 100 intake,  
8 or it will be a medical school with 150  
9 intake. So our regulations are also clear on  
10 that count. Starting off a medical school  
11 with an annual intake of 50, stroke, 100,  
12 stroke, 150. So not more than 150 and not  
13 less than 50.

14                   DR. CRANE: Okay. Can you give me  
15 now some of the guidelines or benchmarks that  
16 you use, and be specific if you can, with  
17 respect to the outcome analysis of performance  
18 of graduating medical students?

19                   DR. KUMAR: See, that is one,  
20 absolutely I have no hesitation in saying that  
21 this particular task is being dispensed of  
22 with the National Assessment and Accreditation

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1 Council of University Grants Commission.  
2 Outcome analysis of graduates and post-  
3 graduates in higher education, including  
4 medical education is being looked after by  
5 them. And the committee which has been  
6 constituted for that purpose has a  
7 representative of Medical Council of India in  
8 it. Therefore, it is a holistic exercise  
9 which is being undertaken by that particular  
10 board. I may not be having the specifics  
11 about it, but yes, Medical Council is  
12 represented on that particular board and  
13 outcome analysis is being looked after by  
14 them.

15 DR. CRANE: Can we expect - I  
16 understand that you're represented, but can we  
17 expect at any particular time some information  
18 on that?

19 DR. KUMAR: Definitely,  
20 definitely, definitely.

21 DR. CRANE: When do you think that  
22 might be forthcoming?

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1 DR. KUMAR: Should be - we should  
2 be able to send that for your consideration  
3 maybe in a month's time.

4 DR. CRANE: Thank you very much.  
5 I appreciate it.

6 DR. KUMAR: My pleasure. My  
7 pleasure.

8 DR. DOCKERY: Dr. Maldonado?

9 DR. MALDONADO: Thank you for all  
10 the information and some of my questions you  
11 answered already. Medical tourism is  
12 something that is developing strongly in India  
13 and I'm sure that you have - I think you  
14 mentioned like 10 percent of your students are  
15 from other countries?

16 DR. KUMAR: No, not 10 percent.  
17 Ten percent of my students are migrating to  
18 America. That is the average which I'm giving  
19 of last 10 years.

20 DR. MALDONADO: Okay. And how  
21 many students do you have from other  
22 countries, from the United States, from

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1 England and from other countries in your  
2 university?

3 DR. KUMAR: See we have got these  
4 - our rules are very clear. In all the  
5 colleges which are under private sector, 15  
6 percent of the seats of the total are  
7 earmarked for the NRI, non-resident Indians,  
8 in which even the foreign applicants are  
9 there. Therefore, on an average, 15 percent  
10 of the seats in private medical colleges which  
11 the number is also big, 152 medical colleges  
12 with nearly an intake capacity of 20,000 will  
13 be having 15 percent, one-five percent, of the  
14 seats again with the non-resident Indians and  
15 foreign nationals are required to be  
16 accommodated. And by and large, all these  
17 seats are getting filled up, because not even  
18 a single seat out of the 32,000 and odd is  
19 remaining vacant in any of the medical schools  
20 in the whole of the country.

21 DR. MALDONADO: My second question  
22 is can foreigners who study medicine in India

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1 practice in India?

2 DR. KUMAR: No.

3 DR. MALDONADO: And under which  
4 conditions?

5 DR. KUMAR: No. The rules are  
6 very clear. As of now, the registering  
7 qualification to be in the Indian Medical  
8 Register is that the doctor with schedule  
9 qualification has to be a citizen of India.  
10 However, there is a rule which provides, and  
11 that rule precisely if I am quoting it right,  
12 it is Section 14, Subsection 4, which says a  
13 person with foreign qualifications is entitled  
14 to provisional registration in India and will  
15 be using his services for three categories of  
16 services: (a), it will be for educational  
17 training and teaching, (b), it will be for  
18 medical research, and (c), it will be for  
19 charity. This is the present position, but  
20 yes, Government of India is seriously thinking  
21 in terms of opening this up in the context of  
22 double citizenship which is under the active

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1 consideration of the Government of India.

2 DR. MALDONADO: Thank you.

3 DR. DOCKERY: Mr. La Porte?

4 MR. La PORTE: Just a point of  
5 clarification. So the NRI quota, all the  
6 private schools maximize it because it's  
7 revenue-generating. They are allowed to  
8 charge a much different tuition for the  
9 private students?

10 DR. KUMAR: See, the Supreme Court  
11 of the country had made a cross-subsidy  
12 structure for all these various colleges. It  
13 had said that there will be a fee revision  
14 committee which will be headed by - which we  
15 have indicated, which will be headed by a  
16 retired high court judge which will have an  
17 education expert in it and which will also  
18 have a financial expert in it. It is this  
19 committee which is expected to be working out  
20 the various chargeable fees for both the group  
21 of students on the basis of actual admissible  
22 expenditure incurred by the institution. So

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1 it is under the strictest surveillance, but  
2 yes, you're right.

3 The chargeable fee in the name of  
4 cross-subsidy is different from the regular 85  
5 percent of the students admitted against open  
6 medicines and those admitted against 15  
7 percent of the NRI quota. However, there is  
8 an embargo. The chargeable fee under the NRI  
9 category under no circumstances will be more  
10 than three times than what it is charged from  
11 the regular students under the 85 percent  
12 quota.

13 MR. La PORTE: You're referring to  
14 I.M. Pai?

15 DR. KUMAR: That is T.M. Pai.  
16 T.M. Pai vs. Union of India, October 2001.

17 MR. La PORTE: I mean, just - it's  
18 a bit of a nuance, but the court decision said  
19 I think every state had to constitute -

20 DR. KUMAR: No, that is old one.  
21 That is only Krishna's judgment, 1993. What I  
22 am referring is T.M. Pai vs. Union of India,

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1 2001, in which that subsidy concept has been  
2 annulled to a substantial degree and they have  
3 clearly said not 50/50 ratio. It will be 85  
4 to 15 ratio with this particular 15 percent  
5 rendering not more than three times the  
6 chargeable institution fee as compared against  
7 what will be chargeable for the 85 percent or  
8 the seats which are filled from the Indian  
9 students.

10 MR. La PORTE: Okay, just one last  
11 question. So, it seems that - I mean I've met  
12 at least one American citizen who was going to  
13 medical school in India. So there's at least  
14 one, and it sounds like there could be  
15 hundreds, maybe even thousands of U.S.  
16 citizens in India going to medical school. Do  
17 you have any idea why none of those programs  
18 has applied to the field program for -

19 DR. KUMAR: No, there are, there  
20 are. There are certain schools in which the  
21 students have been admitted. See, the real  
22 difficulty, as I was telling you, was because

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1 the IMR includes only the Indian citizens.  
2 That is the stumbling block. But I mean, it  
3 has its own advantages and it has its  
4 limitations. When I view it from my side it  
5 looks to me advantage, but when I see from  
6 American side, perhaps it will have a sense of  
7 limitation. But the Government of India is  
8 open about it and things are in the process.

9 MR. La PORTE: No, I wanted to  
10 clarify. What I mean is after we determine  
11 that a particular country has equivalent  
12 accreditation standards, the individual  
13 schools, the individual medical schools in  
14 that country have to apply to the FFEL program  
15 in order for students at that school to get  
16 loans. So, according to our data there isn't  
17 a single school in India that has applied to  
18 the program, even though they're eligible to  
19 do so. So my question is why is that the  
20 case?

21 DR. KUMAR: See, this is the  
22 reason, because - I will tell you the reason.

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1 No, it has got nothing to do with the  
2 standards being questionable one way or the  
3 other. The reason is that the  
4 internationalization policy of Government of  
5 India on this particular count is not  
6 finalized as yet, and therefore it is in the  
7 process. Maybe once that internationalization  
8 schedule of Government of India works up, the  
9 scenario will be - perhaps, you know, better  
10 provide.

11 DR. DOCKERY: Are there other  
12 questions by members of the committee? Dr.  
13 Shah?

14 DR. SHAH: So what you're saying  
15 is, right now the medical schools are not  
16 involved in this and they don't know that they  
17 can apply for this grant program for their  
18 students?

19 DR. KUMAR: No, they are, they  
20 are, but because this is required to be routed  
21 through Ministry of External Affairs and  
22 Ministry of Health and Family Welfare, the

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1 Ministry of External Affairs in regard to its  
2 final policy document. Once that gets going,  
3 then this will be a program which will be  
4 worked up in a very big scale because 289  
5 medical schools, and with added numbers  
6 ultimately it's not just for the cause of  
7 India and Asian countries. Perhaps it will  
8 have a global context and contour.

9 DR. DOCKERY: Other questions from  
10 members of the committee? Is there a motion,  
11 Dr. Caron?

12 DR. CARON: Yes, Mr. Chair. I  
13 move that the NCFMEA, based on the most recent  
14 information and materials received from India  
15 reaffirm its prior determination that the  
16 standards and processes used by the MCI to  
17 accredit medical schools in India are  
18 comparable to those used to accredit medical  
19 schools in the United States. In addition,  
20 the NCFMEA requests that India submit a report  
21 on its accreditation activities as well as  
22 assessment of graduate performance outcomes

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1 for review at the March 2011 meeting of the  
2 NCFMEA.

3 DR. CRANE: Second.

4 DR. DOCKERY: Does that satisfy  
5 your concerns, Dr. Crane, in regard to the  
6 outcomes of students that had graduated from  
7 Indian medical schools?

8 DR. CRANE: I thought the report  
9 was going to be forthcoming a little sooner  
10 than two years.

11 DR. DOCKERY: How will that be  
12 reviewed? What is the will of the committee  
13 in terms of are you willing to wait until 2011  
14 to have that included in that report, or do  
15 you want an interim report that would deal  
16 with just that that could be transmitted to  
17 staff for report to us at our next meeting?

18 DR. CRANE: Yes, my preference  
19 would be an interim report perhaps in 2010.

20 DR. DOCKERY: To report to this  
21 committee?

22 DR. CRANE: Yes.

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1 DR. DOCKERY: Okay. Does that  
2 sound acceptable to you?

3 DR. CARON: Yes, we could change  
4 that to 2010 from 2011.

5 DR. DOCKERY: Just for the report.

6 DR. CARON: Yes, sir.

7 DR. DOCKERY: Okay. Any comments  
8 or questions on the motion? All those in  
9 favor, please say, "Aye."

10 (Chorus of ayes)

11 DR. DOCKERY: Those opposed?

12 (None)

13 DR. DOCKERY: Any opposition?

14 (None)

15 DR. DOCKERY: Thank you very much  
16 for coming and for your excellent  
17 presentation. Thank you.

18 DR. KUMAR: Thank you very much.  
19 Thank you.

20 DR. CARON: Excuse me. Can we  
21 make it clear that they don't have to come all  
22 the way from India for that report?

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1 Gentlemen? Gentlemen, we just wanted to make  
2 it clear that you - I'm sorry.

3 DR. DOCKERY: No. Dr. Caron just  
4 wanted to make it clear that the report that  
5 is due in 2011, the formal report, it is not  
6 necessary for you to make an appearance unless  
7 you have other reasons and you particularly  
8 enjoy coming and being with the committee.  
9 You're always welcome. No, the interim report  
10 that we're talking about is to just address  
11 the graduate - exactly. But also the 2011 is  
12 the one that I'm talking about that you didn't  
13 need to make a personal appearance unless you  
14 - to be considered by the September 2010  
15 meeting. That's the interim report. But the  
16 main report is in 2011.

17 DR. KUMAR: Thank you.

18 DR. DOCKERY: Okay. We will take  
19 just a 10-minute break and then we will  
20 consider Pakistan, to be followed by the  
21 United Kingdom.

22 (Whereupon, the foregoing matter

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