LETTER

Not numbers alone: Response to editorial "Medical education in India: disturbing trends"

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Building on the insightful Editorial by Olinda Timms and Sanjay Pai in the *Indian Journal of Medical Ethics* (October -December, 2025) [1], we wish to highlight a critical gap in India's medical education and workforce planning. Their article rightly underscores the ethical and systemic challenges facing medical training in India. As medical education faculty, with experience in India and overseas including the United Kingdom, and as medical skills trainers in rural settings, their concern — that expanding the number of medical graduates alone is insufficient — particularly resonates with us. The real challenge lies in ensuring the competence of our medical graduates, especially in rural and underserved regions where lack of access to healthcare is most acute.

This concern extends beyond the mere number of doctors to their readiness to manage emergencies and deliver independent care in challenging settings. Incentives such as educational and healthcare support for doctors and their families may make rural postings more attractive to practitioners [2]. However, lasting improvement in healthcare delivery in rural India ultimately depends on an undergraduate and internship training framework that equips medical graduates with the confidence, clinical competence, and contextual understanding required to practise effectively in resource-limited rural settings.

Despite completing internship, many new graduates lack confidence in managing patients independently. Their exposure to emergency care, evidence-based clinical practice and procedural skills remains limited compared to global standards [3]. In several Western systems, a national exit examination ensures uniform quality, and medical graduates are not allowed to practise independently without at least three years of supervised postgraduate training, including general practice [4,5]. In India, by contrast, during internship, graduates particularly in private medical colleges — spend a disproportionate amount of their time on documentation tasks with little hands-on clinical experience [6]. The introduction of competency-based medical education is a step forward, but it remains insufficient to equip our medical graduates for the realities of independent clinical practice. The inability of many interns to provide basic life-sustaining care even to their peers in emergency situations, is a stark reminder of these shortcomings. Producing large numbers of doctors alone will not improve health outcomes if they are unable to stabilise patients in a critical condition until referral or transfer to a higher centre — an all-too-common challenge in rural India.

If mandatory postgraduate general practice training, as practised in many countries, is not feasible in our context, internship programmes should, at the very least, incorporate compulsory modules on life-sustaining and preventive emergency care. The current focus on cardiac arrest management through basic life support courses, though valuable, addresses only a small area of emergencies. A more comprehensive approach is needed — one that equips interns to recognise early warning signs, intervene promptly, and prevent deterioration before a cardiac arrest or other critical event occurs. This shift in focus is essential for two reasons. First, global evidence indicates that survival and meaningful neurological recovery after both in-hospital and out-of-hospital cardiac arrest remains dismally poor [7]. Second, most public spaces in India lack access to automated external defibrillators, further limiting the effectiveness of cardiac arrest management in real-world settings. Training programmes such as the ALERT (Acute Life-Threatening Events: Recognition and Treatment) course, developed at Queen Alexandra Hospital, Portsmouth, NHS UK, demonstrate how early detection and intervention can significantly reduce preventable cardiac arrests. Skill based, interprofessional courses such as ALERT, which train doctors, nurses, and paramedical personnel together to recognise and manage common life-threatening emergencies, could serve as an effective and adaptable model for India [8].

The growing urgency among young doctors to secure postgraduate and super-specialty seats at the earliest opportunity often undermines the development of a strong foundational competence in medicine. This relentless struggle for credentials erodes the essence of medical education as a gradual, experience-based process [9]. There is a vital role for well-trained general practitioners without specialisation and they merit recognition within the National Medical Commission framework through formalised mechanisms for training, and continuous professional development. If AYUSH practitioners are to be included in the broader healthcare pool, they too should receive structured skills training in recognising and managing life threatening emergencies, while continuing to practise within their respective systems.

Equally concerning is the growing incidence of physician burnout and premature health decline, highlighting the need to examine whether medical training and work culture themselves foster chronic stress. The rise in violence against doctors reflects a deeper erosion of trust in the doctor–patient relationship [10]. The independent, self-regulating body of the medical profession, rooted in science and ethics, must remain dedicated to public trust and societal well-being.

India's healthcare needs will not be met by numbers alone but by competence, preparedness and confidence at every level of care. Building a cadre of doctors and allied practitioners capable of stabilising patients and preventing avoidable deaths in resource-limited settings must become our shared national priority.

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References

1. Timms OP, Sanjay A. Medical education in India: disturbing trends. *Indian J Med Ethics.* 2025;10(4) NS:261. https://doi.org/10.20529/IJME.2025.072
2. Banerjee B. Innovative strategies in medical education for addressing gaps in health-care service in rural India. *MAMC J Med Sci.* 2022;8(1):11–17. https://doi.org/10.4103/mamcjms.mamcjms_119_21
3. George SA. Addressing India's healthcare worker shortage: evaluating strategies to improve medical education and retention. *Partners Univ Int Res J (PUIRJ).* 2023;2(3). https://doi.org/10.5281/zenodo.8370878
4. Choules TC. *UK Foundation Programme Curriculum*. London: General Medical Council; 2021[Cited 2025 Dec 10]. Available from: https://www.gmc-uk.org/cdn/documents/fp-curr-oct22-v7_pdf-101343583.pdf
5. Federation of State Medical Boards. *USMLE Overview.* [Cited 2025 Dec 10]. Available from: https://www.usmle.org/
6. Bandhu HC, Bandhu SD, Raje S, Singh GP. A Study of Self-Perceived Competence of Medical Interns in India. *South Asian Res J App Med Sci.*. 2020 Jul-Aug;2(4):37-43. https://doi.org/10.36346/sarjams.2020.v02i04.001
7. Kiguchi T, Okubo M, Nishiyama C, Soar J, Nolan JP, Iwami T et al. Out-of-hospital cardiac arrest across the World: First report from the International Liaison Committee on Resuscitation (ILCOR). *Resuscitation.*152, 39 – 49. https://doi.org/10.1016/j.resuscitation.2020.02.044
8. Smith G. *ALERT®.* Portsmouth Hospitals NHS Trust. [Cited 2025 Dec 10]. Available from: https://www.porthosp.nhs.uk/departments-and-services/alert-r?utm_source
9. Hamid MA, Younis Z, Mir S, Raza A, Shrivastava N, Raj R. Postgraduate medical training in India: inadequacies and challenges faced by young medical graduates. *Cureus.* 2025 Oct 7;17(10): e94053. https://doi.org/10.7759/cureus.94053
10. Pandey SK, Sharma V. Sudden and early death among medical professionals: how to reverse this trend? *Indian J Ophthalmol.* 2023 May;71(5):2286–7. https://doi.org/10.4103/IJO.IJO_3229_22