LETTER

Workforce capacity and the ethics of 'batting'

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Meghnil Chowdhury's commentary in this journal [1] draws attention to a practice familiar to many graduates of Indian teaching hospitals but seldom discussed. I write as a former intern who was a victim of this practice. Batting is often interpreted as an ethical failure of individuals, but I would like to argue that it should be thought of as an ethical consequence of organisational failure. Chowdhury rightly calls for accountability through cultural reform, transparent audits, trainee protection, and oversight by the National Medical Commission (NMC). Such accountability, however, cannot be meaningful without addressing the structural conditions that shape trainees' behaviour.

The first factor to consider is the nature of post-graduate training. First-year residents in many government teaching hospitals are placed in charge of high pressure wards under limited supervision. High workload and erratic routines are compounded by steep hierarchies that leave little room for decisions to be questioned. Trainees may recognise unsafe practices but feel unable to question them, seek help, or admit uncertainty due to the lack of psychological safety [2,3]. Rather than promote learning, the hidden curriculum rewards the appearance of competence and punishes uncertainty. The experience of being coerced to act against professional judgement, despite awareness of the likelihood of harm, corresponds to the moral injury framework Chowdhury uses in relation to batting [4].

The second is how the workforce is distributed across specialities, a dimension the commentary mentions but does not explore in detail. Limited supervision and the pressure to maintain patient flow create the very conditions under which batting becomes a rational, if unethical, adaptation. A related concern is how postgraduate seats are distributed. While the number of both undergraduate and postgraduate seats has expanded substantially over the past decade, growth has been uneven across specialities and institutions. The seats in the core clinical disciplines such as medicine, surgery, obstetrics and gynaecology in prestigious institutions have not kept pace with the demand these branches place on the trainees. Aggregate seat-matching between MBBS and PG numbers does not correct this distribution, since speciality choice is also shaped by hierarchy and the relative prestige and financial return of different disciplines [5]. Adding more postgraduate seats is not enough unless the distribution of those seats across specialities and the structure of training are also corrected.

Accountability must therefore extend beyond institutions and regulators, as Chowdhury suggests. Training programmes must also ensure that residents are assured the supervision, psychological safety, and support needed to exercise sound clinical judgement. Until structural conditions are addressed, batting will continue to be a manifestation of structural violence that constrains young clinicians from providing the care they aspire to deliver [1,4,6].

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