

Correspondence

Re: Who will regulate the regulator?

The article by Ananthakrishnan raises important questions about the direction and philosophy of medical education reform in India.¹ The present moment demands not only a critique of existing regulations but also a clear reimagining of what the Indian medical education system is striving to become. Expansion, faculty shortage, and uneven quality are real concerns, but they are not the symptoms of a deeper absence of educational vision.

The conversation must move beyond how many colleges exist or how many teachers are appointed, to a more fundamental question: what kind of physician is being shaped through this process? Medical education today faces a tension between training for employability and nurturing professional identity. The modern medicine system, while continuing to emphasise compliance, increasingly requires adaptability, ethics, teamwork, and the capacity for lifelong learning.² Therefore, regulation needs to shift its focus from enforcing norms to enabling these capabilities.

The expansion of seats and colleges must be matched by a reform in the purpose and structure of training. While the present competency-based medical education (CBME) framework strives to move towards integrated learning, much more remains to be done to ensure a truly longitudinal 'context-based learning' approach that connects learning with patient care, community needs, and the realities of the health system.

A second, often-overlooked dimension is the future of teaching and how students shape their identities. Today's educator must be a designer of learning experiences, integrating technology, reflective practice, and interprofessional collaboration. Existing faculty development initiatives, such as the basic and advanced courses in medical education (BCME and ACME), have laid a strong foundation for capacity building. However, these programs often remain episodic and skill-focused. What is now needed is a structured, longitudinal framework that recognises medical education as a scholarly career pathway linking faculty development with mentorship, research productivity, and institutional leadership. Without sustained investment in developing the educator as a professional, educational reforms risk remaining fragmented and short-lived.

Equally important is the parallel development of learners within the CBME framework. Beyond competencies, CBME must intentionally nurture students' professional identity formation and sense of belonging within the healthcare community. However, an often-overlooked step is sensitizing students to the very intent of CBME before its implementation. Learners need to appreciate that CBME is not merely a shift in curriculum, assessment, or structure, but a transformation. Early orientation to its goals and multi-dimensional nature enables students to engage purposefully, understanding what they learn, how they learn, and most important, why they learn.

Regulation must also become data-informed and participatory. Instead of relying mainly on inspection reports, periodic publication of outcome data, graduate distribution, community service, research productivity, and learner feedback can create a culture of transparency and accountability. Independent academic audit boards, involving educators, health planners, and community representatives, would lend both legitimacy and diversity to oversight.

Finally, the transformation of medical education should not only aim to produce more doctors but also to redefine what it means to be a doctor in contemporary India. As medicine becomes increasingly technological and fragmented, the system must

intentionally cultivate empathy, moral reasoning, and social responsibility to restore humanism to healthcare. These are not by-products of training; they are outcomes that require deliberate educational design.

Hence, the future of Indian medical education is not moving towards faster expansion or regulatory relaxation, but in building an ecosystem that is evidence-based, inclusive, humanistic, and ethically conscious. The envisioned change is one where learning is continuous, teaching is valued as scholarship, and policy is informed by outcomes rather than intentions. Only then can reform truly align with the nation's broader goals of health, justice, and human development.

REFERENCE

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- 2 Emanuel EJ. The inevitable reimagining of medical education. *JAMA* 2020;**323**:1127–8.

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Re: Urinary iodine excretion: A valuable tool for monitoring salt iodisation programme

Kumari *et al.*¹ offer a valuable perspective by shifting the focus from school-based surveys to family-based monitoring of iodine status. Furthermore, the observation that double fortified salt (DFS) showed no significant difference in urinary iodine (UI) excretion compared to iodised salt (IS) provides critical reassurance for the implementation of the *Anaemia Mukh Bharat* strategy. However, a critical review of the methodology and data interpretation raises specific points that warrant further consideration.

First, regarding the statistical methodology, the authors appropriately reported median UI levels, acknowledging the typically non-normal distribution of UI data. However, the statistical significance of the differences between groups and time points was assessed using the Student's t-test. The Student's t-test is a parametric method that assumes a normal distribution of data. Applying this test to skewed datasets may result in inaccurate estimations of statistical significance. The use of non-parametric tests, such as the Mann-Whitney U test or the Wilcoxon signed-rank test, would be methodologically more appropriate for this dataset.

Second, the authors conclude that the decrease in median UI observed between 2019 and 2021 was likely due to the salt industry complying with revised Food Safety and Standards Authority of India (FSSAI) standards. While the methodology