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Indian Journal of Physiology and Pharmacology

Opinion Article

Family doctor

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Received : 23 October 2018
Accepted : 19 October 2019
Published : 25 January 2021

DOI
10.25259/IJPP_282_2020

Quick Response Code:

INTRODUCTION

There was a time, when there used to be a super-specialist whom worried family members would call when someone falls ill. He/she would come home to find out what was wrong with the patient. He did not need extensive medical test reports or investigations to diagnose the problem. All he/she needed was a thermometer and blood pressure measuring device. Usually, treatment would consist of a pill or two, lot of counselling and some friendly admonishments. Miraculously, the patient would recover too![1]

This 'super-specialist' was the family doctor with a basic medical degree. Families trusted them. These doctors were almost part of the family, sharing their happiness and grief. He/she was not only a physician but a psychologist and family counsellor too. He knew the medical history of the entire family.[1]

FAMILY DOCTOR

Family doctor is a doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital. A family doctor provides primary health care to the family. They can be called as 'on-call' doctors. Families with elderly relatives can avail the services of these doctors for a monthly fee in some places. This avoids the cost, panic and effort of rushing the patient to the hospitals.[2]

Strangely, they are fast disappearing.[3] However, the National Board of Medical Examination has now said that family doctors are crux because they are the backbone of the healthcare industry.

Unlike other physicians who treat a particular disease, family physician cares for one as a whole person. In addition to diagnosing and treating acute and chronic illnesses, family physician provides to the family routine health screenings and counselling on lifestyle changes in an effort to prevent illnesses. Moreover, if required, he/she guides and refers the patient to a specialist. Coordination of family physician and his patient achieves the best possible outcome in the most cost-effective manner.[4]

Family physicians help individual stay healthy with an individualised plan of care. They know the key to maintaining long-term good health is the patient-physician relationship; know family health history and lifestyle to determine health risk factors.[4]

Research shows that people who have an on-going relationship with a primary care physician have better overall health indices.[4]

GOVERNMENT OF INDIA

In a middle income country like India, development requires emphasis on health-care system. Health and education are the major contributors to economic growth of a country. The commission on macroeconomics and health by the WHO stated that middle income countries should undertake fiscal and organisational reforms to ensure universal coverage for priority health interventions. In India, primary healthcare was first emphasised in Sir Bose commission report in India during independence. It envisioned a three tier system for health care delivery with a well-established referral system. Primary care gained central position in policy making after Alma Ata declaration in 1978. Financing for health care is related to governance and polity, while policy making, health-care planning and management are done by public health professionals. Thus, primary care is a broad concept with several sectors. Primary care physicians/family doctors act as frontline health-care providers within primary care teams.[5]

There are different health providers in India. Apart from allopathic medical professionals, there are Ayurveda, Unani, Siddha and Homeopathy system. These predate the development of allopathy and provide care to a major part of population for centuries. They continue to do so even today, despite the economic and even cultural dominance of allopathy.[6]

PROBLEMS IN HEALTHCARE

In a populous country like India, the ratio of available doctors and required doctors is very low. Their distribution is also uneven. Of a total population of 1,028,610,328 according to 2001 census, there were 2,069,540 health workers of which 819 475 (or 39.6%) were doctors. Of all doctors, 77.2% were found to be allopathic and 22.8%, Ayurvedic, homeopathic or unani. The national density of doctors was 79.7 per lakh population. The ratio of urban density to rural density for doctors was 3.8.[7,8]

The other criticisms levelled at the rural MBBS, such as increased likelihood of mistakes or infringement of human rights due to treatment by inadequately trained doctors, bear little credibility. At present, the shortage of doctors in rural India stems from the unwillingness of most doctors, who were born and trained in urban areas, to move to rural areas.[9] An estimated 75% posts of specialist posts at community health centre were lying vacant in a recent survey in public sector health services across India.[10]

Another problem in India is that patients use more than one medical system, either simultaneously or alternating from one to the other. Treatment with such medicine is seen as more affordable, effective, accessible, humane and holistic. From the point of view of allopaths, interest in these other systems is fuelled at least partly by dissatisfaction with allopathy: 'Disillusionment with the often hurried and impersonal care delivered by conventional physicians, as well as the harsh treatments that may be necessary for life-threatening diseases.' They also seem to view 'alternative medicines' as essentially unscientific: Harmless at best, but potentially dangerous, particularly if it causes seriously-ill patients to neglect effective (allopathic) treatment.[6]

Sometimes there is no perceived conflict; sometimes such 'multi-drug therapy' is conceptually chaotic and each system sees the other as harming the patient.[6]

In a study, a medical curriculum for 55 countries was overviewed (using electronic sources). The duration of medical education is relatively consistent across the world with medical training taking about 6 years, ranging from 5 to 8 years, before a licence to practise is obtained. Medical training is typically split into 5 years of schooling, of which the first 3 years are preclinical and the fourth and fifth are clinical, followed by a 1-year apprenticeship on the job. However, there is considerable variation in the intensity of teaching, with shorter courses either being more intense, or requiring the students to be graduates. Interestingly, graduation did not necessarily have to be in a related field. Graduates from several countries were also surveyed informally, which generated some *ad hoc* common themes for example, 'there was a lot of wasted time, but it allowed me to grow up' and 'most of the clinical skills are gained after qualification.' A crucial question, in view of the cost of medical training, is whether currently too much basic science is taught and whether a more focused problem-based learning course supplemented with laboratory-based training in clinical skills is adequate to produce competent doctors in a shorter time. Yet others have argued for inclusion of underserved skills, such as good communication and an evidence-based approach to practice, which would increase the duration of courses. Course content and delivery will affect the course's duration.[9]

In India, medical education and health-care delivery system are at cross roads in India. Vital reforms have been pending for decades in the area of medical education due to structural problems in the regulatory mechanism.

Current health delivery modes to remotest areas are selective and have fragmented strategies. Lack of resources have made the system unaccountable and disconnected to public health goals. People's growing expectations are not addressed and it is unable to ensure financial protection to the poor.[11]

Inaccessible location, bad roads, unreliable functioning of health facilities, transport costs and indirect expenses due to wage loss, etc., makes access to medical care problematic. This makes easier to seek treatment from local quacks. This leads to underutilisation of the existing health infrastructure at primary level contributing to avoidable waste.[5]

Failure of health delivery system can be attributed to three broad factors: Poor governance and the dysfunctional role of the state; lack of a strategic vision and weak management. The structural mismatch in the institutions at the Centre and State levels, with many departments and agencies duplicating work or working at cross-purposes make governance in health ineffective. Contributory factors for a dysfunctional health system are unrealistic and non-evidence-based goal-setting, lack of strategic planning and inadequate funding.[5]

Family physicians encounter difficulties relating to staff, services and infrastructure, which consequently affect their level of satisfaction. Problems with transportation form one of the main difficulties encountered by physicians. Other major areas of problems include: (i) Physical infrastructure, (ii) organisation's working environment, (iii) privileges of staff, (iv) discontentment and (v) human resource development.[11]

AUTHOR'S ANALYSIS

There are many problems faced by doctors in healthcare profession India. The journey to become a doctor in India requires a long time. Students first spend time in coaching for highly competitive entrance exams. Then around 5½ years are required for completion of graduation. Emphasis on theoretical knowledge is laid and not on practical approach that leads to deterioration of skills. This is because they think of gaining practical skills later during specialisation. This again requires preparation or coaching for the competition again. After 3 years of hardship in speciality/PG course, the target becomes super speciality for many, which again consumes time in preparation and 3 years for course itself.

EFFORTS BY GOVERNMENT

Presently many efforts have been made by government to remove the lacunae from the health delivery system. Developments including 'National Council for Human Resources in Health Bill 2011' set a momentum for change. NHP – 2002 focuses on funding and restructuring of the national public health initiatives to enhance equitable access to the health facilities.[12]

To address the shortfall of doctors in rural India, the Medical Council of India started an innovative Bachelor of Medicine and of Surgery (MBBS) rural degree. Reports suggested that it would be a shorter in duration (4 years) than the standard MBBS in India (5·5 years, which includes a 1-year mandatory internship) and the qualifying doctors would be allowed to practise only in rural areas for the first 10 years, after which time they might be eligible to work in urban areas.[9]

The rural MBBS scheme aims to train people from rural areas in those rural areas, believing that they will stay, which offers some hope of providing medical care to large parts of rural India which has limited access to healthcare.

A sharp debate arouse in the Indian media on the grounds that the shorter duration would result in inadequately trained professionals. However, inherent to this debate is the assumption that the current duration of the MBBS in India is right, and more generally, it takes a long time to produce a competent medical doctor. Whether or not they succeed, the Indian Government should be praised for trying to find an innovative solution to a deeply entrenched problem, which is not unique to India. In the end, the quality of care will depend not only on the duration of medical training but also on its quality and, perhaps even more importantly, the 'after-sales' service.[9]

The Department related Parliamentary Standing committee on Health and Family welfare (The Parliament of India), its 92nd report said in 2016 that the target for future should be to have postgraduate opportunities for all medical graduates. To do this, the target should be to make 30–50% of all seats in family medicine.[13]

Taking into account the problems in health-care system of India, the National Medical Commission (NMC) bill was introduced by ministry of health and family welfare in Lok Sabha on July 22, 2019, and passed thereafter by Lok Sabha and Rajya Sabha. To help tackle the disease burden in rural areas, the bill seeks to grant a limited license to certain midlevel practitioners connected with the modern medical profession to practise medicine and prescribe specific drugs in primary and preventive health care. In other cases, they may prescribe medicines but only under supervision of a registered medical practitioner. According to Indian medical association, this would mean allowing person with no medical background to practise modern medicine which would mean legalising quackery.[14,15]

POSSIBLE SOLUTION

Medical education is largely experiential learning and robust systems for continuous medical education and audit are vital to allow these rural doctors to maintain and update their clinical knowledge and skills on an on-going basis.

Selection for specialisation should be based on MBBS exams instead of a separate competitive entrance exam. This would reduce stress and students would focus more on training. Looking at variations in marking systems across the states, the exit exam suggested may be a solution, but some weightage must be given to efforts made by students during their undergraduate course. Training should be more extensive. E-learning should be promoted. The degree exam should be centralised, conducted by MCI or other similar body at a third centre. This will remove local bias and deserving candidates will get the degree.

All those MBBS graduates who may not go for specialisation or fail to pursue it till the end will certainly have sufficient clinical training to do all primary care and will be the backbone of health care in India.

NMC also proposes NEXT, a common final year MBBS exam to be passed by medical students before being allowed to practise medicine and enrolling in state register or national register. This would also be a screening test for foreign medical graduates. However, the medical student fraternity completely rejected the NEXT in its present format saying that merit should be the determining factor for screening postgraduate seats.[14,15]

Health-care administrators should make every effort to diminish difficulties faced by primary care physicians by providing the essential facilities and investing in capital structures, as these are key factors in improving physician's satisfaction.

Investment in human resource (through education and medical care) can give high rates of return in the future. This investment on the people is the same as investment in land and capital. However, man cannot effectively play this central role in an economy if he is not in good health. It is in this light that many authors underlined that the health of a person is primordial for the attainment of high economic growth. This is because sick people cannot study well, cannot produce many and quality goods, their cognitive development might be low, etc. As such, governments across the world became more concerned in ameliorating their populations. Public health investments do not have a short run effect on economic growth. It is only in the long run that there is a positive and significant effect of public health investments on economic growth. As such, future economic growth can be ameliorated by increasing public health investments.[16]

The WHO recommended that the government should spend 10% and 15%, respectively, of its budget on health. India spends 1.15% of the GDP on health,[17] while it is 9.1 for Australia and 16.9 for USA which have a far better health delivery system.[18]

The concept of family doctor must be reviewed and restarted in India in line of countries such as Australia, USA, Singapore and U.K. Although we have a poor doctor patient ratio, a population cum area wise distribution must be planned to make the doctor responsible for the primary care of people allocated to him/her. This will reduce burden of hospitals and will improve the health-care delivery at door steps.

SUMMARY

India being a country with rural majority, the healthcare/delivery system involves several aspects. Apart from quality of health-care professional, health delivery system must be improved. Family doctor becomes more important as it develops a bridge of faith and scientific knowledge to deal with health problems. They will also be effective in health education of families both in rural and urban areas.

Acknowledgment

I would like to thank all from Department of Physiology, AIIMS Patna, for supporting during writing of article.

Declaration of patient consent

Patient's consent not required as patients identity is not disclosed or compromised.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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How to cite this article: Singh R, Dubey P. Family doctor. Indian J Physiol Pharmacol 2020;64(Suppl_1):S41-S5.