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POSTGRADUATE EMERGENCY MEDICINE TRAINING IN INDIA: AN EDUCATIONAL PARTNERSHIP WITH THE PRIVATE SECTOR

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□ **Abstract—Background: Emergency medicine (EM) is a recently recognized specialty in India, still in its infancy. Local training programs are developing, but remain very limited. Private, for-profit hospitals are an important provider of graduate medical education (GME) in India, and are partnering with United States (US) universities in EM to expand training opportunities. Objective: Our aim was to describe current private-sector programs affiliated with a US university providing postgraduate EM training in India, the evolution and structure of these programs, and successes and challenges of program implementation. Discussion: Programs have been established in seven cities in India in partnership with a US academic institution. Full-time trainees have required didactics, clinical rotations, research, and annual examinations. Faculty members affiliated with the US institution visit each program monthly. Regular evaluations have informed program modifications, and a local faculty development program has been implemented. Currently, 240 trainees are enrolled in the EM postgraduate program, and 141 physicians have graduated. A pilot survey conducted in 2012 revealed that 93% of graduates are currently practicing EM, 82% of those in India; 71% are involved in teaching, and 32% in research. Further investigation into programmatic impacts is necessary. Challenges include issues of formal program recognition both in India and abroad. Conclusions: This unique partnership is playing a major early role in EM GME in India. Future steps include official program recognition, expanded numbers of training sites, and a gradual transition of training and education to local faculty. Similar partnership programs may be effective in other settings outside of India.** © 2015 Elsevier Inc.

□ **Keywords—international emergency medicine; India; curriculum; education and training**

INTRODUCTION

The global trend toward a changing burden of disease, with increasing death and disability due to cardiovascular disease, noncommunicable disease, and traumatic injury, has affected the nation of India in a particularly concentrated fashion (1,2). Trauma and noncommunicable diseases are responsible for more than two-thirds of the total morbidity burden and more than half of all deaths in India, with the death toll from these issues expected to rise to 60% of all deaths by 2015 (3). Injury alone is the second most common cause of death after 5 years of age in India (4). Traditional communicable diseases continue to cause a significant disease burden as well, and this shifting epidemiologic profile of disease has resulted in many challenges for the Indian health care system. The developing specialty practice of emergency and acute care has the potential to support the Indian health care system as it attempts to manage the burden of both communicable and noncommunicable disease with a growing trauma burden exacerbated by trends in urbanization and motorization. Effective emergency care systems have increasingly been shown to be a viable and cost-effective means of care delivery (5,6). Therefore,

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as the specialty development of emergency medicine (EM) continues to expand worldwide, it is proving to be an essential component of the health care system in the Indian context (7–10).

Although the number of countries recognizing EM as a specialty continues to rise, there remains a significant shortfall in the number of trained EM specialists in many countries around the world, including India. In India, EM was recognized as an independent specialty by the Medical Council of India in July 2009 (11). This was a tremendous achievement for emergency physicians in India, including those who had lobbied for many years in support of official specialty recognition. However, at this time, for a country of >1.3 billion people, government-sponsored EM training programs supported the training of only 48 emergency physicians each year, as compared to 2347 positions for general medicine physicians and 2124 for surgery in India (12). In comparison, the US currently has 167 residency programs in EM across the country, with 1643 people completing EM training or fellowship in 2013 (13). Given this substantial human resources for health shortfall within the specialty in India, various efforts throughout the country have worked to further development of EM and to increase the pool of specialty trained EM physicians (14,15). Nevertheless, there remains a significant gap in EM training and education.

To this end, several United States (US) academic institutions have been working during the past 6 years to develop postgraduate training programs in EM in partnership with private health care institutions in India. Training programs affiliated with our institution currently span six states, with on-the-ground training occurring at nine in-country partner institutions that are the host sites for the clinical and didactic elements of the specialty training in EM. The decision to partner with private health care institutions was made in part due to the intense interest and coincident philosophical and resource commitments demonstrated by the local partners. Simultaneously, a disinterest shown by government institutions to form international partnerships for the purpose of training and education in EM was present during this time.

The goal of this article is to describe one US university's partnership training programs, explain their development from a pedagogical perspective, and present the successes and challenges related to these programs. We suggest that these types of transnational private-sector partnerships represent a potential avenue for successful development of the specialty of EM and growth of high-quality training in acute care in a variety of other countries and regions through the development of successful educational partnerships for EM education and training.

DISCUSSION

Program Implementation

Using core concepts derived from Accreditation Council for Graduate Medical Education (ACGME)–approved EM residency training programs in the United States in combination with essential elements of postgraduate medical training in India, and the fundamental underpinnings of the Membership Examination of the College of Emergency Medicine (MCEM) for the United Kingdom, we have designed and implemented a 3-year training program in EM for postgraduate physicians in India. Physicians who have completed medical school and are Bachelor of Medicine, Bachelor of Surgery (MBBS) degree holders are eligible to apply for acceptance into the program. Our initial programs were started with a 2-year duration, but as EM specialty recognition was gained in India by the Medical Council of India in 2009, it became clear that a 3-year program was more appropriate as the standard minimum training period comparable with analogous postgraduate MD, MS, and Diplomate of National Board (DNB) programs in India (16). Individual sites have slightly different processes with regard to admissions, although each program routinely conducts in person written entrance examinations and interviews before acceptance into the program and adheres to a nondiscrimination policy. Program costs are financed via tuition payment by each trainee, and trainees are then given a monthly stipend payment by the hospital. This arrangement results in a fair and transparent fee structure at a small cost to the resident that is comparable to fees for postgraduate education in the government sector and is substantially lower than fees for private-sector postgraduate programs (17,18). Initial site identification was made through professional contacts, and the program has since expanded primarily through interested institutions contacting our university directly. Physicians from our institution visit each site on a monthly basis to provide onsite didactics, bedside teaching, and program oversight. At the conclusion of the program, graduates are awarded a certificate of completion of an "International Master's program in Emergency Medicine" (MEM, International) jointly from their host institution and own institution.

Core Knowledge Acquisition

A variety of mechanisms are being implemented through the program to assure adequate and ongoing knowledge acquisition.

- Curriculum: A 36-month modular curriculum (see Table 1) has been implemented based initially on the 2007 Model of Clinical Practice of Emergency