

What Ails Our Postgraduate Medical Education System?

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Learning Point of the Article:

Postgraduate medical training in India faces challenges including inconsistent training quality, inadequate competency-based assessment, excessive service workload, limited research exposure, variable faculty mentoring, and insufficient emphasis on communication, professionalism, and interdisciplinary skills.

What Ails Our Postgraduate Medical Education System?

Postgraduate medical education in India is at a phase of uncomfortable contradiction. We are creating some of the best clinicians and surgeons in the world, but the way many get there is inconsistent, old-fashioned and down to circumstance rather than structure. Despite almost 30 years having passed since most developed healthcare systems shifted to competency-based medical education, much of our postgraduate training remains rooted in the traditional apprenticeship model: “see one, do one, teach one.” The apprenticeship model itself may not be at fault. Still, the general belief, even in academic Meccas, is that postgraduate education is devoid of a structured curriculum, pre-designed teaching modules and faculty-led teaching sessions. The obvious reason is that students are treated as cheap labor, and the faculty has little commitment to them. Most institutions assume higher education through apprenticeship means absorption of knowledge through the skin, imbibing of technical skills by observation and unsupervised performance and no commitment to transfer of attitudes. We all can remember our training days, when we automatically graduated from holding legs to draping to holding retractors to suturing to implant removals to implantation, all without anyone actually showing us

how to do each of these procedures (and of course explaining the rationale why it has to be done in this manner) I cannot remember a single lecture or teaching session (other than clinics) conducted by our faculty during the entire 3 years of my study term. As a consequence, the quality of the specialists being produced varies tremendously.

The concerns are not confined to one area. The deficiencies are in the teacher, the student, the training system, and the environment where learning happens.

The Teacher: Clinician Versus Educator

A good doctor does not necessarily make a good teacher. Likewise, a great surgeon may not always be able to teach residents in a structured way. Today's medical education demands structured teaching skills, feedback mechanisms, communication strategies, and an understanding of adult learning principles. Unfortunately, most faculties in our institutions are never formally trained to teach.

The selection of teachers is not uniform. Appointments are frequently made largely based on seniority, publications or years of service rather than on actual teaching ability, mentorship

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qualities, or clinical competence. Educational contributions or student outcomes are also rarely tied to academic promotions. In many places, research publications become a numbers game rather than an indication of real academic involvement.

However, maybe more importantly, teachers develop not only the knowledge and technical skills of future doctors but also their attitude and professionalism. Residents learn empathy, ethics, discipline, communication and respect primarily by watching. The attitude domain of training is a silent victim when teachers are themselves overworked, disengaged or unable to be role models.

Furthermore, worth mentioning is faculty burnout. Excessive administrative workload, medicolegal pressures, service burden and lack of incentives for teaching reduce enthusiasm for mentorship. In such cases, teaching is often accidental rather than intentional. A word needs to be said about “equal opportunities versus affirmative action” employees. (In our country, it is called a reservation) On the one hand, we need equal numbers of both types of institutions to ensure social justice, and on the other, quality assurance.

The Student: Selected for Examinations, Not Necessarily for Medicine

The current postgraduate student population is very mixed. Residents vary greatly in terms of aptitude, communication skills, emotional maturity, surgical dexterity, and motivation. However, the current system of selection rewards above all the ability to do well in highly competitive multiple-choice entrance examinations.

The selection process is also fairly fallacious in other ways. The common entrance examination does guarantee a certain level of intellectual standard among the students selected. However, the private payment quota dilutes this very premise. It promotes numerous entries who do not have the motivation, interest, commitment or mental caliber to undergo the rigor of higher medical education.

The examination system is also immensely defective. These examinations test theoretical knowledge, but they may not adequately assess qualities essential to clinical medicine, such as decision-making, empathy, teamwork, professionalism, ethical judgment, and resilience under stress. This leads some students to choose specialties for which they do not have the aptitude or passion, but rather for reasons of rank, social perception, financial prospects or external pressure.

I have seen the obsessive behavior of many examiners insisting on specific answers and techniques, often ignoring the great variability in performance of clinical tests and the evidence base that dictates the variability inherent in outcome measures.

This mismatch often presents during residency as poor motivation, burnout, detachment from patient care, or lack of academic curiosity. The modern resident also experiences unprecedented psychological stress from long hours, sleep deprivation, toxic work environments, violence against health care workers, and unrealistic societal expectations. However, structured mental health support systems are still largely absent in most training institutions.

Another worry is the increasing reliance on a coaching culture. Years of entrance examination preparation often result in students being strong on theory but lacking clinical exposure and bedside confidence once they enter residency. We are basically selecting for test performance, not overall clinical potential.

The System: Fragmented and Non-Uniform

The main problem of postgraduate medical education in India is the lack of uniformity. The learning experience of a resident can vary enormously depending on whether the training is in a government medical college, a private institution, a corporate hospital or a peripheral center.

In high-volume government hospitals, residents may get tremendous surgical exposure but usually in a setting of inadequate supervision, high workload and a compromised academic structure. On the other hand, some private facilities may have good infrastructure but lack operational independence due to smaller patient volumes or institutional priorities.

The mismatch between service and education is staggering. Many residents predominantly provide workforce, dealing with paperwork, ward management and service obligations, with little protected time for academic growth, research or reflective learning.

Surgery training itself remains suboptimal. Some trainees complete residency having performed large numbers of procedures independently, sometimes with inadequate supervision. Others graduate with very little practical training. Both situations are bad. Unsupervised training risks patient safety, and substandard exposure threatens future competence.

The examination system is also outdated. Whether or not the candidate is deemed “qualified” is based on endpoint practical examinations of 1 or 2 days. These tests tend to test memory, presentation skills, and examiner perception rather than actual competency. Internationally, modern medical education has moved to longitudinal workplace-based assessment, skill validation, simulation-based evaluation, logbooks and objective structured clinical examinations. Our system, however, still uses many obsolete formats that do not reflect

real-world clinical ability.

The Environment and Infrastructure: Islands of Excellence Amidst Vast Disparity

A further major challenge is the unevenness of infrastructure. Some institutions have robotic platforms, navigation systems, arthroscopy towers, simulation laboratories, and artificial intelligence -assisted diagnostic tools. Some even struggle to maintain basic operating room equipment or access to a C-arm.

The result is very different training outcomes, despite the same degree being awarded at the end of residency. A postgraduate trainee immersed in advanced technology, multidisciplinary meetings, evidence-based protocols and simulation learning enters practice with substantially different preparedness than that of those trained in resource-limited settings.

One of the strengths of Indian medical training, high patient volume, can paradoxically become a weakness. Hospitals are crowded, and a lack of manpower makes residents service providers instead of learners. Clinical exposure without reflection, supervision and structured feedback does not necessarily translate into competency.

In addition, the realities of current clinical practice are changing rapidly. Medicine today demands evidence-based care, communication skills, interdisciplinary collaboration, use of digital documentation, ethics, research methods, use of technology and patient-centered decision-making. Many postgraduate curricula and exit examinations, however, still place a heavy emphasis on factual recall and traditional clinical demonstrations.

Another concern has been the extreme economic and social privileges imagined to be associated with the medical practice itself, which has driven young aspirants and their parents to view medical practice not as a profession but a veritable Eldorado leading them to opt for grossly inadequate institutions (often in countries with little commitment to train our incumbents) at enormous expense.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given the consent for his/ her images and other clinical information to be reported in the journal. The patient understands that his/ her names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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The Way Forward

Reform of postgraduate education must acknowledge that specialist training is not simply about degree-awarding, but it is about competence, professionalism, and patient safety. The first step is to develop a curriculum for each specialty to be taught. Furthermore, creation of time-bound instructional modules involving faculty-led modules, not just clinics but lectures, seminars and journal clubs (not student-led programs which are already there).

Competency-based curricula need to move from paper to practice. Faculty development programs should be made mandatory to train teachers not only as clinicians but also as educators and mentors. Teaching effectiveness and student feedback should be included as meaningful parameters for selection and promotion of faculty."

Assessment systems need an urgent overhaul. In addition to or instead of pure traditional examinations, there should be continuous assessment, structured logbooks, workplace-based assessments, simulation training and objective validation of skills. Essential uniform minimum standards of infrastructure and surgical exposure across institutions need to be made.

Equally important is to develop the resident as a learner, not just as a component of the workforce. Training well-rounded specialists requires dedicated academic time, mentorship, mental health support, ethics training and exposure to research.

India has wonderful clinical material, brilliant students and committed teachers. What is missing is standardization, educational vision and systemic reform. The future of healthcare depends not on the number of postgraduate seats we create, but on whether the specialists graduating from these programs are truly competent to meet the demands of modern medicine.

It is time to move from apprenticeship to accountability, competency and meaningful educational excellence.

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