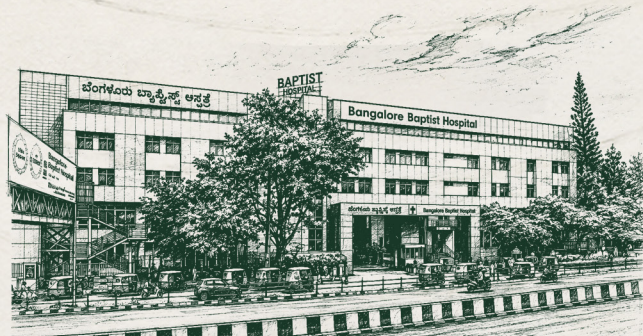


VOICE OF RESIDENTS

LISTENING. UNDERSTANDING. DESIGNING TOGETHER.



ANBAI NATIONAL CONCLAVE 2026

ASPIRE • ELEVATE • LEAD

29-30 AUGUST 2026

BANGALORE BAPTIST HOSPITAL, BENGALURU

**An ANBAI initiative bringing together resident voices, experiences
and insights to strengthen postgraduate medical education.**

LANGUAGE PHILOSOPHY

Clear, human language that respects complexity without becoming unnecessarily academic.
Style: Plain intelligence. Professional warmth. Evidence before rhetoric. Confidence without confrontation.

Design Philosophy

Ivory creates warmth and space.
Forest green brings grounding, growth and identity.
Blush adds a quiet human touch.
Gold marks moments of emphasis and discovery.
Together, they create a visual language that is quiet, contemporary, human and considered more exhibition than report inviting people to encounter, pause, reflect and engage.

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A conversation about residency

What brings joy. What makes it difficult. What helps. What is hoped for

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FOREWORD

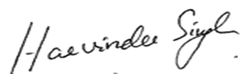
When the idea of exploring the voices and lived experiences of residents was shared with the ANBAI leadership, we felt that the theme was both timely and important. Residency is a formative period in a doctor's life, and listening to residents is an important part of understanding and strengthening postgraduate medical education.

At ANBAI, we believe that improving postgraduate medical education requires listening to those who live within the system. Residents experience the learning environment differently from faculty, administrators and regulators. Each perspective is valid, and each sees only part of the larger ecosystem.

Through our discussions and brainstorming, we encouraged Dr. Carol and her team to take the conversation forward. We were also pleased to connect the team with colleagues and networks across different states, enabling the exploration to extend beyond a single institutional experience.

We hope this work will encourage further conversations within institutions and contribute to the wider dialogue on postgraduate medical education.

We thank the residents who shared their experiences with openness and trust, and Dr. Carol and her team for creating the space to listen, reflect and bring these voices together.



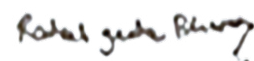
Dr H. S Chhabra

President ANBAI



Dr Lingaiah

Vice president ANBAI



Dr Rahul Guhabiswas

Secretary ANBAI

VOICES OF RESIDENTS

The experience of becoming a Specialist

Residency is often described through training, competence and clinical responsibility.

But what does it feel like to live it?

A space to speak about the moments that bring joy,

the experiences that test them,

the ways they cope,

the hopes they carry,

and the changes they imagine.

We began with a simple act:

We listened.

PREAMBLE

Medicine is changing. The demands of healthcare are changing. Technology is accelerating this transformation, reshaping how care is delivered, how doctors learn and how teams work. Changes that once unfolded over decades are now occurring within a few years.

Within this changing landscape, residency remains a formative chapter in a doctor's life. It is a time of intense learning, responsibility, uncertainty, growth and discovery. It shapes not only clinical competence, but also confidence, character, values and the kind of physician one becomes.

Residency is part of a shared healthcare and education ecosystem that brings together residents, faculty, administrators, institutions and regulators. Each sees a different part of the same ecosystem. The quality of medical education and patient care depends not only on how each part functions, but on how these perspectives understand, support and work with one another.

In a period of rapid change, there is value in pausing to listen and understand. To recognise what is working and should be preserved, what can be strengthened, and what may need to evolve.

The ANBAI Residents Charter 2026 brings together resident perspectives gathered through interviews, reflective activities, the Residents Wall and the Quick Win Design Lab. These perspectives were brought together and examined to identify recurring experiences, themes and priorities emerging from residency.

The Charter translates these insights into principles and actionable considerations for postgraduate medical education. It is not intended to speak for every resident or prescribe a single model of residency. Rather, it offers a collective contribution from within the shared ecosystem, inviting residents, faculty, institutions, regulators and policymakers to listen, understand and design together.

PHILOSOPHY

A shared ecosystem is strengthened when its different perspectives are heard, understood and brought into dialogue.

The design of the ANBAI Residents Charter 2026 begins with this belief. Resident experiences are not viewed as isolated stories or individual concerns, but as insights into the larger environment in which postgraduate medical education takes place.

The Charter therefore moves through three connected ways of working:

LISTEN

Begin with lived experience.

Create space for residents to speak openly about what helps them learn, what challenges them, what they value and what they hope can change.

UNDERSTAND

Look beyond individual experiences.

Bring different perspectives together to recognise recurring themes, relationships, strengths and areas where the ecosystem can do better.

DESIGN TOGETHER

Move from insight to possibility.

Translate what is heard and understood into practical ideas and considerations that residents, faculty, institutions, regulators and other stakeholders can shape together.

This is not a process of finding a single answer to residency. It is an approach to better understanding the ecosystem and creating the conditions for continuous improvement within it.

Listen to experience. Understand the ecosystem. Design together.

OUR INTENT

We wanted to understand residency through the eyes of those living it, while recognising that every resident experience is part of a larger shared ecosystem.

We wanted to listen to what makes residency meaningful, what makes it difficult, how residents navigate challenges, what they value in learning and growth, and what they hope for and worry about in the future.

We also wanted to understand where residents themselves saw opportunities for change. What would they prioritise if they had the opportunity to influence their institution? What could be changed today? What might need to change over time?

At its heart, the intent was simple:

To listen to experience, understand the wider ecosystem, and translate what we heard into possibilities for designing better together.

WE BEGAN WITH QUESTIONS

We began with simple questions, to create space for residents to speak from their own experience.

What brings you joy in residency?

What makes residency difficult?

How do you cope? What does your thesis journey feel like?

What are you hopeful about future?

What are you anxious about future?

If you could change one thing, what would it be?

Simple questions. Open answers. A larger conversation.

The questions were intentionally open and human.

We wanted to listen and understand before creating possibilities and designing solutions.

METHODOLOGY

The ANBAI Residents Charter 2026 was developed through a structured and iterative process of dialogue, reflection, data collection and triangulation. The approach was designed to move from individual experiences to shared understanding, while retaining the authenticity of residents' voices.

BEGINNING WITH EXPERIENCE

The process began with a pilot initiative involving residents at Bangalore Baptist Hospital. This created a safe and open space to explore residents' experiences of learning, working, relationships, challenges and wellbeing during residency.

BROADENING THE CONVERSATION

The pilot was followed by a Bengaluru-wide workshop involving residents from ten NBEMS-accredited institutions. Through group discussions and reflective activities, residents identified common experiences, concerns and emerging themes.

TAKING THE CONVERSATION NATIONAL

The themes emerging from the workshop informed the development of a national survey and guided in-depth interviews with residents across 15 participating states. Interviews continued until data saturation was reached.

BRINGING PERSPECTIVES TOGETHER

Findings from the workshops, national survey and in-depth interviews were triangulated to identify recurring experiences, patterns and priorities. This process allowed individual voices to be understood alongside broader trends and perspectives.

The Charter therefore brings together both the evidence of what residents expressed and the patterns that emerged across their experiences.

MAKING SENSE OF THE VOICES - QUAL ANALYSIS

The qualitative material underwent thematic analysis. Responses were systematically coded, categorised and compared to identify recurring patterns, perspectives and priorities.

Codes were progressively grouped into broader themes, with iterative review to ensure that themes remained grounded in the data. Both convergence and divergence were retained to reflect the diversity of residents' experiences.

Qualitative findings were triangulated with the national survey and other sources, strengthening areas of convergence while preserving differing perspectives.

The resulting thematic framework provided an evidence-informed basis for understanding the residency experience and identifying priorities for action.

Joys in Residency— Thematic Analysis

Thematic Analysis

Higher-order domain	Theme	Codes from the interviews	Representative quotes	Interpretation
CONNECTION	Human connection and belonging	Batchmates, friendship, travelling together, informal gatherings, corridor conversations, laughter, chit-chat, being seen, remembered and valued	“Spending time with my batchmates was one of the loveliest parts of residency.” / “Those moments made me feel seen, recognised, remembered, appreciated, and valued.”	Everyday interpersonal interactions created companionship and a sense of belonging. The most memorable moments were often ordinary interactions rather than formal events.
	Supportive learning relationships	Listening faculty, approachable HOD, faculty check-ins, supportive seniors, enthusiastic teachers, accepting environment	“My Head of Department has always been a listening ear.” / “The consultants were enthusiastic teachers who genuinely wanted us to learn.”	Support was experienced through specific relationships and behaviours: listening, checking in, teaching with genuine interest and creating an accepting environment.
	Family and life beyond residency	Family, child, friends, gym, badminton, coffee, healthy food, books, personal interests	“Seeing my child... that’s my joy.” / “Newness gives me happiness.”	Sources of joy extended beyond the hospital. Family, recreation and personal interests provided emotional connection and preserved aspects of identity outside the clinical role.
CONTRIBUTION	Meaning through patient care	Patient recovery, helping patients, counselling, explaining, advocacy, gratitude, patients returning, patients asking for the resident	“Knowing that I had helped someone made me happy too.” / “I am only a resident, but for them I mattered.”	Patient care became a source of fulfilment when residents could see the human impact of their work and recognise that their contribution mattered.
	Recognition and appreciation	Encouragement, appreciation, patient gratitude, being noticed, being remembered, being valued	“Every word of encouragement stayed with me.” / “Those moments made me feel seen, recognised, remembered, appreciated, and valued.”	Recognition from faculty, peers and patients reinforced the resident’s sense of contribution, worth and professional purpose.

GROWTH	Learning, mastery and competence	New procedures, completing tasks correctly, intubation, complex cases, counselling techniques, achievement, confidence, professional growth	“When I complete one task in the correct way... it is so rewarding.” / “It made me feel that I was growing as a doctor.”	Positive emotion was closely linked to visible progress. Successfully learning or performing something new provided evidence of growing competence and professional identity.
RESTORATION	Small moments of respite	Canteen, corridor conversations, lighter moments, laughter, dance, friends, recreation, Sunday, temporary escape from pressure	“Our pressures will not go away. But in those moments, we forget that.”	Brief periods away from clinical demands provided psychological relief without requiring the pressures of residency to disappear.
	Sleep, rest and recovery	Sleep, fatigue, continuous duties, responsibility, physical strain, rest, relief, control over time	“One day of good sleep makes me so happy.” / “A good sleep... good rest free of responsibilities is what I wish for.”	Rest emerged as a distinct need within an environment of continuous responsibility. Sleep and responsibility-free time represented recovery and restoration.

Overall Thematic Synthesis

The analysis of the interviews identified four higher-order domains: Connection, Contribution, Growth and Restoration.

These domains capture different but interrelated ways in which residents experience positive moments during training:

CONNECTION — *I am part of something.*

CONTRIBUTION — *What I do matters.*

GROWTH — *I am becoming more capable.*

RESTORATION — *I can pause, recover and return.*

Together, the themes suggest that residents’ positive experiences are not limited to “happy events.” They arise from relationships, meaningful clinical contribution, visible professional growth and opportunities for recovery within the demands of residency.

Challenges in Residency

Thematic Analysis

Higher-order domain	Themes emerging from the data	Key codes	What the data suggest
1. Transition & Belonging	Entering an unfamiliar system; finding one's place	New culture, hierarchy, unfamiliar expectations, loneliness, separation, changing postings, repeated adaptation	Residents are learning the culture and unwritten rules of residency alongside medicine. Unclear expectations and repeated transitions can make belonging difficult.
2. Safety, Trust & Voice	Fear of judgement; feedback without psychological safety; trust and confidentiality; wanting to be heard	Harsh correction, public criticism, judgement, fear of speaking, guardedness, being labelled, decisions made before being heard	Residents want to be corrected and challenged, but need an environment in which they can learn, speak and seek help without fear of humiliation, judgement or premature labelling.
3. Learning & Professional Growth	Clinical work competing with learning; limited breadth of exposure; unstructured academic learning	Continuous clinical work, limited teaching, limited cross-specialty exposure, SR teaching gaps, exam stress, inadequate case presentation practice	Residents recognise that clinical work is central to training, but describe a gap between doing the work and having structured opportunities to acquire the wider competencies expected at the end of residency.
4. Life, Wellbeing & Environment	Accommodation and financial pressures; difficulty maintaining health; lack of spaces for recovery and connection	Expensive accommodation, food, sleep, exercise, family responsibilities, finances, lack of common spaces	Residency is embedded within residents' wider lives. Basic living conditions, family responsibilities and the physical environment influence their ability to rest, maintain health and connect with others.
5. Responsibility & Emotional Load	Carrying clinical responsibility; feeling unprotected; emotional burden of difficult encounters	Aggressive relatives, inadequate security, breaking bad news, death declaration, guilt, uncertainty, fatigue	Residents are increasingly carrying real clinical responsibility while still developing the skills and emotional capacity to manage it. Some difficult experiences remain unprocessed and personally carried.

Overall Thematic Synthesis

The analysis of the Challenges interviews identified five interconnected dimensions of the resident experience:

— I am finding my place.

SAFETY, TRUST & VOICE — *I can speak and be heard.*

LEARNING & PROFESSIONAL GROWTH — *I am becoming competent.*

LIFE, WELLBEING & ENVIRONMENT — *I can sustain myself.*

RESPONSIBILITY & EMOTIONAL LOAD — *I am learning to carry responsibility.*

Together, these themes suggest that residents are not only learning medicine. They are learning how to belong, speak, cope, grow and carry responsibility often without these aspects of residency being explicitly taught.

Coping in Residency

Thematic Analysis

Higher-order Theme	Subthemes	Representative Insights
1. Family & Emotional Support	Family, spouse, loved ones, shared time	"My biggest support throughout this journey is my husband/family." Spending time with loved ones helps residents manage the demands of residency.
2. Physical Activity as Coping	Gym, exercise, therapeutic movement	"Going to the gym feels therapeutic." / "When I go to the gym I am in a trance and for that time I don't think of my residency." Physical activity provides a temporary mental separation from residency.
3. Rest & Recovery	Sleep, weekly offs, Sundays, downtime	"Sleeping, whenever I get time to sleep." / "Weekly offs." Rest appears both as a coping strategy and as a scarce resource within residency.
4. Freedom & Autonomy	Unrestricted time, choice, flexibility	"Anything that is not restrictive makes me happy." Moments with fewer constraints provide a sense of freedom and relief from the structured demands of residency.
5. Recreation & Novel Experiences	Sunday outings, new experiences, indoor activities, food	"Sunday outings, going out trying new experiences." / "Having icecreams." Small recreational experiences provide moments of pleasure and normalcy.
6. Supportive Learning Environment	Non-judgmental seniors, healthy work environment, supportive relationships	"A healthy work environment with non-judgmental seniors and a supportive family makes residency more manageable." The environment itself can either amplify stress or make it easier to cope.
7. Adaptation to Clinical Responsibility	Normalising responsibility, adjustment, emotional adaptation	"Once you start doing things... eventually, you realize this is a normal part of residency." Over time, residents appear to adapt to the initial anxiety associated with clinical responsibility.

Overall Thematic Synthesis

The analysis reveals that residents cope through connection, movement, rest, autonomy, recreation and supportive relationships, alongside gradual adaptation to clinical responsibility.

CONNECTION — *People help me carry it.*

MOVEMENT — *I can step away from it.*

RESTORATION — *I can recover.*

AUTONOMY — *I can have some control.*

RECREATION — *I can still experience normal life.*

SUPPORT — *I do not have to navigate it alone.*

ADAPTATION — *I gradually learn to carry the responsibility.*

The striking finding is that coping is often found in small, accessible moments rather than formal interventions: a gym session, sleep, Sunday outing, ice cream, family time, an unrestricted hour, or simply being with people who do not judge.

Aspirations for the Future

Higher-order domain	Theme	Key codes	Representative quotes	Interpretation
AUTONOMY	Financial independence and freedom	Financial security, independence, supporting family, freedom, hobbies	"I do not want to depend on others." / "Money is an important part of it... I want that freedom."	Financial security is valued not as an end in itself, but as a means to independence, choice and the ability to support others.
TIME & BALANCE	Reclaiming time	Sleep, travel, family time, hobbies, own pace, balanced life	"Time... what I lost now. I want it." / "My own pace to work... balanced life... time with family."	The future is imagined as having greater control over time, after the intensity and constraints of residency.
PURPOSE	Ethical and meaningful practice	Ethical practice, learning from institution, making a difference, patient care	"I look forward to make a difference."	The resident's aspiration extends beyond career progression towards practising medicine ethically and creating meaningful impact.
CONNECTION	Good teams and shared work	Teamwork, solving patient challenges, friendship, fun, collaboration	"I enjoy good team... to solve patient challenges... and to have fun together."	The desired future includes a workplace where professional collaboration and human connection coexist.
SAFETY & TRUST	Being a safe specialist	Clinical competence, patient safety, team safety, trust, responsibility	"I should be able to do the best for my patients...they should feel that they are in safe hands. Also my team should feel safe too."	Professional success is ultimately defined by the ability to create safety and trust for both patients and colleagues.

Overall Thematic Synthesis

The analysis reveals five interconnected dimensions of aspirations of the future

AUTONOMY — *I want the freedom to choose.*

TIME & BALANCE — *I want my life back.*

PURPOSE — *I want to make a difference.*

CONNECTION — *I want to work with people I enjoy and trust.*

SAFETY & TRUST — *I want to be a specialist others can feel safe with.*

Together, these aspirations suggest that residents are not simply dreaming of finishing training or earning more. They are imagining a future with greater autonomy, time, purpose, connection and the confidence to practise safely and ethically.

Anxieties about Future

Thematic Analysis

Higher-order domain	Theme	Key codes	Representative quotes	Interpretation
CAREER & ECONOMIC SECURITY	Uncertainty about work and financial security	Job availability, job saturation, underpayment, competition, reasonable pay, employability	“Will I get a job? Will I get a job where I like? Will I be paid reasonable?”	The transition from residency to independent practice is accompanied by uncertainty about employment, remuneration and the ability to establish a sustainable career.
HEALTH & SUSTAINABILITY	Fear that overwork will continue	No sleep, poor food, no exercise, stress, exhaustion, loss of life outside work	“Will that change when I start working? Or it will be same... my health will go?”	Residents are uncertain whether entering professional practice will improve their wellbeing or simply reproduce the conditions of residency.
PROFESSIONAL SAFETY	Fear of violence, medicolegal risk and misinformation	Violence against doctors, public mistrust, misinformation, medicolegal problems, media, lack of support	“Violence on doctors... trust is also not there. I worry about that.” / “We have no idea when we work... so we are scared how to respond.”	Future professional life is perceived as carrying risks for which residents feel insufficiently prepared, particularly around violence, legal complexity and public communication.
PROFESSIONAL IDENTITY	Uncertainty about recognition and equivalence	MD/MS hierarchy, DNB perception, competition, discrimination, equivalence “on paper”, institutional expectations	“Equivalence is in paper, in reality...”	Anxiety extends beyond getting a job to whether the qualification will be recognised and whether residents will be treated equitably in the professional system.

COMPETENCE & RESPONSIBILITY	Fear of becoming fully responsible	Independent practice, mistakes, competence, decision-making, increased responsibility	“Will I be competent? Will I make mistakes?”	The resident recognises that postgraduate training will eventually give way to independent responsibility, creating uncertainty about readiness and the consequences of mistakes.
LOSS & LIFE BALANCE	Fear of losing life beyond medicine	Missing student life, lack of time, hobbies, family, personal life, continuous work	“Whether the same story continues... will I not have any time for anything else?”	The future is feared not only because of professional uncertainty but because residents worry that work may continue to consume their lives.
VOICE & PUBLIC TRUST	Fear of being misunderstood	Media narratives, public perception, misinformation, doctors blamed, lack of support, stereotypes	“No one sees our struggle... the countless sacrifice that we make.”	Residents perceive a gap between the reality of their professional effort and how doctors are represented or understood by society.

Overall Thematic Synthesis

Residents are anxious about entering a professional world in which they will have more responsibility, greater competition and new risks, while fearing that the pressures of residency may simply continue. At the same time, they articulate remarkably specific conditions that would help them transition with greater competence, safety, sustainability and confidence.

Research in Residency

Thematic Analysis

Higher-order Theme	Subthemes	Representative Insights
1. Research Skills & Technical Capacity	Statistics support; citation and referencing; difficulty understanding technical feedback	Residents requested greater support with statistics and citation. Technical feedback from supervisors or statisticians was sometimes difficult to understand because of specialised terminology, requiring repeated clarification.
2. Communication & Translation of Expertise	Technical language as a barrier; accessible guidance	Research guidance was sometimes experienced as being “lost in translation.” Residents wanted technical experts and supervisors to explain concepts in language accessible to novice researchers.
3. Time Burden within Residency	Clinical workload; transition into residency; lack of protected research time	Residents described starting residency while simultaneously adapting to a new hospital, specialty and work culture. Managing a thesis alongside clinical responsibilities created substantial additional pressure.
4. Operational Challenges of Clinical Research	Patient follow-up; fixed submission deadlines; balancing service and research	Prospective research was difficult to sustain alongside clinical duties, particularly when patients moved between OPD, wards, ICU, theatre and discharge.
5. Misalignment between Research Requirements & Resident Interests	Desire for flexibility; optional thesis; alternative scholarly pathways	Some residents questioned whether a thesis should be mandatory and suggested alternatives such as quality-improvement projects, management projects, rural health work and case-based scholarly activities.
6. Structural Rigidity of the Thesis Process	Strict timelines; mandatory milestones; limited flexibility	Rigid timelines were perceived as insufficiently responsive to clinical workload and the realities of conducting research, contributing to avoidable stress.

7. Suggestions for System Redesign	Shared projects across batches; flexible timelines; multiple academic pathways	Residents proposed continuing larger projects across successive batches, allowing greater flexibility in completion timelines and providing alternative routes for scholarly work.
8. Educational Value of Research Training	Ethics; scientific integrity; research governance	Despite frustrations with the process, residents recognised the importance of research training in developing ethical practice, scientific rigour and understanding of research governance.
9. Emotional Experience of Thesis Work	Pressure; cognitive overload; feeling overwhelmed; continuous burden	The thesis was experienced as a persistent cognitive and emotional burden layered onto demanding clinical responsibilities, contributing to a sense of being overwhelmed.

Overall Thematic Synthesis

The thesis experience reflects a tension between the educational value of research and the way research is structurally embedded within residency.

Residents value learning research, but struggle when research becomes another rigid demand layered onto an already demanding clinical programme.

The findings point towards a need to shift from “completing a thesis” towards “learning to do meaningful research” with accessible mentorship, protected time, practical support and greater flexibility in how scholarly competence is demonstrated.

THE RESIDENT EXPERIENCE FRAMEWORK



This framework captures what residents are living today and what they to build for tomorrow. It is not just about training the next doctor, it is about nurturing the whole doctor.

If you become the Director...

Higher-order Theme	Subthemes	Representative Insights
1. Structured Learning & Academic Support	Regular case presentations; communication training; medicolegal education; webinars; co-curricular activities	Residents want a more structured academic programme that goes beyond routine clinical work and prepares them for communication, medicolegal and professional responsibilities.
2. Research & Statistical Support	Statistics support; research guidance; PSM support	Residents proposed accessible research and statistical support, including dedicated PSM support across smaller institutions.
3. Mentorship & Accessible Faculty	Dedicated mentor time; approachable faculty; confidential discussion; supportive communication	“Mentor to spend more time with the students... they should feel comfortable in sharing any issue.” The emphasis is on relationships in which residents can speak openly without fear.
4. Safe, Respectful & Non-Hierarchical Culture	Non-judgemental leadership; respectful communication; discussion spaces; psychologically safe workplace	“Safe non-hierarchical workplace culture.” Residents want faculty and consultants to communicate respectfully and create spaces where learning and discussion are possible.
5. Rest, Recovery & Physical Environment	Weekly off; leave without stress; outdoor spaces; privacy; nutritious food	Residents identified basic conditions for recovery: compulsory weekly offs, accessible leave, private outdoor spaces and nutritious food.
6. Recognition & Appreciation	PG recognition; regular appreciation; rewards	“Appreciate PGs regularly.” Recognition is seen as an important part of creating a positive learning environment.
7. Physical & Personal Safety	Increased security; protection in high-risk settings	Residents specifically identified the need for increased security, particularly in areas where large numbers of people gather.
8. Resident Representation & Voice	RDA representation; DNB inclusion; collective voice	Residents highlighted the need for DNB residents to have representation within resident associations, either through integration with existing associations or an independent DNB resident body.

Overall Thematic Synthesis

The residents’ responses to “If you became Director...” move beyond identifying problems. They describe the institutional conditions they believe would make residency safer, more supportive and more educational.

The recurring priorities are:

LEARNING — *Teach us deliberately.*

MENTORSHIP — *Be available to us.*

SAFETY — *Let us learn without fear.*

WELLBEING — *Give us time and space to recover.*

RECOGNITION — *Acknowledge our effort.*

VOICE — *Give us representation.*

What residents would change is remarkably practical: better teaching, accessible mentors, respectful culture, protected rest, safer spaces, recognition and a voice in the system.

QUAL – QUAN METHOD

We used a sequential mixed-methods, multi-context exploration to identify core resident experiences across states and cultural contexts.

1. QUALITATIVE — Listen

In-depth interviews allowed residents to describe their experiences in their own words and enabled the initial themes to emerge from the data.

2. SURVEY — Test

These qualitative themes were translated into experience statements and presented to a wider resident group, who indicated whether they related, did not relate, or had a different experience.

3. MULTI-CONTEXT IN-DEPTH INTERVIEWS — Explore

Online in-depth interviews with residents from different states and contexts explored the realities behind the responses and examined whether the emerging themes held across different cultural and institutional settings.

4. SYNTHESIS — Identify what is shared

Findings across the stages were brought together to distinguish core experiences that remained consistent across contexts from differences in how those experiences were expressed and lived.

The methodological intent

Listen deeply. Test widely. Explore across contexts. Identify what is shared.

Triangulation

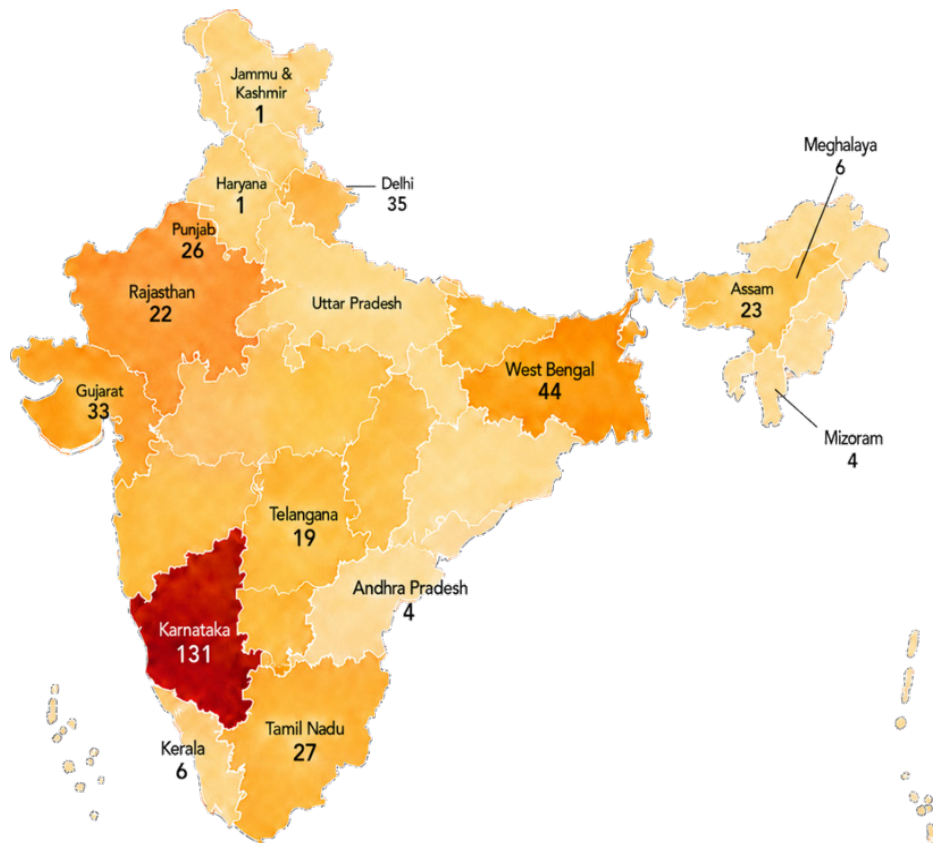
Cross-Method and Cross-Context Convergence Analysis

We compared findings across qualitative interviews, survey responses and multi-context in-depth interviews to identify convergence, complementarity and divergence. Consistent recurrence of the same themes across methods and states supported their interpretation as core resident experiences, while differences in their expression were examined as contextual variation.

National Survey

The national survey was shared with ANBAI state chapters and 15 states participated with a total of 382 responses;

Responses across India



Characteristics of the participants

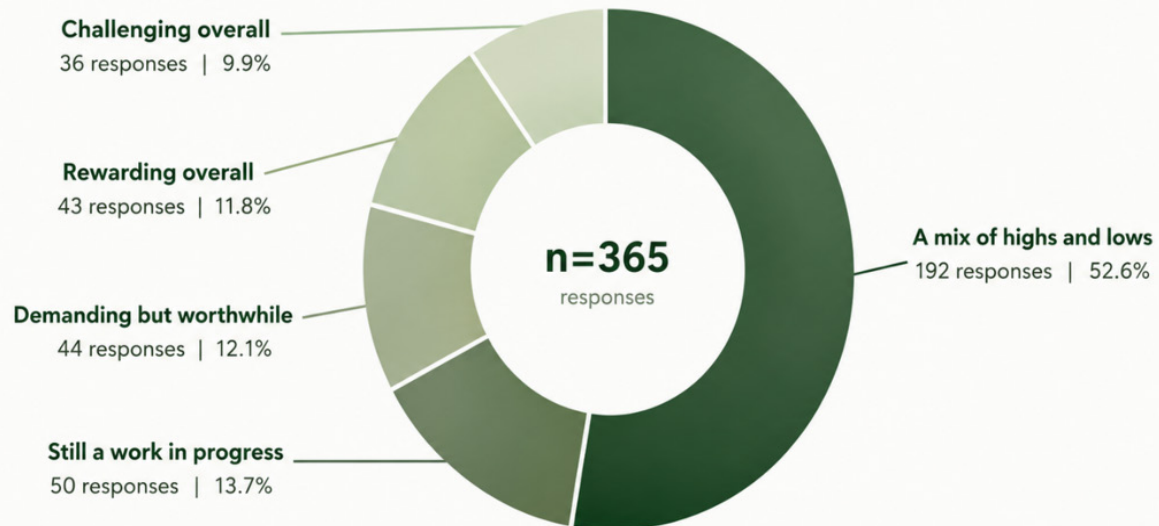
Characteristics	Variable	n(%)
Age	Median (IQR)	29 years (27–31 years)
Gender	Female	183 (48%)
	Male	199 (52%)
Degree pursued	DNB/Diploma/Post Diploma	291 (76%)
	DrNB	91
Year of residency	First	142 (37.1%)
	Second	137
	Third	104

1. APL & ANR Area Hospital, Gudivada, Andhra Pradesh
2. Government General Hospital, Nandyal, Andhra Pradesh
3. Apollo Excelcare Hospital, Guwahati, Assam
4. Apollo Hospital, Guwahati, Assam
5. Downtown Hospital, Guwahati, Assam
6. Hayat Hospital, Guwahati, Assam
7. Health City Hospital, Guwahati, Assam
8. Rahman Hospital, Guwahati, Assam
9. Indraprastha Apollo Hospital, New Delhi
10. Sir Ganga Ram Hospital, New Delhi
11. Apex Heart Institute, Ahmedabad, Gujarat
12. GMERS Medical College & Hospital, Dharpur, Gujarat
13. GMERS Medical College & Hospital, Himmatnagar, Gujarat
14. GMERS Medical College, Gandhinagar, Gujarat
15. GMERS Medical College, Panchmahal, Gujarat
16. GMERS Medical College, Porbandar, Gujarat
17. GMERS Vadnagar, Gujarat
18. KD Hospital, Ahmedabad, Gujarat
19. Sarvodaya Health Care Centre, Faridabad, Haryana
20. Government Medical College, Udhampur, Jammu and Kashmir
21. Aster Hospital, Bangalore, Karnataka
22. Bangalore Baptist Hospital (BBH), Bangalore, Karnataka
23. Bhagwan Mahaveer Jain Hospital, Bangalore, Karnataka
24. Chinmaya Mission Hospital, Bangalore, Karnataka
25. Cura Multi-Specialty Hospital, Bangalore, Karnataka
26. District Hospital, Ballari, Karnataka
27. District Hospital, Chikkaballapur, Karnataka
28. District Hospital, Dharwad, Karnataka
29. District Hospital, Ramanagara, Karnataka
30. District Hospital, Udupi, Karnataka
31. Doddaballapura General Hospital, Doddaballapur, Karnataka
32. Fortis Hospital, Bannerghatta, Karnataka
33. General Hospital, Holenarasipura, Karnataka
34. General Hospital, Kolar, Karnataka
35. General Hospital, Tumkur, Karnataka
36. Gleneagles BGS Bangalore, Karnataka,
37. HCG Cancer Hospital, Bangalore, Karnataka
38. Jaya Chamarajendra Taluk General Hospital, Hassan, Karnataka
39. Jayanagar General Hospital, Bangalore, Karnataka
40. K.C. General Hospital, Bangalore, Karnataka
41. MCH Pavagada, Tumkur, Karnataka
42. Narayana Health / Narayana Hrudayalaya, Bangalore, Karnataka
43. Narayana Nethralaya, Bangalore, Karnataka
44. Nethradhama Super Speciality Eye Hospital, Bangalore, Karnataka

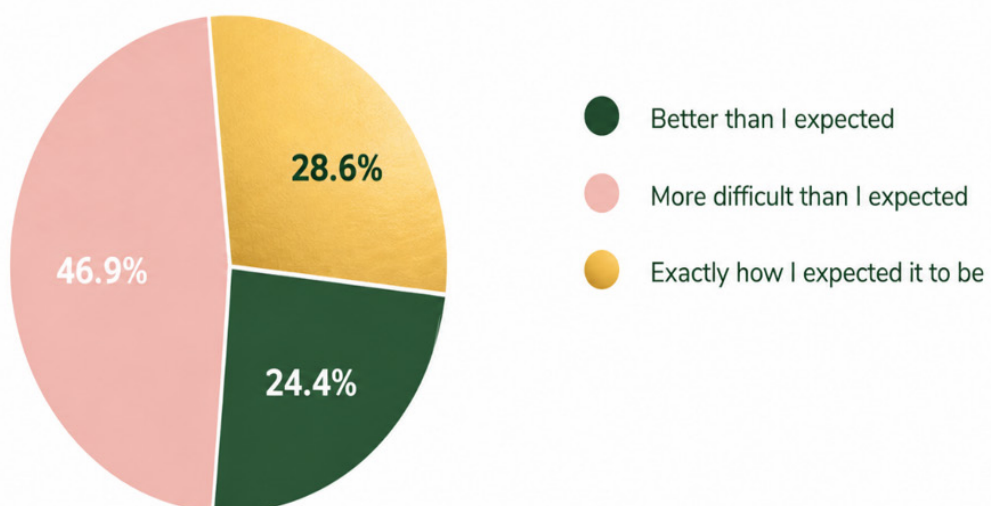
45. NU Hospitals, Bangalore, Karnataka
46. NU Trust Hospitals, Bangalore, Karnataka
47. Prabha eye clinic and research Centre, Bangalore, Karnataka
48. Sankara Eye Hospital, Bangalore, Karnataka
49. Sankara Eye Hospital, Shivamogga, Karnataka
50. SDH Gangavathi, Bangalore, Karnataka
51. Shifaa Hospital, Bangalore, Karnataka
52. Sparsh Hospital, Bangalore, Karnataka
53. Sir C. V. Raman General Hospital, Bangalore, Karnataka
54. Sri Shankara Cancer Hospital & Research Centre, Bangalore, Karnataka
55. St. Martha's Hospital, Bangalore, Karnataka
56. St. Philomena's Hospital, Bangalore, Karnataka
57. Sub-Divisional Hospital, Sagara, Karnataka
58. Taluk Hospital, Bhadravati, Karnataka
59. Taluka General Hospital, Athani, Karnataka
60. Wenlock District Hospital, Mangalore, Karnataka
61. EMS Hospital, Perinthalmanna, Kerala
62. Kerala Institute of Medical Sciences, Thiruvananthapuram, Kerala
63. Kinder Hospital, Kochi, Kerala
64. KIMSHEALTH, Thiruvananthapuram, Kerala
65. Bethany Hospital, Shillong, Meghalaya
66. Nazareth Hospital, Shillong, Meghalaya
67. Civil Hospital, Aizawl, Mizoram
68. Amandeep Hospital, Amritsar, Punjab
69. Civil Hospital, Pathankot, Punjab
70. Oberoi Hospital, Jalandhar, Punjab
71. SKR Hospital & Trauma Centre, Pathankot, Punjab
72. Bhagwan Mahaveer Cancer Hospital & Research Centre, Jaipur, Rajasthan
73. Mahavir Jaipuria Rajasthan Hospital, Jaipur, Rajasthan
74. Rajasthan Hospital, Jaipur, Rajasthan
75. Billroth Hospitals, Chennai, Tamil Nadu
76. Cancer Institute, Chennai, Tamil Nadu
77. Christian Fellowship Hospital, Oddanchatram, Tamil Nadu
78. Ganga Hospital and Medical Centre, Coimbatore, Tamil Nadu
79. KMC, Trichy, Tamil Nadu
80. Kauvery Medical Center and Hospital, Tamil Nadu
81. Krishna Children Hospital, Tirunelveli, Tamil Nadu
82. MGM Healthcare, Chennai, Tamil Nadu
83. SIMS Hospital, Chennai, Tamil Nadu
84. SRM Institute of Medical Sciences, Vadapalani, Tamil Nadu
85. Yashoda Hospitals, Telangana
86. Peerless Hospital & B.K. Roy Research Centre, Kolkata, West Bengal
87. SGCCRI, Kolkata, West Bengal
88. Tata Medical Center, Kolkata, West Bengal

Overall Residency Experience

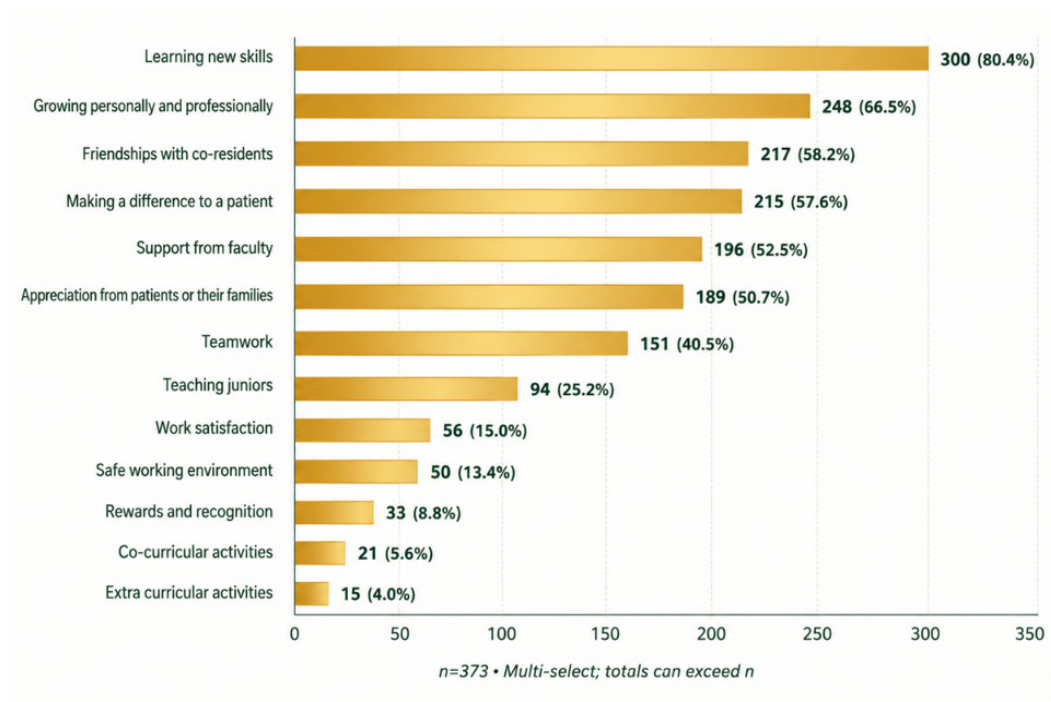
Most residents described residency as a mix of highs and lows.



How has residency matched expectations?



Joys in Residency: (n=373)



Challenges in Residency : (n=378)

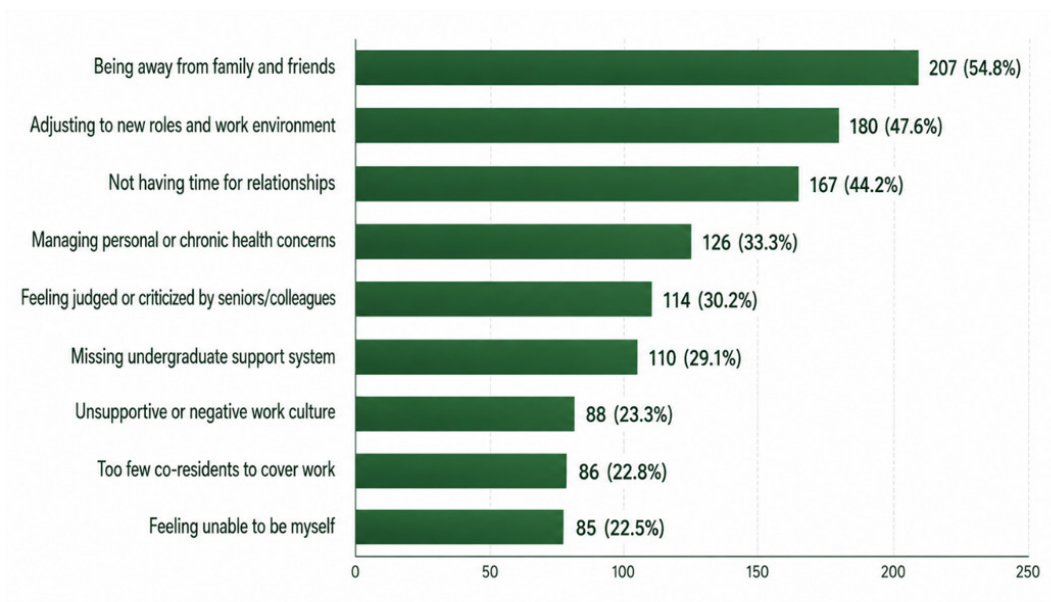
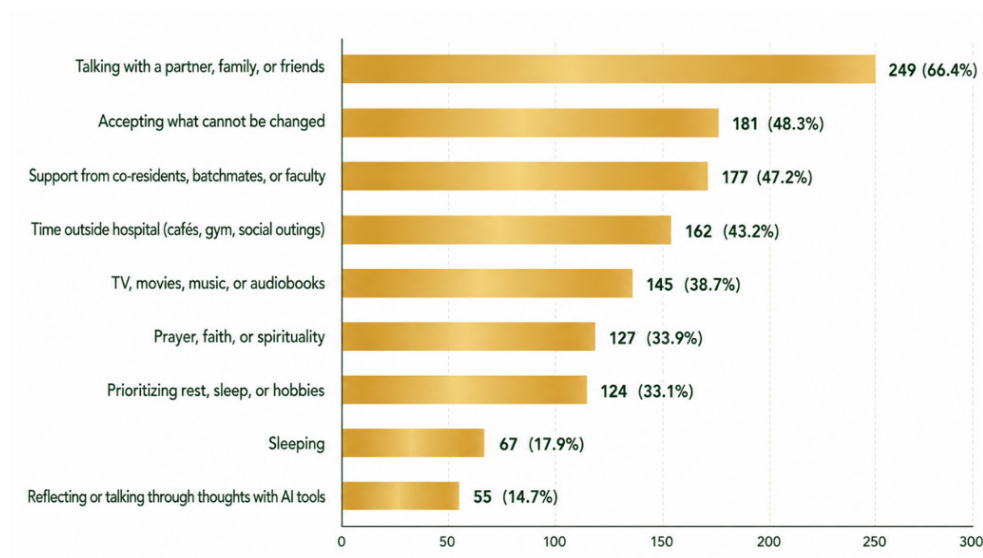


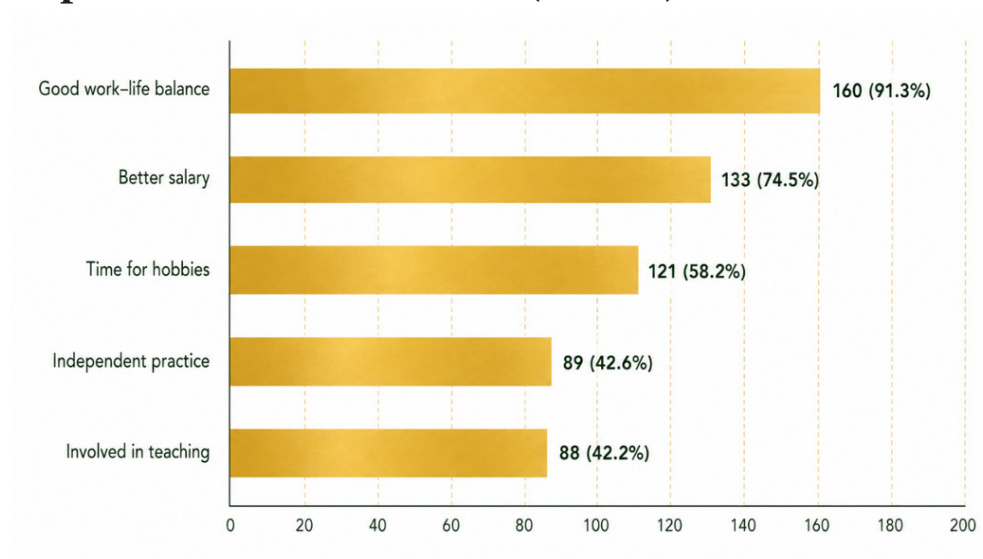
Table: Additional challenges reported by residents

Challenge	N (%)
Burn out/emotional exhaustion	78 (21%)
Limited leaves	57 (15.8%)
No access to accommodation in the institute	47 (12.4%)
Financial burden	53 (14.2%)
Communication of medicolegal concerns	14 (3.7%)

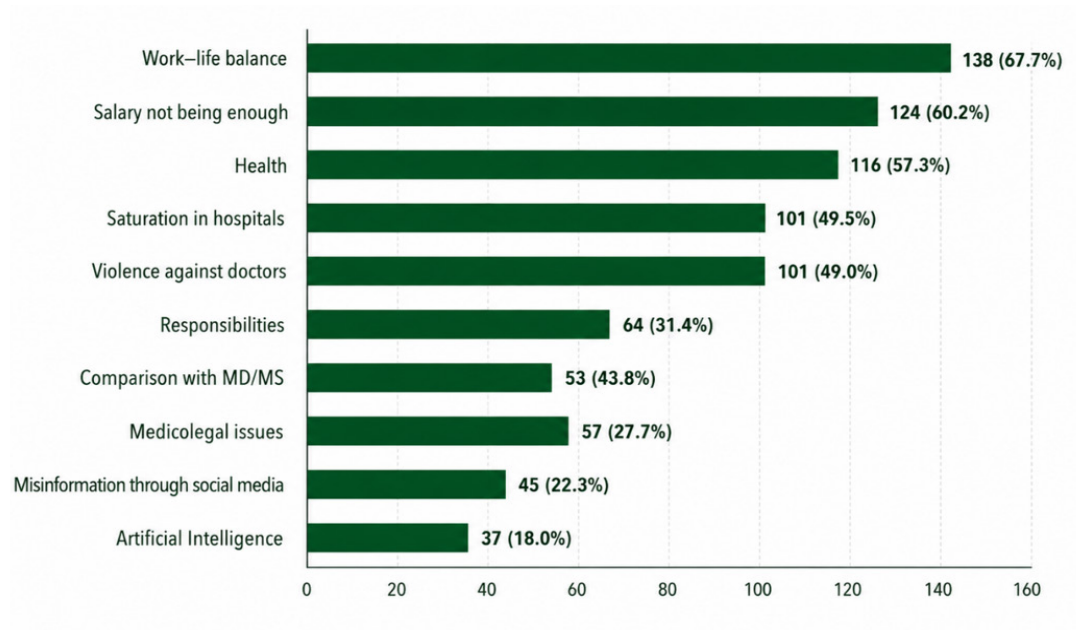
Coping with the challenges of residency (n=376)



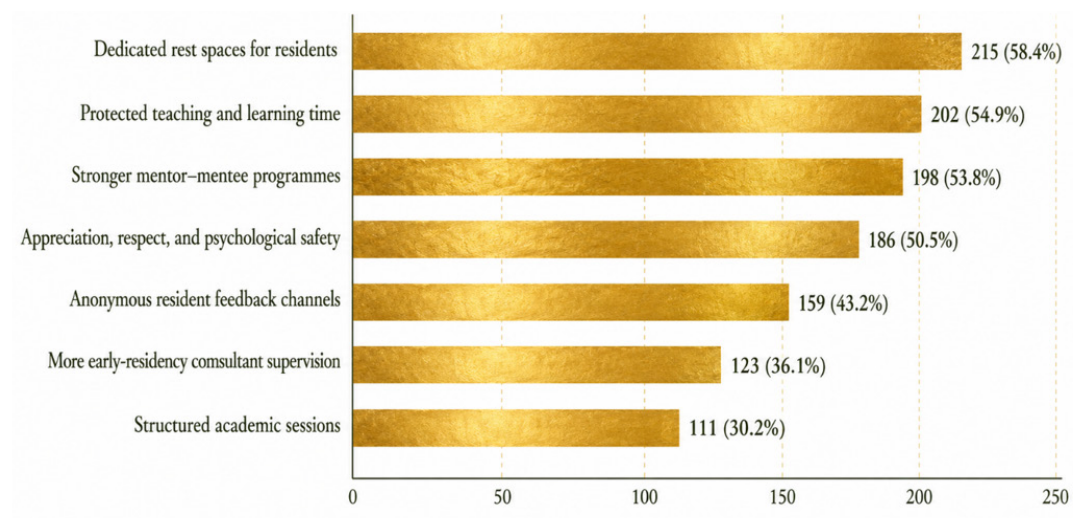
Aspirations about Future: (n=207)



Anxieties about Future: (n=206)



If you were Director,... (n=370)



Across states and cultural contexts, the core resident experience remained remarkably consistent. What varied was how residents described, experienced and responded to these themes within their particular context.

Quick Wins — Designing Within Reality

Residents first proposed changes they believed could improve everyday residency. They were then asked to step into the role of administrators and faculty: to consider the operational constraints, competing priorities and realities of implementation, and then refine their solutions accordingly.

The principle

The goal was not to find the perfect solution. It was to learn how to design a better solution within the realities of the system.

Quick Win section is pragmatic because residents are not positioned simply as people asking for change. They are being invited to understand systems, constraints, trade-offs and implementation and to become co-designers of solutions.

Small, practical changes that can be implemented immediately, without waiting for a new policy, major infrastructure or institutional redesign.

Small changes. Immediate impact. Resident-informed.

Resident need identified	Quick Win	What can change now
"I need someone to talk to."	Named Resident Support Person	Identify a trusted faculty/mentor whom residents can approach confidentially.
"Teaching happens when there is time."	Protected Teaching Slot	Fix a regular, predictable teaching period within the working schedule.
"I don't know whom to approach."	Resident Navigation Guide	One simple page showing whom to contact for academic, personal, safety, research and administrative concerns.
"We need feedback that helps us learn."	Constructive Feedback Routine	End selected clinical encounters/procedures with a brief "What went well? What can improve? What next?" conversation.
"We are exhausted."	Protected Weekly Off / Post-duty Rest	Ensure residents know the expected rest arrangement and whom to approach when it is not possible.
"We don't get recognised."	Everyday Recognition	Regularly acknowledge small clinical, academic, teamwork and patient-care achievements.
"We don't know the culture."	Culture Orientation	At induction, explicitly explain communication norms, hierarchy, expectations, escalation pathways and boundaries.
"We are expected to know things nobody taught us."	Micro-skills Sessions	Short practical sessions on breaking bad news, medicolegal situations, difficult relatives, communication and handling misinformation.
"We don't have space to breathe."	Resident Pause Space	Identify an existing small space where residents can sit, eat, talk or decompress without clinical interruption.
"Research feels overwhelming."	Research Help Desk	A defined contact for statistics, methodology, referencing and basic research queries.

Quick Wins — Action Boards

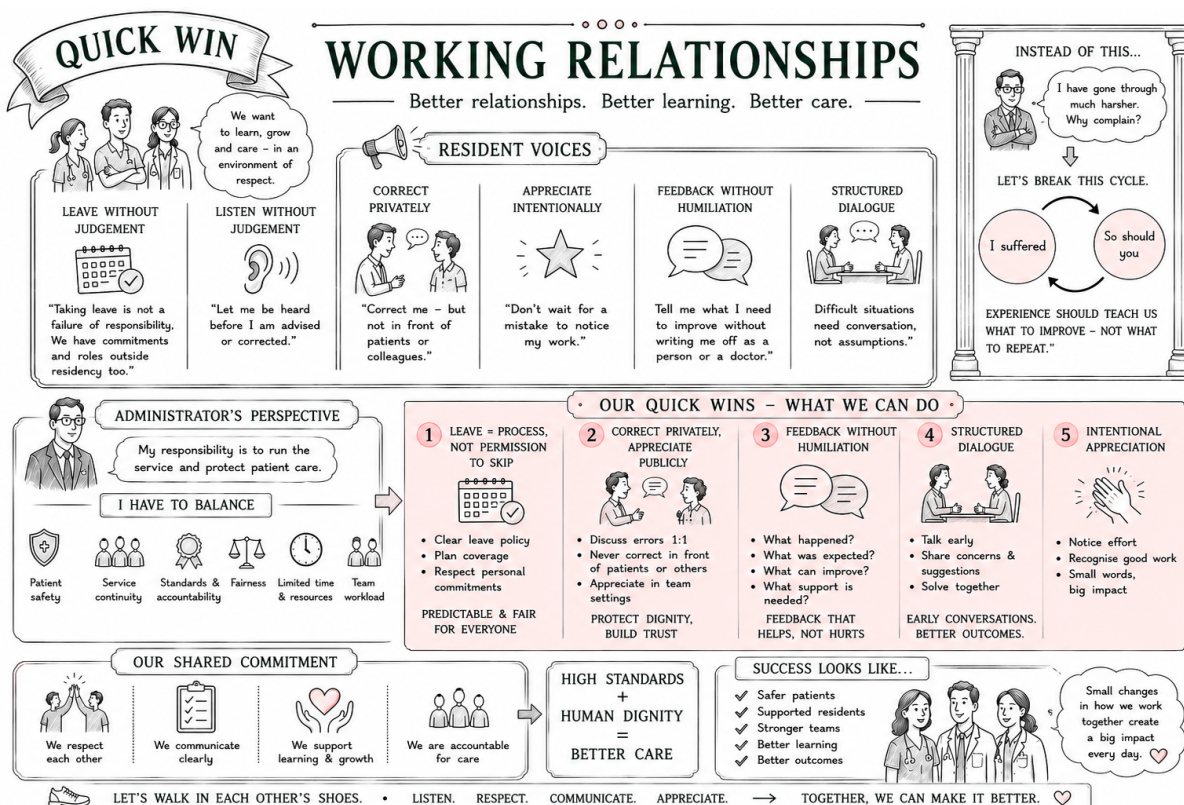
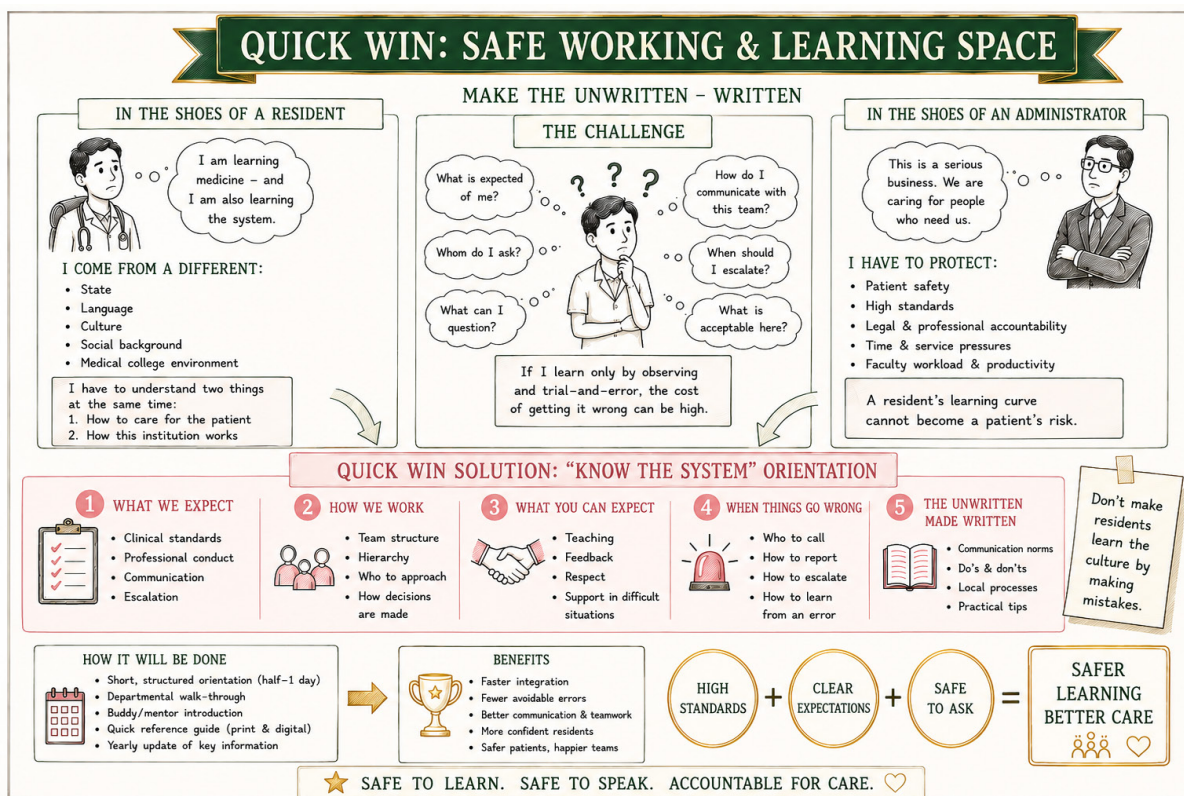
Each Action Board brings together three perspectives: what residents need, the constraints faced by faculty and administrators, and what can realistically be done.

Organised across seven practical areas, the boards offer principles and examples—not prescriptions—so each institution can identify its own low-hanging fruits and adapt them to its context.

These action boards are not a prescription of what every institution should do. They offer practical principles, tested ideas and real constraints as a starting point for each institution to identify its own low-hanging fruits and create an action plan that fits its context.

The approach is deliberately bottom-up: listen to residents, understand the realities of faculty and administrators, work within local constraints, and co-create what is possible.

The goal is not to implement the same solution everywhere, but to build a culture of constructive dialogue, mutual respect and shared responsibility where residents, faculty and administrators learn to work together to make meaningful change.



QUICK WIN : DUTY HOURS

WALK IN THEIR SHOES



We need restricted working hours. Duty hours are too long and unpredictable.

WHAT DO I WANT?

- Predictable duty hours
- Less avoidable extension
- Adequate rest
- Better work-life balance

WHAT DO I HAVE TO PROTECT?



I cannot simply add people or increase the salary bill. Now solve the problem.

WHAT CAN WE CHANGE NOW?

- Identify where hours are unnecessarily extended
- Match staffing to workload peaks
- Stagger duty timings where feasible
- Redistribute routine work within the existing team
- Reduce unnecessary post-call workload
- Allow departments to develop their own workable roster

DUTY-HOUR OPTIMISATION

Reduce avoidable excess working hours through better roster design, workload-based scheduling and departmental flexibility – within the existing manpower and salary budget.

DIFFERENT SHOES, SAME GOAL.

RESIDENT PERSPECTIVE



"I need my hours to be manageable."

ADMINISTRATOR PERSPECTIVE



"I need the hospital to remain viable."

QUICK WIN

HOW CAN WE ACHIEVE BOTH?

Small changes now. Sustainable impact for all.

QUICK WIN : STRUCTURED ACADEMICS

Small. Regular. Planned. Exam-relevant.

We are learning by doing, but we also need deliberate opportunities to learn.



RESIDENT VOICE

- Teaching happens sometimes, not in a planned fashion.
- Clinical work takes priority – teaching gets sacrificed.
- Seminars & academics happen in odd hours.
- We need practice for case presentations, OSCE, exams.
- Not aware if sessions can be downloaded or watched later.
- We are busy. We need teaching that fits into working time.

Patients to be looked after along with academics. Let's make teaching intentional – without stopping patient care.

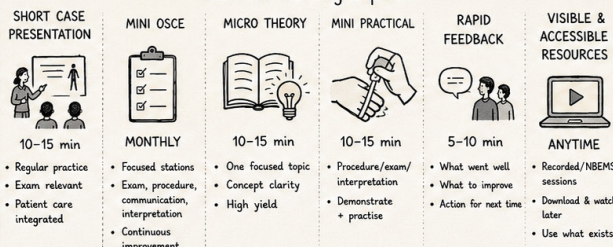


ADMINISTRATOR'S LENS

- Patients must be cared for.
- Consultants have clinical responsibilities.
- More teaching staff = increased salary envelope.
- Everything in working hours must also be available for patients.

REGULAR MICRO-MINI ACADEMIC SESSIONS

Small sessions. Big impact.



STRUCTURED ACADEMIC CALENDAR – PUBLISHED IN ADVANCE
✓ What ✓ When ✓ Who ✓ Where

FINAL YEAR – ONE INTENSE EXAM IMMERSION WORKSHOP

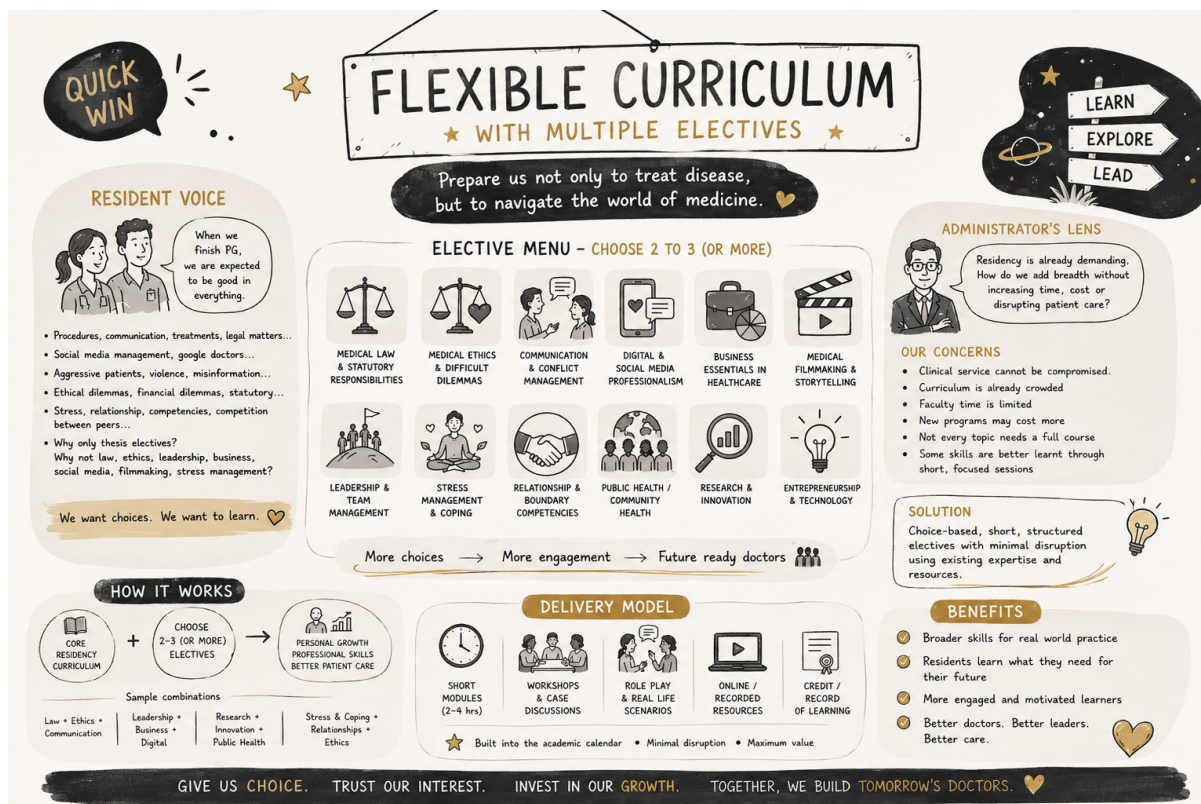
A dedicated time. Focused preparation. Maximum impact.



- ★ Planned in advance
- ★ Time protected
- ★ Faculty focus
- ★ Practice-based
- ★ Feedback-rich

Teach with intention. Learn with purpose. Care with excellence.

NOT MORE HOURS. | BETTER STRUCTURE. | CONSISTENT PRACTICE. | STRONGER RESIDENTS. | BETTER CARE.



A Space To Be

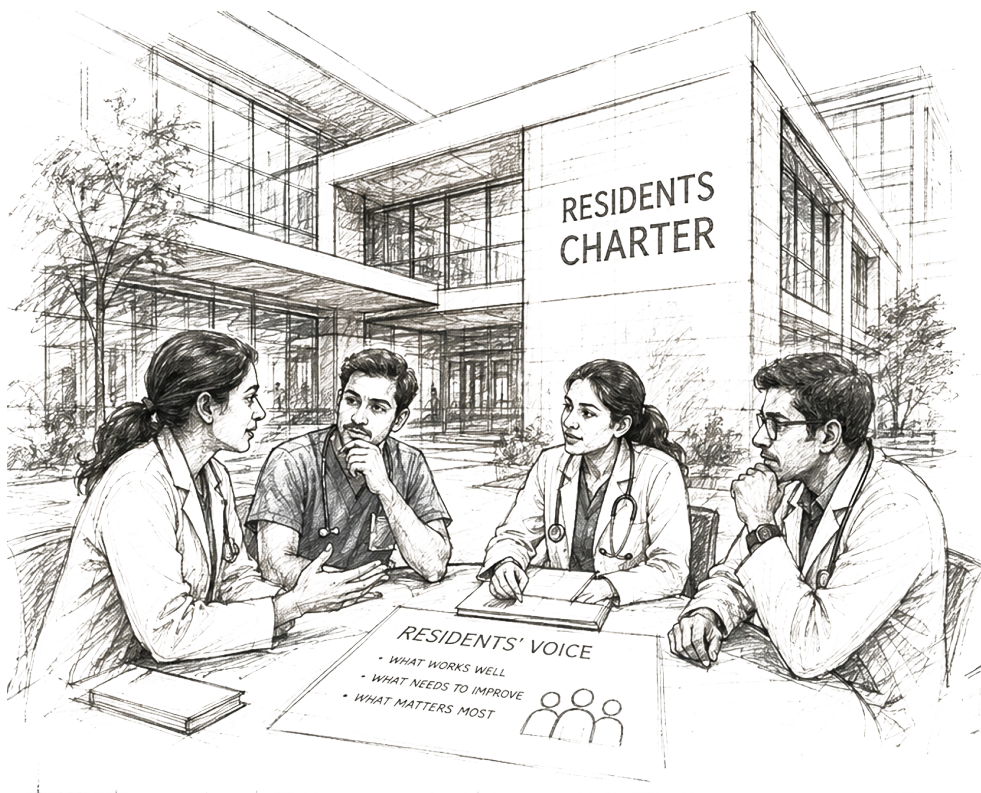
Residents spend long hours in an ecosystem where they encounter illness, suffering, urgency and responsibility every day. They also need a place where, for a while, they do not have to be doctors.

Residents spend much of their lives in the hospital. They deserve a part of it that brings them joy. A space that is beautiful, welcoming and theirs not because they are tired, but because they are human.

A coffee. Music. A book. A conversation. A game. A workout. Plants. Natural light. A Friendly chit chat. A cozy corner.

A space to step away from the work, without stepping away from who they are.





Residents Charter

The **Residents Charter** brings together what residents told us, what emerged from the analysis, and what they believe should shape the residency experience.

It is not a list of demands or a uniform prescription. It is a shared set of principles to help institutions create learning environments that are safe, respectful, supportive and purposeful.

1. BELONGING

Make the culture visible.

Residents should know where they belong, what is expected and how the system works.

2. SAFETY & VOICE

Make it safe to speak and learn.

Residents should be able to ask, question, make mistakes and seek help without fear of judgement or labelling.

3. LEARNING

Protect the opportunity to become competent.

Clinical service and learning should strengthen each other, not compete with each other.

4. RELATIONSHIPS

Teach with respect.

How residents are taught, corrected, encouraged and recognised shapes how they learn and who they become.

5. WELLBEING

Make recovery part of residency.

Sleep, health, relationships, recreation and life outside medicine are part of sustainable training, not privileges after the work is done.

6. RESPONSIBILITY

Prepare residents for the doctor they are becoming.

Residents need graduated responsibility, supervision and practical preparation for communication, difficult situations, safety and independent practice.

7. VOICE & CO-OWNERSHIP

Design residency together.

Residents, faculty and administrators should listen to one another, understand constraints and co-create solutions that work in their own setting.

Reflections

After completing my residency and joining Bangalore Baptist Hospital's Department of Community Medicine as a junior consultant, I began working closely with DNB residents during their postings and thesis guidance. Having recently experienced residency myself, many of their struggles felt familiar.

Over time, I began to see that residency involved far more than academics and clinical work. Residents were navigating heavy workloads, deadlines, personal responsibilities, institutional culture and uncertainty about the future. While every journey was different, many experiences were strikingly common. Yet there were few spaces where residents could openly share these experiences or contribute to shaping the systems in which they trained.

Around this time, workshops in qualitative research and participatory methods, particularly Theatre of the Oppressed, showed me how storytelling, dialogue and collective reflection could help people articulate experiences that conventional questions may not capture. Dr. Carol, our HOD, then posed a question that stayed with me:

How can residency become safer, more meaningful and more supportive without compromising academic rigor?

She encouraged us to move beyond conventional surveys and create space for residents to speak, listen to one another and reflect together. This led first to a pilot focus group with five DNB residents, followed by the Voices of Residents Workshop and a wider survey. What began as a local conversation gradually became an exploration across institutions and regions, revealing both the diversity of residency experiences and the remarkable consistency of the core themes.

What brought me the greatest happiness was seeing what happened when we created a space to express and then make Quick Wins together. The process itself became evidence that change does not always have to begin with a large programme or a new policy. Sometimes, it begins with people listening to one another and discovering that they can create something together.

- *Dr. Savinitha*

Reflections

It has been almost fifteen years since I completed my residency. Yet when I look at residents today, across different batches and generations, I can still recognise the struggles. What has changed is how each generation expresses its needs.

Having been a student, faculty member and administrator, I have had the opportunity to see residency from different sides. When I deliberately put myself in each of these shoes, I see something striking: *everyone is carrying something*. Residents feel unheard and powerless. Faculty often feel that residents are not sufficiently committed. Administrators carry the realities of running a hospital and ensuring that patient care continues. Everyone wants things to improve, yet something often prevents the conversation from happening.

Perhaps the difficulty is not that people do not care. *It is that they are seeing the same system from different places*. Concerns remain unspoken, assumptions grow, and both sides gradually learn to adjust rather than talk. In healthcare, where the work must continue and patients cannot wait, we often tell ourselves that things will somehow settle with time.

The National Conclave gave us an opportunity to pause and ask: *Can we actually listen to each other? Can we understand what lies behind the frustration on both sides? And can we find changes that are practical rather than merely desirable?*

The idea was encouraged by the national leadership, who supported us through their networks and gave us the freedom to explore these conversations. Dr. Savinitha brought the freshness of someone who had recently lived the resident experience, along with an ability to listen and connect. Our psychologists and social workers helped bring the ideas into action. Mentors and senior faculty from different parts of the country brought perspectives from different roles, institutions and levels of responsibility. And my DNB students opened their hearts to us with trust.

As the conversations grew, my hope became simpler.

Not another policy. Not another manual. Not another academic exercise.

But perhaps, if we listen carefully enough, a little more understanding, a little more respect, and a few things that people can actually do differently.

That, for me, is the purpose of *Voices of Residents*.

- Dr. Carol

The Conversation Continues...

We began by listening.
What emerged was more than a collection of problems.

It was a picture of belonging, growth, contribution, wellbeing, responsibility and hope.

The conversations also showed us something important:

Change does not belong to one side.

Residents understand the pressures of the system.

Faculty understand the demands of teaching.

Administrators understand the realities of running institutions.

When these perspectives meet with curiosity, respect and openness, possibilities emerge.

The Quick Wins are an invitation to begin there.

Listen . Understand . Design together.

Not with one side telling the other what to do.

But with residents, faculty and administrators seeing the same system from different places and choosing to understand one another.

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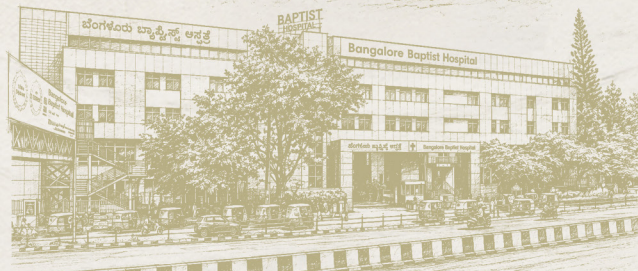
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Not a Finished Answer. A Shared Starting Point.

VOICES OF RESIDENTS

ANBAI Residents Charter 2026



ANBAI NATIONAL CONCLAVE 2026

ASPIRE • ELEVATE • LEAD

29-30 AUGUST 2026

BANGALORE BAPTIST HOSPITAL, BENGALURU