LETTER

The ethical drift in medical education: Prioritising post graduate entrance preparation over professional competence

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There is an emerging and deeply concerning shift in the culture of undergraduate medical education in India, with many MBBS students increasingly prioritising their preparation for postgraduate (PG) entrance examinations, such as the National Eligibility cum Entrance Test for Postgraduate (NEET-PG) and Institute of National Importance Combined Entrance Test (INI-CET), over conventional academic learning and bedside clinical exposure. This sometimes begins from the very first year of training. The rapid expansion of commercial, technology-driven coaching platforms has amplified this trend. While such platforms have facilitated access to learning resources and support exam preparation, their disproportionate influence on student priorities raises significant ethical questions regarding the purpose and integrity of undergraduate medical education.

The MBBS programme is often perceived less as a formative phase to develop into competent and ethical physicians, and more as a mandatory gateway to secure a PG seat [1]. Consequently, study time is largely spent on practising MCQs and memorising facts that are frequently disconnected from a clinical context or patient care. This paradigm shift is further reinforced by peer influence, seniors, and the prevailing coaching culture, leading students to believe that success in PG entrance examinations can be achieved with minimal engagement in medical college teaching or meaningful clinical learning.

The ethical implications of the above shift are multi-layered. A significant number of students attend clinical postings passively or irregularly, engage minimally in patient care, and show declining interest in formative assessments, physical examination skills, and ethical or communication competencies. The resulting competence gap risks producing graduates who may perform well on MCQs but lack essential clinical reasoning, empathy, and accountability, attributes critical to safe, patient-centred medical practice. This is both an academic issue and a public health concern.

The commercialisation of medical education also raises issues of equity and fairness. High-cost coaching platforms create a parallel, profit-driven educational system, accessible primarily to those who can afford it. Students increasingly equate financial investment in coaching with future career prospects. Such commodification of learning risks deepening socioeconomic divides and distorting the merit-based ethos of medical training. Medical education, traditionally grounded in apprenticeship-based learning, mentorship, and service orientation, is being reshaped by market forces that prioritise competitive exam outcomes over ethical and competent practice.

Systemic factors contribute significantly to this trend. The current PG entrance examination pattern places an overwhelming emphasis on factual recall and MCQ-based testing, inadvertently incentivising superficial learning. There is limited alignment between the competencies expected of an Indian Medical Graduate, as outlined in the Competency-Based Medical Education (CBME) curriculum and the assessment format of PG entrance tests [2]. Students thus perceive undergraduate training as misaligned with "what matters" for their future careers. This misalignment not only demotivates engagement in professional values and patient care but also creates a hidden curriculum that promotes competition over collaboration, individual success over collective welfare, and exam scores over ethical practice.

From an ethical standpoint, reform is urgently needed at multiple levels. Medical colleges must foster learning environments where bedside teaching, reflective practice, professionalism, and value-based mentorship are prioritised and protected. Faculty must be equipped and incentivised to counteract the coaching-centred narrative, by making undergraduate learning relevant, clinically integrated, and intellectually stimulating.

Assessment frameworks for PG entrance must evolve beyond memory-based MCQs towards formats that test applied knowledge, clinical reasoning, communication, and professional behaviour, competencies aligned with societal expectations from physicians [3]. Such changes can shift the culture from exam-oriented learning to ethical, patient-oriented learning and practical clinical exposure. The inability of MCQ-based assessments to meaningfully capture psychomotor skills and affective domain competencies remains a serious limitation. Regulatory and accreditation bodies need to critically examine the growing influence of coaching-driven training on the integrity of medical education and align PG entrance assessment frameworks with the competencies outlined in the Graduate Medical Education Regulations, so that students remain motivated to achieve holistic professional competence.

Technology-enabled learning resources have undeniable value, but unchecked commercialisation risks eroding the foundational ethos of medical education due to misuse and overdependence.

The MBBS programme should not be reduced to a mere "hall ticket" to postgraduate training but should remain a comprehensive professional programme aimed at developing competent, ethical, and socially responsive physicians with sound clinical judgement, empathy, and readiness for both independent practice and future specialisation. Reclaiming this ethos requires collective

commitment and moral courage, from educators, regulators, students, and society.

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Where does "integration" end and "mixopathy" begin? Ayurvedic surgery and beyond…

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The Andhra Pradesh Health Minister recently announced [1] that Ayurveda postgraduates trained in surgical studies would be allowed by the state government to practise 58 surgical procedures independently. But what exactly does the term "independently" refer to, and why do accusations of "mixopathy" arise so frequently against Ayurveda practitioners?

In 2020, the Central Council for Indian Medicine (CCIM) introduced an amendment to the Post-graduate Ayurveda Education Regulations of 2016, with the stipulation that "during the period of study, postgraduate scholars of Shalya (surgery) and Shalakya (ophthalmology and ENT)…be practically trained…to independently perform (certain procedures such that) after completion of (their) degree, (they become able) to perform (those) procedures independently" [2]. In particular, it lists 39 sets of procedures for Shalya Tantra postgraduates, and 19 sets of procedures for Shalakya Tantra postgraduates.

However, the amendment does not elaborate on what such "independent" practice might actually entail. For instance:

a) Does this amendment nullify the requirement for biomedical surgeons in the Shalya and Shalakya disciplines for postgraduate training (as such posts could, in the future, be occupied by Shalya and Shalakya postgraduates themselves)?

b) Would it become possible to assimilate, even partially, Shalya and Shalakya postgraduates into biomedical surgery clinics and hospital setups?

c) Would the Shalya and Shalakya postgraduates be licensed to conduct these procedures within their own clinics/hospital set ups, with no legal fallout?

The last is undoubtedly the most pressing question of the three, and the focus of much of the criticism directed at the amendment. Many experts believe that it is impossible for Shalya and Shalakya postgraduates to develop, within three short years of training, sufficient biomedical expertise required to conduct the surgeries listed, without potentially endangering the lives of patients visiting such surgeons [3].

However, why the issue of "mixopathy" arises so frequently in the case of Ayurveda must be examined within broader contexts extending well beyond the domain of surgery. The first pertains to the content and structure of the Ayurvedic (BAMS) course itself. Ayurveda collegiate courses as they stand today are, by their very nature, "integrative". For instance, undergraduate Ayurveda students are taught portions of several biomedical subjects including anatomy, physiology, surgery, and gynaecology, alongside curated Ayurvedic understandings of these [4]. In outpatient departments, students become familiar with the process of issuing diagnoses and making therapeutic recommendations only after laboratory, radiological, or clinical investigations have been done. While this is undoubtedly to provide Ayurveda students the important ability to become conversant with increasingly biomedicalised healthcare frameworks and healthseeker expectations, it also offers them, perhaps unintentionally, incomplete biomedical "tools" to "think with", and "think through", in their encounters with patients. While the ethics of such a hybrid pedagogy can be further examined from several lenses, perhaps the most important one pertains to the realities of grassroots practice in smaller towns and villages.

Many students, during their rotatory internship, join local hospitals as night-duty doctors, considering it a way of earning while studying. However, such posts are available for Ayurveda students, only because biomedical doctors do not consider it a worthwhile posting. Further, even while studying, a large number of students train in the evenings with biomedical practitioners, to pick up skills and techniques required to run a biomedical setup, as many go on to either practise in "hybrid" (Ayurveda cum biomedical),