

COMMENTARY

The ethics of 'batting' in Indian medical training: Avoidance, moral injury, and structural violence

MEGHNIL CHOWDHURY

Abstract

"Batting" — the informal practice of diverting or discharging patients to avoid clinical responsibility — is a pervasive yet inadequately examined feature of Indian medical training. This commentary examines batting as an ethical failure operating at individual, cultural, and structural levels. Drawing on the concepts of the hidden curriculum, moral injury, and structural violence, it argues that batting both harms patients and deforms professional identity. Hidden curricula normalise avoidance as competence; trainees internalise these norms under hierarchical pressure, sustaining moral injury that shapes clinical practice well beyond training. Diffused accountability structures shield institutions from responsibility, rendering patient harm invisible. Addressing this requires embedding ethical accountability into training through cultural reform, transparent audits, trainee protection, and regulatory oversight by bodies such as the National Medical Commission. Confronting batting is essential to uphold medicine's social contract, protect patient safety, and embed responsibility as a daily practice rather than an aspirational value.

Keywords: *Batting, hidden curriculum, moral injury, structural violence, medical education, clinical accountability*

Introduction

The moral foundations of a health system are often revealed not in its exceptional achievements but in its daily, unremarkable routines. In one teaching hospital in India, a woman presented with multiple displaced rib fractures, a clavicle fracture, and haemopneumothorax — injuries with a well-established risk of respiratory compromise. Despite clear clinical indicators, she was discharged on oral analgesics. The medical notes recorded no tenderness, crepitus (cracking sounds in a joint), or surgical emphysema — findings implausible to anyone with even modest bedside experience. For those working on the ground, this was not an aberration but part of a familiar pattern. Interns and residents explained how they were discouraged from admitting patients at night, advised to avoid escalating to seniors, and taught to shift responsibility elsewhere. In many Indian teaching hospitals, this practice is colloquially referred to as "batting" — a term borrowed from cricket, where a batsman deflects or avoids a threatening delivery. In clinical use, "batting" denotes the informal but routinised avoidance of clinical responsibility, typically through premature discharge, deflection to other departments, or deliberate minimisation of risk in clinical

documentation. The "good batsman" efficiently diverts or discharges patients instead of identifying and managing risk. This represents an entrenched hidden curriculum in which avoidance is rewarded, responsibility is penalised, and patients are rendered invisible. While the term is locally specific, analogous practices of responsibility-shifting and avoidant care have been described in other healthcare systems under different names, particularly in ethnographic and organisational analyses of medical training and frontline clinical work [1,2].

The observations discussed here draw on informal, reflective accounts shared by interns and postgraduate trainees in Indian teaching hospitals. As a frontline emergency medicine clinician, and previously as an intern, I too, have repeatedly witnessed — and at times been pressured to participate in — avoidance behaviours embedded in training. This commentary is not intended to assign individual blame, but to make visible the systemic forces distorting daily clinical practice.

The commentary examines batting as an ethical phenomenon embedded within medical training. It analyses how hidden curricula, moral injury, and structural violence interact to normalise avoidance and undermine accountability in patient care. Batting operates across individual behaviour, institutional culture, and structural arrangements — eroding clinical responsibility, injuring trainees' moral integrity, and embedding structural violence into routine care.

Hidden curriculum and the normalisation of avoidance

The avoidance behaviour observed in the above vignette does not emerge spontaneously. It is learned, reinforced, and transmitted through the hidden curriculum — the unspoken norms and practices that shape professional identity more powerfully than formal instruction. While official curricula promote responsibility and patient-centred care, the hidden curriculum often rewards self-preservation and risk avoidance [3,4,5]. Trainees rapidly internalise these norms. Interns may explicitly be told not to admit patients after midnight. Junior residents may be discouraged from escalating cases to seniors. Orthopaedic trainees may learn to downplay injuries to ease bed pressures. These informal practices, seldom documented, shape how responsibility is perceived and avoided.

These practices are sustained by pronounced power asymmetries within healthcare institutions. Interns and junior residents occupy structurally subordinate positions, with limited decision-making authority and a high dependence on senior clinicians for evaluations, references, and future career progression [6]. This vertical hierarchy concentrates clinical authority upwards while dispersing responsibility downwards. Parallel professional hierarchies further shape practice: nurses and allied health professionals, themselves embedded within institutional chains of command, often act as intermediaries in regulating admissions, bed allocation, and escalation. Within this layered power structure, questioning discharge decisions or seeking senior review may be interpreted as inefficiency, lack of competence, or insubordination rather than as an expression of ethical vigilance. These hierarchical and professional subcultures normalise compliance, recasting avoidance as competence.

Over time, the hidden curriculum reframes responsibility as liability. Competence becomes synonymous with successfully navigating institutional expectations rather than safeguarding patient welfare. Empirical studies have documented the influence of such informal forces on identity formation, ethical reasoning, and patterns of clinical decision-making [3,4,5,6]. In India's resource-strained teaching hospitals, this dynamic is intensified. Batting, initially a strategy of self-preservation, becomes a deeply embedded institutional norm.

Moral injury and erosion of professional integrity

The choice to participate in batting is rarely freely made. Interns recount being pressured to discharge unstable patients, humiliated for challenging orders, or implicitly coerced into silence. This dynamic produces moral injury: a form of psychological and ethical harm that arises when individuals are compelled to act against their own moral convictions [7]. Moral injury has been widely studied in healthcare systems and is strongly associated with guilt, shame, alienation, and disengagement [8,9,10]. In Indian medical settings, these effects are magnified by systemic factors such as high patient load, bed scarcity, inadequate supervision, and entrenched hierarchies [11,12]. An intern who recognises the need for admission but is ordered to "bat the patient away" absorbs that moral wound. In such moments, moral injury arises from repeated exposure to ethically compromised choices made under hierarchical constraints. With repetition, empathy dulls, ethical distress becomes background noise, and avoidance becomes reflexive rather than deliberate. The consequences are far-reaching. Clinicians shaped in this environment may perpetuate these behaviours throughout their careers, contributing to defensive medical practice and weakened patient advocacy. Over time, this corrodes trust in the medical profession itself. Moral injury is therefore not confined to individual distress; it functions as a mechanism of ethical degradation within the health system.

Accountability vacuums and structural violence

Batting persists because accountability is diluted to the point of disappearance. Responsibility is distributed through layered hierarchies: interns defer to junior residents, juniors to senior residents, seniors to faculty, and faculty to administrators. When accountability is spread so thin, it becomes effectively absent. Institutional structures reinforce this dynamic. Hierarchies and administrative systems often prioritise operational convenience over patient safety. Senior clinicians may tacitly endorse shortcuts to limit their own workload. Administrators may ignore unsafe practices to avoid bureaucratic complications. In the absence of robust case audits, transparent escalation pathways, and patient advocacy mechanisms, batting remains an expedient strategy for those within the system — even as it exposes patients to preventable harm. The consequences are measurable. Patients with life-threatening injuries are discharged without proper monitoring, missed diagnoses accumulate, and avoidable harm becomes routine. These outcomes are not aberrations, but predictable products of a system designed to deflect responsibility.

The effects of such accountability vacuums are not evenly distributed. Patients with limited social, economic, or institutional capital — including women, individuals from marginalised caste or class backgrounds, those from rural or peripheral regions, those with poor health literacy and ones without formal insurance coverage — are more likely to experience deflection, delayed escalation, or premature discharge. These vulnerabilities are reinforced by asymmetries in communication, differential awareness of patient rights among both healthcare workers and patients, and limited capacity to question or contest clinical decisions. The growing influence of private-sector logics and insurance-driven cost containment further shapes which patients are perceived as "admissible" or "expendable," subtly incentivising avoidance while obscuring its moral cost. Structural violence thus operates through the interaction of institutional design and social stratification, amplifying harm among those already marginalised [11,13].

Paul Farmer's framework of structural violence illuminates this phenomenon. Structural violence occurs when social or institutional arrangements systematically harm individuals by obstructing their access to essential care [14]. In India's teaching hospitals, structural violence is manifested through chronically high patient loads, inadequate supervision, and rigid hierarchies. Patients are rendered invisible by a system that perceives their needs as burdensome. This invisibility reflects a form of biomedical objectification in which patients are reduced to diagnostic entities, administrative liabilities, or cost-bearing units, instead of being recognised as rights-bearing individuals embedded within social, economic, and political contexts [15]. Such objectification is a mechanism through which structural violence is enacted, sustained by socio-politico-economic arrangements that

prioritise efficiency, throughput, and financial risk management over relational care and ethical deliberation. When health is treated as a discretionary service rather than as a fundamental right, patient needs and values become secondary to institutional convenience and system survival.

Reframing health as a right necessitates a corresponding reorientation of accountability — from measuring success primarily through bed turnover, documentation, or risk avoidance to evaluating whether care processes meaningfully respond to patient values, vulnerability, and expressed needs. A rights-based approach foregrounds patient agency and participation in clinical decision-making, requires transparency and justification for avoidant practices such as premature discharge, and obligates institutions to create mechanisms through which patients can question, contest, and seek redress for care decisions. Embedding such patient-facing accountability within training, governance, and regulatory frameworks would strengthen the responses proposed here by aligning ethical responsibility with the lived experiences and rights of those most affected by avoidant care.

Policy and practice implications

Addressing batting requires a structural transformation. Ethical principles must be operationalised through cultural change, clear accountability, and regulatory mechanisms, focusing on:

- **Cultural reform:** Avoidance should no longer be treated as a marker of competence. Ethical reasoning and accountability should be embedded in everyday clinical teaching, including ward rounds and discharge decisions. Faculty must model responsible behaviour.
- **Accountability mechanisms:** Clearly defined chains of responsibility for patient outcomes are essential. High-risk discharges should undergo routine audits. Near-miss events should trigger structured review in a blame-aware but accountable framework. These mechanisms should extend beyond internal professional oversight to include clear communication of care decisions, accessible grievance redressal pathways, and opportunities for patient participation in institutional ethics and quality-improvement processes.
- **Trainee protection:** Whistleblowing and reporting structures should shield trainees from retaliation. Addressing moral injury requires altering the conditions that produce it, alongside offering psychological support.
- **Transparency:** Ethical and safety performance metrics should be integrated into institutional evaluations and made publicly available.
- **Regulatory oversight:** The National Medical

Commission should embed accountability and ethical responsibility within accreditation standards, including patient safety audits, documentation requirements, and faculty role-modelling, with explicit attention to patient rights and participatory accountability.

[Supplementary Table 1, available online only.](#)

Conclusion

Batting is not a benign cultural residue of Indian medical training. It is a persistent ethical failure that injures patients, erodes professional identity, and undermines public trust. Returning to the opening vignette — a woman discharged with life-threatening injuries — it becomes clear how an entrenched culture of avoidance can transform institutional practice into structural harm. Hidden curricula, moral injury, and structural violence are interconnected forces shaping both patient care and the making of doctors.

Addressing batting requires more than exhortations to build professionalism. It demands cultural reform, institutional accountability, and regulatory commitment grounded in the recognition of health as a fundamental right. Medical education must embed responsibility as a daily practice, not an aspirational value, and accountability systems must remain transparent, contestable, and responsive to patient needs and vulnerability. Hospitals are the sites where medicine's moral contract with society is either upheld or eroded. Preserving that contract requires ending the quiet normalisation of avoidance and re-centring patient dignity and agency within everyday clinical decision-making.

Author: Meghnail Chowdhury (drmeghneil@gmail.com, <https://orcid.org/0009-0006-4848-4827>), Registrar, Emergency Medicine, Ruby General Hospital, Kolkata, INDIA.

Conflict of Interest: None declared

Funding: None

To cite: Chowdhury M. The ethics of 'batting' in Indian medical training: Avoidance, moral injury, and structural violence. *Indian J Med Ethics*. Published online first on June 19, 2026. DOI: 10.20529/IJME.2026.038

Submission received: October 21, 2025

Submission accepted: April 3, 2026

Manuscript Editor: Vijayaprasad Gopichandran

Peer Reviewers: Sebin George, Srimathi G

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. Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J, Ozieranski P, Willars J. Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Qual Saf*. 2014 Feb 1;23(2):106-15. <https://doi.org/10.1136/bmjqs-2013-001947>
2. Lipsky M. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation; 1980. Available from: <http://www.jstor.org/stable/10.7758/9781610447713>
3. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. *Acad Med*. 1998 Apr;73(4):403-7. <https://doi.org/10.1097/00001888-199804000-00013>

4. Mahood SC. Medical education: Beware the hidden curriculum. *Can Fam Physician*. 2011 Sep 1[Cited 2026 Feb 25] 57(9):983-5. Available from: <https://pmc.ncbi.nlm.nih.gov/articles/PMC3173411/>
5. Behmanesh D, Jalilian S, Heydarabadi AB, Ahmadi M, Khajeali N. The impact of hidden curriculum factors on professional adaptability. *BMC Med Educ*. 2025 Feb 5;25(1):186. <https://doi.org/10.1186/s12909-024-06618-1>
6. Singh PK, Singh S, Ahmad S, Singh VK, Kumar R. Navigating power dynamics and hierarchies in medical education: Enhancing faculty experiences and institutional culture. *J Postgrad Med*. 2025 Apr 1;71(2):82. https://doi.org/10.4103/jpgm.jpgm_728_24
7. artolovni A, Stolt M, Scott PA, Suhonen R. Moral injury in healthcare professionals: A scoping review and discussion. *Nurs Ethics*. 2021 Aug; 28(5):590-602. <https://doi.org/10.1177/0969733020966776>
8. Houle SA, Ein N, Gervasio J, Plouffe RA, Litz BT, Carleton RN. Measuring moral distress and moral injury: A systematic review and content analysis of existing scales. *Clin Psychol Rev*. 2024 Mar 1; 108:102377. <https://doi.org/10.1016/j.cpr.2023.102377>
9. Purcell N, Bertenthal D, Usman H, Griffin BJ, Maguen S, McGrath S. Moral injury and mental health in healthcare workers are linked to organizational culture and modifiable workplace conditions: Results of a national, mixed-methods study conducted at Veterans Affairs (VA) medical centers during the COVID-19 pandemic. *PLOS Ment Health*. 2024 Dec 23;1(7): e0000085. <https://doi.org/10.1371/journal.pmen.0000085>
10. Dean W, Talbot S, Dean A. Reframing clinician distress: moral injury not burnout. *Fed Pract*. 2019 Sep[Cited 2026 Feb 25] 36(9):400-402. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6752815/>
11. Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. *Lancet*. 2011 Feb 5;377(9764):50. [https://doi.org/10.1016/S0140-6736\(10\)61894-6](https://doi.org/10.1016/S0140-6736(10)61894-6)
12. Rao M, Rao KD, Kumar AS, Chatterjee M, Sundararaman T. Human resources for health in India. *Lancet*. 2011 Feb 12;377(9765):587-98. [https://doi.org/10.1016/S0140-6736\(10\)61888-0](https://doi.org/10.1016/S0140-6736(10)61888-0)
13. Baru R, Acharya A, Acharya S, Kumar AS, Nagaraj K. Inequities in access to health services in India: caste, class and region. *Econ Polit Wkly*. 2010 Sep 18[Cited 2026 Feb 25] 45(38):49-58. Available from: <http://www.jstor.org/stable/25742094>
14. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med*. 2006 Oct;3(10):e449. <https://doi.org/10.1371/journal.pmed.0030449>
15. Svenaeus F. The phenomenology of objectification in and through medical practice and technology development. *J Med Philos*. 2023 Apr;48(2):141-150. <https://doi.org/10.1093/jmp/jhad007>