REFLECTIONS

The unacknowledged cadre: hurdles for MBBS graduates in Kerala's medical landscape

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Abstract

This personal narrative discusses challenges faced by MBBS graduates in Kerala's public healthcare system. Based on observations as a government medical officer, this essay examines a culture where professional skills and humane values are often overshadowed by a system that prioritises postgraduate degrees above all else. It questions the fairness of a structure that sidelines clinicians without higher qualifications, even when they are capable and dedicated. MBBS graduates often suffer a lack of decision-making power and are frequently excluded from institutional leadership and recognition. They are treated as a secondary group, becoming invisible, undervalued, and disempowered. The narrative draws comparisons with historical instances of institutional oppression and shows how extra-clinical talents are often ignored in favour of strict hierarchies. This essay advocates for a change toward a more inclusive and fair system where one's abilities and contributions are not judged solely by the number of degrees held.

Keywords: *medical hierarchy, credentialism, junior doctor disillusionment, hierarchical culture*

The professional journey of a basic medical graduate in Kerala often commences with a disheartening reality: the diminished value of an MBBS degree as perceived within the clinical hierarchy. This systemic undervaluing, as observed by this author during a tenure in the Department of Medicine at a central public healthcare facility in Kerala, represents a troubling trend. This trend formed a part of the author's MBA dissertation, "Attrition of Junior Doctors", and frequently leads to feelings of disillusionment among young medical professionals.

Many consultants treat an MBBS degree as if it holds little more weight than a high school matriculation certificate. This dismissive attitude often leaves basic medical graduates feeling not just undervalued but also professionally dispossessed, disrespected, and defeated.

The erosion of autonomy and professional respect

One prominent feature of this hierarchical environment is the widespread lack of independence for MBBS graduates. Despite their ability to manage patient wards independently, they remain under the constant supervision of postgraduate-qualified consultants. This lack of autonomy can be frustrating and limiting, as the quality of their work and mental well-being often depend on the subjective judgement of these supervising consultants.

Professional boundaries extend to basic clinical tasks. The notion of an independent Outpatient Department (OPD) for MBBS graduates, regardless of their clinical judgment or ability to interact with patients, is institutionally prohibited. While this structure claims to ensure supervision, it can sometimes reduce efficiency and continuity of care.

Credentialism over competence: a flawed metric

A troubling aspect of this system is its preference for an extra degree over proven knowledge, skills, and dedication. Ethical behaviour or fundamental human values do not appear necessary to be considered a "good doctor" in this setting; possessing a postgraduate qualification often suffices to grant authority. The overemphasised focus on "credentials" can possibly overshadow equally vital aspects such as ethics and empathy in such settings.

The clinical decisions made by an MBBS graduate are frequently changed by consultants, often without a solid medical reason. There are many cases where well-considered medication orders are modified without consultation, only to be reverted to days later. This highlights a power imbalance driven by hierarchy rather than best practices. Such arbitrary authority, even in basic patient management, undermines confidence and growth. The message is clear: an additional degree gives the holder unquestionable power to judge and dictate, regardless of their actual skills.

A passage from Dr Shashi Tharoor's *The Era of Darkness* [1] comes to mind, where Sir Syed Ahmed Khan discusses the difficult choices for Indians under colonial rule — either to relinquish their self-respect and be tolerated, or to assert it and face isolation. While very different in context, the psychological similarity stands out. In a system that values compliance over independent thought, many MBBS doctors face the same dilemma: silent submission or dignified exclusion. This metaphor, although not perfect, illustrates the invisible burden carried by those labelled as second-tier, based not on merit but on the lack of a higher credential.

The unit system: a tradition due for review

The unit system in public hospitals is a significant barrier to creating a collaborative and fair environment. The structure tends to centralise authority with senior doctors, which can unintentionally limit the initiative of junior practitioners. While individual practitioners are ultimately responsible for patient care, the unit system requires notification and, in

most cases, consultation with unit heads for critical decisions, such as Intensive Care Unit (ICU) admissions, regardless of their involvement or clinical interest in the case. This traditional structure can, at times, stifle initiative and lead to centralised decision-making — often without a logical reason — rather than distributing tasks based on competence and immediate needs. Changing or significantly reforming this system could address many issues seen among medical professionals.

The marginalisation of diverse talents

Beyond their clinical roles, MBBS graduates are often excluded from essential hospital meetings that involve scheduling and operational planning. These meetings are usually meant for postgraduate-qualified doctors, regardless of their ability to manage or communicate effectively. This exclusion reinforces a narrow view of "ability" in medicine, linking it only to postgraduate credentials.

Moreover, the system often ignores diverse skills that go beyond clinical work. Whether it is proficiency in language, communication, administration, or abilities in unrelated fields like technology or the arts, these talents are frequently overlooked by senior medical professionals. This limited perspective, which only values postgraduate medical degrees, leads to a clear underutilisation of valuable skills. It becomes particularly ironic when those with strong communication skills are passed over in favour of less articulate postgraduate doctors for roles like giving Continuing Medical Education (CME) lectures. This reflects a disconnect between formal qualifications and real capability.

It is hard not to observe the unspoken satisfaction some feel when an MBBS graduate who tries to take charge or gain respect from patients is publicly diminished. Their discomfort seems more about protocol and less about professional standards within a rigid hierarchy.

A call for paradigm shift and mutual respect

The current system fosters an environment where pragmatic thought processes are a luxury, and ego often supersedes logical discourse. Any critique, such as this, is usually perceived as a personal diatribe, risking professional isolation rather than encouraging meaningful dialogue or change. This defensiveness likely arises from a reluctance to give up the power earned through years spent acquiring postgraduate degrees.

However, it is essential to clarify that this critique is not intended to undermine the arduous efforts required to obtain a postgraduate degree. It is a genuine push for a broader acknowledgement of value. The time has come for the medical profession to overhaul its appraisal and leadership structures. A postgraduate qualification should be just one among several key criteria in a robust appraisal system that truly reflects a doctor's contribution.

The profession must champion an evolution towards merit-based leadership, where patient satisfaction, demonstrated leadership acumen, and superior "man management" skills are valued. Only those exhibiting genuine proficiency in these critical areas, rather than simply possessing an additional degree, should be entrusted with the vital responsibility of heading clinical units. Similarly, the platform of CME should be reserved for individuals who can articulate effectively, regardless of their academic distinctions. The ability to convey information, rather than merely accumulating degrees, should determine who represents the profession and shares knowledge.

The system must evolve not only to recognise but actively support and promote MBBS graduates with communication and management skills. This fundamental shift will cultivate an environment where actual skill and competence are acknowledged and rewarded, offering a strong incentive for all practitioners. It will send an unequivocal message that the mere possession of an extra degree is insufficient for professional ascent; demonstrated excellence in diverse, critical skills is equally, if not more, vital. Re-examining traditional structures through participatory dialogue could help create a more inclusive professional culture that values both qualification and demonstrated competence.

This conversation is long overdue and crucial for building a fairer, more effective, and humane medical system in Kerala. The future of healthcare demands nothing less.

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