Original Article

Views of physicians on the establishment of a department of family medicine in South India: A qualitative study

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Abstract

Objective: To explore the experiences and perceptions of physicians involved in establishing a department of Family Medicine in South India. **Methods:** In this study, descriptive qualitative methodology was used. Nine family physicians and one community medicine physician were interviewed. The data were subjected to thematic analysis. **Findings:** The establishment of a department of Family Medicine in South India in response to the local health-care demands needed support from the institution, visionary leaders and alumni of the institution. The key challenges perceived were lack of mentorship, lack of identity and misunderstanding of the work of family physicians. **Conclusion:** This study replicates earlier studies on the role of local health-care needs and visionary leaders in striving towards family medicine-based clinical services that further evolved into training and research opportunities in family medicine. The study identified the challenges and supportive forces behind the initiation of a department of Family Medicine and the role of family physicians in strengthening primary health care.

Keywords: Access to care, department of family medicine, primary care

Introduction

India is the second most populous country in the world with 1.34 billion people. While the National Health Policy aims to provide universal access to health-care services, availability of physicians and nurses in India, averaging to 0.702 and 1.711 per 1000 population respectively, is lower than the average of 3.2 doctors and 8 nurses in countries within the Organisation for Economic Cooperation and Development.[1-3] This shortage of doctors and nurses is a major roadblock towards achieving universal health care.[4]

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Though health-care services are delivered through both public and private health-care systems, primary health care in India is primarily provided through the public health-care system. Physicians in primary health-care facilities have limited scope and their major role is to provide episodic care and implement vertical programs addressing specific diseases.[5] This is in contrast to many countries with integrated and accessible primary health-care systems that have shown to lower costs and improve health outcomes and patient experiences.[6]

The Indian government has proposed to strengthen the primary health-care infrastructure through family medicine (FM)-based primary health-care services to improve access and health outcomes.[7,8] FM as a generalist discipline based on the patient–clinician relationship is counterculture to the specialist-based Indian health-care system. However, FM could play a critical role to improve the health of Indians.[9]

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Until recently there was no post-graduate (PG) Doctor of Medicine (MD) program in FM in India. Since the 1980s, the National Board of Examinations (NBE) has offered a 3-year FM course. However, the course neither emphasize FM principles nor provide teaching and mentoring by family physicians. Many Bachelor of Medicine and Bachelor of Surgery (MBBS) graduates without FM training practice as "generalists." Multiple distance education courses in FM are available to such "generalists" working in private and in public health-care system.[10]

The first MD program in FM in India began in 2012 at Calicut Medical College, Kerala led by a professor in Internal Medicine.[11] Later, the Department of Family Medicine (DFM) established in 2008 at Christian Medical College (CMC), Vellore, started the second MD program in 2017 once the faculty fulfilled the medical teacher eligibility criteria of having two professors in FM.[12] Currently, the DFM at CMC has four professors, four associate professors and one assistant professor in FM with two MD trainees each in their first, second and third years of training. Besides PG training, medical students receive training in FM twice a year for 2wo weeks. Over the years, the DFM has increased its focus in primary care research.[13-17] A DFM providing training for PG residents and medical students with a focus on research in primary care is rare in India. Owing to this rarity, it is important to study the experiences and perceptions of physicians who pioneered the DFM in CMC.

Specifically, the objectives of the study are to explore:
1. Need to establish the DFM,
2. Challenges and the hurdles, and
3. Role of Family Physicians in India.

Methodology

Design

This study utilized a descriptive qualitative method to explore the perceptions and experiences of physicians who developed the DFM in CMC. A descriptive qualitative approach is appropriate when the topic under study is in the exploratory stages to provide an unadorned account of events being studied.[18] Key informant method was used because, by definition, key informants are those who might have specialized information to provide detailed description of the social and cultural patterns of a group.[19] The study proposal was approved by the Institutional Review Board at CMC, Vellore, India.

Recruitment and sample

A purposeful sample of key informant physicians who played key roles in the development of DFM in CMC was identified. Participants who were willing to share their experiences and perceptions were chosen. Participant information and consent forms were sent to the potential participants via email and their participation was confirmed by phone. Eleven physicians were contacted and 10 agreed to take part in the study. One physician did not reply. Thematic saturation was reached at 10 respondents.

Data collection

Interview data were collected between February and July 2018. Upon gaining consent, a 30-45-minute semi-structured interview was conducted with each participant by the primary researcher. The semi-structured interview guide included questions and probes to explore the participants' perceptions and experiences regarding the establishment of the DFM. The interviews were conducted in a location convenient to the participants and were audiotaped and transcribed verbatim.

Data analysis

Thematic analysis involves searching across a data set to identify, analyze and report patterns within the data set.[20] Data analysis occurred in an iterative fashion. After each interview, three researchers independently reviewed each transcript and then met collectively to compare keywords, phrases, categories and emerging themes. Common emerging themes were entered into a coding template that evolved over the course of analysis as new codes emerged. This was followed by additional team analysis to further clarify patterns and overarching themes.

Findings

Five male and five female physicians aged 35-78 years participated in this study [Table 1]. Two participants were retired professors, one each in community medicine and family medicine who each led the urban health centre (UHC) for a period of 10-11 years. All ten family physicians are NBE graduates.

The establishment, maturation and growth of the DFM at CMC, as described by participants, was based on the culmination of vision, pragmatism and actions over decades in response to needs of the local population, family physicians and India itself.

Unified generalist and patient: centred care

Participants saw provision of clinical care to the local population as the initial driving force for the birth of a DFM. Needs of the local population was the impetus for the initial establishment of the UHC. This centre provided access to low-cost clinical services outside the tertiary care hospital for common health problems: "*In the town, there was a clinic where the local population would come and they need not compete with patients from outside and for ordinary sicknesses which require only primary and secondary level care.*" Importantly, the participants felt that the skills and foundational principles of FM essential for comprehensive primary care was practiced at the UHC: "*With increasing specialist focus in tertiary care, we needed one place where the practice is generalist and patient centred, where continuity is respected and the patient was seen in the context of the whole family.*"

To establish a DFM, however, certain key drivers such as administrative and alumni support and visionary leaders were needed. Administrative input was felt to be critically important within a system of specialist's care to identify a physician willing to be trained in FM to meet local needs that eventually gave birth to FM services:

Table 1: Socio-demographic description of study participants

Age	Gender	Specialty	Teaching Cadre	Years of Experience
35-44 years: 4	Males: 5	Family Medicine: 9	Professors: 4	<10 years: 4
45-55 years: 4	Females: 5	Community Medicine: 1	Associate Professors: 3	11-20 years: 4
55-64 years: 0			Assistant Professor: 1	21-30 years: 0
Above 65 years: 2			Retired Professors: 2	31-40 years: 2

"*Medical superintendent asked me whether I would take over this unit because I can manage all branches of medicine. Then she said to make you head of the low-cost unit you need a degree in FM. So, she wrote to the NBE. They were willing to accept me as a candidate. Then she made me the head of the department of low cost. With perseverance, it has blossomed into the DFM.*"

Good patient care to meet the institutional needs was felt to be vital for the continued support from the institution:

"*Good patient care. That's where it starts. It doesn't start with your posts, doesn't start with administration, doesn't start with academics. Establish your rules, geographical area, common illnesses, health promotion, home visit. You should be able to support the institution through this. Then other things, sending in more staff, more doctors, project staff needed for service, beginning training and giving time to do research and study will happen.*"

Internal and external leadership

Leadership was described as a key lynchpin for the success of a department. Visionary leaders, who could inspire staff and push a vision forward, and pragmatic leaders, who would take necessary steps to keep a department moving forward, were an integral part of departmental growth. External support from former alumni was also important as were the early advocates of FM from other clinical specialties who were described to have supported the evolution of FM as a discipline and a department and to have initiated the process of formalizing the DFM:

"*In 2009, a retired professor of internal medicine decided to stay on for one more year. By that time there were talks about starting a new department, establishing FM starting new training, new services. So, her involvement and interest in FM, being a senior professor who was willing to head it for a year. I think that made it more prominent.*"

In addition to visionary leaders were leaders who saw what needed to be done and did it:

"*None of us are from this institution. So, we really don't know the admin ropes. Later, we leaders were self-assigned. Nobody asked me: 'Please start developing this for the post-graduation training or for the undergraduate training'."*

Alumni who were trainers in FM in other countries also promoted FM-based clinical services:

"*There was a constant push from the alumni outside India. Many are trained family physicians and said you have to have FM. How come my Alma Mater, cannot have, does not have a FM department? And that came up in a big way. They said we have to have a department and actually pushed for the department*"

Internal and external identity

As the new DFM grew, many challenges appeared. Major challenges were the lack of identity personally for family physicians and externally as evidenced by the misunderstanding of FM at multiple levels of the health-care system:

"*I am a young faculty who has done FM but in the initial years, I could say the first five years I didn't have an identity in the institution of what am I doing. I always had this question of what am I doing in this institution?*"

The formation of the department was a vital step in creating that identity in the institution, among the public and among medical students:

"*We have our own Department which I am very proud and have recognition from other Departments. They recognise our work. I am able to identify myself among them and patients whom we serve. They recognise what service we are providing. The institution recognises us. Recently the former director mentioned us in his news line. So, I think we are getting our recognition everywhere.*"

At the same time, all participants were concerned about the misunderstanding of FM among medical students, faculty in other departments and the whole institution. The milieu of low-cost care at the UHC was interpreted as low-quality care by other clinicians: "*Inside the institution, there is a lot of misunderstanding and miscommunication because here is, unfortunately, an attachment of free care along with FM. It has given an overall impression of low-quality care to other departments.*" Lack of knowledge about the work of family physicians was the most common cause for the poor understanding of FM:

"*There are still many specialists who don't know about us in the main hospital. I assume that by continuing our work properly, making the right referrals and coordination they eventually would get to know. But it doesn't look like that. Every four years the admin changes and the new admin seems to not know again. What is FM? So that is definitely a challenge.*"

The poor understanding of FM was felt to influence FM trainees during their rotations in other specialties:

"*There is something called hidden curriculum. So, when the residents go there, they are to made feel that actually you are not studying in an*

important speciality. It may affect the student it may not but it is not a good atmosphere."

Revolution or evolution?

All participants believed that the public-sector health-care system in India has to accommodate trained family physicians to fulfill the unmet health-care needs of the country. Many advocated for a major revolution in India's health-care system and in medical education:

"*India needs FM which we have been hearing for 15 or 16 years. The issue is about making policies. No 1: In all medical colleges there should be a DFM and FM should be taught as a subject and students should write an exam so that they learn. No 2: 50% of all post-graduate seats should be FM. It means when you finish your MBBS we should either choose one track for a single subject speciality or the other track as FM. Increase the number of FM seats throughout the country. The third thing is in the government health system, there is no cadre for a specialist in FM, they should have that.*"

Restructuring the current training programs in FM in India was considered to be essential to equip FM graduates to teach and practice FM:

"*There are a lot of people in my batch who have finished studying in FM, but still have identity crisis like: What to do? Where to go? What is their role? So, I was thinking, dialoguing with what we have, maybe in NBE, FM should be rescheduled completely. It is not just going to different clinics, rather we should understand the principles of FM and introduce it in practice and how to teach FM.*"

Yet at the same time, resistance against the establishment of FM at multiple levels of the health-care system was the cause for poor progression of FM in India:

"*There were people in the government system who did not want FM to come. We applied for the MD FM, the Principal called me and said, you are stuck because there is a group which is working against you. A Government Medical College professor wanted to start 10 seats in FM. He gave a proposal to the Dean. But it didn't leave the Dean's office because the lobby of specialists in Chennai blocked it. Market forces are opposing this because they want hospitals causing 80% of expenditure in the private sector in India. The market forces don't want FM which will keep people away from hospitals.*"

Lack of teachers in FM was an additional barrier to implementing FM training programs:

"*Even getting a DFM into every medical college has really not happened. Part of it because we don't have the trained faculty for it. So, it's like a chicken and egg situation. No, we don't have faculty. How can we train the students? Although there are students, where are we going to get the faculty to teach them?*"

During this phase of slow evolution, strong recommendations were made for possible roles of family physicians at different levels of the health system:

"*The most important role, if we have enough of them, would be a first contact physician wherever they are. So, it could be a mission hospital, it could be a district hospital. It could even be a primary health centre but all over the country there is a need for a good first contact, multi-competent physician.*"

Discussion

Our study findings reveal that establishing a new and poorly understood discipline, such as FM in a complex health system as is present in India, needs public demand, support from the institution, visionary and pragmatic leaders, mentorship by experienced family physicians and a willingness to inform policymakers about the value of FM.

The role of public demand for quality primary and secondary health care as the driving force for establishing FM in this institution validates the characteristic of FM as a discipline defined by the needs of the community. The needs of the community convinced administrators to develop training programs in FM. Similar results have been documented in other developing countries such as Kenya and Ethiopia where the role of FM in meeting community health needs had influenced policymakers to implement training programs in FM.[21]

The early leaders in FM, who were not family physicians, influenced policymakers of the institution. The commitment of non-family physicians in their leadership roles as heads of the department and UHC created the atmosphere for family physicians, in the early stage of their careers to recognize the role of academics in nurturing FM. The new FM graduates were later supported by alumni from outside India. Similarly, the role of successful partnerships that support training programs in FM is well documented in other countries such as Haiti, Kenya and Ethiopia.[21]

Our study highlights the challenges in initiating and implementing FM-based clinical services and training programs in an institution and in the larger context of India. The specialist-based culture of the health-care system in the institution and in India has favored widespread misunderstanding of FM. FM is largely believed to be low-cost care for poor people as opposed to cost-effective care. The general misconception about FM is due to the lack of understanding of FM and its role in the health-care system during the formative years of training. Such resistance to FM initiatives has been reported in other countries, such as Indonesia.[21]

There have been minimal initiatives to recruit family physicians to the public-sector health-care system. Consequently, the number of academic DFM and opportunities for medical students and MBBS graduates working as "generalists" to be exposed to FM-based primary care during their formative years of identity formation is negligible. This situation is similar to many African countries where family physicians are not integrated into the health-care system.[22] However, this is in contrast to health-care systems in North, Central and South Americas. For example,

Canada has FM departments in all medical schools and the USA has more than 400 FM training programs.[23]

A recent South African study has confirmed the role of trained family physicians in improving the health indicators of their district hospitals that are similar to the community health centers in India.[24] Hence, Indian policy makers have chosen FM to streamline the delivery of primary health-care services across the country. In this direction, promoting the establishment of academic departments of FM in medical colleges is the most significant step. These academic departments can introduce FM as an integral part of early clinical exposure to medical students and strengthen the primary health-care curriculum, validate the role of family physicians in re-engineering the primary health-care services and reiterate the role of primary health-care services in improving the health of Indian citizens.[25]

Limitations

This is a qualitative study involving participants from one institution in India. Hence, the findings may not be transferable to other emerging FM departments across India.

Conclusion

There is an urgent need for establishing DFM in all medical schools in India. The national policy that aims to provide universal access to health care for all Indian citizens should start by initiating DFM to impart training in comprehensive primary health care. This study articulates the voice of visionary leaders and family physicians involved in establishing the DFM in a private academic institution in South India.

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Conflicts of interest

There are no conflicts of interest.

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