

LETTER

Increasing medical colleges without quality training: a growing concern

SYED SAHIL AMAN

India's healthcare ambitions have led to a historic rise in the number of medical colleges and MBBS seats, expanding from 387 colleges in 2013–14 to over 808 in 2025–26, according to the Press Information Bureau [1]. While this expansion aims to correct the doctor-to-population imbalance, it has unintentionally created new challenges that threaten the quality of medical training.

The rapid creation of institutions has outpaced the growth of qualified faculty and teaching infrastructure. Reports indicate that nearly one-third of faculty positions remain vacant, especially in newer or rural colleges [2]. The National Medical Commission (NMC) has relaxed faculty recruitment norms and promotion criteria to fill these gaps, but experts warn this may dilute the rigor of undergraduate training. A *BMJ* commentary recently raised similar concerns, noting that easing qualifications to meet seat targets risks undermining both clinical supervision and ethical practice [3].

Students in some newly established colleges report limited clinical exposure due to low patient inflow and inadequate facilities. The emphasis on meeting inspection requirements, rather than nurturing competency-based learning, creates a system where degrees multiply, but skill acquisition lags behind [4]. This imbalance could worsen healthcare inequities if newly qualified graduates are insufficiently prepared to serve India's complex clinical realities.

Expansion is necessary, but sustainability demands a parallel focus on quality assurance and mentorship [5]. Strengthening faculty development programmes, enforcing transparent infrastructure audits, and establishing a national mentorship network for new colleges could ensure that growth does not compromise standards. Policies that prioritise numbers alone risk producing doctors without adequate bedside confidence, an outcome that would defeat the very purpose of expanding medical education.

India's future doctors deserve not just a seat, but a system that teaches them to heal with competence, ethics, and empathy. Growth must go hand-in-hand with quality, if we are to build a healthcare system worthy of our ambition.

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Diagnostic and laboratory referrals: Balancing clinical judgement, ethics, and patient autonomy

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The practice of classical medicine is grounded in the integration of the best available scientific evidence, clinical expertise, and patient values. While this triad defines evidence-based medicine, a less obvious yet highly consequential aspect of contemporary care is the physician's preference for specific diagnostic laboratories, imaging centres, radiology specialists, or referral institutions for advanced management. This issue merits careful ethical scrutiny, as it encompasses both legitimate clinical judgement and potential conflicts of interest [1].

In routine clinical practice, physicians often develop preferences for certain laboratories, imaging centres, or radiologists based on accumulated experience with technical quality, analytical and reporting accuracy, expertise, and diagnostic concordance with clinical, surgical, or pathological findings. Such preferences are not inherently unethical. They may even enhance diagnostic precision, reduce pre-analytical and analytical errors, improve disease tracking through consistent reporting standards, and facilitate timely clinical decision-making. Recommending a laboratory known for stringent quality control or an imaging centre with robust protocols and subspecialty competence can thus be viewed as an extension of responsible professional judgement.

However, ethical concerns arise when such preferences are

influenced by non-clinical considerations, including financial inducements, or institutional pressures. The insistence on repeat laboratory investigations or imaging solely because testing was performed elsewhere, or the rejection of valid reports from accredited centres without scientific justification, undermine both patient autonomy and professional integrity. In resource-constrained settings such as India, such practices also impose unnecessary financial and logistical burdens on patients, worsening inequities in access to care and denying justice [2].

The referral of patients to specific specialists or tertiary care centres raises parallel ethical issues. They may be grounded in demonstrable clinical outcomes, procedural expertise, infrastructure availability, and multidisciplinary capacity. Yet commission-driven or monopolistic referral networks distort clinical objectivity and erode public trust in the medical profession. The subtle normalisation of such practice risks placing individual or institutional financial interests above patient welfare.

An ethical middle ground is feasible and necessary. Physicians may appropriately recommend specific laboratories or diagnostic facilities, or specialists based on transparent, clinically justifiable criteria listed above. At the same time, patients must retain the right to choose their diagnostic provider and referral destination. Reports from accredited facilities should be assessed on merit rather than origin, and when diagnostic uncertainty exists, second opinions, or laboratory result verification should be preferred over automatic repetition [3].

Transparency is central to this balance. A clinician might ethically explain, "For this condition, I usually trust this laboratory or imaging centre because their standards and reporting accuracy are consistently high; however, you are free to choose any accredited facility." This preserves patient autonomy while allowing the physician to exercise informed professional judgement. This approach aligns with the foundational ethical principles of respect for autonomy, beneficence, and justice [2].

Regulatory frameworks in India explicitly prohibit fee splitting, referral commissions, and financial inducements from diagnostic laboratories, imaging centres, or hospitals. The National Medical Commission's ethics regulations underscore that professional decisions must be guided solely by patient interest and scientific considerations. Compliance with these standards is not merely a legal obligation but a moral imperative to safeguard the credibility of clinical decision-making and public trust in the profession [4].

Importantly, the solution to unethical referral practices cannot be reduced to individual moral rectitude alone. Systemic reforms are equally necessary. These include transparent disclosure of referral relationships, institutional policies that prohibit inducements, routine audit of referral patterns, accreditation-linked acceptance of laboratory and imaging reports, and regular patient education regarding their right to

choose diagnostic and referral providers. Professional bodies and academic institutions must play a proactive role in reinforcing ethical norms and fostering a culture of accountability.

In conclusion, physician preferences in diagnostic laboratory, imaging, and referral practices are not intrinsically unethical when rooted in clinical quality and patient welfare. They become problematic when driven by financial or institutional interests that compromise transparency and autonomy. A balanced approach — anchored in merit-based assessment, open communication, respect for patient choice, and strict adherence to ethical regulations — offers a pragmatic pathway to reconcile clinical judgement with ethical responsibility.

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From solidarity to isolation: Why do doctors distance themselves from colleagues accused of an offence?

SADANANDA BOLAR NAIK

A doctor in Madhya Pradesh was arrested when several children died, after consuming a toxin-contaminated cough syrup he had prescribed. The Indian Medical Association condemned the arrest, stating that the prescribing doctor