Government of India
Ministry of Health & Family Welfare
ME Division

The National Medical Commission Bill, 2017 was introduced in the Lok Sabha on 29.12.2017. For better understanding of the provisions of the Bill and the intention behind introducing these provisions, a set of Frequently Asked Questions (FAQs) on the NMC Bill and their answers are being hosted on the website of the MoHFW.

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FAQs on NMC Bill

Q. **NMC will be a bureaucratic body.**
A. Not true. At least 16 members and upto 21 out of 25 members would be only senior medical doctors. The chairperson of NMC would have at least 20 years' medical experience, out of which at least 10 years would be as HoD or Head of Institution. Similarly, Presidents of the 4 autonomous boards would have at least 15 years' medial experience out of which 7 years would be in a leadership role.

Q. **Medical practitioners will be able to elect only 5 members in their own body.**
A. The DRPSC has recommended that 'keeping in mind the disastrous experience with an elected regulated body, the Committee is convinced that …….. regulators of the highest standards of professional integrity and excellence will have to be sought by the Government through a rigorous selection process' (Para 3.16). Although the Committee had recommended a purely selected body, the Government has provided for election of 5 (20%) members.

Q. **Why can't members of NMC be selected through UPSC?**
A. UPSC generally selects persons for government jobs at the induction level. Search-cum-Selection Committees are the norm for most high level appointments like members of TRAI, CERC, AICTE, UGC and even UPSC itself.

Q. There was no discussion with State Governments on NMC Bill.
A. Not True. The Committee under the chairmanship of VC, NITI solicited the views of the State Govts. on the reforms required in MCI in the 1st round in May, 2016. Thereafter, the draft NMC bill was circulated by NITI Aayog to all State Governments for their views in August 2016. States were also invited for another round of discussion and to express their views on the draft NMC Bill in September, 2016. The minutes of these meetings may be seen Here.

Q. **No experts were consulted during drafting of the Bill.**
A. NITI Aayog held nine meetings during which consultations took place with 14 experts out of which 10 were eminent doctors. The Committee under the chairmanship of VC, NITI sought views and suggestions of various experts including eminent physicians and surgeons; former Secretaries to the Government of India, Department of Health and Family Welfare; public health experts; President/Vice-President and other Members of the MCI; representatives of the State Governments; and lawyers. The draft NMC Bill was also placed on NITI's official website to seek views/opinion of General Public and experts. Also, a written request to experts was made to give their views on the draft bill. Around 14500 mails, were received from public, experts (including those who were invited by the Committee), private medical Universities, advocacy groups, MCI and State. In addition, written submissions were also received from experts. The minutes of these meetings may be seen Here.

Q. **Why has CEO NITI Aayog been included in the Search Committee?**
A. NITI Aayog is the highest body to advise the Government on policy matters including health and medical education and hence inclusion of the CEO will add value to the selection procedure.

Q. **There is nobody from outside the profession in the Bar Council of India and ISRO.**

A. The DRPSC has observed that 'a perspective has gained ground that self-regulation alone does not work because medical associations have fiercely protected their turf and any group consisting entirely of members from the same profession is unlikely to promote and protect public interest over and above their own self-interests and therefore check and balance mechanisms are required.' (Para 3.20). They have recommended 'opening Council membership to diverse stakeholders such as public health experts and social scientists, health economists, health NGOs with an established reputation, legal experts, quality assurance experts, patient advocacy groups, to name but a few' (Para 3.21). Prof Ranjit Roy Committee Report also recommended introduction of non medical members in NMC for increasing transparency especially in terms of ensuring that the rights of patients are heard and protected. Similar councils in developed world such as GMC, UK the counterpart of MCI, also comprises equal number of medical and non-medical members(lay members). In NMC, given the request of medicos at the draft/ consultation stage, only three non-medical experts have been added and the NMC would still be a body largely constituted of medical experts.

Q. **Power would be centralized in a few hands only.**

A. It was felt by the Committee that a large 108 member General Body as in the existing MCI is too unwieldy and is not conducive to good regulatory organization structure[a1] . Moreover, Most regulators like AICTE, UGC, TRAI, CERC, PNGRB, AERA etc. are small in size. Small body will be able to make decisions at a faster pace.

Q. **Three member autonomous boards are too small.**

A. The three autonomous boards would be assisted by experts, Secretariat and Advisory Committee(s) of Experts as may be constituted by the NMC. The size has been kept small to ensure quick functioning.

Q. **How will the boards be autonomous vis-a-vis NMC?**

A. Since the Presidents and members will be appointed directly by the Government, there will be a limit to the influence of NMC on the functioning of the Boards . Moreover, there is a clear segregation of powers of these four autonomous boards and it has been ensured that standard setting body will be different from those ensure compliance to the standards set.

NMC has two jurisdictions:(1) laying down regulations and policies guiding the boards in discharge of their duties. The Boards then get to decide autonomously individual cases in the light of the regulations laid down. (2) Exercise Appellate jurisdiction over the order of the Boards.

Q. **Full-time members will practically run NMC.**

A. All full-time/part-time members will have the same voting rights in NMC. The only real full-time members would be the Chairperson, Presidents of the four boards and Member Secretary.

Q. **The bill is pro-private medical colleges.**

A. Section 28(1) of the Bill states that no person shall establish a new medical college without obtaining prior permission of the MAR Board. There is no separate provision for private colleges and all the provisions apply uniformly to Government and private

medical colleges. Procedures have been simplified and outcome-based monitoring has been introduced to reduce the necessity of repeated inspections.

Q. **Free increase in number of seats and introduction of PG courses will affect quality of education.**
A. All increased seats would be inspected before recognition. Adherence to prescribed minimum standards would be maintained on the website of the College concerned with heavy penalties in the event of furnishing false information. Licentiate exam will ensure the quality of graduating students.

Q. **Why has a licentiate exam been introduced?**
A. This has been done on the basis of DRPSC recommendations (Para 6.12)

Q. **Can the licentiate exam be merged with common final year exam?**
A. No format for the licentiate exam has been prescribed in the Act. As an expert body the NMC will take a call on the format and design of NLE and frame regulations after appropriate consultation. It is possible for NMC to take a decision to merge the licentiate exam with common final year exam.

Q. **Licentiate exam should be replaced by a common final year exam.**
A. The DRPSC had noted the demand for a common final year exam instead of an exit exam (Para 5.32) but had finally recommended a common exit exam (Para 5.34)

Q. **What are the pros and cons of a common final year exam?**
A. The biggest advantage of a common final year exam is that students will have to appear for only one examination. However, there are several issues which will have to be considered by NMC before deciding to go for a common final year exam. These include:

- Knowledge of only 4 subjects would be tested to grant licence.
- Universities may not agree since their right to confer degrees would be subordinated to an exam conducted by NMC.
- Those who fail would have to stay behind in the concerned medical college, leading to issues of infrastructure and extra fees payment. They would not even become graduates in order to qualify for various recruitment examinations which are open to graduates.
- Students tend to repeat NEET-PG in order to improve their rank, so that they can get admission to PG courses in good colleges. Rank improvement will not be possible with a common final year exam.
- NMC would become party to all litigation related to local issues in Colleges. In the event of a stay order granted due to local reasons such as delayed session in a College, the entire licentiate exam will get affected.
- Foreign medical graduates who wish to practice in India would either have to be asked to rewrite the common final year exam or FMGE will have to be restored.

Q. **Will graduates of AIIMS, etc. be required to take the licentiate exam?**
A. This would not be required since the Institutes of National Importance have their own Act of Parliament and do not fall within the purview of NMC. However, if they wish to take up post-graduation in any medical college within the purview of NMC, then they would have to take the licentiate exam as it will be utilized for post-graduate admissions also.

Q. **Can the licentiate exam be repeated for rank improvement?**
A. Yes the exam can be repeated to improve rank for PG admissions.

Q. **NMC has very little representation of States.**
A. 3 members on rotational basis and 5 elected members would represent States. Thus 8 out of 25 members will be representing States.

Q. **There should be representation from AYUSH streams in NMC.**
A. NMC is primarily meant to regulate education and practice of modern medicine.

Q. **The Member Secretary should be appointed by NMC, not the Government.**
A. Even if Secretary is appointed by the NMC, prior approval of ACC would be required as per standing DOPT instructions. These instructions are invariably followed even in the appointment of Directors of AIIMS, and other Institutes of National Importance. It stands to reason that appointment of Member Secretary also should be through the same rigorous selection procedure as is followed for Chairperson NMC and Presidents of autonomous boards.

Q. **Retrenchment of existing MCI staff will cause hardship.**
A. Adequate compensation will be paid to all such employees as specified in Proviso 2, Section 58(3) of the Act. In view of the past legacy of MCI, it will not be advisable to take these employees into the NMC secretariat.

Q. **Why has a separate autonomous board been constituted as an accreditation body instead of relying on NAAC?**
A. NAAC accreditation is not mandatory. Moreover, accreditation of medical colleges needs to be done on specialised parameters rather than the general parameters used by NAAC. Medical Education (ME) is a specialized area which needs technical expertise for evaluation. AICTE is a separate accreditation body to regulate technical institutions. Similar kind of structure is required to accredit ME institutions.

Q. **There is no representation of SC/ST/OBC in NMC.**
A. There was no representation in MCI also. Other regulators such as AICTE, UGC CERC, TRAI, AERA etc. also do not have any such representation.

Q. **Medical research is a function of ICMR, not NMC.**
A. Section 10(1)(a) of the NMC Act empowers the NMC to 'lay down policies for regulating medical institutions, medical researches and medical professionals and make necessary regulations in this behalf' . The reference here is to medical research as is carried out in medical colleges as defined in Section 2(i). There is no intention to assume the role of ICMR.

Q. **Developing a roadmap for human resources in health and healthcare infrastructure is a function of the Health Ministry, not NMC.**
A. NMC's stand on utilizing medical professionals under the proviso of Section 33, increasing the number of medical seats in the country and designing courses under Section 49(4) has to be shaped by an assessment of the requirements of human resources for health and healthcare infrastructure. MCI did not take active interest in any such

planning for the future. The roadmap referred to in this subsection pertains to the future course of action to be adopted by NMC itself.

Q. **Will there be any change in the role of State Medical Councils?**
A. Under the MCI Act, State Medical Councils look after registration of medical practitioners and enforcement of professional ethics. They will continue to perform these roles. NMC Bill does not poach upon the role of State Medical Councils. It rather promotes the States to constitute State Medical Councils within three years of the commencement of this Act. (Clause 30(1)).

Q. **Fine upto 10 times the annual fees will give a handle for extortion by inspectors.**
A. At present penalties are not graded. It is binary; either recognition or de-recognition. This gives huge leeway to the assessors/inspectors of MCI to extract rent. A graded system of monetary penalties with de-recognition after 3 instances of continued violation and increasing fines are exhausted will actually be more corrective and less extractive than the current provisions of MCI Act . It is further specified in Section 26(1)(f) that the imposition of monetary penalty would be accordance with the regulations made for this purpose.

Q. **Penalty upto 10 times of the annual fee will be insignificant for Government Colleges.**
A. Any penalty on a Government College has to be paid through the consolidated fund. Irrespective of the total amount involved, such unnecessary penal expenditure would be scrutinized by auditors, finance departments and the legislature. Such inbuilt accountability will ensure that corrective action is taken by the concerned State government.

Q. **Why has a parallel PG degree in the form of DNB been retained?**
A. On account of its design, the DNB course allows post-graduate education in comparatively smaller towns which may not have medical colleges. This would help in improving the geographical location of PG seats. Moreover, there is a severe shortage of faculty for medical colleges. To meet the expanded demand for faculty, we need to recognize DNB as equivalent to specialist.

Q. **No steps have been proposed to encourage setting up of medical colleges in remote areas.**
A. Not true. NMC bill provides for relaxation of criteria for the medical colleges which are set up in underserved areas which would be specified in the regulations to the Act. (Proviso to Clause 29 (d)). Further, to address this issue, Government of India is running a scheme to set up 58 medical colleges in underserved areas. 24 more medical colleges are proposed to be taken up in the second phase. In order to enhance the availability of faculty, DNB qualification has been made completely equivalent to MD/MS in the NMC Act and adequate provisions have also been made to allow foreign faculty. The question of allowing equated designations to consultants has to be dealt in the regulations for qualifications of teachers by NMC.

Q. **Second appeal to Government is not proper since Government only would be deciding matters.**
A. All decisions would be taken by autonomous boards and first appeal shall lie to NMC. Government will have no role in decision making and will only serve as an appellate

body for individual cases. Judicial remedy would continue to be available after Government decides appeals.

Q. **Why has the provision for imprisonment of quacks been removed?**
A. Under the MCI act, the penalty for unregistered practitioners was imprisonment upto 1 year and/or fine upto Rs. 1000. This has been replaced by a fine between Rs. 1 lakh and 5 lakh. It may be noted that the incidence of imprisonment under the existing provisions is extremely low and monetary penalty should prove to be a more effective enforceable provision. Further, The Indian Penal Code provides for imprisonment of up to 2 years for death caused due to negligence. This Section 304A can be applied to medical professionals when there is gross negligence. The following sections of IPC 1860 contain the law for medical malpractice in India: 52, 80, 81, 83, 88, 90, 91, 92 304A, 337 and 338. Hence, the bill in consideration refrains from creating a new/additional law to deal with criminal misconduct of doctors. In any case, numerous litigations are pending and thus it has become difficult to enforce provisions.

Q. **Why has prior approval not been mandated for regulations to be made by NMC?**
A. The process of consultations has been made mandatory by specifying in Section 55(1) that regulations would be made only after previous publication. It is also specified that regulations must be consistent with the NMC Act and the rules made thereunder. With these stipulations, full autonomy has been granted to NMC to make regulations.

Q. **How will NMC ensure more accountability?**
A. Rigorous and independent selection of members through a transparent process will ensure greater accountability. The DRPSC felt that 'keeping in mind the disastrous experience with an elected regulatory body…… regulators of the highest standards of professional integrity and excellence have to be sought by the Government through a rigorous selection process'. (Para 3.16) Four Autonomous Boards have been suggested which are given autonomy to frame policies, standards, guidelines etc. These four Autonomous Boards will function under the NMC. There is clear segregation of powers of these four autonomous boards. Further, Central Govt. has power to give directions and supersede to Commission as well as Autonomous Boards.

Q. **Having one representative of each State in the MAC is unfair to States having a large number of doctors.**
A. Each State is represented in the MAC so that the benefit of the States' experiences on policy matters can be obtained and also State specific issues can be raised. The Vice chancellor of the health university or university having maximum number of medical colleges would represent the State. The intention is not to have representation of doctors in proportion to their strength in their State.

Q. **Doctors who fail the licentiate exam will be allowed to practice under the proviso to Section 33.**
A. The proviso to Section 33 is not meant to allow doctors failing the NLE to practice but is intended to allow medical professionals like nurse practitioners, dentists and possibly any shorter duration allopathy courses introduced by NMC in future.

Q. **Why have only 40% seats been regulated in terms of fees?**
A. There was no provision of regulation of fees in the IMC Act. Regulation of 40% seats is a step forward. The proportion of regulated seats has a direct impact on the fees

of remaining seats and a reasonable balance has to be struck so that the fees of unregulated seats do not become unviable.

Q. **Why can't a cap be proposed on the fees for all seats?**
A. The cost of setting up medical colleges varies from State to State and according to the quality of infrastructure created. Moreover in the case of PG seats, the fees varies widely between pre-and para-clinical subjects and highly sought after subjects on the other hand. Hence a uniform cap on the fees that can be charged would be difficult.

Q. **Regulation of fees of 40% seats would lead to regulation of SC/ST/OBC seats only.**
A. SC/ST/OBC quota in medical education is confined to Government/State quota seats only. Fees for all State quota seats would be fixed by State Governments, out of which fees of 40% seats could be fixed in accordance with NMC guidelines.

Q. **What is the proportion of seats for which fees is fixed by State Governments under the present dispensation?**
A. This varies from State to State according to the MoUs signed by private medical colleges. Generally 33-50% of seats in private medical colleges are designated as State quota seats. In most States fees of seats in deemed universities is not regulated by State Governments.

Q. **Why has a provision for bridge course for AYUSH been added in Section 49(4)?**
A. India has a doctor-population ratio of 1:1655 as compared with the WHO standards of 1:1000. In addition, city doctors are not willing to work in rural areas as can be seen in the Urban Rural ratio of doctor density (3.8:1) . There are 7,71,468 AYUSH practitioners in India who can be leveraged to improve the health access situation of the country.

There is already a policy for co-locating AYUSH and allopathy to ensure better utilization of resources. Further, with the government's ambitious target to revamp 1,50,000 Sub Health Centres into Health and Wellness Centres, there is a need of large human resource to meet this challenge. AYUSH has an effective role in integrating the preventive and promotive aspect of healthcare. In addition, with growing incidence of non-communicable diseases (NCD), there is a need to provide holistic prevention and treatment of diseases.

In many places around the world doctors are not taking care of the preventive and wellness aspect of healthcare. Countries such as Thailand, Mozambique, China, and New York have regularized community health workers/non-allopathic health providers into mainstream health services, with improved health outcomes. We also need to take such kind of steps when we have acute shortage of doctors and specialists.

The NMC bill seeks to fill in the gaps of availability of health care personnel by facilitating trained AYUSH practitioners to expand their skillsets through a Bridge Course and provide preventive and promotive allopathic care. The bridge course may help address this demand and better utilization of resources, and make the health sector a bigger provider of employment.The NMC Bill also promotes this through raising exposure of such NCD patients to non-allopathic practitioners in addition to allopathic doctors.

Thus, in order to homogenize and regulate the entry of AYUSH professionals towards practicing modern medicine through a strict regime, this bill has provided for the clause. Various States such as Maharashtra, Assam, UK, Haryana, Karnataka and

Uttar Pradesh etc. have already amended their Acts and permitted AYUSH professionals to practice modern systems and prescribe all modern medicines.

Any bridge course will be introduced only by a unanimous vote as provided in Section 49(4) and hence each one of the allopathic doctors in the NMC will have a veto power. Even if the bridge course is introduced, it will only be for prescribing specified medicines at specified levels. The provision is intended for prescribing a small number of medicines including OTC drugs at the Sub-Centre/PHC level.

Q. **Instead of a bridge course for AYUSH, the focus should have been on nurse practitioners and dentists.**
A. Nurse practitioners and dentists can be allowed under the proviso to Section 33, which is applicable to 'medical professionals'. It needs to be clarified that all professionals associated with modern medicine systems fall in this category and not only MBBS doctors.

Q. **What was the need to include a clause for prescription of allopathic medicine by suitably educated AYUSH doctors?**
As per Supreme Court rulings, AYUSH doctors cannot prescribe any allopathic medicine until there is a provision in the Act. In view of this an enabling provision is required in the Act.

Q. Bridge course would be unscientific and dangerous.
A. NMC will be dominated by allopathic doctors. If all of them unanimously approve a bridge course after due consideration, then there is no reason to assume that it will be unscientific and dangerous. The course would be designed in such a manner that it would enable the participants to prescribe a limited set of medicines in a responsible manner.

Q. **Would AYUSH doctors doing the bridge course be under dual control?**
A. Yes, control over their professional conduct would be exercised by the respective Councils /Commission depending on the medicine prescribed by them.
Q. What would be the fate of the integrated ayurvedic/allopathic course being run in Maharashtra?
A. This course was discontinued in the early 1980s.

Q. Enabling AYUSH practitioners to prescribe medicines in rural areas would relegate rural citizens to being second rate citizens.
A. Healthcare delivery works on a referral system so that it does not put an extra load to the secondary and tertiary care facilities. Many SCs and PHCs ie. Point of contact in rural areas are functioning without doctors. AYUSH practitioner may, if posted, can provide better care. It is expected that the quality of primary and preventive healthcare available to rural citizens would improve as a result of giving proper training to AYUSH doctors. This also needs to be viewed in the light of certain states having already permitted them to practice modern medicine.

Q. The provision of introducing a bridge course only on completely unanimous approval is too restrictive and will be difficult to operationalize.
A. Such a stringent condition has been incorporated in order to ensure that there is absolutely no doubt or misgiving about the course of action to be adopted.