The News Bulletin of National Board of Examinations

NBE

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In this Issue

The 12th Convocation of National Board of Examinations

The 12th convocation of National Board of Examinations was held on Saturday, the 18th February 2006, at Science City Auditorium, Kolkata. Shri Jyoti Basu, Hon'ble, former Chief Minister of West Bengal, was the Chief Guest. Dr.Anbumani Ramadoss, Hon'ble Union Minister of Health and Family Welfare, Govt. of India, delivered the Convocation address. Dr. Surjya Kanta Mishra, Hon'ble Minister of H & F W, Panchayat & Rural Development, Govt. of West Bengal, was the Guest of Honour. Prof. A. Rajasekaran, President, National Board of Examinations, presided over the function.

Nearly 1,500 candidates who passed their practical examination in 2005 were conferred with Diplomate of National Board. Besides, the meritorious students were also given Gold Medals by the Chief Guest.

Dr. Anbumani Ramadoss, complemented the National Board of Examinations for providing opportunities to medical aspirants in post-graduate medical education in different broad and super specialties as well as different postdoctoral Fellowship programmes in

various sub-specialties, in the country. He noted that the National Board of Examinations has taken special measures to increase the expertise of medical graduates in the disciplines of Family Medicine. The Family Physician is likely to be more successful in providing comprehensive services to our communities, especially in rural areas. He emphasized that the linkages of National Board of Examinations with several accredited institutions/hospitals should be further strengthened. The Board should ensure that the specialists' services through the accredited private hospitals are also provided in the neglected areas & regions of the country, as well as to the poor population. Special incentives may be given to such hospitals. He added that our country is so diverse, geographically and demographically that there are a wide range of health problems. The Government health infrastructure and facilities in the rural areas are not adequate in several states. Here the private and corporate hospitals can also play an important role by providing some technical medical facilities to governmental institutions. The public and private institutions must network and help complement each other in selected health related issues. He congratulated the candidates, their families and wished them all success, a bright and successful career ahead and hoped that their contribution shall go a long way in strengthening the health care delivery system in the country.

Forthcoming Journal of NBE

NBE is planning to start a journal during the next few months to enable the sharing of technical materials and experiences of various accredited institutions in the area of post graduate medical education and training. It would be appreciated if you could kindly contribute in the journal in any of the following areas:

- Scientific articles (Title, name of authors, summary 250-300 words, key words, introduction, methodology, results, discussion, references (Vancouver), tables (one on each page)
- Letter to the editor (from DNB students and teachers)
- Review articles related to post-graduate medical education and training
- Book reviews
- Guest editorial on issues related to medical education and training
- NBE institutions review (brief write up on your institutions and how innovative post graduate medical education training is being followed in your institute)
- Interesting clinical cases (brief with photo etc.)
- Any other issue related to medical education

Kindly send these in hard copy & also on floppy by mail or through email: www.nbejournal@yahoo.com

Medical Education in India

(An abstract from the convocation address by Prof. A. Rajaseakaran, on I March 2006, for the 10th convocation of the N.T.R. University of Health Sciences, Vijayawada Andhra Pradesh)

Hon'ble Vice Chancellor, Prof. R.Sambasiva Rao, Members of the Executive Council and Academic Senate of the university, Dean of Faculty, Distinguished guests and my dear graduates. I am grateful to the Vice Chancellor and members of the Executive Council for having invited me as Chief Guest to deliver the convocation address today. I consider it a privilege and honour to address the youth of our Nation who are the future guardians of health. On behalf of the National Board of Examinations, Ministry of Health & Family Welfare, Govt. of India and on my own behalf I congratulate every one of you on successful completion of your course for which degrees are awarded in respective disciplines. Today is a day to rejoice your achievements, days when you realize that opportunities are knocking at your doors and you accept the honour with dignity and decorum.

Please translate your learning and training into actions. Large section of the humanity is expecting your valuable services; you should consider yourself as one of the lucky individuals among millions of our population to avail the opportunity to enter the portals of the medical college and receive your coveted degrees today.

Public Health- Indian Scenario

The health problems in India are different from those in the West; we are at a stage where the western countries were several decades ago. Vector born infections like Malaria and Filariasis are prevalent in both urban and rural areas. India is heading for an explosive increase in HIV infections. It is estimated that about 40 million Indians will be infected by HIV Virus by next two decades. TB and AIDS are companion in arms. They aid and abet each other. It has been stated. 'TB has been a time bomb and AIDS has shortened its fuse'. In a vast country like ours with poverty, ignorance, overcrowding, lack of sanitation and poor nutrition drugs alone are not adequate. To contain TB and AIDS we need socio economic emancipation. More resources should be provided for clean water, good nutrition, sanitation, housing and education; the recent occurrence of Bird flu in India is causing great concern to all of us. Maternal Mortality (MMR) in India with 400 to 500 per 100,000 live births India accounts for 25 % of maternal deaths. After all pregnancy and childbirth is not a disease and no mother should die of childbirth. Ante partum and post partum hemorrhage, puerperal sepsis, obstructed labour, eclampsia and anemia are primary causes. Lack of

trained midwives, facilities for appropriate and timely referral in emergencies account for maternal deaths. Neonatal mortality account for 44 to 48 per 1000 live births due to infections, birth asplysia and prematurity. Non-communicable diseases viz., Cardio Vascular Diseases, Diabetes, Respiratory Diseases (COPD) Cancer and Mental diseases are causing great concern. The prevalence of diabetes and cardio vascular diseases is increasing even in rural areas. Accidents, injuries accounted for 8.5 millions deaths in 2005 which include road traffic accidents, burns, suicides, poisoning and others. 70% of our country's population does not have immediate access to life saving services.

Need For Health Education

80-90 % diseases are due to malnutrition, poverty and poor living conditions. To increase the awareness among public in health education we need to train middle level health professionals who are local persons drawn from every village. The ASHA concept of National Rural Health Mission launched recently by Govt. of India has focused on them to take care of primary health needs of the community. We need to educate every schoolteacher, encourage empowerment of women to take care of the family health. I understand in Cuba every street has an identified health worker who can be contacted when any one falls sick or meet with an emergency. Besides offering first aid, he/she will arrange for transportation and appropriate referrals; here comes the role of health professionals in health care needs of a village.

Medical Education

Our present system of medical education was inherited as legacy of the British. Even though beneficial to our progress it has not fulfilled the aspirations and expectations of our people particularly rural poor. Starting from BHORE Committee (1946) there were several attempts at reorientation of medical curriculum to produce a basic doctor or community physician. Reorientation of Medical Education (ROME PROGRAMME) of WHO for Asian countries was aimed at developing medical education system responsive and relevant to the needs of our country by making necessary curriculum changes. The medical student entering the medical college is not adequately briefed on compassion and care, and learns the communication skills and moral values. Instead his first exposure is to a cadaver in the anatomy dissection hall: Here comes the need for a preparatory course. In the present under graduate medical education the preclinical years, which was two years earlier, has been reduced to one year to learn anatomy, physiology, Biochemistry with too much of information squeezed into the curriculum.

In the present scenario of medical education the teaching is didactic and theory based, More of information imparting than problem solving, the students are more oriented to examinations, Teachers lack training to guide the student to impart knowledge; There is sequestration of what he has learnt in the pre clinical year with hardly any integration with clinical subjects and vice versa. A pre clinical student can learn with interest the functioning of heart and lungs if the clinician makes an audiovisual presentation to them on cardio pulmonary resuscitation or vascular access.

Objective of Medical Education

The primary objective of medical education is to support the health development of the nation; it should be "Community Oriented". Unfortunately the medical education system till date has been hospital based, specialization-oriented and dependent on sophisticated investigatory procedures. The curriculum is over crowded with factual information and this inhibits a student from developing creative and critical thinking to solve problems. The Edinburgh Declaration (1988) states, 'the aim of medical education is to provide health professionals who will promote the health of all people'. Further, it states that scientific research continues to bring rich rewards, but man needs more than science alone, and it is the health needs of the human race as a whole and of the whole person that medical education must affirm. The declaration also emphasizes in shifting the training from passive to active learning. The existing medical education system does not follow the spirit of Edinburgh Declaration. Health professional education is presently centered on tertiary care units, whereas it should necessarily be based on a priority of primary, secondary and tertiary care with the largest component being primary healthcare. Our medical colleges are sequestrated from the community and the present system of medical education is not need based.

Physicians worldwide are trained in the academic niche of tertiary hospitals, where day-to-day discussions resolve around the obscure mechanisms of rare diseases, state-of-the-art diagnostic tools and sophisticated. High-tech medical interventions. Despite strong indications that the requirement is more of training in primary care and more investment in the critical public health issues, precious time is spent on investigation of diseases, which afflict a tiny proportion of the humanity. Graduates from the present medical colleges feel that all this learning is wasted in a primary or secondary care hospital, which in fact is the backbone of our health delivery system. Health care providers are not mere professionals with technical knowledge to solve health problems but are accountable to the society. Medical education and healthcare delivery should be linked. At present these are two systems going parallel, often not complementing each other. Medical education should be linked to all levels of healthcare-primary, secondary and tertiary.

Commercialization of Medical Education

During recent years we have seen mushrooming of private medical colleges in many states. The trend is towards increasing commercialization. The health industry would like to get quick return for their huge investments at the cost of patients who are required to undergo unnecessary investigations and expensive treatment.

Even though charging capitation fees is punishable under the law, the practice continue to go unabated with tacit understanding between different agencies. Through the private medical colleges we are creating a large number of affluent medical professionals from the privileged sections of the society. Having spent a fortune to get medical education how do we expect them to serve the rural population? Many of us feel that the medical degree should be awarded only after two years of service in rural areas irrespective of where the candidate comes from Government or Private medical colleges.

What are the radical changes required in medical education?

There is need to select students with right attitude & aptitude- and prepare doctors for the needs and expectations of the society. The curriculum of medical education needs to be revamped and made primarily self directed and student centered- It should be to encourage problem solving rather than information gathering. To ensure competency rather than acquiring knowledge. Greater emphasis is to be given to solving common clinical problems rather than searching for cases, which one may see once in a blue moon or may not see in his lifetime. Medical Education & Training should aim at improving the quality of individual care- ethics- promotion of healthy life style- and protection of environment. These are rarely emphasized in medical curriculum. Having been trained in Tertiary care hospitals in urban surroundings influenced with pharmaceutical pressures the doctor does not realize need for cost containment, which is more important in health care delivery today. Instances are plenty where rural indebtedness is caused by spending on medicare, which has become a necessary evil even to the less affluent. What is ideal is not always available when he gets to work in the community. He should be encouraged to make innovations to suit to the needs taking into consideration financial and socio cultural constraint. Reaching out in to the villages provide the student better understanding of the community he is expected to serve. With interaction with the people he would develop humility, empathy & better appreciation of public health issues & human values, and foster team spirit with participatory approach. Medical curriculum with focus on social needs should include social and behavioral sciences, epidemiology, biostatics and public health; curriculum need to be modified deleting major portion of our present syllabus, which is hardly applied to them in day to day practice.

NBE President Speaks

What do we expect out of those who are the end products?

At the end of their training they should be able to assess and improve the quality of health care making optimal use of new technologies- Promote health life style- and work efficiently in teams. Our present day training is inadequate to manage all by himself feeling reluctant to serve in the villages. With the type of training offered in tertiary care hospitals most of our graduates are best suited to work as junior doctors in large corporate hospitals to execute the order of their consultants. Future medical training must be such that the young doctor should feel confident to make accurate diagnosis and plan management based on bedside skills along. The doctor has to develop good communication skills. It is well known that simply listening to the patient long enough is adequate to diagnosis most of the diseases. History taking is often ignored. He forgets use of his senses like eyes, ears and hands. The present day student is developing the rapport with the machines than his patients- he is dictated by the technology rather than clinical judgement. There is hardly any place in our curriculum on Bereavement and Death.

Internship & P.G. Training

Majority of medical graduates today tend to opt for post graduation, which has focus on tertiary care and super specialization. The period of Internship- most valuable period where the trainee could learn technical skills and take part in managing emergencies is often spent preparing for entrance examinations at national or international level. It is time that the trainee is assessed continuously during the Internship and also at end of the course before recommending him/her for the award of medical degrees. There is need for continuous assessment on attitude, knowledge and skills with mid term evaluation to identify weakness if any and to correct them.

What type of Doctors we need in India?

I am convinced that we need the following three categories of doctors.

i. Family Physicians (General Practice) (60% - 70%)

ii. Rural Surgeons (General Surgeons) (20% - 25%)

iii. Specialists & Super Specialists for Tertiary Care (10%)

i) Family Physician

World over Family physicians (General practitioners) from the backbone of health care delivery; the family physician is the first referral point for any illness and only on his advice the specialty services should be offered. Who will know the socio economic or environmental background of the disease than the Family physician? The pivotal role played by the family physician is not duly recognized by the society in India. General practice or primary care physician has to be duly recognized and rewarded. Every medical student aspires to become a specialist not realizing the fact that there is great scope for a good general practitioner. You can play an important role in the society. The DNB Family Medicine is a postgraduate programme becoming increasingly popular with more and more institutions seeking recognition through NBE.

ii) Rural Surgery (Versatile General Surgeon)

The concept of rural surgery has evolved in India over the past decade based on the ground reality of surgical practice of surgeons practicing outside high-tech institutions in our country. In India, 400 million people have no access to basic surgical care, "essential surgical care" to create a band of basic multipurpose surgeons, who would acquire the expertise to set up small hospitals in the countryside and provide basic, and emergency limb and lifesaving surgical care to the impoverished and rural population of our country by mobilizing human and material resources from the local community. To create a cadre of health professionals who will be accessible to the total population of the country with basic surgical care to diminish the load of basic surgical care from the tertiary care institutions. This would indirectly, improve the quality of life of our rural population.

Multipurpose surgeons should have training in various surgical disciplines viz,

- Basic general surgery with emphasis on open surgeries
- Basic urology with emphasis on open surgeries
- Basic orthopaedics including trauma
- Basics of Specialty surgeries including paediatric, thoracic and vascular, neuro (including head injury) and burns and plastic.
- Obstetrics and Gynaecology
- Basis of anaesthesia, ultrasound and X-Ray

iii) Specialists & Super Specialists for Tertiary Care

A Super specialist becomes inevitable in well-defined situations. The human system is integrated and no organ functions in Isolation. The relevance of experience in general medicine and surgery should not be left to the background. The mechanization of medicine has robbed it of its essence- its humanism. Specialty services are required to serve tertiary care/ Medical college Hospitals and Corporate Hospitals to perform highly technical procedures like Kidney Transplantation, CABG, Valve Replacement Arthroplasty, Spine surgery Neuro Surgery, Radiation Oncology, Vitreo Retinal Surgery etc. With enormous number of medical graduates coming out of Medical Colleges every year the opportunities for Post graduation are very few. I feel National Board could offer educational opportunities for meritorious and less affluent medical graduates to pursue Postgraduate Training through various specialties. The National Board of Examinations offers DNB Post Graduate Courses in 42 Broad Specialties in Medicine, Surgery and allied branches, in Nine Dental Specialties and conducts Examinations at all India level ensuring uniformity and high standards. Through the 'Centers of Excellence' recognized by the Board Post Doctoral Fellowship Courses are conducted in various Sub-Specialties like Interventional Cardiology, Pediatric Cardiology, Cardiac Anaesthesia, Reproductive Medicine, Spine Surgery, Hand Surgery, Trauma care, Critical Care Medicine, Minimal Access Surgery, Vitreo Retinal Surgery etc., With the availability of experts and infrastructure in many Institutions we expect. Reverse Brain Drain encouraging our Indian doctors settled abroad to return home to serve these Institutions.

'It is necessary to recapture the spirit of humanism and reestablish the special sympathy in doctor patient relationship. To restore the image we need to distance from lure of money, raise the ethical standards and place the welfare and care of patients above all'. It is felt there is decline in values in medical profession. The frustration of patients and relatives is often translated into litigation demanding compensation; to protect himself the doctor falls back on defensive medicine; He over investigates not to miss even a rare disorder. There is need for healthy interaction between medicine and society, which is a two-way reciprocal affair. In India doctor is often brought before a consumer court for any alleged incompetence or offence. The Judiciary in India considers practice of medicine as "**Consumer Industry**" and services rendered to a patient like "**consumer product**". It is unfortunate that the doctor with years of study, knowledge, expertise and experience and above all in spite of the care provided to the patient his services are to be equated as consumer product. In most countries the disputes between doctors and patients are decided by duly constituted professional bodies; Lack of Internal audit and control within the profession is responsible for this sad state of affairs. The medical professionals must develop effective public relations and media management skill. These will help in true projection of our achievements, avoid or dispel rumors, respond to criticism, diffuse controversies and project a positive image.

My dear graduates, every one of you would have found something special from your teachers. Identify suitable role models and set your goals to reach a level higher than them. The health of India is in your safe hands and your are the guiding sprit for the future generation to follow. By your Professional service your will be remembered in patient's prayers Guard and cherish the value of your service. Wish you all Good Luck and Success.

NBE Accredited Hospitals

Dr. Jeyasekharan Hospital & Nursing Home Nagercoil, Tamil Nadu

Providing Affordable and Appropriate Health Care to all Patients

Dr. Renu Devaprasath
Medical Administrator

Dr. Jeyasekharan Hospital was founded in the Southernmost District of India by Late Dr. N.D. Jeyasekharan in 1965. It is now Dr. Jeyasekharan Medical Trust and includes - Dr.Jeyasekharan Hospital and Nursing Home, The Schools of Nursing, Radio-diagnostic Technology and Anaesthesia Technology Training, a Pharmacy, and provides Post graduate medical education in DNB courses.

It is an ISO 9001-2000 BVQI certified multispeciality hospital having departments of Anaesthesia, Bronchoscopy, Cardiology, Dermatology, ENT, Gastroenterology, General Medicine, General Surgery, Maxillo-facial surgery, Nephrology / Haemodialysis, Neurology, Neuro-Surgery, Obstetrics & Gynaecology, Oncology, Ophthalmic Surgery, Orthopaedics, Paediatrics, Paediatric Surgery, Palliative Medicine, Plastic Surgery, Psychiatry, Pulmonology, Radiology / Sonology, Rheumatology and Urology.

There are 18 Full-time Consultants, 20 Medical Officers and 30 part-time / visiting Consultants in the hospital. A total of more than 250 Staff Nurses, 50 Technicians and 150 other Supportive Services Staff work in the institution which has 114 Private rooms, 104 General / Semi private beds and a total of 72 Intensive/Intermediary Care beds and 6 Neonatal Intensive Care beds.The general ward beds are situated in "The Cottages" where patients from the lower socio-economic status can receive treatment with dignity and pride. The average outpatient attendance per day is 500 and about 40 patients are admitted/discharged daily. Approximately 2000 Major and 4000 Minor Surgeries are carried out annually.

Various Intensive and Intermediary Care Units are in the hospital namely, M.I.C.U. (Multidisciplinary Intensive/Intermediate Care Unit), I.C.C.U. (Intensive/ Intermediate Coronary Care Unit), Paediatric Intensive Care Unit (PICU), Paediatric Step Down Ward (PSDW), P.O.W. (Post Operative Ward), a Labour Unit and N.I.C.U. (Neonatal Intensive Care Unit). A level 1 ICU is also available in addition to a 24 hours casualty service with Resident and Senior Doctors on call.

The Institution is recognized by National Board of Examinations, New Delhi to train candidates in General Surgery, Anaesthesia and Family Medicine towards the Post Graduate degree of Diplomate National Board. There is a good library in the hospital which has text books, current journals, back journal, electronic journals and internet access. Surgical workshops, Seminars, Symposia and journal club meetings are conducted regularly. Foreign Medical and Nursing students often come to do their elective postings at Jeyasekharan Hospital.

The Biochemistry, Clinical Pathology, Microbiology Labs along with the Blood Bank, CSSD, Dietetics, EDP, Medical Records, Nursing Services, Occupational Therapy, Physiotherapy, Pharmacy, EMD and Ambulance are the in-house supportive services. The institution prides itself in being the first private hospital in southern Tamil Nadu to have set up a water treatment plant, biogas plant, incinerator and implemented other anti-pollution measures.

The Trust has a School of Nursing recognized by the Tamil Nadu Nursing and Midwives Council for 20 students per year and also Schools of Radiodiagnostic Technology and Anaesthesia Technology Training affiliated to C.M.A.I. which train 10 and 3 students per year respectively.

On the social and welfare front the Institution conducts Medical Camps and Immunization / awareness programmes regularly. The hospital maintains a Government of Tamil Nadu Emergency Accident Relief Centre (EARC) at Kanyakumari which provides Free Emergency Ambulance service. The Dr.Jeyasekharan Centre for Cleft Care which is recognized by Smile Train, U.S.A. has been doing Cleft Surgeries free of cost since 2004.

The hospital is recognized by the Central Government to give treatment to the employees of ISRO, Bharat Sanchar Nigam Limited (BSNL), HUDCO, Tamil Nadu Government and their dependants and retired staff. It is also empanelled by the following agencies / Third Party Insurances-Family Health Plan Limited (FHPL); Good Health Plan Limited (GHPL); Medi Assist India Pvt. Ltd; TTK Health Services (TTK); SBI Life Insurance.

The quality policy of the JMT is to educate personnel, develop management systems and most importantly, offer quick, affordable and appropriate Health Care to all patients in a clean, well maintained institution.

NBE Accredited Hospitals

Sancheti Institute for Orthopaedics & Rehabilitation

Centre of Excellence in Orthopedic Education

Dr. Parag Sancheti, Medical Director

Dr. K. H. Sancheti, Chairman of Sancheti Institute for Orthopaedic and Rehabilitation, is a recipient of Padmashree in 1991 and Padmabhushan in 2003 for his contribution in the field of Orthopaedics and Education related to Orthopaedics. The institute has 150 beds with various ortho super specialties with sate of the art technology, under one roof. The Institute is recognized as a R & D centre by Ministry of Science and Technology, Government of India. "INDUS" is a knee implant researched and developed in by Dr. K. H. Sancheti. A CNG machine has been installed in-house for production of implants customized to the specific need of particular patients. It has Post Graduate Orthopaedics College and a Physiotherapy college having graduate and post graduate degree courses affiliated to Maharashtra University of Health Sciences Nashik. It's Hospital Management College having Post Graduate Diploma in Hospital Management affiliated to University of Pune.

All Resident doctors are given laptops immediately after joining institute. 24 hrs computer lab with unlimited internet facility. A typical day for resident doctors undergoing Post Graduate Orthopaedic Studies is invested in following manner.

Time & Activity

06.30 am to 06.45 am: Dr.K H Sancheti, the chairman, leads the group with prayers followed by meditation.

06.45 am to 07.15 am: A mock Practical Examination is carried out. Students present cases on which teachers grill students with tricky cross questions, giving them a feel of examinations.

07.15 am to 08.15 am: Clinical Meeting chaired by Dr. Parag Sancheti, the Medical Director. Discussion on admissions during preceeding 24 hrs, plan for line of treatment, preoperative planning and post operative appraisals is carried out. Residents are encouraged to ask questions and take part in discussion. Post operative X-Rays are discussed to show the results to resident doctors.

08.15 am to 09.15 am: Unit In-Charge consultants take their residents on rounds of wards. The consultant imparts professional knowledge to residents. Bed side manners and heeling touch by affectionate behavior is also a part of agenda.

09.30 am onwards: Students attend OPD/OT on alternate days. Residents get chances to assist surgery when done by consultant and when resident is given a chance for surgery the consultant assists him.

4 pm to 5 pm: Residents in turn present practical cases to consultant in a clinic.

6 pm to 7 pm: A lecture presentation by senior resident in turn is arranged. The nominated senior resident has to prepare this lecture on Power Point and handover a soft and hard copy to post graduate office two days prior to the lecture.

All such presentations are video filmed, converted to DVD and kept in CD\DVD library, for students to refer when required.

Highlights of Academic Activities

- Evaluation of progress and performance by MCQ test once in three months.
- Practical examination once in six months.
- Log book checking once a month.
- Performance Counseling by Chairman in presence of unit in charge consultant once in six months.

The CME programme for DNB (General Surgery) was held for the Southern region at Dr. Jeyasekaran Hospital and Nursing Home, Nagercoil, from 10th March 2006 to 12th March 2006. There were 33 DNB candidates who attended the programme. The programme was inaugurated by the Vice President, National Board of Examinations, Prof. M.S. Ramachandran. The programme covered the short cases, long cases, ward rounds, discussions etc. Prof. S. Bhardwaj, Vice President, National Board of Examinations chaired the concluding session.

The CME programme in Medicine was held at Government Medical College, Kanyakumari. There were 38 DNB candidates who attended the programme. The Vice President, National Board of Examinations, Prof. M.S. Ramachandran, inaugurated the programme. The programme covered the short cases, long cases, ward rounds, X-rays, CT scans, MRI scans, case scenario, etc. The concluding session was chaired by the Vice-President, Prof. K.M. Shyamprasad.

The Workshop for the National Board of Examinations faculty members and the examiners was held at Government Medical College, Kanyakumari on 12th March 2006. Prof. K.M. Shyamprasad, Vice President of National Board of Examinations, inaugurated the workshop. 75 participants attended the workshop.

Memorandum of Collaboration between NBE & IGNOU

The National Board of Examinations is offering Diplomat National Board (DNB) qualifications in 43 medical specialties through out the country through the accredited hospitals and institutions. The School of Health Sciences (IGNOU) has also been involved in post graduate medical educational programmes through the courses such as Post graduate diploma in Maternal & Child Health (PGDMCH), Post graduate diploma in Hospital & Health Management (PGDHHM), Post graduate diploma in Rural Surgery, Post graduate diploma in Geriatrics medicine, Post graduate diploma in Community Cardiology etc. IGNOU has a vast network of Regional centers, Study Centers and identified hospitals for practical hands on training for the enrolled candidates.

Both the National Board of Examinations and the School of Health Sciences IGNOU have the common concern for the development of need based post graduate medical educational programmes especially in view of the concerns of the Government of India reflected in the National Rural Health Mission 2005, National Health Policy 2002 etc.

The memorandum of collaboration between the two organizations was signed on 3rd February 2006, by the executive director, National Board of Examinations, Prof. A.K. Sood and the Registrar IGNOU, Mr. D.K. Tetri, in the presence, Vice Chancellor IGNOU, Prof. H.P. Dikshit, President National Board of Examinations, Prof. A. Rajasekaran, Prof. S. Bhardwaj, Vice President National Board of Examinations, and Governing Body members, Prof. P.K. Dave, Prof. A.K. Agarwal, Surg. Vice Admiral V.K. Singh and Directors of various Schools at IGNOU. The memorandum lays the foundation for cooperation and joint actions in all such areas which may be identified and mutually agreed from time to time toward the common goal of developing need based post graduate medical educational programmes, development of learning materials, joint conduction of CME programmes for the students and teachers/ trainers, sharing of facilities and expertise etc. The DNB students, especially those enrolled in the DNB course in Family medicine (New Rules) can get the benefit of the courses offered by IGNOU such as Post graduate diploma in Maternal and Child Health, Post graduate diploma in Geriatrics Medicine, Post graduate diploma in rural surgery, Community cardiology etc. by having access to the course materials, getting enrolled in some of these courses etc. Both the institutions can start new short term courses for meeting the needs of the health manpower in the rural areas (such as short term courses in anesthesia, RCH, Public Health, Medical technologies for paramedical, etc.)

Events During Jan to March 06

OSCE training workshop for DNB candidates in Paediatrics, by Indian Academy of Paediatrics (Tamil Nadu), held on February 2, 2006 at Chennai

Forthcoming Events

DNB (Rural Surgery)

National Board of Examinations is launching DNB (Rural Surgery), on pilot basis from June 2006. The concept of rural surgery has evolved in India over the past decade based on the ground reality of surgical practice of surgeons practicing outside high-tech institutions in our country. In India, 400 million people have no access to basic surgical care, termed by the WHO as "essential surgical care". The aim of this course would be to create a cadre of basic multipurpose surgeons, who would acquire the expertise to provide basic and emergency and lifesaving surgical care to rural population of our country. They can form the back bone of health care delivery system and can play a vital role in fulfilling the Rural Health Mission announced by the Government of India.

Goal: After qualifying the final examinations the candidate should be able to function as a consultant (specialist) in Rural Surgery (multiple surgical disciplines) within the constraints of limited resources.

Objectives: At the end of the training period, the candidate should be able to acquire following competencies:

- Basic & general surgery with emphasis on open surgeries.
- Basic orthopaedics including trauma care.
- Obstetrics and Gynaecology.
- Basics of anesthesia, ultrasound and X-Ray.
- Emergency care

Training for DNB in Rural surgery will take place in two kinds of hospitals:

1. Multi specialty hospital which will be called as **Nodal Rural Surgical Training Center:** Two years of training will take place here. This institute will take primary responsibility for the candidate in terms of- Organizing and scheduling the training program for the entire 3 years in consultation with the peripheral institutes. A co-ordinator from both the institutions will be appointed to look after the total training of the candidates; Providing hands on experience to the candidate thus imparting practical surgical skills. Candidate should eventually be able to perform procedures independently and not merely be a first assistant; Placement of the candidate to a peripheral rural surgical centre where the candidate is regularly monitored for skills training and for preparation of the dissertation.

2. **Peripheral Rural Surgical Centre**: One year of training will take place here.This will train the candidate to work in resource limited situations and develop his/her capability to learn to innovate and manage a rural surgical practice; This is also the setting in which the candidate will write up a dissertation based on a topic which is relevant to the rural surgical practice. The candidates will be posted in peripheral Rural Surgical Center for 3-4 months in first, second and third years of training

Eligibility criteria for the Candidates

1. Essential- Any medical graduate with MBBS qualification, who has completed internship and is registered with MCI/State Medical Council can register with the Accredited Institutions for 3 years of training.

2. Desirable- One year experience after completing internship in a peripheral/rural set up. In service candidates from Defence, Central/State Government, Railways, Public sector institutions may also be given preference.

Snippets in Medicine

- National Board of Examinations diplomate is a wanted qualification in Kuwait.
- Incidence of Hepatetis B is more than HIV.
- India is the diabetic capital of the World followed by China, Indonesia and America in that order.

This is a quaterly Newsletter, items to be considered for publication in the next issue should be sent by 15th June, 2006.

Articles published in the Newsletter reflect the opinions of the respective authors and should not be taken to represent the policy af the National Board of Examinations unless specifically stated.

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