

What shall we do for family medicine?

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Abstract

In November 2014 the Pakistan Medical and Dental Council directed that Family Medicine should be taught to final year medical students. Family Medicine will be strengthened as a result. This paper considers some implications of the decision, identifying first the need for more information on primary care services, especially in the private sector, to enable planning of the curriculum and attachments to public and private units. The challenges to medical colleges in providing what will be largely experiential learning are described and the importance of training practitioners is emphasised. The urgent need to overcome the virtual absence in Pakistan of postgraduate training in Family Medicine described, and the quality standards of primary care are explored and the need for attention in the face of student learning is described. Recommendations are offered, including an advisory board on Family Medicine to audit its introduction and performance.

Keywords: Family Medicine, Student learning, Health information, Quality standards, Postgraduate training.

Introduction

Family Medicine, a synonym used for general practice in many countries, refers to the provision of primary care to individuals and family members, from the youngest to the oldest, within the context of the family and the community, and with emphasis on health promotion and disease prevention. The directive of Pakistan Medical and Dental Council (PMDC) in November 2014 that all medical colleges must introduce training in Family Medicine in final year and establish departments of Family Medicine is notable for many reasons, but principally for raising the status of Family Medicine. The training will bring awareness of the subject to medical students and through them to families and friends. Its presence may awaken hospitals and their staff to the importance of Family Medicine in healthcare and help to redress the disparagement

experienced by students and graduates contemplating such a career. Most importantly, the training will energise the campaign for postgraduate programmes in Family Medicine, which hardly exist in Pakistan.¹

The start of training in Family Medicine will raise issues relevant to student learning, such as knowledge of the current state of primary care. This information will help determine the best sites for student attachments for on-the-job learning.

Becoming informed about primary care

Enquiry has shown there were 5,428 Basic Health Units (BHUs) and 602 Rural Health Centres (RHCs) in Pakistan in 2012, a total of 6,030 public primary care facilities.² There is little information on private primary care; the latest found was from 2006 when there were reported to be 73,650 units.³ The Pakistan Social and Living Standards Measurement (PSLSM) Survey 2012-13 showed the relative usage of these facilities for medical consultations.⁴ In Pakistan, 71% consultations were at private hospitals or clinics, 18% at government hospitals or dispensaries and 3% at BHUs and RHCs. In Punjab there was a greater disparity, with 75% at private hospitals or clinics, 17% at government hospitals or dispensaries and 1% at BHUs or RHCs. One may ask, and it is to be hoped students will ask: why the disparity in usage?

A suggested reason for the fairly gross differences is the quality of facilities and services in different locations. In 2006 it was reported that "the quality of care in BHUs is variable but is generally poor. Most centres either operate only a few hours a day or have been closed. Staff absenteeism is rampant."⁵

One study in 2011 found that "primary healthcare services in Pakistan, particularly in rural areas, are in a dismal state. Inadequacies, unfairness and ignorance about the importance of basic healthcare provided by these facilities have led to a disorganised and poorly performing system. Inadequate medicines and supplies, underutilised family planning services, lack of human resources, faulty equipment, and absence of a proper referral mechanism were some of the key findings".⁶

A 2014 report on antenatal care in a group of BHUs in

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Punjab found that only 54% of pregnant women were enrolled in antenatal clinics and the services they received - the history-taking, examination and counselling - were "extremely compromised".⁷ A third of the 54% dropped out of care. Is this a factor in the very high maternal mortality rate (MMR) in Pakistan?

Unease about the standards of care in public primary healthcare suggest that information is needed on BHUs and RHCs that may be suitable for student training. The much greater number of private practices will lead to their consideration for training, but almost nothing is known about them, their staff, structure, facilities or the care provided. A Pakistan government review of private healthcare units published in 2001⁸ was quoted in 2014 as showing there were more than 73,000 private healthcare institutions.⁹ There appears to be no other information on this large part of primary healthcare. One study commented in 2010 that there had been no health facility census and no mechanism for registration of these facilities.¹⁰ A health management information system gives information on public primary care activity, but has not been instituted in the private system in the absence of registration. More will be needed as student attachment becomes a reality.

Introducing Family Medicine to the medical course

Bringing Family Medicine into final year learning is long overdue. The process will present medical colleges and their new departments with many challenges. The first will be the establishment of a curriculum, preferably on a national basis. A challenge exists even in this, since colleges have not been given guidance as yet on the content of the final year that should be devoted to the new subject. Other countries, such as Australia, devote up to 12 weeks of a clinical year to Family Medicine or its equivalent, general practice. A formidable challenge will be recruitment of teaching and supervising staff, a problem in the virtual absence of postgraduate training in Family Medicine. Much student learning overseas comes from attachment to medical practices, and colleges will need to seek doctors keen to offer themselves and their teams as training centres. Discussions in Punjab show both enthusiasm for the programme and readiness to participate, something repeatedly shown in Australia. Training may be in urban or rural areas, in public sites, BHUs or RHCs, or private practices. In every case the choice of places will involve setting of requirements by the department, a site visit and completion of an affiliation agreement between the practice or unit and the medical college.

Another challenge for Family Medicine departments will be provision of audit of the programme and assessment of the students' performance. The first may be by feedback from both teachers and students, while the second will be by formative assessment in the practice, from student case reports and from a final examination. The last will be aided in Punjab by the central process provided for affiliated colleges by the University of Health Sciences (UHS), Lahore.¹¹ Studies from other countries tell that students show enthusiasm in Family Medicine and equivalent courses. More importantly, their perception of the subject is generally heightened by the training, and leads to increased intentions to pursue Family Medicine as a career.^{12,13} With this expectation in mind, it is imperative that postgraduate training be available.

Postgraduate training in Family Medicine

The need for organised postgraduate training in Family Medicine in Pakistan was emphasised in 1992, and a 1989 residency programme at Aga Khan University, developed in conjunction with the College of Physicians and Surgeons, was described.¹⁴ For decades this was the only such training in the country and most of its graduates have gone abroad.

One study declared in 2001 that a "sad state of affairs exists in Pakistan. Medical officers in government health centres and general practitioners in private clinics practise outpatient medicine with no training, supervision or accountability. As medical students they do not receive training in general practice. They learn from mistakes, pharmaceutical representatives and market competition".¹⁵

The virtual absence of training became evident during assessment of postgraduate training undertaken in 2006-07 and led to workshops in Lahore and formation of a Steering Committee on Postgraduate Education in Family Medicine. A training programme is shortly to begin, as one step in making new career opportunities for medical graduates. The need becomes urgent as students learn the principles and skills of Family Medicine and become acquainted with its possibilities. In due time, training will become mandatory for practice in Family Medicine, as is the case in Britain, Australia, Canada and the United States. Training in the subject is likely to have the added outcome of raising the quality standards in practices; something of satisfaction to all.

Raising the quality standards in primary care

The need for new attention to quality standards in primary healthcare is evident in the plethora of reports in Pakistan about poor outcomes in clinical care. One study

told of deficient standards observed in visits to primary care.⁶ It said that the BHUs lacked essential medicines for treatment of acute respiratory infections and diarrhoea, illnesses that should be treated at this level of care. It found immunisation coverage to be low in rural populations served by public facilities; the vaccines were kept in private homes because there was no working refrigerator in the BHUs. Shortcomings in specific clinical presentations have been widely described. Under-diagnosis and under-treatment of hypertension in general practice was reported in 2009;¹⁶ inadequate knowledge and of diagnosis and management of acute myocardial infarction (AMI) was reported in 2009;¹⁷ inadequate informing of patients with psychiatric illnesses was demonstrated in 2009;¹⁸ the overuse of injections was reported in 2005;¹⁹ unsatisfactory diagnosis and treatment guidelines for tuberculosis (TB) was found in 2003,²⁰ 2005²¹ and 2010.²² The need for attention to quality standards in primary care is even more important as training of medical students in Family Medicine is introduced.

According to one 2006 study, "If quality of care is not high on the agenda, a quality culture will never be fostered."²³

A National Council for Healthcare Quality was recommended by the study but no further reference to it has been found. The National Health Service in the United Kingdom has established a Care Quality Commission whose task is to ensure that hospitals, general practices and other health institutions provide safe, effective, compassionate and high quality healthcare.^{24,25} It pursues this aim by inspecting services and publishing the findings to help people make better decisions on their care. Its ratings are 'Outstanding', 'Good', 'Requires improvement', and 'Inadequate' reparative measures and further visits follow the last two levels of report. A modified system of this kind may have attraction for Pakistan as a method of setting quality standards in healthcare and regular monitoring of their achievement. It would be especially valuable in demonstrating to students the importance of quality in the healthcare about which they are learning.

Discussion

In asking what shall we do for Family Medicine, this paper raises with a meaning of intent rather than wishfulness some of the ramifications of the PMDC directive. The first matter is the need for information. While there are regular revisions of data on public primary care, there is a serious deficiency in that on private practices, their staffing, facilities, services and charges; a process made harder by the absence of

registration of practices and clinics. The lack of data also presents a problem for those planning placements of students of Family Medicine in practices and clinics and leads to a set of recommendations.

Recommendation One

A comprehensive review of both public and private primary care providers and facilities shall be undertaken forthwith. The introduction of student training in Family Medicine is expected to raise its status through building understanding of its family and community basis and its emphasis on health promotion and disease prevention. In the virtual absence until now of postgraduate training in Family Medicine, the coming of undergraduate training may even be seen as leading to a revival in the subject and primary healthcare generally. The planning of curricula and courses in the new subject are a major challenge. Following best overseas examples, there is likely to be an emphasis on experiential learning, provided by student attachment to approved family doctors and their practices or public facilities like RHCs or BHUs. Much advantage to students has been seen overseas in learning in rural practices and hospitals, where they gain greater attention and can more readily access community health systems. They may also do better at final assessments.²⁶ The encouragement and support by medical colleges of Family Medicine practitioners in urban and rural practices is an essential element of developing programmes of instruction for medical students. They should be offered training, as needed, assistance with facilities and college recognition.

Recommendation Two

The importance of the potential contribution of primary care practitioners, in private and public practice, in the development of training in Family Medicine shall be recognised by medical colleges and universities.

The void in postgraduate training in Family Medicine in most parts of Pakistan requires urgent attention now that all students are to be trained in the subject. An important aspect of undergraduate training is the awareness it gives of the specialty — for such it is — and the belief that students will increasingly seek to pursue Family Medicine as a career. Until now, a majority of medical graduates opt for primary care as a default, seeing no other opportunity, and, following the oft-used saying, they look for a house or a shop and open a practice.¹ The demands of quality primary care, as epitomised in the Millennium Development Goals (MDGs) for maternal and child health, require structured training for Family Medicine as for all other specialties. It is hoped that the current activity of

PMDC will soon extend to enlarging postgraduate training in Family Medicine, even going so far as making it mandatory for those seeking entry to primary care.

Recommendation Three

The PMDC should call for wider availability of postgraduate training for Family Medicine and consider training as mandatory for those entering such practice.

As described above, concerns about the quality standards of primary healthcare in Pakistan are legion. There are regular reports on such things as immunisation, the attendants at births and the care of childhood diarrhoea, but standards of healthcare in primary care are largely absent and rarely audited. The need for such standards and their regular assessment are essential if the health standards of the population are to attain international goals. The failure to meet the MDG for maternal mortality is evidence of the need for a new approach. The British Care Quality Commission provides an example of a constructive approach.

Recommendation Four

The government should introduce acceptable standards for primary healthcare in both public and private sections together with a system of inspections and reports.

The introduction of Family Medicine training in medical colleges provides challenges in many parts of healthcare. While planning and provision of this training is going ahead rapidly, methods of moving in the other matters raised need direction.

Recommendation Five

A national or provincial advisory board on Family Medicine shall be established to receive reports on training and conduct audits at both undergraduate and postgraduate levels and to report to government.

Conclusion

The introduction of training in Family Medicine in medical colleges has implications in several parts of Pakistan's health system. The need for greatly expanded information on primary healthcare, especially in the private system is described both as a means of improving healthcare and in planning and providing this training. The importance of primary care practitioners in provision of experiential learning for students is outlined and the need for recruitment and then support and recognition of practitioners as trainers is emphasised. The virtual absence of postgraduate training in Family Medicine has been a weakness in Pakistan's healthcare. Training of students

in Family Medicine brings urgency to the development of postgraduate training so that students may access a structured career in the subject. A call is made for establishment of quality standards in primary care and regular audit of performance. An attractive system is described. Finally, an advisory board on Family Medicine training is recommended.

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