Prologue

All healthcare requirements of the citizens were managed previously by doctors of a different stream as ‘friend philosopher and guide’ available 24 × 7 from womb to tomb. They were sincere to diagnose almost all the problems (if not solutions). We all have experienced their care even at odd hours to be ‘People’s Doctor’. Specialization of medicine and its branches has become a trendy to produce experts who know more and more about individual body parts. The family physicians have become an ‘endangered species’. We are putting forward here an honest discussion about future of family medicine in India as an academic discipline for students teachers, regulators, health administrators and policy makers to consider.

Learning to Follow De-Learning

Historically, the health profession has been reflected as an honorable field and with the health-seeker confidence and trust equated healers to a “Surrogate God”. Our ancestors were able to think that medical profession in general and family medicine in particular is for learning and not for earning. Step by step, this bondage has loosened to dislike and at par with other professions. In the age of specialization and Super-specialization (actually sub-specialization), the single-mindedness of our profession metamorphosed in making headway from ‘learning’ to ‘earning’ for which one can blame the general inflation, defeat of value-based education system. Likewise, patients now are remunerating for the amenities and face value rather than empathy as well as care and competency of doctors[1]

We will have to learn the primary care to assess what may work in prevention of all forms of morbidity, mortality and disability including those caused by injuries. People at large move from pillar to post in search of a good doctor who will get time to hear their innumerable problems related to their health and disease. In search of care they are forced to visit specialist fully knowing well that specialists are expected to know more and more about any organ-system only though even lay persons know that disease may not be limited to part/s of their entire body.

We need empowerment of health care education with adequately trained multidisciplinary resource persons (faculty) as facilitator of learning, updated infrastructure, the systems approach in courses and curriculum, graded and shared accountability at all levels, an improved environment of mutual respect for optimum effect. Our greatest enemies are transference and indifference. We never get time to feel our patients who are our next-door helpless neighbors. We have to cry with their pain and laugh out loud sharing their joy.

Trust on the Family Medicine Postgraduates

From the time when Dr. Osler practiced Medicine and Healthcare in the early 20th century a lot has changed in though the archetypes of clinical practice persisted eternally through the ages. On the other hand the delivery of medical care has become delimited, challenging and closely associated with industry; physicians and practices are being held answerable.

Existing medical education emphasizes a lot of the clinical skills training but focus is on the ethical and humanitarian side of medicine which is such a core and defining aspect with impacts and influences all that is going to happen in the life of the physician. Family medicine experts not only need to be aware of the complexities of human diseases but also be sincere to learn the components of care to effectively manage the patients and the downstream battery of activities which supports the same. A cutting edge holistic knowledge has to be imbibed contextually and conceptually where the ocean of wisdom will intermingle.
empathy, clinical skills, communication skills, management skills for the primary care. The holistic approach to care a wide-ranging crisis in the community, where our citizens live without prejudice for capacity to pay, caste, creed or religion, help us grow as strong nation.

At the end of this discussion we will value: An move towards care from heart and not from brain; Community orientation; Learning Contextually and Conceptually; Family-centered care; A lifelong learner on the roads to truth and facts with creativity; Research and Publication; Wise persons who know their limitations; Legal issues in Medical Practice; Add life to years through promotion of primary care; Out of the box solutions.

One point of caution at this stage that, as family Medicine expert, we will have to change the paradigm to prepare us to deliver a panorama of ‘Health care’, and not only the telescopic piecemeal services of ‘Medical care’.

**An Approach from a Noble Profession to the Patient**

The expectations from the Family Medicine post-graduates are in the main an approach from a noble profession to the patient. Being a good listener will help you achieve a greater depth of understanding and be more effective healer of human suffering.

Every single health care provider has some basic approaches to any health seekers. He must lend his fullest concentration to hear the problems of the patient (history) and apply skills carefully to justify the history (clinical acumen). Doctors are expected to attend and provide meticulous care, once they agree to manage the patient with relevant explanations and facts related to the illness and its management in the languages and expressions that the patient and their caregivers can understand; too much jargon can satisfy the ego of the physician but there will be failure of communication if the receiver are unable to follow what was told. The doctors must have updated knowledge and equipment in their possession, as per their level of care. The primary care personnel must be able to anticipate further complications and timely referral as per natural history of the disease with detailed maintenance of data. Doctor’s responsibilities run parallel with their rights to turn away a patient before definitive management by providing basic care for the problems as per protocol of standard medical practice. A superior unconventional way is coming up in different parts of India as ‘group practice’ so that one of the regular healthcare providers is always available as well as more than one can share their opinion regarding single case scenario.\(^{[1]}\)

**Value a Community Orientation**

Family medicine experts need community placement during their training period that is gold mine to acquire knowledge and skill about the ‘hemodynamic’ of their own society. Armed with this they will be able to ‘know how’ the special effects of non-microbial risk factors in the pathogenesis and salutogenesis that prevail as the hidden agenda in their population in the hinterlands. They should learn the art of ‘First responders’ and train to the last man on the road the ‘do-s’ and ‘do not-s’ in any form of pre-hospital set-up during the golden hours and platinum hours that have a colossal bearing on the outcome of any illness from ‘womb to tomb’ and from the headache to head injury.

**Think Beyond Koch’s Postulate and Magic Bullet**

In the contextual and conceptual learning model, the learning will include a transparent knowledge on the natural history of disease as we have to correctly trace the patient in front of us. Each individual is different and diseases have diverse expressions of pathogenesis according to the genetic predisposition to the risk factor/s and risk correlates. In the era of epidemiological transition we have to learn by heart that ‘A stitch in time saves nine’. For example if each of us can counsel each day one chronic alcoholic citizen to stop consumption of alcohol, then a huge burden of alcohol-related diseases and social disorders (including road traffic injury and domestic violence) will come down to reasonable level. Not all disease has a microbial origin and not all health problems have a pharmacological answer.

**Principles of Family-centered Care**

It has been sorrowfully observed that Family medicine training by and large have evaded the learning in true family set up with brilliant exceptions across the country. That correct knowledge, positive attitude and true practice should have included setting the priority with special health care needs, learning by doing that that family-centered care and cultural competence work together, reaping the benefits of collaboration with caregivers with the core competence on psychosocial issues with an impact on morbidity, disability and mortality. We have to promote at individual levels that the support, encouragement and healing touch from caregivers promotes earlier recovery.

**A lifelong Learner for Truths and Facts**

We hope to get newer generations of health care professionals with a passionate learning of Family Medicine who will practice updating till the end of life. They are expected to get lessons in perseverance to get time to know the historical transition of Clinical Practice Guidelines and/or Treatment Protocols for better prognosis in the era of Emerging and re-emerging diseases. Particular attention is expected for those morbidity, disability and mortality where the health problems spurt from multifaceted risk factors and need multidisciplinary approach to solve.

The problem in DNB (Family Medicine) program is that the students are like uncared orphans. Hardly anybody cares whether they are learning or not, whether they are passing out to get the degree or not, whether they are getting placements or not! DNB residents often report informally about their frustration as they are being exploited for cheap labor by the hospitals in the existence of minimum academic atmosphere and training infrastructure.
Still they should follow different learning paradigm such as, self-directed learning, problem based learning, hands-on-supervised learning, presentations, journal club, seminars, among others. The facilitators of teaching-learning should keep an eye on the log books, portfolio learning, projects, reflections that will help the DNB residents toward self-assessments. Everything will move around empathy and Ethics of care on the foundations of evidenced based health care. The concern of the doctors will be reflected at every step with improved patient experience of a coordinated evidenced-based care based on learner-centred approach to gain clinical expertise with respect for patient values.

They should show their creativity in their service to the mankind getting optimum resources from Facilitators, textbook and other knowledge repositories, research publication and others.

**Research and Publication**

“The illiterate of 21st century will not be those who cannot read and write, but those who cannot learn, unlearn and relearn.”: Alvin Toffler

A large pool of scientific evidence is being generated globally on issues related to reduction of morbidity and mortality and promoting health. There are many important issues like interaction between risk factor that act simultaneously; spectrum of problem from womb to tomb, iron supplementation; role of micronutrient for prevention of acute diarrheal diseases and acute respiratory infections; rationale of food fortification, complementary foods; safe delivery practices and micronutrient supplementation in childhood, health benefits and risks of lifestyle modifications; antenatal care and child survival among others.

Research is basically the continuation to innovate in the philosophy of Altruism (paying back to the society) in a journey towards an unknown truth. We have to internalize that research does not mean getting ‘Nobel’ or any recognition. For reasons unknown doctors rarely devote their lives in basic research, yet they have to realize that research help us keep updated. Keep a sincere footprint on the roads you have travelled by publishing what did you think or do in past and present (and future).[9]

Researches are also needed on special emphasis to the process evaluation in the health service with impact analysis on the innovations in search of predictable models that will envision good quality, low cost, non-profitable and sustainable health care. The deliberations by the invited leaders will lead to creating the “Consensus Document for Health Care Sustainability in Developing India” which will encompass the National Recommendations by the Experts.

**Wise Persons Know Their Limitations**

Family medicine specialist being a generalist treat patients of both genders at all stages of life. A significant role of family medicine specialists is to refer their patients to organ specialists as and when the need arises. Patients, because of their long-term association with family medicine specialists, always prefer to maintain their follow-up with their own neighborhood doctor for the ease of comfort, less travel and more personalized approach. This requires family medicine specialists to keep their knowledge and skills upgraded in the advancing medical field. As their specialization is cross-cutting across boundaries, patient and their caregiver have unlimited expectations from the family physicians. So there is eternal need to humbly accept the quintessential responsibility that the society places on their expertise which further necessitates them to keep updating the resource pool. Daily dealing of patient as a ground level situation throws them multiple challenges often which are not linked to each other. These challenges need to be confronted in sit of the busy clinic schedules, mistime urgent calls and administrative and clerical entanglements in the midst of personal family commitment (doctors also have a family—that patients often forget). A genuine and concerned physician will not shy away from accepting their limitation and dive in the pool of vast knowledge that can be availed by attending Continued Medical Education Programmes, conferences, seminars and training sessions. Such investments are worth to make as they not only upgrade them in skills and technology but also provide them the larger platform to share their concerns and hiccups in daily patient management arena.

Beyond Grades/Marks of Formative and Summative assessments backed by liberation of mind we have to update daily with the self-assessment on ground situation by showing the skills and competence in real life. Even in our toughest stressful hours we have to mind our language and empathetic communication. There is always a scope of improvement for better to be turned into the best with our authenticity.

**Issues in Medical Practice**

Family medicine trainees need to be well-versed in the legal concepts governing the practice of medicine. We can never assure ‘cure’, but definitely we can ensure ‘care’. Patients want to experience a flawless and seamless care.

**Value and price**

We have to think of ‘Good for most’ and not ‘Best for many’ to assure the health and well-being through a respectful professional tie in the milieu of updated standard of practice. This high-quality service honors strength, culture, tradition, expertise of everyone bringing in relationship with the hope believe and trust that medical science has metamorphosed from ‘Knowledge based’ to ‘Skill based’. Further we have to think of the ‘Good for most’ and not ‘Best for many’.

**Responsible citizen**

We should be the best friend at worst times with the triple role – Healer, Teacher and Preacher as only the doctor are permitted to enter the bedroom of home and mind.
Family Medicine Training to be Streamlined at Any Cost

Classical Facilitator (Teacher) - Learner (Student) prototype to move in student-centered outcome-based medical education are gaining grounds in different educational institutions over the world; Empowerment with logical reasoning to explore unending potentialities; Profession for learning – not for earning; Knowledge is power if you hone it; Need based training; Utilizing the immense potentialities of trained Family Medicine trained personnel of India; Sharing of expertise across the country.[4]

We can invite practitioners of repute, with an academic inclination, for guest lectures. The students are exposed to novel yet practical as well as difficult approaches in medicines to widen their horizons of learning experience. Encourage them to observe basic skills like bedside electrocardiogram or echocardiogram performed by nurses and paramedical staffs. All clinical teaching need not be done by consultants as the senior residents can guide them as near-peer mentor to gel well. This will help these budding professional to become future medical educators with a moral, social, professional obligation and they cannot remain bystanders in this crucial situation.

Faculty Deployment: Challenges Ahead

With the inception of Departments of Community Medicine and Family Medicine at the newly established All India Institute of Medical Sciences (AIIMS) across the country a sincere and genuine dialogue is required, forwarding faculty development in family medicine.

However as per the post graduate regulation of MCI specifically maintains that family medicine is a separate and distinct specialty from social and preventive medicine/community medicine. As per the MCI regulations only persons with qualification in family medicine and general medicine are eligible to become faculty in family medicine.

The bone of contention lies in the fact that National Board of Examination has initiated Diplomat National Board (DNB) in Family Medicine long before the newly established AIIMS have been entrusted to teach and train ‘Family Medicine’ to Department of Community Medicine and Family Medicine. A legitimate corpus of half a thousand DNB (Family Medicine) postgraduates has been produced by this period. These DNB (Family Medicine) postgraduates had passed through rightful inroads in the recruitment as Medical Specialists in the Central and state government health care delivery jobs also apart from being utilized by Corporate houses and overseas recruiters. Further, these DNB (Family Medicine) postgraduates are confident of their knowledge and skills that is markedly different when compared with the postgraduates in Preventive and Social Medicine or Community Medicine. They have equivalency claims to be recruited as ‘Faculty’ in ‘Family Medicine’ in the medical institutes wherever ‘Family Medicine’ teaching and training has been initiated.

In addition, a bulk of Member of the Royal College of General Practitioners (MRCGP) have been serving Indian citizen in different corners of the country providing health care at grass-root levels as well as providing training for aspiring MRCGP examinees. All over again, MRCGP qualified personnel have genuine claim to get the respectable equivalence with DNB/MD in Family Medicine (in line with other overseas qualifications). This will help them to join in academics as well as Central and State government health care delivery jobs when our country in true shortage of ‘Faculty in medical institutions’ and ‘Trained Medical Specialists’. We hope that the regulatory bodies will share our genuine concern and move forward with the issue. They hope that wisdom should usher by the grace of almighty so that steps will be taken by the policy makers to help our health care learners can be skilled in primary care, a prime concern for World Health Organization among others to improve national health parameters all over the globe.

The Health Secretariat of Government of India has already sent circulars to all the Medical Colleges to launch post-graduation courses in Family Medicine, under the aegis of MCI, across the country. Government Medical College, Kozhikode, Calicut had already started MD (Family Medicine) course, few more MCI recognized institutes are on the pipeline to apply for starting the course. But the gray zone have not cleared yet whether DNB (Family Medicine) postgraduates and/or MRCGPs can be recruited as faculty members for MD (Family Medicine) course.

So the divide has cropped up whether these DNB (Family Medicine) and MRCGP can be made equivalent qualification with the postgraduates in Preventive and Social Medicine and Community Medicine in getting Faculty positions in newly established All India Institute of Medical Sciences (AIIMS) across the country.

Stand on your feet: Never stand on the shoulder of giants

India is on crossroads of steps forward with International financial support as well as the government both accommodating of investment driven growth in the Health Care Industry. The academic institutes and existing healthcare systems both are equal when it comes to trailing such growth opportunities where sustainability is an important part of this progress story with sustainable growth. Academic leaders, health administrators and policy makers are welcome to this nation building forum where the discussions will lead to a consensus for guiding the regulatory bodies will be able to operate in a conducive atmosphere.

Future Lies in Present

A rat race has begun from the last few decades of last millennium towards specialization losing the notion that, we are supposed to treat a person not their organs. On the contrary, we shall put special emphasis on the basic concept of health promotion with a wide-ranging outlook even in the absence of any health problem. Health care providers are confused- not interested in learning and practice this non-glamorous field - ‘Everybody’s responsibility has become Nobody’s responsibility’. History move spirally. In recent times the role of primary care physicians
has been rejuvenated globally from Alma Ata declaration with special trainings modules with or without downstream degrees. We have to unite our voice that we should also be trained in the wholesome care with extensive comprehension of health and disease in the ground situations.[8]

In the undergraduate medical education we affirmatively propose that Medical Council of India should update the medical course and curriculum to add Family Medicine along with newer generation of topics like Emergency Medicine, Injury science, Psychology, and components of First responder training for pre-hospital care, the science and art of Counseling and Empathy, Basics of Capacity building and manpower management among others to provide a strong foundation of primary health care at entry level. We have to spread our ‘Wings of fire’ with the expectations beyond boundaries to raise the slogan to ‘Add life to years through promotion of primary care.’

The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head.” - William Osler