Commentary

Is the National Medical Commission aligning with discontinuity and transitory in times of uncertainty by making the science and art of family medicine redundant?

Sunil Kumar Raina

Department of Community Medicine, Dr. RP Government Medical College, Tanda, Himachal Pradesh, India

Abstract

Policy decisions shape strategies which in turn influence the outcome. The expected outcome of medical education in India is to produce an MBBS graduate of first contact. Are we able to do so or are we failing in that and what are the reasons behind our failure Is it a failure on part of the regulatory body to align with the expected outcome using a continuity of approach or a willingness to accept transitory as the process to achieve the objective?

Keywords: Aligning, discontinuity, family medicine, NMC, redundant? transitory, uncertainty

Context

Strategies are shaped to influence the outcome, meaning thereby that the outcomes are important in deciding the policy initiatives. The expected outcome of medical education in India is to produce an MBBS graduate of first contact. Are we able to do so or are we failing in that and what are the reasons behind our failure Is it a failure on part of the regulatory body to align with the expected outcome using a continuity of approach or a willingness to accept transitory as the process to achieve the objective?

Generally speaking, broad strategies shaping policy formulations across nations in domains of different settings have usually been following two accepted pathways, regulatory and developmental, and despite system and sectoral diversity, policy makers and planners largely depend on these to achieve their objectives. The claimed objective of a regulatory approach in policy is to create a stable policy framework, while at the same time capable of development of rules as well as transitioning those instruments of rulemaking that have a chance of failure, the developmental approach generally accepts anti-fragility as a norm and purports to benefit from failure by stimulating a public–private partnership that is capable of delivering public support to the system which in turn supports anti-fragility. Policies developed with intent to leave a long-lasting impact generally tend to follow a developmental approach and function to instill trust in the system.

Family medicine as a specialty has for long been integral to delivery of health care; therefore, when some think of it as an enigma that MBBS doctors are no longer opting to become family physicians, the thinking is expected, although the same does not come as a surprise to the experts.[1] Family medicine thrives on continuity and benefits from a developmental approach

Address for correspondence: Dr. Sunil Kumar Raina, Department of Community Medicine, Dr. RP Government Medical College, Tanda, Himachal Pradesh, India.
E-mail: ojasrainasunil@yahoo.co.in

Received: 07-10-2023 **Accepted:** 21-11-2023
Published: 28-06-2024

Access this article online

Quick Response Code:

Website: http://journals.lww.com/JFMPC

DOI: 10.4103/jfmpc.jfmpc_1648_23

How to cite this article: Raina SK. Is the National Medical Commission aligning with discontinuity and transitory in times of uncertainty by making the science and art of family medicine redundant? J Family Med Prim Care 2024;13:2541-4.

with community at its center and public–private partnership a more likely option. Though India, for ages, has followed a developmental strategy in its applications and implementation of health care delivery, the same cannot be said about the backbone of this very application as medical education continues to be approached through a more regulatory approach, initially through the Medical Council of India and now through the National Medical Commission. This disconnect may be at the core of not being able to produce doctors of first contact through a sustained failure of incorporation of family medicine as a subject in medical curriculum.

Background

The frame pathway to approach health and the health system, lately, has largely been restrictive in the domains of education and training of MBBS graduates and therefore is largely limited to the understanding of disease, its occurrence, and the personalized care to approach it. The situation has not always been like this. The rapid but orchestrated decline of public health has shifted the focus from health being essentially seen as an inclusive concept and feeding the collective to an exclusive one largely relying on individuals as both contributors and beneficiaries. Health has for a major part of our evolution been seen as continuous, consistent, and relatively certain when compared to disease. This has been strengthened by not just tradition but by a belief system that for long has served us in overcoming uncertainties. The idea of continuity and relative certainty has not only sustained our interest in seeking health but also helped public health and primary care become fundamental to our understanding of healthcare.

Therefore, delivery of healthcare in community or home settings has always seemed to be a logical extension of seeking health as hospitals and hospital care settings were identified to be associated with uncertainty and therefore appeared to carry risk as an essential element to it.

Ingrained within this concept of certainty, health has elements such as trust and access among others. The fact that one could trust someone more than others to deliver in times of uncertainty or diseases made delivery of healthcare accessible, affordable, inclusive, and collective.

The idea of judgment, knowledge, or expertise of the delivery of healthcare was always identified as secondary to trust and access. For the vast majority in India, these two (trust and access), even if not in the exact terminology, have remained our major attractions in terms of the foundational principles for receiving healthcare since ancestry. The fundamentals did not change when we gained independence in 1947. Driven by our commitment of delivering quality healthcare to each and every citizen, India ventured on a journey to not only increase supply of healthcare deliverables but also help build acceptance for use of the deliverables. Without doubt, India has succeeded on both the counts even if not in equal measures. But it appears more of tragedy now that the medical education system capable of delivering more than 1 lakh MBBS doctors is not able to ensure sustenance of trust and access, long envisaged to be delivered through creation of doctors of first contact, to train them as family physicians, due to intrinsic institutional barriers or restrictions.[1]

From developmental to regulation

The running thread of access and trust was not only allowed to stay untouched but also in fact strengthened by policy initiatives, deliberation, and discussions supported through major government involvement in the form of reports, documents, guidelines, or vision statements including and not limited to Bhore Committee Report, Bajaj Commission, Reorientation of Medical Education (ROME scheme), Mehta Committee Report in the early parts of post-independence or the Prime Minister's National Knowledge Commission, the National Health Policy 2002, the Task Force for Development of Human Resource for NRHM, and Planning Commission's Steering Committee on Health in 12th Plan in the later parts.[1] But no document claims to have captured the specifics of the vision and the deliverables in healthcare delivery better than the erstwhile MCI or the now NMC. It is this claim of the MCI/NMC that got shaped up in the form of a regulatory body not just regulating the teaching and training standards of medical education in India but also establishing standards of conduct for the medical professionals. However, it seems that in its fascination for regulation through specifics, the broader goal of development, access and trust got compromised as did continuity. The replacement to this (continuity) was a superstructure of specialties ignoring the background reality of this nation, which continues to live in its rural areas.

Regulating healthcare

MCI/NMC continued emphasis (regarding undergraduate medical education program) on designing a program with the national goal of being capable of delivering an "Indian Medical Graduate" possessing the requisite knowledge, skills, attitudes, values, and responsiveness so that she or he may function appropriately and effectively as a physician of first contact of the community while being globally relevant appears getting more and more unrealized.[2] As our health continues to transition from one level of uncertainty to another, MCI/NMC appears to have been pretending to care without being there.

For the uninitiated in the larger part of the last century, the role of "being there" was fulfilled through an established cader of practitioners called "family doctors/physicians", a part of the very communities where they practiced. This cader, for having fallen into the non-preferred category of the MCI/NMC, faces not just neglect but also gross indifference, and its neglect ensures that "pretending to care without being there" is only accentuated.

The cader (family doctors/physicians) was in fact a "continuity of sort" from conventionally recognized Indian traditional medical systems of ages, Ayurveda, for primary care in rural India in the form of "Vaidya". From among the codified medical systems in

India, Ayurveda continues to enjoy popularity even though the system (Ayurveda) itself has reduced patronizing the Vaidya, who was the fulcrum of the system. He (Vaidya) was not just a treating physician but also a hygienist, a nutritionist, and a counselor, and his/her presence in the village kept the idea of health uncertainty at a distance. Induction of other systems in the name of medical pluralism was never unwelcome in a country as diverse as India as the country was capable of absorbing all and therefore benefitting from all as long as access and trust were there. With primary care and family medicine an almost essential component of this medical pluralism, access and trust were not just ensured but also strengthened, making acceptance of other systems natural.

However, the arrival of Independence raised hopes of more strengthening happening in the field of primary care or general practice as this was not only being seen as the answer to the challenges India was facing in the realm of health and disease but also found to have seen success despite pluralism and diversity. It was anticipated that healthcare delivery as well as the public health will get woven around the family physician and the general practitioner as envisaged by the policy makers of the time and as graduate medical doctors with requisite skills to serve as physicians of first contact became becoming a part of various reports of the time; family medicine and general practice seemed to be on a strong ground. Supported by the comprehensive delivery of public health initiatives, India's health system appeared to be not only uniquely designed for a local approach but also placed strategically to have a global impact. Family medicine was a much recognized academic discipline in most medical schools/colleges in the west, and the monster of selective primary care had not yet taken over public health. As the family physicians were familiar with the terrain of the patient community, navigating the needs of the patients was easy. At the same time, it was easier for the patients to approach. It is not that those hospitals were not required or did not exist, but hospitals were expected to serve as an extension of family practice only. Persistence of the family physician as part of the continuum in places with which the patient was not familiar, the hospitals, was always helpful.

The foundational principles of family medicine, first contact care, whole person care, person-centered care, family-centered care, community-oriented care, life cycle care, ecology of care, continuity of care, comprehensive care, epidemiology of illness, medical generalist, managing complexity, care of multimorbidity, long-term care, clinical prevention, and home care are ideally suited to India's needs. But the creation, over a period of time, of an exclusive focus on a super specialist-oriented and specialty-driven medical education system ensured that making of family physicians lose not just momentum but orientation as well.[1]

The critical shift

In the 92nd report of the department-related parliamentary standing committee on Health and Family Welfare, it was noted that there is a need for postgraduates in family medicine/family physicians. The report said that 'the medical education system is designed in a way that the concept of family physicians has been ignored' and recommended that the Government of India in coordination with State Governments should establish robust PG programs in family medicine and facilitate the introduction of family medicine discipline in all medical colleges. The idea behind such recommendations was to not only minimize the need for frequent referrals to specialists but also decrease the load on tertiary care as well to provide continuous healthcare for individuals and families.[3]

Unfortunately, despite recommendations such has these, the increasing emphasis on "hospitals only" serving the patients in all parts of country continues. India, to its credit, is one of the few countries to have been able to maintain some semblance of primary care till date, and one of the reasons for India's success in mitigating the impact of Covid-19 could be attributed to this only.

By transitioning into an era of hospital care from healthcare, the world around has been changing more rapidly than one can adjust too. Driven by diverse functional units from insurance companies to hospital administrators, a plethora of terminologies are being invented and promoted to create a segregated and compartmentalized healthcare. The idea is to create a hierarchy and then to promote a transition in this hierarchical set-up through a framework which though universalized lacked local connect. It is here that even the recommendations like that of the parliamentary standing committee appear helpless.

For reasons obvious to all of us, we seem to have compromised on continuity and aligned with "anonymity" not because we (as a civilization) ever were fond of anonymity but because it appears in the framework of credibility established for universal application. For those in the hospitals (delivering healthcare), we are all too familiar with the confusion a patient and their family feel when faced with uncertainty, when vital decisions are made without involving them and without anyone claiming complete responsibility.

This non-continuity in an uncertain situation always tends to be costlier in comparison to continuous care and support continuity. The continuous care and support are more likely to serve better in prevention of disease, promotion of health, and higher physician and patient satisfaction and thereby deliver universal health.

The consequences

If not conspiratorial, the decline of family medicine is not accidental but more in line with what is happening across the world, where markets are planning the delivery as well as access to health. Countries have been using different modalities to do so, and unfortunately, regulations are beginning to take the center stage in deciding on this. But the regulators need to realize that discontinuity through large dependence on the hospital care system and engagement with healthcare recipients without a team is bound to be more focused on managing disease

and not on meeting the needs of individuals and families for integrated, personalized care and connect. They must also realize that without the involvement of family physicians, achieving integration and comprehensive delivery of care is a risk we run as we will be forced with a choice to be more entangled with clinical data systems and electronic health records and lose our insights on the complexity of discussions about teams of care and individual relationships.

Conclusions and way forward

The presence of continuity and trust remains central and the defining feature of primary care, the replacement of which with claims of convenience for both patients and doctors demands serious discussion. While claiming regulation and course correction by identifying limitations in the prevailing health systems, its products, men, and material and ignoring changing population dynamics and age-old societal rulings in general, the regulators need to understand that it may actually be colluding with the disruption of continuity, particularly in the area of teaching and training of undergraduates and postgraduate students. Our efforts at regulating have worked on the assumption that the current educational system in medicine and health in India, like the rest of the world, needs to be primarily driven by productivity and hospital financial needs. With regulators not only permitting but also encouraging sub-specialization (called super specialization in India), limiting continuity may become the norm.

Therefore, the thinking will need to address the fundamental by ensuring continuity with patients, families, and communities. If this is to be the guiding principle, the structure of medical education will be mounted on the foundations of family medicine/general practice and primary care.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. Kumar R. The curious case of extinction of family physicians from the Indian Health System – An open letter to the members of the National Medical Commission: Draft competency based Medical Education curriculum regulations 2023 – Complete exclusion of family physicians/family medicine education from the MBBS course curriculum! J Family Med Prim Care 2023;12:1477-84.
2. National Medical Commission Act 2019. Available from: https://www.nmc.org.in/nmc-act/. [Last accessed on 2023 Oct 07].
3. Ninety Second Report, Functioning of the Medical Council of India (Ministry of Health and Family Welfare), Rajya Sabha, The Parliament of India. Available from: http://www.academics-india.com/Parl_Panel_report_on_MCI.pdf. [Last accessed on 2023 Oct 07].