The "catch-all" intern: An ethical issue in Indian teaching hospitals

JUWAYRIYA SADIQ, SHEIKH MOHAMMED FAISAL TURAB

Introduction

Medical internship is intended to be a supervised period of clinical training, exposure to the hospital setting and learning efficient patient care. However, in many Indian teaching hospitals, interns increasingly function as a "catch-all" workforce, informally assuming a wide range of responsibilities.

Observations and systemic issues

MBBS interns in Indian teaching hospitals are often involved in tasks other than their clinical duties, such as coordinating patient transport, including arranging gurneys — due to limited availability of dedicated support staff — and even themselves transporting patients between hospital blocks. Clinical and administrative processes are frequently delayed while awaiting transport, interrupting workflow and reducing time available for supervised clinical learning. Interns are also commonly involved in discharge coordination. While preparing discharge summaries and providing medical counselling are expected duties, interns are frequently required to ensure completion of non-clinical prerequisites for discharge. These include following up and physically collecting missing laboratory reports, coordinating between wards and diagnostic services, and facilitating administrative clearances. Often, patient discharge is delayed with multiple responsibilities falling on interns. In several instances, interns are required to assist patients and families with financial processes, including bill clearance prior to discharge and making sure their insurance is approved. These responsibilities are administrative in nature and fall outside the intended scope of medical internship. Their assignment to interns reflects gaps in administrative staffing rather than training objectives, and places interns in ethically challenging situations involving financial mediation and delayed patient discharge. Staffing constraints contribute significantly to this role diffusion.

In many hospitals, there is also a shortage of nursing professionals [1]. Vital signs monitoring, bedside care, and 24-hour clinical observation are core nursing duties and are also valuable learning experiences for interns under supervision. The concern is not that interns have to participate in these duties; but that interns perform them along with the work of multiple other categories like transport, clerical, and administrative staff, all of which are understaffed. This cumulative burden, not any single task, is what compromises training and patient care.

Discussion and analysis

This situation has various ethical implications. Over-reliance on any single profession to address systemic gaps risks workforce fatigue, diminished morale and compromised quality of care. Exhaustion from all of these tasks diminishes the trainees' ability to engage in ward rounds conducted by consultants and learning opportunities, thereby missing out on the fundamentals of medicine.

Globally, effective hospital systems emphasise adequate staffing across cadres and digitised documentation systems to minimise manual workflows [2]. Continued reliance on paper-based records in many Indian teaching hospitals necessitates physical transport of charts and reports further compounding delays and inefficiencies.

Recommendations and reforms

Addressing these concerns requires system level reforms. Key measures include: electronic medical record implementation, digitisation of patient records, lab results and vital signs to reduce manual workload, strengthening the nursing workforce, assigning sufficient clerical and administrative staff for the appropriate duties and ensuring that internship training for doctors remains aligned with educational competencies expected to be achieved by the end of internship.

Conclusion

Protecting the educational purpose of internship and ensuring efficient patient care and safety are not competing goals but aligned necessities. These reforms safeguard the patients and enhance the educational experience of medical trainees, aligning Indian hospitals with global standards of safe and ethical care.

Authors: **Juwayriya Sadiq** (corresponding author — juwayriyasadiq@gmail.com, https://orcid.org/0009-0006-9641-1569),MBBS graduate, Rajarajeswari Medical College and Hospital, Kambipura, Bengaluru, Karnataka 560074, INDIA; **Sheikh Mohammed Faisal Turab** (tsmfaisal26@gmail.com,https://orcid.org/0009-0006-2352-1097), MBBS graduate, Rajarajeswari Medical College and Hospital, Kambipura, Bengaluru, Karnataka 560074, INDIA.

Conflict of Interest: None declared **Funding:** None

To cite: Sadiq J, Turab SMF. The "catch-all" intern: An ethical issue in Indian teaching hospitals. *Indian J Med Ethics.* 2026 Oct-Dec; 11(4) NS: 339. DOI: 10.20529/IJME.2026.022

Submission received: December 27, 2025

Submission accepted: February 19, 2026

Published online first: April 10, 2026

Copyright and license

©*Indian Journal of Medical Ethics* 2026: Open Access and Distributed under the Creative Commons license (CC BY-NC-ND 4.0), which permits only non-commercial and non-modified sharing in any medium, provided the original author(s) and source are credited.

References

1. Thakur C, Sood N. Nursing Shortage in India: Are There Solutions for Policymakers? *Indian Journal of Continuing Nursing Education.* 2024 Jul-Dec;25(2):85-91. https://doi.org/10.4103/ijcn.ijcn_36_23
2. Kumari R, Chander S. Improving healthcare quality by unifying the American electronic medical report system: time for change. *Egypt Heart J.* 2024 Mar 15;76(1):32. https://doi.org/10.1186/s43044-024-00463-9

Lay persons are not "lay" in Ethics Committees: Why the term merits ethical reconsideration

ABHIJIT PODDAR, SR RAO

A recent Policy Paper from the American College of Physicians (ACP) has argued that essential medical terminology in the health sector carries significant ethical importance [1]. By noting that using "provider" to describe "physicians" diminishes the profession and causes confusion in patient care, the authors delivered a highly relevant and timely message for medical ethics: words do not merely describe reality; they help shape it.

In line with the position taken by the ACP, the same argument applies to the term "lay person" used within human ethics committees (EC), as "lay person" frames public contributors in terms of deficiency — defined mainly by what they are not, rather than what they contribute. The problem is the framing itself, which labels individuals as "lay" and positions them as epistemically subordinate to professionals. The consequences of a "lesser" status could be ethically troubling, undermining the very essence of equitable participation. This includes reduced perceived authority within committees, potential erosion of public trust, and the reinforcement of professional dominance in ethical decision-making [2].

In the EC, lay persons bring an external, independent viewpoint, which is vital for maintaining public trust and protecting participants [3]. They are not a monolithic group. Instead, they could be retired professionals from non-scientific fields, patient advocates with lived experience, community leaders, or individuals with a profound understanding of local cultural nuances.

Interestingly, the use of the term "lay person" is not universal. In the USA, Institutional Review Boards, which oversee human ethics, do not use the term "lay person". Instead, federal regulations (45 CFR 46 and 21 CFR 56) opt for more inclusive choices, requiring a "non-scientist" and an "unaffiliated member" on the committee [4]. Often, one individual can fill both these roles.

In sharp contrast, the UK's Health Research Authority, with its well-developed Research Ethics Committees, explicitly uses "lay members" [5]. They even categorise them as "lay" and "lay-plus members". The former are not registered healthcare professionals and do not have a primary professional interest in clinical research. The latter, "lay-plus members", have never worked in healthcare or research and have never been part of a health service body.

These linguistic differences between two prominent Western civilisations prompt us to wonder how they have remained distinct in expression and to what extent the term "lay person" is rooted across nations. The Declaration of Helsinki (1964, revised 1975) and the Belmont Report (USA, 1979), which influenced the US Common Rule (45 CFR 46), did not explicitly use the term lay person despite solidifying the requirement for non-professional involvement in US ethics committees.

In contrast, the UK not only used the term "laypersons" but also definitively contributed to the transmission of the word to other nations through their significant colonial roots. As former British-occupied nations gained independence, many adopted or adapted legal and ethical frameworks that mirrored the British model. Consequently, we see direct and explicit mandates for "lay persons" in ECs across countries like India (ICMR guidelines), Australia (NHMRC HRECs), South Africa (NDoH guidelines), Kenya (NACOSTI), and New Zealand (HRCA) [6–8].

We therefore argue that moving beyond "lay person" is not just a semantic issue but an ethical imperative. Here, the concerns about inclusivity are not the main issue; rather, they are downstream effects of a deeper epistemic mischaracterisation. We believe that more precise and positively framed terms would better acknowledge their diversity and the specific perspectives in ECs. There are wise options like "community representative", "public member", or "non-medical member" that reflect a more empowering and inclusive environment. However, to make such a change, it is critical to reconsider inherited administrative traditions and move past professional feelings of superiority. Rather than continuing with those that feel normal, it is time to make ethics committees inclusive and align them with contemporary ethical norms by giving up the term "lay person".

Authors: Abhijit Poddar (corresponding author — abhijit2talk@gmail.com, https://orcid.org/0000-0002-6775-1090), Associate Professor (Visiting), Department of Science Policy and Technology, School of Language and Literature/ Humanities, Nalanda University, Rajgir, Bihar, INDIA; Associate Professor, Centre for Bio-Policy Research (CBPR), Mahatma Gandhi Advanced Research Institute (MGMARI), Sri Balaji Vidyapeeth (Deemed-to-be-University), Pondicherry, INDIA; **SR Rao** (raghudbt@gmail.com, https://orcid.org/0000-0002-4267-974X), Founder and Director, Genentech Regulatory Solutions LLP, Hyderabad, INDIA.

Conflict of Interest: None declared **Funding:** None

Acknowledgments: After preparation of the first draft of the manuscript, we used Gemini AI to improve grammar, readability and language choices. After using this tool/service, we reviewed and edited the content as needed and take full responsibility for the final content of the publication.

To cite: Poddar A, Rao SR. Lay persons are not "lay" in Ethics Committees: Why the term merits ethical reconsideration. *Indian J Med Ethics.* 2026 Oct-Dec; 11(4) NS: 340-341. DOI: 10.20529/IJME.2026.047

Submission received: March 14, 2026

Submission accepted: June 10, 2026

Published online first on August 7, 2026

Manuscript Editor: Vijayaprasad Gopichandran

Copyright and license

©*Indian Journal of Medical Ethics* 2026: Open Access and Distributed under the Creative Commons license (CC BY-NC-ND 4.0), which permits only non-commercial and non-modified sharing in any medium, provided the original author(s) and source are credited.

References

1. Snyder Sulmasy L, Carney JK, ACP Ethics, Professionalism and Human Rights Committee. Physicians Are Not Providers: The Ethical Significance of Names in Health Care: A Policy Paper From the American College of Physicians. *Ann Intern Med.* 2026; https://doi.org/