

General Practice (Family Medicine): meeting the health care needs of Nepal and enriching the medical education of undergraduates

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This paper proposes that the discipline of General Practice (Family Medicine) appropriately trains doctors to meet the identified health needs of Nepal and can make an extremely valuable contribution to the medical education of undergraduates. The paper will identify the current health needs of Nepal as revealed in The Human Resources Report of His Majesty's Government (HMG) 2003 and demonstrate how family doctors are ideally qualified to meet a major part of these needs. It will go on to show that including General Practice (Family Medicine) in the undergraduate curriculum will both increase the number of doctors seeking to train and work as family doctors, as well as enriching the education of all medical undergraduates. Throughout the paper I will use the terms "family doctor" and "Family Medicine" in the understanding that these also apply to general practitioners and family physicians and General Practice and Family Medicine. Different terminology is used internationally and in Nepal

Historical background

The concept of having a family doctor is not new Nepal. Before the establishment of medical training in Nepal, doctors received training outside the country up to MBBS or beyond and many returned to work in their home towns. They served their communities and continuing to learn by practice and apprenticeship. People identified a particular doctor as "their doctor" (personal communication Drs GB Shrestha, Dharan; S Koirala, N Kumar, Biratnagar). This is the history of medicine in most of the world. However, the development of medical education and the push for specialities sidelined the traditional MBBS generalist doctor and the demand was created for organ and disease care, rather than whole person care. This worldwide trend caused a crisis in primary health care with widening inequalities in health status and healthcare access, particularly in the developing world. The historic Alma-Ata conference on Primary Health Care was convened in September 1978 and recommendations made on the selection and training of health personnel, in particular physicians and nurses, who would be "socially and technically trained to serve the community" (Recommendation 10)¹. It was recognised that being an expert generalist

required more than the training received in the tertiary centres of the undergraduate years and the stage was set for the development of post graduate training in General Practice.

The first independent University Department of General Practice had been established in Edinburgh in 1957, and by 1986 all medical schools in the United Kingdom had at least one GP appointed to its teaching faculty.² Although the Royal Australian College of General Practitioners was established in 1958, formal post graduate training did not commence until 1975 and by 1977 academic general practice was represented in all Australian medical schools. Sri Lanka established a training programme in 1979, Nigeria in 1981 and Pakistan in 1993. The EU Directive 93/16 obliges members of the European Union to have specialist vocational training in Family Medicine.³

From this emphasis on "orientating the education and training of health workers ... towards the attainment of health for all"³ and the collaboration between WHO and the World Organisation of Family Doctors (WONCA) on "Making Medical Education Better Suited to People's Needs" in 1994, undergraduate medical education programmes were remodelled.⁴ Programmes began to emphasise self directed learning and problem solving, information retrieval, critical thinking and critical appraisal in community based education programmes. Generalist doctors were brought into teaching because of their skills in these identified areas.^{5,2,6} Since 1993 WHO has supported the development of a Network of Community-Oriented Educational Institutions for Health Sciences (The Network) between medical colleges in developing and developed countries. Their emphasis is to be on primary health care in their "education, research and health care activities".¹

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In Nepal

By 1981, Nepali health policy makers realised the need for generalists who could handle the range of medical presentations and public health needs in rural Nepal. In 1982, after discussions with the Ministry of Health, the Institute of Medicine and the University of Calgary established a joint postgraduate general practice training program. Initially half the training took place in Canada, but since phase 3 of the programme commenced in 1991, all the training has been local, with faculty taken from the initial graduates.⁷ A second training program was started at the BP Koirala Institute of Health Sciences (BPKIHS) is part of the WHO sponsored Network of community orientated medical colleges) Dharan in 2002, with the first MD (Family Medicine) candidates to graduate this year. The Nepal Academy of Medical Sciences (NAMS) is also planning a family doctor training programme based at Patan Hospital with their first intake in July 2005. This will provide just over twenty seats in General Practice for the whole of Nepal this year with BPKIHS being the only Institute to have an undergraduate programme in Family Medicine (A draft curriculum for undergraduates has been submitted for consideration to the Dean, Institute of Medicine, Kathmandu).

Only two years ago, His Majesty's Government of Nepal reported that "Currently in Nepal there is under-staffing and hence under utilisation of District Hospital beds (60%) with high utilisation in central hospitals (95%) for problems that could be managed at lower level institutions. Improving access to basic primary and secondary care across the country requires significant increase in staff and beds at district (213%) and zonal level (100%)."⁸ The objectives of the HMG's Second Long-term Health Plan (1997-2017) include the following:

- To extend to all districts cost-effective public health measures and essential curative services for the appropriate treatment of common diseases and injuries
- To provide technically competent and socially responsible health personnel in appropriate numbers for quality health care throughout the country, particularly in the underserved areas.

A start has been made in training such health personnel, but has it been useful? In 2001 a survey of the 44 living MDGP graduates found that a significant proportion was fulfilling the stated aim of district hospital level service. Thirty-nine graduates responded to the survey, of whom 28 were working

outside the Kathmandu valley. Twenty-two of these were in government service, i.e. half the graduates. More recently fewer of the candidates for MDGP have come from the government service, and as most rural jobs are government, this is expected to alter the distribution of future graduates.⁷ Of the sixteen family doctors working within the valley, eight were faculty at IOM or Nepal Medical College and had a major teaching role even though few of them had had any lengthy experience in working in isolated rural settings (personal communication Dr M Gupta). Family doctors are performing surgery, doing obstetrics, giving anaesthetics, involved in public health, and working in emergency medicine.⁷ The total number of family doctors with MD training is still very low however, with 60 graduates to date.⁹

The Unique Qualifications of Family Doctors

Family doctors are competent and equipped to serve diverse communities. They are trained to meet the patient as a first point of contact, address their total health needs, sort out the undifferentiated presentations, both urgent and chronic, offer personal care in one or more fields of medical need and carry out comprehensive care across all ages, genders, occupations and cultures within the context of the family and community.⁴ They "are well prepared to provide comprehensive care to the whole patient taking into account biological, psychosocial and cultural influences on health and disease".¹⁰ The family doctor may refer for more specialised care while retaining a coordinating role and continuity of care over time, and is equipped and motivated to prevent disease and promote health for the individual, the family and the community. The family practice process focuses on the patient-doctor relationship; it sees the patient in the context of his or her family and community. "It is the extent to which this relationship is valued, developed, nurtured and maintained that distinguishes family practice from all the other specialties".¹¹ Research shows that a strong and positive doctor-patient relationship is both cost effective and efficacious in meeting a patient's health needs.

Family doctors are also individual and flexible. Their skills are developed to match the needs of the place where they will practice, and during their professional life they develop new skills and critically evaluate new approaches to care. For example, the rural doctor will have skills in primary surgery, obstetrics including Caesarean section and anaesthetics; the city doctor of the Terai may develop skills in industrial medicine or HIV/AIDS; and the town doctor may develop child and school health or

women's health clinics. The family doctor is a doctor with advanced training meeting the particular needs identified in their community. "The Family Doctor has much to offer as the first point of call ... and as the integrator of health services for the whole family. S/he will become known for continuous care of the family over a length of time and will help the family to make wise choices as well as being an advocate for improved services in the community and a link between the community health care providers and health care services in clinics and hospitals."¹²

The multi-speciality specialist

In Nepal's context the family physicians have to fulfil the role as multi-speciality specialist especially in first level referral hospitals like NGO/Municipality based general hospitals. Two-thirds of the unscreened patients presenting from the community to a general hospital, can be managed in a GP oriented hospital with appropriate basic facilities. It is neither possible nor justifiable to employ many different specialist doctors in a small general hospital to cover the health problems of different age groups, sex or body systems. The number of patients will be very low for each specialist so that the fulltime workload will be insufficient for the doctor's living is not cost effective for the institution. It is also impossible to hire part-time specialists in the periphery. Family physicians are playing key role in establishing general hospitals run by mission organisations, NGOs or the private sector as well as the district hospitals. These hospitals also make ideal environments for clinical teaching purpose for post-graduate family medicine as well as undergraduate training (e.g. UMH Tansen, Lifeline Hospital Damak, AMDA Hospital Damak, HMG/N district hospitals in Surkhet & Ilam).

Family Medicine in the Undergraduate Curriculum

What do family doctors have to contribute to medical education? There are two things to consider. Firstly, family doctors add value to the general medical curriculum for all students and secondly, the presence of family medicine departments within the medical school influences undergraduates to choose family medicine as a career.

The WHO – WONCA joint document of 2002 states that

"Family medicine with its dual emphasis on patient-centred care and population-based health care can add value to the medical school curriculum by providing all students with a solid foundation of generalist physician skills.... Family doctors may serve as important teachers and role models, demonstrating how to integrate the disparate aspects of medical training as they provide comprehensive

care to patients within the context of the patients' families and communities. These concepts are transmitted most effectively when taught throughout the medical school curriculum".¹⁰

No family medicine department is seeking to prepare a student to be fit to undertake general practice without further training and supervision. Rather, departments seek to train undifferentiated graduates who are skilled in facing the general diseases affecting 98% of the population, rather than the 1-2% who need to reach a specialised treatment centre. Students learn how to assess patients who present with undifferentiated problems, not clearly defined diagnoses. Training as a general practitioner comes as a next step. Family doctors are trained in areas of sorting out undifferentiated presentations, considering appropriate and rational investigations and treatments, and considering critically the evidence for interventions and treatments. All medical undergraduates will benefit greatly by being taught and mentored by doctors with this training and expertise especially "when taught throughout the medical school curriculum".¹⁰

"Departments of general practice and primary care are multi-disciplinary, multifunctional with interactions with specialities in clinical medicine, organ-based research, public health, education, nursing and allied health. They are ideally placed to develop inter-professional education".⁶ Kamien talks of the "debilitating effect of departmentalisation" on undergraduate medical education.⁵ General practice can reverse this. Colleges and associations of general practice and family medicine of the UK, Canada, USA and Australia recommend that departments of family medicine be established in all medical schools. Accrediting councils of these nations have made the inclusion of these programmes conditional for accreditation. This is supported by the World Organisation of Family Doctors.^{10,13,14} They have understood the invaluable contribution that can be made to the health of the nation through soundly based general practice.¹⁵

The second consideration is how to attract students to take family medicine as a profession. In the 2001 survey of existing family doctors in Nepal, the strongest factor associated with the current work in rural area was the place of growing up.⁸ and this is consistent with the "Arizona Study" (see below). Newcastle University (Australia) identified that selection criteria and curriculum style and emphasis have an influence on the attitudes that medical students possess and later develop towards primary care medicine.¹⁶

In the “Arizona Study” 2003, Senf, Campos-Outcalt and Kutob, identified the following issues to be important in influencing students to take up family medicine.

1. Select students, who are from rural areas, believe in primary care as important and who are not aiming for a high income profession.
2. Select students who come from lower income earning parents, though not necessarily of lower educational status
3. Give students contacts at all year levels with family doctors and trainees during their medical course
4. The more contact time students have with family doctors, the greater their influence
5. Provide good quality faculty to ensure positive role models (negative role models had a strong negative influence on undergraduates)
6. Develop a positive unofficial culture in the medical school that promotes family medicine. An official culture supporting family medicine will be totally nullified by underlying unsupportive and negative opinions in the backrooms. (Senf, Campos-Outcalt, Kutob 2003)¹⁷

WONCA goes on to add that governments need to

1. provide specialist training opportunities in family practice
2. provide incentives to encourage selection of careers in family practice
3. offer a variety of career opportunities in family medicine
4. support family medicine graduates with competitive salaries after training.¹⁰

Current GPs would support Lewis’ assertion that GPs are less likely to stay in rural areas and other areas of government service if the government does not revise its areas for promotion, provide opportunities for career development and provide adequate salaries for their levels of seniority and professional training.⁹ This is supported by the WHO Alma-Ata review in 1996.¹ To have qualified GPs participating in the training of other GPs means that they need recognition as clinical teachers both in academic status and reimbursement. To provide the best and most appropriate training and to maintain professional credibility, general practice must be taught by general practitioners in their primary and secondary care general practice settings, not tertiary teaching hospitals. “Without a successful model practice, teaching and research are limited” and credibility with other disciplines is undermined.¹⁸ Universities are challenged to explore new forms of

education, new relationships with the community, industry, government and others. It is essential that they incorporate different structures and change traditional education models to better equip students to be attuned socially “to meet the needs of the people they are to serve”.¹ Family practice must be taught in family practices by family doctors.

“Family Practice is a three dimensional speciality incorporating the dimensions of knowledge, skill and process”.¹¹ The knowledge and skills are shared with other doctors, but their particular combinations in one doctor and the process of practice are unique to family medicine. Transmitting these three dimensions of family practice to undergraduates will raise the quality of doctors of all specialities in Nepal while attracting more of them to take up the profession of Family Medicine. Transmitting these dimensions to postgraduate students will amply and appropriately equip them to meet the health care needs of most of the people of Nepal as skilled and competent family doctors.

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