

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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Editorial bias, nepotism, and the “club culture” in Indian medical journals

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We are compelled to address a persistent and troubling issue in Indian medical publishing: the widespread favouritism in editorial decisions. Many Indian journals, rather than serving as impartial scientific platforms, frequently operate in ways that benefit their editorial board members and close associates [1]. As a result, well-researched manuscripts from those outside these circles often encounter unexplained desk rejections or prolonged delays, while submissions from close associates are expedited for publication [2].

This “club culture” is no longer a secret among the research community. Budding young and mid-career faculty are quietly advised that unless they “know someone on the board,” the odds of acceptance are thin. The unfavourable result is not just the demoralisation of sincere contributors but also the corrosion of the scientific integrity that journals are supposed to be upholding. The compromised credibility of peer review does harm to the reputation of the Indian research community as a whole [1,2].

When editorial board members repeatedly publish in their own journals without transparent external review, it creates a glaring conflict of interest—a practice that continues largely unchecked. While international standards provide clear guidelines to prevent such exploitation, some Indian journals still function as echo chambers where a handful of individuals dominate published content, stifling true diversity of perspective [3].

Nepotism in publication is not a trivial administrative flaw but an ethical failing. It shuts the door for deserving researchers, often from less privileged or upcoming institutions, for disseminating their work. Making things worse, it degrades the quality of our medical evidence-based research, since subjective editorial preferences, rather than scientific merit, dictate what reaches print. Such practices also explain why high-quality Indian research is increasingly published in international journals, leaving local publications struggling for visibility and impact [4].

Reform in publication standards is overdue for the restoration of trust. Measures are needed like enforcing double-blind peer review as the default for all submissions and an explicit policy that reviewers with conflicts of interest must recuse themselves, especially for submissions from editors. There should be independent handling editors when board members submit articles. There should be a robust review system, where reviewers’ comments are published alongside published papers, and when a manuscript is rejected, the reviewers’ comments are shared with the