

The Auditability Crisis in Ayurveda Medical Education: Reconstructing IQAC as an Architecture of Evidence, Accountability and Academic Consequence

Dr. Ankit Kumar

¹Deputy Coordinator IQAC, Assistant Professor Kayachikitsa, National College of Ayurveda & Hospital, Hisar, Haryana 125121

Dr. Bharti Gahlawat

²Assistant Professor, Department of PTSR, Sanskriti Ayurvedic Medical College & Hospital, Sanskriti University, Mathura, Uttar Pradesh 281401

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ABSTRACT

Contemporary Ayurveda medical education now operates under intensified regulatory oversight, competency-based reform and accreditation-driven accountability. Yet, quality assurance in many institutions remains documentation-centric, where procedural compliance often replaces demonstrable educational effectiveness. This exposes a deeper governance failure: the institutional ability to record quality has outpaced the institutional ability to prove it. To conceptualize the auditability gap in Ayurveda medical education and develop a governance framework capable of transforming IQAC from a compliance-oriented administrative entity into an evidence-governance architecture. This conceptual framework paper synthesizes NCISM regulatory expectations, NAAC-IQAC quality assurance principles, higher education governance literature, medical education theory, quality-management systems, internal-control frameworks and audit principles to construct an integrated institutional governance model. The proposed **Evidence-Accountability-Consequence (EAC)**

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Model positions IQAC as the institutional nexus for evidence generation, verification, governance intelligence, accountability mapping, corrective intervention and quality-memory preservation. Sustainable excellence in Ayurveda medical education will not emerge from documentation density, inspection readiness or regulatory conformity alone; it will emerge from institutional systems capable of converting every quality claim into verifiable evidence, every evidence gaps into accountable action, and every corrective action into measurable academic consequence.

1. Introduction

Ayurveda medical education in India is situated within an expanding matrix of regulatory prescription, curricular restructuring, accreditation expectations, competency-oriented pedagogy and institutional quality assurance. The National Commission for Indian System of Medicine has formalised minimum standards for undergraduate Ayurveda education, placing curriculum delivery, assessment, attendance, institutional responsibility and educational process within a structured regulatory framework.^{1,2} National higher education policy emphasises quality, accountability, multidisciplinary orientation, institutional transformation and measurable educational outcomes as core features of credible educational governance.³ IQAC-related frameworks further require institutions to develop mechanisms for planning, monitoring, documentation, stakeholder feedback, academic review and continuous quality enhancement.^{4,5}

However, regulatory language does not automatically generate institutional quality. A medical institution may maintain records, committees, calendars, registers, minutes and inspection files without possessing a functional system capable of proving educational improvement. The issue is not whether Ayurveda institutions maintain documents, but whether those documents demonstrate academic improvement, clinical training effectiveness, faculty accountability, student progression, research culture and institutional responsiveness.

Quality assurance in professional medical education cannot be reduced to archival compliance. In health-professional education, quality is connected with clinical competence, patient-care responsibility, assessment integrity, faculty performance, student preparedness and public trust. Medical education quality has historically been analysed through structures, processes and outcomes, while contemporary health-professional education requires competency, workplace-based assessment, feedback systems and outcome-

linked review.⁶⁻¹¹ Therefore, Ayurveda institutions cannot rely only on infrastructure, attendance records or formal files as proof of educational quality.

This paper addresses the auditability gap: the distance between institutional quality claims and the ability to produce credible, traceable, verifiable and consequence-linked evidence. Many institutions can show that an activity occurred; fewer can prove that it was reviewed, corrected and converted into institutional learning.

This article argues that IQAC should not be a passive custodian of records. It must be reconstructed as an evidence-governance architecture through which claims become proof, proof becomes review, review becomes accountability and accountability becomes academic consequence.

2. Methodological Approach: Conceptual Policy Analysis and Governance Framework Development

This article is a conceptual governance framework paper. It does not present primary empirical data, survey findings or interventional outcomes. Instead, it develops an analytical governance argument through critical synthesis of regulatory, educational, quality-management and institutional-control literature. Its purpose is not to measure any single Ayurveda institution, but to construct a transferable framework through which IQAC can be repositioned as an auditable internal quality-governance mechanism.

The methodological approach may be described as conceptual policy analysis with framework development, appropriate for clarifying institutional concepts, examining gaps between policy intent and institutional practice, and proposing a structured governance model.

The analysis draws upon five domains. First, it examines Ayurveda medical education regulatory expectations, particularly undergraduate education standards, curricular structuring and institutional obligations under NCISM-linked frameworks.^{1,2} Second, it analyses IQAC and quality-assurance principles articulated in UGC and NAAC guidance, where internal quality systems are expected to facilitate planning, monitoring, quality assurance and quality enhancement rather than remain record-maintenance structures.^{4,5} Third, it incorporates academic governance principles related to outcome-based education, constructive alignment, competency assessment and workplace-based learning.⁷⁻¹¹ Fourth, it integrates quality-management and audit concepts such as traceability, corrective action, management-system auditing, internal control, evidence verification and continuous improvement.¹²⁻¹⁷ Fifth, it interprets the pedagogical and clinical complexity of Ayurveda education, where quality includes textual competence, clinical reasoning, OPD/IPD exposure, procedural training, research orientation, documentation discipline and ethical patient-care learning.^{1,2}

On this synthesis, the paper identifies the auditability gap as the central governance defect in documentation-heavy quality systems and proposes the Evidence-Accountability-Consequence Model as a conceptual framework for Ayurveda IQAC. The model is not presented as a statistically validated instrument, but as a governance architecture that can be operationalised, piloted and evaluated.

3. Conceptual Clarification: Auditability, Compliance and Quality Governance

A rigorous discussion of IQAC in Ayurveda medical education requires conceptual precision. Terms such as quality, compliance, evidence, accountability and audit are frequently used in institutional discourse, but often without operational clarity. This ambiguity allows institutions to confuse documents with quality and procedural fulfilment with educational improvement.

In this article, auditability is treated as a governance condition rather than a clerical attribute. It refers to the capacity of an institution to produce credible, traceable, verifiable and outcome-linked evidence. In audit and quality-management language, records are meaningful only when they establish continuity, authenticity, responsibility and reviewability.^{12,14,15} Internal control frameworks similarly emphasise that governance systems must not merely produce information but ensure reliability, accountability, risk recognition, corrective action and oversight.^{16,17}

Compliance refers to fulfilment of prescribed regulatory, procedural or documentary requirements. It is necessary but insufficient. An institution may comply with documentation expectations and still fail to demonstrate whether those documents produced academic improvement. Compliance asks whether a requirement was fulfilled; quality governance asks whether fulfilment produced institutional learning, correction and sustainable improvement.

Cosmetic compliance describes documentation without measurable institutional change. Evidence architecture refers to a structured system of records, indicators, reviews, responsibility matrices, action-taken reports and follow-up mechanisms through which institutional claims become auditable. Accountability means defined responsibility for performance, gap correction and follow-up. Academic consequence means institutional action following evidence-based review, including corrective planning, faculty development, departmental intervention, student support, policy revision, recognition, escalation or restructuring.

Table 3.1 The operational meanings used in this paper.

Concept	Operational Meaning in This Article	Governance Implication
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Auditability	Capacity of an institution to generate credible, traceable, verifiable and outcome-linked evidence	Converts institutional claims into examinable proof
Compliance	Fulfilment of regulatory, procedural or documentary requirements	Establishes minimum procedural conformity
Cosmetic Compliance	Documentation without measurable institutional change	Creates appearance of quality without quality behaviour
Evidence Architecture	Structured system of records, indicators, reviews and action reports	Organises documents into decision-support evidence
Accountability	Defined responsibility for performance, gap correction and follow-up	Prevents evidence from becoming passive archival storage
Academic Consequence	Institutional action that follows evidence-based review	Converts quality review into correction, improvement or policy change

This conceptual clarification is essential because the proposed framework does not reject documentation; it rejects documentation without evidentiary integrity, review discipline, responsibility fixation and corrective consequence. In an auditable Ayurveda institution, every major quality claim must be supported by a traceable evidence chain, every chain must be reviewed, every review must identify responsibility, and every responsibility must lead to demonstrable academic action.

4. The Compliance-Auditability Gap in Ayurveda Medical Education

The compliance-auditability gap refers to the distance between formal records and their capacity to prove measurable quality improvement. In Ayurveda medical education, this gap is consequential because institutions must not only fulfil regulatory and documentary obligations, but also demonstrate structured academic instruction, clinical exposure, procedural training, assessment, feedback, mentorship and research orientation.^{1,2,5}

Compliance confirms that a requirement has been addressed. Auditability confirms whether the claim can be verified through credible, traceable and outcome-linked evidence. The distinction is governance-related: a compliant institution may possess files, but an auditable institution possesses evidence chains capable of proving educational value, clinical competence, institutional learning and corrective improvement.¹²⁻¹⁷

4.1 Documentation Without Verifiability

Documentation is indispensable, but documentation without verifiability remains administratively fragile. A record may show that a lecture was scheduled, a meeting conducted, a clinical posting completed or feedback collected. Unless supported by attendance, execution evidence, review notes, performance indicators, follow-up action and outcome analysis, it remains weak institutional proof.

In an auditable system, documents must satisfy four governance tests: authenticity, traceability, continuity and outcome relevance. Authenticity verifies genuineness; traceability links the record to a person, department, date, decision or action; continuity confirms sustained process; and outcome relevance verifies educational, clinical, administrative or research improvement. ISO-based management systems and internal audit principles similarly emphasise documented information, process control, audit evidence, corrective action and continual improvement over mere record preservation.¹²⁻¹⁴

Thus, the question is not whether a document exists, but whether it can survive scrutiny. In legal-governance terms, a document that cannot establish responsibility, process and consequence is not evidence; it is an administrative artefact.

4.2 Review Without Corrective Action

Institutional review becomes meaningful only when it produces correction. Many institutions conduct meetings, prepare minutes and circulate decisions, but the evidentiary loop ends at recording. The absence of structured follow-up transforms review into ritual.

A serious quality system requires a decision trail: issue identified, evidence examined, responsible unit fixed, corrective measure defined, timeline assigned, implementation verified and outcome reviewed. Without this trail, meetings become descriptive rather than corrective. Quality management frameworks consistently emphasise planned action, monitoring, corrective measures and continual improvement as core institutional performance requirements.^{12, 15, 16}

In Ayurveda medical education, this appears when academic audit observations, student feedback, departmental concerns or clinical training gaps are recorded but not converted into Action Taken Reports. The institution appears active, yet the defect remains untreated. Review without corrective action is not quality assurance; it is quality narration.

4.3 Feedback Without Institutional Learning

Student, faculty, patient, alumni and stakeholder feedback are often treated as documentary requirements rather than institutional intelligence. Unless analysed, prioritised, reviewed and translated into policy or corrective action, feedback remains an unused dataset.

In a governance-oriented IQAC system, feedback should function as an institutional diagnostic tool, identifying recurring academic weaknesses, teaching gaps, clinical exposure deficiencies, infrastructure barriers, communication issues, mentorship failures and student-support needs. Its value lies not in collection but in conversion into institutional learning.

The compliance-auditability gap emerges when feedback records exist without evidence of analysis, decision-making, departmental response, corrective action or post-intervention review. In such cases, feedback becomes performative: it proves that the institution asked questions, not that it listened, understood or changed. The absence of feedback-to-action linkage weakens academic responsiveness and stakeholder accountability.^{4, 5, 7, 8}

4.4 Clinical Exposure Without Competence Mapping

Ayurveda medical education cannot be evaluated only through OPD/IPD attendance, hospital footfall or posting completion. Clinical exposure is necessary but not equivalent to clinical competence. A student may be present in a clinical unit without developing diagnostic reasoning, case-taking discipline, therapeutic judgement, procedural understanding or patient communication.

Competence-oriented medical education requires assessment of what learners can perform in authentic or simulated clinical contexts. Miller's framework, workplace-based assessment, Mini-CEX and OSCE-type methods show that educational quality must move from passive exposure to observable performance.^{9-11, 18} Clinical training in Ayurveda should therefore be measured not merely by posting completion, but by whether learning was structured, supervised, documented and assessed.

The auditability gap appears when institutions maintain OPD/IPD numbers but do not convert them into student-level clinical learning indicators. High patient load may support institutional exposure, but it does not prove student participation in case-taking, Roga-Rogi Pariksha, Dosha-Dushya analysis, treatment planning, Panchakarma observation, follow-up documentation or supervised clinical reasoning. Clinical exposure becomes auditable only when mapped to competence.

4.5 Committee Formation Without Governance Output

Higher education institutions frequently establish curriculum, research, feedback, anti-ragging, academic audit, mentorship, examination, clinical governance and IQAC subcommittees. Their existence may satisfy structural compliance, but it does not automatically establish governance effectiveness.

A committee becomes a governance instrument only when it produces measurable output: policy formulation, gap analysis, risk identification, corrective action, monitoring reports, student-support interventions, faculty-development plans, research facilitation, clinical training review or institutional improvement. Without such output, committee formation becomes symbolic compliance.

From an internal-control perspective, governance bodies must define authority, responsibility, reporting lines, review mechanisms and corrective action pathways.^{16,17} A committee without defined deliverables, timelines, documentation discipline and review consequence is not a quality mechanism; it is an administrative enclosure.

The compliance-auditability gap is not caused by absence of records alone. It is caused by absence of evidentiary discipline between records, decisions, actions and outcomes. Ayurveda institutions must move from “Was the requirement fulfilled?” to “What did it produce, who reviewed it, what changed and how was improvement verified?”

5. Discipline-Specific Quality Requirements in Ayurveda Medical Education

Ayurveda medical education is not a simple classroom-instruction model. It is a layered professional formation process involving textual learning, clinical reasoning, diagnostic discrimination, patient-care exposure, procedural training, pharmacy-related understanding, research orientation, integrative awareness and ethical conduct.^{1,2} This complexity requires quality-assurance systems sensitive to the epistemic and clinical structure of Ayurveda, not merely borrowed from generic higher education templates.

A student of Ayurveda is expected to understand classical source texts, interpret foundational concepts, develop Roga-Rogi Pariksha-based reasoning, apply Dosha-Dushya and Samprapti logic, observe OPD/IPD care, understand Panchakarma and procedural therapeutics, engage with Dravyaguna and Rasashastra-Bhaishajya principles, correlate modern diagnostics appropriately, document cases and acquire research literacy. Such education cannot be measured adequately through attendance, infrastructure, lecture hours or examination results alone.

Table 5.1 The discipline-specific quality requirements of Ayurveda education

Quality Domain	Ayurveda-Specific Indicators	Auditability Requirement
Textual Competence	Samhita understanding, Sutra interpretation, classical concept mapping	Textual discussion records, seminar evidence, concept-based assignments
Clinical Reasoning	Roga-Rogi Pariksha, Dosha-Dushya analysis, Agni, Srotas, Samprapti, Yukti	Case sheets, clinical reasoning templates, bedside discussion records
Procedural Training	Panchakarma exposure, procedural observation, indication-contraindication understanding	Skill logs, procedure-observation records, DOPS-type documentation
Patient-Care Learning	OPD/IPD participation, case documentation, follow-up, communication	Student-wise clinical exposure records, Mini-CEX-style assessment
Research Orientation	Protocol writing, data collection, ethics, publication, IPR awareness	Research activity records, proposal logs, manuscript/IPR tracking
Integrative Competence	Modern diagnostic correlation without epistemic dilution	Diagnostic correlation records, case-based integrative discussions
Ethical Conduct	Patient communication, confidentiality, institutional responsibility	Mentorship records, professionalism assessment, patient-care feedback

This table demonstrates why a normal IQAC framework, if applied mechanically, may fail to capture the actual educational burden of Ayurveda. A generic quality form may ask whether clinical postings were conducted. A discipline-sensitive quality system must ask whether students acquired case-taking competence, classical diagnostic reasoning, supervised therapeutic judgement and procedural understanding. A generic academic audit may ask whether lectures were completed. An Ayurveda-specific audit must examine whether Samhita-based interpretation, clinical applicability and concept-to-case translation were achieved.

The quality of Ayurveda education, therefore, exists at the intersection of textual fidelity, clinical applicability, procedural exposure, research discipline and professional ethics. If IQAC does not measure these domains, it may produce institutional documentation without capturing institutional quality.

This also has implications for patient care and public trust. A graduate who has attended classes but has not developed clinical reasoning remains educationally underprepared. A student who has observed OPD but

has not learned how to interpret a case through Ayurveda principles remains clinically incomplete. A department that records patient numbers but does not convert them into learning indicators fails to transform hospital activity into medical education.

Ayurveda institutions must therefore develop evidence systems that are not only regulatory-compliant but discipline-intelligent. The purpose of internal quality assurance should be to convert Ayurveda's complex educational expectations into measurable, reviewable and correctable institutional processes.

6. Repositioning IQAC: From Documentation Custodian to Evidence-Governance Architecture

The Internal Quality Assurance Cell must be repositioned from a documentation custodian to an evidence-governance architecture. In its strongest institutional form, IQAC should not merely collect files from departments, compile reports for accreditation, maintain meeting records or coordinate inspection preparedness. It should function as the internal mechanism through which institutional quality claims are captured, verified, reviewed, corrected and converted into academic consequence.

UGC and NAAC-linked IQAC frameworks already position IQAC as a mechanism for planning, guiding, monitoring and improving institutional quality.^{4,5} However, in practice, the operational reduction of IQAC to documentation management weakens its governance potential. The proposed reframing does not discard documentation; it subordinates documentation to evidence, evidence to review, review to accountability and accountability to consequence.

Table 6.1 In this framework, IQAC should perform seven core governance functions.

IQAC Function	Governance Meaning	Expected Institutional Output
Evidence Capture Mechanism	Structured collection of academic, clinical, research and administrative data	Department-wise evidence repositories
Internal Academic Audit Mechanism	Periodic review of teaching, assessment, clinical training and student support	Internal academic audit reports
Performance Verification Mechanism	Testing whether institutional claims match actual evidence	Verified quality indicators
Gap-Identification Mechanism	Detection of deficiencies in academic, clinical and administrative processes	Gap analysis reports
Corrective Action	Tracking whether identified deficiencies are	Action Taken Reports with

Monitoring Mechanism	corrected	follow-up evidence
Institutional Memory System	Preservation of review cycles, decisions, actions and improvements	Quality archive and dashboard
Accountability and Consequence Mechanism	Linking evidence-based findings to responsible units and institutional decisions	Responsibility matrix and consequence review

This repositioning transforms IQAC into the institutional quality brain: it enables the institution to sense dysfunction, interpret evidence, coordinate correction and preserve learning. Without it, departments may produce isolated documents, but the institution will not develop quality intelligence.

As an evidence-capture mechanism, IQAC should standardise evidence requirements for academic and clinical units. As an internal audit mechanism, it should examine whether teaching plans, assessments, clinical exposure, feedback, mentoring and research activity function as intended. As a performance-verification and gap-identification mechanism, it should test whether institutional claims are supported by records, indicators and outcomes, while distinguishing between absence of activity, weak documentation, poor execution and lack of measurable impact.

As a corrective action and accountability mechanism, IQAC should ensure that deficiencies do not disappear into meeting minutes. Every gap must be linked with a corrective plan, responsible authority, timeline and follow-up verification. As an institutional memory system, it should preserve each quality cycle so that recurring deficiencies are not rediscovered annually.

The central shift is clear: IQAC must stop functioning as a passive archive and begin functioning as an active architecture of institutional judgement. Its legitimacy should be measured not by the volume of files it maintains, but by the evidence it verifies, the gaps it exposes, the responsibility it fixes and the improvements it compels.

7. The Evidence-Accountability-Consequence Model for Ayurveda IQAC

On the basis of the preceding analysis, this paper proposes the Evidence-Accountability-Consequence Model as a conceptual governance framework for repositioning IQAC in Ayurveda medical education. The model rests on an institutionally demanding premise: quality assurance becomes meaningful only when claims are converted into evidence, evidence is verified, deficiencies are mapped to responsible units, corrective action is initiated and improvement is reviewed through consequence. This sequence draws from

quality-management systems, internal audit logic, educational governance and medical education assessment theory.^{12-17, 20-22}

The EAC Model is not another documentation format. It is an internal control architecture designed to prevent quality assurance from collapsing into passive record maintenance. In this model, IQAC functions as the central mechanism for evidence capture, verification, gap diagnosis, responsibility fixation, corrective action and institutional learning.

Table 7.1: Step wise EAC Model for IQAC Summarised

Step	Governance Function	Output
Evidence Capture	Collect structured academic, clinical and administrative data	Department-wise evidence repository
Evidence Verification	Check authenticity, completeness and traceability	Verified quality records
Gap Identification	Compare claim with evidence	Gap analysis report
Accountability Mapping	Fix responsible unit/person/committee	Responsibility matrix
Corrective Action	Define action, timeline and authority	Corrective action plan
Consequence Review	Review whether action improved performance	Review outcome report
Quality Memory	Preserve learning for next cycle	Institutional quality archive

The first step, Evidence Capture, requires each department, clinical unit and committee to maintain structured evidence, including lesson plans, assessment records, clinical postings, OPD/IPD-based student exposure, skill logs, feedback, mentoring records, research output, faculty-development data and review minutes. The purpose is not file accumulation, but department-wise evidence repositories for institutional decisions.

The second step, Evidence Verification, examines whether records are authentic, complete, traceable and relevant to institutional claims. Verification prevents fabricated, retrospective or non-functional documentation from entering the quality system. In an auditable institution, evidence must answer who created it, when, what activity it represents, whether it occurred as claimed and whether it relates to a measurable educational or clinical objective.^{14, 17}

The third step, Gap Identification, compares claims with evidence. Claims of student-centred learning, clinical competence, research culture or mentorship must be tested against records. Gap identification may reveal absence of records, incomplete implementation, poor review, weak outcome linkage or lack of follow-up.

The fourth step, Accountability Mapping, assigns responsibility to the relevant department, committee, faculty member, clinical unit or authority. Without responsibility fixation, gap analysis remains descriptive. Accountability converts institutional deficiency into a governance matter.

The fifth step, Corrective Action, requires an action plan with authority, timeline, expected output and review mechanism. The sixth, Consequence Review, examines whether action produced measurable institutional change. The final step, Quality Memory, preserves cycle learning so recurring deficiencies are not rediscovered annually.

The EAC Model transforms IQAC from a passive documentation body into an active academic governance mechanism. It converts quality assurance from file production into institutional judgement.

8. Discussion: From Inspection Readiness to Institutional Self-Regulation

Ayurveda institutions must move from inspection readiness to institutional self-regulation. Inspection readiness is episodic, externally triggered and documentation-heavy. Institutional self-regulation is continuous, internally governed and evidence-driven.

IQAC fails when reduced to documentation because documentation alone lacks corrective intelligence. A file can preserve activity, but it cannot interpret deficiency, assign responsibility or enforce improvement. When IQAC stores departmental records, its function becomes clerical. When it interrogates records, verifies meaning, identifies gaps and compels corrective action, it becomes governance. This aligns with quality-management principles, where continual improvement requires measurement, review, correction and leadership responsibility rather than mere documentation. ^{12, 13, 15}

Auditability is essential for institutional maturity because it determines whether an institution can defend quality claims under scrutiny. Mature institutions rely on evidence systems, demonstrating how teaching is planned, clinical exposure structured, students assessed, feedback analysed, weak areas corrected and institutional memory preserved. This is critical in medical education, where quality affects competence, patient safety, public trust and professional legitimacy. ^{6, 9, 10, 18}

Ayurveda requires internal quality intelligence because its educational complexity is not reducible to generic higher education metrics. A generic framework may identify classrooms, teachers, examinations and hospital facilities. An Ayurveda-sensitive system must examine textual competence, Roga-Rogi Pariksha-based reasoning, Panchakarma procedural understanding, classical-to-clinical interpretation, case documentation, integrative diagnostic awareness and ethical patient interaction. ^{1,2} the institution must translate discipline-specific educational expectations into auditable indicators.

Evidence without accountability becomes archival. Many institutions collect documents, but no one is structurally responsible for interpretation. When evidence is not mapped to decision-making authority, it becomes storage. Accountability without consequence becomes symbolic; a deficiency may be acknowledged but remain untreated.

The EAC Model addresses this by establishing a sequential governance pathway: evidence, verification, diagnosis, responsibility fixation, corrective action, consequence review and quality memory. It introduces the missing governance chain between institutional record and institutional change.

The model also protects institutions from cosmetic compliance. If quality assurance is judged only by document availability, institutions may produce records without improving performance. If judged by verified evidence, accountable correction and measurable consequence, institutions are compelled to develop genuine quality behaviour. The EAC Model therefore shifts IQAC from compliance management to institutional self-regulation.

This shift requires Ayurveda institutions to accept that quality is not what is declared in files, but what can be continuously proven, reviewed and improved. IQAC must become the internal jurisdiction where educational claims are tested, deficiencies documented, responsibility assigned and institutional behaviour corrected.

9. Institutional and Managerial Implications

The proposed EAC Model has practical implications for institutional governance, academic administration, clinical training, faculty development, student support, accreditation preparedness and legal-administrative safety. Its implementation requires Ayurveda institutions to move from fragmented documentation to integrated dashboards, from informal review to structured audit cycles.

Table 9.1 Proposed EAC Model has practical implications for institutional governance

Area	Practical Implication
Academic Governance	Department-wise outcome dashboards
Clinical Training	Competency-linked clinical exposure records
Faculty Development	FDP linked with performance gaps
Student Support	Longitudinal academic tracking
Institutional Management	Corrective action review meetings
Accreditation Preparedness	Continuous evidence generation instead of last-minute file preparation
Legal/Administrative Safety	Traceable documentary integrity and responsibility fixation

In academic governance, the model requires department-wise outcome dashboards showing planned teaching, completed teaching, assessment performance, remedial action, student progression and academic gaps. This converts departmental functioning from narrative reporting into measurable review.

In clinical training, OPD/IPD exposure must be linked with student competence indicators. Patient numbers alone cannot establish clinical learning. Institutions should maintain student-wise case exposure, bedside learning records, Mini-CEX-style assessments, DOPS-type procedural observation, OSCE/OSPE documentation and clinical feedback. ^{9-11,18,19}

In faculty development, FDPs and CMEs should not remain isolated participation events. They must be linked with identified pedagogical or clinical training gaps and evaluated beyond attendance, extending toward learning, behaviour and results. ²³

In student support, the model requires longitudinal academic tracking of slow learners, advanced learners, attendance-risk students, clinically underexposed students and research-oriented students. This converts student support from episodic intervention into developmental governance.

In institutional management, periodic corrective action review meetings should examine evidence, approve action, assign responsibility, define deadlines and review closure status. This aligns with internal control and audit principles where oversight, responsibility, corrective action and follow-up are core governance requirements. ^{16,17}

In accreditation preparedness, the EAC Model reduces last-minute file preparation by enabling continuous evidence generation. Accreditation then becomes a by-product of institutional discipline rather than an emergency documentation exercise. Traceable documentary integrity and responsibility fixation also protect the institution from vague claims, retrospective reconstruction and non-verifiable compliance.

10. Recommendations for Building an Auditable IQAC System in Ayurveda Institutions

For Ayurveda institutions seeking to develop an auditable IQAC system, the following recommendations are proposed:

1. Develop department-wise evidence dashboards covering teaching plans, course outcomes, assessment, clinical exposure, student support, faculty development, research activity and corrective actions.
2. Convert OPD/IPD data into teaching indicators such as case participation, bedside discussion, follow-up documentation, clinical reasoning exercises and supervised patient-care exposure.
3. Conduct periodic internal academic audits of teaching delivery, assessment quality, clinical training, feedback systems, mentorship, research activity and departmental documentation.
4. Make Action Taken Reports mandatory after every review, feedback analysis, academic audit and committee observation.
5. Create accountability matrices so deficiencies are mapped to departments, committees, faculty units or administrative authorities.
6. Link faculty appraisal with teaching innovation, clinical training, mentoring, research output, documentation discipline and quality-system contribution.
7. Track student progression longitudinally across academic terms, clinical postings, assessments, attendance, mentorship and skill-based evaluations.
8. Integrate Mini-CEX, DOPS and OSCE/OSPE-style assessments to move beyond attendance-based clinical exposure.^{9-11,18,19}
9. Conduct quarterly IQAC governance reviews covering dashboards, pending corrective actions, departmental gaps, clinical indicators, research output and student-support interventions.
10. Maintain a quality memory archive preserving gaps identified, actions taken, outcomes achieved, unresolved issues and lessons for the next cycle.

These recommendations require leadership commitment, departmental participation, faculty cooperation, data discipline and periodic review. The objective is not to increase paperwork, but institutional intelligence.

11. Limitations of the Conceptual Framework

This paper is conceptual and does not present primary empirical data. The proposed EAC Model requires field testing across Ayurveda institutions to assess feasibility, acceptability, administrative burden, implementation barriers and measurable impact on academic and clinical quality indicators.

The framework also requires operational refinement. Specific tools, dashboards, checklists, audit templates, evidence-scoring systems and responsibility matrices must be developed and validated. Institutional diversity may influence applicability because government, private, postgraduate, undergraduate, urban, rural, hospital-rich and resource-limited institutions differ in administrative capacity, faculty availability, patient load, digital infrastructure and quality culture.

The model further assumes leadership commitment and departmental cooperation. Where IQAC is structurally weak, politically marginalised or deprived of administrative authority, implementation may remain superficial. Future research should pilot the EAC Model across multiple Ayurveda institutions and evaluate its effect on audit readiness, documentation integrity, clinical training indicators, faculty accountability, student progression and internal quality culture.

12. Conclusion

Ayurveda medical education does not require ornamental quality structures; it requires auditable institutional governance. The contemporary challenge is not only to maintain records, but to prove whether those records reflect authentic academic functioning, structured clinical training, meaningful assessment, faculty responsibility, student progression and institutional improvement.

IQAC must be reconstructed from a documentation cell into an evidence-governance architecture. Its purpose should be to convert institutional claims into verifiable evidence, evidence into review, review into accountability and accountability into academic consequence. Without this chain, quality assurance remains vulnerable to cosmetic compliance, inspection-driven documentation and administrative theatre.

The Evidence-Accountability-Consequence Model offers a conceptual pathway for this reconstruction. It positions IQAC as an internal control mechanism for evidence capture, verification, gap identification, responsibility fixation, corrective action, consequence review and quality memory. The future credibility of

Ayurveda institutions will depend not on the volume of records they produce, but on their capacity to transform quality from a claim into a verifiable, reviewable and correctable institutional reality.

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