Leadership Reflections in Geriatric Medicine: What Indian Trainees Learned from Interviewing National Experts

Introduction

India is experiencing one of the fastest demographic transitions globally, with older adults projected to constitute nearly 20% of the population by 2050.[1] While geriatric medicine is expanding, structured opportunities for trainees to engage with senior leaders and reflect on career pathways, policy barriers, and system failures remain limited.

As part of the 2025 IAGG ASIO e-TRIGGER educational program, four Indian trainees conducted structured leadership interviews with four nationally recognized geriatric experts — Dr. Prasun Chatterjee (AIIMS, New Delhi), Dr. D. Nagendar (Apollo Institute, Hyderabad), Dr. Guruprasad T. S. (Swarga Foundation, Coimbatore), and Dr. B. Janarthanan (Chennai) – representing academia, clinical medicine, community practice, and policy advocacy. This activity was designed solely as a leadership learning exercise, not as formal qualitative research. We therefore present this letter as a reflection on the educational value of interviewing leaders and offer specific lessons relevant to geriatric care in India.

What we Learned About Careers in Indian Geriatrics

All leaders described career pathways shaped more by systemic neglect than by personal choice. Common challenges included:

- Absence of geriatric departments in most medical colleges
- Limited postgraduate training positions
- Poor recognition of geriatrics as a viable academic specialty
- Inadequate institutional support and mentorship.

A consistent message to trainees was that pursuing geriatrics in India requires resilience, policy literacy, and interprofessional collaboration – skills not traditionally emphasized in medical training.

Policy Gaps that Directly Affect Indian Older Adults

Leaders unanimously highlighted the uneven implementation of the National Programme for Health Care of the Elderly. Despite its inception in 2010, dedicated Regional Geriatric Centres exist in only a subset of Indian states, reinforcing rural–urban inequities.[2] They emphasized that without following measures, India will continue to deliver fragmented and reactive elder care:

- Integration of geriatric screening into primary care and clear referral pathways
- Dedicated geriatric units at district hospitals
- Funding mechanisms that protect older adults from catastrophic health expenditure.

Five Take-Home Messages for Geriatric Education in India

1. Geriatrics must be embedded in undergraduate curricula to counter ageism early
2. Primary care is the true frontline of aging care – screening and prevention must occur before hospitalization
3. Community-based models – home care, rehabilitation outreach, palliative networks – are indispensable in India's resource-constrained settings
4. Career success in geriatrics requires policy engagement, not only clinical expertise
5. Mentorship is transformational: Each trainee reported a significant change in career perspective after a single leadership interview.

Educational Value of Leadership Interviewing

For trainees, this assignment was not only reflective but also catalytic. It fostered empathy, advocacy skills, and clarity about the systemic nature of geriatric neglect in India. The exercise is a low-cost, high-impact educational model that could be replicated across national geriatric training programs.

Limitations

This letter reflects interviews with only four leaders and was not designed to achieve thematic saturation. It should therefore be interpreted as an educational narrative rather than research evidence.

Conclusion

Interviewing senior leaders provided Indian trainees with rare exposure to the structural realities shaping geriatric medicine. Such experiential learning tools may play a critical role in preparing the next generation of geriatricians to address not only diseases, but the policies and systems that determine how India ages.

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Conflicts of interest

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