Editorial

National Medical Commission Act 2019: White paper on accelerated implementation of family medicine training programs towards strengthening of primary healthcare in India

Abstract

Family medicine is the internationally recognized nomenclature for the academic discipline, knowledge domain, and medical specialty of primary care doctors, working in the community setting. Family medicine is defined as a specialty of medicine which is concerned with providing comprehensive care to individuals and families by integrating biomedical, behavioral, and social sciences in the community setting. The distinction of family medicine lies in the tradition of medical generalism, promoting whole person care, in a life cycle mode; providing optimal preventive, promotive, and curative healthcare services in a wide spectrum of setting from home to hospital. In 2016, 92nd report of the department-related parliamentary standing committee on health and family welfare on the "Functioning of the Medical Council of India" has emphasized the need for postgraduate in family medicine. The committee report has noted that "the medical education system is designed in a way that the concept of family physicians has been ignored. The committee recommends that the Government of India in coordination with State Governments should establish robust PG Programs in Family Medicine and facilitate introduction of Family Medicine discipline in all medical colleges. This will not only minimize the need for frequent referrals to specialist and decrease the load on tertiary care but also provide continuous healthcare for the individuals and families. The successive National Health Policies of Government of India–NHP 2002 and 2017 have emphasized the need of family medicine training in India. The recently enacted National Medical Commission Act 2019 has mandated NMC to promote training in family medicine at both undergraduate and postgraduate levels. Therefore, in the background of the stated policies of the Government of India the concept of family doctors, which was earlier neglected should be institutionalized within the mainstream medical education system of India. It is now time to accelerate and upgrade family medicine training and thereby strengthen the concept of comprehensive primary care in India. This white paper presents the review of family medicine training in India and proposes a way forward.

Keywords: Ayushman Bharat Program, Medical Council of India, Ministry of Health and Family Welfa, National Board of Examination, National Health Policy 2002, National Health Policy 2017, National Medical Commission, Primary Care, Universal Health Coverage in India

Introduction

The recently enacted National Medical Commission (NMC) Act 2019 has mandated the NMC to promote training in family medicine at both undergraduate and postgraduate levels.[1] Earlier the Supreme Court of India directed the petitioner (The Academy of Family Physicians of India) in the matter of a public interest litigation (PIL) to approach Government of India as well as the Medical Council of India in the matter of implementation of government policies on family medicine discipline. The Prime Minister of India Shri Narendra Modi, on 14th April 2018 while inaugurating the first Health and Wellness Center under the landmark Ayushman Bharat in Bijapur Chhatisgarh said "The Health and Wellness Centers will in a way work as family doctors for the poor. Earlier there used to be a family doctor in middle class and upper class families. These Wellness Centers will now become the extension of your families. These will be associated with your day-to-day lives." Therefore, in the background of the stated policies of the Government of India, the concept of family doctors, which was earlier neglected should be institutionalized within the mainstream medical education system of India.

The Concept of Family Medicine

Family medicine is the internationally recognized nomenclature for the academic discipline, knowledge domain, and medical specialty of primary care doctors, working in the community setting. It has originated from the historic tradition of general practice. Family medicine is defined as a specialty of medicine which is concerned with providing comprehensive care to individuals and families by integrating biomedical, behavioral, and social sciences in the community setting. Family physician's scope of practice covers all organ systems, genders, and age groups. A family doctor provides primary and continuing care to the entire family within the communities; addresses physical, psychological, and social problems; and coordinates comprehensive healthcare services with other specialists, as needed through a structured referral system. Research (Barbara Starfield) showed that well

trained family physicians are capable of addressing 90% of the illnesses and morbidities outside hospitals, thereby preventing overcrowding at tertiary care hospitals and saving individuals/families from catastrophic out of pocket expenses.

Distinction of Family Medicine

The conventional medical education system is fragmented into hospitals departments originating from organ systems, age variables, and gender. The public health programs are presented as tens of national health programs.

Context of the medical education system in India

With more than 500 medical colleges and a capacity of 70,000 MBBS seats, India now runs the largest medical education system in the world. The number of medical colleges and the MBBS seats continues to increase. In coming 10 years India will be able to induct close 700,000 new MBBS graduates to the existing workforce of 1 million. Unfortunately, the majority of the medical doctors remain concentrated in the urban areas as of today, whereas 70% of the population lives in the rural India. Engaging growing number of MBBS doctors with the health system; more specifically in the community-based health system, both in urban and rural area remains a huge challenge.

The reason for the skewed rural–urban distribution are many fold, however one of the key reason often not discussed is the fact that medical education system in India as of today largely remains tertiary care focused, barring few exceptions. Internationally, most of the developed countries have evolved generalist community-based medical educational programs parallel to the hospitalist/specialist approach. However, in India, the 500 bedded medical college hospital is still considered a gold standard/basic/minimum requirement toward imparting UG and PG programs. In India, during past few decades there has been a growing trend within health system toward development of specialty and super specialty care. No wonder that most students are inspired and inclined to opt for a career in specialty care due to financial reasons as well as a well-defined career path. Community-based health system and primary care remains deprived of doctors. The poor ratio of UG and PG seats as well as growing number of MBBS seats is making the situation worse. It is not uncommon for MBBS students in many parts of India to join coaching classes for PG entrance examination, neglecting clinical postings and internship training.

Postgraduate training as a strategy toward recruitment and retaining medical doctors within health system

Residency training (PG programs) is not only an extension of training after MBBS into respective specialties but also it is a first level of career pathway. The health system gets workforce in return. It is a mutually beneficial situation for doctors as well as the health system. It is well known fact in India also that a good amount of workload is shared by the residents/PG trainees who already possess the basic practicing license of MBBS.

It is no wonder that the United States of America has strategically allowed development of more PG seats as compared to UG seats. According to recent residency match data for 19,000 MBBS graduates there are close to 25,000 PG residency seats. Thereby US system is able to attract and recruit MBBS doctors from all over world by offering them career pathway through residency scheme. In United Kingdom, there is no limit of PG seats. Virtually every medical student in UK gets opportunity for PG training. Most join General Practice registrarship that is a 3-year vocational training in General Practice after MBBS. Vocational training in general practice is mandatory in UK after completion of MBBS as an eligibility toward independent license for general practice. All GPs must complete 3 years of training of which 18 months are to be spent in GP settings. Thus, community PG training has been developed to induct medical students in community-based general proactive vocation as part of the primary healthcare system. All universities in UK have an academic department of General Practice. Thus, for medical students the career pathways are well structured and developed in both hospital setting as well as community/rural setting. The specialists get training at the respective academic departments of the hospitals and grow into consultants/academicians. Similarly, family physicians or general practitioners enter primary care system through residency training in family medicine. Most of the countries in Middle East have already adopted this system.

Policies of government of India on promotion of Family Medicine.

1. Several policy documents of Government of India and WHO have strongly recommended establishment of family medicine training programs in India. In 1983, "The Medical Education Review Committee" setup by Ministry of Health and Family Welfare GOI, under the chairmanship of Dr Shantilal Mehta recommended that 'the undergraduate (MBBS) medical students should be posted; in a general practice outpatient unit in order to be exposed to multidimensional nature of health problems, their origins. The committee also recommends that this specialty should be further developed so that an increasing number of students pursue higher study in area.
2. National Health Policy 2002 stated that in any developing country with in inadequate availability of health services, the requirement of expertise in the area of "Public Health" and "Family Medicine" is markedly more than the expertise required for other clinical specialties.
3. The National Health Policy (NHP) 2017 announced recently and specifically mentions family medicine speciality and mandates popularization of programs like MD in family medicine. NPH 2017 recommends a large number of distance and continuing education options for general practitioners in both the private and the public sectors, which would upgrade their skills to manage the large majority of cases at local level, thus avoiding unnecessary referrals.
4. A WHO SEARO Regional Scientific Working Group Meeting on Core Curriculum of Family Medicine held in Colombo, Sri Lanka, from 9 to 13 July 2003 devised core curriculum

of family medicine for the (a) Undergraduate level, (b) Intermediate level, and (c) Post graduate level (specialist level).

5. In 2007, the working group of medical education under Prime Minister's National Knowledge Commission (NKC) stated that any successful development process must have a pyramidal structure with a strong horizontal base. In terms of medical education, it has to be a strong base of basic scientists and clinical generalists/family medicine specialists, who are the backbone and stability of the system.
6. In 2010, in response to a representation given by Academy of Family Physicians of India, the Ministry of Health and Family Welfare (MOHFW) convened a high level meeting vide letter no. V. 11025/56/2010 ME (P1) under chairmanship of Union Health Secretary Government of India to discuss following: (a) Initiating of MD family medicine at government medical colleges, (b) employment of DNB family medicine qualified doctors within NRHM.
7. In 2011, the WHO Regional Office of South Asia (SEARO) Regional called a consultation on "Strengthening the Role of Family/Community Physicians in Primary Health Care" in Jakarta, Indonesia, 19–21 October 2011.
8. The working group of planning commission for the 12th plan (2012–2017) estimated the projected need for specialists in family medicine (family physicians) as 15,000 per year for the year 2030.
9. **In 2013, the Union Health Secretary Government of India vide Letter No. D.O. V 11025/MEP -1 communicated** with all Principal Secretaries of Medical Education. Health and FW of all State/UTs. In his letter, the Union Health Secretary wrote that There is a need for an integrated generalist approach to diagnosis and treatment and the family physicians are best positioned to deliver this integrated approach to diagnosis, treatment and complete healthcare management of an individual and a single post graduate in Family Medicine can meet the requirement of a Surgeon, Obstetrician and Gynaecologist, Physician and a Paediatrician in a CHC, besides taking care of Public Health need of the community.
10. The National Health Policy 2017 has emphasized the need to popularize MD Family Medicine and up-skill MBBS doctors through continuous professional development programs.
11. The newly enacted National Medical Commission act 2019 specifically mandates to promote UG and PG training in Family Medicine.

Current status and recognition of family medicine training in India

Family medicine is recognized as a distinct specialization. DNB family medicine, awarded by National Board of Examination (NBE) is a MCI recognized qualification since 1983, the year NBE came into existence through an amendment in the MCI act. There are close to 150 DNB family medicine seats offered through various accredited institutions. Only three medical colleges have been recognized to run MD family medicine program. Few diploma programs are also being offered in distance mode. The state institute of health and family welfare of West Bengal is offering a full time diploma in family medicine recognized by the state medical council.

Family medicine has been notified at serial no 06 of schedule II of Post Graduate Regulation 2000 of Medical Council of India. Family medicine also exists at serial no 30 in the list of recognized specialization and postgraduate qualification in the original notification of NBE creation dated 19th September 1983.

All newly constituted AIIMS institutions have department of community medicine and family medicine. It is to be noted that as per PG regulation of MCI family medicine, community medicine, general medicine, and forensic medicine are four distinct and separately specialties. At all of these department of Community Medicine and family medicine only faculty from the community medicine background have been recruited and currently family medicine component does not exist at all.

In 2016, 92nd report of the department related parliamentary standing committee on health and family welfare on the "Functioning of the Medical Council of India" has emphasised the need for PG in family medicine. The committee report has noted that the medical education system is designed in a way that the concept of family physicians has been ignored. The committee recommends that the Government of India in coordination with State Governments should establish robust PG Programs in Family Medicine and facilitate introduction of Family Medicine discipline in all medical colleges. This will not only minimize the need for frequent referrals to specialist and decrease the load on tertiary care, but also provide continuous healthcare for the individuals and families.

Key bottlenecks toward development and popularization of family medicine in India

1. **No family medicine in MBBS curriculum:** Departments of family medicine do not exist at medical colleges in India as per standards set by the Medical Council of India. Non-introduction of the concept of family medicine during MBBS training is leading to general lack of awareness about this discipline among medical students as well as medical teachers.
2. **Skewed UG and PG seat ratio:** Extremely skewed proportion of number of PG seats with respect to MBBS seats leading to disinterest among medical students for gaining clinical skills necessary for independent practice. Also trend of unhealthy of focus on multiple choice questions and coaching classes for preparing PG entrance examinations.
3. **Double brain drain:** Due to lack of PG seats MBBS graduates are either immigrating abroad or concentrating on hospitalist career at urban healthcare institutions leaving behind rural and community setting empty and discarded.
4. **Lack of qualified faculty in family medicine:** Lack of eligible faculty for family medicine due to reasons mentioned above.
5. **Inappropriate accreditation standards:** Irrational accreditation criteria for family medicine training programs

comparable with hospital-based specialist medical branches, whereas family medicine is a community-based specialty. Accreditation parameters applicable for hospital-based specialities are not only inappropriate but also detrimental to the context of family medicine training. The whole essence of the family medicine training is lost.

6. **Lack of flexibility and community responsiveness within DNB family medicine program:** India is a large populous country with diverse community needs. The practice of family medicine varies across geography and practice setting such as urban, semi-urban, rural, hilly, tribal, island, and isolated areas. It is standard practice across world to allow appropriate flexibility with respect to curriculum implementation, clinical rotations, skills acquired, etc., The approach of family medicine training is different as compared to other tertiary care hospital-based specialties.
7. **Lack of defined career pathways:** There is complete lack of structured career pathway for family medicine graduates in India. As much as 70% of the specialist post at CHCs across India are vacant. A single postgraduate in Family Medicine can meet the requirement of a surgeon, obstetrician, and gynecologist, physician and a pediatrician in a CHC managing 90% of the clinical problems that present there, besides taking care of Public Health need of the community. However, due to the absence of any GO (government order) family medicine postgraduates are not considered eligible against specialists posts at CHC or any other appropriate career opportunity in the government health services. Family medicine postgraduates must be given parity with specialist colleagues with respect to recruitment and career progression.

Solutions and the Way Forward

Mandatory introduction in MBBS course and all medical colleges

Family medicine must be introduced to MBBS students at early stage through a mandatory department of family medicine. We request NBE to approach MCI for amendment of "minimum standards for starting a medical college regulation" of 1999 and include family medicine in the list of mandatory department for MBBBS course

Modification in the accreditation criteria for DNB/MD family medicine program (DNB program has been emphasized more)

This is a unique requirement of family medicine in contrast to other hospital-based specialties. This is not considered as relaxation in criteria but rationalizing of the accreditation parameter appropriate for family medicine. The facility should be multispecialty offering services in medicine, pediatrics, OBG, and surgery. A 24 × 7 emergency and obstetrics services is desirable. The current requirement of exclusive beds in each departments of broad specialties of medicine/pediatrics/surgery/OBG for DNB (Family Medicine) should be removed. A dedicated unit is family medicine department of 30 beds at the tertiary care medical college hospitals which is required as per the MCI accreditation guidelines. This should be looked into. The accreditation criteria of the training institutions should be looked into.

Faculty requirement

1. Two consultants from broad specialties such as Family Medicine, General Medicine, General Surgery, Pediatrics, or OBG. Of the two one should be senior and other junior consultant.
2. Any practicing family physicians (without MD/DNB qualification) with minimum 10 years of experience may be attached to the training program and counted at a eligible teacher. Such family physicians would be required to host trainees during clinic rotation. Recruitment of faculty based of experience is called grand parenting program as experienced in most developed countries during development phase of family medicine. A person with only MBBS qualifications could progress to become professor. Though there are many doctors with only MBBS who are excellent clinicians and academically oriented, the relaxation of criteria for being a teacher can lead to influx of doctors who just want the name of a teacher/professor. However, we need to allow those who have completed DNB/MD/equivalent in Family Medicine and work in clinics and not the usual medical colleges/DNB institutions to be adjunct faculty and be recognized as teachers. This intervention is internationally known as "grandfathering program."
3. Diploma holders in any of the above-mentioned specialties may be considered junior consultant or adjunct faculty.
4. At larger institutions where other DNB programs exist, family medicine faculty need not be exclusively counted for family medicine only. These consultants may be shared with other specialty training programs in the institution. This measure is to support developmental stage and uniqueness of family medicine.
5. For a government institution if there is shortage of eligible faculty, faculty may be borrowed, other institutions on part time basis or adjunct designation after due process.
6. The senior faculty should have research activities to his/her credit. These research activities may be publications such as research papers, review articles, case reports, abstracts, papers/poster presented in conferences, etc.
7. The desirable qualification for DNB coordinator should be DNB Family Medicine, however in the absence of such person or till such personal is available, same may be recruited from other clinical specialties mentioned above. There shall be no requirement of any additional experience after PG qualification.
8. Persons having DNB, FM or its equivalent and working in the private sector in Family Practice or in the health services may be engaged as adjunct faculty or as the programme coordinator depending on their eligibility. They may be counted as one of the faculty.

Clinical rotations

The expected skills learned should be in tandem with the requirement of specialist role at CHCs. This may require advance obstetrics and neonatal skills along with lifesaving anesthesia skills. The candidates should also be encourages to complete BLS/ACLS/ATLS courses during their residency. Due to community context, flexibility may be offered in the duration of the existing duration of clinical rotations. For example, if someone wishes to do lesser duration of OBG, this can be divided into 4 months compulsory and 2 months optional, the extra 2 months they can utilize for training in the departments of their choice. Students who choose to continue OBG can do the remaining two months, while other students can choose those 2 months to work in the Specialty of their choice.

Field based mandatory rotational posting

As per the feedback received from many existing training program, for many hospitals it is a major challenge to organize out of hospital 9 month long duration field posting. Many existing programs were shut down due to this criteria. For smaller community hospitals comprehensive care may be an essential requirement. This also means 9 long months of wages for out of hospital work. This schedule is essentially to promote competency in ambulatory care in community setting. Therefore, two flexible options should be offered: (a) Nine month of field posting at a stretch (b) One weekly postings of four hours to a family physicians clinic during the whole period of 3 years while the regular postings at the hospitals will continue. This will provide additional months training in an optional department. Medicine department may be preferred due the generalist scope of family physicians.

Basic Science Teaching

Basic science teaching may be exempted for DNB family medicine training institutions. This has already been completed during MBBS course and moreover family medicine is a practice based discipline.

Career Pathway for DNB FM

1. There is a need to develop equivalence and parity for family medicine doctors as compared to the hospital based specialists.
2. Central government as well as all state governments must issue GOs (government order) with regards to recruitment of DNB/MD family medicine at specialist posts at CHC/ health system and provide them equivalent salary structure and promotion.
3. The specialist in Family Medicine should have chances of moving up the ladder of promotions to the levels of Senior Specialist and Consultant.
4. Department of family medicine at all medical colleges should be mandatory
5. All primary care centers (PHCs) should be renamed as "Family Care Centers"

Innovative schemes for in service doctors

They may be offered modular courses leading the completion of required credits. As an interim measure, till we have adequate number of qualified family doctors, all MBBS doctors who are working in PHCs after 5 years of service may be given 2 years of study leave to do Family Medicine training (they can be given 1 year concession as they are already working in Primary Care) and after that they could be taken in the Specialist Grade, instead of having to go through NEET. They can be recruited.

Post PG fellowships

To make family medicine more attractive and useful 1 year fellowships can be offered in following areas exclusively for those who have completed the FM training.

- Infectious Diseases
- Diabetes mellitus
- Geriatrics
- Maternal and child health
- Palliative care
- Adolescent health
- Mental health
- Musculoskeletal conditions
- Rheumatology
- Clinical Haematology
- Deaddiction medicine
- Lifestyle illnesses
- Pain management
- Occupational Health
- Emergency medicine.

Development of support system for expanded DNB family medicine program

Due to uniqueness and community based context, implementation of the expanded family medicine programs will require additional initiative on the behalf of NBE

1. Engaging a large number of DNB/MD family medicine qualified faculty as adjunct faculty/trainers/preceptors
2. Creating and delivery of modular theoretical courses Board Certified national CMEs
3. Centralized guidance for thesis and research projects
4. Enrolment and training of examiners with DNB/MD FM qualification
5. Creation of new brochure introducing DNB/MD family medicine
6. Creation of new information booklet for seeking accreditation for DNB/MD FM.

NMC (National Medical Commission): What should be done?

1. Representation of family physician faculty on NMC.
2. Inclusion of family medicine department in the list of minimum standard requirement to start a medical college regulation of MCI 1999.

3. Rationalization of infrastructure requirement for family medicine department by modification in PG regulation of MCI 2000.
4. Modification in minimum qualification for teachers in department of family medicine under PG regulation of MCI 2000.

Without removing above regulatory restrictions family medicine can never flourish in India.

Conclusion

DNB family medicine qualification exists since 1983. MD family medicine is a recognized qualification through PG regulation of MCI 2000. These training programs have gone through various stages of experimentations and developments. In the beginning the eligibility to write final DNB family medicine examination was only CME hours without any training. Structured residency training only was introduced much later. The curriculum and course structure has also under gone modified at various periods of time. NBE has made a unique contribution toward development of family medicine, however due to the minuscule scale, this program has not been able to make desirable impact. The MCI – now NMC, the National Medical Commission should also wake up and make family medicine departments as a mandatory discipline for MBBS course and the colleges. If India is to achieve universal health coverage and sustainable development goals by 2030, it is high time to scale it up exponentially to be able to match disease burden of huge population. It is now time to accelerate and upgrade family medicine training and thereby strengthen the concept comprehensive primary care in India. This white paper presents the review of family medicine training in India and proposes a way forward. A pragmatic approach is required meet this aspiration.

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